

**SOCIAL MARKETING STRATEGIES FOR COMBATING HIV/AIDS
IN RURAL AND/OR DISADVANTAGED COMMUNITIES
IN MEXICO, UGANDA, AND THE UNITED STATES**

VOLUME 1

RUTH E. MASSINGILL

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ABSTRACT

With more than 33 million people living with HIV/AIDS, and an infection rate that is increasing rather than falling among high-risk groups, the 30-year history of the AIDS epidemic has been characterised as *'islands of success in a sea of failure.'* Given the lack of a medical cure for the disease, the world has looked to social marketing campaigns to promote behaviour change that would decrease infection rates. Under the best of circumstances, change is difficult, and health behaviour change, especially when it relates to sex and politics, is even more challenging, so social marketers have a difficult task that calls on every technique at their disposal. There is an increasing expectation that HIV/AIDS social marketing interventions will yield measurable results, and that involves fully understanding the AIDS landscape, marketing theory and practice, and the evolving medical picture relating to the pandemic.

This research explores links between social marketing and HIV/AIDS while mapping their marketing connections to both the conventional and alternative medical communities. To better understand the HIV/AIDS landscape, early research focused on three diverse countries— Mexico, Uganda, and the United States—selected for their significant cultural, economic, and political differences.

Given the multiple social perspectives and fields of knowledge involved in this project, a transdisciplinary approach using mixed research methods was selected. Mixed methods for collecting and presenting data included case studies, content analysis, semi-structured interviews, a quantitative survey, and in-depth reaction interviews. Through analysis of 18 social marketing campaigns in the three countries selected for study, the content, focus, purpose, and implications of the controlled public dissemination of HIV/AIDS information were examined. Key informants with professional and academic credentials in the areas of marketing, advocacy, and HIV/AIDS medicine were interviewed to learn rationales behind the campaigns and to explore political and economic factors that affect HIV/AIDS health activism. The last major phase of information gathering surveyed more than 340 patients at a clinic in Houston, Texas, to ascertain their knowledge and perceptions about HIV/AIDS treatment and prevention information. After the survey data was compiled, reaction interviews from key informants provided additional input. Informed by this wealth of secondary and primary research, an Integrated Social Marketing Conversation (Marcon)

Model was created to demonstrate that social marketing campaigns should be localised and customer centred, with participants engaging in an ongoing conversation at every stage. The communication model offers valuable guidelines for more effective dissemination of HIV/AIDS prevention and treatment information to high-risk, high-interest target audiences such as HIV-positive people and the organisations that work with that subculture.

Because this research crosses so many boundaries and addresses an actual need, it should be of interest to a wide variety of individuals and organisations in both academic and professional fields. From marketers to medical practitioners to activists associated with HIV/AIDS issues, this project's findings will apply to their concerns. Also, HIV/AIDS organisations—both government agencies as well as private groups—should find information in this work that addresses their ongoing efforts.

While investigating existing models for HIV/AIDS communication, it became evident that most research and communication models have focused on how HIV/AIDS prevention programmes are working and what is effective, but little has been done in regards to treatment options and information. For that reason, the integrated social marcon model presented in this thesis is an important addition to the body of practical literature on this topic.

Finally, the volatility of the issues examined here and the contacts made during five years of work offer multiple possibilities for follow-up research and fieldwork with opportunities to make a positive contribution in the battle against the HIV/AIDS pandemic.

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TRANSDISCIPLINARY GLOSSARY

AIDS – *Acquired Immune Deficiency Syndrome*

The last and most severe stage of the clinical spectrum of HIV-related diseases. HIV wears down the body's immune system, so people who have HIV may develop AIDS as their immune systems become weaker and unable to fight off infections (Global AIDS Alliance, 2009).

AIDSCAP – *Aids Control and Prevention Project*

Sponsored by Family Health International (FHI), a global health and development organisation established in 1971 whose science-based programs aim to bring lasting change to the world's most vulnerable people (Family Health International, 2010).

AVERT – *Averting HIV and AIDS*

An international AIDS charity that collects and disseminates statistics and other information about the disease (AVERT, 2010a).

ARV/ART – *Antiretroviral Drugs / Antiretroviral Treatment*

Antiretroviral drugs are the class of drugs used to treat HIV/AIDS. ARVs do not kill HIV, but they do slow its growth (Global AIDS Alliance, 2009).

AZT – *Azidothymidine*

The first drug approved to treat AIDS (1987), but it did not prove to be reliably effective (Segala, 2003).

B2B – *Business to Business*

When a business sells products or provides services to other businesses. Although B2B business activity exists both online and offline, the acronym is often used to describe the online variety (Marketing terms.com, 2010).

BCC – *Behaviour Change Communications*

A core strategy in the response against HIV/AIDS in many countries, 'BCC is the process by which information and skills are shared and disseminated to people in the specific target audience with the intention of influencing them to adopt sustained changes in sexual behaviour or attitude, or to engage in other health-seeking behaviour' (Long, 2006, p.5).

BTL – *Below the line*

Using channels such as online, search, direct mail, direct response TV, direct response print, inserts, and promotions to reach targeted individuals, as opposed to above-the-line (ATL) mass media such as television, radio, newspapers, magazines, and yellow pages (Russo, 2006).

CALD – *Culturally and Linguistically Diverse*

The divisions of race, ethnicity, and culture have been found to affect HIV exposure and timeliness of diagnosis in both developing and industrialised countries. Globally, health and human service organisations are recognising the need to enhance services for culturally and linguistically diverse populations (Centers for Disease Control, 2010b).

CAM – *Complementary and Alternative Medicine*

A group of diverse medical and health care systems, practices, and products that are not considered to part of conventional medicine. Complementary medicine is used together

with conventional medicine and alternative medicine is used in place of conventional medicine (National Center for Complementary and Alternative Medicine, 2010).

CDC – *Centers for Disease Control and Prevention*

The United States federal agency whose mission is to protect public health and safety by protecting health and promoting quality of life through the prevention and control of disease, injury, and disability (Centers for Disease Control, 2010a).

CENSIDA – Mexico’s National Centre for Prevention and Control of HIV/AIDS

Since 1988 this national agency has actively promoted prevention and control of HIV/AIDS through public policy (CENSIDA website, 2010).

CFA – *Center for AIDS Information and Advocacy*

Based in Houston, Texas, CFA advocates both locally and nationally for better treatments and better access to care for those living with HIV/AIDS and works with the Houston medical community in the search for a cure (Center for AIDS Information and Advocacy, 2010).

CSM – Condom social marketing

Programs that market condoms through traditional retail channels and usually include a focused IEC effort. Condoms are mainly sold, though a minority may be distributed free. There is typically one condom social marketing program per country (Condom Social Marketing, 2010).

CSW – *Commercial Sex Worker*

Individuals who exchange sex for money, food, clothing, shelter, or other basic necessities. Those involved in exchange sex are at high risk of contracting HIV/AIDS (Global AIDS Alliance, 2009).

Downstream Social Marketing

Marketing that aims to influence behaviour in individuals, as opposed to Upstream Social Marketing, which targets the level above the consumer—such as government leaders, NGOs, and other policymakers—to affect long-term social mobilisation and change that benefits the downstream individuals (Andreasen, 2006).

Drug Cocktail – *See HAART*

FBO – *Faith-Based Organisation*

Nonprofit groups based in a religious ideology that often sponsor humanitarian projects.

GFATM – *Global Fund to Fight AIDS, Tuberculosis and Malaria*

An independent international partnership that funds grants written and overseen by partnerships of local organisations in 128 countries (Global AIDS Alliance, 2009).

HAART – *Highly Active Anti-Retroviral Therapy* *See Drug Cocktail*

Most commonly used drug treatment, first available in mid-1990s. Uses a cocktail of three classes of drugs, which suppress but do not eliminate the virus (Segala, 2003).

HIV – *Human Immunodeficiency Virus*

A retro-virus that damages the human immune system thus permitting opportunistic infections to cause eventually fatal diseases. HIV can be transmitted through blood, sexual contact, or during pregnancy, labour, delivery or breastfeeding (Global AIDS Alliance, 2009).

HIV-positive

The HIV virus is detectable in the blood, but there are few or no symptoms. Many HIV people do not realise they are infected (Segala, 2003).

HIV prevalence rate

The total number of persons (usually adults aged 15-49) with HIV infection alive at any given moment in time (Michiels, 2001).

IAEN – *International AIDS Economics Network*

Their principal objective is to help AIDS economists and policymakers in developing countries interact more effectively with global colleagues to promote compassionate, cost-effective responses to the pandemic (International AIDS Economics Network website, 2010).

IEC – *Information, education and communication*

A critical technique for achieving universal access to HIV prevention, treatment, care and support. However, IEC must be combined with other interventions to succeed (UNAIDS, 2010).

IMC – *Integrated Marketing Communication*

A synergistic approach to marketing in which disciplines such as advertising, sales promotion, public relations, and direct marketing work together in a consistent fashion (Kitchen & De Pelsmacker, 2004).

IRB – *Institutional Review Board*

Also known as an ethical review board, an IRB reviews research projects that involve human subjects to ensure subjects are not placed at undue risk, and that they give uncoerced, informed consent to their participation. IRBs are often associated with academic institutions, but there are also independent IRB services.

Marcom or MarCom or MARCOM – *Marketing Communications*

Traditionally, the most frequently used tool by social marketers has been mass media campaigns, called social marcoms campaigns (Noble, 2005).

Marcon or MarCon or MARCON – *Marketing Conversations*

Thanks to the growth of social media, marketing is becoming more participatory and personalised (Moran, 2007). A Google search for ‘marketing conversations’ locates numerous blogs, twitter accounts, and other online discussions about this change in marketing strategy.

Marketing Mix – *The 4Ps of Marketing*

The combination of product, price, place (distribution), and promotion.

MRS – *Market Research Society*

With members in more than 70 countries, MRS is the world’s largest association for market, social, and opinion research. Its Code of Conduct is designed to support professional industry standards and to reassure the general public that research is carried out in a professional and ethical manner (MRS website, 2010).

MSM – *Men Who Have Sex with Men*

After significant decreases in HIV/AIDS infection rates in the first decade of the

disease, transmission rates among MSM are once again on the rise in the U.S. and many European countries due to sexual risk behaviours (Coates, et al., 2008).

MTCT – *Mother-to-Child Transmission*

Mother-to-child transmission of HIV can occur during pregnancy, labour and delivery, or breastfeeding. Prevention of mother-to-child transmission is one of the most cost-effective interventions available (Global AIDS Alliance, 2009).

NGO – *Non-Government Organisation*

Groups that are not part of a government, sometimes called non-profit or civil-society organisations.

NIH – *National Institutes of Health*

A part of the U.S. Department of Health and Human Services, NIH is the largest source of funding for medical research in the world (National Institutes of Health, 2010).

PAHO – *The Pan American Health Organisation*

An international public health agency with more than 100 years of experience in working to improve health and living standards of the countries of the Americas (Pan American Health Organisation, 2010).

PANCEA – *Prevent AIDS Network for Cost-Effectiveness Analysis*

An NIH-funded research project that gathers information to help increase the efficiency of HIV prevention programs. PANCEA has studied prevention in India, Russia, Mexico, South Africa, and Uganda (Prevent AIDS Network, 2010).

PEP – *Post-Exposure Prophylaxis*

Taking prescribed antiretroviral medications (ARVs) as soon as possible after exposure to HIV, to avoid HIV infection. PEP must begin within 72 hours after exposure to HIV (AIDS.org, 2009).

PEPFAR – *President's Emergency Plan for AIDS Relief*

Proposed by President Bush in 2003 as the U.S. government's 5-year, \$15 billion response to the HIV/AIDS pandemic. In 2009, legislation authorised up to \$48 billion over the next 5 years to combat global HIV/AIDS, tuberculosis, and malaria (About PEPFAR, 2010). The acronym is sometimes said to stand for *Purchasing Expensive Pharmaceuticals from American Retailers* since Bush appointed former head of pharmaceutical giant Eli Lilly to head the initiative (Pisani, 2008, p.285).

PLWHA – *People Living with HIV/AIDS*

Globally, more than 33.4 million people are living with HIV/AIDS. The number has increased every year since the disease was identified in the early 1980s (UNAIDS, 2009a).

PMTCT – *Prevention of Mother-to-Child Transmission* See MTCT

PSI – *Population Services International*

A leading global health organisation with programs targeting malaria, child survival, HIV, and reproductive health. PSI was the first international organisation to use social marketing to combat AIDS (PSI website, 2010).

PSP-One – *Private Sector Partnerships for Better Health*

USAID's flagship project to increase the private sector's provision of high-quality health products and services in developing countries (PSP, 2005).

SM – *Social Marketing*

Defined in 1971 by Kotler and Zaltman as '...the application of the principles and tools of marketing to achieve socially desirable goals' (Kotler & Zaltman, 1971, p.5).

SMART – *Social Marketing Advances in Research and Theory*

A Canadian-based international conference first held in Alberta in 2004.

SPSS – *Statistical Package for Social Sciences*

A popular computer program used for statistical analysis. IBM owns the company.

STD/STI – *Sexually Transmitted Disease/ Sexually Transmitted Infection*

Infections transmitted through vaginal, oral, or anal sex, which are an important risk factor for HIV transmission (Global AIDS Alliance, 2009).

TD Research – *Transdisciplinary Research*

Characterised by the intent to solve real world problems that are complex, multi-dimensional, and not confined by the border of a single discipline. TD research pulls from both scientific and academic expertise to develop knowledge and theory that integrates science and society (Tress, et al., 2006).

UNAIDS – *Joint United Nations Programme on HIV/AIDS*

A joint venture of 10 United Nations organisations with goals for HIV prevention and treatment (UNAIDS, 2009b).

UNESCO – *United Nations Educational, Scientific and Cultural Organisation*

A founding cosponsor of UNAIDS and the lead organisation for HIV prevention with young people in educational institutions, with the goal of universal access to prevention programmes, treatment, care and support (UNESCO web site, 2010).

Upstream Social Marketing – See also Downstream Social Marketing

Social marketing partnerships that include governments, non-government organisations (NGOs), international agencies, and private businesses working in conjunction with downstream targets to create long-term social change (Andreasen, 2006).

USAID – *United States Agency for International Development*

The U.S. government agency responsible for the majority of foreign aid for HIV/AIDS (USAIDS, 2005b).

WHO – *World Health Organisation*

An agency of the United Nations, founded in 1948 to act as a coordinating authority on international public health (World Health Organisation website, 2010).

World AIDS Day – *December 1 each year since 1988*

Established by WHO to raise awareness of the HIV/AIDS pandemic. For several years, the theme was *Stop AIDS. Keep the promise* (World AIDS Day, 2009).

CHAPTER 1

INTRODUCTION

1.1 OVERVIEW

This project is best introduced as a thesis of threes; it encompasses three intersecting topics, incorporates research from three countries, draws perspectives from three disciplines, and examines the global implications of cultural, political, and economic factors.

The combination of topics—social marketing, HIV/AIDS, and conventional and alternative medicine (CAM)—is unusual but vitally important, given the tragic scope and devastation of the HIV/AIDS pandemic. This research explores links between social marketing and HIV/AIDS while mapping their marketing connections to both the conventional and alternative medical communities. Although it is not unusual to find literature relating to aspects of any two of these topics, all of these concepts are rarely woven together. However, initial study indicated justification for connecting these ideas and examining implications that emerged.

The researcher began with three preliminary hypotheses:

H1. International organisations, in conjunction with pharmaceutical companies with vested financial interests, use social marketing to selectively disseminate HIV/AIDS prevention and treatment information.

H2. Social marketing campaigns for HIV/AIDS are likely to be targeted toward specific audiences in rural and/or economically depressed communities.

H3. These social marketing campaigns tend to establish conventional products and treatments as the norm while ignoring increasingly accepted alternative modalities.

To better understand the HIV/AIDS landscape, early research focused on three diverse countries— Mexico, Uganda, and the United States—selected for their significant cultural, economic, and political differences. Through analysis of 18 social marketing campaigns in those countries, the content, focus, purpose, and implications of the controlled public dissemination of HIV/AIDS information were examined. Key informants with professional and academic credentials in the areas of marketing, advocacy, and HIV/AIDS medicine were interviewed to learn rationales behind the campaigns and to explore political and economic factors that affect HIV/AIDS health

activism. The last major phase of information gathering surveyed patients at a clinic in Houston, Texas, to ascertain their knowledge and perceptions about HIV/AIDS treatment and prevention information. After survey data was compiled, in-depth reaction interviews from key informants provided additional input.

Informed by triangulating this combination of qualitative and quantitative information, the researcher created a transdisciplinary audience-centred model designed to localise and personalise communication regarding health choices available to prevent and treat HIV/AIDS.

1.2 OVERALL RESEARCH AIM

The overall aim for this project was to explore the overlapping landscapes of HIV/AIDS, social marketing, and conventional and alternative medicine with the goal of better understanding those shifting relationships and of using that new knowledge to design a communication model for disseminating information about HIV/AIDS prevention and treatment options.

1.2.1 Research questions and sub-questions

Due to its *'logical and intuitive appeal'* (Onwuegbuzie & Leech, 2006), a sequential mixed methods approach was chosen for this research design. *'Philosophically, it is the "third wave," or third research movement, which moves past the paradigm wars by offering a logical and practical alternative'* (Johnson & Onwuegbuzie, 2004). Formulating mixed method research questions is especially difficult since both qualitative and quantitative components must be incorporated within the same inquiry (Exploring, 2007). Another complication with mixed methods research questions is that they evolve as the research progresses, according to Onwuegbuzie and Leech: *'Research questions occupy a place in the mixed methods research process that is central, interactive, emergent, and evolving'* (2006). Writing two or three overarching 'grand tour' research questions, each accompanied by five to seven more narrowly focused sub-questions is an established approach in mixed methods research (Plano Clark & Creswell, 2011; Opfer, 2011).

(See Chapter 4, Sections 4.2, 4.3, and 4.4 for further discussion on methodological choices for this study.)

With the initial hypotheses and the overall research aim as context, three ‘grand tour’ research questions, each with a series of specific sub-questions, were constructed to provide a framework for this study.

Research Question 1:

How have the evolving landscapes of HIV/AIDS, social marketing, and conventional and alternative medicine forged global and national relationships and interactions?

Sub-questions and the chapters where those questions are addressed are as follows:

1. What is social marketing? (*Chapter 2*)
2. How does social marketing work and what can it accomplish? (*Chapters 2 & 3*)
3. How has social marketing been used to combat HIV/AIDS in both developing and industrialised countries? (*Chapter 2*)
4. What political and economic factors affect dissemination of information about HIV/AIDS treatment and prevention? (*Chapter 2*)
5. What role have the media played in the HIV/AIDS dialogue? (*Chapter 2*)
6. Which are the primary HIV/AIDS treatments offered by conventional medicine and by CAM (Complementary and Alternative Medicine)? (*Chapter 2*)
7. What is the current and projected scope of the disease in Mexico, Uganda, and the United States? (*Chapter 2*)

Research Question 2:

Could social marketing influence better-informed behavioural change by including both conventional and alternative medical information in HIV/AIDS campaigns?

Sub-questions and the chapters where those questions are addressed are as follows:

8. What are specific examples of recent HIV/AIDS social marketing campaigns in the target countries? (*Chapter 5*)
9. What commonalities and unique characteristics can be identified as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used? (*Chapter 5*)
10. From the viewpoint of opinion leaders such as marketers, humanitarian activists, and medical practitioners—both conventional and alternative—what factors influence choices about dissemination of HIV/AIDS information? (*Chapter 7*)
11. How are sponsorships selected and how are campaigns evaluated? (*Chapter 7*)

12. Do international business interests influence social marketing's dissemination of HIV/AIDS prevention and treatment information, thereby establishing conventional products and treatments as the norm? (*Chapter 7*)

Research Question 3:

What practical contribution could social marketing make to bridge the knowledge gap between conventional and alternative medical choices for HIV/AIDS prevention and treatment?

Sub-questions and the chapters where those questions are addressed are as follows:

13. Where do recipients of HIV/AIDS information learn about the disease? (*Survey, Chapter 7*)
14. How credible do these recipients consider their information sources to be? (*Survey, Chapter 7*)
15. What perceptions and knowledge do these recipients have about HIV/AIDS? (*Survey, Chapter 7*)
16. How do recipients of HIV/AIDS information perceive their choices as regards prevention techniques and treatment modalities? (*Survey, Chapter 7*)
17. Could social marketing bridge the knowledge gap between conventional and CAM choices for HIV/AIDS prevention and treatment? (*Chapter 8*)
18. What elements should be incorporated in a social marketing campaign to effectively communicate about HIV/AIDS prevention and treatment options? (*Chapter 8*)

1.3 IMPORTANCE OF RESEARCH

This research is important because it is both global and local, and because it is academic as well as practical. Also, this project takes a transdisciplinary approach to examine connections between topics that often would be considered separately. This holistic style of inquiry involves collecting and analysing a great deal of information. The integrative process applies Tress and colleagues' knowledge cycle, in which existing expertise is applied to solving real-world problems, followed by reflection on how to make the knowledge assessable to others (Tress, et al., 2006).

Because the research crosses so many boundaries and addresses an actual need, it should be of interest to a wide variety of individuals and organisations in both academic and professional fields. From marketers to medical practitioners to activists associated

with HIV/AIDS issues, this project's findings will apply to their concerns. Also, HIV/AIDS organisations—both government agencies as well as private groups—should find information in this work that addresses their ongoing efforts. Additionally, the key informants and the survey respondents who participate in the research will have a forum for their observations and opportunities to share knowledge and make new contacts through being involved with the project. Finally, increased visibility generated by publication of these research findings will contribute to knowledge and, it is hoped, increase understanding and commitment to education about HIV/AIDS prevention and treatment.

1.4 DEFINITION OF TERMS

One commonality of the disciplines under study is a high jargon factor—each uses numerous acronyms and terminology that can be confusingly obscure to those outside the discipline. Also, a number of these specialised terms have powerful connotations and cultural associations that are considered insulting or biased by specific groups. Adding to the verbal complexity is the fact that the meanings associated with some terms are in flux; what was once acceptable may now be deemed inappropriate or condescending. This is especially true of ethnic terms such as black or white, where the politically correct designations vary across time and geography. For this project, the U.S. Census Bureau's terminology was used when referring to ethnic groups (Fact sheet, 2010).

Social marketing draws on much of the established terminology in commercial marketing, such as the 4Ps (product, price, place, and promotion), and IMC (Integrated Marketing Communications), but social marketing adds such descriptors as 'upstream' and 'downstream' to distinguish between policymakers and consumers. Social marketing is increasingly confused with social media, especially when the two terms intersect, creating social media marketing. Marcom, the coined term for marketing communications, is sometimes being replaced by marcon, short for marketing conversations, to indicate the move toward personalised, participatory communication.

HIV/AIDS, an acronym for Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome, has an even shorter history than social marketing, but encompasses a world of specialised terminology, especially in relation to the gay community. The terms heterosexual and homosexual are fraught with hidden meanings and pitfalls. Both terms are rarely used in everyday speech, but the slang terms people are more likely to use can be abusive. Homo, used as a pejorative slang term since the

1920s, is the Greek root for ‘same,’ thus its connection to ‘homosexual,’ but it is also a Latin word meaning man, as in ‘homo sapiens’ (Baldi, 2010). Homosexual, which is not currently considered sex specific, was first used by *‘Victorian scientists who regarded same-sex attraction and sexual behaviour as symptoms of mental disorders or moral deficiency’* (AVERT, 2010d). Homosexual men and women adopted the term ‘gay’ to distance themselves from the connotation of being abnormal or ill.

The term gay may come from the nineteenth century French slang for a homosexual man—‘gaie’ (AVERT, 2010d). Gay is used to describe both homosexual men and lesbian women, but has become more associated with homosexual men. In the 1960s gay rights came into everyday use and was associated in a positive way with a sense of identity for homosexual individuals. Lesbian, currently used to refer to homosexual women, is derived from Lesbos, the Greek island where the lesbian poet Sappho lived. ‘Straight’ as a description for heterosexual people is an equivalent term to ‘gay’ (AVERT, 2010d). Numerous specialised terms have come out of the closet and into everyday use as the HIV/AIDS epidemic has become a topic of public discourse. Acronyms such as MSM (men who have sex with men), PLWHA (people living with HIV/AIDS), and CSW (commercial sex worker) are commonly used to segment target markets for social marketing initiatives. Where HIV/AIDS and social marketing intersect, new terms such as condom social marketing (CSM), have arisen.

Organisations involved with HIV/AIDS social marketing often use acronyms, such as WHO (World Health Organisation) and UNAIDS (Joint United Nations Programme on HIV/AIDS). Types of organisations are also designated with acronyms; NGO (non-government organisation) and FBO (faith-based organisation) are two examples. In the medical arena, acronyms pepper the literature, from abbreviations for cumbersome treatment names such as HAART (Highly Active Anti-retroviral Therapy) to CAM (Complementary and Alternative Medicine). To help the reader wind his or her way through this alphabet jungle, a glossary of acronyms and special terms is provided in the preface of this thesis. (*See Transdisciplinary Glossary, pp. viii-xvii.*)

1.5 RESEARCH FRAMEWORK

Given the multiple social perspectives and fields of knowledge involved in this project, a transdisciplinary (TD) approach using mixed research methods was selected. Wickson and colleagues explained that transdisciplinary research is *‘performed with the explicit intent to solve real world problems that are complex....multidimensional, and not confined by the boundaries of a single disciplinary framework’*(2006, p.1047). This

project also fits Wickson's contention that transdisciplinary methodology evolves in an *'iterative relationship with the research...in response to the research context and the learning and changing perspectives of stakeholders'* (p.1048), who become collaborators in generating new knowledge. Tress and co-authors agreed that TD studies cross scientific and academic boundaries to develop *integrated 'knowledge and theory among science and society'* (2006, p.16). Additionally, a transdisciplinary approach incorporates the concept that complexity and paradox exist as a result of different levels of reality, an idea inherent in many non-Western cultures and one that is useful in integrating the contradictions that often surfaced as this project evolved. Finally, TD research emphasises the importance of critical reflection, both on the personal level and across different bodies of knowledge and their methodological approaches (Wickson, et al., 2006).

Mixed methods for collecting and presenting data included case studies, content analysis, semi-structured interviews, a quantitative survey, and in-depth reaction interviews. These techniques were chosen based on the nature of the problem, personal experiences, and resources. A QUAL-QUAN-QUAL 'sandwich' provided abundant opportunities for cross triangulation while allowing the researcher to take advantage of the precepts of TD research. For each research phase, precise, detailed protocols were created and implemented to insure credibility and rigor.

1.6 THESIS STRUCTURE

The thesis consists of nine chapters and six appendices:

- In Chapter 2, a contextual literature review describes the AIDS industry and the roles of social marketing and the medical community. (The literature review was ongoing through all research phases due to the constantly changing landscape of the HIV/AIDS pandemic.) The chapter begins with a broad look at the three topics under study, then focuses more specifically on the HIV/AIDS landscape in Mexico, Uganda, and the United States through cultural, political, and financial overviews of each country.
- Moving from general to specific, Chapter 3 is a theoretical literature review that discusses the most common theories of health behaviour change used by social marketers, including Stages of Change, the model used by the Centers for Disease Control and Prevention (CDC) for all HIV/AIDS campaigns. Some consideration is also given to a discussion of whether social marketing is an effective public health tool with

the ability to effect lasting behaviour change. Since the major theories of health behaviour change include communication processes, this chapter also discusses branches of communication study and effects of emerging communication channels such as social media. Strategic and creative approaches that HIV/AIDS social marketers might find particularly useful for putting theory into practice are examined. This chapter helps limit the scope of inquiry, providing a framework as well as benchmarks for an ongoing dialogue.

- Chapter 4, a methodology for collecting and analysing secondary information, offers an overview of the research approach, and discusses exploratory research, the project timeline, and ethical considerations that must be considered when investigating such a sensitive topic as HIV/AIDS. Protocols for the literature review and the content analysis are presented and evolution of the methodology is discussed.

- Content analysis is used to examine three groups of six campaigns from the three countries under study in Chapter 5. To better manage the wealth of data collected, the information is divided into two broad groups: campaign design and campaign implementation. Cross tabulation matrixes are used to explore commonalities and differences between the 18 campaigns. An in-depth case study of an exemplary campaign for gender equity is included to demonstrate how a representative HIV/AIDS social marketing initiative can use tenets of the discipline to promote behavioural change.

- In Chapter 6, a methodology for collecting and analysing primary data discusses using a ‘sandwich’ of semi-structured interviews, surveys, and reaction interviews as the research moves from global to local in scope. A detailed protocol is presented for the survey design, sampling, data collection, and analysis. This chapter also outlines the method for constructing a communication model that integrates accumulated secondary and primary information to create a practical approach for an HIV/AIDS social marketing campaign. The chapter closes with a critical analysis of the methodology.

- Chapter 7 reports the results from the pre-survey interviews and from the survey responses. This chapter explains how the pre-survey interviews and pilot tests by experts guided the design and content of the survey. Survey results for three categories of information—media sources/credibility, perceptions and knowledge about

HIV/AIDS, and conventional and alternative treatments—are examined on three different levels.

- The culmination of the research project is presented in Chapter 8, which begins with a report of reaction interviews to the survey results. To address gaps in knowledge identified during the research project, the final phase created a communication model for an HIV/AIDS prevention and treatment campaign. The chapter discusses the elements and pitfalls of a communication model, then proposes a customised approach built on the secondary and primary data collected for this study. This new model represents a significant contribution to knowledge.

- In summation, Chapter 9 synthesises the trends and implications suggested by the research and maps relationships between the three topics under study. The initial hypotheses are revisited and the global implications of cultural, political, and financial factors relating to HIV/AIDS are examined. The chapter also includes a reflective critical review, discusses contributions to knowledge, and suggests future research directions.

- The wide variety of references—secondary and primary—is documented after Chapter 9. Sources consulted cover a variety of disciplines and are taken from a multitude of publications and media. Due to the ever-changing nature of the data, a number of sources were taken from online publications, which often offered the most up-to-date material available.

- Appendices A through F include all documents and background materials mentioned throughout the thesis. Appendix A is an informal reflective log of the researcher's personal and professional five-year journey, in keeping with the reflective research approach. Appendices B and C include research documents such as questionnaires and surveys, summaries such as a description of campaigns used for the content analysis, and documentation such as lists of interviews. Appendices D and E contain peer-reviewed works from this thesis that were respectively published or presented in academic settings. Lastly, Appendix F includes the SPSS tables used to support the information presented in Chapter 7.

1.7 CONCLUSIONS

This combination of topics—social marketing for HIV/AIDS as related to conventional and alternative medicine—is one that has not been explored in the manner outlined in this study, so the potential for contributing to gaps in the current body of knowledge is significant. Also, at the conclusion of this project, the researcher will have amassed a wealth of new data that will offer cross-disciplinary publication possibilities in various social marketing and communication venues, as well as in relevant niche publications, health marketing, and alternative medical journals. Additionally, the communication model will offer valuable guidelines for more effective dissemination of HIV/AIDS prevention and treatment information to high-risk, high-interest target audiences. Finally, the volatility of the issues examined here and the contacts made during five years of work offer multiple possibilities for follow-up research and fieldwork with opportunities to make a positive contribution in the battle against the HIV/AIDS epidemic.

CHAPTER 2
CONTEXTUAL LITERATURE REVIEW
CONVERGENCE OF SOCIAL MARKETING, HIV/AIDS, AND CAM

2.1 INTRODUCTION

This review defines and contextualises the relatively new discipline of social marketing, then scrutinises how recent dissemination of HIV/AIDS information has used social marketing techniques, usually in partnership with the conventional medical establishment. Alternative medicine's reported high percentage of use by some categories of HIV/AIDS patients, often in conjunction with mainstream medicine, and the possible ramifications for audiences of HIV/AIDS social marketing campaigns are also investigated. This chapter is meant to provide context for understanding the HIV/AIDS landscape and for examining how social marketing and the medical communities play vital roles in what has become a multi-billion dollar industry. In the interest of looking in more depth at social marketing theory, strategies, and practices, a theoretical literature review is the focus of Chapter 3.

Areas of literature reviewed in this chapter include social marketing (history, theory, and practice), HIV/AIDS (history, scope, and projections), social marketing as a tactic for combating HIV/AIDS, health communications and pharmaceutical-dominated marketing, health activism, CAM (Complementary and Alternative Medicine) and conventional medical approaches to HIV/AIDS, and an overview of media coverage of these issues. Since information regarding the topics that comprise this study was constantly evolving, the literature review continued throughout the project, with the ongoing goal of identifying additional knowledge gaps, especially relating to conceptual relationships across disciplines.

The areas where social marketing, HIV/AIDS communications, and the conventional and alternative medical establishments overlap were of particular interest during the literature review. Societal issues such as evolving public perceptions, the changing political landscape, international economics, and media agendas related to these topics are pertinent since they affect the global HIV/AIDS situation on a daily basis. In addition, the medical status of HIV/AIDS evolved dramatically during the research, changing both the message content and the methods for information dissemination. The researcher was especially intrigued by these shifting and overlapping relationships.

This chapter begins with a broad look at these topics and the areas in which they overlap, and then focuses more specifically on the three countries selected for study. There is widespread agreement that HIV/AIDS is not just a medical condition, so any research on the topic must consider the collision of cultural norms, political agendas, and financial concerns. Therefore, the three countries are each profiled in some detail. These socio-political HIV/AIDS snapshots of Mexico, Uganda, and the United States provide a framework for understanding and interpreting data collected during the four research phases of this project. Because of the scope and volume of information, this chapter's content is confined to providing a broad overview of the AIDS industry in the three countries. The chapter that follows focuses more specifically on social marketing theories and their application, especially for HIV/AIDS campaigns.

2.2 QUESTIONS ADDRESSED DURING THE INITIAL LITERATURE REVIEW

- What is social marketing?
- How does social marketing work and what can it accomplish? (*See Chapter 3 for more in-depth discussion of this question.*)
- How has social marketing been used to combat HIV/AIDS in both developing and industrialised countries?
- What political, cultural, and economic factors affect dissemination of information about HIV/AIDS treatment and prevention?
- What role have the media played in the HIV/AIDS discussion?
- Which are the primary HIV/AIDS treatments offered by conventional medicine and by Complementary and Alternative Medicine (CAM)?
- What is the current and projected scope of the disease in Mexico, Uganda, and the United States?

2.3 SOCIAL MARKETING

Social marketing is a youthful discipline first defined in 1971 by Kotler and Zaltman as

'...the application of the principles and tools of marketing to achieve socially desirable goals...and includes the design, implementation and control of programmes calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communications, and market research' (1971, p.5).

Since the term social marketing was first coined, the definition of the discipline has been evolving. Social marketing might be considered the precocious offspring of a host of communications and marketing theories and models. Like any youngster, the discipline has experienced the tribulations of adolescence, and some predict a difficult path yet ahead before it achieves widespread acceptance and respect. However, in many instances, social marketing has already proven to be an effective catalyst for positive change, both for individuals and for broader social policy, but image problems and ethical concerns still plague the discipline.

2.3.1 The birth of a discipline

In a global community that values convergence and integrated approaches, social marketing might represent the epitome of these concepts, the veritable ‘Renaissance method’ of modern marketing. In their seminal article, Kotler and Zaltman concluded social marketing could prove to be the *‘bridging mechanism’* between behavioural science and the *‘socially useful implementation of what that knowledge allows’* (1971, p.12).

Social marketing's roots in commercial marketing are undisputed, with a strong influence by the 4Ps of marketing—product, promotion, price, and placement—although this model is sometimes viewed as insufficiently customer-based for social marketing’s framework (Niblett, 2005). Unlike cars or toothpaste, the social marketing product is often complex and intangible, requiring effort or even sacrifice from sometimes reluctant consumers (McDermott et al., 2005). For these reasons, Dev and Schultz (2005) suggested modifying the 4Ps model to substitute solutions for product, information for promotion, value for price, and access for place.

Despite this ongoing discussion, there is widespread agreement that social marketing ideally combines a unique mix of several essential elements. Behavioural change, informed by research, is the purpose behind any social marketing intervention. Also required is consumer orientation, in which the social marketer segments and profiles the target audience with the aim of building a long-term interactive relationship. Another common element is facilitating a voluntary exchange from which both parties derive benefits. Finally, the successful social marketer thinks strategically to plan long term, setting specific and measurable objectives, using the marketing mix, and considering the competition, such as the appeal of competing behaviours (Dev & Schultz, 2005; McDermott et al., 2005; Andreasen, 2006).

This unique mix of elements specific to social marketing sets it apart from its ‘relatives’: commercial marketing, social advertising, socially responsible marketing, public relations, and education. Perhaps an even closer kinship could be claimed with another relative newcomer, Integrated Marketing Communications (IMC), which has some parallels with social marketing in that IMC also takes a holistic, long-range view of image, branding, and persuasion while incorporating a mix of tools and techniques. IMC, however, while advocating social responsibility (Densen, 2005), does not necessarily have social change as its primary objective. More recently, widespread use of the term social media has given rise to confusion about social marketing, as discussed in Chapter 3.

2.3.2 A tumultuous ‘childhood’

As early as the 1960s, commercial marketing technologies were being incorporated into health education campaigns in developing countries (Ling et al., 1992) and have continued to play an important role in influencing individual behaviours of populations at risk for diseases such as HIV/AIDS, malaria, and alcoholism (Rogers et al., 1991). As this new approach to healthy behavioural change established a track record, Kotler and Zaltman (1971) asserted ‘social marketing’ could also be effective when applied to a range of other social goals as varied as brotherhood, safe driving, and family planning.

Ten years later, Bloom and Novelli’s investigation (1981) found many social marketing campaigns lacking rigor and theory. They recommended using research to segment audiences, design programmes, and create strategic campaigns. Social marketing’s popularity grew as its potential for improving health and well being was publicised in numerous medical journals by Lefebvre and Flora (1988) as well as by Hastings & Haywood (1991). As the link between public health and commerce (Hastings & Saren, 2003), social marketing has become the primary tool international organisations such as UNAIDS use to combat global health issues. When the effort extends beyond informing to persuading, it is called ‘health activism’ and involves *‘attempts to change the status quo, including social norms, embedded practices, policies, and power relationships’* (Zoller, 2005, p.361).

To raise social marketing’s global profile professionally and academically, several institutes and organisations have been established, from the UK (National Social Marketing Centre), to Scotland (Institute for Social Marketing), to Canada (Social Marketing Network from Health Canada), to Australia (Social Marketing Downunder) to Washington, D.C., (Social Marketing Institute). Conferences, textbooks, and Internet listservs as well as a professional journal are dedicated to the discipline.

2.3.3 Social marketing ‘grows up’

In its early manifestations, social marketing usually concentrated on influencing behaviour (either encouraging change or trying to prevent particular kinds of undesirable behaviours) among specific ‘downstream,’ or consumer, audiences. Looking back, some observers now comment social marketing was in danger of being pigeonholed as a ‘downstream approach,’ which was too narrow in focus and did not effect the kind of sweeping long-term social mobilisation and change that was the true goal. Although social marketing was sometimes able to effectively use the power of marketing to create awareness among specific target audiences and even to persuade members of those groups to consider or adopt lifestyle changes, it became increasingly obvious to many in the field the burden of deep societal change could not rest exclusively on the downstream targets (Andreasen, 2006).

Hastings and Donovan called for the discipline ‘*to embrace a broader perspective that encompasses not just individual behaviour, but also the social and physical determinants of that behaviour*’ (2002, p. 4). From the other side of the Atlantic, Andreasen, who was instrumental in founding the Social Marketing Institute in Washington, D.C., noted the goal of his latest book was to ‘*reposition social marketing as an approach to social change that reaches both upstream and downstream*’ (Andreasen, 2006, p.viii). When social marketing can build partnerships that include governments, non-government organisations (NGOs), international agencies, and private businesses—so-called ‘upstream’ audiences—working in conjunction with downstream targets, then the entire social fabric of a community can be permanently altered (Andreasen, 2006).

2.3.4 The media shape HIV/AIDS discussion

Social marketing advocates such as Hastings and Andreasen agreed a crucial goal lies in moving issues up the public, media, and policy agendas in a society (Hastings & Saren, 2003; Andreasen, 2006). Public agendas include individual communication through such means as polls, chatrooms, and blogs—technologies that empower individuals by providing public forums that bypass traditional mass media. Social marketers can also influence the media agenda, which is instrumental in agenda-setting—telling the public *what* to think about (Protest & McCombs, 1991). In addition, the way the media frame issues can greatly affect how those topics are perceived by the public. For example, AIDS was originally framed in the United States as primarily affecting the homosexual community, resulting in stigma and lack of public concern

about the disease. Rogers, Dearing, and Chang (1991) examined media coverage of AIDS in the 1980s and identified four stages in the media's coverage of the burgeoning epidemic. At first, the disease did not even appear on the media agenda; when it did, there was a marshalling of scientific facts; next, the media personalised the disease through case studies and stories. Nowadays, media focus is more concentrated on exploring political action alternatives. This progression has been reflected in policy changes in the United States; when AIDS was framed as a threat to political stability, upstream audiences saw benefits in forming partnerships to combat the disease (Andreasen, 2006).

Framing, then, is an important technique in social marketing, as it is in many associated fields such as public relations. Andreasen called framing a neutral, academic term for the pejorative 'spin' (2006, p.46). In its most objective role, framing provides context, but it can also shift blame and manipulate data. For example, in their book, *Selling Sickness*, Moynihan and Cassels (2005) argued the conventional medical establishment was successfully marketing false illnesses to the public (and then supplying the drugs to 'cure' those disorders). To help counter this pharmaceutical industry marketing, Moynihan writes reports for the World Health Organization (WHO) on how to better use data in health policymaking (ABC Queensland, 2005).

Framing can also be associated with branding; in an interesting marketplace reversal, some for-profit businesses align themselves with social causes to differentiate their brands from their competitors. Examples include The Body Shop, which has been successful with its social message approach, and Benetton, whose vivid ads have included depictions of a dying AIDS patient and a baby's bottom stamped 'HIV positive.' This series of ads created publicity and visibility for the company but alienated retailers (Joachinsthaler & Aaker, 1997).

It becomes clear social marketing can only solve complex social ills if it builds a network of partnerships and alliances to combat problems on several fronts. The challenge is to operate in the maelstrom of cultural, political, economic, and social concerns while bringing about voluntary behavioural changes among both downstream and upstream audiences.

2.3.5 Image and ethics

Like the once-popular advertising slogan said, '*Baby, you've come a long way*' (Virginia Slims, 1969), but social marketing is still experiencing growing pains and its critics are unrelenting. Beyond marketing-based criticisms of behavioural manipulation,

detractors also say the very market segmentation so central to social marketing perpetuates gender and stereotypical problems. When a particular group is targeted, such as female prostitutes for HIV/AIDS interventions, critics say, other groups may stigmatise that market segment. Also, the use of fear appeals draws mixed responses, both from observers and from the targeted audiences. The use of incentives, central to most social marketing approaches, also has potential pitfalls because they can be interpreted as coercion or bribery and not deliver the long-term behavioural change desired (Dholakia & Dholakia, 2001, p.498).

Lastly, social marketing, like many adolescents, is still not taken seriously by many managers and policy makers, according to Andreasen, who contended the discipline has poor brand 'positioning' and suffers from image problems, in part due to a lack of academic stature and inadequate publicity about its successes (2006, p.215). Regardless of disagreements about how the discipline might evolve, practitioners and policy makers agree it is a concept with boundless potential to use the demonstrated power of marketing for the good of society.

2.4 HIV/AIDS ENTERS THE PICTURE

Perhaps the most highly visible social problem in the world today is HIV/AIDS. Since it was officially diagnosed in the early 1980s, HIV/AIDS has become one of the most deadly health issues worldwide, with an estimated 33.4 million people—2.1 million of them children under 15 years old—living with the disease in 2008. In 2008 alone, 2.7 million people were newly infected with the virus and at least 2 million died. Contrary to popular perception, about half of the infected were women and heterosexual transmission has become the most common means of infection (UNAIDS, 2009a, 2009b). Although epidemiological data indicate that globally the spread of HIV peaked in 1996, the number of people living with HIV worldwide has increased every year, due to a combination of continuing high numbers of infections and increased life spans for those receiving antiretroviral therapy. HIV/AIDS has become both a horizontal epidemic (affecting both sexes) as well as a vertical epidemic (being transferred from mothers to children) (UNAIDS, 2009a, 2009b).

The history of the pandemic has included increasing hysteria as the death toll climbed, unfulfilled hopes for various promising treatments, optimism with the discovery of antiretroviral therapy, disappointing vaccine failures, and the development of sometimes controversial alternative treatments that complement or offer options to drug cocktails.

2.4.1 HIV/AIDS definition and treatments

Perhaps one of the most confusing aspects of the disease (but important to anyone creating an informational campaign) is the difference between being HIV-positive and having AIDS. Simply put, HIV-positive means the HIV virus is detectable in the blood, but there are few or no symptoms. People at this stage often do not realise they are infected and unknowingly transmit the virus to others. HIV infects the T-helper cell, a particular type of immune system cell. The virus slowly reduces the number of T-cells until the infected person develops AIDS. An even more important laboratory marker is viral load, which is measured in the number of copies of the virus existing within the patient per volume of blood. These two factors are monitored to determine when AIDS treatments should begin (Segala, 2003).

The development of AIDS can take two to 15 years, but about half of all people infected with HIV will develop AIDS within 10 years. After that occurs, AIDS compromises the host's immune status, causing illness and eventually death through resultant malignancies and infections. Currently, treatments focus on preventing development of symptoms and diseases associated with HIV. Controlling rather than eradicating the virus is the goal of most treatments; the medical establishment classifies the disease as a chronic condition (Segala, 2003).

In 1987, AZT (azidothymidine) was the first drug approved for treatment of AIDS, but AZT treatments were not reliably effective. By the mid-1990s, a number of new drugs were being used and physicians were hopeful the disease could be eradicated from patients' systems. The most successful drug modality to date is Highly Active Anti-Retroviral Therapy (HAART). This approach, which became available in the mid-1990s, involves treatment with a 'cocktail' of three classes of drugs, which suppress but never eliminate the virus (Segala, 2003). After more than a decade of HAART, it seems that many HIV patients are living longer but getting older faster—showing early signs of dementia and bone weakness associated with the elderly. A large-scale multi-city study in the U.S. found that over half of the HIV-positive population was suffering from what some physicians have termed HIV-associated cognitive motor disorder. Whether this is a result of the drugs or of the disease, or some combination, is still under study (France, 2009). Another complication is that the rate of drug resistance among circulating HIV strains continues to increase, which raises long-term treatment concerns (Sepkowitz, 2006).

Overall, drug treatment regimens are complex, complicated by problems with toxicity, compliance, side effects, and cost. The cost of current treatments clearly

separates the haves from the have-nots; only one-fifth of infected people in developing countries are receiving antiretroviral therapy, primarily due to cost constraints (Sepkowitz, 2006).

2.4.2 Complementary and alternative medicine (CAM)

Alternatives to Western or conventional medicine are collectively referred to as Complementary and Alternative Medicine (CAM) and cover a wide range of treatments, from 'folk medicine' to acupuncture, to biological treatments such as oxidizing agents like hydrogen peroxide. Many of these are not accepted by mainstream medicine as effective treatments for HIV/AIDS or its accompanying infections, but globally the World Health Organisation (WHO) reports that 80% of people use some type of modality that would be considered CAM in the U.S. (Hanna, 1998). Some CAM treatments for HIV/AIDS, either used alone or in conjunction with drug therapies, have shown positive effects according to CAM practitioners, but have not been approved by the U.S. Food and Drug Administration. Most commonly, many CAM practitioners recommend a comprehensive antioxidant 'cocktail' with high levels of nutrients to decrease oxidative cell damage and boost immune function (Tindel, et al., 2005). Numerous alternative treatments for HIV/AIDS are known in the CAM medical community, but they are not widely available and few of the infected are aware of those modalities. However, CAM practitioners say extensive research regarding benefits of these treatments has not been pursued because they cannot be patented and therefore will never generate profits for the pharmaceutical companies, so funding for clinical trials is difficult to obtain (Tindel, et al., 2005). As a result, the body of clinical evidence regarding CAM treatments is limited in comparison to the amount of scientific studies for mainstream medicine.

In the early years of the HIV epidemic, before HAART, CAM use was prevalent in industrialised as well as in developing countries since the few conventional medical treatments available often had negative side effects. In the population in general, studies indicate that the use of CAM for a range of symptoms and diseases, often in combination with conventional medical treatments, is still a common practice. A 2009 study published in *AIDS Patient Care and STDS* found that CAM is still an integral part of HIV therapy, especially among infected women. CAM usage was found to range between 60% and 90% among HIV-infected individuals using HAART, with women reporting higher CAM use than men. In this study, CAM was used almost exclusively in tandem with conventional treatments (Liu, et al.).

2.4.3 The role of the CAM controversy in this study

The ongoing conflict between conventional and alternative medicine is a global dialogue, but it is especially active in industrialised nations such as the United States where the medical industry exceeds \$2 trillion annually and is projected to double by 2017 (Holland, 2007). By contrast, Americans spend about \$40 billion on alternative medicine each year (Barnes, et al., 2009) and even more—over \$48 billion in 2010—on health care for their pets (APPA, 2010). It is worth noting that much of the conventional health care expenditures are paid by various insurance or federal programs, but the majority of alternative medical expenses are paid by individuals, out of their own pockets.

As noted in the previous section, trend watchers see a steady upward movement in alternative medicine use, with CAM services and products representing a sizable market sector in the overall healthcare industry in the United States and in many other countries as well. According to MedausPharmacy, which has been specialising in compounded medications for 70 years, *‘What began as a passing fad in the 1960s has today crossed decades, genders, and ethnicities (and) today national surveys estimate that in a given year, 40% of all Americans incorporate some type of CAM therapy into their healthcare routine’* (MedausPharmacy, 2008).

On its website, MedausPharmacy goes on to say that *‘Government health agencies and the conventional medical community now recognize the scientific validity of CAM therapies’* (2008), but a quick Google search for *alternative medicine validity* shows the debate about the validity of CAM modalities is very much alive, with 3.13 million ‘hits’ for the topic (Google, 2011). The first two listings from that search, both from *Nature Medicine* journal, encapsulate the opposing arguments nicely. Brown, author of the book, *Mavericks of Medicine*, is defending his work against criticisms that it does not include sufficient scientific studies to support his claims for the validity of alternative treatments (2008). In the same issue, Strasser publishes *‘Reply to: The validity of alternative medicine,’* in which he says that unscrupulous ‘pill pushers’ operate in both alternative and ‘orthodox medicine’ venues and their claims should be viewed with suspicion (2008).

Underlying this ongoing debate, clinical research accumulated over the past two decades offers some evidence that supports CAM approaches for treating HIV/AIDS and its related ‘opportunistic’ infections. Numerous studies have evaluated the benefits of CAM treatments such as antioxidants, natural anti-virals, immune modulators,

micronutrients, amino acids, hormonal, enzymatic, and glutathione boosters used in conjunction with conventional medicine (Adams, 2006).

Given the global economic demographics of the disease as well as cultural and social aspects discussed throughout this thesis, the need for inexpensive and effective treatments has encouraged legions of clinical trials for conventional therapies, and to a lesser extent, for alternative therapies. As noted earlier, due at least in part to the scarcity of funding for CAM clinical trials, scientific data for conventional treatments has far outstripped those designed to test alternative HIV/AIDS modalities. However, HIV/AIDS research activity overall has gained momentum with recurring failures to find a vaccine for the disease. One highly publicised example was Merck's humiliation when it tested a vaccine initially deemed promising, but as the trial progressed, the vaccine alarmingly '*appeared to increase the rate of HIV infection in individuals with prior immunity against the adenovirus vector used in the vaccine*' (Sekaly, 2008, p.7). Merck discontinued the study after those findings surfaced.

As with conventional medical trials, not all alternative clinical trials have been successful, but according to CAM practitioners, many have offered promise, and a significant number have yielded positive results. Clinical data collected by universities, medical institutions, and other research groups include a range of specialised studies on the effects of one or more 'natural' substances, sometimes used in conjunction with conventional HIV/AIDS drugs. For example, the possible curative properties of green tea extracts have been the focus of numerous clinical trials. In a 2009 study, researchers investigated the '*therapeutic potential of green tea-derived-epigallocatechin-3-gallate (EGCG) to mitigate the neuronal damage characteristic of HIV-associated dementia (HAD)*' (Giunta, et al., p.217). The resulting data suggested '*EGCG attenuates the neurotoxicity of IFN-gamma augmented neuronal damage from HIV-1 proteins gp120 and Tat both in vitro and in vivo. Thus, EGCG may represent a novel natural compound for the prevention and treatment of HAD*' (Giunta, et al., 2009, p.223).

Centuries-old medical approaches have also been subjected to scientific study relating to their potential to combat HIV/AIDS. Motivated by the scientific evidence that '*anti-retroviral therapy, the current HIV/AIDS treatment modality...does not offer an ultimate cure to HIV/AIDS,*' a group of microbiology and immunology researchers at the Indiana School of Medicine tested a '*panel of extracts of traditional Chinese medicinal herbal plants for their activities against HIV-1 replication*' (Park, et al., 2009, paragraph 1). Their results demonstrated that '*TXE and VAD (two of the extracts tested) inhibit HIV-1 replication, likely by blocking HIV-1 interaction with target cells...and*

point to the potential of developing these two extracts to be HIV-1 entry inhibitors' (Park, et al., 2009, paragraph 4).

Other studies that suggest alternative HIV/AIDS treatments might be effective are taking place around the globe. For example, a group of researchers from the College of Medicine at the University of Nigeria published results of ongoing work regarding the safety and effect of fractionated neem leaf extract (IRAB), determining that this natural substance was *'safe and increases CD4+ cell levels in HIV/AIDS patients,'* indicating IRAB *'may be useful in the formulation of multi-drug combination therapies for HIV/AIDS'* (Mbah, et al., 2007, p.369).

In many studies, there is a 'bridge' between conventional and alternative medicine. For instance, using CAM to alleviate complications brought on by anti-retroviral drug therapy was the focus of a randomised, controlled trial conducted by three major research hospitals in Houston, Texas. The 24-week study tested various blends of lifestyle alterations, niacin (a B-complex vitamin), and fenofibrat (an anti-retroviral drug), and concluded that *'a combination of fenofibrate and niacin with low-saturated-fat D/E is effective and safe in increasing HDL-C, decreasing non-HDL-C and hypertriglyceridemia, and ameliorating hypo adiponectinemia in patients with HIV/ART-associated dyslipidemia'* (Balasubramanyam, et al., 2010, p. 2246).

Some research further blurs the line dividing conventional and alternative medicine. Noting that *'natural products can provide novel anti-AIDS chemotherapeutic leads that are structurally unique or have new mechanisms of action,'* the Natural Products Research Laboratories released a broad study of anti-HIV natural products from several compound classes, including terpenoids, coumarins, alkaloids, polyphenols, tannins, and flavonoids. They reported their research led to the discovery of the *'modified betulinic acid derivative, DSB [PA-457], which is currently in Phase II clinical trial and is the first-in-class HIV maturation inhibitor (MI)'* (Yu, Morris-Natschke & Lee, 2007, p.108).

As the disease enters its third decade and the data base grows, it has become possible to conduct studies that take a broader look at CAM's efficacy in combating HIV/AIDS symptoms over time. A holistic approach toward HIV/AIDS treatments is supported by studies such as the one conducted by a group of researchers at Yale University to examine relationships among non-conventional practices (CAM), adherence, and immune functioning among individuals with HIV. Using information relating to participants' lifestyle, spirituality, and use of conventional and CAM therapies, combined with their medical history of CD4 count and viral load, the researchers determined that *'religious practice was associated with adherence, and*

CAM was associated with viral load,’ leading them to conclude that *‘participation in non-conventional practices in HIV populations may lead to positive health and health behaviors’* and that those findings had important clinical implications (Nightingale, et al., 2011). Similarly, a previous study from the Johns Hopkins School of Medicine had found that HIV patients with lipodystrophy (changes in body-fat distribution as a result of prolonged highly active antiretroviral therapy) were likely to use CAM therapies. Since there are few effective treatments for lipodystrophy, the study revealed almost three-fourths of the patients were inclined to use CAM supplements and visit CAM providers. Study results indicated *‘more conventional CAM, such as exercise, diet, and vitamins as well as meditation/prayer were perceived to be effective for lipodystrophy as well as for improving the overall sense of well-being’* (Cho, et al., 2006, p.481).

As the timeline for HIV/AIDS clinical literature extends, one might expect to see more reviews such as Ullman’s examination of five controlled clinical trials evaluating the homeopathic treatment of people who had AIDS or who were HIV-positive. Ullman points out that *‘homeopathic medicine developed significant popularity in the nineteenth century in the United States and Europe as a result of its successes treating the infectious disease epidemics during that era. Homeopathic medicine is a medical system that is specifically oriented to using nanopharmacologic and ultramolecular doses of medicines to strengthen a person’s immune and defense system rather than directly attacking the microbial agents’* (Ullman, 2003, p.133). The review covers clinical trials in India, California, Oregon, Arizona, Hawaii, New York, and Washington, and references more than three dozen other studies and articles on this topic. Ullman concludes, *‘As a result of the growing number of people with drug-resistant HIV infection taking structured treatment interruptions, homeopathic medicine may play a useful role as an adjunctive and/or alternative therapy’* (Ullman, 2003, p.140).

The newest and perhaps the most promising treatment modalities for HIV/AIDS involve nanotechnological solutions. For example, HIV CAM treatments using noble metal nanoparticles have been successfully proven to kill HIV-1 in vitro for severely ill HIV patients (Adams, 2006). In their August 2005 study titled ‘Interaction of silver nanoparticles with HIV-1,’ Elechiguerra and colleagues stated, *‘[i]n this work, we demonstrate that silver nanoparticles undergo a size-dependent interaction with HIV-1, with nanoparticles exclusively in the range of 1–10 nm attached to the virus’* (2005, paragraph 1). In other words, the study concluded that through this interaction silver nanoparticles *‘inhibit the virus from binding to host cells, as demonstrated in vitro’* (Elechiguerra, et al., 2005, paragraph 1).

Medical literature shows a variety of viruses have been successfully treated with silver-based drugs for more than 100 years (Rentz, 2003), but interaction of nanoparticles with biomolecules and microorganisms is an expanding field of research (Elechiguerra, et al., 2005). A number of studies have verified the virotoxic efficacy of oligodynamic noble metals in tackling some of the most formidable viral organisms, including HIV and its co-infections (Zhong Yin, 1991, Dean & Wilcoxson, 2001, Adams, 2006).

Continuing Elechiguerra and colleagues' work, Lara et al. recently published their study of the mechanism underlying silver nanoparticles' HIV-inhibitory activity. The report concludes that *'silver nanoparticles are effective virucides as they inactivate HIV particles in a short period of time, exerting their activity at an early stage of viral replication (entry or fusion) and at post-entry stages. The data presented here contribute to a new and still largely unexplored area'* (Lara, et al., 2010, p.8).

Nevertheless, the volume of clinical evidence for alternative modalities is still sparse compared to those undertaken for mainstream medicine, but given the high percentage of the population that utilises CAM approaches and the ongoing clinical studies for alternative HIV/AIDS treatments, alternative medicine continues to have a role in the overall medical picture for the disease.

Although alternative and complementary medicine are intersecting topics for this thesis, the scope of the controversy about the validity of CAM treatments is clearly one that far exceeds the reach of this inquiry. Therefore, in the area of alternative medicine, the emphases for the purposes of this study fell into three categories, which are outlined in the three 'grand tour' research questions and their accompanying sub-questions (*See Section 1.2*). First, as part of the initial exploration into the intersections of the three main topics—HIV/AIDS, social marketing, and conventional and alternative medicine—the researcher sought to understand the history and context for alternative therapies in relation to HIV/AIDS.

Secondly, in looking at dissemination of information about HIV/AIDS prevention and treatment options, the researcher examined the kinds of medical information presented in social marketing campaigns directed to various target audiences. As part of the third research question, knowledge and perceptions about HIV/AIDS prevention and treatments—both conventional and alternative—were explored through a survey, and then a communication model that incorporated a broad range of prevention and treatment options was proposed.

Even though the researcher has some personal experience with alternative medicine, (See Appendix A—Reflective Log), in the body of this thesis she has taken care to attribute any claims of its effectiveness to secondary sources consulted in the literature review or to those alternative practitioners and researchers interviewed over the course of this study (See Appendices B.7, B.8 & B.9). When considering CAM issues, the researcher has primarily focused on the three areas outlined above to make this project manageable and to keep it on target with the original research aim.

2.4.4 HIV and social marketing

Since social marketing is a key tactic for combating HIV/AIDS in both developing and industrialised countries, extensive literature exists detailing campaigns past and present (Kaiser, 2006a). Studies document the status of the epidemic and attempt to draw conclusions about the results of campaign efforts. On the other hand, critics charge social marketing messages are not always on target and point to the continuing increase in prevalence rates globally.

Nevertheless, where HIV/AIDS is rampant, social marketing is widely used to motivate low-income and high-risk audiences to adopt healthy behaviours. Population Services International (PSI), the first organisation to use social marketing to combat AIDS, has typically focused on prevention messages and brand-specific advertising. These campaigns are a major expense for drug companies, which spend an average of two-and-half times more on marketing than on research (Hamber, 2005). With this kind of investment at stake, critics say the conventional medical establishment uses influence and financial clout to shape dissemination of health information (Moynihan & Cassels, 2005).

Additionally, in the wake of widespread media coverage about selective reporting of clinical drug trials, U.S. political leaders have questioned '*whether the pharmaceutical industry has systematically misled physicians and patients by suppressing important data on their drugs*' (Graham, 2004, p.21). These concerns, combined with reports documenting the deplorable state of public health care, are spurring public interest in complementary and alternative medicine (CAM), creating a more positive climate for alternative treatments in general (Tindel, 2005; Abraham, 2007). For example, in the UK, media coverage of controversial public funding for CAM, long supported by Prince Charles, has brought the topic to the forefront of public attention (Booth & Henderson, 2006). That dialogue continues, with Prince Charles defending complementary medicine

against charges of *'quackery'* and in turn being called *'well meaning but medieval'* by the conventional medical establishment (Booth, 2010).

2.5 THE AIDS LANDSCAPE IN THREE COUNTRIES

After reviewing the world of social marketing and its relationship to the many aspects of HIV/AIDS, it was clear HIV/AIDS is not just a biomedical phenomenon but has social, cultural, and political roots. Therefore, the next step toward understanding factors that affect social marketing initiatives was to develop overviews of the HIV/AIDS landscape in the three countries under study. These country snapshots of Mexico, Uganda, and the United States consolidated literature review information and offered a more manageable framework for future study of this complex combination of topics.

2.5.1 Mexico: affluence and poverty live side by side

With about 110 million inhabitants, Mexico is the most populous Spanish-speaking country in the world. Three quarters of the population live in cities, with 20 million crowded into the capital, Mexico City, (U.S. Department of State, 2008), where the contrast between riches and rags is painfully evident. Mexico City is a modern international business and arts centre surrounded by sprawling shantytowns and plagued by political turmoil and environmental concerns. A popular response for many Mexicans is to search for work in the United States. More than a million poor Mexicans are arrested each year trying to cross the U.S. border illegally and hundreds die in the attempt (Country profile: Mexico, 2008). They leave behind towns and villages virtually empty of able-bodied men to be husbands and fathers. Even within the country, migration is an established pattern; many women also leave rural homes to take jobs in inner city factories, only to fall victim to violent crime, exploitation, or illness.

Although Mexico is a major oil producer, prosperity is only a dream for most Mexicans; poverty and disease are the realities. Almost 30% of Mexico's population is under 15, with about 700,000 more males than females. Overall, however, life expectancies remain relatively high: 73 years for men and almost 79 years for women (U.S. Department of State, 2008). Average life spans could drop, Mexican health officials fear, as the newest offspring of poverty and ignorance—the AIDS epidemic—impacts more and more vulnerable populations.

The 2007 national census revealed that half of new HIV/AIDS cases in Mexico were occurring among those between 10 and 24 years old (Tizcareño, 2008). Unless it is curbed, this trend bodes ill for the future and predicts additional diversion of resources

from other health, welfare, and education priorities. Mexico ranks 13th globally and third in the Americas in the total number of HIV cases reported, but the increase has been continuous since 1981. With an estimated average of 4,000 new cases annually, AIDS has become the No. 4 cause of death for Mexican men in the 25-to-44 age group (*Epidemiological fact sheets*, 2006, pp.2-7).

AIDS has been reported in all 31 states of the Mexican Republic, with more than half of the infected living in Mexico City. Although the epidemic is largely concentrated among men who have sex with men, higher rates of HIV infection are also being documented among injecting drug users and women. Of the estimated 180,000 people living with HIV/AIDS in Mexico, almost one-fourth are women (International HIV/AIDS Alliance, 2008). As male partners infect more women, heterosexual transmission is on the rise and in some parts of the country is now the predominant mode of transmission. Official estimates of the adult prevalence rate are still relatively low, ranging from 0.3% to 0.4%, but the disease is responsible for about 6,200 deaths a year (International HIV/AIDS Alliance, 2008).

Although Mexico has had HIV/AIDS programs since the early 1980s, only recently has there been a more unified national response in recognition that the disease has become a complex healthcare challenge, with psychological, social, ethical, economic, and political dimensions. Policy makers have realised it is critical to coordinate interdisciplinary responses from diverse organisations (Stewart, et al., 2001, p.5). Since the AIDS epidemic in Mexico is still concentrated in vulnerable populations, political and healthcare leaders are faced with both the challenge and the opportunity to step up prevention measures before the disease spreads to the general population as it has in many parts of the world. There are, however, cultural obstacles to be overcome, in addition to political and economic hurdles.

According to Mexico's National Centre for Prevention and Control of HIV/AIDS (CENSIDA), changing how Mexicans view gender roles and erasing widespread prejudice against gays will be necessary to combat the disease effectively. Mexico's commitment to this problem is a matter of public record. Regional heads of state endorsed the Nuevo Leon Declaration in 2004, a pledge to focus on HIV/AIDS treatment and prevention (USAID, 2005a). The 2008 Secretary of Health, Jose Angel Cordova Villalobos, said the decline in new HIV cases will be achieved mainly through education and awareness. To that end, Villalobos is collaborating with international leaders to focus on 'feminisation of the epidemic' —strategies with a gender perspective (Sanchez, 2008).

In addition to Mexico's new political regime, an army of international groups and national activist organisations are publicly committed to making treatment available to the infected and to changing cultural norms that contribute to the spread of the disease. Dozens of social marketing campaigns directed to specific target groups are underway across the country.

2.5.2 Uganda: the crisis continues

Winston Churchill once referred to Uganda as the pearl of Africa because of the country's natural beauty and tropical climate. But the Sub-Saharan African country of over 30 million also suffers from decades of political corruption, extreme poverty, and increasing rates of HIV/AIDS infection despite years of prevention programs.

Uganda remains one of the most impoverished countries in the world—placed 154 of 177 on the 2007 World Development Report (Country profile: Uganda, 2009). With one of the highest population growth rates in Africa, and half of its citizens under the age of 15, the future is not promising. Diversity and civil unrest make it difficult for political leaders to unify the country; Uganda is home to more than 20 tribes who speak 30 different languages. English is the official language and 85% of Ugandans are Christian; 12% are Muslim and only 3% follow traditional religions (Country profile: Uganda, 2009).

Although an estimated 1.3 million live in the capital city of Kampala, agriculture—primarily coffee exports—is the basis of livelihood for more than three-quarters of the populace. With a per capita income of only US\$217, about 40% of Ugandans live below the poverty line (NationMaster, 2010).

Much of the country's problems are inherited from generations of political upheavals. Uganda developed from the 19th century kingdom of Buganda, which became a British protectorate in 1894. Uganda became independent in the early 1960s. A series of leadership changes followed, with the brutal Idi Amin dictatorship of the 1970s bringing human rights and economic disaster. Successive regimes have struggled with internal dissent, corruption, and ongoing economic and health issues.

Government leaders see education as an important avenue for improving the overall situation in their country, and in 1997 began providing free primary education for up to four children per family, but schools lack staff, classrooms, furniture and books. Dropout rates are high and adult literacy stands at 67% (Country profile: Uganda, 2009).

Even fewer Ugandans have access to health care; doctors, nurses, equipment and medicines are available to less than half of the population. Safe water is a problem for more than a third of Ugandans, contributing to the country's average life expectancy of 49 years (Country profile: Uganda, 2009).

However, the greatest health issue in Uganda since the late 1980s has been HIV/AIDS, when the country was devastated by the epidemic, with prevalence rates as high as 30% in urban areas, especially among pregnant women. When President Museveni came to power in 1986 at the end of the civil war, 'slim disease' had already spread through urban sexual networks and along major highways. Uganda's national program to combat HIV/AIDS is often seen as a model for Africa. The program promoted the ABC approach (abstain, be faithful, use condoms), ensured a safe blood supply, and began HIV surveillance (AVERT, 2010c). Strong government leadership promoted national public education campaigns and encouraged grass roots efforts.

Within a decade, the number of people living with AIDS had dropped dramatically, to less than 6%, although some of that decrease was attributed to a rise in AIDS-related deaths since treatment was not widely available. Nevertheless, behavioural changes such as increased abstinence and monogamy, a rise in the average age of first sex, a reduction in the average number of sexual partners, and more frequent use of condoms were seen as significant contributors to the decreased prevalence. These behavioural changes were arguably in response to the national initiative that mobilized the entire population in the fight against AIDS. For those already infected, Uganda received funding in 2004 from the World Bank to offer free antiretroviral drugs (AVERT, 2010c).

More recently, however, AIDS prevalence is on the upswing yet again, with numbers in urban areas over 10%. About a million Ugandans are living with AIDS and 1.2 million children have been orphaned by the disease. Experts speculate that several factors may be contributing to an increase in infections. Their explanations include a general complacency or 'AIDS fatigue' resulting from the availability of drug treatments, where the perception of AIDS has changed from a death sentence to a treatable, manageable disease. With reduced fear surrounding the disease, experts speculate, risky behaviours have increased (AVERT, 2010c).

Also, the government's controversial focus on abstinence is blamed in part for the increase in infections. Although abstinence has always been a part of the government prevention program—an element in the ABC approach noted earlier—to receive funds from the American government program PEPFAR (President's Emergency Plan for AIDS Relief), a focus on abstinence is required. PEPFAR is channelling large sums of

money to Uganda through pro-abstinence and anti-condom faith-based organizations (FBO), approaches that are being further supported by Evangelical churches in Uganda. Between 2004 and 2007, prevention spending tripled in Uganda, but as a result of pressure from PEPFAR, some Ugandan teachers report being instructed by U.S. contractors to not discuss condoms in schools. Billboards across the country promote abstinence to prevent HIV infection and sometimes discourage condom use (AVERT, 2010c). After several years of condom shortages, UNAIDS data shows a decrease in the frequency that condoms are used during sex with non-regular partners (UNAIDS, 2007).

Unfortunately, it appears the AIDS crisis in Uganda is far from over. Women continue to be the most affected; almost 60% of HIV infections in the country are among women, due in part to statistics that show Ugandan women tend to marry and/or become sexually active at an earlier age than the males and often have older and more sexually experienced partners. Intergenerational sexual relationships play an important role in young women's disproportionate risk of HIV infection, and the number of young girls with partners more than five years older is rapidly increasing. Heterosexual transmission remains the primary mode of HIV infection in the region, with extensive transmission to newborn and breastfed babies (UNAIDS, 2009a).

Although all HIV/AIDS education initiatives fall under the purview of the Uganda AIDS Commission, there seems to be a disconnect between official policy regarding prevention and treatment initiatives and national legal directives. While HIV/AIDS programmes usually address stigma and discrimination against certain population groups, three-quarters of the African countries—including Uganda—have laws criminalizing consensual gay sex. Ugandan members of Parliament have proposed legislation that would further criminalise homosexuality in the country, a move that would dramatically affect the estimated 500,000 gay Ugandans. *'If the Bill is enacted,'* according to Consultancy Africa Intelligence, *'accessing homosexual groups and also funding for programmers aimed at homosexuals groups would become even more difficult. Programme implementers would also be facing prison sentences of up to seven years for attempting to address HIV & AIDS in the homosexual population'* (Nel, 2010).

A recent bright spot on the HIV/AIDS horizon for Uganda may be the results of a medical trial of 840 men aged 15-49 that indicated male circumcision decreases the risk of HIV infection (Gray, et al., 2010). In response to growing evidence that male circumcision can reduce the rate of HIV infection in men by as much as 60% and greatly reduce their female partners' likelihood of developing cervical cancer, PEPFAR is helping fund the procedure in several African countries (Renton, 2009).

2.5.3. The United States: minorities, MSM are most at risk

The United States of America, sometimes termed ‘the great melting pot,’ is a multicultural country made up almost exclusively of immigrants. Geography and climate vary dramatically from border to border in a country that is about two and half times the size of the European Union and slightly larger than China. (Country profile: United States, 2010). The 307 million citizens are predominately of European origin, mostly traceable to the UK, Germany and Ireland. National census figures in 2000 showed the three major ethnic groups as 75% white, 12.5% Hispanic and 12.3% black. Less than 1% are native Americans (U.S. ethnic groups, 2010).

Hispanics make up the largest minority, with the bulk of this group having roots in Mexico. The majority of the black population lives in the southern part of the country. Although the main language is English, Spanish is spoken by an increasing number, especially in states that share a border with Mexico. Of the two major religions, Protestants outnumber Roman Catholics two to one (U.S. ethnic groups, 2010).

The U.S. is fifth in the world in per capita income, averaging \$33,000 per year, but the U.S. Census Bureau estimates that 39 million live below the poverty line, including 13 million children. Roughly 25% of both blacks and Hispanics fall into this category (U.S. Census Bureau, 2008).

Despite eras of strong political and social disagreement, since the colonists successfully won their independence in 1781, the U.S. has only had one country-wide conflict, the War Between the States, which ended in the mid-1860s. The government is a constitution-based Federal Republic with a strong democratic tradition and two major political parties (Country profile: United States, 2010).

The official beginning of the HIV/AIDS epidemic occurred in 1982, when the U.S. Centers for Disease Control established the term Acquired Immune Deficiency Syndrome (AIDS) and referred to four risk factors: male homosexuality, intravenous drug abuse, Haitian origin, and haemophilia (Kaiser, 2006b). The first International AIDS conference was held in Atlanta three years later. Since the beginning of the epidemic, more than half a million people have died of AIDS in the U.S. An estimated one million are living with the disease, but as many as one-third of those are unaware of their status. As a result, those un-diagnosed patients are responsible for transmitting up to 70% of the new infections that occur (UNAIDS, 2009b).

Obviously, the country’s response to AIDS has produced mixed results. Transmissions to unborn children have been much reduced, but every year there are approximately 56,000 new infections. In March 2009 the U.S. capital, Washington D.C.,

reported an HIV prevalence of at least 3% among people over 12 years—similar to rates in some parts of sub-Saharan Africa. Stigma and discrimination toward HIV-positive people still persist, and thousands of uninsured or underinsured Americans struggle to access HIV care and antiretroviral therapy (AVERT, 2010b). Although the United States spends more on HIV/AIDS than any other country, much of the money goes to sex abstinence campaigns rather than for treatment. Americans with adequate insurance or personal funds can receive HAART and monitoring for about US\$10,000/year (Sepkowitz, 2006). With treatments improving survival rates in affluent countries, however, a sense of complacency appears to be driving a decline in safe sex practices, which experts fear could dramatically increase infection rates. The most current UNAIDS data indicates that progress in reducing the number of new HIV infections in the U.S. has essentially stalled, and in fact transmission rates among men who have sex with men (MSM) has steadily increased since the early 1990s as a result of a rise in sexual risk behaviours (UNAIDS, 2009b).

Also, minority ethnic groups continue to be disproportionately affected. Although African-Americans represent only 12% of the population, they account for 46% of HIV prevalence and black women are 19 times more likely than their white counterparts to become infected through heterosexual contact (UNAIDS, 2009b; AVERT, 2010a).

In the early years of the AIDS epidemic, the general public considered HIV/AIDS a gay disease, and prevention efforts did not have widespread support. The disclosure that several well-known entertainment and sports personalities, including film star Rock Hudson and basketball legend ‘Magic’ Johnson, had AIDS helped create public awareness. Gay activists, who understood the communication industry, gave AIDS a political face when they *‘battered down the doors of the medical establishment, assaulted the pharmaceutical industry, and took the press by storm’* (Pisani, 2009, p.308). When U.S. presidents began to break the silence by setting up support and funding for HIV/AIDS, the disease became an issue on the public agenda.

AIDS advocacy groups have been increasingly successful in gaining political support; President Clinton established the White House Office of National AIDS Policy, and in 2003 President George Bush allocated US\$15 billion for PEPFAR’s five-year program. This initiative was reauthorised in 2007 for another five years and US\$30 billion, with the abstinence stipulations discussed earlier, but was primarily directed to international efforts (AVERT, 2010b).

In the first 100 days of President Obama’s term, *Act Against AIDS*, a five-year communications plan, was launched to *‘put the HIV crisis back on the national radar*

screen' (Obama, 2009). The campaign began with mass media to increase public knowledge about the severity of the AIDS crisis in the U.S. The next step was designed to encourage increased HIV testing among the two groups of African-Americans most severely affected, gay or bisexual men and women. This first national HIV/AIDS campaign in more than a decade uses a broad coalition of government, NGOs, and business groups to spread the word that someone is infected with HIV every 9 ½ minutes and aims to combat complacency about the HIV/AIDS crisis in the United States (Obama, 2009).

2.6 SO DIFFERENT...YET SO SIMILAR

Although these three counties occupy widely divergent political, cultural, and economic positions in the world community, such is the overreaching global nature of this disease that many of the same problems and questions emerge when examining their HIV/AIDS social marketing campaigns.

2.6.1 Campaigns focus on prevention

Most campaigns focus on prevention messages over treatment information. PSI, the principal contractor for USAID's 2005 behavioural change campaign in Mexico, puts a strong focus on prevention messages and brand-specific advertising, especially of condoms. Using established communications strategies to target specific audiences, social marketing assistance includes procuring and distributing pharmaceuticals, over-the-counter drugs, and condoms (USAID, 2005a). While this so-called 'manufacturer's model' makes products widely available at lower than market costs, some critics say it also perpetuates reciprocal relationships with the pharmaceutical industry and often establishes conventional products and treatments as the norm (Moynihan & Cassels, 2005). Brand-name condoms and related products are always *sold* (not given away), albeit at reduced prices, because PSI's policy is '*when products are given away... the recipient often does not value them or even use them*' (Population Services International, 2005). On the downside, when subsidies to manufacturers end and promotion decreases, retail prices are usually raised, with a resultant decline in sales by low-income groups. PSI also trains government officials in marketing and communication techniques, further solidifying the relationship between policy makers and the traditional medical industry.

The Global Policy Forum terms these prevention messages the 'health belief model,' which supposedly prevents the spread of AIDS by an infusion of information. The health belief model relies on the supposition AIDS will decrease if people are well educated

about how the disease is transmitted. *'This logic, often promoted by international financial institutions, ignores most of the available data we now have on AIDS prevention initiatives,'* according to the Forum (Basu, 2003, p.1). For example, the Ugandan government's extensive education program has been widely hailed as a model for reducing AIDS among some segments of the country. Unfortunately, AIDS has not subsided in many of the rural and poorer areas, where 87% of the population lives (Basu, 2003).

Looking beneath the favourable publicity about Uganda's program demonstrates how easily statistics can be manipulated. In sectors where the numbers of those living with HIV infections have declined, the reduction can be attributed to an increase in deaths rather than a reduction in new cases (Basu, 2003). The Ugandan model fails to take into consideration the major epidemiological predictor for AIDS infection is not 'risk behaviours' but rather a low income level. Writing in *The Lancet*, Dr. Paul Farmer noted, *'Their risk stems less from ignorance and more from the precarious situations in which hundreds of millions live'* (Farmer, 2001, p. 404.). Since HIV/AIDS is officially categorised as a chronic disease that can be managed but not cured (Beaudin & Chambré, 1996), the majority of funding in Uganda— as well as in other countries where HIV/AIDS is widespread—is earmarked for prevention messages.

As organisations that use social marketing techniques analyze their results, more questions emerge. For example, PANCEA, a NIH-funded research project in Mexico, Uganda, and three other countries, collected and analysed output, cost, and quality data from 200 prevention programs. PANCEA studied the eight prevention modalities that are commonly part of the core prevention response to the HIV epidemic in most countries. Although PANCEA concluded, *'For several, there is a substantial body of scientific evidence suggesting they are effective,'* the organisation comments that for condom social marketing as well as for information, education, and communication (IEC) efforts, *'the evidence of effectiveness is less clear'* (PANCEA, 2005).

2.6.2 Stigma creates an 'underground epidemic'

Another commonality is the role of cultural stigma in HIV/AIDS prevention and treatment (What does culture, 2002). HIV has been called an 'underground epidemic' because of stigma and discrimination associated with the disease, which often discourage people from getting tested or accessing care, according to a 2003 report from the 2nd Forum on HIV/AIDS/STD in Latin America and the Caribbean. The Forum study warned categorizing the epidemic as 'self-contained' is a mistake, and pointed out a

lesser-known fact of stigma and discrimination is *'it prevents allocating resources in the most needed areas and populations'* (HIV infection, 2003, p.12).

In many communities people are reluctant and embarrassed to openly discuss HIV/AIDS. To address this reticence along the U.S.-Mexico border, the SPNS (Special Projects of National Significance) Border Health Initiative is administered by the U.S. Department of Health and Human Services. Relying heavily on social marketing campaigns, SPNS utilizes Spanish language media to blanket the transient communities with 'bold' HIV messages designed to *'reverse the cultural norm that topics related to sexuality, including HIV, are not discussed in public'* (Innovative, 2005) and to educate Mexicans about the risk of the disease. HIV/AIDS is a significant problem along the 2,000-mile border between the United States and Mexico, where mobility, poverty, and lack of access to health care complicate prevention and care (Innovative, 2005).

2.6.3 Financial toll threatens economies

Finally, the economic factor is a global consideration spanning cultures and continents and underlying all HIV/AIDS public policies (UNAIDS, 2006). In many parts of Africa, for example, AIDS is the main threat to social sustainability, where it is estimated up to half of all of today's 15-year-olds will die of the disease (Conflicts, 2005). Of 18 countries in Sub-Saharan Africa that recorded declining life expectancies in the 1990s, all but one (Togo) were considered to have a general HIV/AIDS epidemic, which the World Bank defines as having an HIV prevalence of more than 5% in the adult population (Michiels, 2001). The two extremes are a low level epidemic, where HIV has not spread to more than 1% in any population (e.g. Middle East), to a 'hyper-endemic' state in which HIV prevalence in the general adult population exceeds 15% (only in South Africa) (Bertozzi, et al., 2008, p.65).

Likewise, in many Latin American countries recent reports show the disease is increasingly affecting the youngest and most productive populations as well as poor and marginalised groups. This trend bodes ill for the future and predicts additional diversion of resources from other health, welfare, and education priorities (HIV Infection, 2003). Recognizing expanding HIV/AIDS populations will damage the global economy, governments in both developing and industrialised countries, in conjunction with pharmaceutical companies such as Pfizer, have launched a variety of organised offensives, which include political commitment, law enforcement, government policy, and social marketing and community mobilisation (Pfizer, 2006). For example, the Mexican pharmaceutical market is one of the most lucrative in the world and the most

profitable in Latin America. A recent survey reported that Mexico is the largest consumer of pharmaceuticals in Latin America and the ninth largest worldwide. Pharmaceutical sales jumped from 6.83 billion dollars in 2002 (Gonzalez, 2003) to 11.3 billion dollars in 2005 (Espicom, 2005). Given these numbers, it seems safe to say that major pharmaceutical companies will continue to vie for partnership status in social marketing campaigns and that condoms will be more accessible and socially acceptable.

According to the pharmaceutical industry's own tax records, in 2002, Merck spent 13% of its revenue on marketing and only 5% on research and development (R&D); Pfizer spent 35% on marketing and only 15% on R&D; and the industry overall spent 27% on marketing and 11% on R&D (Basu, 2003, p.5). With this kind of investment at stake, critics say it is not surprising the conventional medical establishment uses its influence and financial clout to shape dissemination of information about HIV/AIDS (Hamber, 2005).

This repression of information was acknowledged by the International Committee of Medical Journal Editors, which includes editors from *The Lancet*, *New England Journal of Medicine*, *Journal of the American Medical Association*, and *Annals of Internal Medicine*. These editors publicly declared selective reporting of clinical drug trials occurs. *'Irrespective of their scientific interest, trial results that place financial interests at risk are particularly likely to remain unpublished and hidden from view,'* according to the editors (Graham, 2004). In the wake of this revelation, some U.S. political leaders called for public examination of *'whether the pharmaceutical industry has systematically misled physicians and patients by suppressing important data on their drugs'* (Graham, 2004, p. 21).

Content of social marketing messages about HIV/AIDS, the role of stigma and culture, and the economic realities of the global medical market created by the epidemic, form a complex and politically charged environment that influences public dissemination of information about health care options and offers a multitude of possibilities for fresh interpretations of the cross-disciplinary relationships and concepts involved.

2.7 HOW HIV/AIDS HAS CHANGED THE LANDSCAPE OF PUBLIC HEALTH

During the decades since HIV/AIDS became a global issue, perhaps the principal constant has been the controversy over what lessons have been learned and what to do next. Following are a few of the divergent voices weighing in on the complex issues surrounding the epidemic:

Too little, too late:

'Even where resources are plentiful, many people with HIV disease do not receive the prevention and care interventions they need. Even in wealthy countries like the United States, more than one-third of all HIV infections are undiagnosed and a large portion of the HIV-positive population receives substandard care. Across the globe, many people in need do not receive services simply because services do not exist' (Academy, 2006).

New treatments are not perfect:

'Today, with the current widespread popularity of antiretroviral therapy, CAM is likely to be used in a more complementary rather than alternative fashion. Also, since effective antiviral drugs are available, people may be more interested in using CAM for HIV-related conditions that do not respond to highly active antiretroviral therapy (HAART), e.g., wasting syndrome. CAM is very important to provide the immune support the body will need for extended years of drug treatments and to battle the onslaught of drug side effects brought on by powerful new drugs' (Hanna, 1998).

Progress leads to more problems:

An epidemiologist who worked for international AIDS groups in Asia for 10 years points out in her controversial book, *The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS*, the convoluted paradoxes of HIV/AIDS 'successes':

'The more effective our prevention programmes are, the less treatment we will need. But the more effective our treatment programmes are, and the longer people live with their infections, the healthier and more sexually active they are, the more prevention programmes we will need because people become less frightened of the disease and consequently will not practice safer sex. We need to make sure we have the money and the staff to bump up prevention services as more people get treated' (Pisani, 2008, p.165).

Information strategies have not targeted key groups:

UNAIDS' *2009 AIDS Epidemic Update* clearly says that countries are not reaching the right audiences with their AIDS prevention and treatment programmes: *'The common failure to prioritise HIV prevention programmes for key populations is especially evident' (UNAIDS, 2009b, p.9)*. Groups listed as often needing more focused prevention programs include injecting drug users, men who have sex with men, sex workers, prisoners, and mobile workers. In addition, UNAIDS reports a lack of prevention programs that address high rates of infection among older heterosexual couples and young people in intergenerational partnerships. Finally, the *'typical shortage of programmes specifically designed for people living with HIV'* is lamented (UNAIDS, 2009b, p.9).

Hope for a better tomorrow:

'We can only hope that the years ahead will be characterised not just by better drugs, new vaccines, and improved prevention methods, but also by the

adoption of the humility necessary to control a disease that is transmitted through sexual activity and drug use — two of proper society's least favourite topics. The prime mover of the epidemic is not inadequate antiretroviral medications, poverty, or bad luck, but our inability to accept the gothic dimensions of a disease that is transmitted sexually. Only when we cease to dodge this fact will effective HIV-control programs be established. Until then, it is no exaggeration to say that our polite behaviour is killing us' (Sepkowitz, 2006, p.2414).

2.8 CONCLUSIONS

This contextual literature review covered a massive amount of ground and raised more questions than it answered, but it confirmed that this research area deserved further study. The confluence of the three topics opened up fascinating, albeit incredibly complex, issues. The three countries were chosen because they offer an intriguing variety: From the U.S. at #5 in per capita income (US\$33,000) to Mexico at #47 (US\$5,200) to Uganda at #156 (US\$217) (NationMaster, 2010), but the problems do not stop at country borders and many commonalities exist. The medical landscape is constantly changing; conventional medicine says no true cure is in sight, and the track record of standard treatments shows increasingly severe complications. Some alternative medical practitioners insist AIDS can be cured, but that alternative treatments have been overshadowed by the widespread use of HAART. Social marketing has been an important component of prevention and treatment programmes all over the world, but information gaps are plentiful and infection rates are still increasing among many at-risk groups. Nevertheless, the power of social marketing to motivate positive behavioural change is highly regarded by policy makers and activists alike, so funding continues to be allocated for social marketing interventions.

To better understand how social marketing can effectively address an epidemic such as HIV/AIDS, the following chapter takes an in-depth look at the foundations upon which social marketing is based, strategic and creative approaches used by practitioners, and the best practices for implementation.

CHAPTER 3

THEORETICAL LITERATURE REVIEW

HOW SOCIAL MARKETING WORKS: THEORIES AND STRUCTURES

3.1 INTRODUCTION

Although social marketing is not a theory, it informs and structures its framework using psychology, sociology, anthropology, and communications (Kotler & Zaltman, 1971). This array gives social marketers a lot of options but also can result in strategies that are not well grounded in recognised theory. Also, as global communication becomes more personal and immediate, social marketing must consider how to best adapt its message dissemination to efficiently reach target audiences. The evolution of social media and its ready acceptance around the world is revolutionising communication, but it may not be a replacement for traditional media in social marketing campaigns that target impoverished populations. Social marketers have never had more opportunities to blend scientific methods and the art of creativity for the purpose of motivating change for the good of individuals and society. Kotler and Zaltman saw this potential when they concluded social marketing could be the *'bridging mechanism'* between behavioural science and the *'socially useful implementation of what that knowledge allows'* (1971, p.12). Almost 40 years later, Kotler and Zaltman's observations still stand as a seminal work in the history of the discipline, although social marketing approaches have been consistently refined and evaluated for efficacy in motivating short-term behavioural change at the individual level and long-term societal transformation at the policy level.

Therefore, this chapter will survey the most common theories of health behavioural change, which encourage people to act in different or more positive ways. Since the major theories of health behaviour change include communication processes, this chapter also includes discussion of the branches of communication study and the broad effects of emerging communication channels. Finally, to cross Kotler and Zaltman's bridge from behavioural science to social implementation, there is a discussion of strategic and creative approaches that might be useful for HIV/AIDS campaigns. In keeping with this melding of theory and practice, sources for this chapter include both social marketing researchers and practitioners. The toolbox of theories and techniques available to social

marketers is vast, so this review helps limit the scope of inquiry and provides a framework for ongoing dialogue in later research phases.

3.2 QUESTION ADDRESSED IN THIS CHAPTER

- *How does social marketing work and what can it accomplish?*

Traditionally, the most frequently used tool by social marketers has been mass media campaigns (Stead & Hastings, 1997), which are called ‘*social marcoms campaigns*’ (Noble, 2005). Social scientists question whether social marcoms are an effective public health tool or, as critics say about commercial marketing, if social marcoms are just another facet of consumer culture that sells peoples’ lives back to them (Pappas, 2006). The answer is far from clear.

3.3 DOES SOCIAL MARKETING WORK?

YES: Pappas, in discussing social marketing communications created by Better World Advertising in San Francisco, many of them for HIV/AIDS prevention, said social marketing is important because it works...when it is well done. Pappas commented it is ‘*hard to do well, but it’s not that mysterious. Corporations spend billions on advertising—they wouldn’t do it if it didn’t work*’ (2006, paragraphs 2, 5). His key concepts for good social marketing are: inclusiveness, research, creativity, testing, and evaluation.

NO: Pappas also said ‘*bad social marketing is bland, safe, and pretty ineffective*’ (2006, paragraph 6). He attributed this to social marketing often being channelled through government agencies, which are cautious and careful not to offend, or because marcoms suffer from scarce resources, government regulations and censorship, or lack of understanding how to motivate change (2006).

10% YES; 90% NO: Studies show social marcoms campaigns have a poor rate of success in changing people’s behaviour. Rossiter and Bellman (2005) found social marcoms are only successful in 10% of cases, compared with 50% of commercial marcoms that succeed in increasing consumer purchases or product usage rates. There could be several reasons for this low rate of success, Noble suggested. First, behavioural change is harder to effect than changes in consumer spending. Second, social marketers target audiences in some of the least accessible sections of society, often minority ethnic

groups. Also, when those targets are from ‘*culturally and linguistically diverse*’ (CALD) communities, the challenge is even greater (Noble, 2005).

YES: In many developing countries, social marketing programmes have become an essential component, if not the main component, of national family planning and HIV prevention strategy. Meekers and Rahaim compiled a database covering 555 years of experience with social marketing programmes that distributed and promoted use of oral contraceptives and condoms. They reported that in 2002, social marketing programmes in 69 countries sold almost 1.6 billion condoms, more than one half of all condoms available from public sources (Meekers & Rahaim, 2005).

NOT SURE: It is difficult to gauge how well social marketing campaigns perform since there is no uniform measure of success—some evaluations examine short-term results, such as condom sales or immediate behavioural change. Long-term behavioural change is more difficult if not impossible to measure, especially in HIV/AIDS social marketing where there is such a short history. As discussed in Chapter 2, data indicates some of the HIV/AIDS behaviour changes achieved in the past two decades have not been permanent. An example is the trend for men who have sex with men—MSM—discontinuing safer sex practices after two decades of being ‘careful’ (Krochmal & Herman, 2003).

In their efforts to effect broader and more lasting behavioural change, social marketers have adopted the commercial marketing concept of using both downstream and upstream marketing approaches that target individual consumers (downstream audiences) as well as policy makers (upstream audiences such as governments and NGOs). Dann noted ‘*safe sex social marketers have historically used upstream marketing to broaden the distribution base of condoms and safe sex information*’ (2006, p.4). Dann also pointed out that upstream social marketing can involve such ‘solutions’ as legislative controls, which remove the choice for voluntary change. Although upstream social marketing can facilitate the exchange process, ultimately, Dann argued, the consumer must have the freedom to accept or reject the ‘offer’ for social marketing to take place, or ‘*social marketing simply ceases to exist where legislation or coercion takes precedence over voluntary choice*’ (2006, p.6).

3.4 THEORETICAL CHOICES FOR SOCIAL MARKETING

By the very nature of its founding tenets, social marketing is at home with health activism and health communication. In discussing theories and models with connections to social marketing, Lefebvre commented that they *'reflect a public health bias in that most social marketing programmes...are designed by people with advanced degrees in social and behavioural science [who are] advancing public health goals'* (2001, p.507). People creating and implementing the campaigns, however, are more likely to have backgrounds in marketing or communication.

Because social marketing draws from such a range of disciplines and theories, the literature contains discussion of theories relating to general behavioural change, with their connections to economics, politics, and culture. HIV/AIDS social marketing interventions frequently use behaviour change communication (BCC) as a core strategy. In a manual for HIV/ AIDS peer educators, Long defines BCC as *'the process by which information and skills are shared and disseminated to people in the specific target audience with the intention of influencing them to adopt sustained changes in sexual behaviour or attitude, or to engage in other health-seeking behaviour'* (2006, p.5). Another category of discussion centres on personal motivators, since people do not always respond in the same ways to incentives or disincentives.

In a perfect world the social marketer has the freedom to move amongst these various disciplines and theoretical frameworks, choosing those elements best suited to the purpose and audience where behavioural change is deemed desirable. In reality, it is a daunting array of theories and tools without clear signposts to point the way through the maze of choices. This chapter focuses on choices most relevant to HIV/AIDS social marketing campaigns.

3.4.1 Theories of health behaviour change

Early generations of HIV social marketing campaigns frequently built their messages around the *health belief model* (Montgomery, 1989), which is based on barriers and benefits and often uses fear or anxiety-arousing messages. This model holds that individuals will be more likely to change their health-related behaviour if they recognise a health risk or condition as important, if they view themselves as susceptible to that risk or condition, and if they regard the benefits of change as outweighing the barriers. After

study of a cohort of homosexual men at two different time points, Montgomery and colleagues concluded although the health belief model has been successfully applied to a variety of less complex and less threatening health conditions, that the '*special features of AIDS may require development of more adequate theoretical frameworks*' (1989, p.323).

Hastings and colleagues noted fear appeals have been '*embraced with enthusiasm by social marketers*' (2004, p.962), but caution fear appeals, in addition to encouraging 'health fatalism,' may actually have negative long-term effects on the brand. A more effective use of fear, especially for young people, according to Backer, Rogers, and Sopory, is a positive rational/emotional approach, which uses fear to grab attention, then relates the fear to a positive outcome (Backer, et al., 1992). Terblanche-Smit investigated whether use of fear increases the likelihood of adopting appropriate behaviour pertaining to HIV/AIDS— if accompanied by high efficacy messages. They found '*encouraging evidence for the persuasive power of fear appeals to improve knowledge and to influence attitudes about HIV/AIDS, especially among adolescents*' (2008, p.302). The study confirmed a causal relationship between susceptibility and fear. Terblanche-Smit concluded, '*Future AIDS campaigns targeted at adolescents must communicate the target audience's susceptibility to the disease to ensure they experience a relevant fear that will drive them to change the way they think about HIV/AIDS and ultimately influence them to modify their sexual behaviour to safe sexual behaviour*' (2008, p.305).

Lee added to the discussion of the practical aspects of fear with four key points:

- 1) Consider the target's stage of change; '*If in the precontemplation stage, fear may work to "wake them up," but if in the contemplation stage, fear may immobilise them*' (2009).
- 2) If fear is used, always follow up (quickly) with a solution.
- 3) Sometimes it is more effective to direct a fear message to a spouse or a friend than the target.
- 4) A credible source is critical (Lee, 2009).

In a report prepared for the UK's National Social Marketing Strategy for Health, McDermott and colleagues (2006) found nutrition social marketing interventions were based on a number of behaviour change models. The most common was the *social cognitive theory*, which emphasises observational learning and self-efficacy and is frequently used in campaigns where individuals have choices of how to respond to their

environments (Lefebvre, 2001). The social cognitive theory explains how people acquire and maintain certain behavioural patterns; this theory also provides a basis for intervention strategies (Bandura, 1997). Evaluating behavioural change depends on environment, people, and behaviour, which are constantly influencing each other. There are both social and physical environments; the social environment includes family members, friends and colleagues, while the physical environment includes factors such as the size of a room, the ambient temperature, or the availability of certain foods (Glanz et al., 2002).

The next most popular model, according to McDermott's report, was the transtheoretical model, popularly known as *stages of change*, which assumes few people are ready to take action and must be moved through early stages of indecision. In 1982, psychologists developed the Stages of Change Theory, which challenged the change paradigm that '*assumed change occurred dramatically and discretely*' (Prochaska, et al., 1994, p.14-15). The stages are: 1) precontemplation, where the client denies there is a problem and resists change, 2) contemplation, where the client acknowledges a problem exists and plans to take action in the future. A chronic contemplator who substitutes worry for work is not uncommon, 3) preparation, where the client is committed to take action 'soon,' but may still need to completely convince him or herself, 4) action stage, where there is a commitment of time and energy. The danger at this stage is equating action with change, 5) maintenance is more challenging than action and outside support is crucial. Prochaska and colleagues said a linear progression through the stages of change is possible but rare; only 20% permanently conquer their problems on the first try (Prochaska, et al., 1994).

Lefebvre pointed out one of the few population-based models available to social marketers is *diffusion of innovation*, which segments any target group into different types of adopters (innovator, early adopter, early majority, late majority, and laggard) and suggests the marketer begin with one or two segments (2001). Diffusion research focuses on conditions that increase or decrease the likelihood that new ideas, products, or practices will be adopted by members of a given culture. Diffusion of innovation theory says that media as well as interpersonal contacts provide information and influence opinion and judgement (Rogers, 1995).

Lefebvre also mentioned the *theory of reasoned action*, which holds that peoples' behaviour is predicted by attitudes toward a particular belief and how they think others will view them (2001, pp.507-515). According to this theory, behaviour is principally influenced by intentions to change and those intentions are influenced by people's perceptions of what important referent groups think about the behaviour. Communication may play a key role in shaping these perceptions and thereby increasing the likelihood of behaviour change.

On a broader policy level, upstream appeals often reference the goal of *sustainable development*, which takes a long-term, generational view and focuses on people's power to make decisions about the future of their society (Dubois, 2003).

In regards to HIV/AIDS interventions, however, Coates and colleagues pointed out behaviour changes effected by cognitive-behaviour approaches, communication theory, peer education, or diffusion of innovation are '*statistically significant*,' but '*rarely sufficient to reduce sexually transmitted or HIV infections*' (2008, p.38). They concluded that behavioural strategies are essential in a comprehensive HIV prevention campaign but are not sufficient in and of themselves to reduce HIV transmission (2008, p.39).

3.4.2 Communication theory

These theories of health behavioural change, when used as the foundation for social marcoms, are all affected by the communication process, so, it is important to consider how communication activity positively or negatively contributes to health behaviour. Communication scholar Gerbner described three relevant branches of communication study:

- Semiotics, which is the study of signs and symbols and how they combine to convey meaning in different social contexts. Semiotics includes verbal, nonverbal, and visual and aural signs and symbols.
- Media effects, which studies resultant behaviour and interaction through exposure to messages.
- Message production, which is the study of how communication is organised through social institutions and systems such as mass media, political

organisations, government, and advocacy groups. Message production can be influenced by sociology, political science, history and public affairs (Gerbner, 1956).

Although these three areas of communication study continue to be important in the design and implementation of a social marketing campaign, Thackeray and Neiger suggested a dramatic shift in the traditional ‘top down’ communication model, in which a sender relays a message through a channel to a receiver, with social marketers acting as gatekeepers of information (2009). They posited that the communication process, at least for those with access to the Internet, is *‘changing from being unidirectional to multidirectional as consumers become active participants by creating, seeking, and sharing information using a variety of channels and devices’* (Thackeray & Neiger, 2009, p.171).

The participatory nature of online social media channels such as Twitter, Facebook, and blogs where viewers/readers converse and create content has grabbed the attention of commercial marketers, but HIV/AIDS social marketers have been slower to adopt social media techniques. However, government agencies such as CDC and NGOs such as Population Services International (PSI) have begun to incorporate social media into their prevention campaigns, especially when targeting younger audiences with access to the Internet. In July of 2010, internationally known HIV/AIDS activist Rae Lewis-Thornton hosted the first-ever HIV/AIDS-themed social media gathering in Chicago—a Tweet-up—aimed at spreading the message about disease prevention (Chaney, 2010).

For those marcoms audiences who actively use new media, this shift in the communication process could affect a) who delivers information, because consumers become creators and senders of messages, b) how information is delivered, since both social marketers and consumers will send messages using new technologies, and c) how information is sought, as consumers proactively seek out information. In support of their hypothesis, the researchers cited a 2005 study by Hesse, et al., which found 49% of adults said they go first to the Internet for health information, while only 11% said they went to their health care provider first (Hesse, et al., cited in Thackeray & Neiger, 2009, p.174).

In response to studies such as this, PSI, the largest social marketing organisation in the world, used targeted Behaviour Change Communications (BCC) in Mexico to focus

on gender equity and prevention messages addressed to young people under 25. An innovative example of PSI's initiatives is a campaign called *Menos Etiquetas*, which relies heavily on 'peer educators' but reinforces that strategy with BTL (below the line) techniques such as blogs, an array of promotional materials in places frequented by youths, and creative Bluetooth viral marketing (Massingill, 2009).

Thackerary and Neiger agreed traditional media channels are not obsolete but are likely to be supplemented with these new technologies that could extend reach and effectiveness (2009, p.175). In a discipline where targeting audience segments is imperative, the ultimate targeting strategy is tailoring, where computer databases make it possible to store a large number of alternative messages on a topic like AIDS prevention and send on request a message that fits precisely with the situation (Singhal & Rogers, 2003, p.170). Cautionary notes concerning new media relate to the target's media access and literacy as well as the potential for consumer information overload; the social marketer must be proactive in soliciting consumer permission to receive information (Thackerary and Neiger 2009, p.174-5).

Numerous studies are underway to determine the extent to which the Internet and social media are changing how people use traditional media and in which groups this is occurring. Media use by the social marketers' segmented target market is obviously a critical factor in dissemination of social change messages, but many of the studies are focusing on more mainstream audiences than groups where HIV/AIDS might be a major concern (UNAIDS, 2009b).

3.5 MOVING FROM THEORY TO ACTION

Once the theories are assimilated and choices are made about how to incorporate scientific method into social marcoms, it is time to cross the 'bridge' to practical application, where the creative process comes into play. According to Andreasen (2006, p.137-8), the social marketing approach involves a series of steps that give structure and direction to the process. That progression should include:

- 1) Selects the target audience segment or segments and determines the amount of focus to be given to each group.
- 2) Listens to the target audience through background reading, formal research, expert advice, and informal conversations

- 3) Designs a course of action
- 4) Pre-tests the programme with the target audience and monitors results
- 5) Crafts programmes that use a media mix
- 6) Expects—and makes—mid-course corrections

At this point, HIV/AIDS social marketers might consider Singhal and Rogers' contention that behaviour change communication strategies that focus solely on individual-level changes subscribe to one or more mistaken assumptions. The first assumption mentioned is that all individuals are capable of controlling their context, when cultural, economic, social, and political factors may affect the availability of such services as testing and condoms. The second assumption is that all persons are on an '*even playing field*,' when in fact women and the poor are more vulnerable to HIV/AIDS. The third assumption of behaviour change communication strategies, according to Singhal and Rogers, is that all individuals make decisions of their own free will, when for example women in many cultures cannot control if they have protection during sex. The last assumption is that all individuals make preventive health decisions rationally (2003, p.212).

Coates and colleagues argued that lowering HIV incidence will require '*elevating the debate on HIV prevention beyond the incessant controversies over individual interventions*' and that policy makers, donors, and advocates must demand national prevention efforts tailored to their epidemics and that address environmental vulnerability factors (Coates et al., 2008, p.40).

3.6 STRATEGIC APPROACHES

Informed by research and guided by science, the social marketer's next step is to construct a plan to motivate behavioural change in the target audience. Given the unique situation surrounding HIV/AIDS audiences, social marcoms strategies should include both cultural and socio-economic factors that combine behaviour strategies with a variety of communication approaches at multiple levels of influence (Coates, et al., 2008, p.39).

3.6.1 Cultural considerations

HIV/AIDS is no respecter of boundaries of any kind, but attitudes and perceptions regarding the disease vary greatly depending on cultural traditions, so the social marketer must consider how messages will be interpreted, especially in groups that are culturally and linguistically diverse (CALD) (Noble, 2005). Examining every aspect of culture is beyond the scope of this review, but high- and low-context communication and cross-cultural factors are likely to affect the design of HIV/AIDS interventions.

Hall developed a typology that suggests cultures are distinguished by low- and high-context messages (Mueller, 1996, pp.114-117). In the case of low-context culture, most of the information is in explicit code using words or symbols. This informational style is typical of most Western cultures. On the other hand, in high-context, or transformational, cultures, up to 90% of meaning is communicated through non-verbal aspects. For example, informational ads would attempt to change behaviour by providing objective facts; transformational ads would attempt to move a consumer emotionally (such as through fear).

International campaigns often must be adapted to match the culture of the target audience because a low-context, cognitive approach may not work with a high-context audience. *LoveLife*, South Africa's major multi-million HIV/AIDS prevention campaign was launched in 1999 using an informational appeal approach that emphasised condom use and '*positive sexuality*.' Not only did the campaign not produce the desired results, it was the world's first organisation to have funding discontinued by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (Terblanche-Smit, 2008, p.174).

Noble suggested four key issues to adapting social marketing marcoms campaigns for use with CALD audiences (2005):

- 1) Segment the audience—This is usually done on the basis of language and/or country of birth, but that kind of segmentation can be too broad. An alternative is acculturation, the journey immigrants travel as they enter and adopt cultural and social traits associated with the new host country. This process is bi-dimensional; immigrants assume some aspects of the host country culture without ever losing all the cultural traits of their birth country. This combination of cultural attitudes often affects attitudes toward behaviours social marcoms are targeting.

2) Adapt pre-existing messages—International campaigns often try to translate the concepts that have worked in other countries. This can be tricky due to cultural differences and language style. The translated message must be credible; it should not sound outdated or condescending. Unfortunately, the kinds of witty plays on language, such as puns, which marketers frequently rely on, cannot be satisfactorily translated.

3) Establish source credibility—the source of the message plays an important cultural role in how it is perceived. Messages from groups perceived as “helping” organisations are received more positively than official government agencies. Some ethnic groups are more trusting of information delivered by a person rather than by an institution.

4) Coordinate and integrate campaigns—Social marketing’s close relative, Integrated Marketing Communication (IMC), is based on the premise that communication efforts have a better likelihood of success when organisations integrate and coordinate to give clear and consistent messages across all internal and external communication (Noble, 2005).

3.6.2 Socio-economic considerations

According to Meekers and Rahaim, social marketing programmes are classified as using either a non-government organisation (NGO) model, which heavily subsidises products, or the manufacturer’s model, which uses temporary interventions with a *‘realistic exit strategy’* and often differ in terms of branding, pricing, and distribution. It is usually assumed that the manufacturer’s model is more feasible in middle-income countries with well-developed commercial infrastructures, and the NGO model is more suited for lower-income countries with less well-developed commercial infrastructures (2005). Niblet cautioned partnerships are key to this process because social marketers *‘do not have the infrastructure and the marketplace environment commercial marketers take for granted’* (2005, p.3).

Additionally, social marketing can be carried out under one of three different management structures. The most common structure for health-oriented social marketing programmes—used in 70% of the campaigns studied—is management by an NGO, particularly in countries with a low per capita income (less than US\$3,000) and urbanisation of less than half of the population (Meekers & Rahaim, 2005). Under the

second structure, the social marketing intervention is managed by local organisations, often based in a health clinic. The third option, most likely to be used in countries with high per capita income and a strong commercial sector, is to partner with a commercial organisation. Meekers and Rahaim also noted that in a middle-income country with a well-developed commercial sector, it might be counterproductive to use the NGO model with a highly subsidised product that competes with existing brands (2005). In fact, Population Services International discontinued its focus on condom social marketing (CSM) in Mexico for this very reason (Massingill, 2009).

The most insidious cultural problem in countries around the world, especially related to HIV/AIDS, is the stigma and discrimination that are frequently associated with the disease and those who are infected. In spite of decades of social marcoms designed to eliminate stigma against HIV/AIDS, discrimination—social, economic, and political—continues to stall efforts to promote testing and treatment (International HIV/AIDS Alliance, 2008). Even market segmentation for the purpose of social marketing targeting can contribute to stigma and perpetuate stereotypes, such as the short-running San Francisco area campaign with the theme, *AIDS is a Gay Disease*. Jones recommended social marketers launch campaigns that are not overtly or covertly sanitising, sanctimonious, or moralising (2006).

3.7 CREATIVE APPROACH:

In designing their creative approach, social marketers should remember change can be motivated in different ways. Pappas pointed out people can be persuaded to change through positive messages that encourage and attract them: *'getting them on the bandwagon.'* Another option to effect change is through disturbing people or causing them discomfort, so they are challenged to change. Pappas said, *'We like it (social marketing) when it makes us feel good, but we don't like it when it confronts our reality, shocks us, airs our dirty laundry, or makes us think too much. But, ultimately, what is the role of controversy? We need to leverage the scarce resources we have and we need to get people's attention'* (2006, paragraph 7). So-called reality-based social marketing, such as the *AIDS is No Picnic* campaign, which used graphic photos of real people in the later stages of AIDS in an effort to shock gay men in San Francisco into using safer sex practices, are attention-getting, but get mixed reviews from the target audience. Krochmal

and Herman said reactions ranged from *'righteous indignation'* by HIV-positive men who felt exploited and exposed to *'hearty encouragement'* from those who welcomed the attempt to show the reality of those with the disease (2003).

Social marketers are sometimes criticised for using attractive people or celebrities as campaign spokespeople. Losh asked, *'Is it wrong to use attractiveness or celebrity if people respond? Can campaigns shock and still remain humanising?'* (2006, paragraph 7). A danger with controversial campaigns, Losh contended, is they run the risk of *'creating cognitive dissonance among the grassroots level'* (2006, paragraph 9).

However, being too fearful of offending when dealing with an issue like HIV/AIDS can sabotage the campaign, some marketers believe. For example, Losh gave a brief historical overview of the careful creative approach to depicting HIV/AIDS in the United States. In 1986, the surgeon general's report depicted condoms but not faces of people. During those early years of the epidemic, informational materials used medical illustrations and impersonal images such as shaking hands, toilets, and doorknobs, relying on symbols instead of a more humanising approach to the disease. In 1988 the surgeon general sent a brochure illustrated with faces and headshots, but no condoms, to 197 million households. Yet another surgeon general report in the early 1990s showed group photos, bar charts, and condoms, but no individual faces (2006, paragraph 3). *'American campaigns are stymied by Puritanism about the body and sexuality,'* Losh concluded (2006, paragraph 5). Using confusing and innocuous symbols to illustrate HIV/AIDS messages is not just problematic in U.S. campaigns. Pisani recalled a *'baffling'* Indonesia campaign showing people playing pool with the slogan, *AIDS, Wait a Second* (2008).

The opposite approach to these non-confrontational and sometimes confusing images are sociological images, compelling visuals that *'span the breadth of sociological inquiry,'* according to *Contexts* (AIDS is a mass murderer, 2009), the online magazine of the American Sociological Association. An example of an AIDS awareness campaign using this technique was *AIDS is a Mass Murderer*, an ad series depicting women having passionate sex with Hitler, Stalin, and Saddam Hussein, who were all shown with evil expressions and appeared much older than the women. This campaign created a spirited dialogue on the magazine's blog and also raised issues about how campaign visuals could be interpreted in several different contexts (AIDS is a mass murderer, 2009).

Sometimes a shocking image or a controversial approach generates its own media sensation. Reaction to an explicit or disturbing campaign element can take on a life of its own, which may increase visibility or might result in image problems. *I Am African* was another HIV/AIDS campaign that spawned intense debate and accusations of racism. For this campaign, international celebrities were depicted with African ‘war paint’ and wearing ethnic garb such as tribal necklaces and Bedouin shawls. The intended message was everyone has a common ancestry, so everyone should be concerned about the AIDS epidemic in African countries (Media, 2006).

The words that accompany images also can generate strong responses. The scope of the HIV/AIDS epidemic has changed public discourse by breaking the silence about topics that were once considered taboo. Depending on cultural factors such as religion and demographic categories like age, taboo topics might include sex before marriage, use of condoms, alternative lifestyles, women’s rights, homophobia, and prostitution (Massingill, 2008).

One strategy for coping with a taboo topic is to represent it with a symbol, which is the ubiquitous red ribbon in the case of AIDS. Used globally, the red ribbon symbol has contributed in giving worldwide visibility to the disease and offers a means of ‘branding’ HIV/AIDS communication activities (Singhal & Rogers, 2003, pp.254-5). In the case of HIV/AIDS, branding has also been achieved through the annual observance of World AIDS Day on December 1 (World AIDS Day, 2009). Branded items can contribute to a health behaviour change in at least four significant ways, according to Lefebvre. They can mark tribal or brand identity, become a social objective by prompting dialogue, create ubiquity and thereby raise awareness of the issue, and cue action by reminding audiences of the desired behaviour (2010b). The use of external incentives, central to most social marketing approaches, also has potential pitfalls because they can be interpreted as coercion or bribery and not deliver the long-term behavioural change desired (Dholakia & Dholakia, 2001, p.498).

The personal benefits inherent in self-interest appeals, however, are frequently used to advantage. Based on the well-established Maslow’s hierarchy of needs, self-interest appeals target common human needs ranging from physiological to safety, social, ego, and self-fulfilment (Wilcox, 2002).

3.8 CAMPAIGN EVALUATION

A recurring theme in the literature about HIV/AIDS social marketing is whether two decades of campaigns have been effective or if they should have accomplished much more. Policy makers who once saw social marketing as the best tool for motivating social change now cite studies that indicate short-term behavioural modification—not permanent change—has perhaps been the outcome of much of the HIV/AIDS prevention efforts.

A lack of global coordination means that countries report infrequently, using different indicators, so it is impossible to find reliable data about levels of infection or effectiveness of programmes (Coates, et al., 2008). Bertozzi and associates concurred: *'Providing evidence for the effectiveness of a prevention programme is a much more complex task than proving the effectiveness of a drug, vaccine, or biomedical prevention intervention such as male circumcision'* (2008, p.67). Bertozzi and colleagues also pointed out that in many countries there is little or no correlation between data collection regarding knowledge of HIV/AIDS and measuring the effect of specific interventions (2008).

Evaluating social marketing campaigns in a consistent, comparable manner is difficult at best. Part of the problem, according to Miller, is that campaigns should be evaluated both on short-term and long-term results. Not surprisingly, short-term results are easier to tabulate. Miller suggested short-term evaluation might include a series of criteria, beginning with, *'Did the campaign reach the target audience?'* The next question of concern relates to simple message comprehension and acceptance (*'I could understand the message,' 'The message was believable,' 'The message was relevant to me.'*). Affective (emotional) and cognitive (rational) responses to the campaign are also an important way to calculate short-term results. Affective responses might include feedback on how the message made the respondent feel and cognitive responses might relate to what the message prompted the respondent to think about. Finally, immediate behavioural responses can be measured fairly quickly, but tracking long-term behaviour outcomes can, in the instance of HIV/AIDS, take decades—even generations—to fully understand. Miller cautioned that evaluation should also include the question, *'Is the change we (probably) observe due to our efforts?'* (Miller, 2006).

The need for accountability is great, but the challenge is getting everyone—donor countries, philanthropies, multinational organizations and countries highly affected by the pandemic to collaborate. As Coates and associates pointed out, *‘One can improve the science, but what good will it do if the science and best practices are not implemented...measured and achieved? That, presently is not the case’* (2008, p.48).

Singhal and Rogers offered a similar reflection: *‘The world is doing a rather poor job of utilising known communication strategies to control the spread of HIV. We must do better in the future’* (2003, p.76). But, they also see reason to be optimistic: *‘Communication strategies can help break the silence about HIV/AIDS and move the discussion from the personal-private to the public-policy sphere’* (Singhal & Rogers, 2003, p.253).

In pursuit of understanding how social marketing campaigns have helped to break that silence and move the world toward positive social change, Chapter 4 details a methodology for comparing 18 HIV/AIDS social marketing campaigns as the first phase of this research study.

CHAPTER 4

METHODOLOGY

COLLECTING AND ANALYSING SECONDARY DATA

4.1 INTRODUCTION

The central purpose for this project was encapsulated in the overall research aim: *To explore the overlapping landscapes of HIV/AIDS, social marketing, and conventional and alternative medicine with the goal of better understanding those shifting relationships and of using that knowledge to design a communication model for disseminating information about HIV/AIDS prevention and treatment options.*

This proposed inquiry may seem straightforward enough, but initial research revealed a universe of complexities swirling around this convergence of topics. Peoples' attitudes varied wildly; there were the 'head in the sand' thinkers who ignored the topic in hopes it would somehow disappear; others found it unpleasant and unfit for polite society; some were frightened to even discuss HIV/AIDS, as if they could become infected merely through conversation; and still others had solidified their opinions and were uninterested in other viewpoints. Perhaps most distressing were the 'voyageurs,' who relished discussing the more explicit sexual aspects of the disease's transmission.

To begin to comprehend the nuances suggested by the research aim, it was necessary to be aware of the nature and capabilities of social marketing; to understand the context for the HIV/AIDS pandemic's cultural, political, and economic concerns; and to explore conventional and alternative medical communication regarding prevention and treatment of the disease. Understandably, bringing together these divergent components was complicated, requiring carefully constructed research questions and sub-questions that called for the flexibility provided by multiple research methods. Analysis therefore involved both qualitative and quantitative approaches, combined with reflective synthesis and some informed crystal ball gazing. The topic was constantly in motion—a global moving target—as the pandemic progressed, as campaigns were launched, as treatments evolved, as the body of knowledge expanded. In addition, such a volatile topic demanded attention to ethical considerations at every stage of the research.

Research for this project is presented in four stages: 1) collecting and analysing secondary information through an ongoing literature review, 2) conducting a cross-cultural content analysis that bridges the gap between secondary and primary information and between qualitative and quantitative techniques, 3) collecting and

analysing primary information by means of semi-structured interviews and surveys, and 4) constructing a communication model designed to aid in the dissemination of information about HIV/AIDS prevention and treatment options. At each stage, a mix of methods— both subjective and objective—moved the process forward. This project was both a personal journey of discovery and a professional opportunity to participate in a crucial global dialogue that will undoubtedly shape the lives of future generations.

4.2 RESEARCH APPROACH

Because this study as originally conceived was global, complex, and paradoxical— involving three broad topics, multiple disciplines, often with contradictory perspectives, and cultural, political, and economic factors in three countries—the amount of material available to the researcher was overwhelming. Guided by the initial hypotheses (*See Section 1.1*) and exploratory research, the overall research aim was constructed to give a framework for the inquiry. The aim was designed to be broad enough to allow the kind of far-reaching examination the researcher envisioned for this project. As Johnson and Onwuegbuzie asserted, ‘*All research in the social sciences represents an attempt to provide warranted assertions about human beings and the environments in which they live and evolve,*’ but ‘*the bottom line is that research approaches should be mixed in ways that offer the best opportunities for answering important research questions*’ (2004).

The traditional research paradigms were considered. A purely quantitative study, which uses what is termed a positivist philosophy, holds that the social observer should be separate from the entities subject to observation, that all social science inquiry should be entirely objective. The researcher is expected to eliminate all biases and be emotionally detached and uninvolved with the objects of study (Johnson & Onwuegbuzie, 2004).

By contrast, qualitative purists, also called constructivists or interpretivists, reject positivism; they contend multiple-constructed realities abound, and they dislike detached and passive styles of writing. They also point out that ‘*fully objective and value-free research is a myth, even though the regulatory ideal of objectivity can be a useful one*’ (Johnson & Onwuegbuzie, 2004). It was quickly apparent that a monomethod approach using either of these paradigms would not be appropriate for the transdisciplinary mix of topics and ideas included in the research aim. Luckily, there was a third option, as explained by Johnson & Onwuegbuzie: ‘*Today’s research world is becoming increasingly interdisciplinary, complex and dynamic; therefore, many*

researchers need to complement one method with another, and all researchers need a solid understanding of multiple methods used by other scholars to facilitate communication, to promote collaboration, and to provide superior research’ (2004).

Although recent by academic standards, the mixed methods approach, (also called integrating, synthesis, quantitative and qualitative methods, multimethod, and multimethodology), has been gaining credibility since it was first employed in the late 1950s (Creswell, 2003). Campbell and Fisk pioneered the use of a ‘*multimethod matrix*’ to examine data collected by various means (1959). This combination of quantitative with qualitative is now commonly viewed as a complementary approach rather than two alternative methods. More recently, mixed methods has been called the ‘third research paradigm,’ recognizing that both qualitative and quantitative approaches are useful, and proposing to ‘*collect multiple data using different strategies, approaches and methods ...so the resulting mixture is likely to result in complementary strengths and nonoverlapping weaknesses*’ (Johnson & Onwuegbuzie, 2004).

The various rationales for mixing qualitative and quantitative approaches, as discussed by Collins and colleagues, were also investigated. These rationales include participant enrichment, instrument fidelity, treatment integrity, and significance enhancement (2006). The fourth of these—significance enhancement, i.e. mixing quantitative and qualitative techniques to maximize the researcher’s interpretations of data—was considered the most relevant for this study due to the diverse data necessitated by the broad range of the research aim.

Alongside determining the research mixing rationale, Onwuegbuzie and Leech recommended that researchers proposing to employ a mixed process should determine their purpose or purposes for mixing qualitative and quantitative approaches (2006). Greene, Caracelli, and Graham identified five general purposes of mixed-methods studies: (a) triangulation (seeking convergence and corroboration of findings from different methods that study the same phenomenon, (b) complementarity (seeking elaboration, illustration, enhancement, and clarification of the results of one method), (c) initiation (discovering paradoxes and contradictions that lead to a re-framing of the research question or questions), (d) development (using the results from one method to help inform the other method), and (e) expansion (expanding the breadth and range of the investigation by using different methods for different inquiry components (1989).

Although every mixed methods study has one or more of these five purposes, this study utilises aspects of each of these purposes, offering opportunities to cross-validate and triangulate and thereby providing balance in a project that included a wealth of

subjective but meaningful material. The richness of the combined data enhanced the overall study, and the paradoxes encountered along the way certainly were reflected in the evolution of the overall research questions. As shown in the research timeline (Figure 4.1), the sequence of data collection helped inform the phases that followed. In the final analysis, the variety of perspectives and the varied sources of data were invaluable as the mixed design contributed to the goal that is so often the desired results of mixed methods: *'not to search for corroboration, but rather to expand one's understanding'* (Johnson & Onwuegbuzie, 2004).

4.3. RESEARCH QUESTIONS

Research questions can be based on theories, past research, previous experience, or managers' practical need to gather data for decision-making in the workplace. Regardless, the research questions are central to the inquiry since they serve as 'signposts' for the reader, *'foreshadowing the specific details of the study'* (Onwuegbuzie & Leech, 2006). In quantitative research studies, the questions tend to be developed a priori, whereas research questions are more likely to be developed either a posteriori or iteratively in qualitative research studies (Onwuegbuzie & Leech, 2006).

Coming to the overall research questions for this project was not a quick process...there were cumbersome versions that seemed to grow more wordy and awkward as the months went by. Creating over-arching umbrella questions that met the established criteria of being feasible (able to be investigated with resources available), clear (include key terms to use in researching the topics), significant (have the potential to contribute to the field), and ethical (Opfer, 2011) was a more challenging task than it first seemed. An overview of the project garnered approving interest from marketing professionals during a presentation at the Academy of Marketing's Doctoral Colloquium in July of 2007 (Marketing, 2007). *The abstract, A practical approach to cultural change, is shown as Appendix E.4.* These experts pronounced the topic worthy and the work done so far on track. Their principal suggestion for change was to refine the central research questions. Eventually, the questions became less convoluted, and at first glance, perhaps innocuous. But beneath the surface lurked a quagmire of ideas, opinions, and a host of additional questions—too many to answer in one thesis, or perhaps even in one lifetime. In time, a series of sub-questions for each research question was also developed to be addressed—and frequently revisited—over the course

of the project. The grand tour questions, which directed the sequence of the research design, were:

RQ 1: *How have the evolving landscapes of HIV/AIDS, social marketing, and conventional and alternative medicine forged global and national relationships and interactions?*

RQ 2: *Could social marketing influence better-informed behavioural change by including both conventional and alternative medical information in HIV/AIDS campaigns?*

RQ 3: *What practical contribution could social marketing make to bridge the knowledge gap between conventional and alternative medical choices for HIV/AIDS prevention and treatment?*

(See Section 1.2.1 for a complete list of sub-questions. They are also listed in the corresponding areas of this thesis where they are addressed.)

4.4. RESEARCH DESIGN

Research methods should follow research questions in such a way, suggested Johnson and Onwuegbuzie, which ‘offers the best chance to obtain useful answers’ (2004). Since mixed research is essentially pragmatic, using induction (discovery of patterns), deduction (testing hypotheses), and abduction (finding the best set of explanations for the results), it requires researchers to take an eclectic approach to method selection (Johnson & Onwuegbuzie, 2004). The design choices for a mixed researcher are numerous; the literature provides a host of possible designs and configurations. Harrison and Reilly undertook an examination of major marketing journals to determine how mixed methods were designed in more than 2,000 articles (2011). They identified four primary mixed methods design types: 1) exploratory design—the most common—(which was usually either an instrument design where qualitative findings were used to develop scale items for a quantitative survey OR a taxonomy development design where qualitative results were used to develop a classification system); 2) explanatory design (where quantitative data is collected and analysed, with a qualitative follow-up to better understand the initial findings); 3) embedded designs (researchers collect both quantitative and qualitative data sequentially or concurrently with one kind of data playing a supporting role or both taking a supporting role in a case study, ethnography, narrative, or other qualitative research design); and 4) concurrent designs (where qualitative and quantitative data are

collected simultaneously, analysed separately and then merged) (Harrison & Reilly, 2011).

Additionally, Harrison and Reilly identified a hybrid design, which incorporated aspects of multiple design types, and is sometimes used when required by the research rationale. The hybrid design described drew on literature and in-depth interviews to develop an instrument, as in an exploratory design. The instrument was developed using exploratory factor analysis. Next, a follow-up phase of interviews was used to further interpret the findings from the survey data. Finally, data were presented separately and then mixed in the discussion section of the report (2011).

The hybrid design's flexibility was appealing for this study. Several factors made this project both exciting and challenging but demanded a customised research design. First, the histories of social marketing and of HIV/AIDS—separately and together—are relatively short. Social marketing was first defined as a profession in 1971 (Kotler, 1971), and HIV/AIDS was not recognised as a disease until the early 1980s (Segala, 2003). Communication efforts to combat the pandemic span only the last two and a half decades, and many of those efforts have enjoyed qualified successes at best (Singhal & Rogers, 2003). A mixed methods approach to examining HIV/AIDS communication has precedent in the literature, when Janz and colleagues published their evaluation of the effectiveness of 37 AIDS prevention projects more than a decade ago (1996). Janz and her fellow researchers began by collecting quantitative survey data about AIDS interventions that were reported to be effective. Next, qualitative data from in-depth site visits identified factors that contributed to success. The site visits also provided case examples that provided context for understanding why the interventions were effective. This combination of methodologies provided a more thorough understanding of the complexities of the activities and the reasons for their effectiveness (Janz, et al, 1996, p.81).

This study's research questions called for a mix of proven research methods, including content analysis, informal and semi-structured interviews, and a quantitative survey to examine perceptions and effects of social marketing HIV/AIDS campaigns. A qualitative blending of all the data would tie the findings together.

Further, the sequential nature of the research design lent itself to a holistic approach since data from one phase informed and developed the next phase. The forward sequential movement could not be expected to be unwaveringly linear, however; research phases were expected to overlap, which prompted backtracking and reinterpretation, thereby enriching overall understanding.

Likewise, using techniques that facilitate the marriage of exploration and explanation suited this project's aim perfectly. The research design, as shown in Figure 4.1 – *Research Timeline*, plots the research journey through a maze of information and ideas. Additional principles used to develop this design were set out by Mertens (2003). Mertens' criteria included giving priority to qualitative collection and analysis, beginning the integrative process at the data collection stage, and using a transformative/emancipatory theoretical perspective. Transformative scholars assume knowledge is not neutral but is influenced by human interests; *'all knowledge reflects the power and social relationships within society...an important purpose of knowledge construction is to improve society'* (Mertens, 2003, p.4).

At all times, the researcher strove to remember the practical nature of the inquiry, which is spelled out in Lefebvre's integrative model for social marketing: *'Behaviour change is an incremental process that must start with people's current realities and the suggested behaviours must be relevant to their lives—not a theory or research finding'* (2010a). Lefebvre stressed that audience research is the key to understanding the *'determinants, context, and consequences of behaviour'* and must be front and centre in any research design that hopes to market behaviour change to a target audience (2010a).

As with any topic where discovery is ongoing, the body of information was extremely volatile, changing faster than academic research could trace its route. Therefore, the most current secondary information was often found at that indiscriminating repository of truth and fiction—the Internet—and required careful sifting to locate the credible and relevant nuggets. As a result, the reference list is peppered with URLs in addition to the expected books and journal entries.

Even more current and often more perceptive than published material is primary information gathered through interviews and surveys. Those insights can be difficult to collect, however, due to cultural and language differences, distance, political and professional reticence, and most challenging of all, the stigma associated with HIV/AIDS.

Finally, the unusual combination of terms—social marketing, HIV/AIDS, and the controversy about conventional and CAM treatments—mandated simultaneously following three distinct research trails, all the while keeping an eye out for intersecting paths.

Exploratory Research

Qualitative, secondary & primary: Informal literature review and discussions

Formulate initial research aim Revise overall research questions.....

Literature Review (ongoing).....

Qualitative, secondary information used to ‘frame’ the problem, provide context, source of campaigns for content analysis

Phase 1

Quantitative, content analysis matrix of 18 campaigns from three countries

Phase 2

Qualitative, semi-structured interviews w/ key informants

Phase 3.....

Quantitative, surveys of downstream targets

Qualitative, reaction interviews with key informants

Phase 4

Integrative, communication model

Analyses, Reflections.....

Quantitative, qualitative

Figure 4.1—Research Timeline

At the end of each research phase, the information collected and analysed was reviewed to ascertain if any corrections in the methodology were indicated. This methodology evolution is discussed in more detail at the end of each methods chapter.

4.5 ETHICS ACROSS TWO CONTINENTS

Any research that involves human subjects will be exposed to intense scrutiny from university research/ethics departments charged with the responsibility of protecting the rights and welfare of research subjects. This project required approval by universities in two countries.

Through Sam Houston State University in Texas, The National Cancer Institute’s Human Participant Protections Education for Research Teams course was completed and IRB (Institutional Review Board) approvals were obtained for human subject interviews. (IRBs were obtained initially for interviews with inmates in the Texas Prison System and later for interviews with HIV/AIDS key informants in Texas and Mexico.)

At Teesside University, the guidelines of the UK Market Research Society (MRS) Code of Conduct provided the ethical underpinnings for the project. MRS, the world's largest association for market, social, and opinion research, is considered the '*voice of the profession*' (MRS website, 2010). Its Code of Conduct covers all aspects of professionalism in designing and setting up projects using every kind of research method. Based on those guidelines, a comprehensive request for ethical approval was submitted to Teesside's Research Ethics Committee, detailing the research protocol to be followed. This request assessed such considerations as

- dealing with possible discomfort, distress or inconvenience to participants and/or researchers,
- following procedures for respecting confidentiality,
- addressing potential conflicts of interest,
- assessing safety risks, and
- providing explanations and obtaining informed consent from human subjects.

After the ethics committees for both the Teesside Business School and the University had approved the application, research could proceed along the lines set up in the protocol.

4.6 COLLECTING AND ANALYSING SECONDARY INFORMATION

For citizens of what is often called the '*post-information age*,' there is an overwhelming amount of data available on any topic imaginable, much of it free for the taking. Never before has secondary data been so readily accessed and perhaps never before has the plethora of words been so intimidating. Researchers have taken note that '*developments in technology have led to a considerable increase*' in the numbers of databases and information systems available, particularly relating to health issues (Sorensen, et al., 1996, p.435). There are both advantages and disadvantages to using previously collected data. On the positive side, the information already exists, which gives the researcher a 'head start' and reduces the amount of time the study might require. There is likewise a reduction in the cost of the study. Use of secondary data offers the researcher access to generations of information, which can facilitate a broader perspective. This use of accumulated knowledge is a way to replicate and confirm previous results (Kuhn, 1970), allowing the researcher to participate in the evolution of scientific progress by using existing data to help solve new puzzles and anomalies.

Disadvantages of secondary data are readily apparent; in addition to the fact that the information was not assembled with the specific objective the researcher has in mind,

the selection, quality, and collection methods are not under the control of the researcher and may be impossible to validate (Sorensen, 1996). Despite those potential shortcomings, secondary data's value is undisputed and is generally the starting point for any study. In the case of this study, initial exploratory research on the combination of social marketing, HIV/AIDS, and alternative medicine led to a conference presentation, presented jointly with a medical colleague, at a UNESCO conference in Paris in the autumn of 2005. Feedback at the conference was intriguing, and a thesis topic was born. *The poster, Curing AIDS: why successful HIV/AIDS treatments are unknown to world government policy makers, is shown as Appendix E.1.*

4.7 LITERATURE REVIEW

Using a literature review to summarise and synthesise broad themes is the standard initial approach to a research question (Cooper, 1984) and was the starting point for this study as well. The researcher considered various ways to organise the review. A chronological organisation was not appropriate since there were three intersecting topics to consider and the researcher anticipated travelling back and forth in time to explore relationships between the topics. A methodological approach was unacceptable since the researcher was more interested in the content of the material than in the specific methods used to collect the information. A thematic organisation around a single topic or issue was not suited to the variety of topics under consideration.

Instead, the researcher chose to use a two-phased literature review: first a qualitative integrative review was used to 'frame' the research problem and provide context for themes and trends, then a theoretical review was undertaken. The results of these two reviews are presented in Chapters 2 and 3 in this thesis. Areas of literature reviewed included social marketing (history, theory, and practice), HIV/AIDS (history, scope, and projections), social marketing as a tactic for combating HIV/AIDS, health communications and pharmaceutical-dominated marketing, health activism, alternative and conventional medical approaches to HIV/AIDS, and an overview of media coverage of these issues. Literature review continued throughout all research phases as new and relevant material became available.

Information came from all quarters, from chance encounters at conferences and seminars, to postings on social marketing listservs, to books and articles that seemed to appear at opportune times. Thousands of travel miles were logged, from a fact-finding visit to the Institute for Social Marketing at the University of Stirling in Scotland, to conferences in Canada, Mexico, Hungary, and Switzerland.

4.7.1 Questions addressed during the literature review

- *What is social marketing?*
- *What can social marketing accomplish and how does it work?*
- *How has social marketing been used to combat HIV/AIDS in both developing and industrialised countries?*
- *What political, cultural, and economic factors affect dissemination of information about HIV/AIDS treatment and prevention?*
- *What role have the media played in the HIV/AIDS dialogue?*
- *Which are the primary HIV/AIDS treatments offered by conventional medicine and by CAM (Complementary and Alternative Medicine)?*
- *What is the current and projected scope of the disease in Mexico, Uganda, and the United States?*

4.8 CONTENT ANALYSIS METHODOLOGY

Content analysis of a number of HIV/AIDS social marketing campaigns was included in the research design of this study as a means of deconstructing a group of campaigns and identifying both commonalities and important differences that affected their effectiveness.

The content analysis process began by enumerating criteria for selecting a group of possible campaigns to consider and then narrowing that list to a manageable sample of campaigns for analysis. Initial examination of the campaigns recorded quantifiable elements. Informed by the literature review and by issues raised during the early semi-structured interviews, a cross-cultural content analysis method was adopted. Cross-cultural content analysis, as defined by Ahmed (1996), merges traditionally quantitative content analysis with qualitative semiotic concepts. Ahmed used a cross-cultural content analysis to compare advertising in a highly collectivist and high-context culture (India) to a highly individualistic and low-context culture (United States). His research indicates analysis of only the verbal content of advertising is not sufficient because advertising generally communicates its messages through a marriage of verbal and visual content. Although cross-cultural advertising research is relatively new, content analysis is well established in the social sciences as an unobtrusive method for examining trends through written and pictorial components (Krippendorff, 2004). Since content analysis is characterised as empirical, exploratory, and inferential, it was an ideal method to organise and examine data from 18 HIV/AIDS social marketing campaigns in the first phase of this research.

4.8.1 Questions addressed during content analysis research

- *What are specific examples of recent HIV/AIDS social marketing campaigns?*
- *What commonalities and unique characteristics can be identified as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used?*

4.8.2 Choosing campaigns for content analysis

Each campaign considered for the content analysis had to include the essential elements required for a social marketing campaign—a behavioural change goal, consumer orientation, facilitating a voluntary exchange with mutual benefits, and use of the marketing mix. (*See Chapter 2.*)

In addition, campaigns selected must have been actively in use as recently as 2004, be connected to one or more recognised HIV/AIDS organisations, and be sponsored by a medical entity such as a government health office, a not-for-profit health services provider, or a pharmaceutical company.

Campaigns that matched these criteria were located through online websites, news articles, journal articles, published reports, organisation fact sheets, and email responses.

From about a dozen qualifying campaigns in each country, six each were chosen from Mexico, Uganda, and the United States, using a pragmatic and judgemental selection based on availability of data and a diversity of campaign purposes, targets, and results.

4.8.3 Initial analysis of campaigns selected

Once the 18 campaigns were selected, the next step was to collect as much information as possible. It was important to accumulate a variety of materials for each campaign, including images. The materials were then organised in three large binders, one for each country. In addition, electronic copies of materials were assembled whenever possible. Next, a standardised questionnaire was used to assess content, focus, approach, and targeted audiences. *Questionnaire to assess prospective campaigns for content analysis is shown as Appendix B.1.* This 5-page questionnaire was based on several content analysis instruments collected from researchers and presenters attending the 2006 Social Marketing Advances in Research and Theory (SMART) conference. One of the most helpful documents collected at that conference was an acronym-resistant questionnaire for condom social marketing (Condom social marketing, 2010).

From the questionnaires, a summary fact sheet was created for each of the 18 campaigns selected for content analysis. *Sample summary fact sheet for content analysis campaign is shown as Appendix B.2.* While this initial analysis was underway, a ‘work in progress’ poster presentation was presented at the SMART conference in Canada in the autumn of 2006. *The poster, Social marketing strategies for combating HIV/AIDS in developing countries: examining traditional campaigns, is shown as Appendix E.2.*

To better cope with the volume of accumulating data, a decision was made to focus first on the Mexico campaigns in more depth. Examination of those campaigns revealed five important considerations in combating the disease in that country:

1. Build alliances with diverse groups
2. Include prevention messages
3. Address stigma
4. Focus on cultural norms
5. Recognise population mobility’s affect on disease transfer

A presentation based on this initial research was part of a special panel session during the AIDS in Culture III conference in Mexico City in the winter of 2006. *The abstract, Getting the word out: promoting cures through social marketing, is shown as Appendix E.3.* The trip to Mexico City offered opportunities to begin a series of semi-structured interviews with key informants connected to some of the campaigns in Mexico and the United States. This is another example of overlapping research phases. The diversity of information that was being generated prompted interest in the visual and verbal persuasion techniques used in the campaigns as well as the role of controversy in promoting behavioural change. An outgrowth of this research was a one-and-a-half-hour workshop presentation during an American Communication Association conference at Taos, New Mexico, in the autumn of 2007. This presentation included examples of HIV/AIDS campaigns’ visual and verbal persuasion approaches and preliminary reflections on the cultural, political, and economic factors that surround the disease. *Workshop handouts for the presentation, Motivating change: visual and verbal persuasion in HIV-AIDS social marketing, are shown as Appendix E.5.*

The concurrent research process continued: conducting semi-structured interviews and collecting additional information on the campaigns under study, both in Mexico and in the United States. In the spring of 2008, a USAID-sponsored project, PSP-One (Private Sector Partnerships for Better Health) hosted an online social marketing conference. The Mexico campaign research formed the basis of a panel presentation that included a recorded script and a PowerPoint show (published online) about the vital role

of partnerships in HIV/AIDS social marketing efforts. *The online presentation, Taking taboo topics public: how social marketing partnerships combat HIV/AIDS in Mexico*, is shown as Appendix D.1.

This virtual presentation led to additional interview contacts, including the director of Population Services International in Mexico. Later that spring, a peer-reviewed paper featuring the Mexico campaigns was presented at the VII International Congress on Public and Non-profit Marketing in Szeged, Hungary, and published in the conference proceedings. *The paper, Creating a culture of change: social marketing's global initiative against HIV/AIDS*, is shown as Appendix D.2.

In addition to the expanding sources of secondary and primary information, monitoring social marketing listservs proved to be a valuable means of tapping into the ongoing dialogue about the theory and practice of social marketing. These listservs also posted conference and publication opportunities. International calls for proposals were highly competitive. One of the more rigorous contests for presentation slots was for the biennial International AIDS conference. A poster featuring three of the social marketing campaigns directed toward women was presented in Mexico City in August of 2008 and the presentation abstract was published online by the International AIDS Society (IAS). *The poster, Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States*, is shown as Appendix E.6 and the abstract is shown as Appendix D.3.

To avoid being overwhelmed by this wealth of information, cross-tabulation matrixes were developed to compare the 18 campaigns. A matrix format was chosen because it can accommodate a range of information; it is capable not only of tabulating those attributes that can be easily quantified (e.g. audience, media mix, sponsors), but can also look at framing and cultural relevance (Porter, 2002). The source of health message frames for the matrix came from Beaudoin's multilevel analysis of HIV/AIDS posters from sub-Saharan Africa. Beaudoin used consequences, prevention, self-efficacy, sources of HIV/AIDS, benefits, and barriers (2007). Those same message frames were used in the content analysis matrix for this project. This diversity of comparative information had the potential to provide a framework for making predictions about the effectiveness of campaigns, which would be extremely important as research progressed. The two resulting matrices were presented in poster form at the First German-Austrian Swiss AIDS-Congress (SODAK) in St. Gallen, Switzerland, in June of 2009. The poster was published on the SODAK website, and the abstract was published in a special issue of the *European Journal of Medical Research*.

The poster, Working toward a world without AIDS: how social marketing inspires long-term cultural change, is shown as Appendix D4.1, and the abstract is shown as Appendix D4.2.

4.9 EVOLUTION OF METHODOLOGY

After selecting the campaigns and collecting and analysing data, it became clear the research should be more narrowly focused on two countries. This was due to the volume of material collected, the need to set some time limits, the repetitive nature of much of the information from the Mexico and Uganda campaigns—especially as related to condom social marketing efforts—and the availability of contacts and resources in Mexico and the United States. Therefore, after the content analysis was completed, Uganda was removed from the remaining phases of the project.

On the other hand, the original research scope limited the social marketing campaigns in the United States to those based in the southern part of the country. It soon became obvious, however, that to have a representative sample, it would be necessary to include national initiatives. However, one regional campaign that met all selection criteria was included, *The New Faces of HIV/AIDS in Houston*, since it won national recognition and inspired campaigns in other cities. Additionally, Houston's rates of HIV infection were twice the national average, with black people accounting for more than half of the new infections each year (AVERT, 2010a), so the city is under national scrutiny by the Centers for Disease Control and Prevention (CDC).

In Chapter 5 the cross tabulation matrices are presented. Commonalities and differences for the 18 HIV/AIDS campaigns in Mexico, Uganda, and the United States are discussed.

At the end of Chapter 5, a case study was added to the original research design as a way to demonstrate the fusion of information from the three topics under study and to provide a bridge to the Phase 2 research. Case studies are frequently presented in social marketing literature (National Social Marketing Centre, Showcase, c2010) and are widely used in studies of social groups and 'consumer tribes' in particular since case studies are considered an effective way to examine a group without control or manipulation (Mitchell & Imrie, 2011).

CHAPTER 5

CONTENT ANALYSIS

DECONSTRUCTING 18 HIV/AIDS SOCIAL MARKETING CAMPAIGNS

5.1 INTRODUCTION

This research phase created an important bridge between the secondary and primary data collection as well as an opportunity to integrate quantitative and qualitative approaches. Although quantitative content analysis when used alone is limited to counting operations, it is a useful technique for examining and organising volumes of information in a systemic fashion. When combined with qualitative methods, however, content analysis is the route to drawing inferences that can be corroborated using other research methods (Stemler, 2001). In this case, collecting and categorising significant amounts of data provided a framework both for direct comparison of quantifiable categories and for identifying more elusive trends and patterns.

With three target countries and dozens of campaigns underway in each, a massive amount of information was available through secondary sources alone. Data collected during the literature review about current political, cultural, and economic factors in the target countries was vital to understanding the environment in which HIV/AIDS social marketing takes place. (*See Chapter 2.*)

For greater manageability, the wealth of data assembled for content analysis was divided into two broad groups: campaign design and campaign implementation. Matrix categories were informed by literature review of commercial and social marketing theories, techniques, and practices. (*See Chapter 3.*) The cross tabulation matrices provided an easily referenced visual comparison of the 18 campaigns. Once the matrices were complete, it was possible to make direct quantitative comparisons. These comparisons led to an integrative qualitative analysis that identified emerging patterns and trends. To demonstrate how an HIV/AIDS programme can use social marketing to promote gender equity, an in-depth case study is presented at the end of this chapter.

5.2 AIMS AND OBJECTIVES

- Assimilate the accumulated information about the HIV/AIDS landscape in the three countries under study

- Using established criteria, select a representative group of campaigns for Mexico, Uganda, and the United States
- Analyse the campaigns using comparative matrices
- Identify emerging themes and implications
- Use these findings to inform subsequent research phases

5.3 QUESTIONS ADDRESSED DURING THIS RESEARCH PHASE

- *What are specific examples of recent HIV/AIDS social marketing campaigns in the target countries?*
- *What commonalities and unique characteristics can be identified as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used?*

5.4 THREE COUNTRIES, WORLDS APART

A sample of six HIV/AIDS social marketing campaigns was selected for each of the three countries initially targeted for this study—Mexico, Uganda, and the United States. Although commonalities exist in the HIV/AIDS social marketing campaigns implemented in these three countries, there are significant differences in their economic, political, and cultural situations.

5.5 CAMPAIGN SELECTION

Criteria for campaign selection consisted of 1) inclusion of the essential elements that define social marketing campaigns, as discussed in Chapter 2; 2) recency, the campaign must have been in active use as recently as 2004; 3) available data, through secondary and primary sources; 4) involvement by at least one recognised HIV/AIDS organisation; and 5) sponsorship by a medical entity such as a government health office, a not-for-profit health services provider, or a pharmaceutical company. Each country had numerous HIV/AIDS social marcoms from which to choose but making sure the campaigns selected for this study met the above criteria required careful documentation using a standardised questionnaire. (*See Appendix B.1.*) Once the selection process was complete, the three groups of campaigns met the goal of the question:

What are specific examples of recent HIV/AIDS social marketing campaigns in the target countries?

The 18 campaigns identified for further study provided an interesting variety of styles and approaches but also demonstrated considerable overlap in categories such as

target audiences, purpose, and implementation. *A summary of the 18 campaigns used for the content analysis is shown as Appendix B.3.*

5.6 EXAMINING THE CAMPAIGNS

Content analysis of the 18 campaigns focused on the question:

- *What commonalities and unique characteristics can be identified as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used?*

For ease of presentation, the items of analysis were divided into two groups: 1) *Crafting the Message* (Figure 5.1) and *Disseminating the Campaign* (Figure 5.2). In keeping with content analysis methodology, the categories were established using emergent coding and were mutually exclusive and exhaustive (Stemler, 2001). (*See Chapter 4 for additional discussion of the methodology.*)

Matrix A focused on the design of the campaigns, beginning with such basic details as dates, message, purpose, audience, and sponsors/partners. This information was available through campaign materials or publicity about the campaigns, and as needed from marketing experts associated with the campaigns. The underlying foundations were also categorised, including frames for the messages, theoretical underpinnings, and references to cultural roots. These categories were developed and coded based on literature review of similar studies, as described in Chapter 4. The last category on this matrix was a simple dichotomous question regarding whether the campaign was adapted for additional use, either in that country or in other countries.

Matrix B used commercial marketing techniques to categorise dissemination tactics for the campaigns, including the media mix (both traditional and new media), products (if any) distributed through the campaign, whether interventions or special events were used, the kinds of spokespersons recruited to present the campaign message, and whether there was a clear ‘call to action’ (a focused command to the audience to act). In light of findings by recent cross-cultural advertising studies (*See Chapter 4.*), the matrix categorised visual as well as verbal campaign approaches. In recognition of marketing’s fundamental question—*Were goals met?*—outcomes, as provided by campaign evaluation materials or representatives, were recorded. Since some campaigns were still ongoing at the time of the content analysis, long-term results were not available.

HIV/AIDS acronyms used in the matrix—such as MSM, PLWHA, and CSW—are defined in the *Transdisciplinary Glossary*. (*See pp.viii-xvii.*)

Matrix A: Crafting the Campaign

	NAME	DATES	MESSAGE	PURPOSE*	AUDIENCE*	SPONSORS*	FRAMES*	THEORY	ROOTS REF	ADAPTED
Mexico	Investing in People	2003-8	Abstinence, fidelity	2,4	D, F/M at-risk groups	1,2,3, G N P	2,4	Health Belief	Yes	No
	Menos Etiquetas	2007-	Gender equity	3,4	D, F/M1	2,3, G N P	2,3	Stages of Change	Yes	N/A
	Programa Hombres	1999-04	Rethink masculinity	4	U/D, M1	1,2,3, N P	3,5	Social Cognitive	Yes	Yes
	Programa Mujeres	2005-	Change gender norms	4	U/D, F1	2,3, G N P	3,6	Social Cognitive	Yes	Yes
	Tu No Me Conoces	2003-4	Remove stigma, get tested	1, 2	D,F/M2,3, MSM, farmers	1, 2, G	1, 4	Health Belief	Yes	No
	VIDA Digna	2005-8	Accept differences	2	D,PLWHA, CSW, MSM	1,2, N P	3,6	Diffusion of Innovation	Yes	Yes
Uganda	ABCs	2002-6	Abstain, BeFaithful, Condom	2,3	D,F/M1,2, general pop	1,2,3, G N P	2,5	Health Belief	Yes	Yes
	Afford Good Life	2006-	Affordable products	2,3	D, F/M, sexually active pop	2,3, C G N P	2,3,5	Diffusion of Innovation	Yes	No
	Be a Man	2006-	Stop transactional sex	4	D,F/M1	1,2,3, C G N	2,3	Social Cognitive	Yes	No
	One Love	2006-	Zero-grazing	3,4	D,F/M, sexually active pop	2,3, C G N	2,3	Social Cognitive	Yes	Yes
	PMTCT	2002-	Protect babies from HIV	3,4	D,M2 w/ pregnant partners	2,3, G N P	2,4	Reasoned Action	Yes	Yes
	Sugar Daddies	2004-	Stop cross-gen sex	3, 4	U/D, F1, M3	1,2, G P	1, 4	Reasoned Action	Yes	Yes
USA	Be the Generation	2005-6	HIV vaccine best hope	5, 6	U/D, Broad target	2, N P	2	Social Cognitive	Yes	No
	I am African	2005	We are all African	2,6	U/D, F/M2,3 parents	3, C N	2,5	Social Cognitive	Yes	No
	MTV Think	2001-	Be safe, get tested	1,3	D, F/M1, MSM	3, C N	2,4	Health Belief	Yes	Yes
	New Faces of HIV	2002-4	Get tested, stigma	1	D, F/M2, African Americans	1, G N	2,3	Reasoned Action	Yes	Yes
	ONE	2002-	Change world one by one	5,6	U/D, broad target	1,2,3, C N P	3,5	Social Cognitive	Yes	Yes
	We All Have AIDS	2005	Solidarity among mankind	2,5,6	U/D, broad target	3, C N	1,4	Diffusion of Innovation	Yes	No

***KEY:** PURPOSES: 1.Seek Testing 2. Stigma/discrimination 3. Prevention 4. Cultural Change 5. Political Mobilization 6. Donations/Volunteers AUDIENCES: Upstream Downstream, Female Male 1.15-24 2. 25-35 3. 36+
 SPONSORS: 1.Local 2. National 3. International Corporate Government Nonprofit Pharma FRAMES: 1. Consequences 2. Prevention 3. Self-efficacy 4. Sources of HIV/AIDS 5. Benefits 6. Barriers

Figure 5.1— Cross tabulation matrix comparing 18 HIV/AIDS campaigns:

Crafting the Campaign

5.7 SUMMARY OF FINDINGS FOR MATRIX A

Name: The campaign name, the first column in each matrix, was the official name for the campaign, which appeared on all materials and in all media. This slogan was generally short, catchy, and the defining identifier for the campaign.

Dates: All campaigns were selected for currency—active at least as recently as 2004—to make them more comparable. The longest running campaign in the 18 selected for study was Mexico's *Programa Hombres*, which began in 1999 and has continued to be updated and adapted for use in Mexico as well as in many other countries. Half of the 18 campaigns had been adapted or updated, so they were in use at the time of this analysis. Even campaigns such as *Tú No Me Conoces* and *New Faces of HIV*, which had more limited timeframes, influenced subsequent social marketing efforts to target audiences.

Message: Each campaign message was unique, respectively exhorting audiences to abstain from sex, build monogamous relationships, change stereotypical thinking about women and gays, practice safe sex, protect unborn children from HIV, get tested for HIV, contribute to efforts to find solutions, and recognise global humanity. The campaigns showed a broad mix of messages, ranging from individualistic behaviour (get tested, abstain from sex, be faithful) to altruistic group behaviour (solidarity among mankind, change the world). Despite these differences in the primary message, central to each campaign there were universal prevention and anti-stigma themes, combined with a commonality of general purpose, namely to stem the tide of the HIV/AIDS epidemic.

Purpose: Using emergent coding, marcom purposes were divided into 1) seek testing, 2) stigma/discrimination, 3) prevention, 4) cultural changes, 5) political mobilisation, and 6) donations/volunteers. Although each campaign had a primary purpose, most also had secondary, or related, purposes as well. For example, cultural change is central to most HIV/AIDS campaigns since cultural norms are widely recognised as a principal factor in spreading infection. Likewise, reducing stigma and discrimination is an underlying goal of most HIV/AIDS initiatives. Some campaigns had both short-term and long-term purposes, such as those with a prominent 'get tested' message that also sought to reduce stigma long-term by creating a dialogue about HIV/AIDS. Purposes ranged from immediate and specific (such as to get donations/volunteers), to generational (gender equity, for example).

Audience: Audiences were divided by Upstream or Downstream, Female or Male, and by age ranges. Also, when campaigns targeted particular lifestyle groups, that information was entered into the matrix. All 18 campaigns had a downstream audience and seven also targeted upstream decision makers. All but one of the Uganda campaigns was specifically aimed at downstream audiences. Nine of the campaigns narrowed their targets even more, focusing on specific lifestyle groups. As previously discussed in Chapter 2, social marketing cannot motivate long-term change by appealing to downstream audiences alone, so social marketing campaigns usually have underlying social change objectives. Some of the campaigns, however, were specific in targeting a particular niche audience. Three of the U.S. campaigns targeted broad audiences and did not focus on particular age, gender, or lifestyle groups.

Sponsors: Partnerships ranged from local to international, and sponsors included a mix of corporate, government, not-for-profit, and pharmaceutical or medical companies/organisations. Every campaign involved multiple entities. Five campaigns had support from local, national, and international groups. Half of the campaigns had partners from at least three kinds of organisations.

Frames: The six message frames used here have a general basis in public health theory and are specifically based on an assessment of HIV/AIDS posters (Beaudoin, 2007). The most common frame used was prevention (11), followed by self-efficacy (9), sources of HIV/AIDS (6), benefits (5), consequences (3), and barriers (2). (Most campaigns used more than one frame.) (*For more about framing, see Chapter 2.*)

Theory: As explained in Chapter 3, social marketing draws on theories from several disciplines and, in some cases, seems to disregard formal theories altogether. Determining which theories might underlie the campaigns was the most difficult category to code in this matrix and involved two researchers carefully examining the campaign designs against established definitions of the most common theoretical models for health communication. The most common behaviour change theory used in this group of campaigns was Social Cognitive (7), followed by Health Belief (4), Diffusion of Innovation (3), Reasoned Action (3), and Stages of Change (1).

Roots reference: Every campaign could be said to have at least a passing reference to cultural roots in its makeup, but in some campaigns, the roots reference was more

integral to the campaign and more pervasive throughout the campaign. Roots references ranged from recognition of long-standing cultural norms such as cross-generational sex to use of language, attire, and symbols, to selection of spokespersons. Further analysis of the strength and influence of roots references is beyond the scope of this study.

Adapted: More than half of the campaigns (10) were considered successful or important enough to warrant adaptation for use in other countries or for updating and re-use in the same country.

5.7.1 Commonalities vs. differences in campaign design

These 18 campaigns shared a number of common concerns and objectives, but each had a unique theme and a distinctive focus and approach. It was important to acknowledge both the commonalities that linked these campaigns as well as the unique elements that set each initiative apart from its neighbours. Since these are all HIV/AIDS social marketing initiatives, each used the tools of social marketing and spoke the language of HIV/AIDS. However, each campaign employed a customised toolbox and had a distinctive voice and inflection.

In keeping with social marketing practices, each campaign sought to motivate changes in behaviour, whether it be to discontinue unhealthy behaviour such as multiple sex partners or to adopt healthy behaviour such as fidelity. In some cases, the exhortation was to change deep-seated attitudes and beliefs, such as rethinking masculinity or considering the idea that common DNA connects all human beings. Audiences were variously asked to make changes for the good of themselves, those they loved, and society as a whole.

The primary short-term purposes for the campaigns varied, but all had at their core the long-term goal of stopping the spread of HIV/AIDS. Appeals also varied widely, from personal (affordable condoms allow you to live the ‘good life’) to global (help wipe out poverty and disease). The only agreement was that there is not one single ‘right’ way to stop the spread of the disease. This group of campaigns, despite the common criteria for their selection for this content analysis, nevertheless demonstrated the international divergence of approaches and philosophies about combating the pandemic.

The majority of the campaigns had clearly defined target audiences, and it can be noted that those campaigns were the ones most likely to be adapted and re-used, suggesting precise targeting may contribute to perceived effectiveness. It also was

apparent that those campaigns with a wide variety of sponsors/partners tended to be long-lived and adapted for repeated use, due in part to the collective resources those collaborations provided. Clearly, campaigns with numerous partners have more political and financial resources. Also, international organisations with a proven track record for HIV/AIDS social marketing are more likely to receive grant funding than smaller, unknown groups.

In terms of framing, the most common frame used was prevention, closely followed by self-efficacy, which indicated that individual behavioural change was a priority. The three campaigns with the broadest target audiences were all U.S. campaigns with altruistic messages and goals. Despite extensive support and outstanding production values, however, two of those campaigns were short-lived (*Be the Generation* and *We All Have AIDS*) and have not been adapted for re-use. The *ONE* campaign has been successful in attracting more than 100 partners and signing up over 2 million members since 2002, but this initiative, although it set out to reach a broad audience, has launched hundreds of specialised promotions for specific groups, such as college students.

Although cultural roots appeared in every campaign, those cultural links were not always appropriate or well accepted by the target audience. For example, the *I Am African* campaign sought to convey a cultural message by showing war paint on the faces of numerous international celebrities. Unfortunately, this approach angered many and created a firestorm of controversy; detractors felt so strongly about the campaign that they created cynical anti-ads. The difficulty of using cultural references effectively while avoiding offensive stereotypes was sometimes a difficult balance and not all of these campaigns were able to find that compromise.

However, if adaptation for further use is an accurate measure of success, some of these campaigns have been very effective.

Matrix B: Disseminating the Message

	NAME	TRAD. MEDIA*	NEW MEDIA*	PRODUCTS	INTERVENE	EVENTS	SPEAKERS*	VISUAL	VERBAL	ACTION	OUTCOME
Mexico	Investing in People	3	1	Condoms	Advocacy seminars	Yes	Comm leaders	Realistic	2nd person	Yes	Not tabulated
	Menos Etiquetas	2,3,4	1,3,4	Condoms	Peer educators	Yes	None	Abstract	2nd person	Yes	Ongoing
	Programa Hombres	2,3,4,5	1,2	Hora H condoms	Peer workshops	Yes	None	Cartoon	3rd person	Yes	Quantified
	Programa Mujeres	2,3	1,2	Video	Peer workshops	Yes	None	Cartoon	3rd person	Yes	Quantified
	Tu No Me Conoces	1,2,5,6	1.	None	1-800 number	None	Media	Realistic	2nd person	Yes	Quantified
	VIDA Digna	2,6	1	Condoms	Training	Yes	Leaders, Anon	Realistic	1st/3rd person	Yes	Not tabulated
Uganda	ABCs	3,5	1	Condoms	HIV ed in schools	Yes	Anonymous	Realistic	1st person	Yes	Quantified
	Afford Good Life	2,3,5,6	1	Condoms	Hotline,discussions	Yes	TV personalities	Realistic	1st, 2nd per	Yes	Ongoing
	Be a Man	1,2,3,5,6	1	None	Games/contests	Yes	Anonymous	Realistic	1st person	Yes	Ongoing
	One Love	1,3,5,6	1	None	Radio call-ins	Yes	TV personalities	Realistic	1st person	Yes	Ongoing
	PMTCT	2,3,5	1	Nevirapine,test kits	Health training	Yes	Actors	Realistic	1st person	Yes	Quantified
	Sugar Daddies	3,5,6	4	None	Anti-AIDS clubs	Yes	Comm leaders	Realistic	2nd person	Yes	Ongoing
USA	Be the Generation	1	1	None	No	Yes	Anonymous	Realistic	1st person	Yes	Uncertain
	I am African	1, 6	1,4	None	No	Yes	Celebrities	Realistic	1st person	Yes	Uncertain
	MTV Think	6	1,2,4	None	Hotline	Yes	TV personalities	Realistic	1st person	Yes	Ongoing
	New Faces of HIV	2,3,4,5	1	Condoms/stickers	Hotline	None	Local PLWHA	Realistic	2nd person	Yes	Quantified
	ONE	3	1,3,4,5	Branded items	No	Yes	Celebrities	Realistic	1st person	Yes	Quantified
	We All Have AIDS	1,3,5	1	Special T-shirt	No	Yes	Celebrities	Realistic	1st person	Yes	Uncertain

***KEY:** TRADITIONAL MEDIA: 1.Print Ads 2. Print Collateral 3. Out of Home 4. Direct Mail 5. Radio 6. TV NEW MEDIA: 1. Website 2. UTube 3. Email 4. Social Media 5. Other
SPOKESPEOPLE: 1. Celebrities 2. Community Leaders 3. Anonymous 4. Audience Members 5. Media Personalities 6. Actors

Figure 5.2—Cross tabulation matrix comparing 18 HIV/AIDS campaigns: Disseminating the Message

5.8 SUMMARY OF FINDINGS FOR MATRIX B

Media categories were grouped as traditional or new media, and then subdivided into media outlets based on an initial examination of the media mix in the campaigns collected during the pre-selection phase.

Traditional media: Subdivided into six areas: 1) print ads, 2) printed materials, such as brochures or booklets, 3) out of home (including billboards, posters, transit ads, flyers), 4) direct mail (not email), 5) radio, and 6) television. Every campaign used at least one medium from this category; six campaigns were heavy users of traditional media, incorporating four or more types of media.

New media: Subdivided into five areas: 1) website, 2) YouTube, 3) email, 4) social media, and 5) other (e.g. Bluetooth viral marketing). Three campaigns used three or more of these techniques. All but one campaign used a website created specifically for that initiative. A majority (12) of the campaigns used only one medium in this category, usually the website.

Products: Items produced or branded particularly for the campaign were used in 11 campaigns. The most common was condoms (7 campaigns). Some items were given away through sponsor support, but others were sold at reduced prices.

Intervention: Interpersonal contact was an important element of 12 campaigns, ranging from telephone hotlines to peer education workshops to interactive games.

Events: Sixteen campaigns incorporated special events into their promotion mix. These included entertainment venues such as dances and political events such as rallies on college campuses.

Speakers: Spokespeople prominently used in advertising and other campaign media were divided into 1) celebrities, 2) community leaders, 3) anonymous, 4) audience members, 5) media personalities, and 6) actors. Media personalities and celebrities were the most popular spokespeople (7 campaigns). Three campaigns featured community leaders and one used community leaders who were also part of the target audience. Four campaigns used actors or anonymous models.

Visual: Campaign materials were classified either as realistic, abstract, or cartoons. Fifteen campaigns used realistic depictions; one used abstract visuals, and two used cartoon characters.

Verbal: Campaign materials were divided by messages presented in the first, second, or third person. Eleven used first person, six used second person, and three used third person. (Two campaigns used mixed verbal approaches.)

Call to Action: Every campaign asked the audience to take action of some sort, from specific (abstain from sex) to general (be more tolerant of other peoples' differences). Looking in more depth at the calls to action was beyond the scope of this project, but could offer interesting insights and cross reference opportunities.

Outcome: This category, too, offers a wealth of future analysis possibilities. For the sake of this study, outcomes were classified as 1) ongoing (campaigns still active)—six campaigns, 2) quantified (specific results have been recorded)—seven campaigns, 3) uncertain (results not clear or were not evaluated)—three campaigns, and 4) not tabulated (evaluations underway but not complete)—two campaigns.

5.8.1 Commonalities vs. differences in disseminating the campaign

In looking at the media mix, traditional media dominated most of the campaigns, most particularly those in Mexico and Uganda that targeted downstream adults. The three Mexico campaigns aimed at youths (*Menos Etiquetas*, *Programas H* and *M*) used new media, but also included significant amounts of traditional media in their overall mix. Of the U.S. campaigns, only *MTV Think* and *ONE* used more new media than traditional media. These choices were apparently based on audience access, preferences, and literacy.

The most common product was condoms, which could be cross-referenced to pharmaceutical sponsorship and prevention messages. *The Afford Good Life* campaign was built around sales of condoms, and the *PMTCT* (Prevention of Mother to Child Transmission) campaign relied on Nevirapine and test kits from medical partners. The *ONE* campaign reinforced its message through branded items (bracelets, tee shirts) that were sold on the website.

Special events and interventions were part of the promotion mix for most of the campaigns, pointing to the increasing importance of innovative 'edutainment' and

interpersonal communication. Many of the campaigns focused on ways to disseminate their message in casual, fun settings. They also provided anonymous ways to gain information, such as through hotlines. The popular interest in celebrities was reflected in the frequent use of media personalities and other recognisable spokespeople. The *New Faces of HIV* campaign went one step further, showing HIV-positive community members in printed materials such as ads, posters, and direct mail pieces. This technique resulted in considerable publicity for the campaign, but also proved so painful for some of the people who had agreed to appear in the campaign materials that those individuals secluded themselves and declined to continue to act as spokespeople for the campaign.

Realism dominated the visual approach for the campaigns, whether they were images of well-known people, as in *We All Have AIDS*, the anonymous models in campaigns such as *ABCs* or *Be the Generation*, or telenovas (soap operas) that dramatised HIV issues. Notable exceptions were the three Mexico campaigns aimed at lower income youths, which used eye-catching abstract images (*Menos Etiquetas*) and cartoons (*Programas H and M*) as part of their media mix. There was a consistent effort to mix HIV/AIDS information with fun, games, humour, and drama.

Verbal messages were predominately presented in the first or second person, which further indicated a desire to make the message personal and immediate and integrate it into everyday life.

Overall, the media and promotion mix used a wide variety of techniques to make HIV/AIDS a topic that was interwoven into people's lives at every turn. This once-taboo topic was inserted into every kind of media, event, or social interaction people might encounter in their everyday lives. It then became difficult to avoid the onslaught of messages, especially for those who were part of the target audience. The goal of the message approach was to woo the audience into seeking out those communication channels that contained HIV/AIDS messages. The audience benefited by being entertained, and, social marketers hoped, were motivated to adopt healthy behaviours. The most recent campaign of the group to target young people (*Menos Etiquetas*) and the *One* campaign went beyond using passive media and incorporated new media, combined with permission marketing, to urge the target audience to actively seek out information about HIV/AIDS.

5.9 CONCLUSIONS: PATTERNS AND TRENDS

All campaigns were influenced by—and in some cases limited by—cultural, economic, and political realities in the country where they were being disseminated. But an integrative qualitative examination yields several trends.

First, collaboration was essential; each campaign involved multiple organisations and community groups designed to build participation in and acceptance for individual and policy change. From a worldview, each country's HIV/AIDS problem has far-reaching implications. Recognising that expanding HIV/AIDS populations will devastate the global economy, governments in both developing and industrialised countries, in conjunction with pharmaceutical companies such as Pfizer, have launched a variety of organised offensives, which include political commitment, law enforcement, government policy, social marketing, and community mobilisation (Pfizer, 2006).

This global cooperation encourages alliances such as those forged to support the campaigns in this study. From a practical standpoint, these partnerships are necessary because social marketers do not have the luxury of the kinds of resources enjoyed by commercial marketers. Rather than work in the commercial spirit of competitive marketing, the strategy is to build a network of groups with common goals and varied resources.

The *Investing in People* campaign was a good example of building local, national, and international alliances with common goals. *Investing in People* was centred in Mexico City, where the country's most HIV/AIDS cases are found. A half-dozen organisations joined forces for this five-year campaign. A key technique was personal communication through workshops and conferences. Trained female advocates and local HIV/AIDS leaders openly discussed sex before marriage, a once-forbidden topic in this strongly Roman Catholic country.

Secondly, most HIV/AIDS campaigns have a stronger focus on prevention messages than on treatment information, with condom use—promoted as 'safe sex'—being a frequent tactic. In keeping with its inclusive approach, social marketing assistance usually involves procuring and distributing pharmaceuticals, over-the-counter drugs, and condoms. It also supports capacity building and financial sustainability programmes for non-government organisations (NGOs) or for-profit companies (USAID, 2005b). In fact, promoting the use of condoms is such an integral part of HIV/AIDS social marketing that the practice has its own acronym: Condom social marketing (CSM), which is central to the *Afford Good Life* campaign strategy. This five-year health

initiative promoted Protector brand condoms, Pilpan oral contraceptives, and Inject injectable contraceptives at subsidised rates.

In recognition of cultural obstacles, the campaigns each address aspects of stigma and traditional cultural norms. USAID, whose infectious disease objectives are designed ‘*to contain and reduce HIV/AIDS in vulnerable populations,*’ focuses on reducing barriers to behaviour change and thereby preventing the HIV/AIDS epidemic in countries such as Mexico from becoming generalised to the population at large (USAID, 2005a). It is generally recognised that changing how people view gender roles and erasing widespread prejudice against gays will be necessary to effectively combat HIV/AIDS. HIV has been termed an ‘underground epidemic’ because of stigma and discrimination associated with the disease. Reducing stigma and discrimination experienced by sex workers, gay men, men who have sex with men, drug users, and people living with AIDS is the central purpose of the *VIDA Digna (Life with Dignity)* campaign, funded by GlaxoSmithKline to urge tolerance and acceptance of people’s differences.

Modern-day mobility and lifestyle patterns are also considerations in crafting social marketing campaigns for at-risk populations, especially for migrant populations or in border areas. Studies of highly mobile groups such as truck drivers, seasonal employees, and sex workers have identified travel or migration as a factor related to increased HIV/AIDS prevalence. Higher rates of infection are also frequently found along transport routes and in border regions. In addition, migration and mobility also increase vulnerability to HIV/AIDS for the partners at home (Population mobility, 2001, p.4). The *Tú No Me Conoces (You Don’t Know Me)* campaign used Spanish-language media to promote awareness of HIV risk and testing for Latinos living on the California-Mexico border.

Matching media choices to the target audience was vitally important, as analysis of these 18 campaigns suggested. Multiple media in more than one language was used to ensure the message reached its intended target. Media choices needed to reflect audience access and levels of literacy. Also, audience preferences for formats such as edutainment media like telenovas had to be considered when selecting the media mix.

Marketers who created these HIV/AIDS campaigns needed to keep in mind the dual role of controversy—both cultural controversy and moral controversy—due to the disease’s connections to sexual practices, ethnic background, and gender roles. Those who did not sufficiently pre-test their campaigns learned a painful lesson when campaigns were criticised as racist, sexist, or anti-religion. Other outside influences, for

example funding tied to issues such as abstinence, influenced the marketers' decisions. Every campaign design had to consider the fact that social marketing messages about HIV/AIDS, the role of stigma and culture, and the economics of the global medical market form a complex environment that influences public discussion about topics once taboo in 'polite' society (Massingill, 2008).

Overall, this content analysis yielded reams of useful information that addressed the research questions for this research phase and moved the project forward. A representative sample of recent HIV/AIDS campaigns was located, selected according to established criteria, and compared using matrices that facilitated identification of campaign design elements and dissemination methods. The selection process itself was an important part of this research phase, demonstrating that there were numerous campaigns in the three targeted countries from which to select. Because the 18 campaigns that were selected all had to meet a list of pre-determined criteria, they already had much in common, but there were distinctive strategies and approaches that made their comparison worthwhile. Setting up the matrices for comparison was another major step in this research phase; this visual format expedited examination of a large amount of data.

Tables 5.1 and 5.2 summarise, respectively, the commonalities and the differences of the 18 campaigns.

1. Seek to motivate changes in behaviour
2. Long-term goal is to curb HIV/AIDS infections
3. Most common frame: prevention
4. Include cultural roots (but not always appropriate to audience)
5. Traditional media dominate media mix
6. Most common product: condoms
7. Edutainment and interpersonal communication included in promotion mix
8. Realism is dominate visual approach
9. 1st or 2nd person verbal approach is most used
10. Mix HIV messages with fun, games, humour, and drama
11. Campaigns reflect alliances with multiple organisations
12. Messages address stigma

Table 5.1—Summary of commonalities in 18 campaigns

1. Appeals vary (ranging from personal to global)
2. Target audiences vary (range from narrow to broad)
3. Short-term goals (range of specific purposes)
4. New media, when used, was primarily to reach youth audiences
5. Abstract images and cartoons were directed to lower income youth targets
6. Each campaign was influenced by culture, economics, and political realities in the country where it was disseminated
7. Media selected and language(s) used reflected the target audience's access and literacy

Table 5.2—Summary of differences in 18 campaigns

The content analysis, in combination with the ongoing literature review, created a bridge to the next research phase: collecting and analysing primary information. Chapter 6 summarises the methodology used to collect and analyse both qualitative and quantitative primary data for the next part of this study.

5.10 CASE STUDY

To add the richness of detail that underlies greater understanding, a noteworthy campaign with international significance was investigated in greater depth through additional secondary research, combined with personal contacts and semi-structured interviews. The result was a case study that looked beyond the statistics at how unique cultural and political issues were addressed to achieve campaign goals. This case study, a combination of secondary and primary sources and a fusion of quantitative and qualitative methods, offers valuable insights into the complex world of HIV/AIDS social marketing and marks a transition to Phase 2 research. The campaign explored in the case study—directed to young men in Mexico—was judgementslly selected to showcase how social marketing is used in HIV/AIDS prevention. The campaign, *Programa Hombres*, is widely considered one of the most successful gender equity interventions and has been adapted for use in more than 20 countries around the world. Additionally, the campaign has been in use long enough to have a track record that provides valuable evaluative data. The unabridged version of this case study was

published in 2011 in an international social marketing text, *Social marketing for public health: global trends and success stories*.

Chapter 4, Love, sex, and HIV/AIDS: using social marketing to redefine gender norms among Mexican youth, is shown as Appendix D.5.

This campaign is exemplary in several ways. It has been in continuous use since 1999 and has met or exceeded goals and expectations. The campaign used audience research to craft a culturally appropriate approach and used a mix of social marketing techniques to disseminate a consistent message. It also has evaluated and measured behaviour change effected by the campaign. *Programa Hombres* is presented here as a representative HIV/AIDS social marcom that uses the tenets of the discipline to promote behavioural change.

Gender equity—Programa Hombres, Mexico 1999-present

Background

Links between traditional gender attitudes and the spread of AIDS prompted a partnership of NGOs to develop Programa Hombres. Since 1999, this initiative has been used in more than 20 countries, including Mexico, to persuade young Latino men to question traditional norms related to manhood.

Programa Hombres is designed to change how young men view gender roles and to urge them to consider the costs of stereotypical definitions of masculinity and femininity as well as the benefits of changing health-threatening behaviours. Program H's conceptual framework began with a 'mapping' of masculinity to understand how men view what it means to be male. Men who were inclined to be more gender-equitable in their attitudes provided insights in the best ways to change the prevailing views about manhood.

Target Audience

Program H targets young men 15 to 24, mostly from low-income groups. Many of these Mexican teens are already sexually experienced according to a 2001 report on reducing HIV infection among youth. This study of 2,064 Mexican students found that 24% of the males and 7% of the females were sexually active, with over 90% of those teens reporting sexual debut before age 15 (Stewart, et al., 2001, p.12).

Campaign Objectives

Knowledge objectives: The initiative was designed to first provide opportunity and information that would spark a thoughtful assessment of life choices: 1) question traditional social norms related to manhood, 2) reflect on the advantages of more

gender-equitable behaviours, and 3) re-think what it means to be a man (Instituto Promundo, 2008a).

Belief objectives: Since research indicated young men generally decide and control how and when young women have sex, promoting gender equity, with a strong focus on sexual health, was crucial.

Program H was designed to change traditional beliefs that

- men should initiate sexual activity early in life;
- men should have multiple sexual partners;
- men should maintain control over their female partners; and
- unsafe sex is more enjoyable than safer sex (Instituto Promundo, 2008a).

Behaviour objectives: Translating these cultural shifts into new behaviours was the key to both short- and long-term successes for the programme. Specifically, Program H sought to reduce the number of sexual partners and increase the use of condoms when both partners agreed to have sex. In the long term, however, Program H aims to create a culture where both sexes 1) adopt more gender-equitable lifestyles, 2) make healthy life choices, and 3) build respectful relationships (Instituto Promundo, 2008a).

Positioning

For the young men targeted by Program H, the challenge is to redefine ‘*what it means to be a man*’ (Nascimento, 2005). Programa Hombres repositions manliness to include responsible monogamous relationships, safe and loving sex, and respect for women.

Campaign strategies

Successful campaigns speak to the target in culturally sensitive ways. In this situation, the challenge was to present the messages in words and images that honour the culture while working to change the very pillars of centuries-old societal norms. Involving Program H’s target audience at every stage was a key strategy on the path to accomplish this cultural balancing act. Youths from two low-income communities of Rio de Janeiro developed the campaign materials, which have been adapted for use in other Latin American countries as well as in India and Tanzania, and more recently, the Balkan region in Europe. From radio spots to postcards, and from YouTube videos to special events, campaign materials promote a new male identity that is ‘cool,’ responsible, open to conversation, and respectful toward his partner.

Intervention activities for each campaign consisted of two main components: 1) a field-tested curriculum with a manual and an educational video for promoting attitude

and behaviour change, and 2) a lifestyle social marketing campaign for promoting changes in community or social norms (Nascimento, 2005).

A curriculum product to promote change

The educational techniques, manuals, and accompanying videos that make up the curriculum for Program H are termed '*social technologies*,' a concept developed by Instituto Promundo and defined as '*all educational material, methodological procedures or tested techniques, validated and with a proven social impact created with the aim of solving a social problem*' (Instituto Promundo, 2008b).

The curriculum provides a framework to examine gender issues, a 20-minute cartoon video, and 70 activities organised under five themes. Activities include role-plays, brainstorming exercises, discussion sessions, and individual reflections for small groups. The intervention is designed to be used over a six-month period for a total of 120 hours. To serve as gender-equitable role models for the young men, adult men facilitated the exercises (Pulerwitz, et al., 2006, pp.12-13).

Pricing strategies

Making the programme materials as widely available as possible, especially to high-risk groups, is the overriding consideration in setting prices. The five-volume manual, available in English, Spanish, and Portuguese, can be downloaded at no charge from Instituto Promundo's Web site, or it can be ordered in a bound volume for US\$50. The 20-minute cartoons for both programmes, with their accompanying discussion guides, are offered on VHS for US\$15 or on DVD for US\$20 (Instituto Promundo 2008a).

Place strategies

With more than 77% of Mexico's population living in cities, most national HIV prevention programmes focus on urban populations (USAID, 2005a). Young men are less likely than young women to seek health services, making it difficult to reach them with information and other services, so Program H takes information to them in the communities where they live. Entertainment venues such as bars, community dances, and parties proved to be effective ways to reach the target audience. In addition, the Mexican Ministry of Health adopted Program H and 10,000 copies were printed with the government's seal, lending official credibility to the initiative (Instituto Promundo, 2008a).

Promotion strategies

Unlike many developing countries where social marketing is used to combat HIV/AIDS, Mexico has a high average literacy rate; almost 93% for men and 90% for women (U.S. Department of State, 2008). As might be expected, young people are more

likely to use the Internet, although of Mexico's 110 million people, only about 20% have access to the Web (Internet World Stats, 2007). The Latin culture is family/relationship oriented, so personal communication is often more effective—and more credible—than mediated communication channels. Nevertheless, social marketers are increasingly incorporating new media tools to stretch their budgets while expanding their reach to young computer-savvy audiences. As part of that outreach, comprehensive information about Programa Hombres is available online and the cartoon videos can be viewed on YouTube (Instituto Promundo 2008a).

In addition to the curriculum, Alliance H—Promundo and its partner organisations—developed a '*lifestyle social marketing*' process to promote gender-equitable lifestyles among young men. For Program H, young men in the target audience identified their preferred sources of information and cultural outlets in the community. Messages that it is 'cool and hip' to be a more 'gender-equitable' man were presented via radio spots, billboards, posters, postcards, and dances (Instituto Promundo, 2008b).

Promundo also partnered with SSL International, makers of Durex condoms, who provided a branded condom, Hora H, at production cost. Hora H condoms were distributed in non-traditional venues and shops such as funk balls and cafes as a central part of the campaign. Promoting the use of condoms is such an integral part of HIV/AIDS social marketing that the practice has its own acronym: condom social marketing (CSM) and manufacturers' agreements such as the one with SSL International is common. Population Services International, however, has discontinued CSM in Mexico due to administrative and political hurdles and because Mexico, unlike poorer countries, has many condom brands vying for market share (Massingill, 2009).

The Program H campaign was called *In the Heat of the Moment*, a theme chosen because young men said they frequently heard their peers say, '*Everybody knows you should use a condom, but in the heat of the moment...*' (Pulerwitz, et al., 2006, p.14). The campaign's theme and media mix, combined with easy access to condoms, present a persuasive message encouraging young men to respect their partners, to avoid using violence against women, and to practice safer sex.

Evaluation

To assess Program H's impact in Mexico, researchers adapted Promundo's Gender-Equity in Men (GEM) Scale to fit the cultural context of young men in Mexico. The adapted scale measured traditional attitudes about gender roles related to HIV/AIDS and pregnancy prevention, violence, sexual relationships, domestic chores and care giving,

and homosexuality. Informants also provided information on HIV-related risk, such as STI symptoms, condom use, and number of sexual partners (Pulerwitz, et al., 2006).

Overall, Program H evaluations showed group discussions that prompt critical reflection about the costs of traditional manhood, and a media campaign that demonstrates gender equitable behaviours encourage young men to make changes that protect themselves and their partners from HIV infection. Findings indicated improvements in both condom use and a reduction in reported STI symptoms with groups that participated in Program H training (Hutchinson, et al., 2004, p.4).

The conclusion was that addressing unequal gender norms, especially machismo attitudes, is a vital part of HIV prevention strategies. These changes can conceivably extend into future generations, leading to a culture with stronger, healthier personal relationships.

CHAPTER 6
METHODOLOGY
COLLECTING AND ANALYSING PRIMARY DATA

6.1 INTRODUCTION

Much can be learned from existing literature, but when it is time to move from general to specific information gathering, it is necessary to collect new material that speaks directly to the research questions. This chapter is informed by the results of the content analysis, as reported in Chapter 5, and has the task of describing the methodology for the next research phase: collecting and analysing primary data, which included interview and survey techniques. This chapter outlines an integration of qualitative and quantitative methods to answer queries unique to this study. The same kind of integrative methodology was applied to analysing the resulting data and to designing a customised communication model with both theoretical and practical applications.

To collect the primary information needed, a QUAL-QUAN-QUAL research ‘sandwich’ was used. This research design takes advantage of mixed methods’ *‘methodological pluralism or eclecticism, which frequently results in superior research compared to monomethod research’* (Johnson & Onwuegbuzie, 2004).

A quantitative survey was inserted between a series of semi-structured interviews (pre-survey) and reaction interviews (post-survey). There is precedent for this combination of methods, especially in marketing research. Chisnall observed that *‘questionnaires and interviewing...are opposite sides of the same coin’* (2001, p.173), so their interdependence makes them suitable research companions. In today’s world of increasing electronic ‘high tech’ interaction, this research design went against the trend to collect data from afar. Instead, primary research was conducted almost completely through ‘high touch’ personal interaction. Both interviews and surveys involved personally speaking with the respondents and called on the researcher’s skills in persuasion and the ability to project a non-judgemental attitude. The only exceptions to this personal approach were situations in which distance or other barriers precluded face-to-face communication. In those few cases, the telephone or email, usually in combination, were used. Chisnall commented the personal interaction between an interviewer and the interviewee is a conversation with a specific purpose that can yield

data of '*impressive quality*,' especially in situations where the topic is sensitive or even taboo (2001, pp.173-180), which is usually the case with HIV/AIDS.

This chapter outlines the methodology for collecting and analysing this sensitive primary data as the researcher moves from global to local in scope. A rationale is presented for the interviews, both pre-and post-survey, and a detailed protocol describes the method for the survey design, sampling, data collection, and analysis. This chapter also outlines the method for constructing a communication model that integrates secondary and primary information to create a practical approach for an HIV/AIDS social marketing campaign. Finally, the role of reflection in integrative and participatory projects such as this is explained.

6.2 SEMI-STRUCTURED INTERVIEWS WITH KEY INFORMANTS (PRE-SURVEY)

Semi-structured interviews with opinion leaders from the three areas of expertise—marketers, humanitarian leaders, and medical practitioners (both conventional and alternative)—explored the rationale behind the content choices, cultural influences, and economic factors influencing the public dissemination of HIV/AIDS information. These key informants included those who design and implement social marketing campaigns in the targeted countries, representatives of companies that participate in those campaigns by providing supplies and other forms of support, and public image experts and medical practitioners of both conventional and alternative medicine, especially those involved in prevention and treatment of HIV/AIDS.

The value of this kind of ethnographic qualitative research has become widely recognised as a result of Strauss and Corbin's grounded theory approach, which holds that the processes of data collection and data analysis are closely connected, with each informing and guiding the other (1998). Qualitative inquiry was once regarded as only a preliminary foray prior to quantitative, or 'real,' scientific analysis, but researchers have come to accept that some kinds of information can only be collected by in situ immersion in actual social settings. As a result, grounded theory is now used by social researchers across a range of disciplines, from 'pure' ones such as sociology to applied disciplines such as health studies (Strauss & Corbin, 1998). Grounded theory's two key principles are perfectly suited to this research project: 1) the foundation for qualitative research is participants' understanding of their social environment, and 2) researchers should creatively tailor their approach to their own research settings and interests (Strauss & Corbin, 1998).

Interview questions were administered in a uniform way to those people identified through exploratory and secondary research as key informers. Questions were designed to collect both procedural information and expert opinions. Interviews were conducted via email, phone, or, when possible, in person. A standard bank of questions assured uniformity, but open-ended questions also allowed for variance in opinion and opened the door to new research directions. *The question banks for pre-survey interviews are shown as Appendix B.4 (Mexico interviews) and Appendix B.5 (U.S. interviews).*

These interviews, which focused on issues that surfaced during the literature review and the content analysis, are summarised below. All of the interview respondents had some involvement with HIV/AIDS social marketing campaigns and some of them had a direct connection with one or more of the content analysis campaigns in Mexico or the United States. The interviewer's challenge was to establish a rapport with the interviewees, who held widely divergent and often passionate views on the topics discussed, and to report their comments as objectively as possible.

6.2.1 Questions to be addressed during pre-survey interviews

- *From the viewpoint of opinion leaders such as marketers, humanitarian activists, and medical practitioners—both conventional and alternative—what factors influence choices about dissemination of HIV/AIDS information?*
- *How are sponsorships selected and how are campaigns evaluated?*
- *Do international business interests influence social marketing's dissemination of HIV/AIDS prevention and treatment information, thereby establishing conventional products and treatments as the norm?*

6.2.2 Analysis of interview data

Since the interview collection period was concurrent with much of the secondary data collection and analysis (*See Figure 4.1—Research Timeline*), it was possible to weave the interview information into paper and poster presentations of the work in progress, as noted in the Chapter 4. Additionally, some of the interviews were conducted while attending HIV/AIDS or social marketing conferences. (*See Chapter 4.*) Several of the interviews with key informants in Mexico became part of a case study focused on two of the content analysis campaigns and was published in 2011 as a chapter, "Love, Sex, and HIV/AIDS: Using Social Marketing to Redefine Gender Norms Among Mexican Youth," in *Social Marketing for Public Health: Global Trends*

and Success Stories. Editors for the book included Philip Kotler and Nancy Lee, two internationally known key figures in social marketing. (See Appendix D.5.)

6.3 SURVEYS OF DOWNSTREAM TARGETS

Informed by quantitative and qualitative research from the first two research phases, Phase 3 called for field research of a designated downstream audience to ascertain knowledge and perceptions about aspects of HIV/AIDS. Due to the sensitive nature of the topic, surveys were anonymous, but respondents signed informed consent forms. Those surveyed were not necessarily HIV/AIDS patients; their principal commonality was that they were all receivers of information about HIV/AIDS prevention techniques and treatment modalities. They were surveyed at an HIV/AIDS clinic in Houston, Texas. Respondents were told their participation in the study would help guide the design of a model for effectively disseminating information about HIV/AIDS. *The Informed Consent Form is shown as Appendix C.1.*

6.3.1 Questions to be addressed during Phase 3 research (survey)

- *Where do recipients of HIV/AIDS information learn about the disease?*
- *How credible do these recipients consider their information sources to be?*
- *What perceptions and knowledge do these recipients have about HIV/AIDS?*
- *How do recipients of HIV/AIDS information perceive their choices as regards prevention techniques and treatment modalities?*

6.3.2 Research design

In structuring the survey instrument, Onwuegbuzie and Teddlie's framework for dealing with data in mixed methods research was a useful guide. In this approach, researchers analysing quantitative and qualitative data within a mixed methods framework were advised to include at least some of the following seven stages: 1) data reduction—(e.g. exploratory thematic analysis for qualitative data and descriptive statistics, exploratory factor analysis, or cluster analysis for quantitative data); 2) data display—(pictorial descriptions of matrices, charts, or graphs); 3) data transformation—(converting quantitative data into narrative form for qualitative analysis or converting qualitative data into numerical codes that can be presented statistically); 4) data correlation—(quantitative data being correlated with qualitative data or vice versa); 5) data consolidation—(quantitative and qualitative data combined to create new variables or data sets); 6) data comparison —(comparing data from quantitative and qualitative

sources); and 7) data integration—(qualitative and quantitative data integrated into a coherent whole) (2003). Of these seven stages, this project utilises: 1) data reduction (descriptive statistics for survey data), 2) data display (extensive use of matrices, charts and graphs for data reported throughout the study), 4) data correlation, 6) data comparison, and 7) data integration (examining qualitative and quantitative information to correlate, compare, and integrate the communication model and the concluding discussion.

The principal goal of the surveys was to collect categorical quantitative data. This kind of descriptive research design is a useful way to count and describe specific features or characteristics of certain kinds of people and has the added advantage of *'giving insights into behaviour as well as measuring particular attributes and habits'* (Chisnall, 2001, p.35). In marketing, descriptive research can be used to develop profiles of types of customers and their preferences. In this case, it was important to have a baseline profile of the target audience for the model that was to be created in Phase 4.

As Wellings and Macdowall pointed out, survey investigation is the *'mainstay of data collection procedures,'* with the knowledge, attitude, and behaviour (KAB) survey being a popular method for *'investigating comprehension of messages and self-reported behaviour changes'* (2000). Understanding where the target audience has obtained information about HIV/AIDS and how credible those sources are perceived to be would guide the researcher in choosing communication channels for a future campaign. Also, it was important to clarify the target's perceptions about aspects of HIV/AIDS. For that purpose, the second part of the survey included 20 statements ranging from innocuous to provocative, which could be divided into broad categories. After being written, rewritten, and mercilessly revised as the instrument evolved, statements were arranged in four different sequences (creating four versions of the survey) to mitigate bias based on responses to previous statements. *Versions 9.2, 9.3, and 9.4 of page 2 of the survey are shown as Appendix C.3.* The researcher also considered that KAB survey data is limited in its ability to monitor changes in a broad social context since the focus is on individuals, who *'are particularly susceptible to the influence of the social desirability response'* (Wellings & Macdowall, 2000). The third section of the survey was designed to learn which HIV/AIDS treatments, including a variety of alternative treatments, were familiar and which ones were perceived as being effective. For statistical purposes, respondents were also asked to answer nine demographic questions.

Since data collection requires interaction between investigators and respondents, it is considered a reactive technique whose very intrusion can interject bias into the process (Chisnall, 2001, p.47); however, a non-reactive technique would not have yielded the kinds of information needed. Throughout the process of developing the research design, possible sources of error were considered, with particular attention to developing the most reliable sample possible given logistical limitations, creating clear and straightforward questions, organising fieldwork for objective administration, and coding data for tabulation and analysis without compromising anonymity.

6.3.3 Sampling

Judgement or purposive sampling, also called non-probability sampling (Chisnall, 2001, p.111), was used for this survey due to time and resource limitations. This kind of sampling, also sometimes referred to as expert choice, occurs when sample selection is *'dependent on human judgement, and not on the rigorous application of probability theory'* (Chisnall, 2001, p.111). The target group for the survey was people working at or visiting the Montrose Legacy Community Health Services clinic, one of the major HIV/AIDS health clinics in Houston, Texas, located in an area where many of the city's gay residents live. The director of the HIV prevention programme for the City of Houston, who conducted extensive research in the Houston metropolitan area, recommended this site. The director was interested in the outcome of this study and assisted in gaining approval to administer the survey. Based on Raosoft's sample size calculator, a 5% margin of error with a confidence level exceeding 93% was sought. The possible population size for the Legacy Clinic was calculated to be 75 to 100 patients per day on average, according to clinic administrators (many patients come to the clinic every month), so a generous projected population size of 2000/month with a 50% response distribution was factored into the calculator, which then called for a sample size of 283 valid responses (Raosoft, 2004). To exceed this minimum sample size, the researcher's stated goal was to collect a minimum of 300 completed and valid responses. No quotas were set for variables such as gender or ethnic affiliation.

Both reliability and validity are considerations in any research design. This survey is simple and is not time sensitive, so it could be replicated in the future with a similar target audience to compare findings. The survey could also be replicated with different target audiences for the purpose of comparison. Bias is unavoidable in any survey, but as noted above, efforts were made to limit bias whenever possible. Although survey results could not be generalised to the general public, from the results of the survey it

should be possible to make inferences related to those people who visit STD or AIDS clinics in the Houston region. Further research would be required to learn if these results are indicative of knowledge and perceptions about HIV/AIDS in other parts of the country.

6.3.4 Survey instrument

Design of the survey instrument, which took place over several months, involved examination of work done to date, review of the research questions for the entire project, and additional secondary research. Also, other HIV/AIDS surveys conducted in the Houston area were examined. U.S. Census categories were consulted to refine the demographics section of the survey, particularly regarding ethnic groups (Fact sheet, 2010).

A panel of experts was assembled to act as consultants and to pilot test the evolving versions of the survey. In addition to supervisors at Teesside University, this group included HIV medical and marketing experts, communications experts, qualitative and quantitative researchers, and administrators at three Houston clinics, including the Legacy Clinic. *A list of survey consultants is shown as Appendix C.5.* The survey underwent nine iterations before the final instrument was deemed ready to administer. During this process, questions were discarded or rewritten, language was edited for clarity, the sequence of some questions was altered, scaling methods were refined, demographic categories were clarified, and the survey format was revised for simplicity and readability. In addition, based on suggestions from Houston clinic administrators, a Spanish language version of the survey was created. Translation issues arose, especially in regards to translating the alternative HIV/AIDS treatments. The Spanish-speaking medical consultants at the clinics were not familiar with many of the listed treatments, so Spanish/English medical dictionaries were also used. Since Spanish varies greatly between the Spanish spoken in Mexico, in Spain, and in other Spanish-speaking countries, a back translation (translating the Spanish version back into English) was done by a bilingual speaker who had lived and worked in the city for a number of years.

The completed survey instrument uses closed ended, open ended, nominal scale, and Likert scale questions. Likert's attitude scale was deemed appropriate for much of the data collection because it has been in use for decades, during which time it has been shown to have good reliability and to give useful information about the degree of respondents' feelings (Chisnall, 2001, p.212-17).

The three-page survey begins with a brief description and an initial filter question, followed by seven sections:

Filter question—*Have you seen or heard information about prevention and treatment of HIV/AIDS?*

The survey administrator stopped the survey if the answer to this question was *No*. If *Yes*, the respondent was directed to continue.

Section A—(Addresses sub-question 13) A multi-response section that uses a nominal scale to list 20 possible sources of HIV/AIDS information and asks recipients to check *all that apply*.

Section B—(Addresses sub-question 14) Uses a five-point Likert-style scale to measure the respondents' perceived credibility, from *Not at all Credible* to *Extremely Credible*, for each of the sources listed in Section A.

NOTE: Both Sections A and B offer an open-ended *Other* category.

Section C—(Addresses sub-question 15) Includes a list of 20 statements, presented in varying sequences (four versions of this page of the survey will be used). Respondents are asked to indicate their level of agreement. These statements grew out of an integrative analysis of Phases 1 and 2 and seek to obtain respondents' opinions and perceptions. Many of the statements reference hotly debated stereotypes, social issues, and medical controversies. A Likert scale with six choices, from *Strongly Agree* to *Strongly Disagree*, is used. A number of reverse-phrased questions are included, which reduces bias since respondents will have to read each question carefully to be sure of its meaning (Field, 2009, p.675).

Section D—(Addresses sub-question 16) A multi-response section that uses a nominal scale of HIV/AIDS treatments—both conventional and alternative—and asks respondents to mark *all they have heard of*.

Section E—(Addresses sub-question 16) Using the list of treatments from Section D, respondents are asked to mark all that they *think can be effective in treating HIV/AIDS*.

Section F—The first five demographic questions establish age, gender, sexual orientation, ethnic identification, and education level. Ethnic groups were defined by consulting the current U.S. Census categories for ethnic background. The next two questions are designed to identify respondents who work or volunteer with HIV/AIDS organisations. The last question seeks to establish if the respondent's HIV status is negative or positive.

Section G—This open-ended question solicits additional comments respondents would like to make.

HIV/AIDS Knowledge and Perceptions Survey (English) is shown as Appendix C.2.

HIV/AIDS Knowledge and Perceptions Survey (Spanish) is shown as Appendix C.4.

6.3.5 Data collection

External field research requires careful planning and clear criteria for collecting data. An instruction sheet ensured data collection techniques were consistent across all times of collection, which occurred during two two-day sessions over the space of three weeks. These guidelines included directions for 1) approaching possible respondents, 2) introducing the survey project, 3) answering questions respondents might ask, 4) getting consent forms signed, and 5) collecting, 6) coding and 7) transporting the surveys.

Guidelines for Data Collection is shown as Appendix C.6.

6.3.6 Data evaluation

Before beginning the process of tabulating, analysing, and interpreting data, it is important to identify potentially important relationships between variables. One way to approach this is to develop a series of working hypotheses, which are a result of *a priori* thinking about the subject, preliminary investigation of related information, or advice from experts (Chisnall, 2001, p.42-4). To this end, an outline of desirable survey outputs was created to clarify how the data could be used to answer the research questions and contribute to the overall aim of the research. This outline formed the initial contents structure of Chapter 7.

After data collection is completed, the information must be aggregated, edited, coded, tabulated, and analysed.

Editing—Every question must be checked to see if it has been answered or if the respondent has declined to answer.

Coding—Numerical values must be assigned to survey responses.

Tabulation—After editing and coding, survey responses were converted to electronic format using SPSS (Statistical Package for the Social Sciences) software, one of the most widely used programmes for statistical analysis in social science (SPSS, 2009). These computerised data mining techniques allow researchers to discover trends and patterns of behaviour that previously went unnoticed.

6.3.7 Data analysis

Section F—The first step was to examine the demographics of the respondents and develop a profile of those who completed the survey. Initially, the demographics of

greatest interest were age group, gender, sexual orientation, ethnic group, and HIV status, as these are the categories that many HIV/AIDS campaigns target, as demonstrated by the content analysis in Chapter 5.

Sections A and B—Were divided into Traditional mass media (1-7), Online media (8-12), and Interpersonal sources (13-19). These groupings did not appear on the survey instrument to avoid bias in survey responses. They are based on the media mix responses tabulated during the content analysis and through input from the survey consultants.

Sections D and E—Were divided into Alternative treatments (1-15) and Conventional treatments (16-18). They were not so designated on the survey instrument, also to avoid bias in responses. The groups are based on information obtained from conventional and alternative medical sources during pre-survey interviews.

Section G—Comments from the open-ended question were collected for anecdotal information.

The next step in the data analysis was to use SPSS to create simple descriptive analyses of the responses to sections A, B, C, D, and E. For *Section A*, responses were reported in terms of the actual number of total respondents who selected each medium and the percentage of the total sample those responses represented. For *Section B*, the number of total respondents who rated each medium as *Not at all Credible* was compared with the number who answered *Credible* or *Extremely Credible*. Again, percentage comparisons were also made. For *Section C*, responses were grouped judgementally into categories suggested by pilot testing and interviewees. To provide an initial overview, the responses were reported as percentages of those who *Agree/Strongly Agree, Disagree/Strongly Disagree* and *Not sure/No Opinion*. For *Sections D and E*, there is a simple comparison of percentages of total respondents who are familiar with each treatment and the percentage that thinks each treatment can be effective. This descriptive overview of responses provided a basis to move into more complex analysis.

Additional analysis involved cross-tabulation of responses against demographic variables using Pearson's chi-square test to determine measures of association. The chi-square test is commonly used to compare observed frequencies in certain categories to the frequencies one might expect to get in those categories by chance. Assumptions that must be met for the test are that in the 2x2 tables, all expected frequencies should be greater than 5 to be valid and significance should be less than 0.05 (Field, 2009). Row and column frequency percentages will be used to interpret those statistically significant

associations between variables since the percentages will reflect data patterns more reliably than the simple frequencies, which will be dependent on sample sizes. (Field, 2009, p.686-701). If the results of these analyses indicate further calculations are needed to fully answer the research questions, additional analysis could be undertaken.

6.3.8 Data disposal

Data will be securely stored during the course of the study and will be destroyed by the researcher five years after collection. Respondents' anonymity will be maintained throughout, in keeping with the MRS Code of Conduct (MRS, 2010).

6.4 CONSTRUCTING A MODEL (PHASE 4)

To address the gaps in knowledge identified during this study, a practical communication model was constructed for a social marketing campaign. This model was informed by the data collected during Phases 1-3 that aim to identify successful as well as unproductive messages and approaches for HIV/AIDS campaigns.

6.4.1 Questions addressed during Phase 4 research (communication model)

- *Could social marketing bridge the knowledge gap between conventional and CAM choices for HIV/AIDS treatment and prevention?*
- *What elements should be incorporated in a social marketing campaign to effectively communicate about HIV/AIDS prevention and treatment options?*

6.4.2 Strengths and weaknesses of models

The model for this project is unique in that it not only builds on the extensive literature review collected for this study, but also incorporates data from the content analysis, pre- and post- survey interviews, and survey responses to create a customised practical model directed to a target audience similar to the one surveyed. In addition to drawing on considerable secondary and primary data, this model also integrates CAM aspects, a component not presently included in HIV/AIDS social marketing messages. The methodology for constructing this model involved integrative analysis of qualitative and quantitative data, including examination of established communication, behaviour, HIV/AIDS campaigns, and social marketing models examined during the literature review.

Mortensen described a model as a metaphor that allows a complex idea to be presented in a simpler, abstract form (1972). Models are therefore useful in aiding

understanding of new concepts, but also run the risk of over-simplifying complex subjects (Chapanis, 1961). Keeping these strengths and weaknesses in mind, the communications model for the HIV/AIDS campaign was created using current model approaches, which incorporate a nonlinear, constitutive view of communication (Littlejohn & Foss, 2009).

6.5 EVOLUTION OF METHODOLOGY

As this methodology was developed, it was soon apparent that creating a survey instrument is a complex process and that the questions needed considerable tweaking, testing, and rewriting. To that end, the group of consultants mentioned previously was formed and versions of the survey were emailed back and forth as the final instrument was formulated. Getting approval to conduct the survey called on all of the researcher's powers of persuasion and required great patience as weeks dragged into months waiting for several levels of administrators to agree. In addition, practical considerations involved recruiting and training students to help with the survey and developing specific guidelines to keep the survey process consistent during each survey period. Strong people skills emerged as one of the most essential elements for success at this stage of the research.

Once the survey responses were collected, another learning curve involved the logistics of installing SPSS and learning how to put the data into the programme for analysis. This is where the pragmatic, left-brain skills came to the forefront.

After survey responses were tabulated, the need for reaction interviews required locating additional contacts and prevailing on those busy professionals to schedule time for in-depth interviews. Once again, interpersonal skills were important. An early version of the research progression had envisioned using a focus group for reaction data, but the complicated logistics of arranging a focus group across the range of distances and disciplines proved unrealistic. Additionally, the methodological shortcomings of focus groups (Gibbs, 1997) caused the researcher to conclude that in-depth interviews would be preferable in place of a focus group.

All in all, this portion of the research was much more time-consuming than originally anticipated, and the sandwich of qualitative-quantitative-qualitative not only required shifting from one kind of research approach to another; it also involved shifting from right to left brain and back to right brain thinking and working. These shifts in cognitive approach offered many opportunities for reflection, which is an important aspect of transdisciplinary research, as discussed in Chapter 1. Personal reflections—

both on the subject of the research and on the experiences during the research progression—became an important part of the integrative and participatory process (Tress, et al., 2006). The researcher’s informal notes and observations of what she had learned about the subject as well as her comments about negative and positive experiences helped shape the forward movement of the project and contributed greatly to the concluding chapter. Inspired by Bridges’ *Reflections on a reflective log* (1999), the comments and informal record of experiences for this project have been gathered into a reflective log, which is shown as *Appendix A*.

6. 6 THE JOURNEY THROUGH THE RESEARCH PROCESS: A SUMMARY OUTLINE

As is usual with mixed methods research, the research process was fluid. The sequential phased process was constantly evolving, as this outline demonstrates, noting additions, deletions, and changes from initiation of the research process through final reflections and conclusions.

a) Initial components of the research concept

- Three intersecting topics: HIV/AIDS, social marketing, conventional/alternative medicine
- Cultural, political, and economic factors in 3 countries: Mexico, Uganda, and United States
- Perspectives from 3 disciplines: marketing, advocacy (political discipline), and medicine (science discipline)

b) Three beginning hypotheses

c) Exploratory research

d) Overall research aim (evolved during phases 1-2)

e) Selection of mixed methods rationale/purposes

f) Research questions and sub-questions formulated (evolved throughout research process)

g) Select mixed methods research design (evolved during phases 1-3)

h) Literature review (ongoing throughout entire process)

Addressed RQ1 and sub-questions 1-4

i) Phase 1 research (content analysis of 18 campaigns from 3 countries)

Addressed RQ2 and sub-questions 8-9

+Added national United States campaigns (See Section 4.8)

+Added case study (Section 5.10)

j) Phase 2 research (semi-structured interviews with key informants)

Addressed RQ2 and sub-questions 10-12

-Deleted Uganda from Phases 2 & 3 (See Section 4.8)

+Added IRB from Sam Houston State University (See Section 4.4)

k) Phase 3 research (surveys and reaction interviews)

Addressed RQ3 and sub-questions 13-16

+Added survey consultant team (See Section 6.3.4 and Appendix C.5)

+Added approvals from Legacy Clinic (See Section 6.5)

-Deleted Thomas Street and City of Houston STD clinics from survey considerations

+Added Spanish version of survey (See Appendix C.4)

+Added Pearson's chi-square tests (See Section 7.5)

+Added Cronbach's alpha analyses (See Section 7.6)

>Changed to in-depth interviews in place of focus group for reaction data

l) Phase 4 research (communication model)

Addressed RQ 3 and sub-questions 17-18

+Added a 4-stage choice-based process (See Section 8.8)

>Changed from the original concept of a 'dummy campaign' to a communication model for a social marketing campaign (See Section 8.9)

m) Analyses and reflection

+Added Reflective log (Appendix A)

+Added transdisciplinary glossary (See pp.xiii-xvii)

n) References

+Added entries through the final edit of the thesis

o) Appendices

+Added Peer-reviewed and published work from this thesis (Appendix D)

+Added Peer-reviewed and presented work from this thesis (Appendix E)

CHAPTER 7

PRIMARY INFORMATION ANALYSIS

7. 1 INTRODUCTION

By this point, the researcher had navigated across boundaries of many kinds: social, cultural, geographic, political, and historical. Also, the journey involved frequent circumnavigation of disparate topics: HIV/AIDS, social marketing, and complementary and alternative medicine (CAM). Much of this journey was taken by vicarious means—studying what others had published in a variety of formats—but some information was gained in a more personal way by travelling to conferences in the United States, Mexico, Canada, and Europe, where there were opportunities to be exposed to current academic research and to participate in conversations about practical responses to the epidemic. Back-grounded by this transdisciplinary review and further informed by analysing HIV/AIDS campaigns from three countries, it was time to move from contemplating global issues to examining localised concerns. The path of transition from general to specific and from secondary to primary information integrated qualitative and quantitative research techniques that generated specific conversations about HIV/AIDS.

A QUAL-QUAN-QUAL ‘sandwich’ of interviews with key ‘upstream’ informants, surveys of a typical ‘downstream’ audience, and reaction interviews formed the basis for understanding how information about HIV/AIDS is selected and disseminated at the local level. This chapter highlights lessons learned during pre-survey interviews, which helped shape the questionnaire that was administered to more than 350 people at an HIV/AIDS clinic in Houston, Texas. The survey, designed to assess knowledge and perceptions about the disease by a high-risk audience, provided pivotal data for this research study and was analysed on several levels, as reported in this chapter. The survey results and reaction comments about the data comprise Phase 3 of this project and were vital to creation of the communication model and the HIV/AIDS social marketing process presented as the final research phase in Chapter 8.

7. 2 PRE-SURVEY INTERVIEWS: STRATEGIES BEHIND THE CAMPAIGNS

The goal during this research phase was to explore behind the scenes: marketing rationales, political influences, and financial considerations that influenced campaign

choices, ranging from broad considerations such as sponsorships to specifics such as message and appeal. The best sources for this information were key decision makers from the organisations or agencies that launched the campaigns, social marketing experts who designed and evaluated the projects, and medical practitioners who participated as content experts or acted as liaisons with the medical community. This section explains some of the inner workings of HIV/AIDS social marketing campaigns and allows opinion leaders with widely differing viewpoints to describe their perspectives.

These interviews were conducted as both informal and formal conversations. Many of the informal interviews overlapped with Phase 1 research and were conducted in person, via email, or by telephone. The formal interviews were conducted in person after much of the secondary research was concluded. The key informants interviewed were chosen from among the many contacts who participated in exploratory interviews or were recommended during secondary research. The pre-survey interviews were judgementally selected to represent a variety of disciplines and viewpoints. Convenience and availability also influenced the selection. *A list of key informants interviewed pre-survey is shown as Appendix B.8.* This accumulated information is important because it presents a cross-disciplinary look at these issues in a way that has not been done previously, thereby filling a gap in existing knowledge.

7.2.1 Aims and objectives for interviews

- Interview a variety of opinion leaders who are knowledgeable about HIV/AIDS social marketing campaigns.
- Gather both quantitative and qualitative information from these key informants, probing for both factual background as well as professional opinions.
- Reflect on their responses in relation to the original research questions.

7.2.2 Questions addressed in the interviews

- *From the viewpoint of opinion leaders such as marketers, humanitarian activists, and medical practitioners—both conventional and alternative—what factors influence choices about dissemination of HIV/AIDS information?*
- *How are sponsorships selected and how are campaigns evaluated?*

- *Do international business interests influence social marketing's dissemination of HIV/AIDS prevention and treatment information, thereby establishing conventional products and treatments as the norm?*

7.2.3 Highlights of pre-survey interviews with upstream opinion leaders

Dissemination of information: from famine to feast?

A long-time HIV/AIDS counsellor and activist in the Houston area remembers when people were simply given their test results, with no counselling and no groups or Internet sources to explain their treatment options. From the standpoint of policymakers, the disease did not get on the political agenda until detailed data became available. A social marketing expert who directed the City of Houston's HIV prevention programme said the city's HIV/AIDS prevalence rates began to be reported by demographic breakouts in 1999. When city leaders saw that 62% of those infected were African American, administrators declared a state of emergency and began to allocate funds for prevention initiatives. Houston is now a national model for HIV/AIDS research and resources for those who want information.

A doctor who recently completed his conventional medical training in Texas saw a lot of AIDS ads when he was in high school, but hasn't seen much public information about the disease in the last couple of years. He said he never learned anything about HIV or AIDS from the ads other than you should always protect yourself when having sex. He thinks education in campaigns would be very helpful because it would broaden people's knowledge about the disease so they would better understand how HIV/AIDS is transmitted and care options for those infected.

A wealth of information can be confusing for the infected without some kind of structure or process. A Houston activist and administrator for an agency that locates housing for people living with HIV/AIDS said the newly diagnosed can be overwhelmed by the plethora of facts. *'There is too much information available once someone is positive, but the truth is, by the time the person wraps their head around what is going on, it is an avalanche of information that oftentimes cannot be managed properly. It is important to have someone like a case manager available who can guide you through the maze to achieve the desired service or outcome,'* she said.

Sponsorships: Not easy at the local level

As discussed in Chapters 2 and 3, sponsorships for HIV/AIDS campaigns are central to most programmes with a national or international scope. A doctor at an

HIV/AIDS clinic in Germany co-directed a documentary of interviews with HIV-positive people from all walks of life. The film, *Blissfully Lost*, was financed by GlaxoSmithKline and was screened at the 2009 German-Austrian-Swiss AIDS Congress (SODAK) in St. Gallen. The doctor and her co-director, a South African filmmaker, had complete control over the content of the documentary, but they said GlaxoSmithKline did almost nothing to promote the film's premiere during the conference, where the pharmaceutical giant had a prominent booth. Conferences such as the Congress are a testament to the financial stake the medical industry has in the AIDS epidemic; much of the conference costs are underwritten by pharmaceutical companies, which go to great expense to have a strong presence at such events, where they promote new modalities and drugs. Market forces are always a factor in the HIV/AIDS equation; the director of Population Services International (PSI) Mexico, said his agency recently stopped condom social marketing in Mexico, due to administrative and political hurdles and because Mexico has many condom brands vying for market share.

On the local level, sponsorships are extremely important but very scarce. The Houston HIV activist said most major corporations would give to larger organisations with national exposure, but very little is done by sponsors/donors on the local level. Also, some agencies are barred from using sponsors. Additionally, city or county agencies cannot have pharmaceutical sponsors, but privately owned clinics can do so. So, local groups are more likely to form coalitions to combat HIV/AIDS or to seek grants from local government. In addition, if local groups apply for funds from national agencies such as the Centers for Disease Control and Prevention (CDC), there are restrictions on message approach and content. For example, campaigns that use CDC funds cannot appear to encourage sexual activity. To make the most of those resources that are available, activist organisations work hard to make sure local policy makers understand the impact of the disease and to tie HIV/AIDS to other social challenges such as addiction and incarceration. On the other hand, city-sponsored campaigns can use internal media such as the metro bus system for free, so the City of Houston HIV office makes use of bus placards to promote campaign messages and organise community volunteers to help distribute posters and brochures.

Lessons learned

The City of Houston HIV office has collected a massive amount of data about the disease in Houston, assembling statistical data from various sources and using focus

groups and surveys to better understand the disease's scope and effects in the area. One commonality the research pointed to was a feeling of pride, whether it was pride in culture, in ethnicity, or in being gay. Focus group responses indicated a need for a sense of belonging. An anonymous gay key informant said, *'As terrible as this sounds, there was a time when it was cool to be an HIV-positive gay man...you were the "in thing." Now, I don't see us having any identity at all.'*

Putting a public face on the disease was a key strategy for an award-winning campaign to encourage testing that Torma Communications, a Houston marketing agency, helped design for the city's HIV office. The campaign, *New Faces of HIV in Houston*, used a focus group comprised of members of the target audience to determine the most effective way to reach the target, to construct the campaign message, and to refine materials. The agency's owner served as a facilitator and organiser of the process rather than the sole designer. One of the focus group members, who was also one of the people who was pictured in the campaign, said the use of real people who lived with the disease every day instead of caricatures or cartoons caught the interest of the media and resulted in extensive free publicity for the programme.

The marketing agency's owner agreed the campaign's reach was greatly extended by the media response to the local faces, but offered a note of caution. Although many people like the idea of being a celebrity, *'be sure those appearing in the campaign are ready for that kind of public exposure,'* she said. The campaign launched on World AIDS Day, tying in to an established international event that increases visibility for HIV/AIDS issues each December 1. The campaign was successful in short-term results, showing a substantial increase in testing and calls to the publicised hotline number. But, long-term behavioural change is the hardest to measure, according to campaign sponsors.

Still, gaps in knowledge about HIV/AIDS treatments are a recognised problem for all groups, according to City of Houston research figures. Younger Houston men in particular—both gay and straight and both white and Hispanic—seem ill informed about how the disease is spread and treated. Overall, knowledge about treatment for HIV/AIDS had the lowest rating for all participant groups, including the HIV-positive MSM (men who have sex with men) subset, clearly an area of weakness.

However, conversations are taking place, prompted both by behaviour change communication efforts like the *Faces* campaign and informal discussions led by area activists. Some of the topics and the candid approach to them are controversial. Why

even use controversy? One marketer's answer to that question was *'because it gets people talking.'* He pointed out AIDS has made it okay to talk about a lot of things in public that were once unacceptable. It has altered public discourse in profound ways. *'We have crossed the conversation barrier and made people not only consider themselves, but their family and friends as well.'*

7.3 SURVEY RESULTS: DOWNSTREAM PERCEPTIONS

With these key informants' observations and facts as background, the next step was to go downstream—to the target audience—for primary data. As described in the methodology in Chapter 6, this quantitative survey was designed to gather baseline information establishing the perceived knowledge level of a high-risk, high-interest downstream audience regarding AIDS treatment and prevention choices, as well as their perceptions about information sources and their opinions regarding cultural and economic issues that surround the disease. The survey process took about nine months, from design through analysis. Both the process and the results were informative. This section of the chapter traces the survey progression from creating the instrument to preparations for administering the questionnaire, to data collection and tabulation. The data was then analysed in terms of simple descriptors, followed by cross tabulations to determine significant associations. Lastly, responses to 20 statements of fact and opinion were divided into three groups and tested for reliability.

7.3.1 Aims and objectives:

- Create a survey instrument designed to ascertain perceptions and knowledge about HIV/AIDS health choices.
 - Obtain a sample of at least 300 valid responses from a targeted population.
 - Correlate survey results with information from the key informant interviews.
- (See Chapter 6 for a detailed protocol for the survey design and sampling.)*

7.3.2 Questions addressed in the survey

- *Where do recipients of HIV/AIDS information learn about the disease?*
- *How credible do these recipients consider their information sources to be?*
- *What perceptions and knowledge do these recipients have about HIV/AIDS?*
- *How do recipients of HIV/AIDS information perceive their choices as regards prevention techniques and treatment modalities?*

7.3.3 Organising the survey

In keeping with the questions listed above, the completed survey instrument was divided into sections designed to learn A) where respondents obtained information about HIV/AIDS, B) how credible they believed those sources to be, C) opinions about HIV/AIDS cultural, medical, and social issues, D) HIV/AIDS treatments respondents knew about, and E) HIV/AIDS treatments they believed to be effective. A final section collected demographic data describing the respondents' age, gender, sexual orientation, ethnic identification, education level, involvement with HIV/AIDS organisations, and HIV status. (*The evolution of the survey design is explained in Chapter 6, Section 6.3.4.*)

7.3.4 Administering the survey

The site selected for the survey, formerly known as the Montrose Clinic, was founded in 1978 near downtown Houston, Texas, to provide STD testing and treatment to gay and bisexual men. When the AIDS crisis began, the clinic became the first HIV antibody-testing site in the state and the second in the nation. With the help of various federal and local programmes, the clinic grew to provide HIV/AIDS prevention education, social services, and medical care for men and women living with the disease. In 2005, the clinic became part of Legacy Community Health Services and expanded to be a full-service community health centre that provides healthcare services in a '*culturally sensitive, judgment-free, and confidential environment*' (Legacy website, 2010). In addition to HIV/AIDS testing, education, treatment, and social services, Legacy also provides no-cost or low-cost healthcare for other chronic health conditions. The centre serves over 20,000 men, women, and children each year (Legacy website, 2010).

Gaining approval to conduct the survey took four months and involved email contacts, telephone conversations, and personal meetings with Legacy administrators. The survey instrument was fine-tuned at the suggestion of Legacy staff members and the researcher's Institutional Review Board (IRB) approval from Teesside University was accepted. Logistics for conducting the survey were discussed and survey dates were set.

7.3.5 Collecting the data

The base of operations for data collection was a small folding table in the foyer of the clinic so everyone entering could be asked to complete a survey instrument. Simple,

colourful signs—in English and Spanish—were placed on the entry doors and over the table. (*Facsimiles of the survey signs are shown as Appendix C.7.* A variety of small gifts and candy was placed in a ‘grab bag’ and each person who completed a survey could select an item. Although the gifts were inexpensive trinkets, most people were pleased by these small incentives. A few people asked if there was an incentive to take the survey and seemed happy with their modest reward. Other respondents just wanted to participate and did not select a gift. The survey sample was by convenience and consent; everyone who entered the clinic while the surveys were being administered was asked to participate. Since there was also a pharmacy at the clinic, some people only came to pick up medicines and were less likely to agree to take the survey since they did not have to wait for an appointment. This non-probability sampling is often used when there are time and resource limitations (Chisnall, 2001).

The guidelines for survey administration that were prepared for this survey were strictly followed in all respects to ensure consistency of survey administration, anonymity of respondents, and security of the data. Consent forms and surveys were always kept in separate folders, and the four different versions of the survey were equally distributed. *Guidelines for survey data collection is shown as Appendix C.6.*

As required by the methodology, surveys were collected on four different days over a three-week period. The response rate was excellent; more than 90% of the people who visited the clinic agreed to participate. Clinic administrators expressed surprise at the high rate of participation and asked for tips on getting similar responses to future in-house surveys. *Personal observations about the survey process are included in the reflective log shown as Appendix A.*

At the end of each survey day, responses were hand coded with the date. (Each of the four versions already had a code printed on the bottom right hand corner designating the version number.) Completed survey responses were carefully transported and stored in a secure location until they could be edited, coded, and tabulated.

7.3.6 Data cleansing

When survey responses were examined, 11 had to be discarded due to incomplete responses, most because the respondent was called to his/her appointment before completing it; a few respondents agreed to take the survey, then returned it with one or two pages left blank. Thirteen Spanish language responses were collected and included in the database. Valid responses were numbered and entered into four SPSS (Statistical Package for the Social Sciences) files. (Since there were four versions of the survey, the

responses to each version were entered as a separate file, then the responses to Section C were re-ordered, and the four files were merged.) There were 342 valid cases in the merged file. The next step was to clean the data, checking all system missing entries against the original responses and correcting the data entries as needed. Next, to determine accuracy of data entry, the first 50 responses were checked against the data entered for each case. Minor coding errors were discovered in fewer than 5% of the cases, so then every fifth original response was compared with its corresponding data entry, and corrections were made as warranted. Overall, fewer than 2% of these cases required coding corrections. The handwritten comments from Section G of the survey were transcribed in a separate document. *Comments from Legacy Clinic survey respondents is shown as Appendix C.8.* Some data was re-coded to simplify analysis. For example, in Section C, *Not Sure* was combined with *Neither Agree Nor Disagree* responses. In Section F, *Prefer Not to Say* regarding sexual orientation was combined with system missing entries, and on the HIV status question, *Don't Know* and *Prefer Not to Say* were combined and shown as system missing entries.

7.4 DESCRIPTIVE FINDINGS

Once data was entered and cleaned, the first output was to run descriptors of each category to begin to answer the questions addressed in the survey. These initial results were shared with the Legacy Clinic administrators as well as with other key informants during survey reaction interviews. (*See Chapter 8.*) This preliminary information was the basis for a work in progress poster presented in April 2010 during an area research conference sponsored by the College of Humanities and Social Sciences at Sam Houston State University in Huntsville, Texas. *The poster, Positive or negative: HIV/AIDS knowledge & perceptions, is shown as Appendix E.7.*

7.4.1 Demographics of respondents

The demographic profile of the Legacy Clinic respondents was interestingly diverse.

Age: The age of respondents, which was expected to be a significant variable in responses to many of the survey questions, was well reported, with 340 (99.4%) responding to this question. The largest age group, as shown in Figure 7.1, was the 37-47 year-olds, which represented more than 30% of the respondents, followed by the 26-36 year-olds, with 26%, and the 48-58 year-olds, with 22.5%. Young people 18-25 were 15.5% of the sample, and those 59 or older made up only 5.3% of respondents. People under 18 were not included in the survey due to legal concerns.

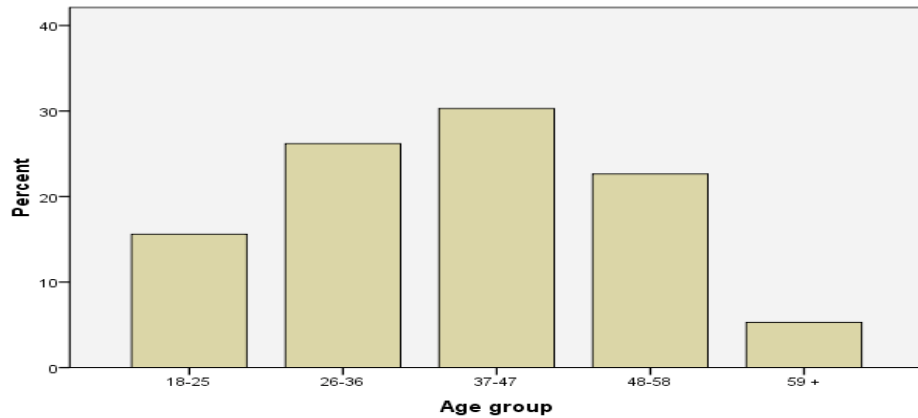


Figure 7.1—Age group distribution of survey respondents.

Ethnicity: Regarding ethnic group distribution, the two largest groups were white/Caucasian at 37.1% and black/African American at 35.7%. The next largest ethnic group was Hispanic at 15.5%. Those identifying themselves as multiracial made up 5.3% of the total and the remaining ethnic groups were each less than 3%. As with age, more than 99% of the 342 respondents provided ethnic group information.

Gender: There were almost twice as many male as female respondents: 62.9% men compared to 31.9% women. Research done during survey design indicated the gender demographic question should be asked as, *Which gender do you most identify with?* since respondents were likely to include transsexual and transgender individuals.

Sexual orientation: Also in response to target audience research, the sexual orientation category offered three choices: heterosexual (42.4% of respondents), homosexual (38%), or bisexual (9.9%).

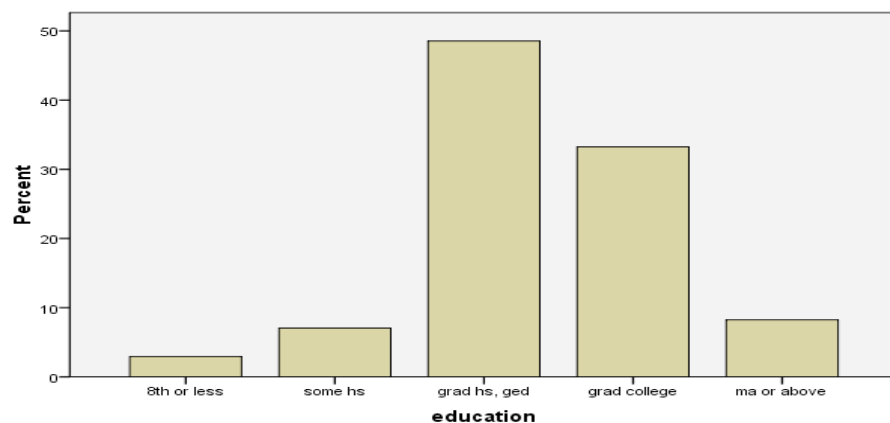


Figure 7.2—Education levels of survey respondents.

Education background: Overall, the education level of respondents was high, as shown in Figure 7.2, with 48.2% having high school diplomas and an additional 33% being college graduates.

Religious affiliation: Less than half of the respondents chose to provide their religious affiliation. Of those who did respond, the greatest number identified themselves as Baptist (12%), Catholic (12%), and the more general Christian (11%). Non-denominational, none, and agnostic together accounted for another 14%.

Involvement with HIV/AIDS groups: Relatively few respondents were in paid positions with HIV/AIDS organisations (6.7%), but almost twice as many (11.4%) were unpaid volunteers with such organisations.

HIV status: Not surprisingly, given the audience traditionally served by Legacy Clinic, more respondents were HIV-positive (54.1%) than HIV-negative (31.3%), and 14.6 % did not give their status.

7.4.2 Responses to Section A: sources of HIV/AIDS information

At the suggestion of survey consultants, the timeframe of 4-5 years was incorporated during one of the many survey revisions. Sources were grouped into three categories. *Traditional Mass Media* included TV, radio, books, newspapers, magazines, out of home (billboards, transit ads, posters, flyers, brochures), and events (seminars, workshops, conferences). *New (Online) Media* included medical websites, HIV/AIDS groups' websites, blogs/online bulletin boards, online newsletters/ journals, emails, and social media (Facebook, Twitter, etc). *Interpersonal Sources* included community organisations, religious organisations, educational institutions, conventional medical doctors, alternative medical doctors, friends/family members, and fellow workers. These groupings were informed by the content analysis of 18 HIV/AIDS campaigns (*See Chapter 5*) and by input from the survey consultants. Percentages selected do not add up to 100% because recipients could mark as many sources as they wished, so a total of all percentages is not meaningful. Additionally, since respondents were relying on memory rather than formal media logs such as those used by Arbitron (Arbitron website, 2010), these responses should be viewed as being filtered by perception.

Question addressed

- *Where do recipients of HIV/AIDS information learn about the disease?*

Traditional mass media sources: As shown in Figure 7.3, each form of traditional media was selected by a third or more of the respondents, with television being the most

popular (70.2%), and events such as seminars, workshops, and conferences being least popular—selected by only 32.7%.

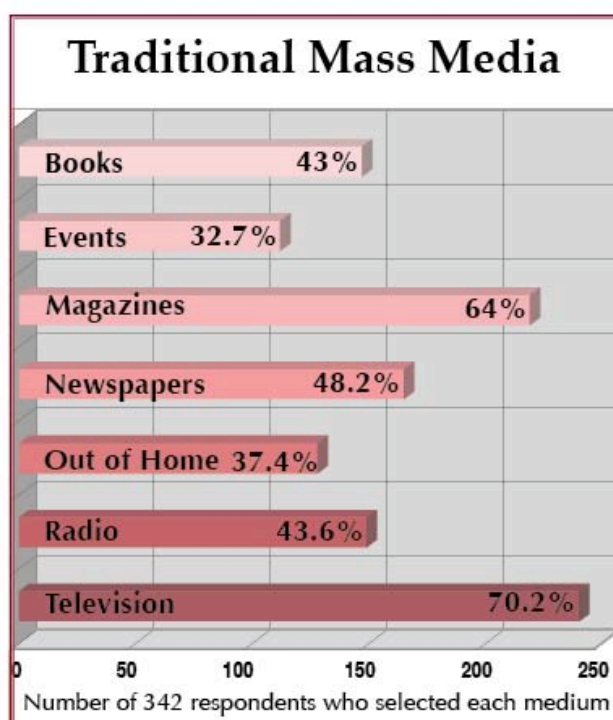


Figure 7.3—Traditional mass media selected: Number and percentage of respondents who selected each of seven traditional media sources.

New media sources: Overall, as shown in Figure 7.4, new media were much less likely to be sources of information about HIV/AIDS than traditional media. The most popular new media source was medical websites (38.6%), while blogs/online bulletin boards, and social media (Facebook, Twitter, etc) were each selected by fewer than 13%. Surprisingly, HIV/AIDS websites were only used by about a third of the respondents.

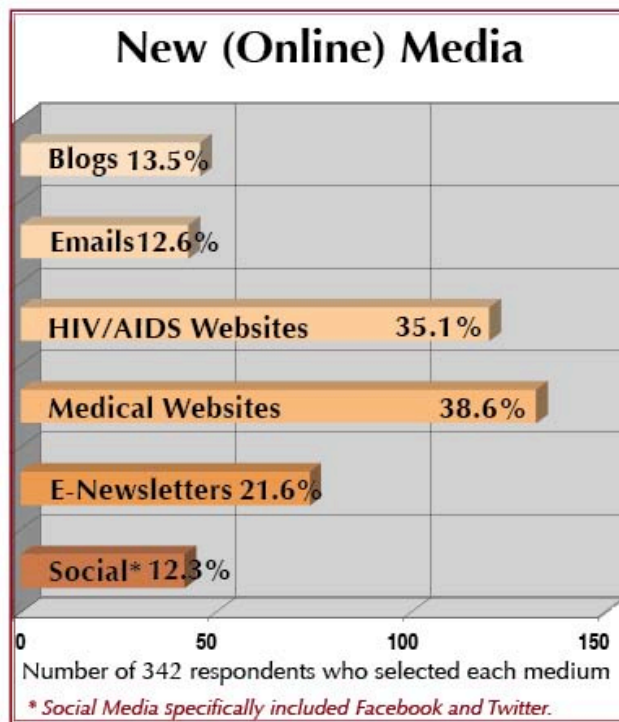


Figure. 7.4—New media selected: Number and percentage of respondents who selected each of six new media sources.

Interpersonal sources: Interpersonal sources, especially family and friends (48.2%), community organisations, and conventional medical doctors (35.7% and 35.1% respectively), were generally more popular sources for HIV/AIDS information than new media, but not as frequently selected as traditional media, as shown in Figure 7.5. Alternative medical doctors (12%) were the least likely interpersonal source, according to respondents. Religious sources were only selected by 16.7%, which was in keeping with the response to the religious affiliation demographic question, in which 35% of the 50% who responded to the question expressed a religious affiliation.

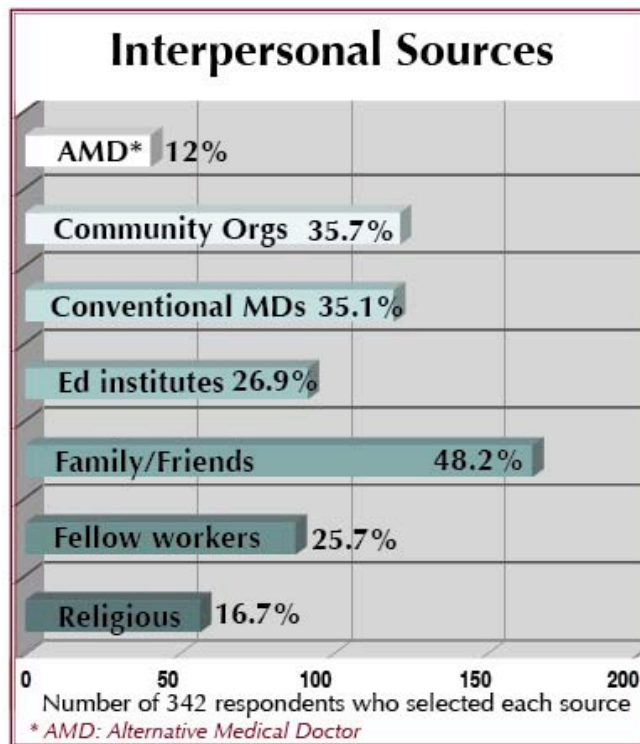


Figure 7.5—Interpersonal sources selected: Number and percentage of respondents who selected each of seven interpersonal sources.

Other sources listed by respondents were varied, ranging from ‘mother’ to ‘case worker’ to ‘self,’ but did not add significantly to the information already collected.

7.4.3 Responses to Section B: credibility of HIV/AIDS information sources

This section used the same media groups as in Section A, but it should be noted that recipients could mark media sources in section A which they did not rate in section B, or vice versa. A number of conclusions can nevertheless be inferred from the data. For ease of initial comparison, only three points of the Likert scale were used in these figures; *Credible* and *Extremely Credible* were combined to compare with *Not at all Credible* responses. Other possible responses were *Somewhat Credible* and *Undecided*. For the same reasons explained in Responses to Section A, percentages do not total 100% and the number of responses does not total 342 (the total number of survey respondents).

Question addressed

- *How credible do these recipients consider their information sources to be?*

Credibility of traditional mass media sources: In general, as shown in Figure 7.6, television was the most credible traditional medium (56.1%), closely followed by books

(55%), while out-of-home sources (billboards, transit ads, posters, flyers, brochures) were rated the lowest in believability of the traditional media group. Radio was the traditional medium least likely to be considered credible, with 8.8% designating it as *Not at all Credible*.

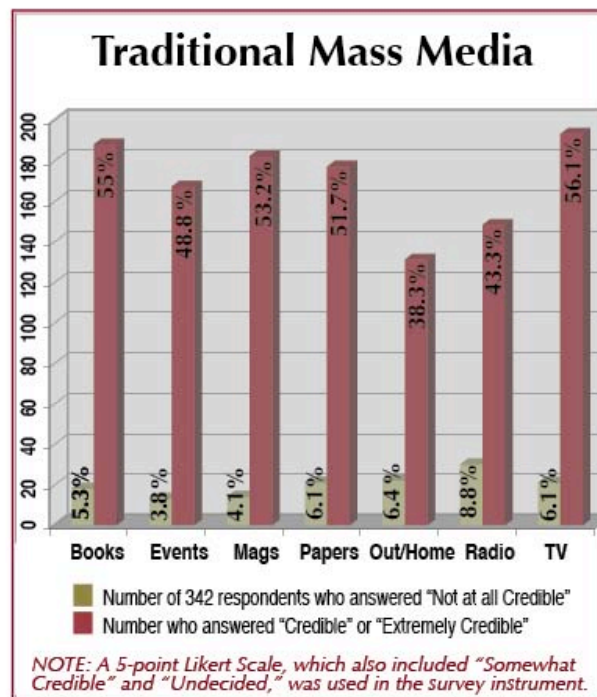


Figure 7.6—Credibility of traditional media: Number and percentage of respondents who answered Not at all Credible vs. Credible or Extremely Credible.

Credibility of new media sources: Using the same kind of comparison, as shown in Figure 7.7, medical web sites were considered credible by more respondents (57%) than television, and HIV/AIDS groups' websites (53.3%) were comparable to magazines in believability. Notably, social media were most likely to be considered *Not at all Credible* (14.9%).

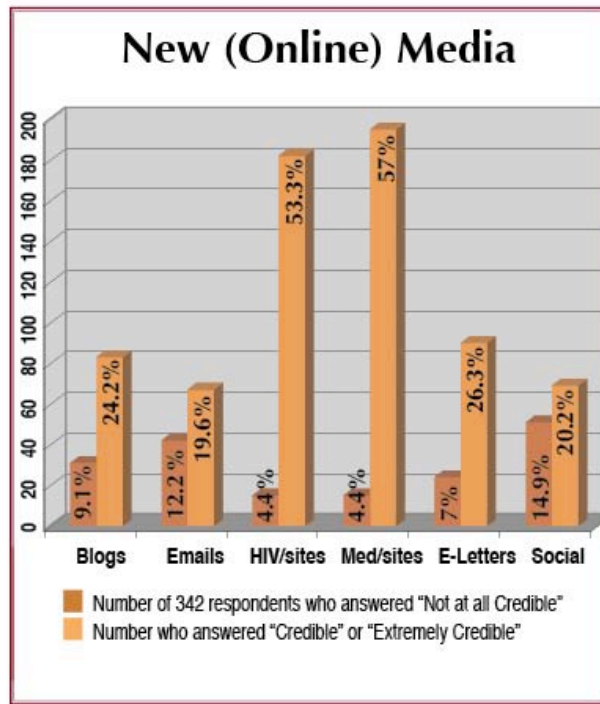


Figure 7.7—Credibility of new media: Number and percentage of respondents who answered Not at all Credible vs. Credible or Extremely Credible.

Credibility of interpersonal sources: In terms of credibility for interpersonal sources, conventional medical doctors (57%) outranked television and were equal to medical websites, as shown in Figure 7.8. Also, a variety of other sources were listed as credible, including the Legacy Clinic, fiancé, self, and ‘person with HIV.’

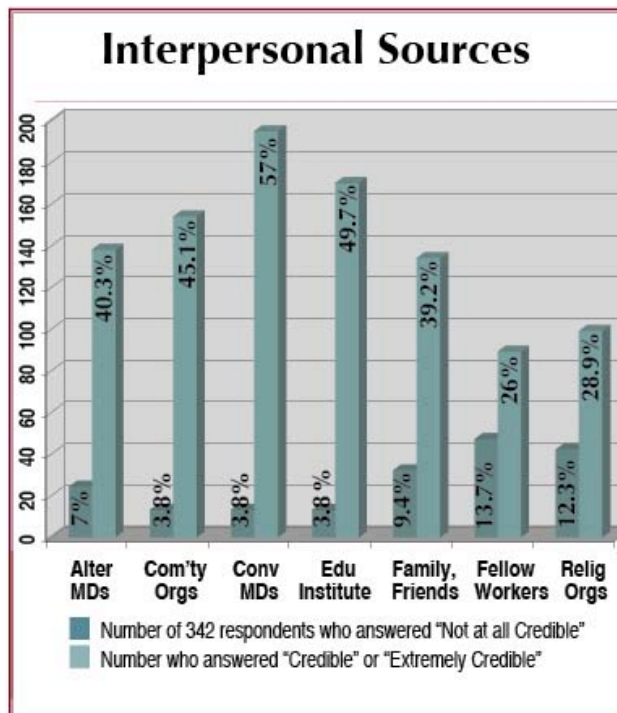


Figure 7.8—Credibility of interpersonal sources: Number and percentage of respondents who answered Not at all Credible vs. Credible or Extremely Credible.

7.4.4 Responses to Section C: perceptions and knowledge

In this section, statements of knowledge and perception were arranged in four different random orders on survey versions 9.1 through 9.4 (*See Chapter 6, Research Design, Section 6.3.2*), with no groupings specified. The four versions were equally distributed among the respondents. For the initial report of simple descriptive responses, statements were grouped judgementally according to broad categories that surfaced during the literature review and from interviews that helped formulate and refine the statements. Initial categories included: I.) Stigma: Cultural Stereotypes—statements 1,3,4,10,13,15 (*See Table 7.1*), II.) Medical: Prevention and Treatment—statements 5, 6, 8, 9, 11,12,16 (*See Table 7.2*), and III.) Global Socio-Political issues —statements 2,7,14,17,18, 20 (*See Table 7.3*). Note: all statement numbers used in this report correspond to version 9.1 in both the English and Spanish versions (Only one version of the Spanish survey was created since it was correctly anticipated that most respondents would prefer English.) Statement 19 is considered separately because it was the only first person question and did not logically fall into one of the three categories outlined above.

Question addressed

- *What perceptions and knowledge do these recipients have about HIV/AIDS?*

This section of the survey is a combination of opinion and fact-based statements, but many of the so-called ‘facts’ are extremely controversial, with advocates who are convinced the statement is truth, and others who will argue just as vehemently it is fiction. For example, most conventional medical doctors would be certain that statement 12, *Alternative medical treatments for HIV/AIDS have shown promising results*, is without merit, but some CAM practitioners are confident alternative modalities hold the solution to the epidemic. Nevertheless, the goal was to learn what the respondent believed or perceived to be true, which marketers must accept as that individual’s own reality (Griffin, 2010).

Fact or fiction arguments aside, knowledge levels are important for those designing communications about the disease. For example, in regards to HIV/AIDS prevention, it would be important to know if respondents believed condoms ensure safe sex 100% of the time, or if they were aware of studies that indicate the failure or leakage rate for condoms is at least 20% (Crosby, et al., 2008), and possibly as high as 30% (Carey, et

al., 1992). On matters of stigma, responses to statements that link HIV/AIDS with ‘immoral behaviour’ provide a context for shaping future messages about the disease. Likewise, attitudes toward global issues such as the controversy that surrounds pharma’s financial connections to the AIDS industry imply the target audience’s levels of awareness and activism. For this initial comparison of Section C statements, the rating categories *Agree* and *Strongly Agree* were combined as were the categories *Disagree* and *Strongly Disagree*. The system missing entries, *Not Sure*, and *Neither Agree nor Disagree* were collectively reported as *Not Sure*.

Responses to Stigma: cultural stereotypes: On the whole, as shown in Table 7.1, the survey respondents had a high percentage of disagreement with each of these ‘moralistic’ statements that represent some of the common stigmatising and discriminatory stereotypes toward people with HIV/AIDS. Given the demographic makeup of the respondents, especially the high percentage of HIV-positive people (54.1%), the only surprising responses were the significant proportion who agreed with or were ambivalent about these statements, especially the 23% who were not sure if HIV/AIDS resulted from immoral behaviour.

Stigma statements	Agree %	Disagree %	Not sure %
1. Poor people are more likely to get AIDS.	21.1	57.6	21.3
3. HIV/AIDS is primarily a gay disease.	7.3	82.4	10.3
4. Getting HIV/AIDS is usually a death sentence.	13.2	70.7	16.1
10. HIV/AIDS is God's way of punishing the wicked.	6.7	83.9	9.1
13. People with HIV/AIDS (do not)* deserve the same rights in the workplace as other workers.	5.5	88.1	6.4
15. HIV/AIDS infections are often a result of immoral behaviour.	14.9	61.7	23.4

*reverse phrasing was re-coded for analysis

Table 7.1—Responses to cultural stereotypes statements: More respondents disagreed with each statement than those who agreed or were not sure combined.

Responses to Medical: prevention and treatment statements: As shown in Table 7.2, the majority of the respondents disagreed with this list of prevention and treatment related statements, with the exception of statement 12, where responses were split almost evenly between *Agree* and *Not Sure*. This would seem to indicate a high level of ambivalence or a lack of knowledge about alternative treatments for HIV/AIDS.

Regarding statements of fact, it is noteworthy that almost one third did not know if an HIV/AIDS vaccine is available (Medical experts predict no vaccine will be available for at least another 20 years: Padian, et al., 2008). More than a fifth were not sure if an HIV-positive woman could avoid having an infected baby (Prevention of mother-to-child transmission is one of the most cost effective interventions available: Global AIDS Alliance, 2009). Likewise, more than a fifth were not sure if antiretroviral drugs are a cure for the disease (Drug cocktails suppress but do not eliminate the virus: Segal, 2003). Also troubling is the 18% who believed condoms to be a fail-safe barrier to infection (Failure rates have found to be as high as 30%: Crosby, 2008). Also, a significant number was woefully lacking information or misinformed regarding statement 16, where the medical evidence overwhelmingly shows that women can contract the disease more easily than men during unprotected sex (Gates, 2007).

Medical statements	Agree %	Disagree %	Not sure %
5. Antiretroviral drugs are a cure for HIV/AIDS.	8.2	68.4	23.4
6. Giving antiretroviral drugs to people not infected is a good way to prevent HIV/AIDS.	10.3	58.5	31.3
8. A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.	12.5	66.7	20.8
9. You cannot get HIV/AIDS during sex if condoms are always used.	18.4	68.1	13.5
11. An effective HIV/AIDS vaccine is available.	15.2	53.2	31.6
12. Alternative medical treatments for HIV/AIDS have shown promising results.	43.3	14.6	42.1
16. It is biologically easier for woman to get HIV/AIDS than it is for men.	21.9	39.8	38.3

Table 7.2 —Responses to prevention and treatment statements:
More respondents disagreed with each statement except Statement 12.

Responses to Global: socio-political issues: As shown in Table 7.3, responses to the socio-political statements are somewhat mixed, but there are indications of awareness about global issues and trends. More than half support prosecuting people who knowingly infect others and agree that the AIDS industry is profitable for drug companies. Almost 60% are not aware that globally HIV/AIDS infections are more likely to occur through heterosexual contact than by homosexual contact. As was the case with some of the medical statements, the percentages of *Not Sure* on well-documented trends such as statement 18: *Young people under 25 account for almost half of new HIV/AIDS infections globally*, is somewhat surprising and disturbing.

Socio-political statements	Agree %	Disagree %	Not sure %
2. Globally, the number of people with HIV/AIDS is decreasing.	8.8	65.8	25.4
7. People who knowingly expose others to HIV/AIDS should be prosecuted as criminals.	54.5	19.8	25.7
14. Treating HIV/AIDS is a lucrative business for pharmaceutical companies.	51.7	16.4	31.9
17. HIV/AIDS prevention efforts often receive more funding than treatment efforts.	24.3	27.5	48.2
18. Young people under 25 account for almost half of new HIV/AIDS infections globally.	45.9	12	42.1
20. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	21.1	57.6	21.3

Table 7.3—Responses to socio-political statements:
Responses to these statements were mixed; respondents agreed with three statements, disagreed with two and were not sure about the remaining statement.

Response to Statement 19: *I am not personally worried about getting HIV/AIDS:* 19.6 % agreed; 51.7% disagreed, 28.6% were not sure. Since more than half of the respondents said they were HIV-positive, the validity of this response is called into question and this data was not used in later analysis of Section C.

7.4.5 Responses to Sections D & E: HIV/AIDS treatments

Figure 7.9 gives a side-by-side comparison of the percentage of the 342 respondents who had heard of each treatment (left) to the percentage who thought each treatment was effective. Respondents could mark as many as they wished in both sections, so the numbers do not add up to 100%, but the responses are useful for comparisons. Although they are not so labelled, the first 15 treatments listed are alternative medical modalities, and the last three are conventional medical treatments. In every case, the percentage of respondents who had heard of a treatment was greater than the percentage that thought that treatment could be effective against HIV/AIDS.

Question addressed

- *How do recipients of HIV/AIDS information perceive their choices as regards prevention techniques and treatment modalities?*

An older conventional modality from the late 1980s, AZT (Azidothymidine), was the best-known treatment (51.2%), but only 35.1% considered it effective. It is intriguing to note that HAART (Highly Active Antiretroviral Therapy), sometimes called ‘drug cocktails,’ and which is the most commonly used conventional treatment for HIV/AIDS, was only recognised by 40.1% of respondents and was deemed effective by 39.8%. Porcine liver extracts and Venus flytrap were the least recognised (1.8% and 3.2% respectively).

Under other treatments known or considered effective, several respondents listed ‘cocktails’ and antiretrovirals as well as alternative treatments that included ozone, DCA, CM4, and black walnut hull extract. Clearly, many of the respondents did not know HAART is an antiretroviral cocktail.

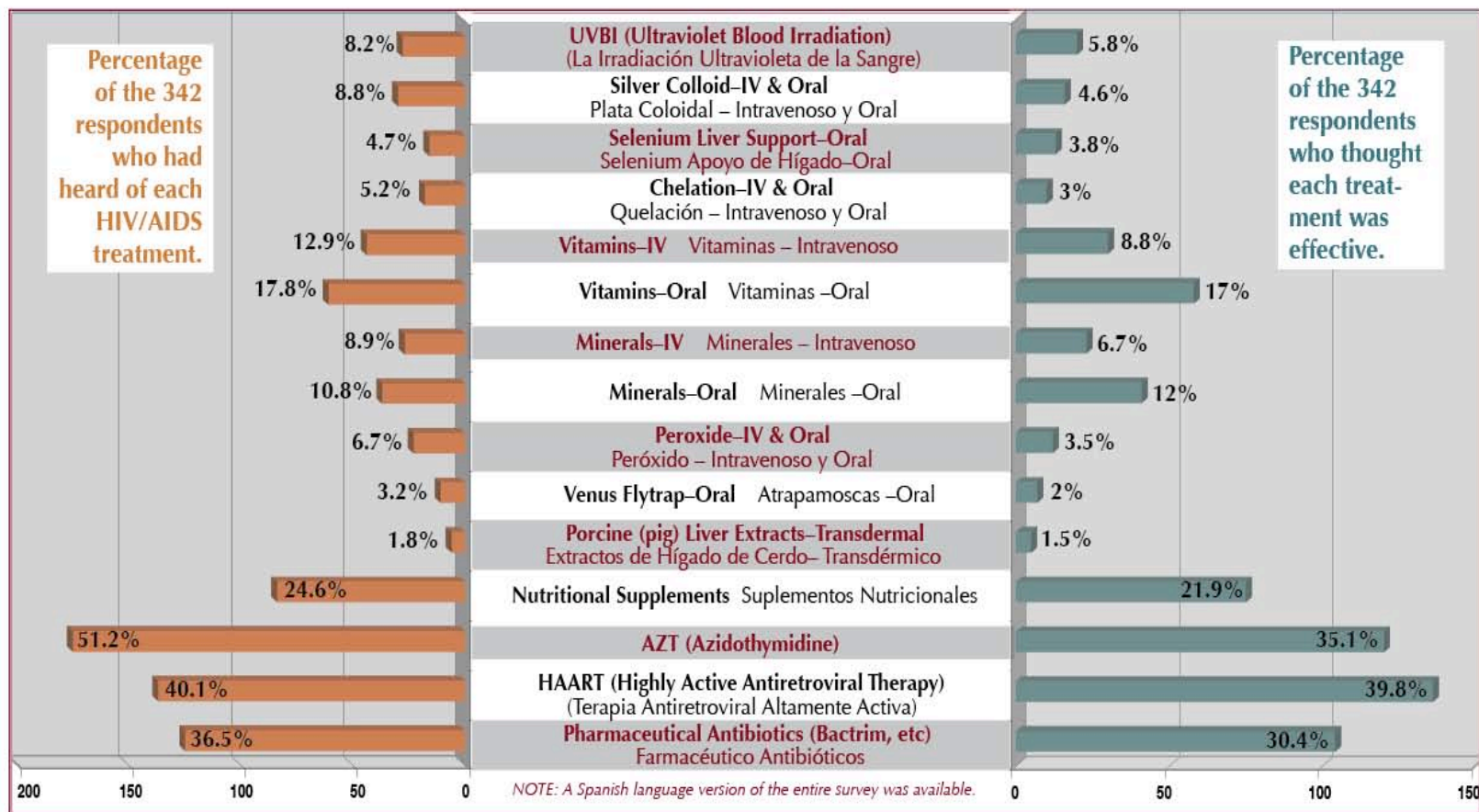


Figure 7.9—HIV/AIDS treatments: Percentage of respondents who had heard of alternative and conventional treatments (left), and the percentage who considered those treatments effective (right).

7.5 STATISTICALLY SIGNIFICANT RELATIONSHIPS

Using SPSS 15.0.1 (SPSS, 2007), cross-tabulation tables were run to search for significant relationships between responses from each of five demographic groups (age, gender, status, sexual orientation, and ethnic group) against survey sections A, B, C, D, and E. Pearson's chi-square test of association was used, which is a common method for determining relationships between two categorical variables. Field (2009) describes Pearson's chi-square test as '*an extremely elegant statistic based on the simple idea of comparing the frequencies you observe in certain categories to the frequencies you might expect to get in those categories by chance*' (2009, p. 688). Field also specifies the importance of looking at row and column percentages to interpret test results, which will reflect the patterns of data more reliably than the simple frequencies since the frequencies will be dependent on sample sizes in different categories (p.692).

A chi-square probability of 0.05, (meaning the finding has a five percent chance of not being true and a 95% chance of being true), is commonly interpreted by social scientists as justification for rejecting the null hypothesis that the row and column variables are only randomly related (Field, p. 697). However, for practical application in the business world, a 90% chance of being true (probability=0.1), can't be considered proven, but those relationships would be considered as part of the larger picture (Creative Research Systems, 2010). Therefore, when a number of significant associations emerged relating two variables, 'borderline' associations were also examined for a tendency toward significance.

Tests of association have other possibilities for error; if the survey sample is not truly random, a significance test may overstate the accuracy of the results since it only considers random error (Creative Research, 2010). In addition, when using significance tests, the expected frequencies should be greater than five although it is considered acceptable in larger contingency tables to have up to 20% of expected frequencies below five (Field, 2009, p. 691-2). With these cautionary notes in mind, a number of significant relationships emerged in the data from each section of the survey.

7.5.1 Section A: sources for HIV/AIDS information: cross tabs with significance

Looking at the relationship between gender and individual traditional sources (*See description of source groupings, Section 7.4.2*), only four revealed significant differences between males and females. Collectively, these are shown in Table 7.4.

Kind of media selected	Male	Female
Television	60.3%	39.7%
Radio	57.3%	42.7%
Magazine	70.6%	29.4%
Out of Home	57.7%	42.3%

Table 7.4—Relationships between traditional media sources and gender: Males were more likely than females to get HIV/AIDS information from these sources.

Men were more likely than women to obtain HIV/AIDS information from television ($\chi^2 = 13$; $df = 1$; $p < 0.001$), radio ($\chi^2 = 9.32$; $df = 1$; $p < 0.003$), and out-of-home media ($\chi^2 = 6.62$; $df = 1$; $p < 0.011$). Compared with women, men had a strong preference for magazines ($\chi^2 = 4.91$; $df = 1$; $p < 0.028$).

When the relationship between status and traditional media sources was examined, three were found to have significant differences, as shown in Table 7.5.

Kind of media selected	HIV-Negative	HIV-Positive
Television	40.9%	59.1%
Radio	46%	54%
Out of home	44.1%	55.9%

Table 7.5—Relationships between traditional media sources and HIV status: HIV-positive respondents were more likely than HIV-negative people to get HIV/AIDS information from these sources.

Respondents who were HIV-positive were more likely than those who were HIV-negative to obtain information about the disease from television ($\chi^2 = 5.16$; $df = 1$; $p < 0.024$), radio ($\chi^2 = 8.07$; $df = 1$; $p < 0.005$), and out-of-home media ($\chi^2 = 4.7$; $df = 1$; $p < 0.031$).

When looking for relationships between demographic variables and individual new media sources (See Section 7.4.2 for an explanation of this grouping), status was once again the most frequently significant variable, as shown in Table 7.6:

Kind of media selected	HIV-Negative	HIV-Positive
HIV/AIDS websites	27.4%	72.6%
On line newsletters	48.4%	51.6%
Social media	53.8%	46.2%

Table 7.6—Relationships between new media sources and HIV status: HIV-positive respondents were more likely than HIV-negative people to get HIV/AIDS information from websites and newsletters and less likely to get information from social media.

HIV-positive people were more likely than HIV-negative ones to get information from HIV/AIDS websites ($\chi^2 = 6.18$; $df = 1$; $p < 0.014$) and online newsletters ($\chi^2 = 4.68$; $df = 1$; $p < 0.032$), but less likely to consult social media sources such as Facebook and Twitter ($\chi^2 = 5.74$; $df = 1$; $p < 0.018$).

Not surprisingly, there was also a significant association between age group and use of social media; but curiously the 26-36 age group was more likely (52.4%) than the 18-25 year-olds (26.2%) to obtain information from social media sources ($\chi^2 = 27.23$; $df = 4$; $p < 0.001$). In the older age groups, cell sizes for social media selected were less than five, so were not considered.

Additionally, sexual orientation was a significant variable for HIV/AIDS groups' websites as information sources, with homosexuals (51.4%) being much more likely than heterosexuals (32.4%) or bisexuals (16.2%) to use this medium ($\chi^2 = 15.58$; $df = 2$; $p < 0.001$).

When examining individual interpersonal sources (*See description of this grouping in Section 7.4.2*), for relationships with demographic variables, status surfaced again as a significant variable in three sources, which are shown as Table 7.7.

Kind of source selected	HIV-Negative	HIV-Positive
Educational institution	48.8%	51.3%
Friends/family	44.4%	55.6%
Fellow workers	52%	48%

Table 7.7—Relationships between interpersonal sources and HIV status.

Those who were HIV-positive were more likely than HIV-negative respondents to obtain information from educational institutions ($\chi^2 = 6.96$; $df = 1$; $p < 0.009$) and

friends and family ($\chi^2 = 7.10$; $df = 1$; $p < 0.009$), while HIV-negative respondents were more likely to consult co-workers ($\chi^2 = 10.25$; $df = 1$; $p < 0.002$).

The only other significant association to surface for this group of sources was between conventional medical doctors and ethnic group; where white/Caucasian showed a much higher reliance on MDs (51.7%) than did the other two main ethnic groups (blacks/African Americans: 28.8% and Hispanics: only 9%). ($\chi^2 = 21.11$; $df = 6$; $p < 0.003$). The other ethnic groups did not have sufficient cell counts to be considered.

Printouts of significant cross tabulation tables and Pearson's chi-square tests of association for the media sources discussed in this section are shown as Appendix F.1.a.

7.5.2 Section B: credibility of sources

Fewer categories with significant associations surfaced in Section B, with status once again having the most noteworthy differences. HIV-positive people were more likely than HIV-negative respondents to view educational institutions as *Credible* (58% vs. 42%) or *Extremely Credible* (57.4% vs. 42.6%). ($\chi^2 = 9.98$; $df = 4$; $p < 0.042$). Also, those who were HIV-positive were more likely than HIV-negative respondents to view their co-workers as *Not at all Credible* (81.6% vs. 18.4%) ($\chi^2 = 14.85$; $df = 4$; $p < 0.006$).

Printouts of significant cross tabulation tables and Pearson's chi-square tests of association for source credibility discussed in this section are shown as Appendix F.1.b.

7.5.3 Section C: knowledge and perception statements: cross tabs with significance

The 20 statements from this section of the survey were divided into the same groupings as those used in the descriptive analyses discussed previously: stigma, medical, and socio-political statements.

Statistically significant responses to Stigma: cultural stereotypes

When looking for relationships between the same five demographic variables used above (age, gender, status, sexual orientation, and ethnic group) and the individual knowledge and perception statements in the stigma group (*See Section 7.4.4 for a discussion of this grouping*), status was once again the most frequently significant variable for three of the statements and showed a tendency toward significance in two others as shown in Table 7.8. Only statement 15: *HIV/AIDS infections are often a result of immoral behaviour*, did not show a significant association with status.

Stigma statements—Strongly Disagree	HIV-Negative	HIV-Positive
1. Poor people are more likely to get AIDS.	31.4%	68.6%
3. HIV/AIDS is primarily a gay disease.**	38.4%	61.6%
4. Getting HIV/AIDS is usually a death sentence.	27.9%	72.1%
10. HIV/AIDS is God's way of punishing the wicked.**	39.4%	60.6%
13. People with HIV/AIDS (do not) deserve the same rights in the workplace as other workers.*	32.8%	67.2%

**reverse phrasing was re-coded for analysis*

***shows a tendency toward significance*

Table 7.8—Relationships between stigma statements and HIV status:
HIV-positive respondents were more likely than HIV-negative people to strongly disagree with each statement.

Statements 1, 4, and 13 each showed a strong association with status ($\chi^2 = 9.85$; $df = 4$; $p < 0.044$, ($\chi^2 = 11.98$; $df = 4$; $p < 0.018$, $\chi^2 = 11.91$; $df = 4$; $p < 0.019$). Statement 3 ($\chi^2 = 8.58$; $df = 4$; $p < 0.074$) and statement 10 ($\chi^2 = 9.42$; $df = 4$; $p < 0.052$) displayed a tendency toward significance. In every instance, although both agreed with the statements, HIV-positive people were more likely to strongly agree than those who were HIV-negative. Statement 1 also showed a tendency toward significance with ethnic group; whites were much more likely to agree (43.6%) than blacks or Hispanics (both 23.6%). ($\chi^2 = 35.41$; $df = 24$; $p < 0.062$) In this case, as in most cross tabulations involving ethnic group, only blacks, Hispanics, and whites consistently had sufficient cell counts to be considered.

Statistically significant responses to Medical: prevention and treatment

When looking for relationships between demographic variables and the individual knowledge and perception statements in the medical group (*See Section 7.4.4 for a discussion of this grouping*), ethnic group was significant for three of the statements and showed a tendency toward significance in one other as shown in Table 7.9. Only statement 6: *Giving antiretroviral drugs to people not infected is a good way to prevent HIV/AIDS*, did not show any significant associations.

Medical statements—Disagree	Black	Hispanic	White
5. Antiretroviral drugs are a cure for HIV/AIDS.	33.6%	15.5%	41.4%
9. You cannot get HIV/AIDS during sex if condoms are always used.	29.2%	14.6%	46.7%
11. An effective HIV/AIDS vaccine is available.	22.2%	16.2%	47.5%
12. Alternative medical treatments for HIV/AIDS have (not)* shown promising results.**	26.7%	23.3%	43.3%

**reverse phrasing was re-coded for analysis*

***shows a tendency toward significance*

Table 7.9 —Relationships between medical statements and ethnic group:
Whites were more likely than blacks or Hispanics to disagree with each statement.

This group shows a significant pattern in which whites were much more likely to disagree with each medical statement than either blacks or Hispanics, and blacks were more likely to disagree than Hispanics. (Statement 5: $\chi^2 = 40.55$; $df = 24$; $p < 0.02$; Statement 9: $\chi^2 = 45.21$; $df = 24$; $p < 0.006$; Statement 11: $\chi^2 = 50.45$; $df = 24$; $p < 0.002$; Statement 12: $\chi^2 = 33.37$; $df = 24$; $p < 0.098$). As with previous group comparisons, other ethnic groups had numerous cell counts below 5, so were not considered.

Responses to statement 12 also indicated a significant relationship with age, showing that the 37-47 year-olds were much more likely to agree (38.6%) than 18-25 year-olds (12.5%) or 26-36 year-olds (21.6%) ($\chi^2 = 37.99$; $df = 4$; $p < 0.003$).

Sexual orientation was significant for Statement 8: *A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby*) Heterosexual people were more likely to disagree (50.9%) than homosexuals (33.3%) or bisexuals (15.7%). ($\chi^2 = 9.85$; $df = 4$; $p < 0.044$). Conversely, homosexuals were more likely to disagree (50%) than heterosexuals (35.9%) or bisexuals (14.1%) with Statement 16: *It is biologically easier for women to get HIV/AIDS than it is for men.* ($\chi^2 = 16.91$; $df = 8$; $p < 0.032$). No significant relationships were found for Statement 6: *Giving antiretroviral drugs to people not infected is a good way to prevent HIV/AIDS.*

Statistically significant responses to Global: socio-political issues

When looking for relationships between demographic variables and the individual knowledge and perception statements in the socio-political group (*See Section 7.4.4 for a discussion of this grouping*), results were mixed. Ethnic group was significant for three of the statements and showed a tendency toward significance in one other as

shown in Table 7.10. Additionally, status was significant for two statements in this group and sexual orientation was significant for one statement.

Socio-political statements--Disagree	Black	Hispanic	White
2. Globally, the number of people with HIV/AIDS is decreasing.**	34.3%	11.8%	47.1%
14. Treating HIV/AIDS is (not)*a lucrative business for pharmaceutical companies.	27.2%	17.4%	48.9%
20. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	28.2%	11.5%	50%

*reverse phrasing was re-coded for analysis
 **shows a tendency toward significance

Table 7.10 —Relationships between socio-political statements and ethnic group: Whites were more likely than blacks or Hispanics to disagree with each statement.

This group shows a significant pattern in which whites were much more likely to disagree with each socio-political statement than either blacks or Hispanics, and blacks were more likely to disagree than Hispanics. (Statement 2: $\chi^2 = 36.29$; $df = 24$; $p < 0.53$; Statement 14: $\chi^2 = 39.43$; $df = 24$; $p < 0.026$; Statement 20: $\chi^2 = 39.8$; $df = 24$; $p < 0.024$).

Status was significant for statement 14 above; HIV-positive people were much more likely than HIV-negative ones to strongly agree (77.3% vs. 22.7%: $\chi^2 = 11.66$; $df = 4$; $p < 0.021$). Likewise, status was significant for Statement 7: *People who knowingly expose others to HIV/AIDS should be prosecuted as criminals*, where HIV-positive people were much more likely to strongly disagree (81.5% vs. 18.5%) than HIV-negative individuals ($\chi^2 = 15.25$; $df = 4$; $p < 0.005$).

Statement 17: *HIV/AIDS prevention efforts often receive more funding than treatment efforts*, and 18: *Young people under 25 account for almost half of new HIV/AIDS infections globally*, had no significant relationships with any demographic variable.

Printouts of significant cross tabulation tables and Pearson's chi-square tests of association for stigma, medical, and socio-political statements discussed in this section are shown as Appendix F.1.c.

7.5.4 Section D: recognised HIV/AIDS treatments

When the relationship between status and treatments known was examined, five were found to have significant differences, which are shown in Table 7.11:

Treatment known	HIV-Negative	HIV-Positive
Vitamins-oral	22.6%	77.4%
Minerals-oral**	21.9%	78.1%
Peroxide-IV**	9.1%	90.9%
Peroxide-oral**	10%	90%
Nutritional supplements	23.7%	76.3%
AZT	24.8%	75.2%
HAART	25.8%	74.2%
Pharm. antibiotics	21.9%	78.1%

*** shows a tendency toward significance*

Table 7.11—Relationships between treatments known and HIV status:
HIV-positive respondents were much more likely than HIV-negative people to recognise each of these treatments.

Not surprisingly, in every case, HIV-positive respondents were much more likely to have heard of these treatments: Vitamins-oral ($\chi^2 = 5.47$; $df = 1$; $p < 0.020$); Nutritional supplements ($\chi^2 = 7.43$; $df = 1$; $p < 0.007$); AZT ($\chi^2 = 20.38$; $df = 1$; $p < 0.001$); HAART ($\chi^2 = 10.91$; $df = 1$; $p < 0.002$); and Pharmaceutical antibiotics ($\chi^2 = 17.44$; $df = 1$; $p < 0.001$). Additionally, three other treatments showed a tendency toward significance that reflects the pattern of HIV-positive respondents being more likely to have heard of treatments. Those modalities were: Minerals-oral ($\chi^2 = 3.38$; $df = 1$; $p < 0.067$); Peroxide-IV ($\chi^2 = 3.74$; $df = 1$; $p < 0.054$); and Peroxide-oral ($\chi^2 = 3.17$; $df = 1$; $p < 0.076$).

Examining the relationship between sexual orientation and treatments known resulted in three being found to have significant differences, which are shown in Table 7.12.

Treatment known	Heterosexual	Homosexual	Bisexual
Nutritional supplements	30.4%	58.2%	11.4%
AZT	38.4%	51.2%	10.4%
Pharm. antibiotics	35.6%	53.4%	11%

Table 7.12—Relationships between treatments known and sexual orientation:
Homosexuals were much more likely to recognise each of these treatments.

For each treatment, homosexual respondents were far more likely to know of the modality than were heterosexuals or bisexuals (Nutritional supplements: $\chi^2 = 12.79$; $df = 2$; $p < 0.003$); (AZT: $\chi^2 = 12.48$; $df = 2$; $p < 0.003$); (Pharmaceutical antibiotics: $\chi^2 = 11.04$; $df = 2$; $p < 0.005$).

There were only two significant associations between known treatments and ethnic background in which expected frequencies were above five. In both of those cases—Vitamins-oral and Nutritional supplements—whites were more likely to know of the treatments than blacks or Hispanics (Vitamins-oral: 57.7% white, 18.3% black, and 13.3% Hispanic: ($\chi^2 = 17.27$; $df = 6$; $p < 0.009$); Nutritional supplements: 49.4% white, 25.3% black, and 10.8% Hispanic ($\chi^2 = 17.14$; $df = 6$; $p < 0.010$).

Understandably, a significant association was found between age and AZT, with 34.9% of the 37-47 year-olds recognising the modality, compared with only 9.1% of 18-25 year-olds ($\chi^2 = 14.97$; $df = 4$; $p < 0.006$).

Printouts of significant cross tabulation tables and Pearson's chi-square tests of association for treatments discussed in this section are shown as Appendix F.1.d.

7.5.5 Section E: HIV/AIDS treatments considered effective: cross tabs with significance

Examining the relationship between status and treatments considered effective showed seven to have significant differences, which are shown in Table 7.13.

Effective treatment	HIV-Negative	HIV-Positive
Silver colloid-IV	75%	25%
Vitamins-oral	22.9%	77.1%
Minerals-oral	18.2%	81.8%
Nutritional supplements	22.4%	77.6%
AZT	27.5%	72.5%
HAART	23.9%	76.1%
Pharm. antibiotics	17.4%	82.6%

Table 7.13—Relationships between treatments considered effective and HIV status: HIV-positive respondents were much more likely than HIV-negative people to consider each of these treatments effective, except for silver colloid-IV.

With the exception of Silver Colloid-IV, which has much smaller counts than the other treatments shown in this table, HIV-positive people were far more likely than HIV-negative respondents to consider these treatments effective: Vitamins-oral ($\chi^2 = 5.21$; $df = 1$; $p < 0.023$); Minerals-oral ($\chi^2 = 5.46$; $df = 1$; $p < 0.020$); Nutritional supplements ($\chi^2 = 7.61$; $df = 1$; $p < 0.007$); AZT ($\chi^2 = 6.23$; $df = 1$; $p < 0.014$); HAART ($\chi^2 = 13.59$; $df = 1$; $p < 0.001$); and Pharmaceutical antibiotics ($\chi^2 = 21.45$; $df = 1$; $p < 0.001$). In the case of Silver Colloid-IV, 75% of HIV-negative people considered the treatment effective while only 25% of HIV-positive respondents agreed ($\chi^2 = 5.21$; $df = 1$; $p < 0.023$).

Nutritional supplements also showed significant relationships when cross-tabulated with age, ethnic group, and sexual orientation. Whites (37%) were somewhat more likely than blacks (31.5%) and far more likely than Hispanics (12.3%) to consider nutritional supplements effective ($\chi^2 = 21.35$; $df = 6$; $p < 0.003$). Additionally, homosexuals (59.2%) were much more likely than heterosexuals (29.6%) or bisexuals (11.3%) to view this treatment favourably ($\chi^2 = 12.31$; $df = 2$; $p < 0.003$). And finally, those aged 37-47 were most likely (36.0%) to consider nutritional supplements effective, followed by 48-58 year-olds (33.3%), and 26-36 year-olds (18.7%); 18-25 year-olds were the lowest with 7% ($\chi^2 = 12.87$; $df = 4$; $p < 0.013$).

Significant associations also surfaced for ethnic groups in relation to UVBI, selenium liver support, peroxide-oral, and porcine liver extracts, but the cell counts were under five in each. Lastly, a significant relationship was found between sexual orientation and pharmaceutical antibiotics, with homosexuals being more favourable (56.1%) than heterosexuals (32.7%) and bisexuals (11.2%) ($\chi^2 = 12.97$; $df = 2$; $p < 0.003$).

Printouts of significant cross tabulation tables and Pearson's chi-square tests of association for treatments discussed in this section are shown as Appendix F.1.e.

A list of cross tabulation tables that showed NO significance is shown as Appendix F.2.

7.6 SECTION C: FURTHER ANALYSIS OF GROUPINGS

Principal component analysis was used to look for patterns in the 20 statements in Section C. This initial analysis showed some correlations, especially in the stigma grouping discussed earlier (*See Section 7.4.4.*) However, since the 20 statements were extremely diverse and many were subjective in nature, statistical associations were

somewhat tenuous, but did point toward groupings along the lines developed previously (Stigma, Medical, and Socio-political). To ascertain reliability, statements with reverse phrasing were 'turned around' prior to running a Cronbach's alpha analysis on each group to measure the consistency of the questions. According to Field, Cronbach's alpha is the most common measure of scale reliability, and a value of 0.7 or 0.8 is often quoted as acceptable for cognitive tests such as intelligence assessments (2009:674). However, when *'dealing with psychological constructs, values below 0.7 can realistically be expected because of the diversity of constructs being measured'* (Kline, 1999, cited by Field, 2009, p. 675). Wincent and Westerberg also cite research where alpha values were *'rather modest'* (α :0.58 and 0.50), but point out they are within the minimum level for exploratory studies, which can consider values down to 0.50 as acceptable (2005, p. 279). Field cautions that Cronbach's results can show higher values when there are a lot of items on the scale and not because the scale is necessarily reliable (2009, p. 675). Wincent and Westerberg also note the Cronbach's alpha coefficient depends on the number of items in the construct (2005, p. 279).

With these guidelines and cautions in mind, Cronbach's alpha analyses were used to test whether the three subjective groups' items were homogenous. The stigma group (re-named the Hedonist/Moralist) was analysed and showed a strong reliability (Cronbach's α :0.685). Analysis indicated, however, that re-grouping and re-coding some of the remaining statements would provide higher reliability, so the Cautious Optimist/Raving Pessimist group (Cronbach's α :0.619) and the Global Activist/Political Ostrich group (Cronbach's α :0.514) were created.

Printouts of reliability statistical tables using Cronbach's alpha analysis are shown as Appendix F.3.

7.6.1 Group 1: The **hedonist** or the **moralist** is aware of stigma and stereotypes toward those affected by HIV/AIDS and has strong opinions about how people living with AIDS are treated in society. He or she probably knows people who are affected by the disease and may be personally HIV-positive. The statements included in this group analysis are shown as Table 7.14.

Poor people are more likely to get HIV/AIDS.**
HIV/AIDS is primarily a gay disease. ^
Getting HIV/AIDS is usually a death sentence. **
HIV/AIDS is God's way of punishing the wicked. ^
HIV/AIDS infections are often a result of immoral behaviour.
People with HIV/AIDS (do not) deserve the same rights in the workplace as other workers. **

**With statistical sig. relating to status

^With a tendency toward sig. relating to status

Table 7.14—Defining statements for the moralist or hedonist: *The moralist would be likely to agree with these statements; the hedonist would probably disagree.*

7.6.2 Group 2: The **cautious optimist** or the **raving pessimist** may not have the most current facts, but likes to believe the future looks somewhat promising regarding reducing the rate of HIV infections. He/she harbours hope that people with AIDS can look forward to increasingly effective treatments. The statements included in this group analysis are shown as Table 7.15.

Globally, the number of people with HIV/AIDS is decreasing. **
Antiretroviral drugs are a cure for HIV/AIDS. (ethnic/status) **
Giving antiretroviral drugs to people not infected prevents HIV/AIDS.
You cannot get HIV/AIDS during sex if condoms are always used. **
An effective HIV/AIDS vaccine is available.**
Alternative medical treatments for HIV/AIDS have shown promising results. ^

** With statistical sig. relating to ethnic group

^ With sig. relating to age and a tendency to sig. with ethnic group

Table 7.15—Defining statements for the cautious optimist or the raving pessimist: *The cautious optimist would be likely to agree with these statements, while the raving pessimist would probably disagree.*

7.6.3 Group 3: The **global activist** or the **political ostrich** is aware of some of the global issues surrounding HIV/AIDS and is not sure policy makers and leaders are making the right choices regarding the disease. He/she has some strong opinions about prevention and treatment policies but may not fully understand complicated medical issues. The statements included in this group analysis are shown as Table 7.16.

A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.*
Treating HIV/AIDS is a lucrative business for pharmaceutical companies.^\$
It is biologically easier for woman to get HIV/AIDS than it is for men. *
HIV/AIDS prevention efforts often receive more funding than treatment efforts.
Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact. \$
Getting HIV/AIDS is usually a death sentence. ^
People who knowingly expose others to HIV/AIDS should be prosecuted as criminals. ^

* With statistical sig. relating to sexual orientation

^ With sig. relating to status

\$ With sig. relating to ethnic group

Table 7.16—Defining statements for the global activist or the political ostrich:
The global activist would be more likely to agree with these statements, although he/she would not always be correct regarding statements of fact.

These three groupings help to build profiles of the target audience that could be useful in better understanding the customer, thereby contributing to a more focused strategic marketing approach.

7.7 CONCLUSIONS

Pre-survey interviews helped form a picture of the local situation regarding HIV/AIDS in the Houston, Texas, area. Increasing HIV/AIDS prevalence rates indicate a need for information, and more importantly, as key informants indicated, for education about treatment and prevention of the disease. It was apparent during pre-survey interviews that although plenty of HIV/AIDS information is now available from a variety of sources, it is fragmented, confusing, and incomplete, particularly regarding treatment options. After interviewing key informants from medical, advocacy, and marketing disciplines, it appeared that people either are not accessing important information or, even if they have information, they do not understand the complexity of the disease and its treatments. Funding at the local level for educational campaigns is sparse, and national funds, when they can be obtained, often come with stipulations regarding message content. Gaps in knowledge are a recognised problem, especially for HIV-positive MSM in Houston, according to statistical research compiled by a coalition of agencies in the city. The AIDS epidemic has changed the nature of public discourse, making once taboo topics open for conversation and debate.

These observations and background statistics helped shape a knowledge and perceptions survey directed to visitors of an HIV/AIDS clinic in Houston. The demographic highlights of the 342 valid responses included: 66% male; 42% heterosexual, 38% homosexual, and 10% bisexual; 37% white, 36% black, and 16% Hispanic; 48% high school graduates and 33% college graduates. Regarding HIV status, 31% were negative and 54% were positive.

Responses from each of the four sections of the survey were illuminating and individual comments were informative and poignant.

Information sources and credibility

'We need more education in schools. Many people believe the numbers are going down drastically and there is a readily available cure.'

'Knowledge is power!'

'Censorship of information based on religious beliefs is unethical...some religious organisations try to enforce their beliefs on those in need.'

'It's sad we have gotten comfortable with these diseases. To really educate yourself, you have to make an effort.'

—Legacy Clinic survey respondents

In summary, as shown in Table 7.17, based on data supplied by the 342 respondents, without separation by any demographic classification, the top six sources (by percentage) of ALL information sources MOST likely to be the basis for information about HIV/AIDS were in descending order: 1) television, 2) magazines, 3) family/friends or 4) newspapers (both 48.2%), 5) radio, and 6) books. However, when asked to rate the credibility of those sources, the top six rated as *Credible* or *Extremely Credible* were: 1) medical websites or 2) conventional medical doctors (both 57%), 3) television, 4) books, 5) HIV/AIDS websites, and 6) magazines. Significantly, three traditional media sources appear in both 'top six' lists: television, magazines, and books.

Most popular sources	Most credible sources
1. Television	1. Medical websites
2. Magazines	OR Conventional MDs (both 57%)
3. Family/friends	2. Television
OR Newspapers (both 48%)	3. Books
4. Radio	4. HIV/AIDS websites
5. Books	5. Magazines

Table 7.17—Summary of the MOST popular and the MOST credible sources of HIV/AIDS information.

At the other end of the spectrum, as shown in Table 7.18, the six sources LEAST likely to be the basis of information about the disease were, beginning with the smallest percentage: 1) alternative medical doctors, 2) social media, 3) emails, 4) blogs/online bulletin boards, 5) religious organisations, and 6) e-newsletters. However, the six sources with the lowest credibility rating—the six with the highest percentage of *Not at all Credible* responses—were, beginning with the highest percentage: 1) social media, 2) fellow workers, 3) religious organisations, 4) emails, 5) family/friends, and 6) blogs/online bulletin boards. No traditional media sources fell into this least credible group.

Least popular sources	Least credible sources
1. Alternative MDs	1. Social media
2. Social media	2. Fellow workers
3. Emails	3. Religious organisations
4. Blogs/online bulletin boards	4. Emails
5. Religious organisations	5. Family/friends
6. E-newsletters	6. Blogs/online bulletin boards

Table 7.18—Summary of the LEAST popular and the LEAST credible sources of HIV/AIDS information.

Treatments and effectiveness

'I am not very familiar with HIV/AIDS and its treatments or lack thereof. It's okay to say I am not very educated in this matter.'

'Lots of treatments....I didn't know any of them.'

'I have been positive for 30 years and have never taken any drugs ever for the illness.'

'I didn't check any treatments because I have never heard of any of them.'

—Legacy Clinic survey respondents

As indicated by survey data and by comments such as the ones above, respondents were woefully uninformed about both conventional and alternative treatments for HIV/AIDS. These survey results confirm previous studies (*See Section 7.2.3.*) showing a knowledge gap about treatment options, especially among HIV-positive people. Given this audience's relatively high level of education, the obvious conclusion is that this high-risk, high-interest group is not well educated about HIV treatment facts. This is a cause for concern and a justification for action.

Knowledge and perceptions

'Taking this survey made me realise how much I don't know about HIV/AIDS.'

'Having four friends with HIV, I still don't know what they go through to stay well every day. I feel it's not an open subject to talk about.'

'I have had a family member living with AIDS for 10 years. I have seen her almost die five times. I believe given funding a cure could be found. I have to hope.'

—Legacy Clinic survey respondents

Responses to the knowledge and perceptions statements also indicate a lack of knowledge about established medical facts, such as how HIV infection can be prevented (For example, 32% agree or don't know if condoms are 100% effective against infection.), the status of an HIV/AIDS vaccine (Over 46% either think there is an effective vaccine or don't know if one exists). Additionally, although the majority of responses repudiated discriminatory and stigmatising statements such as *HIV/AIDS is God's way of punishing the wicked*, almost 16% either agreed with that or were not sure.

Responses to socio-political questions were more uniform, with more than half agreeing that treating HIV/AIDS is a lucrative business for pharmaceutical companies and that people who knowingly expose others to the disease should be treated as criminals. Once again, a lack of knowledge about global disease trends was apparent when more than half (57.6%) disagreed with the established statistic that more people worldwide get HIV/AIDS by heterosexual than homosexual contact.

Cross tabulation analysis for statistical associations between responses to the four sections of the survey against demographic variables (age, gender, sexual orientation, ethnic group, and HIV status) showed the most frequent relationships to involve HIV status. Of a total of 81 significant (or with a tendency toward significance) relationships, 36 (44%) related to status, followed by 21 (26%) relating to ethnic group. Surprisingly, gender was only a significant factor in four cases, which all related to media sources. These findings further support the conclusion that an educational campaign regarding HIV treatment options should target HIV-positive individuals. The three profile groups that emerged during reliability analyses can provide useful background in developing such a campaign.

In the following chapter, key informants discuss their reactions to the survey results and provide updates on the changing AIDS landscape from medical and advocacy perspectives. Their comments, in combination with information amassed during this research project, will assist in crafting a communication model for HIV/AIDS social marketing directed to an audience similar to the surveyed group.

CHAPTER 8
AN HIV/AIDS COMMUNICATION MODEL
PUTTING KNOWLEDGE TO WORK

8.1 INTRODUCTION

To address the gaps in knowledge identified during this research in a practical way, the final phase of the project was to create a communication model for a social marketing campaign. This model drew on the most effective techniques identified by secondary and primary campaign analysis, was informed by insights from opinion leaders associated with different aspects of HIV/AIDS, and utilised information gleaned from survey responses. As discussed in Chapter 7, these responses provided useful insights regarding popular sources of HIV information and their perceived credibility, as well as feedback about treatment options, and opinions on cultural, medical, and socio-political issues.

At this final stage of the project, the researcher had accumulated a rich resource of quantitative and qualitative material, that when examined in a holistic, transdisciplinary manner, had meaningful theoretical and practical implications. Building an effective communication model for an HIV/AIDS campaign directed to a targeted audience involved numerous choices that integrated theory and practice from academic sources and from professionals. Incorporating successful ideas gleaned from researchers and stakeholders meant bridging the boundaries of several disciplines and reconciling the many paradoxes inherent in a multi-dimensional, complex global problem. The challenge was to see the HIV/AIDS conundrum from a holistic ‘big picture’ view, and then to craft a customised approach for a targeted audience with a specific communication goal. Using this kind of transdisciplinary approach was an ideal way to draw together a large body of disparate data and transform it into a plan for practical implementation. This integration of disciplinary knowledge cultures led to the development of new common methods and, through reflection, to a choice-based communication process that addressed knowledge gaps identified during previous research stages.

The information available for this transdisciplinary fusion was extensive and diverse, encompassing theory and processes for social marketing in general and the lessons learned from previous HIV/AIDS social marcoms. Those lessons were often

ambiguous and contradictory, especially regarding use of fear, cross-cultural approaches, and reality-based social marketing. The relatively brief history of HIV/AIDS social marketing and a lack of scientific campaign evaluation added to an uncertain overall picture. A diverse group of key informants from multiple disciplines offered both collaborating and wildly divergent viewpoints. Survey data from more than 340 respondents at an AIDS clinic in Houston yielded intriguing glimpses into knowledge gaps and misperceptions about the disease from an audience the researcher—and the Legacy Clinic administrators—had expected to be much better informed about the disease. In addition, those respondents' media use patterns provided useful direction for future message dissemination, and their comments offered valuable anecdotal information. Up-to-date medical information made the message content for the model current and in line with recommended modalities.

Before beginning the integration process for this wealth of material, reaction interviews to the initial survey results were conducted with two respected HIV/AIDS doctors (one alternative and one conventional), administrators at the clinic where the survey was conducted, and a long-time HIV/AIDS nurse/activist who was the director of a major AIDS research consortium in Houston. *The question bank for the reaction interviews is shown as Appendix B.6.*

From this amassed quantitative and qualitative material, a four-stage process was developed to demonstrate how to understand the target audience, create a plan to motivate behaviour change, take action to promote that change, and evaluate short- and long-term results. This customised campaign process used choices and inputs tailored to an HIV/AIDS social marcon specifically for HIV-positive individuals. Based on this process, an audience-centred, participatory 'marketing conversation' model was created. In keeping with the participatory style of social marketing, which always involves interpersonal conversations and interventions, this model was called a social marcon, or social marketing conversation (Moran, 2007), to indicate the importance of transdisciplinary participation and social interaction. As explained in Chapter 7, analysis of survey research, buttressed by secondary and primary qualitative information, revealed a need for a prevention and treatment campaign directed specifically to HIV-positive people, so the application of the model was based on unique inputs from this research project. However, the communication model and its practical application, as presented in this chapter, are adaptable for other HIV/AIDS audiences.

This chapter first summarises key informants' reactions to the survey results, then discusses the elements and pitfalls of a communications model. The four-stage, choice-

based process for developing an HIV/AIDS prevention and treatment social marcon is presented next. These four stages form the basis for the researcher's own integrated social marcon model.

8.2 AIMS AND OBJECTIVES

- Develop a communication model, informed by research Phases 1-3, incorporating CAM information about HIV/AIDS.

8.3 QUESTIONS ADDRESSED

- *Could social marketing bridge the knowledge gap between conventional and CAM choices for HIV/AIDS treatment and prevention?*
- *What elements should be incorporated into a campaign that would effectively communicate about HIV/AIDS prevention and treatment options?*

8.4 REACTION INTERVIEWS

At the end of research Phase 3, in-depth interviews were conducted to follow up on some of the issues that had surfaced, to seek updates in the ever-changing world of the HIV/AIDS epidemic, and to solicit feedback to the survey responses. Key informants included Dr. Mark Nichols, vice president of clinical affairs for the Bering Dental Clinic in Houston, Paul Simmons, executive director of the Center for AIDS in Houston, and Dr. Jacques Clermont, collaborator for INSERM, France's National Institute of Health and Medical Research. Also, Tina Megdal, senior director of client services, and Amy Leonard, health educator, both with Legacy Clinic, provided observations on the survey results. *A list of key informants interviewed post-survey with brief biographical information for each, is shown as Appendix B.9.*

8.4.1 The conventional medical doctor's perspective

Given that Houston has the fourth largest population of people with full-blown AIDS in the United States (behind New York City, Philadelphia and Chicago), the city's AIDS facilities often serve as national and international models. Houston's infection rate is nearly twice the national average, with African Americans accounting for more than half of the new infections each year (Bering Omega website, 2010). Bering Omega Community Services provides healthcare and social services to one in three people with HIV or AIDS in the Houston area, targeting the 50% of those living with HIV/AIDS who are *'indigent, uninsured, and under-served HIV-positive individuals and their*

caregivers who have no other healthcare alternatives' (Bering Omega website, 2010). Dr. Mark Nichols is one of the world's foremost authorities on HIV oral pathology for immune-deficient individuals. Under his direction, the Bering Omega Dental Clinic has become a United Nations model agency.

Nichols commented that Houston's high HIV/AIDS prevalence rate can be attributed, at least in part, to the city being a *'gay mecca'* in the southern United States and that a high concentration of minorities have returned to the city because they feel comfortable in its gay community. To reduce future infections, Nichols supports informational campaigns directed to youths beginning as young as age 10. He doesn't think abstinence programmes are working and advocates supplying teens with condoms to reduce the risk of infection. He realises that is not a popular idea because many Americans have problems dealing with the concept of a sexually transmitted disease.

He was not surprised by the survey responses indicating lack of confidence in conventional HIV/AIDS treatments (35% thought AZT was effective and 40% thought HAART was effective) *'Drug cocktails don't work for everyone,'* Nichols said. About one-third of survey participants were unsure if an HIV/AIDS vaccine was available and, although Nichols knows there is no vaccine for the disease, he shares their ambivalence; *'I am pessimistic about a vaccine,'* he said. For those who do take drug cocktails, the financial cost is high; as much as \$20,000 a year for medical care, drugs, and treatment for HIV-related illnesses. Nichols pointed out more than 50% of Bering Omega's clients earn less than \$6,000/year, so without subsidised funding at clinics such as Omega, HAART treatment would be impossible (The 2009 poverty level guideline in the U.S. was \$10,830/year.) (U.S. Department of Health, 2009). Beyond those immediate problems, Nichols agreed with the survey responses that the larger challenge is to remove the stigma associated with HIV/AIDS.

8.4.2 The HIV/AIDS advocate's perspective

Unfortunately, as is the case worldwide, prevention efforts are not curbing the spread of HIV in the Houston area (Bering Omega website, 2010). The Center for AIDS Information and Advocacy (CFA) *bridges 'the gap between the science of HIV/AIDS and the community'*...advocating locally and nationally for better treatments and better access to care for people living with HIV/AIDS while keeping the community *'informed, updated, and involved in the search for a cure'* (Center for AIDS website, 2010). Paul Simmons is a board-certified nurse for HIV care, but has spent the last five years in advocacy positions. As director of CFA, Simmons commented that he

remembers when hospitals had special units for HIV/AIDS patients to separate them from the general population. This served to further accentuate the stigma and misperceptions associated with the disease. Although the medical hysteria is gone now that HIV/AIDS has shifted from an acute to a chronic disease, Simmons agreed with Nichols that Americans are conflicted about sexuality and PLWHA are still highly stigmatised. He believes in involving HIV/AIDS patients in every facet of communication programmes: *'When patients are informed and involved, they can have a profound influence'* on curbing infection rates, Simmons said.

But lack of information is not the problem. *'The 50,000 HIV/AIDS cases in Houston are not the result of cognitive information deficits; the problem is high-risk behaviour.'* He thinks an answer might lie with a new treatment programme the CFA is launching in Houston. The HIV/AIDS equivalent of the 'morning after' birth control pill, Post Exposure Prophylaxis (PEP) starts HIV drugs within 72 hours of a suspected exposure to HIV. Houston is the second city in the U.S. to offer a PEP programme, and Simmons has high hopes it will help reverse the increasing rate of infection. He said the upsurge in risky behaviour and the ensuing rise in infections are occurring because *'HIV-positive people are fatigued; they have technology-mediated sex lives and they are tired of that. People with HIV are the medical equivalent of skydivers; they are risk-takers and thrill seekers.'*

8.4.3. The alternative doctor's perspective

Dr. Jacques Clermont has been involved in cutting-edge nanotechnology research for alternative HIV/AIDS treatments for more than a decade. He directed a clinic in Mexico that treated AIDS patients using those modalities. He was surprised that survey participants were *'incredibly ignorant about the number of treatments available for HIV/AIDS as well as their effectiveness'* and that so many respondents *'didn't know what HAART was even though they were probably receiving it.'* Clermont said the attitude toward alternative treatments in Mexico is much more positive than in the U.S. *'In general, people are more inclined to use indigenous/traditional medicine. They are acclimated to it and it is cheaper.'* But, as shown by survey respondents' positive or neutral view of alternative treatments for HIV/AIDS (44% agreed that alternative treatments have shown promising results and 42% were not sure), CAM is finding increasing favour in the U.S. According to Clermont, this is due in part to the public's lack of trust in pharmaceutical companies and concerns about side effects of synthetic medicines. *'Ninety-two to 96% of all Americans, led by women concerned about their*

children, are using alternative medicines.’ Clermont said this movement toward CAM would not be possible without medical websites, one of the survey respondents’ most credible sources for HIV/AIDS information.

Clermont also pointed out market forces influence information available through traditional mass media. *‘In the U.S., 26% to 45% of broadcast media advertising is paid for by mega-corporations. The synthetic conventional medical business wants everything to be a chronic disease [creating] lifetime drug treatments and therefore lifetime sales. AIDS has become a for-profit industry.’* Although almost 20% of the survey recipients agreed that condoms always ensured ‘safe sex,’ Clermont pointed out that 60 years of research has proven time and again that condoms have on average an 80% success rate. *‘A 20% failure rate may be acceptable if you’re trying to have two babies instead of four, but for controlling sexually transmitted diseases like HIV/AIDS, this is a devastating figure.’*

8.4.4. HIV/AIDS clinic administrators’ reactions

Like the key informants above, Legacy Clinic administrators Tina Megdal and Amy Leonard were ‘surprised and dismayed’ by the many prevention and treatment knowledge gaps revealed by the survey. (See Chapter 7.) They were also concerned that even small percentages of respondents would agree with stigmatising and discriminatory statements such as *HIV/AIDS is primarily a gay disease* (17.6% agreed or were not sure) and *HIV/AIDS is God’s way of punishing the wicked* (15.8% agreed or were not sure). Overall, Megdal and Leonard viewed the survey results as an indication that Legacy Clinic needed to initiate more conversations with clients about these issues, keeping in mind the information sources that were popular and credible.

8. 5 LESSONS LEARNED

As HIV/AIDS moved from being regarded as solely a health issue affecting specific groups to being perceived as a development issue with global ramifications, communication programmes, especially for prevention, have been given the task of solving a range of problems associated with the disease. When funds became available, social marcoms were hastily launched in great numbers. The content analysis in Chapter 5 revealed many of these campaigns used similar approaches, and that half of the initiatives analysed have been adapted for re-use. The importance of strong and diverse communication efforts was a given in every initiative, but cultural and moral controversies frequently arose in response to the campaigns.

After two decades of implementing HIV/AIDS social marcoms in countries all over the world, researchers and marketers began stepping back to take stock of lessons learned and approaches that seemed to be making a difference. In 2001, a comprehensive report by the Food and Agriculture Organisation of the United Nations published suggestions for a communication plan for HIV prevention and mitigation in Sub-Saharan Africa, where the epidemic had already killed more than 11 million and infected another 24.5 million (Michiels, 2001). The report asserted that the communications approach should be research-based, multi-sectoral (using multiple agencies and organisations), gender-sensitive, participatory, culturally and socially appropriate, and in full respect of human rights. Michiels suggested that whenever possible, it was important to '*empower, strengthen and support community-based initiatives rather than imposing externally planned programmes*' and that people living with HIV/AIDS should actively participate in problem-solving and implementing responses (Michiels, 2001, p.2).

Also, the report recommended breaking the '*conspiracy of silence*' surrounding the epidemic through information dissemination and using appropriate communication programmes to address stigma and discrimination (Michiels, 2001). Michiels made a distinction between the use of *institutional communication* (to strengthen multi-sectoral teamwork, build support of policy-makers, and keep a dialogue open among stakeholders), *educational communication* (to energise training, promote reflection at the community level, and increase effectiveness of front-line communicators), and *social communication* (to allow community mobilisation, create social dialogue on sensitive issues, and foster informed decision making and social change) (2001). Overall, the report concluded that the communication focus in the future should concentrate on encouraging safer sex practices and avoiding further infections by increasing the knowledge of at-risk groups. In addition, the report recommended communication programmes to inform PLWHA about diet, nutrition, and safer sex (Michaels, 2001).

As previously noted in Chapter 2, of the Sub-Saharan African nations, Uganda has often been seen as a model for decreasing HIV/AIDS prevalence. A 2002 USAID report summarised the factors that contributed to Uganda's relatively successful national response:

- President Museveni publicly acknowledged Uganda's AIDS problem and committed to mobilising efforts against it.

- A budget for a national AIDS programme was established early in the epidemic.
- Uganda adopted a multi-sectoral approach to HIV/AIDS prevention.
- The Uganda AIDS Commission was established.
- AIDS control programmes were established in several government ministries.
- Political, community, and religious leaders became involved in the response.
- Radio messages on HIV/AIDS were broadcast widely.
- Condom social marketing, backed by USAID, was implemented countrywide (Husain & Bery, 2002).

One of the most comprehensive evaluations of multiple AIDS campaigns in the United States was published in 1996, and assessed 37 AIDS prevention and service projects funded by the Robert Wood Johnson Foundation. The foundation also issued a grant to conduct a process evaluation of the initiatives with the purpose of identifying lessons learned, including promising strategies and obstacles to implementation (Janz, et al., 1996). Not surprisingly, all programmes took a multifaceted approach to AIDS prevention. Rated as the top four activities in effectiveness were small-group discussions (61%), outreach to high-risk populations (28%), train peers/volunteers (23%), and provide safer-sex kits (22%) (Janz, et al., 1996). Interestingly, intervention activities that were *never* rated among the most effective included counselling for the patient, family members or significant others, and educating policy makers. The researchers concluded recipients of HIV/AIDS information were more likely to learn when messages were presented in multiple formats using different communications strategies. The central lesson, they concluded, was that AIDS prevention activities should be *'flexible, tailored, repeated, credible, and involve members of the target population in the process'* (Janz, et al., 1996, p.95).

Evaluations of HIV/AIDS initiatives are ongoing, but many of the lessons learned are similar to the ones discussed above. In 2009, the National Social Marketing Centre in the UK assembled an Internet database, ShowCase, of *'fully researched social marketing campaign case studies to demonstrate that social marketing can achieve and sustain positive changes in people's behaviour to promote healthy lifestyles'* (National Social Marketing Centre, 2010). Like the campaign evaluations already mentioned, the ShowCase campaigns used a strong mix of intervention techniques. Also, the health campaigns all incorporated national social marketing benchmark criteria, including understanding and segmenting the audience, focusing on behavioural theory, and

utilising the classic marketing exchange concept (National Social Marketing Centre, 2010).

8.6 CROSS-CULTURAL MARKETING IN A GLOBAL ECONOMY

If HIV/AIDS social marketing campaigns are being designed and implemented according to ‘the rules’ of the discipline, why is the pandemic continuing to spread and, according to some studies, worsen? As discussed in Chapter 2, one of the broad criticisms of HIV/AIDS initiatives has been lack of appropriate cultural roots and market segmentation. Both of these concepts are integral to the social marketing process, but incorporating them into campaign design is complex and difficult. Despite globalisation, cultural variations are infinite and target audiences are difficult to categorise in neatly defined groups. The ease and speed of global communication has allowed marketers to bridge national borders with ease; global brands like McDonalds and Coke are recognised all over the world, but behavioural change concepts are not readily communicated across cultures.

The history of international marketing is full of cultural and translation blunders that are amusing in retrospect but were embarrassing and costly for advertisers. Marketers have realised one size does not fit all; generic marketing messages are not effective across cultural divides (Mueller, 1996). Even in a world where globalisation and technology facilitate international conversations, cultural differences, combined with economic disparities, are deep and wide. Marketers know that messages must be tailored and appropriate. Cross-cultural marketing focuses on the differences between communication styles and needs among people of different cultures. The first step in cross-cultural marketing, according to Tian, is to recognise that no culture is superior to another: *‘There is no room for ethnocentrism in the 21st Century marketing practice’* (2009, p.2). The paradox of international marketing is that the world is becoming more homogeneous, with distinctions between national markets fading and disappearing for many products, but, on the other hand, the *‘differences among nations, regions, and ethnic groups in terms of cultural factors ...become more obvious’* (Tian, 2009, p.1).

Hermeking agreed in a discussion of his research into how culture affects media consumption and preferences. The prediction that culturally different markets would converge into a world culture that would facilitate standardised global marketing is now recognised as an illusion. Cultures are *not* converging; *‘too many non-cultural hard factors and cultural soft factors still exist or arise [requiring] strategies of adaptation or localisation,’* Hermeking said (2005, p.1). He also pointed out that people prefer local

brands, so smart marketers localise their products or services and advertise them as if they were from the home country rather than from a foreign country (Hermeking, 2005).

While cultures are often thought of as varying across countries, it is important for marketers to realise that variations within cultures may be even greater than variations between cultures. Mueller pointed out that each culture has numerous subcultures—*'groups of people with shared value systems based on common experiences'* (1996, p. 88-89). Subcultures can be based on categories such as nationality, racial or political groups, geography, age, or income. People can belong to several subcultures at the same time, further complicating the task of market segmentation.

Cross-cultural marketing, then, is international marketing on a personalised level. It requires finding a balance between localisation and globalisation, and, perhaps most importantly, it requires implementing strategies that respect differences while seeking to unify brand messages (Defining cross-cultural marketing, 2009). Without a doubt, communicating to people of diverse cultures is one of the greatest challenges in marketing communications (Mueller, 1996).

8.7 MODELS ARE STILL PICTURES OF A MOVING PROCESS

Communication models are a good example of this paradox of globalisation vs. localisation. They offer an organised process that can be used for tailoring communication messages to specific groups. In other words, models try to standardise global trends while providing a blueprint for customisation or localisation. The challenge is identifying the best model for the communication goal and tailoring it appropriately. In HIV/AIDS social marketing, this challenge is particularly complex—HIV/AIDS is a global health problem that affects thousands of subcultures. As discussed in the literature review (*See Chapters 2 and 3*), HIV/AIDS issues such as stigma, poverty, and medical questions cross all boundaries, but underlying causes, motivators, and implications vary widely. Perhaps because of the overwhelming complexity of the problem, social marketing campaigns for HIV/AIDS often repeat the same formulas and rely on the same models as used in previous campaigns (*See content analysis in Chapter 5*).

Volumes of literature discuss the nature of models, their strengths, and their shortcomings. In brief, a model is sometimes described as a metaphor that portrays an event in an abstract form, thereby bringing order and coherence to complexity (Mortensen, 1972). Most importantly, models should have heuristic value, offering new ways to conceive of hypothetical ideas and relationships (Mortensen, 1972). The

dangers inherent in using models include oversimplification; abstraction by nature is a simplifying process, so the resulting model cannot encompass the complexities of the subject matter under inquiry and may miss important points of comparison (Chapanis, 1961). Critics also warn that a model cannot consider all the possible variables and their relationships to the communication process, so models should not be confused with reality (Mortensen, 1972). Additionally, Kaplan said using a model limits awareness of unexplored possibilities of conceptualisation and may crystallise our thoughts at a stage when they would be better left in solution (1964).

8.7.1 Evolution of communication models

Nevertheless, communicators have been building models since Aristotle developed his Model of Communication, and centuries of model building since then have provided a staggering number of possibilities for social marketers to choose among. Aristotle's model was prescriptive, designed to instruct people to be effective persuasive speakers, but modern-day models are likely to be descriptive, with the goal of describing, predicting, or controlling communication (Littlejohn & Foss, 2009). Early models portrayed communication as a mechanistic process, showing messages travelling through channels in a linear fashion. Shannon's information theory model (1948), which broke the communication process down into eight components, beginning with the source and ending with the destination, is often seen as the beginning of the modern field. It offered a general model that provided common ground for diverse disciplines such as journalism, rhetoric, linguistics, and speech (Foulger, 2004). It is, therefore, the most influential linear model, and a version of it often appears in communication textbooks.

Linear communication models based on the Shannon model are message-centred, depicting communication as action in which a source transmits a message through a channel to a receiver. This kind of model is described by the acronym SMCR (source, message, channel, receiver). In the mid-1950s, Schramm created a circular model that showed communication as an interactive process in which messages were encoded and decoded by interpreters. This second-generation communication model, which relied on a transmissive view, was called communication as interaction. However, the focus soon shifted from the exchange of messages to creation of meaning, giving rise to the third generation of models. Barnlund's idea of communication as transaction used a complex graphic representation of spirals and arrows to show communication components as

interrelated and constantly evolving. This nonlinear modelling represented a shift from transmissive to a constitutive view of communication (Littlejohn & Foss, pp.175-177).

8.7.2 Dangers of over-abundant choice

Due to the cross-disciplinary nature of social marketing, in addition to communication models, the marketer also can select from numerous models of behaviour change, theories of social change, and social marketing models, just to name a few. With this embarrassment of model riches, marketers—like their customers—might succumb to the paralysis of having too many choices, as described by Schwartz in *Paradox of Choice*. Schwartz contended people want choices, but that ironically, consumers can have too many choices, which confuses and immobilises the decision-making process. For example, when given free samples of jams in a store, 30% of people exposed to six jams bought a jar, but only 3% of people exposed to 24 jams bought a jar (2009). Schwartz explained the phenomenon this way: *'A large array of options discourages customers because it forces an increase in the effort that goes into making a decision. So consumers decide not to decide'* (2004, p.20). Schwartz also gave this example concerning health care: *'Patients prefer to have others make their decisions for them; 65% surveyed said if they were to get cancer, they'd want to choose their own treatment, but only 12% of people with cancer wanted to do so. We always think we want choice, but when we actually get it, we may not like it'* (2004, p.32). These are important ideas to consider from both sides of the marketing exchange process when constructing a communication model for social marketing.

From a practical standpoint, a model—whether a hand-drawn series of connecting lines and circles or a sophisticated depiction worthy of a fine artist—must be understandable and functional. The illustrative example presented in this chapter incorporates the considerations discussed above while selecting from the most appropriate multi-disciplinary concepts to construct a model for an integrated social marketing conversation.

8.8 PUTTING THEORY INTO PRACTICE: A four-stage choice-based process for developing an HIV/AIDS prevention and treatment social marcon

This customer-centred approach demonstrates how to design a customised prevention and treatment campaign directed to HIV-positive people similar to those surveyed in Chapter 7, but the process could be adapted for a campaign using other motivational messages directed to different audiences. The choice-based process uses

background research to organise the most relevant options (*See Chapters 2, 3, 5, and 6*), then uses contextual factors from the secondary research and inputs from the primary research to create customised campaign components in each of four stages: 1) understanding the audience, 2) creating a plan to motivate change, 3) implementing the plan, and 4) evaluating and enhancing the campaign. Each of the four stages is linear, but the simplified model derived from the four stages is circular, with the customer at the centre so he/she can participate in every stage, as shown in Figure 8.5.

The four stages are based on established social marketing plans and processes, which use various linear progressive diagrams (Andreasen, 2006; National Social Marketing Centre, 2007; Corporate Culture, 2008), to demonstrate how the social marketer moves from initial situation and audience research to strategic planning and implementation, with testing and updating an integral part of the process. Although the social marketing process is usually depicted in a linear fashion, practitioners are encouraged to continuously research and pre-test to refine and enhance as appropriate. With HIV/AIDS campaigns, this ongoing assessment is particularly important because of the ever-changing political, cultural, and medical landscape. For the model presented in this chapter, the choices, the contextual factors, and the inputs at each stage are compiled from transdisciplinary secondary and primary information collected during Phases 1-3 of this project. Utilising the stages involves examining the choices (in this case the choices relate to an HIV-positive audience), then considering contextual factors such as those presented in Figures 1 through 4. Next, the marketer applies unique inputs collected during primary research to develop a customised campaign. Each of the four stages involves making a series of choices, then refining those choices with relevant knowledge. The overall movement is from general to specific and from global to personalised. The four stages combine theory and practice while melding HIV/AIDS, social marketing, and medical research.

8.8.1 Stage 1: Know the audience

The goal for the first stage was to create a customised profile of the ‘customer in the round,’ combining data from diverse sources through fusion and synthesis (National Social Marketing Centre, 2007). The resulting profile answers the question, *Who is expected to change?* The Stage 1 process is shown as Figure 8.1.

A CHOICE-BASED PROCESS FOR DEVELOPING A LOCALISED HIV/AIDS PREVENTION AND TREATMENT SOCIAL MARCON

1 Use **research** to understand the **customer** and to **segment** the audience into subgroups, using information from diverse sources to create a comprehensive profile.
Q: WHO is expected to change?
Key concept: RESEARCH

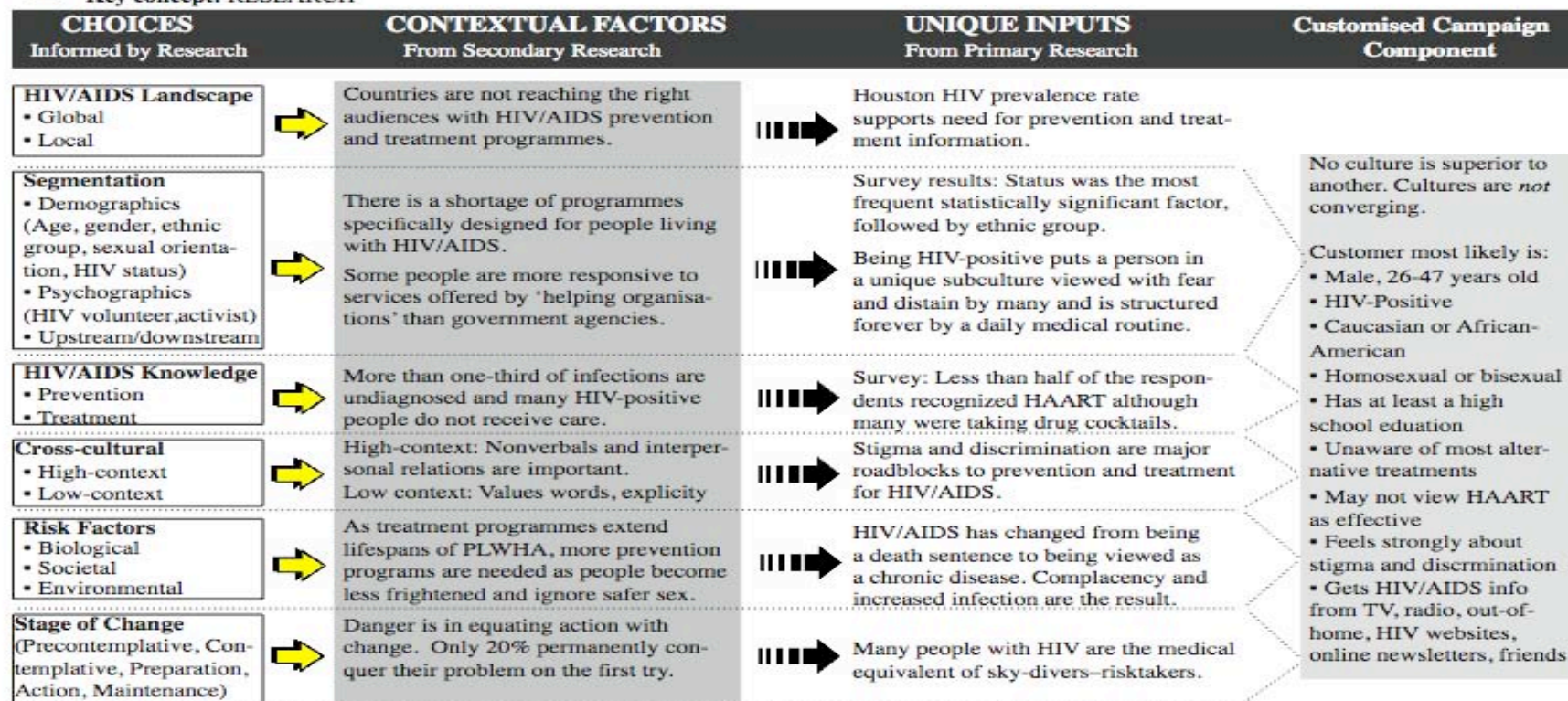


Figure 8. 1—Stage 1 of the HIV/AIDS Social Marcon Process
 This illustrated example yields a profile of the targeted HIV-positive subculture customer.

In addition to segmentation based on analysis of survey responses, Stage 1 considered the customer's level of knowledge about HIV/AIDS prevention and treatment options, cultural contexts, risk factors and the target audience's stage of change. The key concept for this stage was research, moving from global (general) to localised (specific). Involving the audience from the outset, beginning with planning and implementing and continuing through the evaluation/redesign stage, enhances credibility, makes the interventions more marketable, and enhances learning and behavioural change (Janz, 2001).

Risk factors were divided into three categories in the AIDSCAP handbook for behaviour change communication (BCC):

- Biological risk factors, which exist because of the biology of the human body, include high STD infection rates, being female (because women are more vulnerable to HIV infection from sex with an infected partner), age (especially girls under 18), lack of male circumcision, and female circumcision.
- Societal risk factors are social conditions that increase risk or HIV exposure and include migration, travelling or working away from home, sexual expectations, poverty, illiteracy, and gender discrimination.
- Environmental factors prevent people from accessing services and products that decrease HIV exposure. They include low availability of condoms, lack of STD services and drugs, laws discriminating against PLWHA, economic inequities, and sexual abuse (Mahler & Flanagan, 2009, p. 7-8).

Knowing where the customer is positioned in the change process is also important. As social marketers know, change is easy to talk about but harder to motivate and even more difficult to accomplish. Heath and Heath say change is hard because people are trying to alter behaviours that have become automatic and therefore need close supervision by the rational brain. *'The bigger the change, the more the effort will sap people's self-control. When people exhaust their self-control, they are exhausting the energy to think creatively, to focus to inhibit impulses, and to persist despite frustration or failure. Those are exactly the mental 'muscles' needed to make a change. Change is hard because people wear themselves out'* (2010, p. 6).

After moving through the Stage 1 process, the marketer would have assembled a highly personalised profile of the customer, informed by extensive research of the global 'landscape' as well as the unique aspects of the HIV-positive subculture.

8.8.2 Stage 2: Plan to motivate change

The goal for the second stage was to create a customised plan to motivate behavioural change in the target audience. The Stage 2 process, shown as Figure 8.2, answers the questions, *What is the change to be achieved?* and *When is the timeframe?* The key concept for this stage is inclusiveness: engaging customers and collaborators in the process.

A CHOICE-BASED PROCESS FOR DEVELOPING A LOCALISED HIV/AIDS PREVENTION AND TREATMENT SOCIAL MARCON

2 Develop a **theory-based** plan to motivate positive **behaviour change**. Consider **competition** and **collaborate** with other organisations. **Involve** customers and collaborators in designing and delivering the programme.

Q: WHAT is the change to be achieved? **WHEN** is the timeframe?

Key concept: INCLUSIVENESS

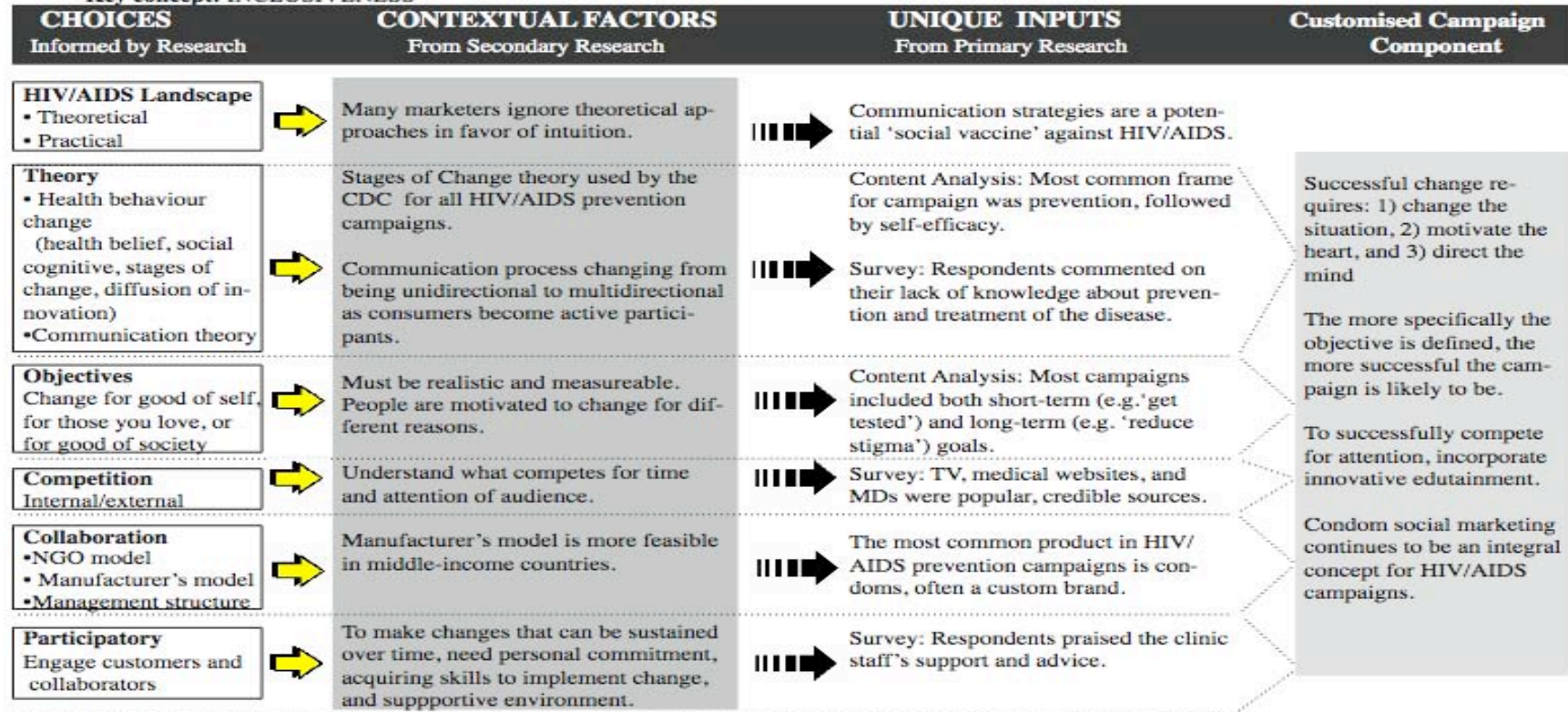


Figure 8. 2— Stage 2 of the HIV/AIDS Social Marcon Process

This illustrated example includes choices to construct a theory-based, participatory plan for behaviour change in the HIV-positive subculture.

When constructing a plan to motivate behaviour change, Michiels said the marketer should ask: *What causes the gap between existing and desired behaviours?* Is it that people do not know, do not care, or do not do? If they do not know, they need information; if they do not care, they must be made critically aware; if they do not do, the social marketer should set objectives for behaviour change (2001).

Since HIV-positive individuals can be considered a subculture, the social marketer should design culturally relevant and language-appropriate interventions. Janz and colleagues said, *'Cultural sensitivity is not just taking a book and putting in ethnic names and different hair; [it] needs to be built in and not tacked on'* (1996, p. 88). Common vernacular must be melded with formal terminology to ensure understanding of important terms and concepts. For example, many survey respondents did not know HAART is commonly called a drug cocktail.

Collaborating with community groups is essential for acceptance of the message, Janz said. *'The first lesson is work with the community, hire from the community, report back to the community. Programmes that have come down from on high, the university or the health department, have serious problems with recruitment'* (1996, p. 90).

It is also important to remember the power of anecdotal 'evidence.' Schwartz said consumers often give more weight to comments by friends and family members than to scientific evidence derived from dozens of sources. The word of mouth experience may be more believable because it is based on a personal, detailed account (2004).

After moving through Stage 2, the marketer would have chosen among diverse theoretical foundations for the campaign, created specific and measurable objectives, and developed innovative communication strategies appropriate for the target customer.

8.8.3 Stage 3—Act to promote change

The goal for the third stage was to create a customised implementation process based on one of several creative approaches. The marketer would consider such components as branding and types of messages to create a positive exchange, using an integrated methods mix. The Stage 3 process, shown as Figure 8.3, answers the questions, *Where?* and *How?* The key concept is creativity.

A CHOICE-BASED PROCESS FOR DEVELOPING A LOCALISED HIV/AIDS PREVENTION AND TREATMENT SOCIAL MARCON

3

Use **Interventions** to overcome **barriers** that prevent customers from adopting change. Create a positive **exchange** by tailoring incentives and disincentives, using appropriate products or services. A **methods mix** will yield maximum impact.

Q: WHERE? and HOW?
Key concept: CREATIVITY

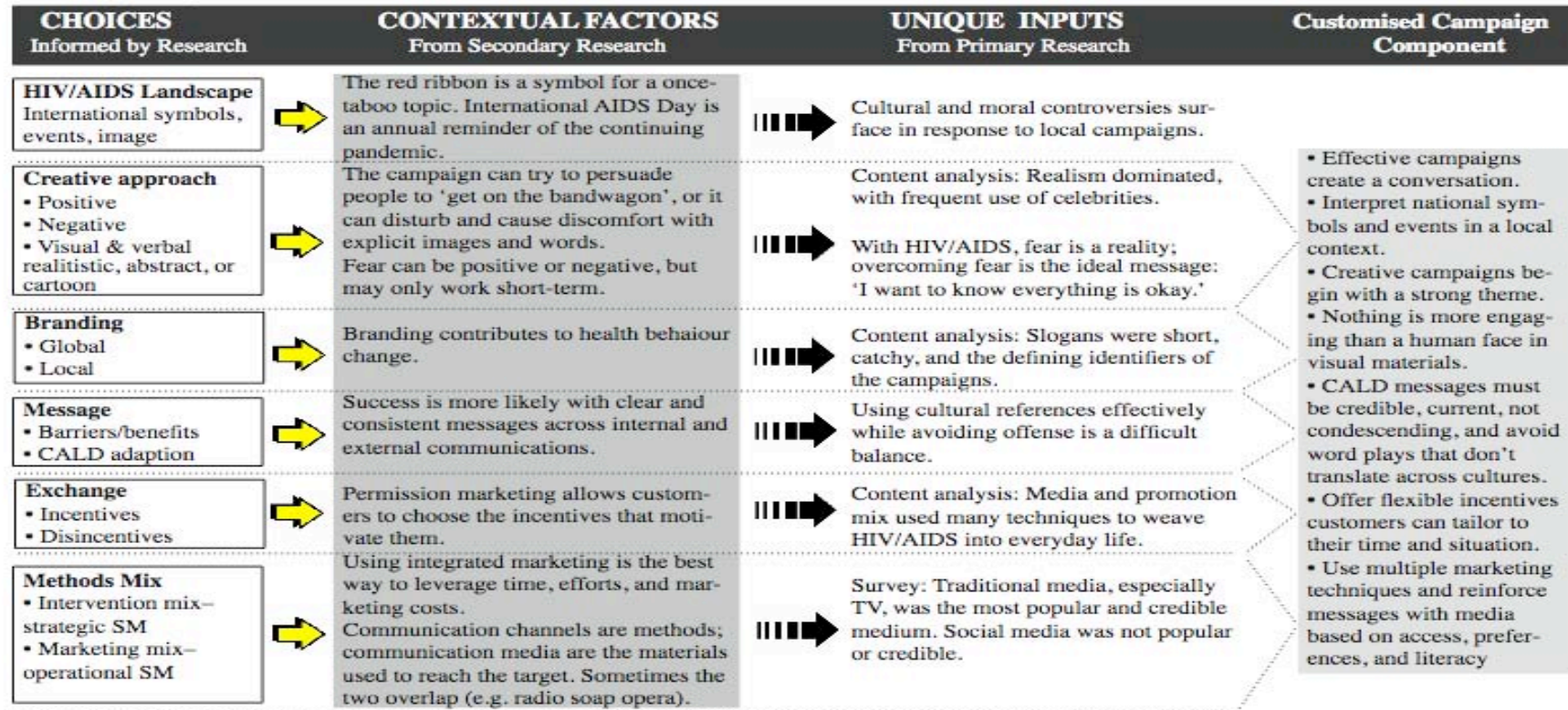


Figure 8. 3— Stage 3 of the HIV/AIDS Social Marcon Process

This illustrated example includes choices for implementing a customised campaign targeted to HIV-positive individuals.

Important creative choices must be made at this stage, based on knowledge of the customer and input from the target audience. The marketer builds creative messages and appeals that can be reinforced through multiple communication channels and a variety of conversations. Instead of lecturing about the facts, marketers can create forums for open discussion. These conversations give participants more control over the intervention and reduce pluralistic ignorance –the belief that one is alone in one’s beliefs or experiences (Janz, 1996).

Incentives are important to many customers. Janz suggested providing creative rewards and enticements such as contests, pay for getting tested, or academic credit for being peer educators. She also recommended a menu of choices: *‘Offering A might work for awhile, but when they come back, they want B’* (1996, p. 89). For example, some Legacy Clinic clients were motivated to complete the HIV/AIDS survey by the promise of an inexpensive ‘grab bag’ gift, while others were motivated solely by the opportunity to voice their opinions.

Reaching the target with a message once is not enough; frequency is also important. Essential HIV/AIDS messages should be repeated several times. Research shows *‘one-time only education efforts may increase participants’ knowledge of HIV transmission and prevention, but will have little impact on individuals’ attitudes, values, and risk behaviours’* (Janz, 1996, p. 90).

Marcons get customers talking about the message by utilising formal and informal channels. Michiels suggested using traditional and popular media in a local context as well as cultural expressions such as poems, dances, and drama (Michiels, 2001).

At the end of Stage 3, the marketer will have a blueprint for a creative campaign based on the marketing conversation concept. Also, this localised campaign will have been designed to make the most effective use of international branding and image recognition. The marketer will also select a diverse mix of techniques that fit the customer’s lifestyle.

8.8.4 Stage 4—Review, evaluate, and enhance

The goal for the fourth stage was to provide a process for reviewing, evaluating, and enhancing the social marcon. The Stage 4 process, shown as Figure 8.4, answers the questions, *Is the campaign accomplishing behaviour change goals?* and *How could it be enhanced/improved before re-use?* The key concept is test and evaluate.

A CHOICE-BASED PROCESS FOR DEVELOPING A LOCALISED HIV/AIDS PREVENTION AND TREATMENT SOCIAL MARCON

4

Review, evaluate and enhance: Solicit feedback using both qualitative and quantitative methods to determine **short-term** and **long-term** results.

Q: Is the campaign accomplishing change goals? HOW could it be improved before re-use?

Key concept: TEST and EVALUATE

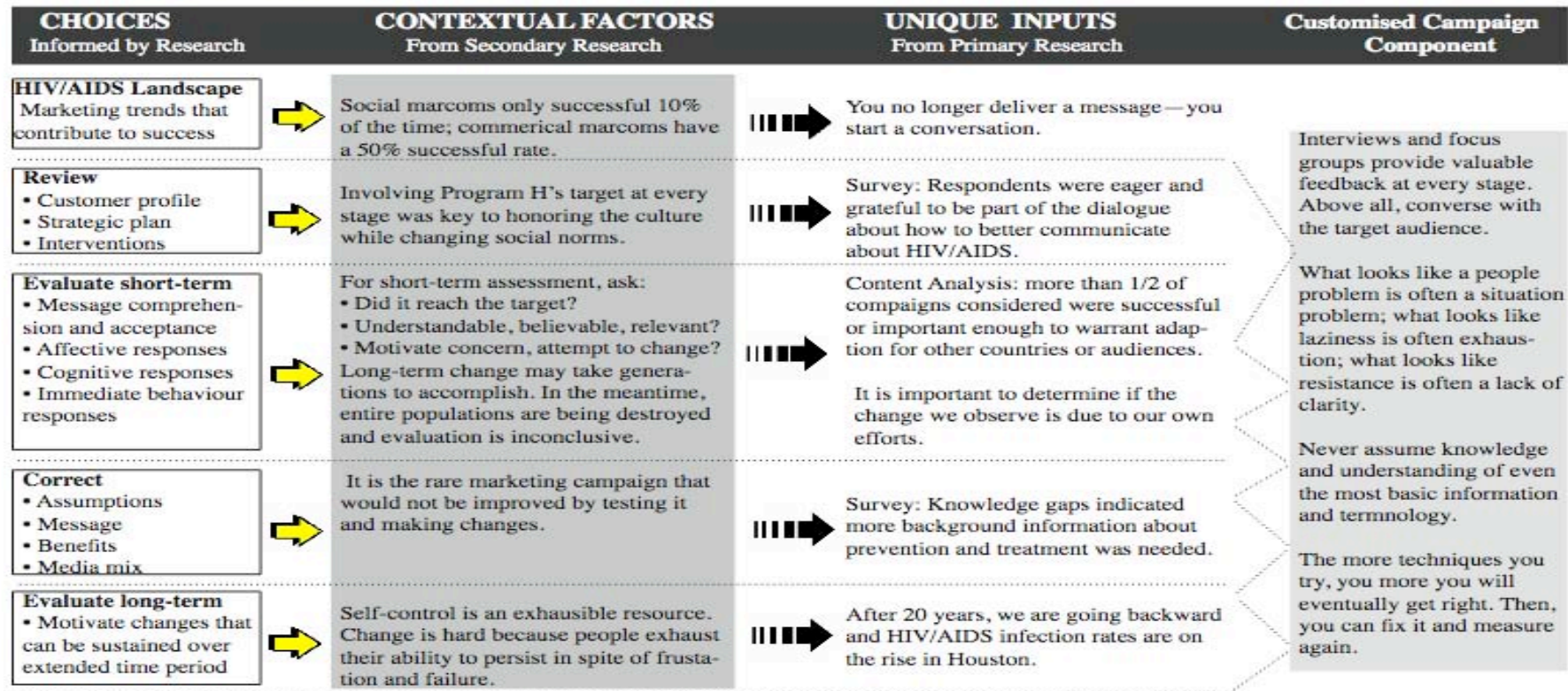


Figure 8.4—Stage 4 of the HIV/AIDS Social Marcon Process

This illustrated example gives participants a chance to review, evaluate, and enhance the campaign before the four-stage process begins again.

Ideally, the social marketer has collected knowledge and perception information from the target audience before constructing the plan and implementing the campaign. Message testing is also useful and efficient. Including funds in the initial plan for evaluating short-term results is crucial and is sometimes part of the funding agreement.

Moran pointed out testing and making changes would improve most campaigns. He noted that using Internet channels makes change quick and cheap. *'The Web is the biggest direct marketing opportunity to ever come along. You can try anything. You can measure its impact. You can fix it and measure it again. The more things you try, the more you will eventually get right. Don't try to get it perfect the first time. Do it wrong quickly'* (2007, p.xix).

At the end of Stage 4, the marketer has created a dialogue that involved the customer and other participants, such as sponsors, in each stage of the process, making modifications as warranted along the way. Short-term results can be tabulated, and the cycle begins again with the goal of sustaining positive change and motivating change among other members of the targeted subculture.

8.9. AN INTEGRATED SOCIAL MARCON MODEL

This four-stage process can be simplified into a model to better illustrate the central concepts. As shown in Figure 8.5, this circular model depicts the target audience at the centre and indicates customers participating during each of the four stages in the communication process. The model reflects the concept that marketing communication is shifting to marketing conversation; that marketers no longer merely deliver messages; they initiate conversations. Instead of *'old-style monologues delivered through media channels, marketers and customers share control of the conversation'* (Moran, 2007, p.7). While this participatory dialogue is occurring and the communication process is moving through the four stages, the global context is always in the background, but the focus is on localisation and personalisation.

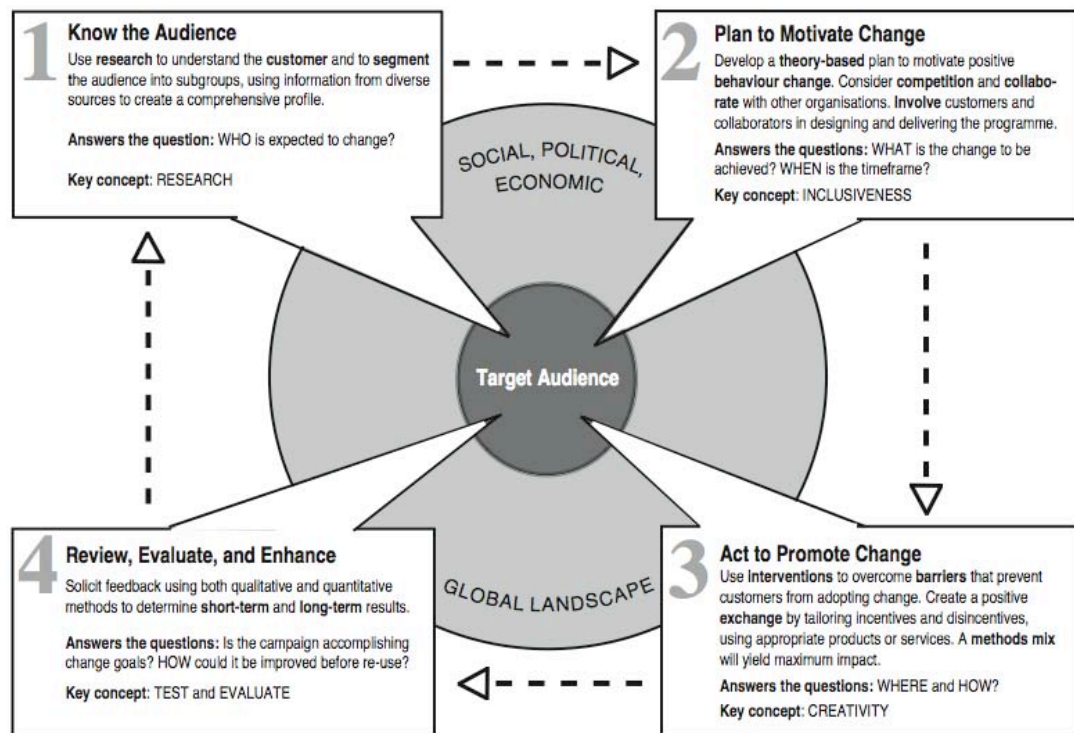


Figure 8.5—The Integrated Social Marcon Model

This model is audience-centred and is depicted as circular rather than linear, with continuous audience input. Social, political, and economic factors exert background influence at every stage.

8.10 CONCLUSIONS

This chapter represents the culmination of the four research phases that comprised this project. At this point, the researcher had the task of synthesising the transdisciplinary streams of information that were collected over a five-year period. Using the model approach allowed the voluminous data to be categorised and streamlined to create a communication model that incorporates CAM information about HIV/AIDS and addresses the research question, *What practical contribution could social marketing make to bridge the knowledge gap between conventional and alternative medical choices for HIV/AIDS prevention and treatment?*

Key informants were carefully selected to represent the perspectives of conventional and alternative medicine as well as advocacy and marketing topics. Their input helped consolidate and summarise the global and local issues that were of concern in this study. These reaction interviews confirmed that HIV/AIDS is a complex and devastating epidemic complicated by cultural, political, and economic issues. Even high-risk groups are ill-informed, both on the global level regarding trends, and on the local level regarding

treatments and practical prevention techniques. These gaps in knowledge are dangerous and likely are contributing to the increasing rates of HIV/AIDS infection. Although information is available from diverse sources, people are confused by the jargon, overwhelmed by the volume of material, and perhaps most of all, fatigued by decades of ‘being careful.’ Now that HIV/AIDS is classified as a chronic disease, it has fallen off the critical list on the world’s political agenda, and with the widespread use of HAART, alternative therapies are less visible. Although social marketing initiatives have been plentiful since HIV/AIDS was recognised as a global health issue, it now appears much of the behaviour change has not translated into long-term cultural transformation. Many social marcoms have had short-term timelines and were hastily launched without sufficient background knowledge or appropriate targeting of audiences that are culturally diverse. Also, some campaigns have not appropriately targeted the unique characteristics of high-risk HIV/AIDS groups in their distinctive cultural context.

A better approach, many marketers now agree, is creating strategic conversations with the target audience and getting the customer involved at every stage of the intervention. To address the sub-question—*What elements should be incorporated into a campaign that would effectively communicate about HIV/AIDS prevention and treatment options?*—this chapter presents a four-stage process based on proven social marketing approaches but tailored to an HIV-positive audience, the high-risk group identified in this study as having significant knowledge gaps.

The four stages: understanding the audience, creating a plan to motivate change, implementing the plan, and evaluating and enhancing the campaign, guide the communication process. Since marketing research shows customers can have too many choices, which discourage action, or too few choices, which may be viewed as coercive or monotonous, this social marketing process uses a series of choices at each stage that specifically apply to the target audience. Each category of choice is further informed by secondary and primary research relating to the situation. The result is a customised marcon, or marketing conversation, devised especially for—and by—the target audience.

In Stage 1, it was determined that the target audience for this marcon is likely to be male, HIV-positive, white or black, and homosexual or bisexual. The target customer is unaware of most alternative treatments for HIV/AIDS, feels strongly about stigma and discrimination associated with the disease, and gets information about HIV/AIDS primarily from traditional mass media, disease-specific online sources, and friends.

Stage 2 used the same choice-centred process to construct a theory-based, participatory plan for behaviour change. The resulting plan incorporates specific objectives, innovative ‘edutainment,’ and condom social marketing, keeping in mind how and why people change.

The implementation of the plan devised in Stage 2 was the next stage of the process and focused on localising national symbols and events while using engaging visual and verbal techniques, combined with appropriate cultural references. The customised component in Stage 3 recommends flexible incentives and multiple marketing techniques that take into consideration the target audience’s media access, preferences, and literacy.

Since social marcoms have been found to be unsuccessful 90% of the time (and there is insufficient data on the success rates for social marcoms), it is essential to include a process for reviewing, evaluating, and enhancing the campaign. In Stage 4, the conversation with the target audience would be especially valuable for uncovering underlying barriers to change, confusion about terminology, or additional knowledge gaps.

While investigating existing models for HIV/AIDS communication, it became evident that most research and communication models have focused on how HIV/AIDS prevention programmes are working and what is effective, but little has been done in regards to treatment options and information. For that reason, the integrated social marcom model presented in this chapter is an important addition to the body of practical literature on this topic. The circular, customer-centred model illustrates the changing approach to marketing, from passive marketing communication to active marketing conversations. The four-stage cycle revolves around the target audience and is constantly influenced by international social, political, and economic factors, but the model is highly customised and localised to achieve the maximum impact and results. Key informants consulted during this project expressed interest in the communication model and promised to provide opportunities to further extend this inquiry after this part of the research journey draws to a close.

The next chapter concludes this project by summarising trends and implications suggested by the research, discussing the project’s contributions to knowledge, and suggesting future research directions.

CHAPTER 9
CONCLUSIONS
PAST, PRESENT, AND FUTURE

9.1 CONCLUDING THE ‘THESIS OF THREES’

In keeping with the concept of a ‘thesis of threes,’ as introduced in Chapter 1, this project concludes with a summary of three timeframes: past, present, and future. The past 30 years saw the onset of HIV/AIDS, followed by numerous social marketing campaigns to combat the disease, which was complicated by the changing medical landscape for prevention and treatment. Examining the history of the relationship between these three disciplines gives context for understanding the present-day HIV/AIDS industry as a by-product of cultural, political, and economic factors. This complexity makes for an uncertain future but offers plentiful opportunities to participate in the global dialogue and to make positive contributions.

This chapter summarises the complexities of this research project from a historical standpoint and offers practical suggestions for disseminating HIV/AIDS information to upstream and downstream audiences, thereby facilitating better informed dialogues, health choices, and policy actions. Gaps in knowledge that are bridged by this work are discussed, followed by a critical review of the study and suggestions for future research directions.

9.2 PRELIMINARY HYPOTHESES

After selecting a combination of three topics—social marketing, HIV/AIDS, and conventional and alternative medicine—and choosing three countries that provided a diverse picture of the epidemic across the globe, the researcher began with three preliminary hypotheses that gave background context during the exploratory research:

H1. International organisations, in conjunction with pharmaceutical companies with vested financial interests, use social marketing to selectively disseminate HIV/AIDS prevention and treatment information.

H2. Social marketing campaigns for HIV/AIDS are likely to be targeted toward specific audiences in rural and/or economically depressed communities.

H3. These social marketing campaigns tend to establish conventional products and treatments as the norm while ignoring increasingly accepted alternative modalities.

As discussed in Section 9.4, support for each of these hypotheses was provided by secondary and primary research, but the assertions continue to be controversial among many opinion leaders associated with the HIV/AIDS industry. This kind of paradox is common in transdisciplinary research, especially when investigating such a complicated and far-ranging problem.

9.3 RESEARCH QUESTIONS

As the project progressed, the overall ‘grand tour’ research questions were formulated:

RQ 1: *How have the evolving landscapes of HIV/AIDS, social marketing, and conventional and alternative medicine forged global and national relationships and interactions?*

RQ 2: *Could social marketing influence better-informed behavioural change by including both conventional and alternative medical information in HIV/AIDS campaigns?*

RQ 3: *What practical contribution could social marketing make to bridge the knowledge gap between conventional and alternative medical choices for HIV/AIDS prevention and treatment?*

To answer these umbrella questions, 18 sub-questions were addressed in this thesis using secondary and primary information that synthesised concepts and implications across several disciplines. Answering these questions required consulting a diversity of sources and reconciling conflicting opinions in search of practical solutions to the complex real-world conundrum that is HIV/AIDS. A transdisciplinary, mixed methods approach was selected as the most appropriate way to deal with the complexity and paradox created by the convergence of the three topics under study. Both qualitative and quantitative techniques were used to collect data to answer the research questions.

9.4 THE PAST: A RESEARCH JOURNEY REVIEWED

Since the researcher was cross referencing such a wide range of ideas and disciplines in ways not previously explored, this review of three decades of HIV/AIDS, social marketing, and conventional and alternative medicine had the complex task of mapping relationships between these topics in new contexts. This report consolidates what has been

learned, re-learned, and ignored during the past 30 years, as viewed from the perspectives of HIV/AIDS activists (the political aspects), marketers (the cultural aspects), and the conventional and CAM medical communities (the biomedical and financial aspects).

9.4.1 The global picture

With millions of people dead, millions more living with HIV/AIDS, and an infection rate that is increasing rather than falling among high-risk groups, the history of the AIDS epidemic has been characterised as *'islands of success in a sea of failure'* (Bertozzi, 2008). Although the disease crosses national borders with ease, governments have been less united about attacking the epidemic. AIDS has become a multi-billion dollar industry, and that kind of money, combined with the international political scale of the disease, has brought its attendant corruption, mismanagement, and ineptitude. HIV/AIDS is no respecter of position or status, but poverty exacerbates AIDS and AIDS exacerbates poverty (Michiels, 2002). Those with the financial means can get treatments that do not cure the disease but greatly extend their lives, albeit with sometimes unpleasant side effects and a future of technology-mediated routine. The poor, however, often have no access to testing or treatment, so the average lifespan in many developing countries continues to fall, which has disastrous social and economic consequences. Ignorance about prevention is widespread among the educated as well as among the illiterate, despite an overwhelming amount of information available through traditional and new media sources. Since it is spread through sexual contact and drug use, AIDS is an unpleasant, even taboo topic, so many people do not want to know if they are positive, fearing the associated stigma and discrimination as much as the physical symptoms. As a result, as many as one-third of the infected may be undiagnosed. HIV/AIDS is now classified as a chronic disease, but the long-term effects of antiretroviral drug treatments are only beginning to become evident, while alternative treatments are mostly unknown and seldom used, even as complementary immune support. A vaccine is years away at best, most medical experts agree.

9.4.2 Social marketing weighs in

Given the imperfect biomedical situation regarding treatment, the world has looked to prevention strategies, notably social marketing campaigns, to stem the tide of the disease. Unfortunately, social marcoms have been found to be far less effective than commercial marcoms, because 'selling' long-term behaviour change is much more complicated than

promoting a consumer product. Since social marketing itself is not a theory, but draws from a long list of related disciplines, practitioners have a large—and some might say unwieldy—toolbox from which to build campaign strategies. Indications are many social marketers disregard this daunting list of theoretical approaches, preferring to be, as Walsh and colleagues noted, *'broadly eclectic and intuitive tinkerers in their use of available theory'* (1993, p.115).

However, as social marketing has evolved since its 'birth' in 1971, it has been redefined as a way to motivate not only short-term behavioural change at the consumer (downstream) level, but also as a way to promote long-term societal change at the policy (upstream) level. But, change is difficult and health behaviour change, especially when it relates to sex and politics, is even more challenging, so social marketers have a difficult task that calls on every technique at their disposal.

Social marketing has been a major player in the war against AIDS in the three countries examined in this study. Uganda, Mexico, and the United States are representative of how HIV/AIDS attacks the poor, the religious, and the well to do, all with deadly results. Nevertheless, the social marketing interventions from each of these countries included in the content analysis in this study have much in common. Collaboration was always essential; getting multiple agencies and NGOs to participate in interventions was a top priority. Condom social marketing was a popular approach and sometimes the centrepiece of prevention campaigns. Mobile groups such as migrant workers, truck drivers, and sex workers are at high risk for infection in any country, and were frequently the target for prevention or testing campaigns. Perhaps the greatest universal constant in the campaigns in all three countries was the goal of reducing stigma and discrimination associated with the disease, considered the most damaging cultural obstacle to reducing the spread of the disease and its devastating effects on people living with HIV/AIDS.

There is an increasing expectation that HIV/AIDS social marcoms will yield measurable results, and that involves fully understanding both the AIDS landscape and marketing theory and practice. *'To be effective, HIV prevention programmes need to understand how the target audience perceives HIV, condoms, monogamy, opportunistic infections, anti-retroviral drugs, and the herbal therapies that have been used for centuries'* (Singhal & Rogers, 2003, p.158).

So, it is important that social marketers understand the many facets of AIDS among the population where an intervention is planned, and they need to win the confidence of

the target. According to Singhal and Rogers, traditional health providers already have a high degree of credibility and are usually the first source of help sought by individuals when they become ill. *'In developing countries, traditional healers are much better positioned than medical doctors to care for HIV/AIDS patients'* (2003, p.158-9).

Unfortunately, Western-trained medical doctors, with whom social marketers are likely to be collaborating, usually look upon traditional practitioners as quacks (Singhal & Rogers, 2003).

9.4.3 Gaps in knowledge

The survey conducted for this study revealed an alarming number of knowledge gaps in regards to HIV/AIDS prevention and treatment as well as a lack of information about global trends for the pandemic. Despite relatively high education levels (one-third were college graduates), respondents were uncertain or misinformed about a number of important medical facts regarding how HIV/AIDS is transmitted and how the disease can be prevented. Even the most common treatment, HAART, was only recognised by 40% and considered effective by even fewer. Respondents were particularly ill informed about alternative treatments, although more than 40% agreed that alternative treatments for the disease have shown promising results.

Not surprisingly, since more than half of the respondents were HIV-positive, most rejected stereotypical statements about people with HIV/AIDS, although a significant percentage either agreed or were ambivalent about several of the stigmatising statements in the survey.

Regarding global economics, more than half of the respondents agreed that treating HIV/AIDS is a profitable business for pharmaceutical companies, but they are less certain about global trends regarding transmission of the virus and how funding is allocated for treatment vs. prevention efforts.

Although respondents had many sources available to them for learning about HIV/AIDS, they tended to put their trust in online disease-specific sources, conventional medical doctors, and traditional mass media, especially television, books, and magazines. They were least likely to trust social media, fellow workers, and religious organisations.

Statistical analysis of the survey data indicated an educational campaign directed to an HIV-positive audience would be highly desirable and could be informed by the three profile groups that emerged during reliability analysis: the moralist/hedonist, the cautious optimist/raving pessimist, and the global activist/political ostrich.

9. 5 THE PRESENT: REFLECTIONS ON AN EPIDEMIC

After contemplating the research completed to date, it becomes clear that public communication about HIV/AIDS essentially revolves around three factors: culture, politics, and money—and not necessarily in that order of importance. Although the specifics of these issues vary from one country to the next, the global implications cross all physical and conceptual boundaries.

9.5.1 Cultural factors

Although categorised as an underground epidemic because of stigma and discrimination associated with the disease, HIV/AIDS has become everyman's—and everywoman's—problem. The actual prevalence numbers are uncertain because of reluctance to seek testing and treatment, but there is certainty that the global pandemic has spread each year since the first diagnosis in 1981. HIV/AIDS is now both a horizontal epidemic—affecting both sexes—as well as a vertical epidemic—being transferred from mothers to children. The history of the epidemic includes increasing hysteria as the death toll climbs, unfulfilled hopes for various promising treatments, optimism with the discovery of antiretroviral therapy (HAART), disappointing vaccine failures, and alternative treatments that CAM practitioners claim offer encouraging options to drug cocktails. In many countries, especially the United States, there is a climate of increasing scepticism toward big business in general and the pharmaceutical and media industries in particular (Edelman, 2011). As a result, the public may be increasingly receptive to 'green' and natural products of all kinds, including medical treatments.

Social marketing has gained widespread acceptance among international organisations as the tool of choice for campaigns to motivate healthy lifestyle choices by individuals and to promote long-term policy changes. These health activism initiatives typically use culturally sensitive approaches to build rapport and persuade. However, the visual/verbal presentation varies widely, depending on the target audience, and appeals vary from personal fear to altruistic concern. HIV/AIDS campaigns are typically targeted to audiences segmented by such factors as demographics (often using ethnicity, gender, or age), behaviour (such as sex workers), or lifestyle (frequently the gay community). The campaigns in Mexico and the U.S. share many commonalities, especially those that bridge the border between the two countries, but each campaign reflects the cultural differences of the targeted audience. Interestingly, one commonality between the two countries is that the highest prevalence rate for HIV/AIDS is found in the prison cultures, but social

marketing is not being widely used to combat this problem.

Finally, the phenomenon of complacency, sometimes called *'disinhibition'* (Abraham, 2007), may be driving a decline in safe sex practices, especially in Western countries where anti-retroviral drugs (ARVs) are widely available and considered a kind of 'cure' for the disease. This trend toward increased risky sexual behaviour among some groups calls into question the way HIV/AIDS information has been presented and perceived.

9.5.2 Political factors

Politics, the universal tactic of negotiation and compromise, comes into play at every level of human discourse and HIV/AIDS is no exception, as policy makers pursue agendas with a wide range of goals. Therefore, communication about the disease is invariably shaped by political concerns and people live or die as a result of those decisions.

From a practical standpoint, most campaigns emphasise prevention over treatment since there is no known cure for the disease and the primary political directive is to reduce rates of infection. It follows, then, that the downstream audience is usually the target, with a focus on short-term behavioural change. Additionally, evaluation of campaigns is difficult, so measurement of their effectiveness frequently is based on product successes such as increased condom sales.

As previously explained, collaboration is essential, but 'communication by committee' is time-consuming and fraught with dissension. Still, most social marketing initiatives rely on partnerships that cross all boundaries—cultural, political, and geographical—but those partners may have differing viewpoints and aims. For example, in 2003 U.S. President Bush approved a five-year African aid package, saying his country had a *'moral duty to act...[since] every day of delay means 8,000 more AIDS deaths in Africa and 14,000 more infections'* (Campaigners, 2003). Despite these noble sentiments, the plan was criticised by many who pointed out a third of the money earmarked to be spent on prevention had to be used for projects promoting abstinence rather than safer sex. Similarly, in countries like Mexico, which is predominately Roman Catholic, earmarking funds for a disease often associated with lifestyles or practices that conflict with the teachings of the church is a political hurdle.

An intriguing political response to the problem of attracting substantial support is the 'positioning' of women as the primary victims—'the innocents'—in the battle against AIDS. This widespread rhetoric is designed to gain broad political support from faith-based organisations as well as from political leaders looking for the most acceptable route

to public approval. Since women comprise about half of those infected worldwide, this marketing approach lends itself to a wide range of emotional/rational appeals. On the eve of the June 2007 EU summit, Bill Gates, a major contributor of funds to fight AIDS, appealed to the G8 countries to pledge new resources to *'beat AIDS.'* Gates said in part, *'A top priority must be to address the prevention needs of women and girls...biologically, women are twice as likely as men to contract HIV. And many women—including those who are married—have little power to ensure their partners are faithful or use condoms. A woman shouldn't need her partner's permission to save her own life'* (Gates, 2007).

9.5.3 Economic factors

In the final analysis, it is all about money. Whether the focus of the discussion is on individual health care, allotment of national resources, or international business, the bottom line is the top consideration and the principal catalyst for action. AIDS represents both crisis and opportunity in the world of finance.

On the global scale, economic concerns about projected costs of AIDS treatment and the resultant depletion of resources is spurring policy makers to look for far-reaching solutions to avoid a future collapse of their health care systems. In terms of opportunity, the disease offers the possibilities of massive profits for aggressive marketers. Promoting the use of condoms is such an integral part of HIV/AIDS social marketing that the practice has its own acronym: condom social marketing (CSM) (Condom, 2010). After realising sales in Mexico of 19 million condoms in 2004, the Washington-based charitable organisation DKT International noted *'dynamic social marketing'* was essential to its success (DKT, 2005).

Even greater opportunities abound when it comes to conventional drug treatments for AIDS victims. In industrialised countries such as the United States, Americans with adequate insurance or personal funds can receive HAART (Highly Active Anti-retroviral Treatment) and monitoring for about \$10,000 (£5,000) a year. The cost of current treatments clearly separates the haves from the have-nots; only one-fifth of infected people in developing countries are receiving anti-retroviral therapy, primarily due to cost constraints. Several social marketing campaigns included in the content analysis in this study solicited funding to provide treatments and to fund research for an HIV/AIDS vaccine, heralded by some in the medical community as the health grail of the disease.

In this rush to find effective treatments and ultimately, a cure, there have been many stumbles and some documented deceits, such as selective reporting of clinical drug trials,

as acknowledged by the International Committee of Medical Journal Editors (Graham, 2004, p.18). Some media critics have termed mainstream media the *'flagship of medicalisation'* (Hamber, 2005). In developing countries, the media have become globalised, privatised, and deregulated, resulting in a highly advertising-driven and commercial industry. In 2003, the Panos Institute, a global network based in London that focuses on *'amplifying the voices of the poor and marginalised,'* issued a report examining how communication has been used to respond to the AIDS pandemic and calling for media to support informed debate rather than merely disseminating information (Scalway, 2003).

For example, the Ugandan government's extensive education program has been widely hailed as a model for reducing AIDS among some segments of the country. Unfortunately, AIDS has not subsided in many of the rural and poorer areas, where 87% of the population lives. Looking beneath the favourable publicity about Uganda's program demonstrates how easily statistics can be manipulated. In sectors where the numbers of those living with HIV infections have declined, the reduction can be attributed to an increase in deaths rather than a reduction in new cases (Basu, 2003, p.1).

Finally, some critics go so far as to allege that chronic diseases such as AIDS are too profitable to cure (Siegal, 2003; Hoadley, 2007). They point out that medical innovations such as nanotechnology are changing the landscape of possibilities regarding treatment and new discoveries about the cause of AIDS are not being published in medical journals or pursued by conventional medicine. Professionals in the alternative medicine community claim that some CAM treatments for HIV/AIDS, either used alone or in conjunction with drug therapies, have shown positive effects. However, alternative practitioners say extensive research regarding benefits of these substances has not been pursued because they cannot be patented and therefore will never generate profits for the pharmaceutical companies (Hanna, 1998; Abraham, 2007).

Therefore, research to date seems to offer support for the initial hypotheses developed at the beginning of this study, but by no means is there universal agreement. These three factors—cultural content of social marketing messages about HIV/AIDS, the role of political expediency, and the economic realities of the global medical market created by the epidemic—form a complex and politically charged environment that influences public dissemination of information about health care options. The deeper beneath the surface one looks, the more relationships, conflicts, and knowledge gaps are uncovered, contributing to the body of knowledge about these topics and justifying further study.

9.5.4 Hopeful news

Overall, the good news for social marketers is that HIV/AIDS is not a medical problem—it's a behavioural problem, so in the absence of a vaccine for a therapeutic cure of HIV/AIDS, communication strategies potentially represent a key '*social vaccine*' against HIV/AIDS (Singhal & Rogers, 2003, p.206). That idea puts social marketing front and centre in the fight against the disease.

More good news is that social marketers have at their disposal an array of theories, tools, and practices. Experts urge social marketers to draw upon the multiple theories described in this thesis, *plus* motivational theories for message development; social network theories for message dissemination; organisational development and B2B (Business to Business) marketing models for coalition and partnership development and management; political theories and agenda-setting research for policy initiatives; and cross-cultural theories for international social marketing (Lefebvre, 2001, p.516).

But there is a cautionary footnote: '*Fewer than 20% of a problem population are prepared for action at any given time, yet more than 90% of behaviour change programmes are designed with this 20% in mind,*' according to Prochaska and colleagues, who developed the Stages of Change theory (1994, p.15). That may be a reason for choosing the transtheoretical model as a foundation for HIV/AIDS social marcoms. Prochaska also reported the Centers for Disease Control and Prevention (CDC) adopted the Stages of Change model for all of the HIV/AIDS prevention campaigns sponsored by that agency. The CDC's campaign assessment revealed the number one reason given for practicing safer sex was to be a more responsible person, followed by the second most common reason: to keep from contracting AIDS (Prochaska, et al., 1994).

9. 6 THE FUTURE: CONTRIBUTING TO THE HIV/AIDS CONVERSATION

The overall aim for this project was to *design a communication model for effectively disseminating information about both conventional and alternative HIV/AIDS prevention and treatment options*. Informed by the secondary and primary research from research phases 1-3, an Integrated Social Marcon Model was created to convey that social marketing campaigns should be customer-centred, with participants engaging in an ongoing conversation at every stage. The process that underlies this model uses a choice-based approach, informed by contextual factors and research inputs, to develop a customised and personalised campaign.

9.6.1 Other contributions to knowledge

In addition to the social marcon model, this research also contributes to knowledge in the following areas:

- It addresses a crucial gap in the social marketing/HIV/AIDS literature, which has mostly omitted emerging CAM information. This research maps connections to the increased popularity of alternative treatments shown by recent studies and reviews emerging studies that seem to indicate CAM could play a positive role in HIV/AIDS treatment.
- It crosses several disciplines—health activism, health communications, alternative medicine, social marketing, clinical studies of HIV/AIDS, capability and sustainability studies among others—to examine this global concern holistically.
- It looks specifically at several recent or current campaigns in Mexico, Uganda, and the United States to draw comparisons and contrasts based on common points of analysis. This particular kind of comparison has not previously been undertaken.
- It includes input from the alternative medical community, a group that to date has been ignored by the social marketing dialogue, and gives that group an opportunity to participate in the dialogue about HIV/AIDS treatment options.
- This research links quasi-clinical HIV/AIDS and social marketing, exploring practical ways to disseminate information about new treatment options and demonstrating that emerging clinical discoveries—be they conventional or alternative—need effective and straightforward communication to motivate change in public policy and individual behaviour.
- Keen interest in this research approach from colleagues, from conference presentations, and from publishers in several disciplines indicates the value and need for such a combination of topics. (*See appendices D and E.*)
- If the media are unable or unwilling to perform this information/activism function, it is essential to employ other ways to reach stakeholders in this vital issue. This project

offers an alternative to gatekeeper media routes and is especially viable for new media, which bypass traditional media vehicles.

- It provides an innovative, holistic examination of broad concerns and proposes specific techniques and approaches—moving from theoretical to practical and from a global viewpoint to local implementation, using a transdisciplinary approach to bringing together opinions and perceptions not previously considered in tandem.

9.6.2 Limitations of research

As with most international research projects, time, distance, and resources are limiting factors. Because Mexico and Southern United States contacts were more accessible for the researcher, most personal interviews were conducted with key informants in those countries. However, it was also possible to interview a broader range of experts through contacts made at international conferences where information from this project was presented (*See Appendices D and E*).

Sampling for the survey was based on convenience and consent, but a high percentage of possible respondents agreed to take the survey and more than 340 valid responses were collected over a four-day period. Additionally, the survey required self-analysis and self-reporting from respondents with diverse racial and cultural backgrounds. The survey was constructed and pilot-tested with these limitations in mind and a Spanish-language version of the survey was available for non-English speakers. Due to cost and time constraints, this survey was only conducted in one city—Houston—but the clinic chosen for the survey site was considered a representative example of an HIV/AIDS clinic in a large urban area in the southern part of the United States.

Finally, by its nature, transdisciplinary research must encompass conflicting information, paradox, and complexity, which requires reflection and holistic thinking and does not yield precise pragmatic ‘solutions.’ However, this research approach proved to be appropriate for this wide-ranging and complicated study and has yielded significant new knowledge.

9.6.3. Critical review

If beginning anew with this study and having the luxury of hindsight, much time could have been saved by focusing more quickly on the overall aim for the study and by being more efficient and better organised at every stage of the research. The reflective log (*See Appendix A*), deals with many of these unnecessary side trips and research missteps. On

the other hand, what is a research project if not a learning experience where hypotheses are created and discarded, and research directions are pursued, then changed or discarded in favour of other ideas?

Because this project was broad ranging, using mixed methods and crossing several disciplines from both academics' and practitioners' perspectives, it was unavoidably chaotic and sometimes overwhelming. Also, because it was original work (not replicating a previous study), extensive methodology was needed, which was written, refined, and re-written several times before emerging as shown in Chapters 4 and 6.

Additionally, this project represented a 'moving target,' in which the landscape was constantly changing, requiring ongoing literature review and updating of interview data, and of course, frequent rewrites of the thesis itself. For more about this five-year journey, see the *Reflective Log* in Appendix A.

9.6.4 FUTURE RESEARCH

Because of the massive amount of secondary and primary information generated during this project, the opportunities for future research are extensive.

In addition to the findings and recommendations presented in this thesis, this inquiry raised issues that touch a variety of disciplines:

Behavioural psychology: HIV/AIDS is not a biomedical problem; it is a behaviour problem, and much of the prevention efforts to date have been focused on trying to provide a rational solution to an irrational problem. Also, the role of complacency in fuelling the increasing infection rate is an intriguing concept.

Communications: The visual and verbal communications aspects of HIV/AIDS social marketing, especially as they relate to the use of new media, offer a rich, unmined area for further study and comparison.

Cross-cultural communication: This study suggests many avenues for further research relating to messages directed to HIV/AIDS subcultures, such as controversial, reality-based marketing, explicit vs. subtle messages, and cultural adaptation.

Sociology: The idea that HIV/AIDS has changed society's reticence about public discussion of formerly taboo topics such as premarital sex, condoms, gay sex, etc.

deserves further study. (See the *Transdisciplinary Glossary* for more terms that have been added to the public lexicon since HIV/AIDS became part of the public agenda.)

Gender studies: The idea of women as the ‘innocent victims’ of the HIV/AIDS epidemic is also an interesting line of inquiry.

Marketing: The question of choice—what is not enough, what is too much—is an interesting concept relating to HIV/AIDS campaigns for behavioural change. The implications of moving from marcoms to marcons is also a timely topic.

Political science/Religion: Since HIV/AIDS has such close connections to religion and politics, the idea that many of the ‘helping organisations’ have taken a ‘missionary position’ regarding the disease (such as PEPFAR’s stipulations for abstinence-based prevention campaigns) is certainly of international interest.

Real world applications: Perhaps most important of all, this researcher’s collaboration with practitioners on the clinical side of this issue as well as with policy makers who have political clout promises possibilities for practical application of this research. There is an opportunity to make a difference—to change the content and approach of HIV social marketing and effect upstream as well as downstream change.

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**SOCIAL MARKETING STRATEGIES FOR COMBATING HIV/AIDS
IN RURAL AND/OR DISADVANTAGED COMMUNITIES
IN MEXICO, UGANDA, AND THE UNITED STATES**

VOLUME 2

RUTH E. MASSINGILL

**A thesis submitted in partial fulfillment
of the requirements of Teesside University
for the degree of Doctor of Philosophy**

April 2011

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APPENDIX A
A REFLECTIVE LOG

*Travelling high roads, visiting low places,
and following bunny trails
from Texas to Teesside and back home again*

Reflective Log

2005-2010

This is a personal chronicle of my research journey over towering mountains of information, past pillars of statistics, through labyrinths of opinion and theory, and across ethical minefields. At the same time, there was the academic maze to navigate, with its ironclad procedures, reams of reports, and educational conventions.

This was also an intensely personal journey that took me out of my comfort zone, where I encountered people and experiences that would never have touched my sheltered university life in Texas.

Along the way, I logged thousands of actual miles travelling from Texas to Teesside, with forays north to Canada, south to Peru and Mexico, and across the pond to a number of European cities. I met a wonderfully diverse group of individuals with fascinating—sometimes shocking—knowledge they were kind enough to share.

This arduous pursuit was undertaken with the realisation there would be dead ends and missed markers aplenty, but I hoped by journey's end logical patterns would emerge as the sanity of method came to the forefront. I admit I rambled down a goodly number of bunny trails—diversions that yielded no useful result—but isn't that part of the research process? Over the years, I experienced curiosity (which set this endeavour in motion), frustration, steep learning curves, exhilaration, and empathy. At one point, I was told that writing a PhD thesis was the '*largest and most self-indulgent thing*' I would ever do. If that is the case, this reflective log is the most hedonistic thing of all. Certainly the entire project has been self-serving in that I have received immeasurable rewards, which have more than compensated for the time, expense, and discomfort—both physical and emotional.

This, then, is my five-year chronology of milestone places and experiences, combined with my serious—and sometimes not-so-serious—musings on the mundane as well as the profound.

2005

Paris, September 2005

The inspiration for this project was my desire to go to Paris. For years, I had longed to visit France. Time was passing and I was still in Texas, although I frequently

presented academic papers in major U.S. cities. So, in the Spring of 2005, I searched the Internet for communication conferences scheduled to meet in the City of Lights.

Success! I found a call for abstracts by an organisation meeting at UNESCO. A colleague and I sent a proposal, which was accepted for presentation. In researching and writing my part of the paper, I was stunned by the scope of the HIV/AIDS epidemic. I also discovered the field of social marketing—heretofore unknown to me—and through my colleague I started to learn about the medical aspects of the disease. Our research suggested unhealthy relationships between drug companies and dissemination of information about medical issues, especially relating to diseases such as HIV/AIDS, where billions of dollars were being spent for prevention and treatment programs. We reported that companies such as Merck and Pfizer typically spent more on marketing their drugs than on research and development.

Our paper included this statement:

‘With this kind of investment at stake, it is not surprising the traditional medical establishment uses its influence and financial clout to control the dissemination of information. It does so by violating the most intrinsic human freedom and endangering the most basic of human capabilities—access to knowledge.’

The paper was controversial, some even said it was ‘incendiary,’ but my interest was sparked. I had found my PhD topic. (And, yes, Paris is now one of my favourite cities; I have returned several times since.)

MILESTONE:

11-14 September 2005—*Curing AIDS: Why Successful HIV/AIDS Treatments are Unknown to World Government Policy Makers*. Fifth International Conference on the Capability Approach, UNESCO. Paris, France (co-author: James Adams)

Teesside, September 2005

While researching the converging topics of HIV/AIDS, social marketing, and their relationship to conventional and alternative medicine, I also began looking for a PhD program that would fit my life situation and make me eligible for promotion at the university in Texas where I teach communication classes. *Bear’s Guide to Earning Degrees by Distance Learning* helped me determine that part-time distance programs in public relations/social marketing were available, especially in Europe and Australia.

Since leaving my job for a full-time research program was not feasible, I began to search for an English-language university with international GAAP certification that offered PhD marketing degrees via distance learning. Social marketing is not a common degree in the United States, so I turned my attention to universities in the UK. Staff at

Teesside Business School agreed to meet with me and discuss my proposal while I was in Europe for the UNESCO conference. In mid-September, the 6 a.m. train from London took me north to Middlesbrough and a taxi delivered me to the campus, where I found my way to the Business School for an appointment that would significantly affect the next five years of my life.

After discussing my proposed topic with faculty and staff from the Teesside Business School, a question I was to answer many times over the next few years was broached: *'Why travel so far to earn your degree and why are you specifically interested in Teesside?'* I explained that in addition to offering the kind of program and flexibility I needed to advance in my academic career, Teesside was squarely in the middle of my roots; my family originally came from Masongill, near Settle, Yorkshire. Masongill was the family seat of the Massengills during the Middle Ages. Daniel Marsingell, a sailor from nearby Whitby, immigrated to Virginia in the mid-1650s and was the forbearer for the many Massingills now living in the States. I had learned these facts years ago from a hefty book in my personal library—*The Massengills, Massengales and Variants 1472-1931*, written by Samuel Evans Massengil, M.D., and published in 1931. So, I feel a special affinity to Yorkshire and was delighted with the prospect of exploring the area while spending my annual residency at Teesside.

Beyond these personal and professional motivations, however, I was intrigued with the idea of tackling a far-ranging project that would challenge me to understand cultures outside my experience and would allow me to become constructively involved in the international dialogue about social policies to combat HIV/AIDS. Happily, Terry Robinson, Reader in Marketing, and Helen Bussell, acting Assistant Dean in the Teesside Business School, enthusiastically agreed to supervise my research and my enrolment was approved in December of 2005. So at an age when many of my contemporaries were looking forward to retirement, I was blithely committing to a project that would devour much of my spare time and money for the next five years and would require me to travel to Teesside each year for several weeks in residence at the university.

MILESTONE:

December 2005—Officially enrolled at Teesside

Huntsville, Texas, May 2006

As one requirement for moving from enrolment to registration at Teesside, I completed a graduate level research methods class through Sam Houston State University, where I have been a tenured instructor for more than 15 years. This class gave me needed background in mixed methods research, with an emphasis on the qualitative techniques that would be dominant in much of my work. This class also reminded me of the student role I had not experienced in many years; I was accustomed to being the professor who assigned, facilitated and graded. Learning to switch back and forth between being student and instructor was valuable; it gave me insights that were helpful to me as learner and as educator. Also, since I had to take the class online due to my own teaching schedule, I gained valuable insights into the pros and cons of this method of teaching, which served me well a few years later when I began teaching some of my communication classes online.

MILESTONE:

May 2006—Earned an ‘A’ in research methods and packed my bags for my first residency at Teesside

Teesside, May-June 2006

My first annual trip to Teesside was a learning experience in logistics as I figured out how to get from London Gatwick to Kings Crossing to catch the northbound train. That was also the year of too-much luggage; I mistakenly packed one massive (and extremely heavy) suitcase, thinking its wheels would make it manageable. I soon realised my error when I discovered there were no escalators in the London tube and elevators were rare and well hidden. After that experience, with each succeeding year, I would travel lighter, although a laptop computer was always mandatory, and it was the heaviest item in my luggage.

Once my luggage and I made it to Middlesbrough that first year, I settled into a rented room in a house I shared with other students, one who was a graduate business school student from China with whom I developed a continuing friendship.

With my journalism background, being curious about people’s lives and asking incisive (some might say nosy) questions comes naturally, but following a strict research protocol during the interviewing process was a departure from my experiences

as a reporter. When I became a graduate student in England, it was helpful to have recently gone through the IRB (Institutional Review Board) process for *Prison City*, a book I co-wrote about communication in the Texas criminal justice system.

Since I often presented papers at international conferences wearing the twin hats of a communication faculty member for Sam Houston State University in Texas and a graduate student at Teesside, I had to satisfy the research/ethics committees at both institutions. Of course, the applications had to be written in American English (organization, for example) for SHSU and in British English (organisation) for Teesside! Eventually I created my own ‘cheat sheet’ for the *z* words; for *horizon*, *magazine*, *size*, and *citizen*, it was okay to use *z*; in most other cases, I should convert the *z* to an *s*. The language selection in my word processing program was immensely helpful and soon all of my academic papers were written in UK English.

Also, I quickly learned the terms *thesis* and *dissertation* have opposite meanings in Europe and in the U.S. In the states one writes a thesis as a requirement for a master’s degree and a dissertation to earn a PhD. At Teesside, I would be writing a thesis for my PhD. This would cause much confusion among my colleagues back in Texas, and meant that I would have completed a thesis for my master’s degree (from the University of Wyoming) and another for my PhD. So, I began the challenge of life with one foot in British academia and the other in higher education in the U.S.

Stirling, Scotland, June 2006

While I was working on my ethics application, my research proposal, and registration paperwork at Teesside, I contacted Laura McDermott, research officer at the Institute for Social Marketing (ISM) at the University of Stirling, and asked for an interview. She agreed and I was once again on a northbound train, first to Edinburgh, where I stayed in a bed and breakfast booked over the Internet. A map of the city and questions of bus drivers and various other citizens confused me further, so I had an extended walking tour of the city before finding my room. The next day, I retraced my path and found the bus to Stirling. As with many of my first visits to a new city, getting there was an exercise in critical thinking and problem solving.

When I reached Stirling, attractively sited in the countryside, McDermott and several of her colleagues at the ISM were welcoming and encouraging. They shared case studies and behind-the-scenes strategies for some of their campaigns, including a draft report discussing which theoretical models were proving most effective in national anti-obesity campaigns.

Back at Teesside, I struggled to produce a comprehensive ethics application; since my project would involve interviews with and a survey of human subjects, *and* since my topic was HIV/AIDS, the application received careful scrutiny. My Teesside director of studies, Terry Robinson, was especially helpful as I edited and rewrote the application, which had the added benefit of helping me focus on my project's purpose and protocol. By the time I completed my 2006 residency and headed home, the ethics application was approved and my request to be accepted as an MPhil candidate at Teesside had been submitted. (At that time, Teesside, like most British universities, first accepted graduate students as MPhil candidates and, when the student's work warranted, he or she could apply to transfer to PhD status.)

MILESTONES:

Summer 2006—University of Teesside's Research Ethics Committee approved my application

September 2006—Registration as an MPhil candidate in the Teesside Business School was approved

Texas and Mexico, Summer 2006

Back in Texas, I taught summer school and attended my 25th high school reunion, in a world far removed from my experiences in the U.K. Many of the 39 people from my high school class were at the reunion, and they were mystified that I would, first of all, begin work toward a doctorate at an age when most of them were grandparents with their golden retirement years in their sights. My colleagues at Sam Houston were equally confounded at the thought of me travelling halfway around the world each year to study in Europe. Several commented, *'I can't believe you travel all that way by yourself!'* My students, on the other hand, thought it sounded like a wonderful adventure, which of course it already was proving to be. I explained to some of my colleagues that yet another reason I was pleased with my choice was the higher education culture in Europe. Everyone I encountered at Teesside and at various conferences I attended wanted me to succeed with my research and with earning my degree. I never experienced even a hint of the caste system of PhD vs. non-PhD that is so prevalent in many U.S. universities or encountered the 'academic hazing' I have frequently seen in U.S. academia.

That summer I also took my second trip to a medical clinic in Mexico, where HIV/AIDS was being treated using alternative therapies. The clinic's director was a client of The Massingill Agency, my firm that specialises in health care communication.

My research into HIV/AIDS medical issues was proving helpful in my work with this client. I summarised some of my secondary and primary research in an HIV/AIDS backgrounder for a media kit. I was surprised to learn many of the stereotypes about HIV/AIDS were false, but generally widespread, perceptions. I learned that in 2005, more new infections (13,000 daily) and deaths (8,000 daily) had occurred than during any previous year of the pandemic. I also noted that worldwide, about half of the infected were women, and heterosexual transmission was the most common means of infection. Even more frightening, I discovered that in the U.S. alone, an estimated one-third (or more) of the HIV infections were undiagnosed.

The most intriguing fact I learned while working with my Mexico clinic client was that an international team of researchers and physicians had begun IRB-sanctioned pilot programs using the latest nanotechnology and sub-nanotechnology. The early results in the summer of 2006 showed remarkable outcomes in patient blood tests measuring viral load reductions. My interest in emerging alternative treatments for HIV/AIDS was certainly captured by these statistics!

Lima, Peru, August 2006

At summer's end, I travelled to Peru to attend a communication conference where I was an invited presenter on advertising campaigns that cross cultural boundaries. I found the discussion about aspirational ads to be an intriguing question that related to my research into which behavioural change approaches were effective in combating HIV/AIDS. Although many advertising professionals were eschewing aspirational approaches as too elitist, some professionals think that is a short-sighted viewpoint, as explained in this blog:

'An aspiration is defined as "a strong desire, longing, aim or goal. To strive toward an end: to soar." If you were to ask American families what they aspire to, you are likely to hear responses about health and happiness, giving their kids a better life, making sure college is paid for, vocational fulfilment, contentedness even. You see, while American consumers have bought into the cultural narrative that "progress" is constituted by attaining the most feature-laden cell phone, the things people fundamentally care about are unchanging' (Guest Blogger: Elizabeth Paul, The Martin Agency <http://blog.communispace.com/index.php/2009/09/09/redefining-aspiration>, Sept 2009).

Aside from fulfilling a long-time desire to visit Peru, this international gathering of communicators raised some intriguing questions for me about culture and advertising, and helped me prepare for an upcoming Mexico conference on AIDS in Culture. It was

also my first bilingual (English/Spanish) conference, where simultaneous translations took place while the speakers were presenting.

MILESTONE:

3-6 August 2006—*Aspiration Advertising Campaigns as Intercultural Conduits* (invited presentation) Congress of the Americas. Lima, Peru

Banff, Canada, October 2006

I had attended many academic conferences over the years, but in October I travelled to Canada to present a poster at my first social marketing conference. This was also the first poster presentation I had done—my desktop publishing skills and my B.A. in art found a practical use. I had been to Banff before so I already knew it was breathtakingly beautiful, especially in the autumn. This conference was an excellent introduction to the international world of social marketing. I was fascinated by the research presentations, informed by their methodologies, and delighted with the variety of people I met. I returned home with a fistful of business cards and presentation handouts, some of which helped me plan the Phase 1 of my research—a content analysis of recent HIV/AIDS campaigns.

MILESTONE:

19-21 October 2006—*HIV/AIDS Social Marketing: A Comparative History* (poster session) Social Marketing Advances in Research and Theory (SMART) Conference. Banff, Canada

Mexico City, December 2006

Ciudad de México was an exciting place to be at the end of 2006. Civil unrest as a result of the recent presidential election generated all-night protests in the central zócalo, officially known as Plaza de la Constitución. I was staying in a hotel one block from the city square and could hear the protestors chanting and singing through the night. During the day, every rooftop and every street was guarded by **Policía Federal** in full riot gear. Since it was also the celebration of the Virgin of Guadalupe, a national holiday, in the evening protestors rode through the streets on bicycles, wearing white and carrying colourful posters and red roses representing the Virgin, who is said to have appeared to a poor Indian on December 12, 1531, and was a key figure in acceptance of the Catholic religion by the indigenous peoples of Mexico. This combination of political and religious history was the background for the third AIDS in Culture conference, sponsored by CENSIDA (Mexico's National Centre for Prevention and Control of

AIDS) and *Enkidu*, a gay activist magazine. At first, I was taken aback by the explicit nature of the some of the presentations, but as I talked with the organisers of the conference, I learned much about the disease's scope and political issues in the country's largest city. Once again, I collected business cards as well as personal stories from those attending the conference.

Language was a barrier, but not an impossible obstacle; the editor of *Enkidu* served as interpreter for all presentations. I sometimes had problems remembering to say several sentences and then stop for the interpreter to give my comments in Spanish. I have not had the opportunity to attend that annual conference again, but I did attend a gathering of the conference organisers and local HIV activists when I returned to Mexico City two years later (See 2008 entry.).

MILESTONE:

9-12 December 2006—*Getting the Word Out: Promoting Cures Through Social Marketing* (paper presented as part of a special panel session, 'Making History: Curing AIDS with Nanotechnology') AIDS in Culture III: Explorations in the Cultural History of AIDS. Mexico City (co-author: Lauren Maddox)

Texas, Winter 2006

What is the question, anyway?

Refining my overall research question was an ongoing challenge; much easier said than done, as the saying goes. Seasons came and went, and my overall question evaded perfection, but siren-like, invited interminable tinkering. While I tinkered, I applied for scholarships and grants, signed up for a social marketing listserv I learned about from one of my recent contacts, and submitted a proposal for a conference that would be close to home—in New Mexico, just west of my home state: only 743 miles (1195 kilometers) away. I also found myself struggling to remember to use the correct formal style for each project I was working on; I was alternatively working with Chicago style, MLA, APA, and also the official style required by Teesside: Harvard.

2007

Huntsville, Spring 2007

When (a few) funds came rolling in

Some of the applications I made paid off—literally. I was awarded the Scott Scribes Scholarship for Older Adults (I was glad to have the scholarship despite the name) by

the Writers' League of Texas, which paid most of my Teesside tuition for the year. Also, I received a bursary from the Academy of Marketing to attend its 2007 Doctoral Colloquium in Surrey later that year. I was very grateful for both, both for the votes of confidence in my work and for the financial assistance they brought.

That spring also brought to fruition my first book project, which I had been working on for over three years as the lead author. *Prison City: Life with the Death Penalty in Huntsville, Texas*, was released by Peter Lang Publishing in April. Although neither fame nor fortune came with the publication of *Prison City*, (the royalties were just enough to take a couple of friends out to dinner in Houston), completing this book about the execution capital of the world cleared the way for me to focus exclusively on my HIV/AIDS research. Also, since *Prison City* examined how communication techniques used by inmates, information officers for the prison system, and community leaders affect the political, cultural, and economic landscape, similar issues applied to my Teesside project. Additionally, the *Prison City* research revealed the incidence of HIV/AIDS in U.S. prisons was higher than among any other population in the country, which I found to be the case in other countries as well. All in all, the *Prison City* project was a good preface to my thesis work; I now knew I could do a large research and writing project that stretched over several years and required synthesising massive amounts of information.

MILESTONE:

April 2007—Massingill, Ruth and Sohn, Ardyth. *Prison City: Life with the Death Penalty in Huntsville, Texas*. New York: Peter Lang Publishing, Inc.

St. Petersburg, Florida, May 2007

Despite a broken nose (no, not as a result of asking nosey questions; I really did walk into a door—duh!), after my spring teaching term was over, my university department chair asked that I participate in a seminar, '*Teaching diversity across the curriculum*,' given at the prestigious Poynter Institute in St. Petersburg, Florida. This intensive seminar provided useful training in how to better communicate with diverse populations and offered suggestions for being more inclusive of various cultural groups, including ethnic groups and gay and transgender populations. I quickly realised this experience would help me better understand social marketing campaigns directed toward specific groups where HIV/AIDS prevalence was a problem. The seminar also made me more aware of language and cultural issues that affected messages directed to specific audiences.

Teesside, June 2007

When I returned to Texas, it was time to pack (as lightly as possible) for my annual residency at Teesside. I made arrangements for the care of my animal companions and flew to Madrid to visit a long-time Texas friend, who lived near the city centre and taught English at the Spanish police academy. From Madrid, I took an overnight sleeper train to Paris (yes, I *had* to spend a weekend eating chocolate pastries and fresh strawberries in the city where my adventures began), then boarded more trains to London and on to Middlesbrough. Along the way, I was reminded that keyboards across Europe vary, which made me glad I had hauled my Mac laptop with me, despite the bulk and weight. I was also bemused by the subtle differences of design for practical items such as lavatories (I spent a minute or so in the public restroom at the Gardens of Versailles trying to turn the water on so I could wash my hands—the lever was on the floor.)

That year, I was able to live in an on-campus residence hall, which was much more convenient as well as economical. I had a bed, a desk, a tiny bath and the shared use of a kitchen. The weeks I spent at Teesside each year were an interesting contrast to my multi-tasking life in the States. When I came to Teesside, I had no home or animals to care for, no car to maintain (I walked or took the train everywhere I went), and very few possessions that required my time. I washed my clothes by hand and dried them on the radiators. I didn't iron and I carried only a few necessities in a tiny purse. I shopped carefully for groceries, aware the items I purchased would have to be carried back to my room. I realized that, at least for those weeks, having so few 'things' was a relief and being able to focus only on my research was a wonderful luxury. It also sharpened my thinking and increased my productivity.

During that year's residence at Teesside, I completed my application requesting transfer from MPhil to PhD. This process helped further clarify and focus my study. I was honoured to be invited to present my Phase I research during the University's Post Graduate Research Students' Networking Forum. And, I was asked to write a short article for the postgraduate Business School newsletter. My article, *'From Texas to Teesside,'* began with this paragraph:

'It's a long way from Houston, Texas, to Middlesbrough, but I quickly felt welcome when I first visited the Teesside campus almost two years ago to explore the possibility of becoming a distance learning student in social marketing...

...And ended like this:

'Now, when my colleagues and friends hear about my experiences at Teesside, they no longer ask "why"; they understand the reason I travel so far each year. In fact, I think they are a bit jealous! And, although I have resumed my "regular" life in Texas, I look forward to returning to Teesside next summer.'

Surrey, England, July 2007

The doctoral colloquium was a positive experience that came at a point in my project where advice and encouragement from the professional world was most welcome. The conference was hosted by Kingston Business School, which is organised around a quad of ancient buildings reached by forest trails. The day of the colloquium was filled with presentations by a number of the doctoral students and workshops presented by marketing professionals. Practical suggestions abounded, and each student presenter received feedback on his/her work from a panel of international experts. In an introductory talk, one speaker commented that *'most people only get one PhD, because they don't want to go through (the process) again.'* I used some of the handouts from those sessions to help me at each stage in my project, including the tips to prepare for my viva (short for viva voce—'lively discussion'), or the less poetic 'oral defence.'

The information gleaned from the colloquium and the associated conference proved helpful when it was time to respond to questions from the assessors who examined my transfer document. Not surprisingly, the assessors pointed out I should clarify/rewrite the main research question. I agreed with their assessment and noted I was about to begin the second phase of my research, which would involve a number of semi-structured interviews and should help focus my study.

MILESTONES:

2-3 July 2007—*A Practical Approach to Cultural Change: Using Social Marketing to Combat HIV/AIDS in Mexico*, Academy of Marketing 2007, Doctoral Colloquium, Surrey, England

Summer 2007—Teesside Business School approves transfer from MPhil to PhD status (later approved at the university level)

Taos, New Mexico, October 2007

During the autumn term (my Teesside director of studies asked that I learn to say *'autumn'* instead of *'fall'* as we are wont to do in Texas), I prepared materials for a 1 ½ hour workshop focusing on visual and verbal persuasion methods in some of the social marketing campaigns from my content analysis. This conference setting was an

American West version of the Surrey conference; it was in the wilderness outside of the old Indian town of Taos. I took a bus from Taos to the campus hosting the conference, arriving at dusk and promptly getting lost on the winding forest paths. Finally, the sound of flutes led me to the conference centre, where a bonfire warmed the crisp mountain air and Indian musicians were performing ancient melodies. Even though I was only a short plane ride from home, I was assuredly in another country and another culture. To add to the international scene, my assigned roommate was Tugba (pronounced Tuba) Kalafatoglu, president of a global management and public affairs consulting firm in Istanbul. Tugba told me her firm advised politicians on message development and campaign strategies and assisted business leaders with global marketing and cross-cultural leadership. Her business card joined my growing stack of international contacts.

My workshop visuals generated a lively discussion about the HIV/AIDS campaigns and provided fresh insights from an audience that was not overly familiar with the topic.

While preparing for this workshop, I had also begun work on a book chapter about social marketing in Mexico. Through the social marketing listserv I had been joined months earlier, I learned of plans for an international book of social marketing success stories and submitted a proposal. I was delighted to receive a contract to write a chapter based on my research of two Mexico initiatives.

MILESTONE:

4-6 October 2007—*Motivating Change: Visual and Verbal Persuasion in HIV-AIDS Social Marketing*, American Communication Association, Taos, New Mexico

2008

Huntsville, February 2008

2008 was to be the hardest year of my project due to injuries that made travel and even typing difficult and painful. I think of that year as being book ended with broken bones. A hard fall in the early spring broke my right shoulder and made writing or driving impossible for a number of weeks. Luckily, I was able to move some of the classes I was teaching that spring to an online format, and my next conference commitment was an Internet event.

Internet, March 2008

This was another first for me—a live online conference. It turned out to require at least as much preparation as a traditional conference presentation. I created a

PowerPoint, wrote a script to accompany the visuals, and recorded the commentary via phone prior to the conference. While the conference was in session, I monitored comments and responded to questions. The conference was sponsored by PSP-One (Private Sector Partnerships for Better Health), a USAID project to *'increase the private sector's provision of high-quality health products and services in developing countries.'* My script went through an approval process that erased any hint of criticism of the financial ties to health care in poor countries. The pro-business 'spin' was clear. Nevertheless, it was an interesting experience and one of the comments I received during the conference was from the director of Population Services International-Mexico, who provided updated information about PSI's social marketing approach in Mexico. We visited via email and phone and his input became part of the book chapter I was writing for *Global trends and success stories*.

MILESTONE:

10-15 March 2008—Taking Taboo Topics Public: How Social Marketing Partnerships Combat HIV/AIDS in Mexico (part of a panel titled: 'Partnership Based Approaches: What Works?'), *Social Marketing in the Developing World: What Have we Accomplished and What Does the Future Hold?* 2008 PSP-One on-line conference

Szeged, Hungary, June 2008

My physical therapists assured me the broken shoulder would be sufficiently healed for travel by June, but they were a bit optimistic. Nevertheless, I packed even lighter than the previous year, and set off for my conference presentation at the International Congress on Public and Nonprofit Marketing. I still am grateful to the many fellow passengers that summer who lifted my luggage in and out of the overhead bins and carried bags down flights of stairs for me. Conference organisers met my flight in Budapest and accompanied several conference attendees to our hotel in Szeged. By this point, my annual travel to different international locations had made my passport suspect to airport security and customs agents, who questioned me carefully and usually required a special security inspection of my person and my luggage. A British customs agent was particularly memorable; when she saw my U.S. passport, she sent me to the back of the line, then quizzed me at length about how long I would be in England and the exact date I would be leaving. But, for the most part, I encountered careful but cheerful people who gave me information and helped me understand travel requirements of their country.

The Szeged conference was attended by academics from universities across the EU and I added more business cards and memories to my collection. As usual, some people were intrigued by my topic and others were astonished at my choice. One colleague commented that she would not want to *'touch anyone with HIV.'*

MILESTONE:

12-13 June 2008—*Creating a Culture of Change: Social Marketing's Global Initiative Against HIV/AIDS*. VII International Congress on Public and Nonprofit Marketing. Szeged, Hungary

Teesside, June 2008

By this point, my annual return to Teesside was a homecoming of sorts. Everyone at the Business School welcomed me back and my supervisors made sure I had a desk and a computer as well as access codes for my stay. With such efficiency, I was able to settle in to work the day after I arrived and moved into my room in Parkside Residence Halls, overlooking the expansive and beautiful city park. I shared a kitchen with several other summer students, including a group of Chinese undergraduates who were studying English so they could enrol in classes in the autumn. Internet access in my room was an added bonus and made it possible for me to work at all hours, even on weekends when the library had short hours.

Amid my growing mounds of data, I began to draft chapters of my thesis. My wily director of studies insisted I begin with my methodology chapter, which he knew was the most difficult and also the chapter I was secretly dreading. By the end of my residency that year, I had several chapters in various stages.

Mexico City, August 2008

At the end of the summer, I had the opportunity to attend the International AIDS Conference in Mexico City. This biannual conference was truly a world event, drawing professionals and academics from the medical and social science areas, as well as local, national, and international organisations associated with HIV/AIDS prevention and treatment efforts. About 25,000 participants gathered in Mexico City, generating worldwide publicity. The conference was a whirlwind of demonstrations, concurrent presentations, information being dispensed in every possible medium, and informal and formal discussions about all aspects of the pandemic. Pharmaceutical sponsorship was highly visible, and 'safe sex' was a recurring theme.

Competition was stiff for presentation slots at the conference, even for poster presentations. My poster focused on three campaigns from my Phase I research that targeted women. AIDS XVII offered opportunities to make contacts with people central to some of the campaigns I examined during Phase I and to conduct interviews with key informants as a continuation of my Phase II research. I especially enjoyed my interview with the co-director of Instituto Promundo, a Brazilian NGO that partners with other Latin America organisations to create and implement HIV/AIDS social marketing campaigns.

Those contacts and interviews also allowed me to update and obtain images for my book chapter in *Social Marketing for Public Health: Global Trends and Success Stories*, which would be edited by Philip Kotler, Nancy Lee, and Hong Cheng.

MILESTONE:

3-8 August 2008 –*Until AIDS Do Us Part: Social Marketing Campaigns Empower Women At Risk in Uganda, Mexico, and the United States*. XVII International AIDS Conference.
Mexico City

Huntsville, Winter 2008

After so much travel, my broken shoulder was not healing well, so I declined an invitation to return to Mexico City in October to present a paper titled *Virtual Virtuosity: How the ONE Campaign Uses Social Media to Combat Global Poverty and HIV/AIDS*, at the 2nd Congress of the Americas. Unfortunately, staying in Texas proved unsafe; in November I fell and broke my right ankle, which kept me homebound until after the first of the year. But I did finish edits and rewrites on my book chapter, parts of which would reappear in greatly shortened form as a case study in my thesis. A bright spot during that time was an email with comments from *Global Trends* editor Phil Kotler (known as the ‘father of social marketing’):

‘I am absolutely pleased with what I read. Each chapter is a treasure-trove of information, analysis, campaign description, and evaluation.’

‘My regard for the importance of the book has grown immensely. This book should have a long shelf life. The campaigns provide classic models of social marketing. Any social marketer tackling any of these issues will draw excellent guidance into developing his or her campaign.’

Huntsville, Spring 2009

This was a time when I focused on teaching my four spring term classes at Sam Houston, learned to manoeuvre on crutches and focused on getting my body back to its pre-broken condition. On the research front, I completed my Phase II work and prepared a complex poster summarising my content analysis results for a conference in Switzerland. (*All of the posters and projects mentioned in this Log are shown as subsequent appendices in this volume.*)

St. Gallen, Switzerland, June 2009

In route to Teesside that summer, I first flew to Zurich to attend the First German-Austrian Swiss AIDS-Congress SODAK 2009, '*Prepare for the Long Run.*' The conference was held in St. Gallen, an hour's train ride from the capital. In keeping with the congress theme, I had a poster presentation in the social science track that used cross tabulation matrixes summarising my content analysis research from Phase I.

This conference attracted about 800 attendees, and the second congress was already scheduled for June of 2011. Although the congress call for abstracts included both medical and social science tracks, most of the attendees were from the medical community. Several medical professionals at the congress commented to me that my research on the cultural aspects that contribute to the AIDS pandemic is equally important in the battle against the disease and should have had a more prominent role in conference discussions. I also received a number of compliments on the production of my poster, which again utilised my desktop design skills to create a poster that was more elaborate and colourful than most others on display.

Observations from attending conference sessions and from informal discussions with presenters and attendees included:

- Pharmaceutical companies were much in evidence as conference sponsors and as vendors dispensing literature and branded specialty items.
- Complacency was widely considered to be a prime enemy in the fight against HIV infection, as many people now consider that HIV/AIDS is not an automatic death sentence but can be treated with HAART therapy. (Not curable, but controllable)
- However, drug-resistant HIV is an increasing problem, fostering research and development of a host of new drugs.
- With so many drugs available, interest in CAM therapy is greatly diminished.

- However, presentations included promising reports on the efficacy of green tea extract and stem cell studies.
- Many of the new European social marketing campaigns for HIV/AIDS feature condoms as prominent elements, couples in suggestive poses, and graphic language.
- This conference primarily focused on HIV/AIDS as a biomedical problem, with culture and stigma taking a back seat.
- Condoms were repeatedly recommended as the fail-safe prevention method (and samples of various brands were available in most vendor booths).

Like AIDS XVII, this congress was a source of interesting contacts as well as the newest medical information about conventional AIDS treatments. A highlight was attending the Swiss premiere for an HIV/AIDS documentary on HIV/AIDS in Europe, *'Blissfully Lost,'* which was created by a doctor who worked at a German HIV clinic and a filmmaker from Cape Town, South Africa. I learned about the documentary by chance—the only promotion for it was on a postcard I happened to pick up in sponsor GlaxoSmithKline's booth. But the card's one paragraph caught my attention:

...28 years of public discourse, TV spots, posters, celebrity-upvalued campaigns and putting condoms over bananas have left their mark on the collective psyche. What do you think of HIV/AIDS?

My interest peaked, I took a taxi to the small art theatre where the screening was scheduled. Only a handful of people attended, but I was pleased I had gone. The documentary included interviews with a diverse group of people and was designed to inform and promote dialogue about the disease. After the screening, I met the creators of the film and spent several hours at a local watering hole getting to know the two of them and learning about their lives and projects. We have kept in touch about the possibility of screening the documentary in Houston at some point.

After the conference, it was back to Zurich for a weekend as a tourist and then a flight to Manchester and the now-familiar train trip to Middlesbrough and Teesside.

MILESTONE:

24-27 June 2009—*Working Toward a World Without AIDS: How Social Marketing Inspires Long-term Cultural Change*. First German-Austrian Swiss AIDS-Congress SODAK 2009. St. Gallen, Switzerland

Teesside, June 2009

When I reached Teesside, I learned I was now attending the 2009/10 University of the Year; Teesside had been named to this prestigious honour by Times Higher Education. It was a great achievement, especially for a so-called ‘new university’ like Teesside and there were posters and pennants everywhere. Again, I moved into Parkside Residence Halls, unpacked my one small suitcase, and connected my laptop. I was ready for my annual residency. I soon wished I had brought a fan; Middlesbrough was having a heat wave—not that hot by Texas standards, but there is little or no air conditioning in Middlesbrough, certainly not in the residence halls or in the Business School offices. Sweating (‘glowing’ as Texas ladies are supposed to say) while typing was the only choice.

However, I still managed to organise and categorise my work to date. I refined and expanded my thesis outline and continued drafting (and revising) chapters. I also updated my literature review to include several articles and books that provided fresh insights as well as reinforcement of my own findings from Phases I and II. I consulted marketing texts on survey methodology to support my own research design for Phase III, using that information as background for writing the survey methodology. And, to further order my work in the coming months, I developed a status report form for tracking my thesis progress and setting goals for each chapter.

Additionally, my Director of Studies and I revisited and re-checked my original ethical approval on 9 June 2009 and determined there had been no significant change in methodology that would impact ethical approval. This was important since I was planning a survey of patients and staff at an HIV/AIDS clinic in Houston.

The ever-expanding amount of information plus the genuine interest in my research topic from people I interviewed or consulted indicated I had chosen a significant area of study with many possibilities for making contributions to knowledge. It was also heartening that the panel of experts who pilot tested my survey expressed scholarly and professional interest in my research, asking that I share the results with them.

Houston, Autumn, 2009

Creating my survey was time-consuming, but was finally accomplished thanks to a panel of experts I assembled to pilot test the instrument. Getting permission to administer the survey at a Houston HIV/AIDS clinic was more difficult and required

persistence, persuasion, patience, and numerous meetings with clinic administrators. Five months later, approval was in hand, and I began to organise the logistics of travelling to Houston to survey clinic patients and staff. I recruited several of my undergraduate students to help with data collection. Some of the students were naturally outgoing and did not hesitate to approach everyone who came into the clinic. A couple of students were actually frightened—one told me she feared to use the restroom facilities at the clinic. Another student was horrified when she learned we would be working at an AIDS clinic. ‘*So, some of the people might actually have AIDS?*’ she asked in all seriousness.

The patients were all ages, genders (sometimes difficult to determine), and ethnic group. Their educational background ranged from high school dropout to doctorate. But HIV/AIDS was the common thread that connected them all. Some spoke very freely about their HIV/AIDS experiences; most were appreciative we were collecting information to better inform people about the disease and possible treatments. Both staff and patients commented they found information in the survey that made them realise they needed to do more research into treatment choices. Some took time to tell us their personal stories. One of my student assistants wrote this entry in his own reflective log:

‘I remember one guy in particular who came in with a huge smile on his face. When we asked him to participate in our survey, the man smiled, said no problem, and took a clipboard from my hand. As he was filling out the survey, he began to converse with us about how he got AIDS when he was a kid in high school and had no knowledge of AIDS or HIV. He said he's had AIDS for about half of his life, and that he belongs to a Houston organisation that raises money for AIDS and HIV awareness. He told me he had been working for this organisation for about 13 years and last year alone, he raised over \$100,000 for HIV/AIDS education so kids could be more aware of the disease and learn to be safer about sex so they could live the life he never got to have. He then finished the survey, handed it to me, gave me a big smile and told me thanks for what we were doing. He told us that it meant a lot and that we had no clue how big of a difference we were actually making. I think I'll always remember him and that conversation because it really did touch my heart.’

Some people were intent on taking the survey. One woman did not have her reading glasses with her and asked one of the students to read the survey so she could be included. The students kept commenting, ‘*I can't believe people are so open.*’ By contrast, a couple of patients' only question when asked to participate, was, ‘*Is there an incentive?*’ In fact, we did have a grab bag of candy and small party favours, which the respondents seemed to find a sufficient reward. There was clearly a feeling of

community at the clinic—people knew each other and were mostly positive and upbeat in their attitude toward life.

The clinic administrators were surprised at the high rate of response to our survey—we collected more than 340 valid surveys during four days. The elements that seemed to make the process go so smoothly included:

- The ‘goodie bag’ was a fun element—the silly toys and candy made people smile.
- People responded to the students and the fact the project was education based.
- A polite but persistent approach paid off.
- We had a good location in the front foyer; everyone who came in walked past us.
- We had good signage—colourful and simple in both English and Spanish.
- People liked being asked for their opinions and wanted to help with the project.

2010

Huntsville, Spring 2010

This spring was a whirlwind of research and teaching as I prepared for my annual residency, to take place in April instead of in the summer. This schedule would allow me to complete most of my thesis while I was at Teesside, do rewrites and edits over the summer and submit the final version by the end of the year. Since I would be leaving for England in the middle of the spring term, my three classes were set up as online courses—now I could teach from anywhere in the world as long as I had an Internet connection.

The biggest challenge was all that needed to be done before I left Texas. In addition to putting all of my survey data into SPSS so I could ‘crunch the numbers,’ I needed to do my reaction interviews to the survey data.

In the odd way that serendipity had so often come to my rescue since I began this project, it happened again. This time, the catalyst was a donkey named Ricardo. I am a passionate animal lover, and I learned of a no-kill animal shelter on the outskirts of Huntsville. I went for a tour, met the owner of the shelter and decided to sponsor an animal. I chose Ricardo, a beautiful donkey who had been rescued from the Grand Canyon several years ago. My monthly contribution would help keep Ricardo in donkey vittles and apple treats. I also learned the director of the shelter had been an HIV/AIDS counsellor and activist who helped found the Center for AIDS Information and Advocacy in Houston. He provided a referral to that organisation’s director, and to an

internationally known HIV/AIDS medical doctor, both who proved to be key informants for my reaction interviews.

I was also excited to receive a copy of the *Global Trends* book, which was released internationally in soft cover that spring.

MILESTONE:

Published—‘Love, Sex, and HIV/AIDS: Using Social Marketing to Redefine Gender Norms Among Mexican Youth,’ Chapter 4, *Social Marketing for Public Health: Global Trends and Success Stories*. Eds. Hong Cheng, Philip Kotler, and Nancy Lee. Sudbury, Mass.: Jones and Bartlett

Teesside, April-May 2010

On the road again: back to Teesside for my fifth—and last—residency. I was determined to work as many hours each day as I could so I would have most of my thesis written and reviewed before I returned to Texas. I took only a few items of clothing and left my cell phone at home. No distractions. So, I struggled with the SPSS data (with the help of a faculty expert in statistics), assimilated my interview data, interpreted, edited, wrote, and rewrote. And rewrote. This time I shivered in the chill air of April and was grateful for warm water in the down-the-hall bath I shared with three computer undergrads in a rented house several blocks from the university. I also continued to teach my three online classes; I graded the students’ final projects and posted their grades from England. My only leisure time was the Friday I ‘skipped school’ and took the train to my favourite Yorkshire town—Whitby, that seaside city from which my ancestor sailed centuries ago. Sitting in the train, I enjoyed anew the verdant fields, the flocks of sheep, and the quaint train station at every village. In Whitby I bought a few gifts to take to friends back in the States and ate lunch at my favourite waterfront restaurant. Then, it was time to catch the evening train back to Middlesbrough and my waiting laptop.

Huntsville, Summer 2010

The writing and re-writing continued through the summer. I was drowning in data and some days it seemed I would never find the right words to introduce, explain, and conclude each chapter. Formatting proved to be hugely time-consuming. The thesis grew to two volumes—one for the body of the thesis, the other for the six appendices, even bulkier than the main document. A perfectionist by nature, I urged myself to

remember the advice from that doctoral colloquium in Surrey three years ago: *'The perfect is the enemy of the good.'* I was determined to create a *good* thesis even if it could never be quite perfect. By the middle of August, everything was there, from abstract and acknowledgements to references and appendices. I was ready for my supervisors to do one last 'big read' before the volumes were shipped off the examiners.

While my committee members valiantly tackled my thesis, I mined the chapter on my survey results to fashion a paper, which I submitted to the 2nd World Social Marketing Conference, to be held in Dublin in April 2011.

Huntsville, Autumn 2010

In late autumn, I received this heartening email:

'I work for the Research team at The NSMC (previously the National Social Marketing Centre) which is based in London, UK. One of our resources, which is widely used within the social marketing industry, is ShowCase, an online database of social marketing case studies. We are always looking for new and innovative examples of social marketing good practice to contribute to our growing wealth of knowledge and learning. In searching for suitable projects for ShowCase I came across 'Programme H,' which you had written about in the book 'Social Marketing Public Health: Global Trends and Success Stories'. Programme H is exactly the kind of social marketing/behaviour change project we would like to write up and publish on our website.

Would you be interested in contributing to the write up of Programme H for ShowCase? Please confirm whether you would like to be featured on ShowCase.'

Of course, my response was an enthusiastic 'yes.' The case study has since been written and edited and will appear in ShowCase in 2011.

Additionally, my Dublin proposal was accepted, so I registered for the 2nd World Social Marketing Conference and marked my calendar to be in Ireland in April of 2011. I'm honoured to be one of the presenters at this international event that will feature the social marketing giants from around the world.

Aside from completing the final edits on both volumes of my thesis, I ended 2010 with one other positive note: I learned that *Global Trends* had been published in Google Books, extending its reach and usefulness as a social marketing text.

Huntsville, December 2010

Looking back...

By the time I reached the fourth stage of this research expedition, I had crossed many borders—literally and figuratively. In a literal sense I had traversed many borders, trekking outside the ubiquitous portals of the Internet to personally visit an array of countries and speak with a diverse mix of people. My travels in pursuit of a degree led to encounters with a variety of natural and man-made disasters, but delays and minor discomfort were the only tolls I paid. These events stand out in my memory:

Hurricane: Sept 2005—My travel companions and I were stuck in London because Hurricane Rita closed the Houston airport (and the rest of the city, too). Rita was the most intense tropical cyclone ever observed in the Gulf of Mexico, coming inland with winds of 120 mph. Luckily, the B&B had vacancies for an extra three days and my plastic was up to the challenge.

Terrorism: July 2007—A bomb at the Glasgow airport filled the southbound trains with travellers trying to make their flights in London, so I wedged myself onto a train to Surrey. When I was ready to head home from London on July 4, half of Heathrow Airport was closed due to another bomb threat, but my flight made it out on schedule.

Volcano: April 2010—The Iceland volcano disrupted flights in much of Europe for several weeks. I was on the first plane out of Houston to Frankfurt after five days of closures. Arriving in Frankfurt, I became part of an ocean of people. I saw rooms of cots where people had been sleeping for days, and learned there were no flights to England. By mere chance I discovered my airline, Lufthansa, was running a few buses to major European airports. I managed to get the last seat on a bus headed for London. For 12 hours we rolled across Europe with two 10-minute rest stops. At midnight, we crossed the channel at Dover, and then were deposited at Heathrow at 2 a.m. to make our way to our final destination. I spent the rest of the night sitting in Heathrow airport and visiting with a journalist from Birmingham who was on same bus. When morning came, we took the underground to the central train station, where I purchased a ticket to Middlesbrough. I was immensely grateful to be in England and not sleeping on a cot in the Frankfurt airport.

But most of all, I am grateful to the many people who offered encouragement, advice, information, and insights. I met supportive and interesting people on trains, planes, and buses. Helpful people showed up at my office door in Texas, at my work

cubicle in Teesside, and at each conference I attended; my casual reading provided important links to people with diverse perspectives on my topic.

On a personal level, I travelled beyond my comfort level and was prompted to extend my range of empathy and tolerance in ways I never before contemplated. Through it all, life went on, with its large and small triumphs and tribulations: financial problems, divorce, death of a parent, work crises, and losses of long-time friends and pets.

On an academic level, I had journeyed across continents of knowledge previously unknown to me, emerging with a fuller understanding of just how much I still did not comprehend.

When I called a temporary halt in my travels to reflect and record, I realized I had only charted a miniscule region; there are worlds more to explore.

APPENDIX B
CONTENT ANALYSIS AND INTERVIEW DOCUMENTS

- B.1** Questionnaire to assess campaigns for content analysis
- B.2** Summary fact sheet for content analysis campaign (sample)
- B.3** Summary of the 18 campaigns used for content analysis
- B.4** Question bank for pre-survey interviews – Mexico
- B.5** Question bank for pre-survey interviews – Houston
- B.6** Question bank for reaction interviews (post-survey)
- B.7** List of exploratory research interviews
- B.8** List of key informants interviewed – pre-survey
- B.9** List of key informants interviewed – post-survey

APPENDIX B.1 Content Analysis

Social Marketing Campaign Name:

Description:

Year Began:

Country:

- Mexico
 Uganda
 United States

Specifically Disseminated: _____

Sponsorship:

- Government dept (s) _____
 International organization(s): _____
 for –profit corporation / business(s): _____
 industry association (s): _____
 pharmaceutical company (s): _____
 educational institution(s): _____

Specific intended target group:

- no, campaign is aimed at a mass audience
 yes, campaign is aimed at a very specific group

Is a specific group being targeted?

- men who have sex with men
 teens/young adults
 sex workers
 people living with AIDS
 mature adults (30-64)
 parents
 at-risk groups
 other: _____

Is a specific gender being targeted?

- no; n/a
 males specifically
 females specifically

Are there any other identifying characteristics of the group being targeted?

- n/a; no other identifying characteristics
 yes – Specifically: _____

Type of Mixed Media Used:

- billboards
 banners
 cartoon / comics
 discussion groups
 forums
 literature / printed materials
 postcards

NAME

FALL 2006

- posters
- radio commercials (Length: _____)
- television ads (Length: _____)
- training
- videos
- workshops
- other: _____

Messages Presented:

Slogan/Tag Line:

Message Recommendations / Purpose (check all that apply):

- none
- "safe sex"
- protect yourself/take care of yourself
- use condom
- fewer partners/avoid multiple partners
- monogamy/one partner
- abstinence
- get tested
- don't share needles
- don't be afraid of getting AIDS through casual contact situations
- take responsibility
- learn the facts/know the facts
- write for info
- phone for info
- pick up information/brochure/pamphlet
- get help/counseling/treatment
- see your doctor
- talk to your parents
- talk to your kids
- give money/donation
- other: _____

Other Notes on Purpose:

Call to Action Present:

- no
- yes

Role of Spokesperson:

- n/a/not sure
- announcer
- singer
- average/neutral person
- first-hand experience
- victim/survivor/friend of victim
- expert

NAME

FALL 2006

- authority figure
- government / political official
- community leader
- celebrity
- cartoon figure
- other: _____

Name of Celebrity(s): _____

If authority figure, expert, community leader, or government official, what occupation?

- n/a
- police officer
- fire fighter
- judge
- teacher/professor
- minister/priest
- doctor
- nurse
- Other: _____

Spokesperson Characteristics:

Sex:

- n/a or not sure
- male
- female

Age:

- n/a or not sure
- child
- teenager
- young adult (18-30)
- mature adult (30-64)
- elderly (65+)

Race:

- n/a or not sure
- white
- black
- Hispanic
- Asian
- Other: _____

Reference to Cultural Roots:

- No/not sure
- Yes

If yes, cite specific examples:

- Language
- Country/area flag or seal
- Clothing / style

NAME

FALL 2006

- Music
- Lifestyle
- Other: _____

Product Promotion:

- No/not sure
- Yes

If yes, what is the product(s)?

- Book/literature
- Condoms – male
- Condoms – female
- Treatment Kits
- Video
- Other: _____

Types of Appeals Present (Check all that apply): Evidence of Appeals on Page 5

- Decision-making
- Fear
- Positive / rational
- Self-interest
- Social-cognitive
- Sustainable development
- Two-step flow

Overall Tone of Message:

- Negative (threat, fear, sad)
- Neutral
- Positive (up-beat, humor)
- Not sure

Social Marketing Elements:

Product / Solutions: Is there a clear social marketing product being offered?

- No
- Yes – Specifically: _____

Is there an “actual product” being offered?

- No
- Yes – Specifically: _____

Is there an ‘augmented product’ being offered

- No
- Yes - Specifically: _____

Price / Value: Are issues of price addressed?

- No
- Yes – Specifically: _____

Promotion / Information: Is adequate information being offered?

- No
- Yes – Specifically: _____

NAME

FALL 2006

Placement / Access: Are place and placement issues addressed?

No

Yes – Specifically: _____

Other Campaign Notes:

Evidence of Appeals:

Appeal:

- _____
- _____
- _____
- _____

Appeal:

- _____
- _____
- _____
- _____

Appeal:

- _____
- _____
- _____

APPENDIX B.2

Sugar Daddies

Description:	Working to stop cross-generational sex, which is sex with a person at least 10 years older
Currency:	Began in 2004 - 2005
Int'l Orgs:	PSI, National AIDS Committee
Pharm Co.:	None Mentioned
Purpose:	Sugar Daddy relationships are a major reason why HUV infection rates are up to 6 times higher for teenage girls than their male counterparts. Also to break the silence, raise public awareness of dangers involved, and change societal views (PSI Profile)
Target Audience:	Young women (15 – 24), their parents, and older male partners
Where Dissem.:	Uganda, Cameroon, Kenya, in schools
Media Mix Used:	Television, radio, print, seminars (with media coverage of the seminars) (PSI Profile). Government-sponsored posters, offering chastity scholarships, radio soap opera (CSM).
Msgs Present:	Sugar Daddy + Young Girl = Danger (PSI Profile). Golden Rule approach (CSM). Also, saving yourself for marriage is the right thing to do (GHF)
Use of Celebrities:	Yes, Tim Lwanga, Uganda's Minister of Ethics and Integrity. Also Archbishops (PSI)
Refs to Roots:	Having a sugar daddy could be a root, as it is a societal norm
Prod. Promotion:	Deemphasize condoms

APPENDIX B.3

Summary of the 18 campaigns used for content analysis

MEXICO

1. *Investing in People*

This five-year initiative to reduce barriers to behaviour change and care seeking began in 2003. It was a localised version of a series of similar campaigns that were underway in several countries. Focused in Mexico City, where the largest number of HIV/AIDS cases were found, *Investing in People* was the joint effort of a half-dozen international, national, and local organizations. A key technique was personal communication through workshops and conference presentations conducted by trained female advocates and local HIV/AIDS leaders (<http://www.usaid.gov/policy/budget/cbj2006/lac/pdf/mx523-023.pdf>).

2. *VIDA Menos Etiquetas*

Sponsored by Population Services International-Mexico, this gender-equity initiative incorporated the research and successful techniques of *Programas H* and *M* to reach young people at risk. *Menos Etiquetas* used peer educators to initially broach themes that included gender norms, HIV/AIDS, and stigma. A traditional media mix including posters, postcards, stickers and flyers was teamed with below-the-line social media such as blogs and Bluetooth viral marketing (<http://www.psi.org/mexico>).

3. *Programa Hombres (Project H)*

Links between traditional gender attitudes and the spread of AIDS prompted a partnership of NGOs to develop *Programa Hombres*. This five-year initiative has been used in more than twenty countries, including Mexico, to persuade young Latino men to question traditional norms related to manhood. An extensive media mix included educational videos available in three languages—Spanish, English, and Portuguese—interactive workshops, and collateral materials as well as radio, outdoor media, and direct mail. The campaign slogan, '*In the Heat of the Moment*,' urged use of the Hora H condom brand, manufactured by the makers of Durex condoms and distributed in non-traditional venues such as funk balls and cafes (www.promundo.org.br).

4. *Programa Mujeres (Project M)*

Building on their success in educating young men about the costs of traditional macho culture, in 2005 the Program H partners and World Education launched *Programa Mujeres* to encourage young women to take control of their sexual and reproductive health. This social marketing campaign was based on research that included a review of Latin American literature to define the concept of female empowerment, focus group discussions with groups of young women aged 14-24 who lived in marginalised communities outside Queretaro, Mexico, and interviews with empowered young women (www.promundo.org.br).

5. *Tú No Me Conoces (You Don't Know Me)*

The *Tú No Me Conoces* social marketing campaign promoted awareness of HIV risk and testing of Latinos living on the California-Mexico border. The 8-week campaign included Spanish-language radio, print media, a website, and a toll-free HIV-testing referral hotline. Campaign results included an increase in HIV testing at partner clinics; 28% of testers who heard or saw an HIV advertisement specifically identified the campaign. (<http://www.docstoc.com/docs/43661964/Southern-California-Border-HIVAIDS-Project-TU-NO-ME-CONOCES>).

6. *VIDA Digna (Life with Dignity)*

Reducing stigma and discrimination experienced by sex workers, gay men, men who have sex with men, drug users, and people living with AIDS was the central purpose of the three-year *Vida Digna* campaign, launched in 2005 by the Colectivo Sol alliance and funded by GlaxoSmithKline. The campaign was centred in the central states of Mexico, a conservative area characterised as having '*the weakest civil society response to AIDS.*' *Vida Digna* used anonymous testimonials to urge tolerance and acceptance of people's differences (<http://www.aidsalliance.org/sw45511.asp>).

UGANDA

1. *ABCs (Abstinence, Being Faithful and Condoms)*

This campaign took a moralistic approach—'*Sex can wait until marriage*'—and used outdoor media as well as local spokespeople such as community leaders and ministers to urge abstinence before marriage and fidelity to spouses. Practical AIDS information was provided and condom use was also advocated to reduce risk of infection. This program and others like it have generated international controversy about whether condoms are effective in reducing HIV prevalence and raising associated concerns about increased promiscuity (<http://www.pbs.org/now/science/aidsdebate.html>).

2. *Afford Good Life*

AFFORD was a five-year health marketing initiative led by the Johns Hopkins Bloomberg School of Public Health and funded by the U.S. Agency for International Development. Designed to increase accessibility and affordability of AIDS products and services, the campaign promoted Protector brand condoms, Pilpan oral contraceptives, and Inject injectable contraceptives. Consumers were encouraged to use these products properly and could access them at subsidised rates. A centrepiece of the campaign was '*The Good Life Gameshow,*' an entertainment education quiz show using an integrated multimedia approach, including community interaction, and radio and television shows (<http://www.jhuccp.org/africa/uganda/afford.shtml>).

3. *Be a Man*

Targeted primarily to young men 15 to 24, this campaign was launched in 2006 to prompt reflection on the costs of traditional male attitudes and behaviours, which research has shown contribute to an increase in HIV infections. '*Society's expectations of men are setting them up for failure,*' according to Vincent Kiwanuka, the *Be a Man* campaign's coordinator. The media mix heavily utilised radio drama and television, including broadcasts during the World Cup. The goal was to encourage sexual relationships based on mutual respect and love (<http://www.hcpartnership.org/Press/press2006-06-21.php>).

4. *Onelove*

Launched in January 2009, the South African *Onelove* campaign aimed to reduce new HIV infections in South Africa by 10% by 2011. The focus of the campaign, led by Soul City Institute for Health and Development Communication, was on multiple concurrent partnerships (MCP), one of the key drivers of the HIV pandemic in Southern Africa. The campaign's goal was to shift social norms away from multiple sexual partnerships and encourage monogamous relationships. *Onelove* challenged gender stereotypes and cultural norms that reinforce MCP and highlighted the risks associated with transactional, drunk, and intergenerational sex. The campaign used

mass media, including the Soul City television drama series, a radio drama, print materials, and social mobilisation and advocacy (<http://www.comminit.com/en/node/286237/347>).

5. PMTCT (Prevention of Mother to Child Transmission)

'*The Social Marketing Approach to PMTCT*' is a Population Services International [PSI] project that used a branded franchise network of trained midwives to help pregnant women reduce transmission risk during birth. The midwives were also trained on HIV testing procedures and counselling skills. The central message of this campaign was it is possible to have an HIV-negative baby even when both parents are HIV positive. Since 2003, a broad media mix has disseminated this message to male partners of pregnant women 25-45, primarily in low-income, low-literary, peri-urban, and rural areas of Uganda (<http://www.psiwash.org/resources/pubs/Uganda2004.pdf>).

6. Sugar Daddies

Addressing the widespread problem of cross-generational sex (sex with a person at least 10 years older), this campaign, begun in 2004, sought to raise awareness of the dangers of 'sugar daddy' relationships. This practice is a major reason HIV infection rates have been six times higher for teenage girls than for their male counterparts. Target audiences include young women 15 to 24, their parents (who often encourage such relationships), and older male partners. The PSI-sponsored initiative features recognised male role models such as Uganda's Minister of Ethics and Integrity Tim Lwanga urging men to '*stop preying on young girls*' (<http://psi.org/resources/pubs/cross-gen.pdf>).

UNITED STATES

1. Be the Generation

This program aimed to create a supportive environment for HIV vaccine research by mobilizing existing community partnerships and networks to educate key communities about this research in 20 U.S. cities where HIV vaccine clinical trials were ongoing or planned. Coordinated media and collateral materials segment targeted audiences by gender, ethnicity, and lifestyle, showing images of two people, one older and one younger. Extensive educational materials were available online. The uniform message was the young generation's '*great cause*' is to end AIDS and that a vaccine is the best hope of accomplishing that goal (www.bethegeneration.org).

2. I am African / (Keep a Child Alive)

This campaign, heavily saturated with celebrities, promoted the idea that everyone has some DNA with connections to an African heritage, so all people should work together to help with the AIDS problem. Begun in 2005, donations for AIDS drugs were particularly sought. *I am African* was linked with the *Keep a Child Alive* campaign, which sought to help AIDS orphans in Africa by providing them with ARVs [treatment cocktails]. The *I am African* images of celebrities such as Gwyneth Paltrow and Sting wearing 'war paint' with the campaign slogan beneath sparked controversy about the use of eye-catching visuals that '*insensitively perpetuate stereotypical ways of thinking about AIDS or Africa*' ([www.keepachildalive.org; http://percipere.typepad.com/media/2006/08/cause_celebre_o.html](http://percipere.typepad.com/media/2006/08/cause_celebre_o.html)).

3. *MTV Think*

This award-winning public information campaign began in 2006 and was notable for bringing MTV on board as a major sponsor. The goal was to reach sexually active 16- to 24-year-olds with information about HIV and related issues, since according to UNAIDS, half of new HIV infections worldwide are among people under the age of 25. Discussion of safe-sex issues, condom use, and HIV testing were urged through television and web media. According to sponsor The Kaiser Family Foundation, this was a *'multi-platform, interactive community for the first generation of Americans who have lived their entire lives during the AIDS epidemic'* (<http://www.kff.org/hivaids/hip060506nr.cfm>).

4. *The New Faces of HIV in Houston*

Due to HIV high prevalence among African Americans in Houston, in 2002 the Harris County Hospital District and the Houston Department of Health and Human Services launched a social marketing campaign to raise awareness and increase testing among this population. Media included radio, public transit, direct mail, and brochures targeting women. Images of both men and women were featured in the materials, with the slogan, *'We look just like you, but you don't have to be like us. Do the right thing. Get tested'* (<http://www.hchdonline.com/HIV/newfaces.htm>).

5. *ONE*

With more than 60 partners, this campaign was set up to rally Americans one by one to push for increased donations to fight poverty and AIDS. The campaign had a broad target audience, ranging from students to ministers to punk rockers to soccer moms. The call to action was *'We're not asking for your money, we're asking for your voice.'* In line with this approach, on June 11, 2007, ONE launched ONE Vote '08, its *'largest and boldest initiative ever,'* vowing to make extreme poverty and global disease an issue in the 2008 U.S. elections (www.one.org).

6. *We all have AIDS*

Launched in 2005 on World AIDS Day, this campaign created by American designer Kenneth Cole was heavily supported by celebrities and prominent AIDS activists. The message was to reduce stigma associated with AIDS to prevent, contain, and eradicate the disease. The consistent theme for all ads was *'We all have AIDS...if one of us does.'* International celebrities participating included President Nelson Mandela, Arch Bishop Desmond Tutu, Sharon Stone, Will Smith, and Sir Elton John (www.WeAllHaveAIDS.com).

APPENDIX B.4

Using Social Media as a Health Promotion Tool: The Mexican Experience

Date: _____

Code: _____

1. What is your academic or professional background?
2. Describe the health organization you work for.
3. What health campaigns have you been involved with?
4. What has been your role in those campaigns?
5. Background and rationale behind the campaign approach?
6. Can you describe those campaigns?
 - a. What was the target audience or target market? Describe its characteristics.
 - b. When was the campaign executed? Scope/timeframe of campaign?
 - c. What kind of research was conducted before designing the campaign?
 - d. Who designed the campaign?
 - e. What have you learned by executing this campaign?
 - f. What were this campaign's objectives?
 - g. What were the messages disseminated? Why did you choose those messages?
 - h. Who were the sponsors/partners? How were they selected?
 - i. Were there medical advisers/image consultants, etc?
 - j. Campaign strategies—which were most effective? (might include policies, internal PR, etc)
 - k. What media outlets were used to disseminate information? Which were more effective?
 - l. Was social media used? If so, who decided to use it? Have anybody assessed the used of social media?
 - m. Who sponsored the campaign?
 - n. Budget/funding sources?
 - o. How do recipients of information perceive their choices as regards prevention techniques and treatment modalities?
 - p. What are their unanswered questions, gaps in knowledge?
 - q. How is campaign evaluation conducted? (Is there a written report available?)
 - r. Role of controversy/political concerns in getting funding/approval for campaigns?
 - s. The most important lessons learned? What will you do differently in future campaigns?
 - t. Trends you see in the use of social marketing campaigns for disease preventions/information?
 - u. Possible to get samples of materials? (Okay to reproduce images?)

APPENDIX B.5
Question bank for pre-survey interviews (Houston)

1. Briefly, please talk about your professional background as it relates to HIV/AIDS.
2. How long have you been working with fundraising/communications efforts to combat HIV/AIDS in Houston?
3. Which techniques have you found are most effective in gaining the support of Houston policymakers/upstream audiences?
4. Did you participate in developing the rationale behind the campaign approach for *New Faces of Houston*?
5. Was it difficult to make the decision to be pictured in the campaign literature? (Only addressed to interviewees who were pictured in the campaign)
6. What kinds of problems has being a spokesperson for the campaign created for you? (Same as #5)
7. How important are sponsors/partners to successful HIV/AIDS campaigns?
8. Which kinds of campaign media strategies do you think are most effective in Houston?
9. How do recipients of HIV/AIDS information perceive their choices as regards prevention techniques and treatment modalities in this city?
10. What are their unanswered questions, gaps in knowledge?
11. In your experience, what is the role of controversy/political concerns in getting funding/approval for campaigns in Houston?
12. What do you think were the most important lessons learned in this campaign?
13. What would you like to see done differently in future HIV/AIDS campaigns?
14. What trends do you see in the use of social marketing campaigns for HIV/AIDS prevention/information?
15. Is there anything you would like to add that I have not asked?

APPENDIX B.6
Question bank for reaction interviews (post survey)

1. Briefly, please talk about your professional background as it relates to HIV/AIDS.
2. What are your initial reactions to the Legacy Clinic survey results? (Interviewer summarises highlights of results and shows charts of result trends).
3. Regarding HIV/AIDS in Houston: What kinds of support have been provided by local or national policymakers?
4. What techniques/approaches have been most effective in getting support?
5. How important are sponsorships/partnerships in combating HIV/AIDS?
6. Do those sponsorships influence which products and treatments are considered mainstream? If so, how?
7. What is the role of controversy in getting messages out about HIV/AIDS?
8. After 30 years, what are the most important things we have we learned in the area of (medical, marketing, advocacy) for prevention and treatment of HIV/AIDS?
9. Where do we go from here? What would you like to see done differently in the future regarding (medical, marketing, advocacy?)
10. In general, how effective do you think social marketing campaigns are in motivating people to change their behaviour regarding preventing HIV/AIDS?
11. Can social marketing campaigns motivate lifestyle changes regarding treatments for HIV/AIDS?
12. Is there anything you would like to add that I have not asked?

APPENDIX B.7
List of exploratory research interviews
2005-2010

Dr. S.K. Banerjee, Homeopathic Physician, Kolkata, West Bengal, India. *Email and telephone communication, June 2007.*

Kemper B. Crabb, Director of the Order of Servants of the King, a charity organisation that builds churches, schools, orphanages, and hospitals in remote areas of India, Nepal, and Uganda. *Personal interview, March 2007.*

Sameer Deshpande, PhD, Assistant Professor, Marketing, University of Wisconsin, and Faculty member, Centre for Socially Responsible Marketing, Lethbridge, Alberta, Canada. *Personal communication, October 2006.*

Tugba Kalafatoglu, Tugba Kalafatoglu and Associates, Istanbul, Turkey. *Personal communication, October 2007.*

Dr. Susan Kern, Principle investigator, 'Lazarus Study: HIV/AIDS Interaction with HIV/AIDS.' *Personal interview, June 2006.*

James Kiwanuka-Tondo, Assistant Professor, Department of Communication, North Carolina State University, Raleigh, NC. *Personal and email communication, October 2006.*

Dr. Jesus Meza Lueza, Profesor- Investigador, Comunicadio Y Periodismo, Campus Ciudad de Mexico. *Personal communication, August 2006.*

Laura McDermott, Research Officer, Institute for Social Marketing, University of Stirling & The Open University, Stirling, Scotland. *Personal interview, June 2006.*

John Harold Estrada Montoya, Profesor Investigador, Salud Pública, VIH/SIDA, Ciudad Universitaria, Bogota, Colombia. *Personal communication, August 2006.*

David Olson, Director of Public Affairs, Population Services International, Washington, DC. *Personal communication, August 2008.*

Lars Ivar Ovesen-Lein Borge, HIV/AIDS Activist and conference organiser, Mexico City. *Personal interview, December 2006.*

Andrew Waldhausen, Director, Gay & Lesbian Network, South Africa. *Personal interview, August 2008.*

Agustín Villalpando, Editor, *Enkidu Magazine*, Mexico City. *Personal communication, December 2006.*

APPENDIX B.8
List of key informants interviewed—pre-survey

TEXAS/USA

Françoise Armand, Social Marketing and Pharmaceutical Partnerships Director, Private Sector Partnerships One, Bethesda, MD. *Email communication, March 2008.*

Dr. Carlos Arreola, a long-time HIV/AIDS counsellor and activist in the Houston area. Helped found the CFA (see glossary). *Personal interview, March 2009.*

Barbara Bijelic, Research Assistant, PSP-One Program, International Health Division, Bethesda, MD. *Email communication, January 2008.*

Susan Diemont-Conwell of Torma Communications in Houston helped design the campaign, *New Faces of HIV in Houston*. *Telephone and email interviews, January 2008.*

Dena Gray, a Houston activist and administrator for Houston's Housing and Community Development Department, an agency that locates housing for people living with HIV/AIDS. She is responsible for public service funds totalling approximately \$12 million annually. Gray was also pictured in the *New Faces of HIV in Houston* campaign. *Email interview, January 2008.*

Maria de la Luz Martinez, Translation consultant, Austin, Texas. *Email and telephone communication, May 2008.*

Beau J. Mitts, Manager, HIV Prevention Program, City of Houston. *Personal interview, January 2008.*

Ken Malone, HIV Testing Project Coordinator, Thomas Street Health Centre, Houston, TX. *Personal interview, September 2009.*

Eric Roland, Senior Director of Marketing, Legacy Community Health Services, Houston, TX. *Telephone and email interviews, February 2008.*

Karen Russell, Incremental Marketing, Inc., Clear Lake Shores, TX. *Email interview, February 2008.*

Dr. Blair Winegar, Conventional medical doctor who completed his training in Texas. *Personal communication, October 2009.*

Sandy Won, International Center for Research on Women (ICRW), Washington, DC. *Email communication, February 2009.*

EUROPE

Dr. Nele Jensen, who worked at an HIV/AIDS clinic in Germany, co-directed a documentary of interviews with HIV-positive people from all walks of life. *Personal interview, June 2009.*

Daréll Lourens, a South African filmmaker who filmed and edited The HIV/AIDS documentary, *Blissfully Lost*, which was financed by GlaxoSmithKline and was screened at the 2009 German-Austrian-Swiss AIDS Congress in St.Gallen. *Personal interview, June 2009.*

Elizabeth Sutherland, PhD, Associate Scientist II, Health Services Research, Family Health International, Durham, NC. *Personal communication, June 2009.*

MEXICO/LATIN AMERICA

Pepe Aguilar, Director, DEMYSEX, Mexico. *Email communication, May 2008.*

Hilda Peñaloza Andaluz, Coordinadora Administrativa, Population Services International, México. *Email communication, February 2009.*

Gerardo Ayala, Salud y Genero, Mexico. *Email communication, February 2009.*

Gary Barker, PhD, Executive Director/Diretor Executivo, Instituto Promundo, Rio de Janeiro, Brasil. *Email communication, April 2008.*

Alejandro Brito, Director, LETRA S, Mexico. *Email communication, May 2008.*

Oliver LeTouzé, Director, PSI México. *Email and telephone communication, April 2008.*

Anna Luiza, Promundo Instituto, Brasil. *Email communication, February 2009.*

Alejandra Megloli, Director, Mexfam, Mexico. *Email communication, May 2008.*

Marcos Nascimento, Co-Director, Promundo Instituto, Brasil. *Email and telephone communication, May 2008.*

Lars Ivar Owesen-Lein Borge, HIV/AIDS Activist and conference organiser, Mexico City. *Personal interview, August 2008.*

Christine Ricardo, Co-Director, Promundo Instituto, Brasil, *Email and personal interviews, August 2008.*

Agustín Villalpando, Editor, *Enkidu Magazine*, Mexico City. *Personal communication, August 2008.*

APPENDIX B.9

List of key informants interviewed post-survey (reaction interviews)

Dr. Jacques Clermont, Collaborator for INSERM, France's National Institute of Health and Medical Research, commented from the perspective of an alternative medical doctor doing research and working with HIV/AIDS patients.

Tina Megdal, Senior Director of Client Services, Legacy Clinic in Houston, provided observations on the results of the survey at Legacy.

Amy Leonard, Health Educator for Legacy Clinic in Houston, provided observations on the results of the survey at Legacy.

Dr. Mark Nichols, Vice President of Clinical Affairs for the Bering Dental Clinic in Houston, commented from the perspective of a conventional medical doctor working with HIV/AIDS patients.

Paul Simmons, Executive Director of the Center for AIDS Information and Advocacy (CFA) in Houston, commented from the perspective of a long-time HIV/AIDS activist.

Note: All were personal interviews, which took place in Houston in March and April of 2010.

APPENDIX C
SURVEY DOCUMENTS

- C.1** Research Subject Informed Consent Form
- C.2** HIV/AIDS Knowledge and Perceptions Survey (English)
- C.3** Survey: Versions 9.2, 9.3, and 9.4 of Page 2
- C.4** HIV/AIDS Knowledge and Perceptions Survey (Spanish)
- C.5** Survey Consultants
- C.6** Guidelines for Survey Data Collection
- C.7** Facsimiles of the Survey Signs (English) (Spanish)
- C.8** Comments from Legacy Survey Respondents

APPENDIX C.1
Research Subject Informed Consent Form

Title of Project:

Social Marketing Strategies for Combating HIV/AIDS in Rural and Disadvantaged Communities in Uganda, Mexico, and the Southern United States

Prospective Research Subject:

Read this consent form carefully and ask as many questions as you like before you decide whether you want to participate in this research study. You are free to ask questions at any time before, during, or after your participation in this research. There will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate.

Purpose and Procedures:

You are being asked to participate in a research study designed to evaluate your knowledge and perceptions about HIV/AIDS. Your responses will help guide the design of a model for effectively disseminating information about HIV/AIDS.

This survey is being administered to a sample of people whose principal commonality is that they are all receivers of information about prevention techniques and treatment modalities available for HIV/AIDS. You should not experience any discomfort as a result of participating in this study and you can decline to answer any question. Your responses will be strictly anonymous; they cannot be connected to you in any way. If this research is published, no information that would identify you will be written. You may stop the survey at any time.

This survey is part of a research project being conducted by a Ph.D. candidate at the University of Teesside in Middlesbrough, England. For questions or concerns regarding this research, contact Ruth Massingill at 80 Waterwood, Huntsville, Texas 77320, or at 1-936-581-1322.

Authorization:

I have read and understand this form, and I consent to voluntarily participate in this research study. I understand I will receive a copy of this form. I realize I am free to withdraw my consent and to withdraw from this study at any time without negative consequences.

Participant Name (printed): _____

Participant Signature:

Date:

HIV/AIDS Knowledge and Perceptions Survey

This is part of a research study regarding knowledge and perceptions about HIV, HIV/AIDS, and/or AIDS (referred to as HIV/AIDS in this survey). Your responses will help guide the design of a model for effectively informing people about HIV/AIDS.

- I. Are you 18 or older? (If not, stop survey.)**
- II. Have you seen or heard information about prevention and treatment of HIV/AIDS? (If no, stop survey; if yes, proceed.)**

A. From which of these sources have you learned about HIV/AIDS in the past 4-5 years? Check ALL that apply.

- | | |
|--|--|
| <input type="checkbox"/> 1. TV
<input type="checkbox"/> 2. Radio
<input type="checkbox"/> 3. Books
<input type="checkbox"/> 4. Newspapers
<input type="checkbox"/> 5. Magazines
<input type="checkbox"/> 6. Out of home (billboards, transit ads, posters, flyers, brochures)
<input type="checkbox"/> 7. Events (seminars, workshops, conferences)
<input type="checkbox"/> 8. Medical websites
<input type="checkbox"/> 9. HIV/AIDS groups' websites
<input type="checkbox"/> 10. Blogs, online bulletin boards | <input type="checkbox"/> 11. Online newsletters, journals, etc
<input type="checkbox"/> 12. Emails
<input type="checkbox"/> 13. Social media (Facebook, Twitter, etc)
<input type="checkbox"/> 14. Community organizations
<input type="checkbox"/> 15. Religious organizations
<input type="checkbox"/> 16. Educational institutions
<input type="checkbox"/> 17. Conventional medical doctors
<input type="checkbox"/> 18. Alternative medical doctors
<input type="checkbox"/> 19. Friends or family members
<input type="checkbox"/> 20. People you work with
<input type="checkbox"/> 21. Other (Specify) _____ |
|--|--|

B. Using the scale below, rate each of these sources of HIV/AIDS information according to how credible (believable) they have been in your experience.

	Not at all credible	Somewhat credible	Undecided	Credible	Extremely credible
1. TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Radio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Newspapers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Magazines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Out of home (billboards, bus ads, posters, flyers, brochures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Events (seminars, workshops, conferences)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Medical websites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. HIV/AIDS groups' websites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Blogs, online bulletin boards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Online newsletters, journals, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Emails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Social media-Facebook, Twitter, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Community organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Religious organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Educational institutions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Conventional medical doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Alternative medical doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Friends or family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. People you work with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Other (Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Please check the response that best represents how you feel about these statements:

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Sure
1. Poor people are more likely to get HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Globally, the number of people with HIV/AIDS is decreasing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. HIV/AIDS is primarily a gay disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Getting HIV/AIDS is usually a death sentence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Antiretroviral drugs are a cure for HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. People who knowingly expose others to HIV/AIDS should be prosecuted as criminals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. You cannot get HIV/AIDS during sex if condoms are always used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. HIV/AIDS is God's way of punishing the wicked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. An effective HIV/AIDS vaccine is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Alternative medical treatments for HIV/AIDS have shown promising results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. People with HIV/AIDS deserve the same rights in the workplace as other workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Treating HIV/AIDS is a lucrative business for pharmaceutical companies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. HIV/AIDS infections are often the result of immoral behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. It is biologically easier for women to get HIV/AIDS than it is for men.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. HIV/AIDS prevention efforts often receive more funding than treatment efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Young people under 25 account for almost half of new HIV/AIDS infections globally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I am not personally worried about getting HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Please mark ALL of the following HIV/AIDS treatments that you have heard of.

- | | |
|--|---|
| <input type="checkbox"/> 1. UVBI (Ultraviolet blood irradiation) | <input type="checkbox"/> 11. Peroxide-IV |
| <input type="checkbox"/> 2. Silver colloid-IV | <input type="checkbox"/> 12. Peroxide-oral |
| <input type="checkbox"/> 3. Silver colloid-oral | <input type="checkbox"/> 13. Venus flytrap-oral |
| <input type="checkbox"/> 4. Selenium liver support-oral | <input type="checkbox"/> 14. Porcine (pig) liver extracts-transdermal |
| <input type="checkbox"/> 5. Chelation-IV | <input type="checkbox"/> 15. Nutritional supplements |
| <input type="checkbox"/> 6. Chelation-oral | <input type="checkbox"/> 16. AZT (Azidothymidine) |
| <input type="checkbox"/> 7. Vitamins-IV | <input type="checkbox"/> 17. HAART (Highly active antiretroviral therapy) |
| <input type="checkbox"/> 8. Vitamins-oral | <input type="checkbox"/> 18. Pharmaceutical antibiotics (Bactrim, etc) |
| <input type="checkbox"/> 9. Minerals-IV | <input type="checkbox"/> 19. Other (Specify) _____ |
| <input type="checkbox"/> 10. Minerals-oral | |

E. Based on your own knowledge or experience, please mark ALL of the following HIV/AIDS treatments that you think can be effective in treating HIV/AIDS.

- | | |
|--|---|
| <input type="checkbox"/> 1. UVBI (Ultraviolet blood irradiation) | <input type="checkbox"/> 11. Peroxide-IV |
| <input type="checkbox"/> 2. Silver colloid-IV | <input type="checkbox"/> 12. Peroxide-oral |
| <input type="checkbox"/> 3. Silver colloid-oral | <input type="checkbox"/> 13. Venus flytrap-oral |
| <input type="checkbox"/> 4. Selenium liver support-oral | <input type="checkbox"/> 14. Porcine (pig) liver extracts-transdermal |
| <input type="checkbox"/> 5. Chelation-IV | <input type="checkbox"/> 15. Nutritional supplements |
| <input type="checkbox"/> 6. Chelation-oral | <input type="checkbox"/> 16. AZT (Azidothymidine) |
| <input type="checkbox"/> 7. Vitamins-IV | <input type="checkbox"/> 17. HAART (Highly active antiretroviral therapy) |
| <input type="checkbox"/> 8. Vitamins-oral | <input type="checkbox"/> 18. Pharmaceutical antibiotics (Bactrim, etc) |
| <input type="checkbox"/> 9. Minerals-IV | <input type="checkbox"/> 19. Other (Specify) _____ |
| <input type="checkbox"/> 10. Minerals-oral | |

F. Demographics (For statistical purposes only—your responses are anonymous.)

1. Age Group: 18-25 26-36 37-47 48-58 59+
2. Which gender do you most identify with? Male Female
3. Sexual orientation: Heterosexual Homosexual Bisexual Prefer not to say
4. Which of the following groups do you most identify with? (Check only one.)
- | | |
|--|--|
| <input type="checkbox"/> American Indian, Alaska Native
or Pacific Islander | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Asian/Asian American | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Black/African American or Negro | <input type="checkbox"/> Multi-racial |
| | <input type="checkbox"/> Other (Specify) _____ |
5. Which of the following best describes your education level? (Check only one.)
- 8th grade or less
- Some high school
- Graduated high school/have my GED
- Graduated from college
- Master's degree or above
6. Religious affiliation: _____ Prefer not to say
7. Are you in a paid position with an organization involved with HIV/AIDS? Yes No
8. Are you an unpaid volunteer with an organization involved with HIV/AIDS? Yes No
9. My HIV status is: Negative Positive Don't know Prefer not to say

G. Other comments (Use back of page if needed)

Thanks for your participation!

C. Please check the response that best represents how you feel about these statements: (V9.2)

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Sure
1. HIV/AIDS is God's way of punishing the wicked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Getting HIV/AIDS is usually a death sentence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Globally, the number of people with HIV/AIDS is decreasing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor people are more likely to get HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. HIV/AIDS prevention efforts often receive more funding than treatment efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. HIV/AIDS is primarily a gay disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I am not personally worried about getting HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Alternative medical treatments for HIV/AIDS have shown promising results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Antiretroviral drugs are a cure for HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. An effective HIV/AIDS vaccine is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. You cannot get HIV/AIDS during sex if condoms are always used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People with HIV/AIDS deserve the same rights in the workplace as other workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. People who knowingly expose others to HIV/AIDS should be prosecuted as criminals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Young people under 25 account for almost half of new HIV/AIDS infections globally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. It is biologically easier for women to get HIV/AIDS than it is for men.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. HIV/AIDS infections are often the result of immoral behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Treating HIV/AIDS is a lucrative business for pharmaceutical companies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Please check the response that best represents how you feel about these statements: (V9.3)

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Sure
1. Alternative medical treatments for HIV/AIDS have shown promising results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Young people under 25 account for almost half of new HIV/AIDS infections globally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. People with HIV/AIDS deserve the same rights in the workplace as other workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. HIV/AIDS infections are often the result of immoral behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. HIV/AIDS prevention efforts often receive more funding than treatment efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. HIV/AIDS is primarily a gay disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. HIV/AIDS is God's way of punishing the wicked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Getting HIV/AIDS is usually a death sentence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. An effective HIV/AIDS vaccine is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Poor people are more likely to get HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I am not personally worried about getting HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Globally, the number of people with HIV/AIDS is decreasing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Antiretroviral drugs are a cure for HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. It is biologically easier for women to get HIV/AIDS than it is for men.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. People who knowingly expose others to HIV/AIDS should be prosecuted as criminals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. You cannot get HIV/AIDS during sex if condoms are always used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Treating HIV/AIDS is a lucrative business for pharmaceutical companies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Please check the response that best represents how you feel about these statements: (V9.4)

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Sure
1. An effective HIV/AIDS vaccine is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Alternative medical treatments for HIV/AIDS have shown promising results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Young people under 25 account for almost half of new HIV/AIDS infections globally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Getting HIV/AIDS is usually a death sentence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. HIV/AIDS prevention efforts often receive more funding than treatment efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. People with HIV/AIDS deserve the same rights in the workplace as other workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Antiretroviral drugs are a cure for HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. HIV/AIDS is God's way of punishing the wicked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. HIV/AIDS is primarily a gay disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. You cannot get HIV/AIDS during sex if condoms are always used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Poor people are more likely to get HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Globally, the number of people with HIV/AIDS is decreasing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I am not personally worried about getting HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. It is biologically easier for women to get HIV/AIDS than it is for men.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. HIV/AIDS infections are often the result of immoral behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Treating HIV/AIDS is a lucrative business for pharmaceutical companies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. People who knowingly expose others to HIV/AIDS should be prosecuted as criminals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Encuesta sobre conocimiento y percepción sobre VIH/SIDA (APP C.4)

Esta encuesta es parte de una investigación sobre el conocimiento y las percepciones que tienen las personas sobre el VIH y el Síndrome de Inmunodeficiencia Adquirida (SIDA). Para acortar la información, esta encuesta menciona SIDA en lugar de Síndrome de Inmunodeficiencia Adquirida. Sus respuestas ayudarán a diseñar un modelo de educación para informar a las personas sobre la prevención y el tratamiento del VIH/SIDA.

I. ¿Es usted mayor de 18 años? (Si no, encuesta sobre la parada.)

II. ¿Ha visto información sobre prevención y el tratamiento del VIH/SIDA? (Si no, encuesta sobre la parada.)

A. ¿De cuáles de estos es recursos usted ha aprendido sobre VIH/SIDA en los pasados 4-5 años? Seleccione todas las respuestas que apliquen.

- | | |
|---|---|
| <input type="checkbox"/> 1. Televisión
<input type="checkbox"/> 2. Radio
<input type="checkbox"/> 3. Libros
<input type="checkbox"/> 4. Periódicos
<input type="checkbox"/> 5. Revistas
<input type="checkbox"/> 6. Anuncios fuera de la casa (carteleros, letreros, hojas sueltas)
<input type="checkbox"/> 7. Eventos (seminarios, talleres, conferencias)
<input type="checkbox"/> 8. Páginas Web escritas por personal médico
<input type="checkbox"/> 9. Páginas en la Web creadas por personas que tienen VIH/SIDA
<input type="checkbox"/> 10. Blogs, tableros de anuncios en línea | <input type="checkbox"/> 11. Periódicos en línea
<input type="checkbox"/> 12. Correos electrónicos
<input type="checkbox"/> 13. Facebook, Twitter, My Space, etc.
<input type="checkbox"/> 14. Organizaciones comunitarias
<input type="checkbox"/> 15. Organizaciones religiosas
<input type="checkbox"/> 16. Instituciones educativas
<input type="checkbox"/> 17. Doctores convencionales
<input type="checkbox"/> 18. Doctores en medicina alternativa
<input type="checkbox"/> 19. Amigos o familiares
<input type="checkbox"/> 20. Personas con las que trabaja
<input type="checkbox"/> 21. Otro (Especifique) _____ |
|---|---|

B. Seleccione la respuesta que mejor represente cuán creíble (verosímil) usted piensa que son los siguientes recursos que hablan sobre VIH/SIDA.

	No lo encuentro creíble	Algo creíble	Inseguro	Creíble	Extremadamente creíble
1. Televisión	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Radio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Libros	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Periódicos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Revistas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Anuncios fuera de la casa (carteleros, letreros, hojas sueltas)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Eventos (seminarios, talleres, conferencias)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Páginas Web escritas por personal médico	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Páginas en la Web creadas por personas que tienen VIH/SIDA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Blogs, tableros de anuncios en línea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Periódicos en línea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Correos electrónicos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Facebook, Twitter, MySpace, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Organizaciones comunitarias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Organizaciones religiosas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Instituciones educativas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Doctores convencionales	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Doctores en medicina alternativa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Amigos o familiares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Personas con las que trabaja	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Otro (Especifique) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Haga una marca a lado de los tratamientos de VIH/SIDA de los que haya escuchado o leído.

- | | |
|---|--|
| <input type="checkbox"/> 1. UVBI (la irradiación ultravioleta de la sangre) | <input type="checkbox"/> 11. Peróxido – IV (intravenoso) |
| <input type="checkbox"/> 2. Plata coloidal –IV (intravenoso) | <input type="checkbox"/> 12. Peróxido –oral |
| <input type="checkbox"/> 3. Plata coloidal–oral | <input type="checkbox"/> 13. Atrapamoscas –oral |
| <input type="checkbox"/> 4. Selenium apoyo de hígado–oral | <input type="checkbox"/> 14. Extractos de hígado de cerdo– transdérmico |
| <input type="checkbox"/> 5. Quelación – IV (intravenoso) | <input type="checkbox"/> 15. Suplementos nutricionales |
| <input type="checkbox"/> 6. Quelación –oral | <input type="checkbox"/> 16. AZT (Azidothymidine) |
| <input type="checkbox"/> 7. Vitaminas – IV (intravenoso) | <input type="checkbox"/> 17. HAART (Terapia antiretroviral altamente activa) |
| <input type="checkbox"/> 8. Vitaminas –oral | <input type="checkbox"/> 18. Farmacéutico antibióticos (Bactrim, etc) |
| <input type="checkbox"/> 9. Minerales – IV (intravenoso) | <input type="checkbox"/> 19. Otro (Especifique)_____ |
| <input type="checkbox"/> 10. Minerales –oral | |

E. De acuerdo con su propio conocimiento o experiencia, por favor marque TODOS los casilleros de los siguientes tratamientos del VIH / SIDA que cree que puede ser eficaz en el tratamiento del VIH / SIDA.

- | | |
|---|--|
| <input type="checkbox"/> 1. UVBI (la irradiación ultravioleta de la sangre) | <input type="checkbox"/> 11. Peróxido – IV (intravenoso) |
| <input type="checkbox"/> 2. Plata coloidal –IV (intravenoso) | <input type="checkbox"/> 12. Peróxido –oral |
| <input type="checkbox"/> 3. Plata coloidal–oral | <input type="checkbox"/> 13. Atrapamoscas –oral |
| <input type="checkbox"/> 4. Selenium apoyo de hígado–oral | <input type="checkbox"/> 14. Extractos de hígado de cerdo– transdérmico |
| <input type="checkbox"/> 5. Quelación – IV (intravenoso) | <input type="checkbox"/> 15. Suplementos nutricionales |
| <input type="checkbox"/> 6. Quelación –oral | <input type="checkbox"/> 16. AZT (Azidothymidine) |
| <input type="checkbox"/> 7. Vitaminas – IV (intravenoso) | <input type="checkbox"/> 17. HAART (Terapia antiretroviral altamente activa) |
| <input type="checkbox"/> 8. Vitaminas –oral | <input type="checkbox"/> 18. Farmacéutico antibióticos (Bactrim, etc) |
| <input type="checkbox"/> 9. Minerales – IV (intravenoso) | <input type="checkbox"/> 19. Otro (Especifique)_____ |
| <input type="checkbox"/> 10. Minerales –oral | |

F. Información demográfica (Sus repuestas serán confidenciales.)

1. Edad: 18-25 26-36 37- 47 48-58 59+
2. ¿Con qué género se identifica mejor? Masculino Femenino
3. Orientación sexual: Heterosexual Homosexual Bisexual Prefiero no decir
4. ¿Con cuál de los siguientes grupos usted se identifica más? (Seleccione sólo una contestación.)
- | | |
|--|--|
| <input type="checkbox"/> Indio Americano, Original de Alaska | <input type="checkbox"/> Hispano |
| <input type="checkbox"/> O de las islas del Pacífico | <input type="checkbox"/> Blanco/Caucasico |
| <input type="checkbox"/> Asiático/Asiático Americano | <input type="checkbox"/> Mezcla de razas |
| <input type="checkbox"/> Negro/Africano Americano | <input type="checkbox"/> Otro (Especifique)_____ |
5. ¿Cuál de las siguientes opciones mejor describe su educación académica? (Seleccione sólo una contestación.)
- El grado octavo o menos
- Algún instituto
- Instituto/tiene graduado mi GED
- Graduado colegial
- Maestría o doctorado
6. Afiliación religiosa: _____ Prefiero no decir
7. ¿Trabaja usted en alguna organización que se encargue de educar, tratar personas que tienen HIV/AIDS, o que enseñe a prevenir la enfermedad? Sí No
8. ¿Es usted un voluntario en alguna organización sobre HIV/AIDS? Sí No
9. Mi HIV estatus es: Negativo Positivo No sé Prefiero no decir

G. Otros comentarios (Use la parte de atrás de la página si necesita más espacio.)

APPENDIX C.5 SURVEY CONSULTANTS

Jacques Clermont, Doctor of Naturopathic Medicine and collaborator for INSERM, France's National Institute of Health and Medical Research

Solly Diaz, MHA, Division Manager-Southwest Region, City of Houston Department of Health and Human Services, Houston, Texas

Hugh Fullerton, PhD., Researcher and retired educator, Texas

Amy Leonard, Health Educator, Legacy Clinic, Houston, Texas

Ken Malone, HIV Test Project Coordinator, HIV Services, Harris County Hospital District, Houston, Texas

Tina Megdal, Senior Director of Client Services, Legacy Clinic, Houston, Texas

Beau J. Mitts, MPH, Technical Assistance Manager, HIV/AIDS Care, Treatment, and Houston Program, Bureau of HIV/AIDS Prevention and Control, New York City Department of Health and Mental Hygiene. (Formerly Manager, HIV Prevention Program, City of Houston Health and Human Services, Houston, Texas)

Wanda Reyes, PhD, Assistant Professor of Mass Communication, Sam Houston State University, Huntsville, Texas

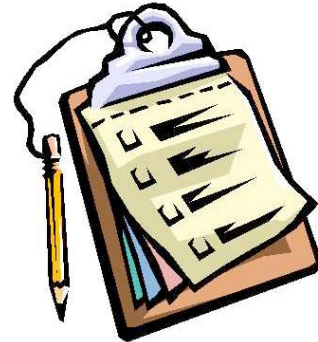
Ardyth Broadrick Sohn, PhD., Professor and Director, Hank Greenspun School of Journalism and Media Studies, University of Nevada Las Vegas, Las Vegas, Nevada

Christopher White, PhD., Associate Professor of Mass Communication, Sam Houston State University, Huntsville, Texas

APPENDIX C.6: Guidelines for Survey Data Collection

- 1) Preparing—Read the consent form and the survey before going into the field. Take the survey and think about what questions respondents might have.
- 2) Organize copies of the blank consent forms and the five versions of the survey in separate folders. Be sure to have separate folders for the five different versions of the surveys. All folders should be clearly labelled. Have several pens for respondents' use.
- 3) Have separate folders for completed surveys and signed consent forms. At no time should the consent forms be filed with the corresponding surveys.
- 4) Approaching possible respondents—Greet the person, give your name and explain that you are asking people to take a brief survey about their knowledge and perceptions about HIV/AIDS. This is part of a research project to help find effective ways to inform people about HIV/AIDS.
- 5) Time frame/anonymity—Explain that taking the survey will only take about 10-15 minutes and will be anonymous—names will never be used but their information will be important and useful.
- 6) Filter questions—
 - a. *Are you 18 or older?* (No minors can take the survey.)
 - b. *Have you seen or heard information about prevention and treatment of HIV/AIDS?*
If NO, say thank you, and do not distribute a survey. If YES, continue.
- 7) Distribution of different survey versions—Distribute version 1 of the survey to the first respondent, version 2 to the second respondent, and so on. After five surveys have been completed, begin the cycle over again.
- 8) Getting consent forms signed—There must be a signed consent form for the survey to be valid. Give a copy of the consent form to the respondent and ask him/her to sign and return a copy. Stress again that surveys and consent forms will be kept separate and will not be linked in anyway. The person's name will NEVER be used in any way. (If the person requests a copy of the consent form, give him/her a copy.)
- 9) Answering questions respondents might ask:
 - Q: Can I decline to answer a question? YES
 - Q: Can I stop the survey at any time? YES
 - Q: Whom can I contact if I have a question? Contact and phone # on the form.
 - Q: Why must I sign a form? For a survey to be valid, respondents must give consent.
- 10) Coding—At the end of the collection period, code the surveys and the consent forms using the collection site and date codes provided. Do NOT code the surveys in the presence of the respondents.
- 11) Transporting the surveys—Surveys should be kept in a secure place while being transported to the site where they will be edited, coded, and tabulated.

Take a ^{quick} survey



Grab a ^{funny} gift

If you are 18 or older, please take a few minutes to fill out our HIV/AIDS survey. Your anonymous responses will help us find better ways to inform people about HIV/AIDS prevention and treatment.

Thanks for your help!



This research project has IRB approval from the University of Teesside.

**Participar en
una encuesta**



Recibir un regalo!

**Si usted tiene 18 años o más, por favor,
tómese unos minutos para participar en un
encuesta sobre VIH/SIDA. Su respuesta
anónima nos ayudará a informar a gente
sobre el tratamiento y la prevención
de VIH / SIDA.**

Gracias por tu ayuda!



Este proyecto de investigación aprobado por la Universidad de Teesside.

APPENDIX C.8
Comments from Legacy Survey (Nov/Dec 2009)

Taking this survey made me realize how much I don't know about HIV/AIDS.

Great work by everyone pulling together.

I've been infected for 23 years.

I am not very familiar with HIV/AIDS and its treatments or lack thereof. New to Houston and have never been face to face with HIV/AIDS and its effects and or the amount of people that have it. I suppose it's ok to say that I am not very educated in this matter.

Having 4 friends with HIV, I still don't know much about what they go through to stay well every day. I feel maybe that it's not a open subject to talk about.

We need more help to get good service.

Thanks for your help.

Thanks for all you do for the HIV community.

I am transgender.

Positive for 30 years and have never taken any drugs ever for the illness.

Nice to participate.

Answered "not sure" on items I don't know, #16, yes! But only if the other party is unaware of the infected person's condition; #19, depends on the person (ex are they rapists, cheating or just dating) question was too broad.

Lots of treatments.... I didn't know any of them.

I know that my God is good. I've been exposed since 1992 till now. I'm still here.

All the best on your research project. Happy and safe Holidays and 2010.

More education in schools; many people believe the #'s are going down drastically and there is a readily available cure.

If it was not for the good doctors and caseworkers, I would have been very ill. This is a good clinic and I love how you all work with me and let me know I am not in the dark.

The people helping out are doing a wonderful job.

Part D: Some of these therapies used together can be effective treatments.

I have been negative for the last 4 years of my life, and was HIV in 1987.

Knowledge is power!

Work as LVN for HCHD.

There are some religious teachings that I disagree with in regard to HIV education. I believe a full dissemination of scientifically proven HIV prevention methods should be mandatory for any organization funded for such efforts. The censorship of this education based on "beliefs" is ethically challenged. While some religious organizations are beneficial in their teaching method, others try to enforce their beliefs on those in need.

I myself have 2 sons with AIDS. Thanks for your support.

I feel that people with no insurance is treated unfairly and results are not always correct.

Thanks.

Hoping for a cure.

The research being done in vector treatment looks promising.

I have had a family member living with AIDS for almost 10 years. In that time I have seen her almost die 5 times. With the meds she always got better. She is living a full life and is very healthy. I believe given funding a cure could be found. I have to hope.

Good luck with your school project.

I think it's sad that we have gotten comfortable with these diseases and to really educate yourself, you have to make the effort. There needs to be awareness.

I am a Leeper graduate of 2007.

My daughter is HIV, possibly AIDS, age 33, contracted HIV at 21 from husband-Now ex.

DCA Drug will cure Cancer & AIDS/HIV, but we can't get it in the USA as a legal treatment. Availability in Canada only.

My boyfriend is HIV positive.

I have some thoughts that I am infected with HIV one time and it was horrible.

Thanks and good luck.

I didn't check any treatments because I have never heard of any of them.

APPENDIX D

PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

- D.1** Presentation, *Taking taboo topics public: how social marketing partnerships combat HIV/AIDS in Mexico* (2008).
- D.2** Paper, *Creating a culture of change: social marketing's global initiative against HIV/AIDS* (2008).
- D.3** Abstract, *Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States* (2008).
- D.4.1** Poster, *Working toward a world without AIDS: how social marketing inspires long-term cultural change* (2009).
- D.4.2** Abstract, *Working toward a world without AIDS: how social marketing inspires long-term cultural change* (2009).
- D.5** Book chapter, *Love, sex, and HIV/AIDS: using social marketing to redefine gender norms among Mexican youth* (2011).

PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

D.1 Presentation Title: *Taking taboo topics public: how social marketing partnerships combat HIV/AIDS in Mexico* (part of a panel titled: Partnership Based Approaches: What Works?)

Presented at: 2008 PSP-*One* Online Social Marketing Conference: *Social marketing in the developing world: what have we accomplished and what does the future hold?*

Conference website with list of presenters:

<http://www.icohere-presentations.com/Assist/PSP-OneReg08/PSP1conference.htm>

Dates: 10-15 March 2008

Publication: Recorded online script with accompanying PowerPoint, plus on-line participation during the conference.

Presentation published at:

www.psp-one.com/files/4986_file_Massingill__presentation_p1.pdf

Note: PSP-*One* (Private sector partnerships for better health) is USAID's flagship project to increase the private sector's provision of high-quality reproductive health and family planning and other health products and services in developing countries (<http://www.psp-one.com>).



**Taking Taboo Topics Public:
How Social Marketing Partnerships Combat HIV/AIDS in Mexico**

Introduction

- ❑ Social marketing influences low-income, high-risk populations to make healthy behaviour changes.
- ❑ Key tactic for combating HIV/AIDS
- ❑ Spread of infection can be managed: level and prevalence of HIV/AIDS are altered by human intervention/decisions.



Social marketing has been widely used to influence low-income, high-risk populations to make healthy behaviour changes. This application of marketing principles has also become an important tool for persuading upstream audiences to make long-term policy changes that achieve socially desirable goals.

As the human, social, and economic costs of the HIV/AIDS pandemic mount, social marketing is now a key tactic for combating the disease.

This is particularly appropriate since the spread of the infection can be managed. Passive contagion, a core tenet of classic disease diffusion models, is not appropriate for HIV/AIDS since human intervention and human decision-making can alter both the level and the prevalence of the disease.

A Case for Social Marketing in Mexico

- ❑ Increase in HIV/AIDS cases each year since early 1980s
- ❑ Affecting youngest and most productive populations as well as poor and marginalized
- ❑ #4 cause of death for men 25-34
- ❑ Diverting resources from other health, welfare, and education priorities



As the human, social, and economic costs of the HIV/AIDS pandemic mount, policymakers worldwide are earmarking funds and forming alliances to combat the spread of the disease. Mexico, where the first AIDS case was diagnosed in 1983, faces serious threats to social sustainability as infections steadily multiply. Recent reports show the disease is increasingly affecting the youngest and most productive populations as well as poor and marginalized groups.

Mexico ranks 13th globally and third in the Americas in the total number of HIV cases reported; unfortunately, the increase in new cases has been continuous since the early 1980s. With an estimated average of 4,000 new cases annually in Mexico, AIDS has become the No. 4 cause of death for men in the 25 to 34 age group. Higher rates of HIV infection are also being documented among injecting drug users and women.

Overall Research Question

How have alliances of government decision makers, the health care community, and AIDS activists allowed social marketers to bring about voluntary behavioural changes in Mexico?



How have alliances of government decision makers, the health care community, and AIDS activists allowed social marketers to bring about voluntary behavioural changes in Mexico?

A Population of Campaigns

- ❑ Six campaigns selected for comparison
- ❑ Examined purpose, sponsors, audience, where disseminated, media mix, messages, product promotion, and appeals
- ❑ Commonalities and unique characteristics identified
- ❑ Research methods: content analysis, semi-structured interviews with key decision makers



This presentation analyses six recent HIV/AIDS campaigns in Mexico, examining their ability to motivate change and their potential for informing target audiences about new health choices. Analysis of the campaigns identified the commonalities and unique characteristics as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used. Semi-structured interviews with opinion leaders were used to explore the rationale behind the content choices, cultural influences, and economic factors influencing the public dissemination of HIV/AIDS information. The six campaigns share a number of common concerns and objectives although each has a unique theme and a distinctive focus and approach. All campaigns, however, rely heavily on partnerships and present messages that openly discuss once-taboo topics.

Finding #1: Collaboration is Essential

- ❑ Social marketers do not have infrastructure/marketplace environment of commercial marketers
- ❑ Build network of groups with common goals, varied resources.
- ❑ Good example: “Investing in People” in Mexico City, with largest number of AIDS cases ...
- ❑ Taboo topic: Sex before marriage

Recognizing that expanding HIV/AIDS populations will devastate the global economy, governments in both developing and industrialized countries, often in conjunction with pharmaceutical companies, have launched organized offensives, which include political commitment, law enforcement, government policy, social marketing, and community mobilization.

This global cooperation encourages alliances such as those forged to support the campaigns in this study. From a practical standpoint, these partnerships are essential because social marketers “do not have the infrastructure and the marketplace environment commercial marketers take for granted.” Rather than “divide and conquer,” in social marketing the strategy is to build a network of groups and individuals with common goals and varied resources.

The “Investing in People” campaign is a good example of such alliances...

Partnership Lesson #1:

Build local, nat'l & internat'l alliances with common goals

Investing in People

Purpose: Reduce barriers to behavior change & care seeking, and increase access to services that facilitate safer behavior.
Diminish stigma.

Timeframe: 2003-2008

Sponsors: USAID, CENSIDA, Mexico City AIDS Program, Futures Group International, Mexican National Institute for Public Health, PSI

Audiences: Vulnerable populations, at-risk groups

Where: Mexico City

Media Mix: Trained 40 women advocates, workshops, condom marketing

Messages: Safe behaviors: Abstinence, fidelity, and delay of sexual debut

Speakers: Local HIV/AIDS leaders deliver conference presentations

Products: Condoms

Appeals: Self-interest, sustainable development

...This five-year initiative, which began in 2003, is centered in Mexico City, where the largest number of HIV/AIDS cases are found. "Investing in People" is the joint effort of a half-dozen international, national, and local organizations. A key technique is personal communication through workshops and conferences conducted by trained female advocates and local HIV/AIDS leaders, who openly discuss sex before marriage, a once-forbidden topic in this strongly Roman Catholic country.

Finding #2: Focus on Prevention

- ❑ Messages usually focus on prevention
- ❑ Social marketing involves procuring, distributing pharmaceuticals, OTC drugs, condoms
- ❑ Condom Social Marketing (CSM)
- ❑ Mexico: largest consumer of pharmaceuticals in Latin America
- ❑ Taboo topic: Use of condoms

Most HIV/AIDS campaigns have a stronger focus on prevention messages than treatment information, so social marketing assistance usually involves procuring and distributing pharmaceuticals, over-the-counter drugs, and condoms. For example, PSI [Population Services International], the principal contractor for USAID's 2005 behavioural change campaign in Mexico, emphasizes prevention messages and brand-specific advertising, especially of condoms. Under this "manufacturer's model," partnerships are negotiated with commercial manufacturers, suppliers, and distributors of health products, and products are made available at lower than market costs. Brand-name condoms and related products are always sold rather than given away, albeit at reduced prices, because PSI's policy is "when products are given away... the recipient often does not value them or even use them." In fact, promoting the use of condoms is such an integral part of HIV/AIDS social marketing that the practice has its own acronym: Condom social marketing [CSM], which is central to the Vida campaign strategy...

Partnership Lesson #2: Recruit commercial sponsors for additional resources

VIVE Condoms

Purpose:	Make condoms socially acceptable
Timeframe:	2004-2005
Sponsors:	PSI, USAID
Audiences:	Men who have sex with men, female sex-workers, truckers, migrants, prisoners, young adults (15-24) people living with AIDS, men in uniform
Where:	Southern and Central Mexico, non-traditional outlets in high-risk areas--bars, markets, parks, bus stations
Media Mix:	Commercial distribution of condoms, discussion and interactive activities
Messages:	Appropriate condom use, testing results confidential, required treatment is guaranteed, Vive tu Vida
Products:	VIVE condom brand
Appeals:	Sustainable development, self-interest

The VIVE condom brand, popular in several Latin American countries, is the centerpiece of recent "Vida" educational efforts directed to prisoners and other high-risk groups in southern and central Mexico. A recent survey reported that Mexican society has become the largest consumer of pharmaceuticals in Latin America and the ninth largest worldwide. Pharmaceutical sales jumped from US\$6.83 billion in 2002 to an estimated US\$11.3 billion in 2005. Given these numbers, it seems safe to say that major pharmaceutical companies will continue to vie for partnership status in social marketing initiatives and that condoms will continue to be more accessible and socially acceptable.

Finding #3: Stigma Goes Underground

- ❑ “Underground epidemic”
- ❑ People living with AIDS, esp. women fear rejection by families and loss of jobs.
- ❑ “Vida Digna” in central Mexico, with “weakest civil response to AIDS”...
- ❑ Taboo topic: Alternative lifestyles

HIV has been called an “underground epidemic” because of the stigma and discrimination associated with the disease.

USAID, whose infectious disease objectives in Mexico are designed “to contain and reduce HIV/AIDS in vulnerable populations,” focuses on reducing barriers to behavior change and thereby preventing the HIV/AIDS epidemic in Mexico from becoming generalized to the population at large.

Reducing stigma and discrimination experienced by sex workers, gay men, men who have sex with men, drug users, and people living with AIDS is the central purpose of the three-year Vida Digna [Life with Dignity] campaign, launched in 2005 by the Colectivo Sol alliance and funded by GlaxoSmithKline...

Partnership Lesson #3: ***Involve the target audience from the outset***

Vida Digna (Life with Dignity)

Purpose:	Reduce stigma and discrimination of AIDS
Timeframe:	2005-2008
Sponsors:	AIDS Alliance, Colectivo, Sol, Positive Action, GlaxoSmithKline
Audiences:	People living with AIDS, sex workers, drug users, men who have sex with men
Where:	Mexico - Aguascalientes, Guanajuato, Queretaro, San Luis Potosi
Media Mix:	Training, literature, commercials, community leaders
Messages:	Equality begins with accepting people's differences
Speakers:	Community leaders, key decision makers, media
Appeals:	Social cognitive, sustainable development

...The campaign is centered in the central states of Mexico, a conservative area characterized as having “the weakest civil society response to AIDS.” Vida Digna uses anonymous testimonials to urge tolerance and acceptance of people’s differences. The International HIV/AIDS Alliance’s research indicates people living with AIDS, especially women, are fearful of rejection by their families and dismissal from their jobs if their HIV status is revealed.

Finding #4: Cultural/Gender Norms

- ❑ Machismo and homophobia fueling Mexico's AIDS epidemic
- ❑ Young men often control how and when young women have sex
- ❑ Changing gender norms: "Programa Hombres" and
- ❑ "Programa Mujeres"--female empowerment
- ❑ Taboo topics: Women's rights and homophobia

According to Mexico's National Center for the Prevention and Control of HIV/AIDS [Censida], changing how Mexicans view gender roles and erasing widespread prejudice against gays will be necessary to effectively combat the disease. Speaking at a conference in February of 2006, Censida's director, Jorge Saavedra, said machismo and homophobia are fueling the country's HIV/AIDS epidemic. Saavedra was quoted in *Dominican Today* as saying machismo undermines prevention messages and "puts women, as well as men, at risk," and that "fighting homophobia is one of the best ways to fight HIV."

Links between traditional gender attitudes and the spread of AIDS prompted a partnership of NGOs to develop Programa Hombres [often called Program H]...

Partnership Lesson #4: Initiatives must be multimedia & multilingual

Programa Hombres (Project H)

Purpose:	Help young men question traditional social norms related to manhood, reflect on the advantages of more gender-equitable behaviors and re-think what it means to be a man. Develop strategic relationships at the macro-policy level.
Timeframe:	1999-2004
Sponsors:	Began with Brazil's Instituto Promundo. Partners include PAPA! Institute, ECOS, and Salud Y Genero, PAPA/WHO, USAID, UNAIDS, IPPF/WHO, UNFPA, The Population Council, PATH, SSL International
Audiences:	Young men, 15-24
Where:	Mexico -Tested in more than 20 countries
Media Mix:	Educational videos, manuals, and workshops, information folders, radio spots, billboards, postcards, banners
Messages:	Chega Junta Cara, "In the Heat of the Moment"
Speakers:	Workshops facilitated by young men
Products:	Hora H condoms
Appeals:	Self-interest, decision-making

...This five-year initiative has been used in more than 20 countries, including Mexico, to persuade young Latino men to question traditional norms related to manhood since the male youth often control how and when young women have sex. An extensive media mix included educational videos available in three languages—Spanish, English, and Portuguese—interactive workshops, and collateral materials, as well as radio, outdoor media, and direct mail. The campaign slogan, "In the Heat of the Moment," urged use of the Hora H condom brand, manufactured by the makers of Durex condoms and distributed in non-traditional venues such as funk balls and cafes.

Partnership Lesson #5: Utilize global support for women

Programa Mujeres (Project M)

Purpose:	Promote young women's reflections on gender norms, and their self-efficacy and empowerment
Timeframe:	2005-
Sponsors:	Began with Brazil's Instituto Promundo. Partners include PAPAI Institute, ECOS, and Salud Y Genero, MacArthur Foundation, World Education (USA), OAK Foundation and the Special Secretariat of Womens Policies (Brazil)
Audiences:	Young women, 15-24
Where:	Brazil, Mexico, and soon India
Media Mix:	"Once upon a Girl" educational cartoon, discussion guide
Messages:	Sexual and reproductive health, educational, professional development, community involvement
Products:	Video for sale on website
Appeals:	Social-cognitive

Building on their success in educating young men about the costs of traditional macho culture, in 2005 the Program H partners and World Education launched Programa Mujeres [Project M] to encourage young women to take control of their sexual and reproductive health. This social marketing campaign was based on research that included a review of Latin American literature to define the concept of female empowerment, focus group discussions with groups of young women aged 14-24 who lived in marginalized communities outside Queretaro, Mexico, and interviews with empowered young women.

Finding #5: Population Mobility Danger

- ❑ Travel or migration factor in AIDS prevalence
- ❑ Risk to partners at home
- ❑ U.S./Mexico: Border health initiative to make testing and care more accessible and acceptable...
- ❑ Taboo topics: Sex outside of marriage, prostitution

Studies of highly mobile groups such as truck drivers, seasonal employees, and sex workers have identified travel or migration as a factor related to increased HIV/AIDS prevalence. Higher rates of infection are also frequently found along transport routes and in border regions. In addition, migration and mobility also increase vulnerability to HIV/AIDS for the partners at home.

Not surprisingly then, HIV/AIDS is a significant problem along the 2,000-mile border between the United States and Mexico, where mobility, poverty, and lack of access to health care complicate prevention and care. The SPNS [Special Projects of National Significance] Border Health Initiative is administered by the U.S. Department of Health and Human Services to raise awareness about HIV and to make testing and care more accessible...

Partnership Lesson #5: Construct trans-border alliances

SPINS Border Health Initiative

Purpose:	Identify infected people and refer to primary care, raise awareness, make testing more accessible, advance skills in delivering health and social services to people with AIDS
Timeframe:	2004-
Sponsors:	U.S. Department of Health and Human Services, CARE Act
Audiences:	Migrant farm workers, trans-border populations, sex workers
Where:	2,000-mile border between U.S. and Mexico, truck stops and border crossings, and communities
Media Mix:	One-to-one outreach, radio, TV, promotores (volunteer health workers), printed materials
Messages:	Bold messages that HIV is a community problem, identify testing and clinical resources, reverse cultural norms (use of Spanish language, culturally specific)
Speakers:	Local, well-known media personalities
Appeals:	Decision-making, social cognitive

...In many of the rural border communities people are reluctant and embarrassed to openly discuss HIV/AIDS or the sex worker industry. Relying heavily on social marketing, SPNS utilizes Spanish language media to blanket the transient communities with “bold” HIV messages designed to “reverse the cultural norm that topics related to sexuality, including HIV, are not discussed in public” and to educate Latinos about the risk of the disease. SPINS border outreach initiatives are designed to be culturally sensitive to the Latino culture, which values trust and relationship building.

Conclusions

- ❑ Communications about AIDS is complex and highly political
- ❑ HIV/AIDS crosses all boundaries; no one unaffected
- ❑ Social marketing is able to create upstream and downstream behaviour changes
- ❑ Partnerships are crucial
- ❑ Taboo topics must be discussed



As demonstrated by these six Mexico-based campaigns, the content of social marketing messages about HIV/AIDS, the role of stigma and culture, and the economic realities of the global medical market created by the epidemic form a complex and politically charged environment that influences public dissemination of information.

As HIV/AIDS social marketing establishes a track record in Mexico, organizations using such initiatives can begin to analyze long-term results. Nevertheless, it already seems clear that the power of social marketing is a strong tool for motivating change and informing target audiences about new health choices. Over a period of less than two decades, alliances of HIV/AIDS social marketers have been able to operate successfully in the maelstrom of cultural, political, economic, and social concerns while bringing about voluntary behavioral changes among both downstream and upstream audiences.

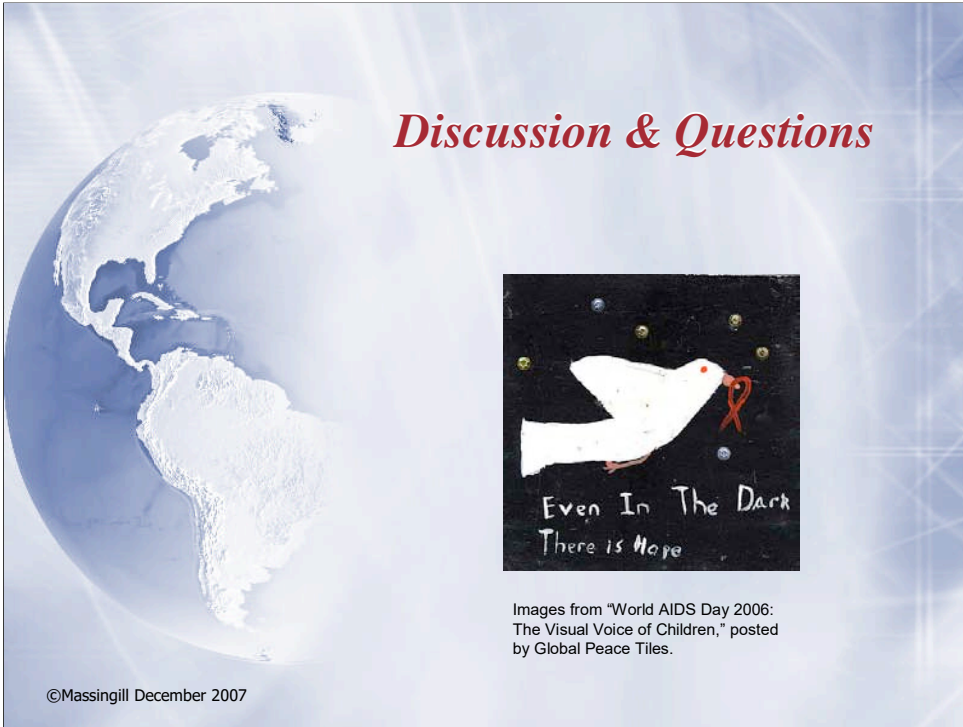
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Discussion & Questions



Images from "World AIDS Day 2006:
The Visual Voice of Children," posted
by Global Peace Tiles.

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PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

D.2 Paper Title: *Creating a culture of change: social marketing's global initiative against HIV/AIDS.*

Presented at: VII International Congress on Public and Nonprofit Marketing
Szeged, Hungary

Conference website:
<http://www.aimpn.org>

Dates: 12-13 June 2008

Publication: Paper published in conference proceedings.

**CREATING A CULTURE OF CHANGE:
SOCIAL MARKETING'S GLOBAL INITIATIVE AGAINST HIV/AIDS**

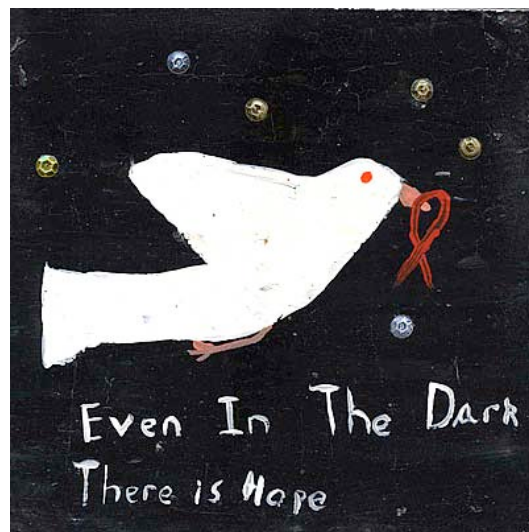
RUTH MASSINGILL

PH.D. CANDIDATE

UNIVERSITY OF TEESSIDE, MIDDLESBROUGH, ENGLAND, UK

MASS COMMUNICATION FACULTY

SAM HOUSTON STATE UNIVERSITY, HUNTSVILLE, TEXAS, USA



ABSTRACT

Social marketing [SM] is a key tactic for combating HIV/AIDS. When SM builds successful partnerships with upstream audiences who focus on downstream targets, a community's social fabric can be permanently altered.

This paper scrutinises how SM techniques are used to disseminate HIV/AIDS information, often with conventional medicine's sponsorship and alternative medicine's increasing influence.

Analysis of eighteen SM campaigns from Uganda, Mexico, and the U.S. indicates public communication revolves around 1) cultural content of SM messages about HIV/AIDS, 2) political expediency, and 3) economic realities of the global marketplace, forming a complex environment that influences dissemination of information about health care options. Semi-structured interviews with opinion leaders involved in designing, sponsoring, and implementing selected campaigns provide insights into lesson learned so far from these initiatives.

Image from "World AIDS Day 2006: The Visual Voice of Children," posted by Global Peace Tiles.

**CREATING A CULTURE OF CHANGE:
SOCIAL MARKETING'S GLOBAL INITIATIVE AGAINST HIV/AIDS**

INTRODUCTION

For more than three decades, social marketing, “the application of the principles and tools of marketing to achieve socially desirable goals,” (Kotler and Zaltman, 1971: 5) has been widely used to influence low-income and high-risk populations to make healthy behaviour changes. Although these campaigns often created awareness among specific target audiences and even persuaded members of at-risk groups to adopt lifestyle changes, it became increasingly obvious that the burden of deep societal change could not rest exclusively on these downstream targets (Andreasen, 2006). As a result, social marketing has come to be seen as a tool for social change on all levels. When social marketing can build partnerships that include governments, non-government organizations [NGOs], international agencies, and private businesses—so-called upstream audiences—working in conjunction with downstream targets, then the entire social fabric of a community can be permanently altered (Andreasen, 2006).

Therefore, social marketing has been a key tactic in combating HIV/AIDS, both in developing and in industrialized countries, for the past 20 years. These campaigns typically define a purpose relating to a specific target audience, use a variety of media to disseminate the campaign message, and are based on a recognized behavioural change model (McDermott, *et al.*, 2005). Numerous international organizations now have a track record of designing and implementing social marketing campaigns in countries where infection rates are on the rise. As the human, social, and economic costs of the HIV/AIDS pandemic mount, policymakers worldwide are earmarking funds and forming alliances to combat the spread of the disease.

This research explores links between social marketing and HIV/AIDS while mapping connections to the conventional and alternative medical communities. It is not unusual to find literature relating to any two of these terms, but rarely are all woven together. This project defines and contextualises social marketing, then it scrutinises how dissemination of HIV/AIDS information uses social marketing techniques, usually in partnership with conventional medicine. Alternative medicine's increasing influence and the consequent ramifications for audiences of HIV/AIDS social marketing campaigns are also investigated. This combination of topics—social marketing for HIV/AIDS as related to conventional and alternative medicine—is one that has not been explored in the manner outlined in this study, so the potential for contributing to the current body of knowledge is significant.

RESEARCH QUESTIONS

1. What is social marketing? What can it accomplish? How does it work?
2. How has social marketing been used to combat HIV/AIDS in both developing and industrialised countries?

3. What political and economic factors affect dissemination of information about HIV/AIDS treatment and prevention? What role do the media play?
4. What are specific examples of recent HIV/AIDS social marketing campaigns?
5. What commonalities and unique characteristics can be identified in this population of campaigns as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used? What lessons have been learned so far?

METHODOLOGY

To answer these questions, this study began with a comprehensive literature review, followed by content analysis of a population of 18 social marketing campaigns selected from three countries that represent diverse situations regarding the disease. This analysis provided context for semi-structured interviews with key informants from selected campaigns. The ethical guidelines of the U.K. Market Research Society Code of Conduct were examined and adhered to throughout the course of this study.

Literature Review: Areas of literature reviewed included social marketing [history, theory, and practice], HIV/AIDS [history, scope, and projections], social marketing as a tactic for combating HIV/AIDS, health communications and pharmaceutical-dominated marketing, health activism, Complementary and Alternative Medicine (CAM) and conventional medical approaches to HIV/AIDS, criminal justice concerns as relating to prisoner health care, and an overview of media coverage of these issues.

Content Analysis: A population of six HIV/AIDS social marketing campaigns was selected for each of the three countries targeted for this study—Mexico, Uganda, and the southern United States. The HIV/AIDS initiatives that were included each contained the recognized elements of social marketing campaigns, as well as several additional criteria selected by the researcher. Previous literature review revealed widespread agreement that social marketing combines a mix of several essential components: Behavioural change, informed by research, is the purpose behind any social marketing intervention. Also required is consumer orientation, in which the social marketer segments and profiles the target audience with the aim of building a long-term interactive relationship. Another common ingredient is facilitating a voluntary exchange from which both parties derive benefits. Finally, the successful social marketer thinks strategically, setting specific and measurable long-term objectives, using the marketing mix, and considering the appeal of competing behaviours (Andreasen, 2006; McDermott *et al.*, 2005).

Beyond meeting this definition for social marketing, criteria for campaign selection included currency—active as recently as 2004— implementation by a recognized international organization, and participation of a major medical organization or pharmaceutical company. The points of analysis were easily comparable aspects: purpose, target audience segmentation, where the campaign was disseminated, media mix used, messages presented, and types of appeals employed. The most common social marketing appeals to motivate health-related behaviour

change were determined through extensive literature review and informal interviews with social marketing researchers at the Institute for Social Marketing at Stirling University in Scotland.

Semi-structured Interviews: Interviews to date have included representatives from sponsoring organizations Population Services International, Instituto Promundo, Mexfam, Democracy and Sexuality (DEMYSEX) and LETRA S, as well as campaign spokespeople, health agency officials, medical practitioners, and community HIV/AIDS activists.

FINDINGS

I. CONVERGENCE OF SOCIAL MARKETING, HIV/AIDS, AND MEDICAL COMMUNITIES

The areas where social marketing, HIV/AIDS communications, and the conventional and alternative medical establishments overlap were of particular interest. Societal issues such as evolving public perceptions, the changing political landscape, international economics, and media agendas related to these topics are pertinent since they affect the global HIV/AIDS situation on a daily basis.

Research question 1: What is social marketing? What can it accomplish? How does it work?

Social marketing was first defined as a discipline 35 years ago, but has rapidly gained recognition as a “bridging mechanism” between behavioural science and the “socially useful implementation of what that knowledge allows” (Kotler and Zaltman, 1971:12). Social marketing's roots in commercial marketing are undisputed, with a strong influence by the 4Ps of marketing—product, promotion, price, and placement—although this model is sometimes viewed as insufficiently customer-based for social marketing’s framework (Niblett, 2005).

Social marketing ideally combines several elements. Behavioural change, informed by research, lies behind any social marketing intervention. Also required is consumer orientation, which segments audiences and builds long-term interactive relationships. Facilitating a voluntary exchange with mutual benefits is necessary. Successful social marketers think strategically, set long-term objectives, use the marketing mix, and consider the competition (Andreasen, 2006; McDermott *et al.*, 2005; Dev and Schultz, 2005).

As early as the 1960s, commercial marketing was incorporated into health education campaigns in developing countries (Ling *et al.*, 1992) and continued to play an important role in influencing behaviours of populations at risk for diseases such as HIV/AIDS, malaria, and alcoholism (Rogers *et al.*, 1991). When the effort extends beyond informing to persuading, it is called “health activism” and involves “attempts to change the status quo, including social norms, embedded practices, policies, and power relationships”(Zoller, 2005:361).

In 1981, however, Bloom and Novelli found many social marketing campaigns lacked rigor and theory. They recommended using research to segment audiences, design programs, and create strategic campaigns. Social marketing's popularity grew when its potential was publicised by Lefebvre and Flora (1988) and Hastings and Haywood (1991) in medical journals. As the

link between public health and commerce (Hastings and Saren, 2003), social marketing is the primary method international organisations such as UNAIDS use to combat global health issues.

Hastings and Donovan (2002) as well as Andreasen argue social marketing should be repositioned as an “approach to social change that reaches both upstream and downstream” (Andreasen, 2006: viii). However, Niblet cautions partnerships are key to this process because social marketers lack “infrastructure and the marketplace environment commercial marketers take for granted” (2005:3).

Although social marketing is not a theory, it informs and structures its framework using psychology, sociology, anthropology, and communications (Kotler and Zaltman, 1971). Social marketers may employ the health belief model (Basu, 2003), the transtheoretical model of health behaviour change [stages of change], diffusion of innovation, social cognitive theory, or theory of reasoned action (McDermott *et al.*, 2006; Lefebvre, 2001: 507-515). Nevertheless, many disregard theoretical approaches, preferring to be “broadly eclectic and intuitive tinkers” (Walsh *et al.*, 1993: 115). Despite criticisms of manipulation, overuse of fear appeals (Hastings *et al.*, 2004), and improper use of incentives (Dholakia and Dholakia, 2001), social marketing demonstrably effects social change.

Research question 2: How has social marketing been used to combat HIV/AIDS in both developing and industrialised countries?

Perhaps the most highly visible social problem in the world today is HIV/AIDS. Since it was first diagnosed 25 years ago, HIV/AIDS has become one of the most deadly health issues worldwide, with an estimated 40 million people—2.3 of them children—now living with the disease. Contrary to popular perception, about half of the infected are women and heterosexual transmission is now the most common means of infection (UNAIDS, 2006). HIV/AIDS is called an “underground epidemic” because of associated stigma and discrimination, which discourage people from getting tested or accessing care (HIV infection, 2003).

Where HIV/AIDS is rampant, social marketing is widely used to motivate low-income and high-risk audiences to adopt healthy behaviours. Population Services International, the first organisation to use social marketing to combat AIDS, uses targeted Behaviour Change Communications (BCC) to focus on prevention messages. Brand-specific advertising is often an integral part of HIV/AIDS campaigns, representing a major expense for drug companies, which spend on average two-and-a-half times more on marketing than on research (Hamber, 2005). With this kind of investment at stake, critics say the conventional medical establishment uses influence and financial clout (Moynihan and Cassels, 2005) to shape dissemination of health information.

Research Question 3: What political and economic factors affect dissemination of information about HIV/AIDS treatment and prevention? What role do the media play?

Additionally, in the wake of widespread media coverage about selective reporting of clinical drug trials, U.S. political leaders have questioned “whether the pharmaceutical industry has systematically misled physicians and patients by suppressing important data on their drugs”

(Graham, 2004: 21). These concerns, combined with reports documenting the deplorable state of public health care, are spurring public interest in complementary and alternative medicine [CAM], creating a more positive climate for alternative treatments in general (Tindel, 2005; Abraham, 2007). Likewise, in the UK, recent media coverage of controversial public funding for CAM, which is strongly supported by Prince Charles, has brought the topic to the forefront of public attention (Booth and Henderson, 2006).

Examining the media's role from a dissemination standpoint, clearly new interactive methods of building social networking communities have revolutionised how target audiences access and use information, significantly altering the international dialogue about HIV/AIDS. Many of the campaigns analysed rely heavily on online media, especially if they are targeting young, politically active, or well-educated audiences.

In toto, these factors form a complex and politically charged environment that influences dissemination of information about health care options and offers a multitude of possibilities for fresh interpretations of the cross-disciplinary relationships and concepts involved.

II. DECONSTRUCTING 18 HIV/AIDS SOCIAL MARKETING CAMPAIGNS

Research question 4: What are specific examples of recent HIV/AIDS social marketing campaigns?

Dozens of social marketing HIV/AIDS campaigns are underway in the three countries targeted for this study. Campaigns from Mexico, Uganda, and the U.S. demonstrate how NGOS and government leaders use social marketing to motivate changes in cultural attitudes and health-related behaviours. The campaigns selected for study:

MEXICO

1. Investing in People

This five-year initiative to reduce barriers to behaviour change and care seeking began in 2003. It is a localised version of a series of similar campaigns currently underway in several countries. Focused in Mexico City, where the largest number of HIV/AIDS cases is found, "Investing in People" is the joint effort of a half-dozen international, national, and local organizations. A key technique is personal communication through workshops and conference presentations conducted by trained female advocates and local HIV/AIDS leaders.

2. VIVE Condoms

The VIVE condom brand, popular in several Latin American countries, is the centrepiece of recent "Vida" educational campaigns directed to prisoners as well as other high-risk groups in southern and central Mexico. Population Services International, the primary sponsor for this campaign, uses both traditional [pharmacies, health clinics] and non-traditional [bars, hotels, brothels, salons] sales outlets to make condoms accessible and socially acceptable. The slogan is "Vive to mejor momento" or "live your best moment."

3. VIDA Digna (Life with Dignity)

Reducing stigma and discrimination experienced by sex workers, gay men, men who have sex with men, drug users, and people living with AIDS is the central purpose of the three-year “Vida Digna” campaign, launched in 2005 by the Colectivo Sol alliance and funded by GlaxoSmithKline. The campaign is centred in the central states of Mexico, a conservative area characterised as having “the weakest civil society response to AIDS.” Vida Digna uses anonymous testimonials to urge tolerance and acceptance of people’s differences.

4. *Programa Hombres (Project H)*

Links between traditional gender attitudes and the spread of AIDS prompted a partnership of NGOs to develop Programa Hombres. This five-year initiative has been used in more than twenty countries, including Mexico, to persuade young Latino men to question traditional norms related to manhood. An extensive media mix includes educational videos available in three languages—Spanish, English, and Portuguese—interactive workshops, and collateral materials as well as radio, outdoor media, and direct mail. The campaign slogan, “In the Heat of the Moment,” urges use of the Hora H condom brand, manufactured by the makers of Durex condoms and distributed in non-traditional venues such as funk balls and cafes.

5. *Programa Mujeres (Project M)*

Building on their success in educating young men about the costs of traditional macho culture, in 2005 the Program H partners and World Education launched Programa Mujeres to encourage young women to take control of their sexual and reproductive health. This social marketing campaign was based on research that included a review of Latin American literature to define the concept of female empowerment, focus group discussions with groups of young women aged 14-24 who lived in marginalised communities outside Queretaro, Mexico, and interviews with empowered young women.

6. *SPNS Border Initiative*

The SPNS [Special Projects of National Significance] Border Health Initiative is administered by the U.S. Department of Health and Human Services to raise awareness about HIV and to make testing and care more accessible. Relying heavily on social marketing, SPNS utilises Spanish language media to blanket the transient communities with “bold” HIV messages designed to “reverse the cultural norm that topics related to sexuality, including HIV, are not discussed in public” and to educate Latinos about the risk of the disease. SPNS border outreach initiatives are designed to be culturally sensitive to the Latino culture.

UGANDA

1. *ABCs (Abstinence, Being Faithful and Condoms)*

This campaign takes a moralistic approach—“Sex can wait until marriage”—and uses outdoor media as well as local spokespeople such as community leaders and ministers to urge abstinence before marriage and fidelity to spouses. Practical AIDS information is provided and condom use is also advocated to reduce risk of infection. This program and others like it have generated international controversy about whether condoms are effective in reducing HIV prevalence and raising associated concerns about increased promiscuity.

2. *Afford*

AFFORD is a five-year health marketing initiative led by the Johns Hopkins Bloomberg School of Public Health and funded by the U.S. Agency for International Development. Designed to increase accessibility and affordability of AIDS products and services, the campaign promotes Protector brand condoms, Pilpan oral contraceptives, and Inject injectable contraceptives. Consumers are encouraged to use these products properly and have access to them at subsidised rates. A centrepiece of the campaign is “The Good Life Gameshow,” an entertainment education quiz show using community interaction, and radio and television shows.

3. *PMTCT (Prevention of Mother to Child Transmission)*

“The Social Marketing Approach to PMTCT” is a Population Services International [PSI] project that uses a branded franchise network of trained midwives to help pregnant women reduce transmission risk during birth. The midwives are also trained on HIV testing procedures and counselling skills. The central message is that it is possible to have an HIV-negative baby even when both parents are HIV positive. Since 2003, a broad media mix has disseminated this message to male partners of pregnant women 25-45, primarily in low-income, low-literary, rural areas.

4. *Trust Condoms*

Designed to reach people in rural, isolated areas of the country, particularly women, this campaign’s central purpose is to launch a new condom brand. The stated rationale for the effort, which began in 2006, is that combating the AIDS pandemic must go hand-in-hand with sensitising those who live in outlying areas. The British and Norwegian governments contributed funds for the campaign.

5. *Be a Man*

Targeted primarily to young men 15 to 24, this campaign was launched in 2006 to prompt reflection on the costs of traditional male attitudes and behaviours, which recent research has shown are contributing to an increase in HIV infections. “Society’s expectations of men are setting them up for failure,” according to Vincent Kiwanuka, the “Be a Man” campaign’s coordinator. The media mix heavily utilises radio drama and television, including broadcasts during the World Cup. The goal is to encourage sexual relationships based on mutual respect.

6. *Sugar Daddies*

Addressing the widespread problem of cross-generational sex (sex with a person at least 10 years older), this campaign, begun in 2004, seeks to raise awareness of the dangers of “sugar daddy” relationships. This practice is a major reason HIV infection rates are six times higher for teenage girls than for their male counterparts. Target audiences include young women 15 to 24, their parents (who often encourage such relationships), and older male partners. The PSI-sponsored initiative features recognised male role models such as Uganda’s Minister of Ethics and Integrity Tim Lwanga urging men to “stop preying on young girls.”

UNITED STATES

1. *We all have AIDS*

Launched in 2005 on World AIDS Day, this campaign created by American designer Kenneth Cole is heavily supported by celebrities and prominent AIDS activists. The message is to reduce stigma associated with AIDS to prevent, contain, and eradicate the disease. The consistent theme for all ads is “We all have AIDS...if one of us does.” International celebrities participating include President Nelson Mandela, Arch Bishop Desmond Tutu, Sharon Stone, Will Smith, and Sir Elton John.

2. ONE

With more than sixty partners, this campaign’s purpose is to rally Americans one by one to push for increased donations to fight poverty and AIDS. The campaign has a broad target audience, ranging from students to ministers to punk rockers to soccer moms. The call to action is “We’re not asking for your money, we’re asking for your voice.” In line with this approach, June 11, 2007, ONE launched ONE Vote ’08, its “largest and boldest initiative ever,” vowing to make extreme poverty and global disease an issue in the 2008 election.

3. *I am African /Keep a Child Alive*

This campaign, also heavily saturated with celebrities, promotes the idea that everyone has some DNA with connections to an African heritage, so all people should work together to help with the AIDS problem. Begun in 2005 and updated every year since, donations for AIDS drugs are particularly sought. “I am African” is linked with the “Keep a Child Alive” campaign, which seeks to help AIDS orphans in Africa by providing them with ARVs [treatment cocktails]. Images of celebrities such as Gwyneth Paltrow and Sting wearing “war paint” with the campaign slogan beneath has sparked controversy about the use of eye-catching visuals that “insensitively perpetuate stereotypical ways of thinking about AIDS or Africa.”

4. *Be the Generation*

This program seeks to create a supportive environment for HIV vaccine research by mobilizing existing community partnerships and networks to educate key communities about this research in twenty U.S. cities where HIV vaccine clinical trials are ongoing or planned. Coordinated media and collateral materials segment target audiences by gender, ethnicity, and lifestyle, showing images of two people, one older and one younger. Extensive educational materials are available online. The uniform message is that the young generation’s “great cause” is to end AIDS and that a vaccine is the best hope of accomplishing that goal.

5. *MTV Think*

This award-winning public information campaign began in 2006 and is notable for bringing MTV on board as a major sponsor. The goal is to reach sexually active 16- to 24-year-olds with information about HIV and related issues, since according to UNAIDS, half of new HIV infections worldwide are among people under the age of 25. Discussion of safe-sex issues, condom use, and HIV testing are urged through television and web media. According to sponsor The Kaiser Family Foundation, this is a “multi-platform, interactive community for the first generation of Americans who have lived their entire lives during the AIDS epidemic.”

6. *The New Faces of HIV in Houston*

Due to high HIV prevalence among African Americans in Houston, in 2002 the Harris County Hospital District and the Houston Department of Health and Human Services launched a social marketing campaign to raise awareness and increase testing among this population. Media include radio, public transit, direct mail, and brochures targeting women. Images of both men and women are featured in the materials, with the slogan, “We look just like you, but you don’t have to be like us. Do the right thing. Get tested.”

Research question 5: What commonalities and unique characteristics can be identified in this population of campaigns as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used? What lessons have been learned so far?

The campaigns share a number of common concerns and objectives although each has a unique theme and a distinctive focus and approach. Each uses a customised media mix to disseminate messages to selected audience(s), but core commonalities are evident throughout. Behavioural models underlying the campaigns were carefully examined.

First and foremost, collaboration is essential; each campaign involves multiple organisations and community groups designed to build participation in and acceptance for individual and policy change. From a worldview, each country’s HIV/AIDS problem has far-reaching implications. Recognising that expanding HIV/AIDS populations will devastate the global economy, governments in both developing and industrialised countries, in conjunction with pharmaceutical companies such as Pfizer, have launched a variety of organised offensives, which include political commitment, law enforcement, government policy, social marketing, and community mobilisation (Pfizer, 2006). This global cooperation encourages alliances such as those forged to support the campaigns in this study.

Secondly, the campaigns all incorporate prevention strategies, with condom use being a frequent tactic. In keeping with its inclusive approach, social marketing assistance usually involves procuring and distributing pharmaceuticals, over-the-counter drugs, and condoms. It also supports capacity building and financial sustainability programs for non-government organisations [NGOs] or for-profit companies (USAID, 2005).

In recognition of cultural obstacles, the campaigns each address aspects of stigma and traditional cultural norms. USAID, whose infectious disease objectives are designed “to contain and reduce HIV/AIDS in vulnerable populations,” focuses on reducing barriers to behaviour change and thereby preventing the HIV/AIDS epidemic in countries such as Mexico from becoming generalised to the population at large (USAID *Health Profile*, 2005). It is generally recognised that changing how people view gender roles and erasing widespread prejudice against gays will be necessary to effectively combat HIV/AIDS.

A number of social marketing campaigns draw on research showing that in many cultures, young men often control how and when young women have sex. Some of the traditional gender norms the campaigns were designed to change are 1) Men should initiate sexual activity early in

life, 2) Men should have multiple sexual partners, 3) Men should maintain control over their female partners, and 4) Unsafe sex is more enjoyable than safer sex. Addressing these gender norms, especially among young people, is increasingly recognised as a vital strategy to prevent the spread of HIV infection (Promoting, 2006).

Modern-day mobility and lifestyle patterns are also considerations in crafting social marketing campaigns for at-risk populations, especially for migrant populations or in border areas. Studies of highly mobile groups such as truck drivers, seasonal employees, and sex workers have identified travel or migration as a factor related to increased HIV/AIDS prevalence. Higher rates of infection are also frequently found along transport routes and in border regions. In addition, migration and mobility also increase vulnerability to HIV/AIDS for the partners at home (*Population Mobility*, 2001: 4).

Persuasive messages for the campaigns are informed by the tenets of one or more established behavioural models. Early generations of HIV social marketing campaigns frequently built their messages around the health belief model, which uses fear or anxiety-arousing messages. In the long term, however, the use of fear appeals draws mixed responses, both from observers and from the targeted audiences. Hastings and colleagues noted fear appeals have been “embraced with enthusiasm by social marketers” (2004: 962), but cautions fear appeals, in addition to encouraging “health fatalism,” may actually have negative long-term effects on the brand. A more effective appeal, especially for young people, according to Backer, Rogers, and Sopory, is the positive rational/emotional approach, which uses fear to grab attention, then relates the fear to a positive outcome (Backer, *et al.*, 1992). The use of external incentives, central to most social marketing approaches, also has potential pitfalls because they can be interpreted as coercion or bribery and not deliver the long-term behavioural change desired (Dholakia and Dholakia, 2001: 498). The personal benefits inherent in self-interest appeals, however, are frequently used to advantage. Based on the well-established Maslow’s hierarchy of needs, self-interest appeals target common human needs ranging from physiological to safety, social, ego, and self-fulfilment (Wilcox, 2002).

Consequently, the current generation of social marketing campaigns is usually grounded in theoretical models other than fear or short-term benefits. In a report prepared for the UK’s National Social Marketing Strategy for Health, McDermott and colleagues (2006) found nutrition social marketing interventions were most frequently based on social cognitive theory, which emphasises observational learning and self-efficacy and is frequently used in campaigns where individuals have choices of how to respond to their environments (Lefebvre, 2001). A somewhat similar appeal is the behavioural decision making model, which uses risk comparisons and probability (Maibach and Parrott, 1995).

Another popular approach, according to McDermott’s report, was the transtheoretical model, known as “stages of change,” which assumes few people are ready to take action and must be moved through early stages of indecision. Lefebvre pointed out one of the few population-based models available to social marketers is diffusion of innovation, which segments any target into

types of adopters (innovator, early adopter, early majority, late majority, and laggard) and suggests the marketer begin with one or two segments (2001:507-515). On a broader policy level, upstream appeals often reference the goal of sustainable development, which takes a generational view and focuses on people's power to make decisions about the future of their society (Dubois, 2003). Typically, each social marketing initiative in this study combines aspects from several of these approaches to ensure acceptance and motivate lasting social change.

SUMMARY OF LESSONS LEARNED

Interviews with key informants revealed important lessons from campaign implementation. Most important are that successful campaigns: 1) Build local, national, and international alliances with common goals, 2) Recruit commercial sponsors for additional support, 3) Involve the target audiences from the outset, 4) Incorporate multimedia and multilingual tactics, 5) Utilize global support for women, 6) Construct trans-border alliances, and 7) Tackle once-taboo topics openly and candidly.

ANALYSIS AND EVALUATION

PRELIMINARY REFLECTIONS

After literature review, content analysis, and a number of semi-structured interviews were completed, it became clear that public communication about HIV/AIDS essentially revolves around three factors: culture, politics, and economics. The specifics of these issues vary from one country to the next, but the global implications cross all physical and conceptual boundaries.

Cultural:

Although categorised as an underground epidemic because of stigma and discrimination associated with the disease, HIV/AIDS has become everyman's—and everywoman's—problem. The actual prevalence numbers are uncertain because of reluctance to seek testing and treatment, but it is certain the global pandemic has spread each year since the first diagnosis in 1981. HIV/AIDS is now both a horizontal epidemic—affecting both sexes—as well as a vertical epidemic—being transferred from mothers to children.

Social marketing has gained widespread acceptance among international organisations as the tool of choice to motivate healthy lifestyle choices and to promote long-term policy changes. These initiatives typically use culturally sensitive approaches to build rapport and persuade. However, the visual/verbal presentation varies widely, depending on the target audience, and appeals vary from personal fear to altruistic concern. HIV/AIDS campaigns are typically targeted to audiences segmented by such factors as demographics [often using ethnicity, gender, or age], behaviour [such as sex workers], or lifestyle [frequently the gay community]. The Mexico and U.S. campaigns share many commonalities, but each reflects the audience's cultural differences. Finally, the phenomenon of complacency, sometimes called “disinhibition”(Abraham, 2007), may be driving a decline in safe sex practices, especially in Western countries where anti-retroviral drugs [ARVs] are widely available and considered a

kind of “cure” for the disease. This may be an example of misperceptions arising out of media and social marketing messages. Regardless, such a trend toward increased risky sexual behaviour among some groups calls into question the way HIV/AIDS information has been presented and perceived.

Political

Politics, the universal tactic of negotiation and compromise, comes into play at every level of human discourse and HIV/AIDS is no exception, as policymakers pursue agendas with a wide range of goals. Therefore, communication about the disease is invariably shaped by political concerns and people live or die as a result of those decisions.

From a practical standpoint, most campaigns emphasise prevention over treatment since there is no known “cure” for the disease and the primary political directive is to reduce rates of infection. It follows, then, that the downstream audience is often the target, with a focus on short-term behavioural change. Additionally, campaign evaluation is difficult, so measurement of effectiveness is frequently based on product successes such as increased condom sales.

As previously explained, collaboration is essential, but “communication by committee” is time-consuming and fraught with dissention. Still, most social marketing initiatives rely on partnerships that cross all boundaries—cultural, political, and geographical—but those partners may have differing viewpoints and aims. For example, in 2003 U.S. President Bush approved a five-year African aid package, saying his country had a “moral duty to act...[since] every day of delay means 8,000 more AIDS deaths in Africa and 14,000 more infections” (Campaigners, 2003). Bush’s plan was criticised because a third of the money slated for prevention had to promote abstinence rather than safer sex. Similarly, in countries like Mexico, which is predominately Roman Catholic, earmarking funds for a disease often associated with lifestyles or practices that conflict with the teachings of the church is a political hurdle.

An intriguing political response to the problem of attracting substantial support is the “positioning” of women as the primary victims— “the innocents”—in the battle against AIDS. This widespread rhetoric is designed to gain broad political support from faith-based organisations as well as from political leaders looking for the most acceptable route to public approval. Since women comprise about half of those infected worldwide, this marketing approach lends itself to a wide range of emotional/rational appeals. On the eve of the June 2007 EU summit, Bill Gates, a major contributor of funds to fight AIDS, appealed to the G8 countries to pledge new resources to “beat AIDS.” Gates said in part, “A top priority must be to address the prevention needs of women and girls...biologically, women are twice as likely as men to contract HIV. And many women—including those who are married—have little power to ensure their partners are faithful or use condoms” (Gates, 2007).

Financial

Whether the focus of the discussion is on individual health care, allotment of national resources, or international business, economics is a principal catalyst for action. AIDS represents both crisis and opportunity in the world of finance.

On the global scale, concern about projected costs of AIDS treatment is spurring policymakers to look for far-reaching solutions to avoid a future collapse of their health care systems. In terms of opportunity, the disease offers possibilities of massive profits for aggressive marketers. Promoting the use of condoms is such an integral part of HIV/AIDS social marketing that the practice has its own acronym: condom social marketing [CSM] (Condom, 2006). After realising sales in Mexico of 19 million condoms in 2004, the charitable organisation DKT International noted “dynamic social marketing” was essential to its success (DKT, 2005).

Even greater opportunities abound when it comes to conventional drug treatments for AIDS victims. In industrialised countries such as the United States, Americans with adequate insurance or personal funds can receive HAART [Highly Active Anti-retroviral Treatment] and monitoring for about £5,000/year. The cost of current treatments clearly separates the haves from the have-nots; only one-fifth of infected people in developing countries are receiving anti-retroviral therapy, primarily due to cost constraints.

In this rush to find effective treatments and ultimately a cure, there have been many stumbles and some documented deceits, such as selective reporting of clinical drug trials, as acknowledged by the International Committee of Medical Journal Editors (Graham, 2004:18). In 2003, the Panos Institute, a global network based in London that focuses on “amplifying the voices of the poor and marginalised,” issued a report examining how communication has been used to respond to the AIDS pandemic and calling for media to support informed debate rather than merely disseminating information (Missing, 2003).

Finally, some critics claim that medical innovations such as nanotechnology are changing the landscape of possibilities regarding treatment and new discoveries about the cause of AIDS are not being published in medical journals or pursued by conventional medicine (Siegal, 2003). The conventional medicine community, on the other hand, cites the benefits of international alliances and increased life expectancies for those receiving HAART (Sepkowitz, 2006).

As the international debate continues, these three factors—cultural content of social marketing messages about HIV/AIDS, the role of political expediency, and the economic realities of the global medical market created by the epidemic—form a complex and politically charged environment that influences public dissemination of information about health care options. The deeper beneath the surface one looks, the more relationships, conflicts, and knowledge gaps are uncovered, justifying further study.

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PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

D.3 Abstract Title: *Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States*

Presented at: AIDS 2008 - XVII International AIDS Conference, Mexico City

Dates: 3-8 August 2008

Publication: Abstract no. WEPE0802

<http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200719099>

Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States

R. Massingill

Issues: When world leaders completed their 25th annual tally of the unrelenting progress of the AIDS pandemic, it was sadly apparent women have achieved global infection equity. Women are biologically twice as likely to contract HIV as men and now make up more than 50 percent of adults living with the disease (UNAIDS, 2007). From the cradle to the grave, women's health destinies are often linked to cultural traditions of female acquiescence and powerlessness, as well as gender norms that give men control of when and how women have sex.

Description: To combat these too-common circumstances, alliances of local, national, and international groups are designing social marketing campaigns to empower women.

This study tells the human stories behind recent successful initiatives that targeted women at risk in three countries:

- Sugar Daddies addressed the widespread problem of cross-generational sex in Uganda, where HIV infection rates are six times higher for teenage girls than for their male counterparts.
- The New Faces of HIV in Houston was launched to increase testing among African American women, who account for 70 percent of the newly diagnosed HIV-positive women in the United States.
- Programa Mujeres encouraged Mexican women aged 14-24 to take control of their sexual and reproductive health in a society where traditional gender roles fuel annual increases in HIV infections.

Lessons learned: Although these empowerment projects were worlds apart in language and culture, each targeted highly vulnerable groups. Relying on global support for the HIV prevention needs of women, the campaigns demonstrated important lessons for future initiatives: forging collaborative partnerships with common goals and varied resources; involving the target audience at every stage; and crafting culturally sensitive multimedia, multilingual messages.

Next steps: Examples of materials and experiences from participants in these campaigns will inspire audiences to contribute ideas for continuing this worldwide empowerment of women.

PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

D.4.1 Poster Title: *Working toward a world without AIDS: how social marketing inspires long-term cultural change*

Presented at: First German-Austrian Swiss AIDS-Congress SODAK 2009, St. Gallen, Switzerland

Dates: 24-27 June 2009

Poster published at www.soedak2009.com

Actual Size of Poster: 32" x 48"

D.4.2 Abstract Title: *Working toward a world without AIDS: how social marketing inspires long-term cultural change*

Published in: *European Journal of Medical Research*, 14.1 (2009) p. 32

Working Toward a World Without AIDS:

How Social Marketing Inspires Long-Term Cultural Change

Ruth Massingill, University of Teesside (England), Sam Houston State University (USA)

From the machismo mindset of Latin America to the Sugar Daddy tradition of African countries to the widespread acceptance of casual sex in the United States, cultural norms are recognized as complicit in the global HIV/AIDS epidemic. Preventing the continued spread of AIDS infections requires permanently altering the social fabric

of such societies. Social marketing—using marketing techniques to achieve social goals—is widely used to motivate high-risk groups to adopt healthy behaviors, which often requires altering generations-long cultural traditions relating to sex and gender.

For more than two decades, social marketing has been a vital tool in this cultural battle against HIV/AIDS.

RESEARCH QUESTION:

Which social marketing approaches have been successfully used to motivate long-term changes in cultural norms that contribute to the spread of HIV/AIDS?

From content analysis and interviews with key informants, 18 campaigns in three countries were compared using cross-tabulation matrices.



Almost 30 years after the onset of HIV/AIDS, the pandemic is a political, economic and health crisis. Public events such as World AIDS Day urge increased political action.

NAME	DATES	MESSAGE	PURPOSE*	AUDIENCE*	SPONSORS*	FRAMES*	THEORY	ROOTS	REF	ADAPTED
Mexico	Border Initiative	2004	Tu No Me Conoces	1, 2	D, FM2, 3 MSM, farmers	1, 2, G	1, 4	Health Belief	Yes	No
	Investing in People	2003-8	Abstinence, fidelity	2, 4	D, FM at risk groups	1, 2, 3, G N P	2, 4	Health Belief	No	No
	Menos Etiquetas	2008-	Gender equity	3, 4	D, FM1	2, 3, G N P	2, 3	Stages of Change	Yes	No
	Programa Hombres	1999-04	Rethink masculinity	4	U/D, M1	1, 2, 3, N P	3, 5	Social Cognitive	Yes	Yes
	Programa Mujeres	2005-	Change gender norms	4	U/D, F1	2, 3, G N P	3, 6	Social Cognitive	Yes	Yes
	VIDA Digna	2005-8	Accept differences	2	D, PLWHA, CSW, MSM	1, 2, N P	3, 6	Diffusion of Innovation	Yes	Yes
Uganda	ABCs	2002-6	Abstain, Be Faithful, Condom	2, 3	D, FM1, 2, general pop	1, 2, 3, G N P	2, 5	Health Belief	Yes	Yes
	Afford Good Life	2006-	Affordable products	2, 3	D, FM, sexually active pop	2, 3, C G N P	2, 3, 5	Diffusion of Innovation	No	No
	Be a Man	2006-	Stop transactional sex	4	D, FM1	1, 2, 3, C G N	2, 3	Social Cognitive	Yes	No
	One Love	2006-	"Zero-grazing"	3, 4	D, FM, sexually active pop	2, 3, C G N	2, 3	Social Cognitive	Yes	Yes
	PMTCT	2002-	Protect babies from HIV	3, 4	D, M2 w/ pregnant partners	2, 3, G N P	2, 4	Reasoned Action	Yes	Yes
	Sugar Daddies	2004-	Stop cross-gen sex	3, 4	U/D, F1, M3	1, 2, G P	1, 4	Reasoned Action	Yes	Yes
USA	Be the Generation	2005-6	HIV vaccine best hope	5, 6	U/D, Broad target	2, N P	2	Social Cognitive	Yes	No
	I am African	2005	We are all African	2, 6	U/D, FM2, 3 parents	3, C N	2, 5	Social Cognitive	Yes	No
	MTV Think	2001-	Be safe, get tested	1, 3	D, FM1, MSM	3, C N	2, 4	Health Belief	Yes	Yes
	New Faces of HIV	2002-4	Get tested for HIV	1	D, FM2, African Americans	1, G N	2, 3	Reasoned Action	Yes	Yes
	ONE	2002-	Change world one by one	5, 6	U/D, broad target	1, 2, 3, C N P	3, 5	Social Cognitive	Yes	Yes
	We All Have AIDS	2005	Solidarity among mankind	2, 5, 6	U/D, broad target	3, C N	1, 4	Diffusion of Innovation	Yes	No

*KEY: PURPOSES: 1. Seek Testing 2. Stigmatization 3. Prevention 4. Cultural Change 5. Political Mobilization 6. Donations/Volunteers AUDIENCES: Upstream Downstream, Female Male 1. 15-24 2. 25-34 3. 35+ SPONSORS: 1. Local 2. National 3. Corporate Government 4. Nonprofit Pharma FRAMES: 1. Consequences 2. Prevention 3. Self-efficacy 4. Sources of HIV/AIDS 5. Benefits 6. Barriers



Because cultural norms often contribute to the spread of HIV/AIDS, many campaigns address issues such as gender equity.

Interpersonal communication that provokes thoughtful discussion is a vital component of effective campaigns.



New media reach high-risk, tech-savvy audiences, especially the 15-24 group. The ONE campaign has 100 partner organizations and two million members, many on college campuses.

NAME	TRAD. MEDIA*	NEW MEDIA*	PRODUCTS	INTERVENE	EVENTS	OUTCOME	SPEAKERS*	VISUAL	VERBAL	ACTION	
Mexico	Border Initiative	1, 2, 5, 6	1	None	1-800 number	None	Quantified	Media	Realistic	2nd person	Yes
	Investing in People	3	1	Condoms	Advocacy seminars	Yes	Not tabulated	Comm leaders	Realistic	2nd person	Yes
	Menos Etiquetas	2, 3, 4	1, 3, 4	Condoms	Peer educators	Yes	Ongoing	None	Abstract	2nd person	Yes
	Programa Hombres	2, 3, 4, 5	1, 2	Hora H condoms	Peer workshops	Yes	Quantified	None	Cartoon	3rd person	Yes
	Programa Mujeres	2, 3	1, 2	Video	Peer workshops	Yes	Quantified	None	Cartoon	3rd person	Yes
	VIDA Digna	2, 6	1	Condoms	Training	Yes	Not tabulated	Leaders, Anon	Realistic	1st/3rd person	Yes
Uganda	ABCs	3, 5	1	Condoms	HIV ed in schools	Yes	Quantified	Anonymous	Realistic	1st person	Yes
	Afford Good Life	2, 3, 5, 6	1	Condoms	Hotline, discussions	Yes	Ongoing	TV personalities	Realistic	1st, 2nd per	Yes
	Be a Man	1, 2, 3, 5, 6	1	None	Games/contests	Yes	Ongoing	Anonymous	Realistic	1st person	Yes
	One Love	1, 3, 5, 6	1	None	Radio call-ins	Yes	Ongoing	TV personalities	Realistic	1st person	Yes
	PMTCT	2, 3, 5	1	Nevirapine, test kits	Health training	Yes	Goal not met	Actors	Realistic	1st person	Yes
	Sugar Daddies	3, 5, 6	4	None	Anti-AIDS clubs	Yes	Ongoing	Comm Leaders	Realistic	2nd person	Yes
USA	Be the Generation	1	1	None	No	Yes	Cancelled	Anonymous	Realistic	1st person	Yes
	I am African	1, 6	1, 4	None	No	Yes	Uncertain	Celebrities	Realistic	1st person	Yes
	MTV Think	6	1, 2, 4	None	Hotline	Yes	Ongoing	TV personalities	Realistic	1st person	Yes
	New Faces of HIV	2, 3, 4, 5	1	Condoms/stickers	Hotline	None	Quantified	Local PLWHA	Realistic	2nd person	Yes
	ONE	3	1, 3, 4, 5	Branded items	No	Yes	Quantified	Celebrities	Realistic	1st person	Yes
	We All Have AIDS	1, 3, 5	1	Special T-shirt	No	Yes	Uncertain	TV Celebrities	Realistic	1st person	Yes

*KEY: TRADITIONAL MEDIA: 1. Print Ads 2. Print Collateral 3. Out of Home 4. Direct Mail 5. Radio 6. TV NEW MEDIA: 1. Website 2. UTube 3. Email 4. Social Media 5. Other SPOKESPERSONS: 1. Celebrities 2. Community Leaders 3. Anonymous 4. Audience Members 5. Media Personalities 6. Actors



Abstinence or safe sex? Condom social marketing creates moral controversy.



Audience research and specific goals must be established in advance. Campaigns with too-broad targets and unclear calls to action are difficult to quantify.



Celebrities and activists offer visibility to HIV/AIDS campaigns.

Findings indicated successful HIV/AIDS campaigns are sensitive to the cultural context of the target audience, using multilingual and multimedia communication. Initiatives with the most lasting results involved members of the target

audience at every stage, from program design through implementation and evaluation. Also, key informants agreed building long-term partnerships and coalitions is challenging but imperative for significant behavioral changes. Overcoming social, political and economic barriers requires cooperation by policymakers across the globe.

Next, an anonymous survey will measure the target audience's knowledge and perceptions of HIV/AIDS information, with the goal of designing an effective communication model.

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**Working toward a world without AIDS:
How social marketing inspires long-term
cultural change**

Ruth E. Massingill

University of Teesside, Business School, Huntsville, United States

From the machismo mindset of Latin America to the Sugar Daddy tradition of African countries to the widespread acceptance of casual sex in the United States, cultural norms are recognized as complicit in the global HIV/AIDS epidemic. Preventing the continued spread of AIDS infections requires permanently altering the social fabric of such societies. Social marketing—using marketing techniques to achieve social goals—is widely used to motivate high-risk groups to adopt healthy behaviors, which often requires altering generations-long cultural traditions relating to sex and gender. For more than two decades, social marketing has been a vital tool in this cultural battle against HIV/AIDS.

This paper addresses the question: Which social marketing approaches have been successfully used to motivate long-term changes in cultural norms that contribute to the spread of HIV/AIDS?

Description: To answer this question, the researcher established criteria and selected 18 recent HIV/AIDS social marketing campaigns for content analysis. Follow-up consisted of semi-structured interviews with key informants connected to the campaigns. Informed by this secondary and primary information, the campaigns were compared using a cross-tabulation matrix.

Conclusions: Findings indicated that successful campaigns are sensitive to the cultural context of the target audience, using multilingual and multimedia methods of communication. Initiatives with the most lasting results were those that involved members of the target audience at every stage, from program design through implementation and evaluation. Additionally, key informants agreed that building long-term partnerships and coalitions was challenging but imperative to achieving significant behavioral changes. The complexity of overcoming social, political and economic barriers required cooperation by policymakers across the globe.

Next steps: The researcher is developing an anonymous quantitative survey to determine perceptions of AIDS treatment and prevention information as presented in recent social marketing campaigns.

2 Prävention / Prevention

P200

Abstract zurückgezogen

P201 (PW)

**Prävention für Menschen mit HIV:
Sexualverhalten und beeinflussende Faktoren**

Dunja Nicca, Synove Daneel, Pietro Verzazza

Infectious Diseases Unit, Hospital St. Gallen, St. Gallen, Switzerland

Hintergrund: Präventionsinterventionen sollten auch Menschen die bereits mit einer HIV-Infektion leben einschliessen. Während im amerikanischen Raum solche Programme bereits Erfolge zeigten, gab es in der Schweiz und vielen anderen europäischen Ländern bisher keine systematischen Programme. An einer ambulanten Sprechstunde wurde ein theoriebasiertes Pilotprogramm zur Unterstützung von präventivem Sexualverhalten von Menschen mit HIV entwickelt und umgesetzt. Erste Resultate, zu eingeschlossenen Patienten in Bezug auf deren Sexualverhalten werden präsentiert.

Methodik: Präventionsinterventionen werden alle 6 Monate durch geschulte Fachpersonen (Ärzte/Pflegende) durchgeführt. Von März bis Dezember 2008 wurde bei 332 Personen eine erste Intervention durchgeführt. Demographische und gesundheitsbezogene Variablen wurden mit dem Fragebogen der Schweizerischen HIV Kohortenstudie erfasst. Sexualverhalten und Motivation wurden mit einem für die Evaluation entwickelten Fragebogen nach jeder Intervention durch Fachpersonen erfasst. Für die Analyse wurden 3 Gruppen mit unterschiedlichem Sexualverhalten verglichen.

Resultate: Von 401 in der Sprechstunde registrierten Patienten erhielten 83% (332) eine erste Präventionsintervention. Der mittlere Alterswert war 46 Jahre (IQR 40-50), 69% davon waren Männer. 122 (37%) Patienten gaben an, keinen Sex zu haben; 193 (58%) gaben sicheres Sexualverhalten und 17 (5%) nicht präventives Sexualverhalten an. Diese drei Gruppen waren vergleichbar bezüglich: Alter, Geschlecht, Ausbildung, Ethnie, Transmissionsgruppe. Signifikante Unterschiede zwischen den Gruppen zeigten sich, in Bezug auf: sexuelle Präferenz, fester Partnerschaft, Einzelhaushalt, Alkoholkonsum, CD4 Zellzahl, und HIV-RNA. Die Gruppe mit nicht präventivem Sexualverhalten zeigte signifikant häufiger bisexuelle Präferenz, Alkoholkonsum und HIV RNA>400.

Schlussfolgerungen: In den ersten zehn Monaten konnte ein hoher Anteil der hier erfassten Patienten erreicht werden, was als gute Integration des Programms in den klinischen Alltag interpretiert werden darf. Unterschiede zwischen den Gruppen zeigten sich vor allem im Verhaltensbereich und in Bezug auf Gesundheitsfaktoren, dies sollte in der Entwicklung von Interventionen berücksichtigt werden.

PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

- D.5.1 Book Cover Image:** *Social marketing for public health: global trends and success stories* (2011) Cheng, H., Philip Kotler, P., and Lee, N., eds., Sudbury, Mass., Jones and Bartlett
- D.5.2** Massingill, R., Chapter 4: *Love, sex, and HIV/AIDS: using social marketing to redefine gender norms among Mexican youth*



Social Marketing for **PUBLIC HEALTH**

GLOBAL TRENDS AND SUCCESS STORIES



Hong Cheng | Philip Kotler | Nancy R. Lee

APPENDIX E

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

- E.1** Poster, *Curing AIDS: why successful HIV/AIDS treatments are unknown to world government policy makers* (2005).
- E.2** Poster, *Social marketing strategies for combating HIV/AIDS in developing countries: examining traditional campaigns* (2006).
- E.3** Abstract, *Getting the word out: promoting cures through social marketing* (2006).
- E.4** Abstract, *A practical approach to cultural change: using social marketing to combat HIV/AIDS in Mexico* (2007).
- E.5** Workshop handouts, *Motivating change: visual and verbal persuasion in HIV/AIDS social marketing* (2007).
- E.6** Poster, *Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States* (2008).
- E.7** Poster, *Positive or negative, HIV/AIDS knowledge & perceptions* (2010).

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.1 **Poster Title:** *Curing AIDS: why successful HIV/AIDS treatments are unknown to world government policy makers*

Presented at: Fifth International Conference on the Capability Approach, UNESCO, Paris, France

Dates: 11-14 September 2005

Actual Size of Poster: 33" x 21"

Curing AIDS: Why Successful HIV/AIDS Treatments are Unknown to World Government Policy Makers

Dr. James W. Adams, University of California, Los Angeles
Ruth Massingill-Pate, Sam Houston State University

INTRODUCTION

To most of the world, an AIDS diagnosis is tantamount to a death sentence. This is both tragic and unnecessary. Physician-led clinics in Uganda, Kenya, and South Africa have demonstrated successes in treating HIV/AIDS, yet few health care industry professionals know about these curative therapies. Almost none of the world's government policymakers acknowledge them. While AIDS has been growing into a global epidemic, the health communications profession has been evolving toward a more sophisticated and pharmaceutical company dominated marketing approach.



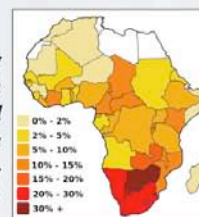
Quantum medical diagnostics and treatment, such as that shown in the photograph at left, will become standard medical practice in the 21st Century. Many of these modalities should be routinely used in conjunction with HIV/AIDS treatments.

ENGAGING WITH THE CAPABILITY APPROACH

- ❑ The traditional medical establishment uses its influence and financial clout to control dissemination of health information, violating the most intrinsic human freedom and endangering the most basic of human capabilities: access to state-of-the-art, life-saving health knowledge.
- ❑ HIV/AIDS destroys people's capacity for resilience.
- ❑ Emotional appeals (*i.e.*, fear) are ignored by the public since no action can be taken to deal with vulnerabilities.
- ❑ AIDS has become an international for-profit business despite its threat to sustainable development.
- ❑ A focus on the bottom line, rather than on human welfare, represents a collision of medical ethics against economics.

PARIS UNESCO, 11-14 Sept. 2005

The debilitating effects of AIDS on the work force and health resources are a macro-economic disaster.



The number of HIV/AIDS infected now surpasses 50 million. In many parts of Africa, AIDS is the main threat to social sustainability; half of all 15-year-olds will die of the disease.

WHAT IS HIV/AIDS?

The *Lancet* has reported for more than 12 years that people who are HIV-positive do not necessarily develop AIDS. Dr. Luc Montagnier, the discoverer of the HIV virus, has stated that HIV is "not a sufficient cause of AIDS on its own." If the definition of HIV/AIDS is incorrect, it follows then the possibility exists of successful new, "alternative" treatments.

CONCLUSION

Lack of knowledge about alternative HIV/AIDS treatments is affecting public policy decisions. Government policy makers, the international healthcare community, and AIDS victims are unable to participate in making informed choices, curtailing their capabilities and endangering future generations.



Social marketing for AIDS often focuses on prevention messages and brand-specific advertising, especially with respect to condom use.

This approach fails to inform the public that micro-viruses easily penetrate the molecular structure of latex condoms, affording minimal protection.

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.2 **Poster Title:** *Social marketing strategies for combating HIV/AIDS in developing countries: examining traditional campaigns*

Presented at: Social Marketing Advances in Research and Theory Conference (SMART), Banff, Canada

Dates: 19-21 October 2006

Actual Size of Poster: 30" x 24"

Social Marketing Strategies to Combat HIV/AIDS: Analysing Recent Campaigns in Three Countries

Ruth Massingill, University of Teesside (England) & Sam Houston State University (USA)

INTRODUCTION

For three decades, social marketing has motivated low-income and high-risk audiences to adopt healthy behaviours. Social marketing is a key tactic for combating HIV/AIDS, both in developing and industrialized countries. Campaigns often focus on prevention messages while addressing stigma and cultural concerns.

As the pandemic's death toll climbs, however, the effectiveness of some HIV/AIDS campaigns is being challenged. Critics charge social marketing messages are not always on target and voice concerns about international drug companies' involvement in product selection and information dissemination.

Nevertheless, many commonalities emerge when examining populations of social marketing campaigns in countries with widely divergent political, cultural, and economic positions in the world community.



UNITED STATES
The power of knowledge—Current U.S. campaigns feature celebrities such as Iman (left), global ambassador for Keep a Child Alive, and a host of other stars and AIDS activists to reduce ignorance and stigma. Designer Kenneth Cole created "We All Have AIDS." In 2003, CBS, Viacom and the Kaiser Family Foundation launched "Know HIV/AIDS."



MEXICO

Revising cultural norms—Programas Hombres (below) and Mujeres (below left) are designed to change how young men and women view gender roles and to urge them to consider the costs of traditional macho culture. Media include print, outdoor and video. The campaigns are sponsored by alliances of NGOs and government organizations.

METHODOLOGY

A population of six HIV/AIDS social marketing campaigns was selected in each of the three countries targeted for this study. The countries chosen represented diverse situations regarding the disease and offered convenient resources and contacts. Other criteria included currency, implementation by a recognized international organization, and sponsorship by one or more major pharmaceutical companies.

Points of analysis for the 18 campaigns included: Purpose, target audience segmentation, campaign dissemination, media mix, message presentation (defined by characteristics of text, image and sound), use of celebrities, references to localized roots, product promotion and type of appeal(s) employed.

HYPOTHESES

- International organizations, in conjunction with pharmaceutical companies, use social marketing to selectively disseminate HIV/AIDS prevention and treatment information.
- Social marketing campaigns for HIV/AIDS tend to be targeted toward specific audiences in rural and/or economically depressed communities.
- These campaigns establish conventional products and treatments as the norm, ignoring increasingly accepted alternative modalities.



UGANDA

Selling condoms and abstinence—AIDS social marketing often focuses on brand-specific advertising to rural areas, as with the Population Services International 1990s brand, Prudence, and its newest product, Trust. PSI's "Sugar Daddy" campaign uses community role models such as Tim Lwanga, Ugandan minister of ethics and integrity, to discourage cross-generational sex. Targets are older men, young women and parents of young girls.

OUTCOMES

The information from this comparative content analysis, conducted by Ruth Massingill and research assistant Lauren Maddox, will provide the basis for semi-structured interviews with opinion leaders involved in social marketing campaigns—marketers, humanitarian leaders and medical practitioners (both conventional and alternative). Interviews will explore the rationale behind the content choices, cultural influences and economic factors influencing dissemination of HIV/AIDS information.

At the conclusion of the project, the researcher will have created and tested a communication model designed to evaluate changes in perceptions and understanding regarding health choices available to prevent and treat HIV/AIDS.

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.3 **Abstract Title:** *Getting the word out: promoting cures through social marketing*

Presented at: AIDS in Culture III: Explorations in the Cultural History of AIDS, Mexico City

Dates: 9-12 December 2006

Panel Abstract for:

Explorations in the Cultural History of AIDS III, Mexico City, Dec. 9-12, 2006

MAKING HISTORY: CURING HIV/AIDS WITH NANOTECHNOLOGY

PANEL SESSION INTRODUCTION

HIV/AIDS has killed at least 28 million people since 1982 (USAID, 2006). The number of HIV/AIDS infected now surpasses 50 million. In the 25 years since the first reported cases of HIV/AIDS in 1981, the disease has become a global pandemic. Unfortunately, the epidemic's history is a story of largely unfulfilled hopes for various treatments.

However, new nanotechnology treatments are offering solutions. In 2005, silver nanoparticles were demonstrated *in vitro* to attach and inhibit HIV-1 from binding to host cells through size-dependent interaction (*see*, Elechiguerra, *et al.*, Interaction of silver nanoparticles with HIV-1, *J. Nanobiotechnology*. 2005, 3, 6.). In 2006, U.S. physicians demonstrated remarkable results in follow-up human pilot programs in Texas.

Social marketing will be a key tactic for informing both policy makers—and the public—of these successes, because social marketing can operate in the maelstrom of cultural, political, economic and social concerns.

PART I: BRIEF HISTORY OF HIV/AIDS TREATMENTS

The history of drug treatment regimens for HIV/AIDS is complex. It is complicated by problems with toxicity, compliance, side effects and cost. In 1987, AZT (zidovudine) was the first drug approved for treatment of AIDS. By the mid-1990s, a number of new drugs were being developed, such as Highly Active Anti-Retroviral Therapy (HAART). HAART treatment involves a combination of three classes of drugs: protease inhibitors, nucleoside reverse transcriptase inhibitors and non-nucleoside reverse transcriptase inhibitors, all of which interfere with the enzymes the virus uses to replicate itself. A viral load below 50—the level at which the virus is no longer detectable in blood—is the goal of therapy, but is seldom achieved.

Newer research shows, however, that the most effective drug therapies fail to prevent replication of the virus. This unfortunate result makes eliminating HIV with antiretroviral therapy unrealistic. Also, the virus often develops resistance during therapy, resulting in a steady viral load increase. Additionally, co-infections are on the rise. These co-infections include both fungal and bacterial infections, as well as common viral infections such as CMV (cytomegalovirus, which affects vision) and viral pneumonia.

Fortunately, nanotechnological solutions to HIV/AIDS hold great promise. The interaction of nano- and sub-nanoparticles with biomolecules and microorganisms is an expanding field of research (*see, e.g.*, Elechiguerra, *et al.*, Interaction of silver nanoparticles with HIV-1, *J. Nanobiotechnology*. 2005, 3, 6.).

Medical literature shows a variety of viruses have been successfully treated with silver-based drugs (Rentz, Viral pathogens and severe acute respiratory syndrome: Oligodynamic Ag⁺ for direct immune intervention, *J. Nutritional & Environmental Medicine*. 2003, Jun; 13(2): 109-18).

Emerging medical studies confirm the stellar, broad-spectrum virotoxic efficacy of oligodynamic noble metals both *in vitro* and *in vivo* (Gordon & Holtorf, A Promising Cure for URTI Pandemics, Including H5N1 and SARS: Has the Final Solution to the Coming Plagues Been Discovered? [Part II]. *Townsend Letter*, Feb/Mar 2006. This includes some of the most formidable viral organisms like HIV (including co-infections) (*Id.*; *see also*; Dean, *et al.*,

Reduction of viral load in AIDS patients with intravenous mild-silver protein—Three case reports, *Clinical Practice of Alternative Medicine*, Spring 2001; Oka, *et al.*, 1994; Hussain, *et al.*, Cystine protects Na, K-ATPase and isolated human lymphocytes from silver toxicity, *Biochem. Biophys. Res. Comm.*, 1992, 189.1444-1449; Aiken, In vitro MIC Test Against HIV-1, published account via email, AA-90 Results. Vanderbilt School of Medicine, Dec. 16, 1997; *et al.*, 2005; Zhong-Yin, *et al.*, Zinc inhibition of rennin and the protease from Human Immunodeficiency Virus Type 1, *Biochemistry*, 1991 Sept 10.30(36): 8717-21).

This portion of the panel and supporting paper will briefly discuss the 25-year history of HIV/AIDS treatments, as well as present a synopsis of current nanotechnology treatments.

PART II: U.S. CASE STUDIES (2006)

In 2006, U.S. physicians operating under Investigational Review Board (IRB) authority demonstrated highly encouraging results using silver nanoparticles to treat HIV/AIDS patients during a pilot program in Texas. This pilot program followed up a University of Texas (Austin)—University of Mexico (Monterrey) study published in 2005, which demonstrated silver nanoparticles *in vitro* attached to and inhibited HIV-1 from binding to host cells through size-dependent interaction (*see*, Elechiguerra, *et al.*, Interaction of silver nanoparticles with HIV-1, *J. Nanobiotechnology*. 2005, 3, 6.).

Under this IRB program, patients received oral-only administration of tiny silver particles set in water. HIV-infected patients, after examination and blood test, orally ingested a nanoparticle-sized solution for 30 days, then retested for improved CD4 counts and viral load. The program consisted of an initial physician examination, two blood tests (one at 15 days, the last at 30 days) to measure CD4 and viral loads, then a final analysis of results.

Patients in this pilot program were on both conventional therapy and non-conventional therapy. The best results were obtained with patients who were not on conventional therapy. One HIV-positive patient showed a remarkable drop of over 68% viral load in only 15 days.

This portion of the panel and supporting paper are based upon three case studies from the pilot program.

PART III: GETTING THE WORD OUT: PROMOTING CURES THROUGH SOCIAL MARKETING

For more than three decades, social marketing has been widely used to motivate low-income and high-risk audiences. Where successful treatments exist, social marketing should now be used to inform governmental policy makers and the public of their existence. This appears especially true with new nanotechnological treatments now in the process of being made available.

Social marketing has been a key tactic in combating HIV/AIDS, both in developing and industrialized countries, for the past 20 years. Social marketing campaigns have previously focused on prevention and treatment messages; yet, these campaigns have also addressed the cultural concerns and stigma related to the disease.

In Mexico, where the increase in new HIV cases has been continuous since 1981, social marketing is the tool of choice for promoting positive change, both for individuals (downstream audiences) and for broader social policy (upstream audiences), with the goal of preventing this “underground epidemic” from becoming generalized to the population at large (HIV Infection, 2003; USAID, 2005). Numerous campaigns address this challenge, including USAID initiatives, whose infectious disease objectives in Mexico target stigma and discrimination. The principal contractor for the USAID campaign, Population Services International [PSI], was the first organization to use social marketing to combat the AIDS epidemic. In addition to procuring and distributing pharmaceuticals, over-the-counter drugs and condoms, PSI trains government officials in marketing and communication techniques.

Mexico is a highly competitive market for products such as condoms, according to the Washington-based charitable organization DKT International. After realizing sales in Mexico of 19 million condoms in 2004, DKT noted “dynamic social marketing” was essential (DKT, 2005). Likewise, PSI, in conjunction with CENSIDA [The National Center for the Prevention and Control of HIV/AIDS] and CONASIDA [The National Council for Prevention and Control of AIDS], is using extensive condom social marketing in high-risk areas of southern Mexico (PSI, 2006).

Since HIV/AIDS is also a significant problem along the U.S.-Mexico border, programs such as the SPNS (Special Projects of National Significance) Border Health Initiative rely heavily on social marketing campaigns, using Spanish language media to blanket the transient communities with “bold” HIV messages (Innovative, 2005). Innovative media strategies also characterize Project Hombres, Project Diversity and Project Mujeres, which were developed by a partnership of Latin American NGOs to combat Mexico’s cultural, gender and lifestyle barriers (World, 2006).

As HIV/AIDS social marketing establishes a track record in Mexico, organizations using this technique can begin to analyze results. For example, PANCEA, a three-year NIH-funded research project in Mexico and four other countries, is studying the effectiveness of the eight prevention modalities commonly used to respond to the HIV epidemic (PANCEA, 2005).

Building on these self-evaluations, this portion of the panel and supporting paper use the essential elements of social marketing to compare Mexico HIV/AIDS campaigns, identifying commonalities as well as unique characteristics in purpose, targeted audience, content/focus and strategic approach. The result is a practical overview of how social marketing can successfully operate in the maelstrom of cultural, political, economic and social concerns while bringing about voluntary behavioural changes among both downstream and upstream audiences.

PANEL SPEAKERS AND MODERATOR

PART I.

Presenter: James Adams, J.D., N.M.D., PhD (cand.), is Research Director of the International Institute of Integrative Medicine. He is a 2006 Research *Collaborateur* with *INSERM*, the French National Institute of Health. Adams has directed international medical clinics and worked as a trial lawyer. He is an adjunct faculty member for UCLA.

Adams is the author of 40 professional volumes, and has edited over 90 reference volumes in law and medicine. He has presented international papers and abstracts on HIV/AIDS research at UNESCO (Paris Conference, 2005), ICASA Conference (Abuja, Nigeria, 2005), and other venues. He is currently working on his Ph.D. in bimolecular nanotechnology.

Contact information: adams.ucla@pdq.net

PART II.

Lead Presenter: Susan Kern, M.D., is a senior physician at the Family Health Group in Houston, Texas. She has practiced medicine for over 20 years. Kern graduated from the University of Texas Medical School and the University of Houston. She has served as a clinical medical director and spent several years working as a RN prior to graduating from medical school.

Kern has also trained and worked overseas with advanced international modalities and technologies. She is presently Principal Investigating Physician for a nanotechnology pilot program treating HIV/AIDS patients in the U.S.

Contact information: drsusankern@yahoo.com

Co-Presenter: James Adams (see above for biographical information)

Contact information: adams.ucla@pdq.net

PART III.

Presenter: Ruth Massingill, B.A., M.A., Ph.D. (cand.) has more than 20 years experience in public relations, advertising and publications. She has served as a university administrator and is presently a tenured faculty member at Sam Houston State University. Recent awards include Outstanding Educator (American Advertising Federation, 2002) and Outstanding Faculty (University of Phoenix-Houston, 2003). Ms. Massingill is lead author for a book on communication issues (Peter Lang Publishing, Inc., 2007).

She founded The Massingill Agency, a public relations firm specializing in social marketing and media relations for alternative health care organizations. She regularly presents papers dealing with communications topics at national and international conferences (*e.g.*, ICA/ACA, Peru, 2006; UNESCO, Paris Conference 2005). Currently, she is earning her Ph.D. in social marketing from the University of Teesside, Middlesbrough, England.

Contact information: ruthmassingill@yahoo.com

PANEL SESSION MODERATOR/CHAIR:

Charles Wallace, M.D., currently practices medicine in the U.S. Dr. Wallace earned his B.A. in chemistry/biology from Gustavus Adolphus College in 1973. He received his medical degree from Howard University School of Medicine in Washington, D.C., in 1978. In 1994, he received a fellowship from the National Cancer Institute to study paediatric HIV disease and oncology. He is an Associate Investigating Physician for a nanotechnology pilot program treating HIV/AIDS patients in the U.S.

His post-graduate medical training included a surgical internship and a urologic residency at Howard University Hospital and affiliated hospitals, including Walter Reed Army Hospital, Children's Hospital, and D.C. General Hospital. He was a chief resident at D.C. General Hospital in his final year as a resident.

Wallace has practiced urologic medicine and integrative medicine for 22 years. He is a Fellow with the International College of Surgeons. Wallace has testified on health care issues before the U.S. Senate. He presently is affiliated with the Methodist Hospital/University of Tennessee. Wallace is a member of the Academy for the Advancement of Medicine. Dr. Wallace has received the distinguished Physician Recognition Award from the American Medical Association.

Contact information: Telephone: 901.272.3200

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.4 **Abstract Title:** *A practical approach to cultural change: using social marketing to combat HIV/AIDS in Mexico*

Presented at: Academy of Marketing 2007 Doctoral Colloquium, Surrey, England

Dates: 2-3 July 2007

**A PRACTICAL APPROACH TO CULTURAL CHANGE:
USING SOCIAL MARKETING TO COMBAT HIV/AIDS IN MEXICO**

SUBMITTED TO:

**ACADEMY OF MARKETING 2007
DOCTORAL COLLOQUIUM
2-3 JULY 2007**

ABSTRACT

Social marketing has been widely used to influence low-income, high-risk populations to make healthy behaviour changes. This application of marketing principles has also become an important tool for persuading upstream audiences to make long-term policy changes that achieve socially desirable goals. As the human, social, and economic costs of the HIV/AIDS pandemic mount, social marketing is now a key tactic for combating the disease. This paper analyses six recent HIV/AIDS campaigns in Mexico, examining their ability to motivate change and their potential for informing target audiences about new health choices. Although each campaign has a unique theme and a distinctive focus, all share common objectives. Collaboration is essential; each campaign involves multiple organizations, thereby building acceptance for change at all levels. The campaigns all incorporate prevention strategies, and in recognition of Mexico's cultural obstacles, each addresses aspects of stigma and traditional cultural norms. Persuasive messages are informed by the tenets of established behavioural models. As a result, alliances of HIV/AIDS social marketers in Mexico have been able to operate successfully in the maelstrom of cultural, political, economic, and social concerns while bringing about voluntary behavioural changes among both downstream and upstream audiences.

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.5 **Workshop Title:** *Motivating change: visual and verbal persuasion in HIV-AIDS Social Marketing*

Presented at: American Communication Association, Taos, New Mexico

Handouts from Workshop:

- a. Controversial ads
- b. Every generation
- c. I am African
- d. Miscellaneous campaigns
- e. One campaign

Dates: 4-6 October 2007



“Friendly fire” is a term that has been used to describe social marketing campaigns aimed at shooting down the enemy-AIDS-but that do some collateral damage by either reinforcing negative stereotypes or creating an environment that makes people not want to acknowledge they are at risk. Les Pappas of Better World Advertising, which created the “HIV is a gay disease” and “HIV (not fabulous)” campaigns, says we don’t like social marketing when it “challenges our denial, shocks us, makes us feel uncomfortable, airs our dirty laundry, or makes us think too much.”

www.social-marketing.com/blog/2006/10/friendly-fire-stigma-social-marketing.html

Every generation has its great cause.

mine was civil rights
ours is ending AIDS

An HIV vaccine is our best hope of ending the AIDS epidemic.

Right now, there is no vaccine to prevent HIV infection, but scientists are working to find one. To succeed, they will need thousands of people from all walks of life to support HIV vaccine studies and encourage those who volunteer. You can't get HIV from a vaccine study, but you can help end the AIDS epidemic. Learn more about how you can do your part. Visit www.bethegeneration.org. Together, we can be the generation that ends the AIDS epidemic. Call 1-800-449-0240 for more information.

[bethegeneration.org](http://www.bethegeneration.org)

HIV VACCINE RESEARCH

Every generation has its great cause.

mine was a
better life for my family
ours is ending AIDS

Every generation has its great cause.

mine was starting
the fight against AIDS
ours is ending it

This program seeks to create a supportive environment for HIV vaccine research by mobilizing existing community partnerships and networks to educate key communities about this research in twenty U.S. cities where HIV vaccine clinical trials are ongoing or planned. Coordinated media and collateral materials segment target audiences by gender, ethnicity, and lifestyle, showing images of two people, one older and one younger. Extensive educational materials are available online. The uniform message is that the young generation's "great cause" is to end AIDS and a vaccine is the best hope of accomplishing that goal.

www.bethegeneration.org



Social marketers aim at the unique needs and experiences of their target audiences. But campaigns that target particular groups are often seen as reinforcing stereotypes. It has also been suggested that American HIV/AIDS campaigns are stymied by Puritanism about the body and sexuality. Most HIV/AIDS campaigns are serious in tone, although Europeans are not adverse to injecting humor into the topic. "How do you balance out the criticisms over the larger issue of effectiveness?" asked one public official who oversees San Francisco's policies for preventing HIV/AIDS.

ONE THE CAMPAIGN TO MAKE POVERTY HISTORY



With more than sixty partners, this campaign's purpose is to rally Americans one by one to push for increased donations to fight poverty and AIDS. The campaign has a broad target audience, ranging from students to ministers to punk rockers to soccer moms. The call to action is "We're not asking for your money, we're asking for your voice." In line with this approach, June 11, 2007, ONE launched ONE Vote '08, its "largest and boldest initiative ever," vowing to make extreme poverty and global disease an issue in the 2008 election.

www.one.org

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.6 **Poster Title:** *Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States*

Presented at: XVII International AIDS Conference, Mexico City

Dates: 3-8 August 2008

Actual Size of Poster: 48" x 42"

Until AIDS Do Us Part

Social Marketing Campaigns Empower Women At Risk in Mexico, Uganda and the United States

Ruth Massingill, Sam Houston State University (USA), Teesside University (England)

When world leaders completed their 25th annual tally of the unrelenting progress of the AIDS pandemic, it was sadly apparent women have achieved global infection equity.

Women, biologically twice as likely to contract HIV as men, now account for half of the adults living with the disease worldwide. Young women are at great risk, with an estimated 45 percent of new infections globally occurring among 15- to 24-year-olds.

From the cradle to the grave, women's health destinies are often linked to cultural traditions of female acquiescence and powerlessness, as well as gender norms that give men control of when and how women have sex.

To combat these too-common circumstances, alliances of local, national and international groups are designing social marketing campaigns to empower women.

These three case studies examine initiatives that targeted women at risk in three countries. Each campaign focused on a contributing factor—gender equality, cross generational sex and stigma, but the lessons learned are applicable to all cultures and countries.



Addressing gender norms—societal messages that dictate appropriate or expected behavior for males and females—is increasingly recognized as a key strategy to prevent the spread of HIV infection, particularly among young people.

Programa Mujeres

Encouraged young Mexican women (15-24) to take control of their sexual and reproductive health in a society where machismo fuels annual increases in HIV/AIDS infections.



WHO WAS INVOLVED?

- Instituto Promundo
- PAPA Institute, ECOS and Salud y Genero
- MacArthur and OAK Foundations
- World Education
- Special Secretariat of Women's Policies

HOW WAS IT IMPLEMENTED?

- Began in Brazil, then adapted for other countries
- Target audience developed campaign materials
- Used "social technologies"
- Peer-promoters led small discussion groups
- No-words cartoon about Maria

WHAT WERE THE RESULTS?

- Changing attitudes/behaviors, building sense of self-efficacy and empowerment
- Positive response led to use in India



Cultural traditions in many developing countries have created an environment in which girls as young as 15 are encouraged to exchange their bodies for modest financial support, entering empty sexual relationships with men who are a generation or more older.



Sugar Daddies

Addressed the widespread problem of cross-generational sex in Uganda, where HIV infection rates are six times higher for teenage girls than for their male counterparts.

WHO WAS INVOLVED?

- Population Services International
- Uganda Ministry of Health
- YouthAIDS
- Straight Talk Foundation

HOW WAS IT IMPLEMENTED?

- Theme: "Cross Generational Sex Stops With You"
- Seminars with media coverage
- Extensive use of billboards
- Radio talk shows, soap opera
- Chastity scholarships

WHAT WERE THE RESULTS?

- Extensive media publicity
- Public dialogue, awareness
- Community involvement



To help counteract the detachment of anonymous billboards and posters, eight HIV-positive African-Americans in Houston put their faces on a citywide HIV prevention and education campaign with the theme, "You don't have to be like us."

New Faces of HIV

Launched in Houston, Texas, to decrease stigma and increase testing among African American women, who account for 77 percent of the HIV-positive women in Harris County.



WHO WAS INVOLVED?

- The Harris County Hospital District
- Houston Dept. of Health & Human Services
- Local HIV/AIDS advocacy groups

HOW WAS IT IMPLEMENTED?

- Posters and stickers in music shops, public restrooms
- Radio spots on local African-American stations
- Brochures in beauty salons
- Transit placards
- 24-hour HIV hotline

WHAT WERE THE RESULTS?

- Extensive media publicity
- More than 100% increase in participants
- Advocacy by campaign participants
- Additional budget allocation



Although these empowerment projects were worlds apart in language and culture, each targeted highly vulnerable groups. Relying on global support for the HIV prevention needs of women, the campaigns demonstrated important lessons for future initiatives:

- Forge collaborative partnerships with common goals and varied resources;
- Recruit commercial sponsors for additional resources;
- Involve the target audience at every stage;
- Craft culturally sensitive multimedia, multilingual messages; &
- Utilize global support for women.

In-depth examination of these three campaigns confirms that communication about HIV/AIDS is complex and highly political. But, facilitating open dialogue is crucial since the disease crosses all boundaries, creating dramatic shifts in the world economy, affecting global politics and uprooting generations of cultural traditions.

As a result, once-taboo topics such as explicit discussions about sexual practices and alternative lifestyles, use of condoms, and gender equity are now part of the international dialogue.



PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.7 **Poster Title:** *Positive or negative, HIV/AIDS knowledge & perceptions*

Presented at: 1st Annual College of Humanities & Social Science Research
Conference, Sam Houston State University, Huntsville, Texas

Dates: 9 April 2010

Actual Size of Poster: 48" x 36"

POSITIVE OR NEGATIVE

HIV/AIDS Knowledge and Perceptions

RUTH MASSINGILL
Sam Houston State University (USA)
Teesside University (England)

This quantitative survey was designed to gather baseline information establishing the perceived knowledge level of a high-risk, high-interest downstream audience regarding HIV/AIDS issues and concerns. It is part of a larger project that examines HIV/AIDS social marketing campaigns in Mexico, Uganda and the United States. The overall aim is to understand which appeals and approaches are most effective in motivating lifestyle changes to prevent infection and improve treatment results. Information collected will be used to help guide the design of a model for effectively informing similar audiences about HIV/AIDS.

RESearch QUESTIONS:
The survey was designed to answer four questions:
1. Where do recipients of HIV/AIDS information learn about the disease?
2. How credible do these recipients consider their information sources to be?
3. What perceptions and knowledge do these recipients have about the disease?
4. How do recipients of HIV/AIDS information perceive their choices as regards prevention techniques and treatment modalities?

METHODOLoGY:
Anonymous surveys with separate signed consent forms were administered at the Legacy Clinic in Houston over a four-day period. Respondents were not necessarily HIV/AIDS patients; their principal commonality was they were all receivers of information about HIV/AIDS. Sample selection was by consent and convenience.
Demographic highlights of the 342 valid responses: 66% male; 42% heterosexual, 38% homosexual and 10% bisexual; 37% White, 36% Black and 16% Hispanic; 48% high school grads, 33% college grads. Regarding HIV status, 31% were negative and 54% were positive.

"Taking this survey made me realize how much I don't know about HIV/AIDS."
—Straight woman HIV-negative

"Positive for 30 years and have never taken any drugs ever for the illness."
—Bisexual man HIV-positive

"I know my God is good. I've been exposed since 1992 until now. I'm still here."
—Straight man HIV-negative

"Some of these therapies used together can be effective."
—Gay man HIV-positive

"We need more education in schools. Many people believe the numbers are going down drastically and there is a readily available cure."
—Straight woman HIV-negative

"Knowledge is power!"
—Gay man HIV-positive

"It's sad we have gotten comfortable with these diseases. To really educate yourself, you have to make an effort."
—Bisexual man HIV-positive

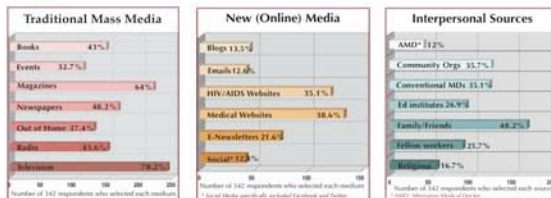
"Lots of treatments. I didn't know any of them."
—Gay man HIV-negative

"I have had a family member living with AIDS for 10 years. I have seen her almost die five times. I believe given funding a cure could be found. I have to hope."
—Straight woman HIV-negative

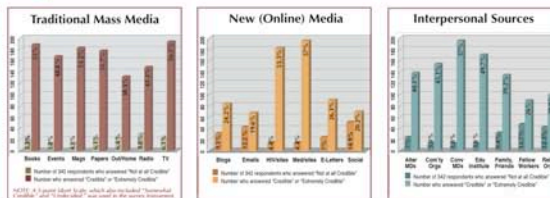
"If not for the good doctors and case workers, I would have been very ill. I love how they let me know I am not in the dark."
—Straight woman HIV-positive

"Having four friends with HIV, I still don't know what they go through to stay well every day. I feel it's not an open subject to talk about."
—Gay man HIV-negative

1 FROM WHICH SOURCES HAVE YOU LEARNED ABOUT HIV/AIDS IN THE PAST 4-5 YEARS?
Twenty choices included mass media, new media, and personal sources, but were not so labeled. Respondents were asked to select all media sources that applied to the question.



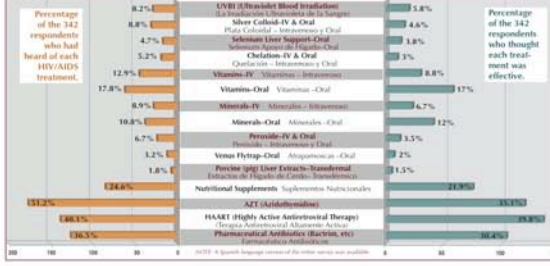
2 RATE EACH OF THESE SOURCES OF HIV/AIDS INFORMATION ACCORDING TO HOW CREDIBLE (BELIEVABLE) THEY HAVE BEEN IN YOUR EXPERIENCE.



3 PLEASE CHECK THE RESPONSE THAT BEST REPRESENTS HOW YOU FEEL ABOUT THESE STATEMENTS: These were arranged in a random manner but fell into categories relating to cultural stereotypes, prevention and treatment, and global socio-political issues.



4 A) MARK ALL OF THESE HIV/AIDS TREATMENTS YOU HAVE HEARD OF, B) BASED ON YOUR EXPERIENCE, MARK ALL TREATMENTS YOU THINK CAN BE EFFECTIVE IN TREATING HIV/AIDS.



APPENDIX F
SPSS TABLES FROM CHAPTER 7

F.1	Cross Tabulation Tables with Significance Or a Tendency toward Significance Using Pearson’s Chi-Square Test of Association	
F.1.a.	Crosstabs: Sources and Demographic Variables	F1
F.1.b.	Crosstabs: Source Credibility and Demographic Variables	F18
F.1.c.	Crosstabs: Perception Statements and Demographic Variables	F29
F.1.d.	Crosstabs: Treatments Known and Demographic Variables	F71
F.1.e.	Crosstabs: Effective Treatments and Demographic Variables	F93
F.2	List of Crosstabs with No Significance	F114
F.3	Reliability Statistics: Cronbach’s Alpha Analysis Tables	F116

CROSSTABS: SOURCES AND DEMOGRAPHIC VARIABLES

SOURCES VS. GENDER

			Which gender do you identify yourself with		Total
			male	female	
sources you have learned about HIV/AIDS in the last 4-5 years- TV	not selected	Count	77	18	95
		Expected Count	63.0	32.0	95.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-TV	81.1%	18.9%	100.0%
		% of Total	23.8%	5.6%	29.3%
	selected	Count	138	91	229
		Expected Count	152.0	77.0	229.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-TV	60.3%	39.7%	100.0%
		% of Total	42.6%	28.1%	70.7%
Total		Count	215	109	324
		Expected Count	215.0	109.0	324.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-TV	66.4%	33.6%	100.0%
		% of Total	66.4%	33.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	13.001(b)	1	.000		
Continuity Correction(a)	12.086	1	.001		
Likelihood Ratio	13.850	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	12.961	1	.000		
N of Valid Cases	324				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 31.96.

			Which gender do you identify yourself with		Total
			male	female	
sources you have learned about HIV/AIDS in the last 4-5 years- Radio	not selected	Count	133	48	181
		Expected Count	120.1	60.9	181.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	73.5%	26.5%	100.0%
		% of Total	41.0%	14.8%	55.9%
	selected	Count	82	61	143
		Expected Count	94.9	48.1	143.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	57.3%	42.7%	100.0%
		% of Total	25.3%	18.8%	44.1%
Total		Count	215	109	324
		Expected Count	215.0	109.0	324.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	66.4%	33.6%	100.0%
		% of Total	66.4%	33.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	9.320(b)	1	.002		
Continuity Correction(a)	8.611	1	.003		
Likelihood Ratio	9.301	1	.002		
Fisher's Exact Test				.003	.002
Linear-by-Linear Association	9.291	1	.002		
N of Valid Cases	324				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 48.11.

			Which gender do you identify yourself with		Total
			male	female	
sources you have learned about HIV/AIDS in the last 4-5 years- Magazine	not selected	Count	66	47	113
		Expected Count	75.0	38.0	113.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Magazine	58.4%	41.6%	100.0%
		% of Total	20.4%	14.5%	34.9%
	selected	Count	149	62	211
		Expected Count	140.0	71.0	211.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Magazine	70.6%	29.4%	100.0%
		% of Total	46.0%	19.1%	65.1%
Total		Count	215	109	324
		Expected Count	215.0	109.0	324.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Magazine	66.4%	33.6%	100.0%
		% of Total	66.4%	33.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.914(b)	1	.027		
Continuity Correction(a)	4.382	1	.036		
Likelihood Ratio	4.849	1	.028		
Fisher's Exact Test				.036	.019
Linear-by-Linear Association	4.898	1	.027		
N of Valid Cases	324				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 38.02.

			Which gender do you identify yourself with		Total
			male	female	male
sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	not selected	Count	144	57	201
		Expected Count	133.4	67.6	201.0
		% within Sources	71.6%	28.4%	100.0%
		% of Total	44.4%	17.6%	62.0%
	selected	Count	71	52	123
		Expected Count	81.6	41.4	123.0
		% within Sources	57.7%	42.3%	100.0%
		% of Total	21.9%	16.0%	38.0%
Total		Count	215	109	324
		Expected Count	215.0	109.0	324.0
		% within Sources	66.4%	33.6%	100.0%
		% of Total	66.4%	33.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.621(b)	1	.010		
Continuity Correction(a)	6.013	1	.014		
Likelihood Ratio	6.552	1	.010		
Fisher's Exact Test				.011	.007
Linear-by-Linear Association	6.601	1	.010		
N of Valid Cases	324				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 41.38.

SOURCES VS. STATUS

			My HIV status is		Total
			Negative	Positive	
sources you have learned about HIV/AIDS in the last 4-5 years- TV	not selected	Count	24	65	89
		Expected Count	32.6	56.4	89.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-TV	27.0%	73.0%	100.0%
		% of Total	8.2%	22.3%	30.5%
	selected	Count	83	120	203
		Expected Count	74.4	128.6	203.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-TV	40.9%	59.1%	100.0%
		% of Total	28.4%	41.1%	69.5%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-TV	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.164(b)	1	.023		
Continuity Correction(a)	4.582	1	.032		
Likelihood Ratio	5.311	1	.021		
Fisher's Exact Test				.025	.015
Linear-by-Linear Association	5.147	1	.023		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 32.61.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- Radio	not selected	Count	50	118	168	
		Expected Count	61.6	106.4	168.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	29.8%	70.2%	100.0%	
		% of Total	17.1%	40.4%	57.5%	
	selected	Count	57	67	124	
		Expected Count	45.4	78.6	124.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	46.0%	54.0%	100.0%	
		% of Total	19.5%	22.9%	42.5%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio			36.6%	63.4%	100.0%	
% of Total			36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.071(b)	1	.004		
Continuity Correction(a)	7.388	1	.007		
Likelihood Ratio	8.046	1	.005		
Fisher's Exact Test				.005	.003
Linear-by-Linear Association	8.043	1	.005		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 45.44.

			My HIV status is		Total		
			Negative	Positive			
sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	not selected	Count	55	119	174		
		Expected Count	63.8	110.2	174.0		
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	31.6%	68.4%	100.0%		
		% of Total	18.8%	40.8%	59.6%		
	selected	Count	52	66	118		
		Expected Count	43.2	74.8	118.0		
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	44.1%	55.9%	100.0%		
		% of Total	17.8%	22.6%	40.4%		
		Total		Count	107	185	292
				Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	36.6%	63.4%	100.0%		
		% of Total	36.6%	63.4%	100.0%		

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.701(b)	1	.030		
Continuity Correction(a)	4.180	1	.041		
Likelihood Ratio	4.676	1	.031		
Fisher's Exact Test				.035	.021
Linear-by-Linear Association	4.685	1	.030		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 43.24.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites	not selected	Count	78	108	186	
		Expected Count	68.2	117.8	186.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites	41.9%	58.1%	100.0%	
		% of Total	26.7%	37.0%	63.7%	
	selected	Count	29	77	106	
		Expected Count	38.8	67.2	106.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites	27.4%	72.6%	100.0%	
		% of Total	9.9%	26.4%	36.3%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
% within sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites			36.6%	63.4%	100.0%	
% of Total			36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.180(b)	1	.013		
Continuity Correction(a)	5.568	1	.018		
Likelihood Ratio	6.316	1	.012		
Fisher's Exact Test				.016	.009
Linear-by-Linear Association	6.159	1	.013		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 38.84.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- Online newsletter,journals,ect	not selected	Count	77	153	230	
		Expected Count	84.3	145.7	230.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Online newsletter, journals	33.5%	66.5%	100.0%	
		% of Total	26.4%	52.4%	78.8%	
	selected	Count	30	32	62	
		Expected Count	22.7	39.3	62.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Online newsletter, journals	48.4%	51.6%	100.0%	
		% of Total	10.3%	11.0%	21.2%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Online newsletter, journals	36.6%	63.4%	100.0%	
		% of Total	36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.676(b)	1	.031		
Continuity Correction(a)	4.055	1	.044		
Likelihood Ratio	4.565	1	.033		
Fisher's Exact Test				.038	.023
Linear-by-Linear Association	4.660	1	.031		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 22.72.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- Social media,facebook, Twitter, ect	not selected	Count	86	167	253	
		Expected Count	92.7	160.3	253.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Social media, facebook, Twitter	34.0%	66.0%	100.0%	
		% of Total	29.5%	57.2%	86.6%	
	selected	Count	21	18	39	
		Expected Count	14.3	24.7	39.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Social media facebook, Twitter	53.8%	46.2%	100.0%	
		% of Total	7.2%	6.2%	13.4%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Social media facebook, Twitter	36.6%	63.4%	100.0%	
		% of Total	36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.737(b)	1	.017		
Continuity Correction(a)	4.914	1	.027		
Likelihood Ratio	5.535	1	.019		
Fisher's Exact Test				.020	.014
Linear-by-Linear Association	5.718	1	.017		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.29.

			My HIV status is		Total
			Negative	Positive	
sources you have learned about HIV/AIDS in the last 4-5 years-Educational institutions	not selected	Count	68	144	212
		Expected Count	77.7	134.3	212.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Edu institutions	32.1%	67.9%	100.0%
		% of Total	23.3%	49.3%	72.6%
	selected	Count	39	41	80
		Expected Count	29.3	50.7	80.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Edu institutions	48.8%	51.3%	100.0%
		% of Total	13.4%	14.0%	27.4%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Edu institutions	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.956(b)	1	.008		
Continuity Correction(a)	6.256	1	.012		
Likelihood Ratio	6.820	1	.009		
Fisher's Exact Test				.010	.007
Linear-by-Linear Association	6.932	1	.008		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 29.32.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- Friends or family members	not selected	Count	44	106	150	
		Expected Count	55.0	95.0	150.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Friends or family members	29.3%	70.7%	100.0%	
		% of Total	15.1%	36.3%	51.4%	
	selected	Count	63	79	142	
		Expected Count	52.0	90.0	142.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Friends or family members	44.4%	55.6%	100.0%	
		% of Total	21.6%	27.1%	48.6%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
% within sources you have learned about HIV/AIDS in the last 4-5 years- Friends or family members			36.6%	63.4%	100.0%	
% of Total			36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.101(b)	1	.008		
Continuity Correction(a)	6.468	1	.011		
Likelihood Ratio	7.127	1	.008		
Fisher's Exact Test				.011	.005
Linear-by-Linear Association	7.076	1	.008		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 52.03.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- People you work with	not selected	Count	68	149	217	
		Expected Count	79.5	137.5	217.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- People you work with	31.3%	68.7%	100.0%	
		% of Total	23.3%	51.0%	74.3%	
	selected	Count	39	36	75	
		Expected Count	27.5	47.5	75.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- People you work with	52.0%	48.0%	100.0%	
		% of Total	13.4%	12.3%	25.7%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- People you work with	36.6%	63.4%	100.0%	
		% of Total	36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	10.251(b)	1	.001		
Continuity Correction(a)	9.380	1	.002		
Likelihood Ratio	10.009	1	.002		
Fisher's Exact Test				.002	.001
Linear-by-Linear Association	10.216	1	.001		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 27.48.

SOURCES VS. SEXUAL ORIENTATION

		sexual orientation			Total	
		heterosexual	homosexual	bi-sexual	1.00	
sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites	not selected	Count	109	73	16	198
		Expected Count	92.9	83.3	21.8	198.0
		% within sources	55.1%	36.9%	8.1%	100.0%
		% of Total	35.3%	23.6%	5.2%	64.1%
	selected	Count	36	57	18	111
		Expected Count	52.1	46.7	12.2	111.0
		% within sources	32.4%	51.4%	16.2%	100.0%
		% of Total	11.7%	18.4%	5.8%	35.9%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within sources	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.578(a)	2	.000
Likelihood Ratio	15.750	2	.000
Linear-by-Linear Association	14.892	1	.000
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.21.

SOURCES VS. AGE

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
sources you have learned about HIV/AIDS in the last 4-5 years- Social media, facebook, Twitter, ect	not selected	Count	42	67	98	74	17	298
		Expected Count	46.5	78.0	90.3	67.5	15.8	298.0
		% within sources	14.1%	22.5%	32.9%	24.8%	5.7%	100.0%
		% of Total	12.4%	19.7%	28.8%	21.8%	5.0%	87.6%
	selected	Count	11	22	5	3	1	42
		Expected Count	6.5	11.0	12.7	9.5	2.2	42.0
		% within sources	26.2%	52.4%	11.9%	7.1%	2.4%	100.0%
		% of Total	3.2%	6.5%	1.5%	.9%	.3%	12.4%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within sources	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	27.230(a)	4	.000
Likelihood Ratio	27.492	4	.000
Linear-by-Linear Association	17.841	1	.000
N of Valid Cases	340		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 2.22.

SOURCES VS. ETHNIC GROUP

			which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/african american or negro	hispanic	White / caucasian	multiracial	other	
sources you have learned about HIV/AIDS in the last 4-5 years- Conventional medical doctors	not selected	Count	6	3	88	42	66	10	6	221
		Expected Count	5.9	2.6	79.5	34.6	82.8	11.7	3.9	221.0
		% within sources	2.7%	1.4%	39.8%	19.0%	29.9%	4.5%	2.7%	100.0%
		% of Total	1.8%	.9%	26.0%	12.4%	19.5%	2.9%	1.8%	65.2%
	selected	Count	3	1	34	11	61	8	0	118
		Expected Count	3.1	1.4	42.5	18.4	44.2	6.3	2.1	118.0
		% within sources	2.5%	.8%	28.8%	9.3%	51.7%	6.8%	.0%	100.0%
		% of Total	.9%	.3%	10.0%	3.2%	18.0%	2.4%	.0%	34.8%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within sources	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.106(a)	6	.002
Likelihood Ratio	23.099	6	.001
Linear-by-Linear Association	5.224	1	.022
N of Valid Cases	339		

a 5 cells (35.7%) have expected count less than 5. The minimum expected count is 1.39.

**CROSSTABS:
SOURCE CREDIBILITY AND DEMOGRAPHIC VARIABLES**

SOURCE CREDIBILITY VS. STATUS

			My HIV status is		Total
			Negative	Positive	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-events, seminars, workshops, conferences	not at all credible	Count	1	8	9
		Expected Count	3.4	5.6	9.0
		% within Sources	11.1%	88.9%	100.0%
		% of Total	.5%	3.7%	4.1%
	somewhat credible	Count	5	14	19
		Expected Count	7.2	11.8	19.0
		% within Sources	26.3%	73.7%	100.0%
		% of Total	2.3%	6.5%	8.8%
	undecided	Count	12	30	42
		Expected Count	15.9	26.1	42.0
		% within Sources	28.6%	71.4%	100.0%
		% of Total	5.5%	13.8%	19.4%
	credible	Count	27	42	69
		Expected Count	26.1	42.9	69.0
		% within Sources	39.1%	60.9%	100.0%
		% of Total	12.4%	19.4%	31.8%
	extremely credible	Count	37	41	78
		Expected Count	29.5	48.5	78.0
		% within Sources	47.4%	52.6%	100.0%
		% of Total	17.1%	18.9%	35.9%
Total		Count	82	135	217
		Expected Count	82.0	135.0	217.0
		% within Sources	37.8%	62.2%	100.0%
		% of Total	37.8%	62.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.447(a)	4	.077
Likelihood Ratio	9.022	4	.061
Linear-by-Linear Association	8.171	1	.004
N of Valid Cases	217		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 3.40.

			My HIV status is		Total
			Negative	Positive	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-community organizations	not at all credible	Count	0	8	8
		Expected Count	2.9	5.1	8.0
		% within Sources	.0%	100.0%	100.0%
		% of Total	.0%	3.5%	3.5%
	somewhat credible	Count	15	14	29
		Expected Count	10.5	18.5	29.0
		% within Sources	51.7%	48.3%	100.0%
		% of Total	6.5%	6.1%	12.6%
	undecided	Count	17	38	55
		Expected Count	19.8	35.2	55.0
		% within Sources	30.9%	69.1%	100.0%
		% of Total	7.4%	16.5%	23.9%
	credible	Count	26	51	77
		Expected Count	27.8	49.2	77.0
		% within Sources	33.8%	66.2%	100.0%
		% of Total	11.3%	22.2%	33.5%
	extremely credible	Count	25	36	61
		Expected Count	22.0	39.0	61.0
		% within Sources	41.0%	59.0%	100.0%
		% of Total	10.9%	15.7%	26.5%
Total		Count	83	147	230
		Expected Count	83.0	147.0	230.0
		% within Sources	36.1%	63.9%	100.0%
		% of Total	36.1%	63.9%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.045(a)	4	.060
Likelihood Ratio	11.565	4	.021
Linear-by-Linear Association	.456	1	.500
N of Valid Cases	230		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 2.89.

			My HIV status is		Total
			Negative	Positive	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-educational institutions	not at all credible	Count	1	7	8
		Expected Count	3.0	5.0	8.0
		% within Sources	12.5%	87.5%	100.0%
		% of Total	.5%	3.2%	3.6%
	somewhat credible	Count	11	13	24
		Expected Count	9.0	15.0	24.0
		% within Sources	45.8%	54.2%	100.0%
		% of Total	5.0%	5.9%	10.8%
	undecided	Count	8	33	41
		Expected Count	15.3	25.7	41.0
		% within Sources	19.5%	80.5%	100.0%
		% of Total	3.6%	14.9%	18.5%
	credible	Count	34	47	81
		Expected Count	30.3	50.7	81.0
		% within Sources	42.0%	58.0%	100.0%
		% of Total	15.3%	21.2%	36.5%
	extremely credible	Count	29	39	68
		Expected Count	25.4	42.6	68.0
		% within Sources	42.6%	57.4%	100.0%
		% of Total	13.1%	17.6%	30.6%
Total		Count	83	139	222
		Expected Count	83.0	139.0	222.0
		% within Sources	37.4%	62.6%	100.0%
		% of Total	37.4%	62.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.976(a)	4	.041
Likelihood Ratio	10.886	4	.028
Linear-by-Linear Association	2.611	1	.106
N of Valid Cases	222		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 2.99.

			My HIV status is		Total
			Negative	Positive	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-people you work with	not at all credible	Count	7	31	38
		Expected Count	14.7	23.3	38.0
		% within Sources	18.4%	81.6%	100.0%
		% of Total	3.3%	14.5%	17.8%
	somewhat credible	Count	13	25	38
		Expected Count	14.7	23.3	38.0
		% within Sources	34.2%	65.8%	100.0%
		% of Total	6.1%	11.7%	17.8%
	undecided	Count	25	39	64
		Expected Count	24.8	39.2	64.0
		% within Sources	39.1%	60.9%	100.0%
		% of Total	11.7%	18.2%	29.9%
	credible	Count	18	24	42
		Expected Count	16.3	25.7	42.0
		% within Sources	42.9%	57.1%	100.0%
		% of Total	8.4%	11.2%	19.6%
	extremely credible	Count	20	12	32
		Expected Count	12.4	19.6	32.0
		% within Sources	62.5%	37.5%	100.0%
		% of Total	9.3%	5.6%	15.0%
Total		Count	83	131	214
		Expected Count	83.0	131.0	214.0
		% within Sources	38.8%	61.2%	100.0%
		% of Total	38.8%	61.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.848(a)	4	.005
Likelihood Ratio	15.338	4	.004
Linear-by-Linear Association	13.554	1	.000
N of Valid Cases	214		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.41.

SOURCE CREDIBILITY VS. AGE

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	18-25
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-Medical Websites	not at all credible	Count	6	1	5	3	0	15
		Expected Count	2.2	4.7	4.6	2.9	.6	15.0
		% within Sources	40.0%	6.7%	33.3%	20.0%	.0%	100.0%
		% of Total	2.3%	.4%	2.0%	1.2%	.0%	5.9%
	somewhat credible	Count	2	2	3	4	2	13
		Expected Count	1.9	4.1	4.0	2.5	.5	13.0
		% within Sources	15.4%	15.4%	23.1%	30.8%	15.4%	100.0%
		% of Total	.8%	.8%	1.2%	1.6%	.8%	5.1%
	undecided	Count	6	7	11	9	1	34
		Expected Count	5.0	10.6	10.4	6.6	1.3	34.0
		% within Sources	17.6%	20.6%	32.4%	26.5%	2.9%	100.0%
		% of Total	2.3%	2.7%	4.3%	3.5%	.4%	13.3%
	credible	Count	7	41	31	15	2	96
		Expected Count	14.3	30.0	29.3	18.8	3.8	96.0
		% within Sources	7.3%	42.7%	32.3%	15.6%	2.1%	100.0%
		% of Total	2.7%	16.0%	12.1%	5.9%	.8%	37.5%
	extremely credible	Count	17	29	28	19	5	98
		Expected Count	14.5	30.6	29.9	19.1	3.8	98.0
		% within Sources	17.3%	29.6%	28.6%	19.4%	5.1%	100.0%
		% of Total	6.6%	11.3%	10.9%	7.4%	2.0%	38.3%

Total	Count	38	80	78	50	10	256
	Expected Count	38.0	80.0	78.0	50.0	10.0	256.0
	% within Sources	14.8%	31.3%	30.5%	19.5%	3.9%	100.0%
	% of Total	14.8%	31.3%	30.5%	19.5%	3.9%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	29.176(a)	16	.023
Likelihood Ratio	28.049	16	.031
Linear-by-Linear Association	.015	1	.902
N of Valid Cases	256		

a 13 cells (52.0%) have expected count less than 5. The minimum expected count is .51.

SOURCE CREDIBILITY VS. ETHNIC GROUP

			which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	hispanic	white/ caucasian	multiracial	other	american indian, alaskan native, or pacific islander
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience- blogs, online bulletin boards	not at all credible	Count	0	0	7	2	19	1	1	30
		Expected Count	.6	.4	10.4	4.6	11.8	1.7	.5	30.0
		% within Sources	.0%	.0%	23.3%	6.7%	63.3%	3.3%	3.3%	100.0%
		% of Total	.0%	.0%	3.0%	.8%	8.1%	.4%	.4%	12.7%
	somewhat credible	Count	1	0	8	3	14	2	2	30
		Expected Count	.6	.4	10.4	4.6	11.8	1.7	.5	30.0

		% within Sources	3.3%	.0%	26.7%	10.0%	46.7%	6.7%	6.7%	100.0%
		% of Total	.4%	.0%	3.4%	1.3%	5.9%	.8%	.8%	12.7%
	undecided	Count	2	2	28	13	42	5	1	93
		Expected Count	2.0	1.2	32.3	14.2	36.6	5.1	1.6	93.0
		% within Sources	2.2%	2.2%	30.1%	14.0%	45.2%	5.4%	1.1%	100.0%
		% of Total	.8%	.8%	11.9%	5.5%	17.8%	2.1%	.4%	39.4%
	credible	Count	1	0	20	14	11	3	0	49
		Expected Count	1.0	.6	17.0	7.5	19.3	2.7	.8	49.0
		% within Sources	2.0%	.0%	40.8%	28.6%	22.4%	6.1%	.0%	100.0%
		% of Total	.4%	.0%	8.5%	5.9%	4.7%	1.3%	.0%	20.8%
	extremely credible	Count	1	1	19	4	7	2	0	34
		Expected Count	.7	.4	11.8	5.2	13.4	1.9	.6	34.0
		% within Sources	2.9%	2.9%	55.9%	11.8%	20.6%	5.9%	.0%	100.0%
		% of Total	.4%	.4%	8.1%	1.7%	3.0%	.8%	.0%	14.4%

Total	Count	5	3	82	36	93	13	4	236
	Expected Count	5.0	3.0	82.0	36.0	93.0	13.0	4.0	236.0
	% within Sources	2.1%	1.3%	34.7%	15.3%	39.4%	5.5%	1.7%	100.0%
	% of Total	2.1%	1.3%	34.7%	15.3%	39.4%	5.5%	1.7%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	37.884(a)	24	.036
Likelihood Ratio	38.451	24	.031
Linear-by-Linear Association	15.108	1	.000
N of Valid Cases	236		

a 21 cells (60.0%) have expected count less than 5. The minimum expected count is .38.

SOURCE CREDIBILITY VS. SEXUAL ORIENTATION

			sexual orientation			Total
			heterosexual	homosexual	bi-sexual	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-friends or family members	not at all credible	Count	13	8	7	28
		Expected Count	12.6	12.4	3.0	28.0
		% within Sources	46.4%	28.6%	25.0%	100.0%
		% of Total	5.1%	3.1%	2.7%	11.0%
	somewhat credible	Count	24	15	5	44
		Expected Count	19.8	19.5	4.7	44.0
		% within Sources	54.5%	34.1%	11.4%	100.0%
		% of Total	9.4%	5.9%	2.0%	17.3%
	undecided	Count	19	35	4	58
		Expected Count	26.2	25.7	6.1	58.0
		% within Sources	32.8%	60.3%	6.9%	100.0%
		% of Total	7.5%	13.7%	1.6%	22.7%
	credible	Count	34	36	7	77
		Expected Count	34.7	34.1	8.2	77.0
		% within Sources	44.2%	46.8%	9.1%	100.0%
		% of Total	13.3%	14.1%	2.7%	30.2%
	extremely credible	Count	25	19	4	48
		Expected Count	21.6	21.3	5.1	48.0
		% within Sources	52.1%	39.6%	8.3%	100.0%
		% of Total	9.8%	7.5%	1.6%	18.8%
Total		Count	115	113	27	255
		Expected Count	115.0	113.0	27.0	255.0
		% within Sources	45.1%	44.3%	10.6%	100.0%
		% of Total	45.1%	44.3%	10.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.345(a)	8	.038
Likelihood Ratio	15.050	8	.058
Linear-by-Linear Association	.924	1	.337
N of Valid Cases	255		

a 2 cells (13.3%) have expected count less than 5. The minimum expected count is 2.96.

**CROSSTABS:
PERCEPTION STATEMENTS AND DEMOGRAPHIC VARIABLES**

PERCEPTION STATEMENTS VS. STATUS

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about-Poor people are more likely to get HIV/AIDS	strongly agree	Count	1	10	11
		Expected Count	4.0	7.0	11.0
		% within Statements	9.1%	90.9%	100.0%
		% of Total	.3%	3.4%	3.8%
	agree	Count	21	24	45
		Expected Count	16.5	28.5	45.0
		% within Statements	46.7%	53.3%	100.0%
		% of Total	7.2%	8.2%	15.4%
	neither agree nor disagree	Count	29	33	62
		Expected Count	22.7	39.3	62.0
		% within Statements	46.8%	53.2%	100.0%
		% of Total	9.9%	11.3%	21.2%
	disagree	Count	24	48	72
		Expected Count	26.4	45.6	72.0
		% within Statements	33.3%	66.7%	100.0%
		% of Total	8.2%	16.4%	24.7%
	strongly disagree	Count	32	70	102
		Expected Count	37.4	64.6	102.0
		% within Statements	31.4%	68.6%	100.0%
		% of Total	11.0%	24.0%	34.9%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.845(a)	4	.043
Likelihood Ratio	10.574	4	.032
Linear-by-Linear Association	1.374	1	.241
N of Valid Cases	292		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 4.03.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about - HIV/AIDS is primarily a gay disease	strongly agree	Count	2	6	8
		Expected Count	2.9	5.1	8.0
		% within Statements	25.0%	75.0%	100.0%
		% of Total	.7%	2.1%	2.7%
	agree	Count	8	4	12
		Expected Count	4.4	7.6	12.0
		% within Statements	66.7%	33.3%	100.0%
		% of Total	2.7%	1.4%	4.1%
	neither agree nor disagree	Count	6	23	29
		Expected Count	10.6	18.4	29.0
		% within Statements	20.7%	79.3%	100.0%
		% of Total	2.1%	7.9%	9.9%
	disagree	Count	28	51	79
		Expected Count	28.9	50.1	79.0
		% within Statements	35.4%	64.6%	100.0%
		% of Total	9.6%	17.5%	27.1%
	strongly disagree	Count	63	101	164
		Expected Count	60.1	103.9	164.0
		% within Statements	38.4%	61.6%	100.0%
		% of Total	21.6%	34.6%	56.2%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.576(a)	4	.073
Likelihood Ratio	8.674	4	.070
Linear-by-Linear Association	.146	1	.703
N of Valid Cases	292		

a 2 cells (20.0%) have expected count less than 5. The minimum expected count is 2.93.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about - Getting HIV/AIDS is usually a death sentence	strongly agree	Count	2	7	9
		Expected Count	3.3	5.7	9.0
		% within Statements	22.2%	77.8%	100.0%
		% of Total	.7%	2.4%	3.1%
	agree	Count	14	9	23
		Expected Count	8.4	14.6	23.0
		% within Statements	60.9%	39.1%	100.0%
		% of Total	4.8%	3.1%	7.9%
	neither agree nor disagree	Count	19	26	45
		Expected Count	16.5	28.5	45.0
		% within Statements	42.2%	57.8%	100.0%
		% of Total	6.5%	8.9%	15.4%
	disagree	Count	38	55	93
		Expected Count	34.1	58.9	93.0
		% within Statements	40.9%	59.1%	100.0%
		% of Total	13.0%	18.8%	31.8%
	strongly disagree	Count	34	88	122
		Expected Count	44.7	77.3	122.0
		% within Statements	27.9%	72.1%	100.0%
		% of Total	11.6%	30.1%	41.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.982(a)	4	.017
Likelihood Ratio	11.916	4	.018
Linear-by-Linear Association	5.289	1	.021
N of Valid Cases	292		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 3.30.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about-Antiretroviral drugs are a cure for HIV/AIDS	strongly agree	Count	1	10	11
		Expected Count	4.0	7.0	11.0
		% within Statements	9.1%	90.9%	100.0%
		% of Total	.3%	3.4%	3.8%
	agree	Count	2	7	9
		Expected Count	3.3	5.7	9.0
		% within Statements	22.2%	77.8%	100.0%
		% of Total	.7%	2.4%	3.1%
	neither agree nor disagree	Count	29	40	69
		Expected Count	25.3	43.7	69.0
		% within Statements	42.0%	58.0%	100.0%
		% of Total	9.9%	13.7%	23.6%
	disagree	Count	42	53	95
		Expected Count	34.8	60.2	95.0
		% within Statements	44.2%	55.8%	100.0%
		% of Total	14.4%	18.2%	32.5%
	strongly disagree	Count	33	75	108
		Expected Count	39.6	68.4	108.0
		% within Statements	30.6%	69.4%	100.0%
		% of Total	11.3%	25.7%	37.0%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.332(a)	4	.053
Likelihood Ratio	10.208	4	.037
Linear-by-Linear Association	.027	1	.870
N of Valid Cases	292		

a 2 cells (20.0%) have expected count less than 5. The minimum expected count is 3.30.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about - People who knowingly expose others to HIV/AIDS should be prosecuted as criminals	strongly agree	Count	40	43	83
		Expected Count	30.4	52.6	83.0
		% within Statements	48.2%	51.8%	100.0%
		% of Total	13.7%	14.7%	28.4%
	agree	Count	33	43	76
		Expected Count	27.8	48.2	76.0
		% within Statements	43.4%	56.6%	100.0%
		% of Total	11.3%	14.7%	26.0%
	neither agree nor disagree	Count	24	55	79
		Expected Count	28.9	50.1	79.0
		% within Statements	30.4%	69.6%	100.0%
		% of Total	8.2%	18.8%	27.1%
	disagree	Count	5	22	27
		Expected Count	9.9	17.1	27.0
		% within Statements	18.5%	81.5%	100.0%
		% of Total	1.7%	7.5%	9.2%
	strongly disagree	Count	5	22	27
		Expected Count	9.9	17.1	27.0
		% within Statements	18.5%	81.5%	100.0%
		% of Total	1.7%	7.5%	9.2%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.249(a)	4	.004
Likelihood Ratio	15.945	4	.003
Linear-by-Linear Association	14.376	1	.000
N of Valid Cases	292		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.89.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about - HIV/AIDS is God's way of punishing the wicked	strongly agree	Count	2	5	7
		Expected Count	2.6	4.4	7.0
		% within Statements	28.6%	71.4%	100.0%
		% of Total	.7%	1.7%	2.4%
	agree	Count	7	3	10
		Expected Count	3.7	6.3	10.0
		% within Statements	70.0%	30.0%	100.0%
		% of Total	2.4%	1.0%	3.4%
	neither agree nor disagree	Count	6	18	24
		Expected Count	8.8	15.2	24.0
		% within Statements	25.0%	75.0%	100.0%
		% of Total	2.1%	6.2%	8.2%
	disagree	Count	14	39	53
		Expected Count	19.4	33.6	53.0
		% within Statements	26.4%	73.6%	100.0%
		% of Total	4.8%	13.4%	18.2%
	strongly disagree	Count	78	120	198
		Expected Count	72.6	125.4	198.0
		% within Statements	39.4%	60.6%	100.0%
		% of Total	26.7%	41.1%	67.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.424(a)	4	.051
Likelihood Ratio	9.413	4	.052
Linear-by-Linear Association	.173	1	.678
N of Valid Cases	292		

a 3 cells (30.0%) have expected count less than 5. The minimum expected count is 2.57.

		My HIV status is		Total	
		Negative	Positive	Negative	
How do you feel about - People with HIV/AIDS deserve the same rights in the workplace as other workers	strongly agree	Count	0	8	8
		Expected Count	2.9	5.1	8.0
		% within Statements	.0%	100.0%	100.0%
		% of Total	.0%	2.7%	2.7%
	agree	Count	3	4	7
		Expected Count	2.6	4.4	7.0
		% within Statements	42.9%	57.1%	100.0%
		% of Total	1.0%	1.4%	2.4%
	neither agree nor disagree	Count	9	10	19
		Expected Count	7.0	12.0	19.0
		% within Statements	47.4%	52.6%	100.0%
		% of Total	3.1%	3.4%	6.5%
	disagree	Count	29	28	57
		Expected Count	20.9	36.1	57.0
		% within Statements	50.9%	49.1%	100.0%
		% of Total	9.9%	9.6%	19.5%
	strongly disagree	Count	66	135	201
		Expected Count	73.7	127.3	201.0
		% within Statements	32.8%	67.2%	100.0%
		% of Total	22.6%	46.2%	68.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.914(a)	4	.018
Likelihood Ratio	14.388	4	.006
Linear-by-Linear Association	.054	1	.817
N of Valid Cases	292		

a 3 cells (30.0%) have expected count less than 5. The minimum expected count is 2.57.

		My HIV status is		Total	
		Negative	Positive	Negative	
How do you feel about - Treating HIV/AIDS is a lucrative business for pharmaceutical companies	strongly agree	Count	17	58	75
		Expected Count	27.5	47.5	75.0
		% within Statements	22.7%	77.3%	100.0%
		% of Total	5.8%	19.9%	25.7%
agree		Count	34	44	78
		Expected Count	28.6	49.4	78.0
		% within Statements	43.6%	56.4%	100.0%
		% of Total	11.6%	15.1%	26.7%
neither agree nor disagree		Count	38	50	88
		Expected Count	32.2	55.8	88.0
		% within Statements	43.2%	56.8%	100.0%
		% of Total	13.0%	17.1%	30.1%
disagree		Count	12	15	27
		Expected Count	9.9	17.1	27.0
		% within Statements	44.4%	55.6%	100.0%
		% of Total	4.1%	5.1%	9.2%
strongly disagree		Count	6	18	24
		Expected Count	8.8	15.2	24.0
		% within Statements	25.0%	75.0%	100.0%
		% of Total	2.1%	6.2%	8.2%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.662(a)	4	.020
Likelihood Ratio	12.139	4	.016
Linear-by-Linear Association	1.485	1	.223
N of Valid Cases	292		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.79.

		My HIV status is		Total	
		Negative	Positive	Negative	
How do you feel about - I am not personally worried about getting HIV/AIDS	strongly agree	Count	8	14	22
		Expected Count	8.1	13.9	22.0
		% within Statements	36.4%	63.6%	100.0%
		% of Total	2.7%	4.8%	7.5%
agree		Count	26	10	36
		Expected Count	13.2	22.8	36.0
		% within Statements	72.2%	27.8%	100.0%
		% of Total	8.9%	3.4%	12.3%
neither agree nor disagree		Count	24	57	81
		Expected Count	29.7	51.3	81.0
		% within Statements	29.6%	70.4%	100.0%
		% of Total	8.2%	19.5%	27.7%
disagree		Count	23	40	63
		Expected Count	23.1	39.9	63.0
		% within Statements	36.5%	63.5%	100.0%
		% of Total	7.9%	13.7%	21.6%
strongly disagree		Count	26	64	90
		Expected Count	33.0	57.0	90.0
		% within Statements	28.9%	71.1%	100.0%
		% of Total	8.9%	21.9%	30.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	23.678(a)	4	.000
Likelihood Ratio	22.979	4	.000
Linear-by-Linear Association	6.726	1	.010
N of Valid Cases	292		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.06.

PERCEPTION STATEMENTS VS. ETHNIC GROUP

			which group do you identify with?						
			american indian, alaskan native, or pacific islander	asian/asian american	black/african american or negro	hispanic	White / caucasian	multiracial	other
How do you feel about - Alternative medical treatments for HIV/AIDS have shown promising results	strongly agree	Count	3	1	27	9	9	7	2
		Expected Count	1.5	.7	20.9	9.1	21.7	3.1	1.0
		% within statements	5.2%	1.7%	46.6%	15.5%	15.5%	12.1%	3.4%
		% of Total	.9%	.3%	8.0%	2.7%	2.7%	2.1%	.6%
	agree	Count	1	1	38	10	35	3	1
		Expected Count	2.4	1.1	32.0	13.9	33.3	4.7	1.6
		% within statements	1.1%	1.1%	42.7%	11.2%	39.3%	3.4%	1.1%
		% of Total	.3%	.3%	11.2%	2.9%	10.3%	.9%	.3%
	neither agree nor disagree	Count	2	2	44	22	62	7	3
		Expected Count	3.8	1.7	51.1	22.2	53.2	7.5	2.5
		% within statements	1.4%	1.4%	31.0%	15.5%	43.7%	4.9%	2.1%
		% of Total	.6%	.6%	13.0%	6.5%	18.3%	2.1%	.9%
	disagree	Count	2	0	8	7	13	0	0
		Expected Count	.8	.4	10.8	4.7	11.2	1.6	.5
		% within statements	6.7%	.0%	26.7%	23.3%	43.3%	.0%	.0%
		% of Total	.6%	.0%	2.4%	2.1%	3.8%	.0%	.0%
	strongly disagree	Count	1	0	5	5	8	1	0
		Expected Count	.5	.2	7.2	3.1	7.5	1.1	.4
		% within statements	5.0%	.0%	25.0%	25.0%	40.0%	5.0%	.0%
		% of Total	.3%	.0%	1.5%	1.5%	2.4%	.3%	.0%

Total	Count	9	4	122	53	127	18	6
	Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0
	% within statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.366(a)	24	.097
Likelihood Ratio	36.283	24	.052
Linear-by-Linear Association	1.664	1	.197
N of Valid Cases	339		

a. 21 cells (60.0%) have expected count less than 5. The minimum expected count is .24.

		Which group do you identify with?								Total
		american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander	
How do you feel about- Poor people are more likely to get HIV/AIDS	strongly agree	Count	2	0	6	3	4	2	0	17
		Expected Count	.5	.2	6.1	2.7	6.4	.9	.3	17.0
		% within Statements	11.8%	.0%	35.3%	17.6%	23.5%	11.8%	.0%	100.0%
		% of Total	.6%	.0%	1.8%	.9%	1.2%	.6%	.0%	5.0%
	agree	Count	2	0	13	13	24	2	1	55
		Expected Count	1.5	.6	19.8	8.6	20.6	2.9	1.0	55.0
		% within Statements	3.6%	.0%	23.6%	23.6%	43.6%	3.6%	1.8%	100.0%
		% of Total	.6%	.0%	3.8%	3.8%	7.1%	.6%	.3%	16.2%
	neither agree nor disagree	Count	3	1	33	7	25	4	0	73

		Expected Count	1.9	.9	26.3	11.4	27.3	3.9	1.3	73.0
		% within Statements	4.1%	1.4%	45.2%	9.6%	34.2%	5.5%	.0%	100.0%
		% of Total	.9%	.3%	9.7%	2.1%	7.4%	1.2%	.0%	21.5%
	disagree	Count	0	3	31	12	34	6	0	86
		Expected Count	2.3	1.0	30.9	13.4	32.2	4.6	1.5	86.0
		% within Statements	.0%	3.5%	36.0%	14.0%	39.5%	7.0%	.0%	100.0%
		% of Total	.0%	.9%	9.1%	3.5%	10.0%	1.8%	.0%	25.4%
	strongly disagree	Count	2	0	39	18	40	4	5	108
		Expected Count	2.9	1.3	38.9	16.9	40.5	5.7	1.9	108.0
		% within Statements	1.9%	.0%	36.1%	16.7%	37.0%	3.7%	4.6%	100.0%
		% of Total	.6%	.0%	11.5%	5.3%	11.8%	1.2%	1.5%	31.9%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	35.416(a)	24	.062
Likelihood Ratio	37.491	24	.039
Linear-by-Linear Association	.952	1	.329
N of Valid Cases	339		

a 20 cells (57.1%) have expected count less than 5. The minimum expected count is .20.

		Which group do you identify with?								Total
		american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander	
How do you feel about- Globally the number of people with HIV/AIDS is decreasing	strongly agree	Count	2	0	9	1	1	1	1	15
		Expected Count	.4	.2	5.4	2.3	5.6	.8	.3	15.0
		% within Statements	13.3%	.0%	60.0%	6.7%	6.7%	6.7%	6.7%	100.0%
		% of Total	.6%	.0%	2.7%	.3%	.3%	.3%	.3%	4.4%
	agree	Count	1	0	6	4	4	0	0	15
		Expected Count	.4	.2	5.4	2.3	5.6	.8	.3	15.0
		% within Statements	6.7%	.0%	40.0%	26.7%	26.7%	.0%	.0%	100.0%
		% of Total	.3%	.0%	1.8%	1.2%	1.2%	.0%	.0%	4.4%

	neither agree nor disagree	Count	1	3	35	15	25	5	2	86
		Expected Count	2.3	1.0	30.9	13.4	32.2	4.6	1.5	86.0
		% within Statements	1.2%	3.5%	40.7%	17.4%	29.1%	5.8%	2.3%	100.0%
		% of Total	.3%	.9%	10.3%	4.4%	7.4%	1.5%	.6%	25.4%
	disagree	Count	2	1	35	12	48	4	0	102
		Expected Count	2.7	1.2	36.7	15.9	38.2	5.4	1.8	102.0
		% within Statements	2.0%	1.0%	34.3%	11.8%	47.1%	3.9%	.0%	100.0%
		% of Total	.6%	.3%	10.3%	3.5%	14.2%	1.2%	.0%	30.1%
	strongly disagree	Count	3	0	37	21	49	8	3	121
		Expected Count	3.2	1.4	43.5	18.9	45.3	6.4	2.1	121.0
		% within Statements	2.5%	.0%	30.6%	17.4%	40.5%	6.6%	2.5%	100.0%
		% of Total	.9%	.0%	10.9%	6.2%	14.5%	2.4%	.9%	35.7%
Total	Count	9	4	122	53	127	18	6	339	
	Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0	
	% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%	
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	36.290(a)	24	.051
Likelihood Ratio	37.135	24	.042
Linear-by-Linear Association	9.076	1	.003
N of Valid Cases	339		

a 20 cells (57.1%) have expected count less than 5. The minimum expected count is .18.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about - HIV/AIDS is primarily a gay disease	strongly agree	Count	3	0	5	0	2	1	0	11
		Expected Count	.3	.1	4.0	1.7	4.1	.6	.2	11.0
		% within Statements	27.3%	.0%	45.5%	.0%	18.2%	9.1%	.0%	100.0%
		% of Total	.9%	.0%	1.5%	.0%	.6%	.3%	.0%	3.2%
	agree	Count	0	0	6	2	5	1	0	14
		Expected Count	.4	.2	5.0	2.2	5.2	.7	.2	14.0
		% within Statements	.0%	.0%	42.9%	14.3%	35.7%	7.1%	.0%	100.0%
		% of Total	.0%	.0%	1.8%	.6%	1.5%	.3%	.0%	4.1%
	neither agree nor disagree	Count	3	1	11	4	13	2	0	34
		Expected Count	.9	.4	12.2	5.3	12.7	1.8	.6	34.0
		% within Statements	8.8%	2.9%	32.4%	11.8%	38.2%	5.9%	.0%	100.0%
		% of Total	.9%	.3%	3.2%	1.2%	3.8%	.6%	.0%	10.0%
	disagree	Count	1	1	38	14	39	3	1	97

		Expected Count	2.6	1.1	34.9	15.2	36.3	5.2	1.7	97.0
		% within Statements	1.0%	1.0%	39.2%	14.4%	40.2%	3.1%	1.0%	100.0%
		% of Total	.3%	.3%	11.2%	4.1%	11.5%	.9%	.3%	28.6%
	strongly disagree	Count	2	2	62	33	68	11	5	183
		Expected Count	4.9	2.2	65.9	28.6	68.6	9.7	3.2	183.0
		% within Statements	1.1%	1.1%	33.9%	18.0%	37.2%	6.0%	2.7%	100.0%
		% of Total	.6%	.6%	18.3%	9.7%	20.1%	3.2%	1.5%	54.0%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	43.208(a)	24	.009
Likelihood Ratio	28.976	24	.221
Linear-by-Linear Association	7.353	1	.007
N of Valid Cases	339		

a 22 cells (62.9%) have expected count less than 5. The minimum expected count is .13.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about- Antiretroviral drugs are a cure for HIV/AIDS	strongly agree	Count	3	0	5	5	2	1	0	16
		Expected Count	.4	.2	5.8	2.5	6.0	.8	.3	16.0
		% within Statements	18.8%	.0%	31.3%	31.3%	12.5%	6.3%	.0%	100.0%
		% of Total	.9%	.0%	1.5%	1.5%	.6%	.3%	.0%	4.7%
	agree	Count	1	0	7	2	2	0	0	12
		Expected Count	.3	.1	4.3	1.9	4.5	.6	.2	12.0
		% within Statements	8.3%	.0%	58.3%	16.7%	16.7%	.0%	.0%	100.0%
		% of Total	.3%	.0%	2.1%	.6%	.6%	.0%	.0%	3.5%
	neither agree nor disagree	Count	1	1	30	13	24	6	3	78
		Expected Count	2.1	.9	28.1	12.2	29.2	4.1	1.4	78.0
		% within Statements	1.3%	1.3%	38.5%	16.7%	30.8%	7.7%	3.8%	100.0%
		% of Total	.3%	.3%	8.8%	3.8%	7.1%	1.8%	.9%	23.0%
	disagree	Count	2	3	39	18	48	6	0	116
		Expected	3.1	1.4	41.7	18.1	43.5	6.2	2.1	116.0

		Count								
		% within Statements	1.7%	2.6%	33.6%	15.5%	41.4%	5.2%	.0%	100.0%
		% of Total	.6%	.9%	11.5%	5.3%	14.2%	1.8%	.0%	34.2%
	strongly disagree	Count	2	0	41	15	51	5	3	117
		Expected Count	3.1	1.4	42.1	18.3	43.8	6.2	2.1	117.0
		% within Statements	1.7%	.0%	35.0%	12.8%	43.6%	4.3%	2.6%	100.0%
		% of Total	.6%	.0%	12.1%	4.4%	15.0%	1.5%	.9%	34.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	40.546(a)	24	.019
Likelihood Ratio	35.501	24	.061
Linear-by-Linear Association	7.045	1	.008
N of Valid Cases	339		

a. 22 cells (62.9%) have expected count less than 5. The minimum expected count is .14.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about - You cannot get HIV/AIDS during sex if condoms are always used	strongly agree	Count	4	0	8	7	4	1	0	24
		Expected Count	.6	.3	8.6	3.8	9.0	1.3	.4	24.0
		% within Statements	16.7%	.0%	33.3%	29.2%	16.7%	4.2%	.0%	100.0%
		% of Total	1.2%	.0%	2.4%	2.1%	1.2%	.3%	.0%	7.1%
	agree	Count	0	0	17	6	15	1	0	39
		Expected Count	1.0	.5	14.0	6.1	14.6	2.1	.7	39.0
		% within Statements	.0%	.0%	43.6%	15.4%	38.5%	2.6%	.0%	100.0%
		% of Total	.0%	.0%	5.0%	1.8%	4.4%	.3%	.0%	11.5%
	neither agree nor disagree	Count	2	0	23	4	12	2	1	44
		Expected Count	1.2	.5	15.8	6.9	16.5	2.3	.8	44.0
		% within Statements	4.5%	.0%	52.3%	9.1%	27.3%	4.5%	2.3%	100.0%
		% of Total	.6%	.0%	6.8%	1.2%	3.5%	.6%	.3%	13.0%
	disagree	Count	1	3	40	20	64	6	3	137
		Expected	3.6	1.6	49.3	21.4	51.3	7.3	2.4	137.0

		Count								
		% within Statements	.7%	2.2%	29.2%	14.6%	46.7%	4.4%	2.2%	100.0%
		% of Total	.3%	.9%	11.8%	5.9%	18.9%	1.8%	.9%	40.4%
	strongly disagree	Count	2	1	34	16	32	8	2	95
		Expected Count	2.5	1.1	34.2	14.9	35.6	5.0	1.7	95.0
		% within Statements	2.1%	1.1%	35.8%	16.8%	33.7%	8.4%	2.1%	100.0%
		% of Total	.6%	.3%	10.0%	4.7%	9.4%	2.4%	.6%	28.0%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	45.213(a)	24	.005
Likelihood Ratio	39.125	24	.026
Linear-by-Linear Association	7.517	1	.006
N of Valid Cases	339		

a. 19 cells (54.3%) have expected count less than 5. The minimum expected count is .28.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about - An effective HIV/AIDS vaccine is available	strongly agree	Count	2	0	11	4	3	1	0	21
		Expected Count	.6	.2	7.6	3.3	7.9	1.1	.4	21.0
		% within Statements	9.5%	.0%	52.4%	19.0%	14.3%	4.8%	.0%	100.0%
		% of Total	.6%	.0%	3.2%	1.2%	.9%	.3%	.0%	6.2%
	agree	Count	0	0	16	7	5	2	0	30
		Expected Count	.8	.4	10.8	4.7	11.2	1.6	.5	30.0
		% within Statements		.0%	53.3%	23.3%	16.7%	6.7%	.0%	100.0%
		% of Total	.0%	.0%	4.7%	2.1%	1.5%	.6%	.0%	8.8%
	neither agree nor disagree	Count	1	1	50	16	30	5	4	107
		Expected Count	2.8	1.3	38.5	16.7	40.1	5.7	1.9	107.0
		% within Statements	.9%	.9%	46.7%	15.0%	28.0%	4.7%	3.7%	100.0%
		% of Total	.3%	.3%	14.7%	4.7%	8.8%	1.5%	1.2%	31.6%
	disagree	Count	5	3	22	16	47	6	0	99
		Expected	2.6	1.2	35.6	15.5	37.1	5.3	1.8	99.0

		Count								
		% within Statements	5.1%	3.0%	22.2%	16.2%	47.5%	6.1%	.0%	100.0%
		% of Total	1.5%	.9%	6.5%	4.7%	13.9%	1.8%	.0%	29.2%
	strongly disagree	Count	1	0	23	10	42	4	2	82
		Expected Count	2.2	1.0	29.5	12.8	30.7	4.4	1.5	82.0
		% within Statements	1.2%	.0%	28.0%	12.2%	51.2%	4.9%	2.4%	100.0%
		% of Total	.3%	.0%	6.8%	2.9%	12.4%	1.2%	.6%	24.2%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	50.452(a)	24	.001
Likelihood Ratio	54.079	24	.000
Linear-by-Linear Association	14.490	1	.000
N of Valid Cases	339		

a. 20 cells (57.1%) have expected count less than 5. The minimum expected count is .25.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ African American or negro	Hispanic	White / Caucasian	multiracial	other	
How do you feel about - Treating HIV/AIDS is a lucrative business for pharmaceutical companies	strongly agree	Count	2	0	33	6	35	6	2	84
		Expected Count	2.2	1.0	30.2	13.1	31.5	4.5	1.5	84.0
		% within Statements	2.4%	.0%	39.3%	7.1%	41.7%	7.1%	2.4%	100.0%
		% of Total	.6%	.0%	9.7%	1.8%	10.3%	1.8%	.6%	24.8%
	agree	Count	2	0	25	16	45	3	1	92
		Expected Count	2.4	1.1	33.1	14.4	34.5	4.9	1.6	92.0
		% within Statements	2.2%	.0%	27.2%	17.4%	48.9%	3.3%	1.1%	100.0%
		% of Total	.6%	.0%	7.4%	4.7%	13.3%	.9%	.3%	27.1%
	neither agree nor disagree	Count	3	3	45	13	33	7	3	107
		Expected Count	2.8	1.3	38.5	16.7	40.1	5.7	1.9	107.0
		% within Statements	2.8%	2.8%	42.1%	12.1%	30.8%	6.5%	2.8%	100.0%
		% of Total	.9%	.9%	13.3%	3.8%	9.7%	2.1%	.9%	31.6%
	disagree	Count	1	1	10	8	10	0	0	30
		Expected	.8	.4	10.8	4.7	11.2	1.6	.5	30.0

		Count								
		% within Statements	3.3%	3.3%	33.3%	26.7%	33.3%	.0%	.0%	100.0%
		% of Total	.3%	.3%	2.9%	2.4%	2.9%	.0%	.0%	8.8%
	strongly disagree	Count	1	0	9	10	4	2	0	26
		Expected Count	.7	.3	9.4	4.1	9.7	1.4	.5	26.0
		% within Statements	3.8%	.0%	34.6%	38.5%	15.4%	7.7%	.0%	100.0%
		% of Total	.3%	.0%	2.7%	2.9%	1.2%	.6%	.0%	7.7%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	39.433(a)	24	.025
Likelihood Ratio	42.250	24	.012
Linear-by-Linear Association	4.052	1	.044
N of Valid Cases	339		

a. 21 cells (60.0%) have expected count less than 5. The minimum expected count is .31.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about - I am not personally worried about getting HIV/AIDS	strongly agree	Count	4	0	9	0	9	3	1	26
		Expected Count	.7	.3	9.4	4.1	9.7	1.4	.5	26.0
		% within Statements	15.4%	.0%	34.6%	.0%	34.6%	11.5%	3.8%	100.0%
		% of Total	1.2%	.0%	2.7%	.0%	2.7%	.9%	.3%	7.7%
	agree	Count	0	0	10	10	17	2	2	41
		Expected Count	1.1	.5	14.8	6.4	15.4	2.2	.7	41.0
		% within Statements	.0%	.0%	24.4%	24.4%	41.5%	4.9%	4.9%	100.0%
		% of Total	.0%	.0%	2.9%	2.9%	5.0%	.6%	.6%	12.1%
	neither agree nor disagree	Count	2	1	33	13	43	5	0	97
		Expected Count	2.6	1.1	34.9	15.2	36.3	5.2	1.7	97.0
		% within Statements	2.1%	1.0%	34.0%	13.4%	44.3%	5.2%	.0%	100.0%
		% of Total	.6%	.3%	9.7%	3.8%	12.7%	1.5%	.0%	28.6%
	disagree	Count	1	2	31	11	27	4	1	77
		Expected Count	2.0	.9	27.7	12.0	28.8	4.1	1.4	77.0

		% within Statements	1.3%	2.6%	40.3%	14.3%	35.1%	5.2%	1.3%	100.0%
		% of Total	.3%	.6%	9.1%	3.2%	8.0%	1.2%	.3%	22.7%
	strongly disagree	Count	2	1	39	19	31	4	2	98
		Expected Count	2.6	1.2	35.3	15.3	36.7	5.2	1.7	98.0
		% within Statements	2.0%	1.0%	39.8%	19.4%	31.6%	4.1%	2.0%	100.0%
		% of Total	.6%	.3%	11.5%	5.6%	9.1%	1.2%	.6%	28.9%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	39.077(a)	24	.027
Likelihood Ratio	36.587	24	.048
Linear-by-Linear Association	1.067	1	.302
N of Valid Cases	339		

a 19 cells (54.3%) have expected count less than 5. The minimum expected count is .31.

		Which group do you identify with?								Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander
How do you feel about - Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact	strongly agree	Count	1	0	15	8	6	2	0	32
		Expected Count	.8	.4	11.5	5.0	12.0	1.7	.6	32.0
		% within Statements	3.1%	.0%	46.9%	25.0%	18.8%	6.3%	.0%	100.0%
		% of Total	.3%	.0%	4.4%	2.4%	1.8%	.6%	.0%	9.4%
	agree	Count	0	2	23	5	13	1	0	44
		Expected Count	1.2	.5	15.8	6.9	16.5	2.3	.8	44.0

		% within Statements	.0%	4.5%	52.3%	11.4%	29.5%	2.3%	.0%	100.0%
		% of Total	.0%	.6%	6.8%	1.5%	3.8%	.3%	.0%	13.0%
	neither agree nor disagree	Count	2	2	52	27	50	8	4	145
		Expected Count	3.8	1.7	52.2	22.7	54.3	7.7	2.6	145.0
		% within Statements	1.4%	1.4%	35.9%	18.6%	34.5%	5.5%	2.8%	100.0%
		% of Total	.6%	.6%	15.3%	8.0%	14.7%	2.4%	1.2%	42.8%
	disagree	Count	2	0	22	9	39	5	1	78
		Expected Count	2.1	.9	28.1	12.2	29.2	4.1	1.4	78.0
		% within Statements	2.6%	.0%	28.2%	11.5%	50.0%	6.4%	1.3%	100.0%
		% of Total	.6%	.0%	6.5%	2.7%	11.5%	1.5%	.3%	23.0%
	strongly disagree	Count	4	0	10	4	19	2	1	40
		Expected Count	1.1	.5	14.4	6.3	15.0	2.1	.7	40.0
		% within Statements	10.0%	.0%	25.0%	10.0%	47.5%	5.0%	2.5%	100.0%
		% of Total	1.2%	.0%	2.9%	1.2%	5.6%	.6%	.3%	11.8%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	39.799(a)	24	.022
Likelihood Ratio	39.215	24	.026
Linear-by-Linear Association	5.690	1	.017
N of Valid Cases	339		

a 19 cells (54.3%) have expected count less than 5. The minimum expected count is .38.

PERCEPTION STATEMENTS VS. AGE

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
How do you feel about - HIV/AIDS is primarily a gay disease	strongly agree	Count	1	6	3	1	0	11
		Expected Count	1.7	2.9	3.3	2.5	.6	11.0
		% within Statements	9.1%	54.5%	27.3%	9.1%	.0%	100.0%
		% of Total	.3%	1.8%	.9%	.3%	.0%	3.2%
	agree	Count	5	1	5	2	1	14
		Expected Count	2.2	3.7	4.2	3.2	.7	14.0
		% within Statements	35.7%	7.1%	35.7%	14.3%	7.1%	100.0%
		% of Total	1.5%	.3%	1.5%	.6%	.3%	4.1%
	neither agree nor disagree	Count	10	5	11	5	2	33
		Expected Count	5.1	8.6	10.0	7.5	1.7	33.0
		% within Statements	30.3%	15.2%	33.3%	15.2%	6.1%	100.0%
		% of Total	2.9%	1.5%	3.2%	1.5%	.6%	9.7%
	disagree	Count	15	17	31	29	5	97
		Expected Count	15.1	25.4	29.4	22.0	5.1	97.0
		% within Statements	15.5%	17.5%	32.0%	29.9%	5.2%	100.0%
		% of Total	4.4%	5.0%	9.1%	8.5%	1.5%	28.5%
	strongly disagree	Count	22	60	53	40	10	185
		Expected Count	28.8	48.4	56.0	41.9	9.8	185.0
		% within Statements	11.9%	32.4%	28.6%	21.6%	5.4%	100.0%
		% of Total	6.5%	17.6%	15.6%	11.8%	2.9%	54.4%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within Statements	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	28.254(a)	16	.029
Likelihood Ratio	27.695	16	.034
Linear-by-Linear Association	1.894	1	.169
N of Valid Cases	340		

a 11 cells (44.0%) have expected count less than 5. The minimum expected count is .58.

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
How do you feel about - Alternative medical treatments for HIV/AIDS have shown promising results	strongly agree	Count	11	14	17	17	0	59
		Expected Count	9.2	15.4	17.9	13.4	3.1	59.0
		% within Statements	18.6%	23.7%	28.8%	28.8%	.0%	100.0%
		% of Total	3.2%	4.1%	5.0%	5.0%	.0%	17.4%
	agree	Count	11	19	34	20	4	88
		Expected Count	13.7	23.0	26.7	19.9	4.7	88.0
		% within Statements	12.5%	21.6%	38.6%	22.7%	4.5%	100.0%
		% of Total	3.2%	5.6%	10.0%	5.9%	1.2%	25.9%
	neither agree nor disagree	Count	24	44	45	25	5	143
		Expected Count	22.3	37.4	43.3	32.4	7.6	143.0
		% within Statements	16.8%	30.8%	31.5%	17.5%	3.5%	100.0%
		% of Total	7.1%	12.9%	13.2%	7.4%	1.5%	42.1%
	disagree	Count	4	8	1	11	6	30
		Expected Count	4.7	7.9	9.1	6.8	1.6	30.0
		% within Statements	13.3%	26.7%	3.3%	36.7%	20.0%	100.0%
		% of Total	1.2%	2.4%	.3%	3.2%	1.8%	8.8%
	strongly disagree	Count	3	4	6	4	3	20
		Expected Count	3.1	5.2	6.1	4.5	1.1	20.0
		% within Statements	15.0%	20.0%	30.0%	20.0%	15.0%	100.0%
		% of Total	.9%	1.2%	1.8%	1.2%	.9%	5.9%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within Statements	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	37.986(a)	16	.002
Likelihood Ratio	39.001	16	.001
Linear-by-Linear Association	1.318	1	.251
N of Valid Cases	340		

a 7 cells (28.0%) have expected count less than 5. The minimum expected count is 1.06.

PERCEPTION STATEMENTS VS. SEXUAL ORIENTATION

			sexual orientation			Total
			Heterosexual	Homosexual	Bi-sexual	
How do you feel about - A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby	strongly agree	Count	12	5	1	18
		Expected Count	8.4	7.6	2.0	18.0
		% within Statements	66.7%	27.8%	5.6%	100.0%
		% of Total	3.9%	1.6%	.3%	5.8%
	agree	Count	8	12	0	20
		Expected Count	9.4	8.4	2.2	20.0
		% within Statements	40.0%	60.0%	.0%	100.0%
		% of Total	2.6%	3.9%	.0%	6.5%
	neither agree nor disagree	Count	19	31	9	59
		Expected Count	27.7	24.8	6.5	59.0
		% within Statements	32.2%	52.5%	15.3%	100.0%
		% of Total	6.1%	10.0%	2.9%	19.1%
	disagree	Count	55	36	17	108
		Expected Count	50.7	45.4	11.9	108.0
		% within Statements	50.9%	33.3%	15.7%	100.0%
		% of Total	17.8%	11.7%	5.5%	35.0%
strongly disagree	Count	51	46	7	104	
	Expected Count	48.8	43.8	11.4	104.0	
	% within Statements	49.0%	44.2%	6.7%	100.0%	
	% of Total	16.5%	14.9%	2.3%	33.7%	
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within Statements	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.908(a)	8	.031
Likelihood Ratio	17.302	8	.027
Linear-by-Linear Association	3.753	1	.053
N of Valid Cases	309		

a 2 cells (13.3%) have expected count less than 5. The minimum expected count is 3.52.

			Heterosexual	Homosexual	Bi-sexual	1.00
How do you feel about - Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact	strongly agree	Count	15	12	0	27
		Expected Count	12.7	11.4	3.0	27.0
		% within Statements	55.6%	44.4%	.0%	100.0%
		% of Total	4.9%	3.9%	.0%	8.7%
	agree	Count	17	18	6	41
		Expected Count	19.2	17.2	4.5	41.0
		% within Statements	41.5%	43.9%	14.6%	100.0%
		% of Total	5.5%	5.8%	1.9%	13.3%
	neither agree nor disagree	Count	60	53	21	134
		Expected Count	62.9	56.4	14.7	134.0
		% within Statements	44.8%	39.6%	15.7%	100.0%
		% of Total	19.4%	17.2%	6.8%	43.4%
	disagree	Count	39	26	4	69
		Expected Count	32.4	29.0	7.6	69.0
		% within Statements	56.5%	37.7%	5.8%	100.0%
		% of Total	12.6%	8.4%	1.3%	22.3%

	strongly disagree	Count	14	21	3	38
		Expected Count	17.8	16.0	4.2	38.0
		% within Statements	36.8%	55.3%	7.9%	100.0%
		% of Total	4.5%	6.8%	1.0%	12.3%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within Statements	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.307(a)	8	.102
Likelihood Ratio	16.158	8	.040
Linear-by-Linear Association	.024	1	.878
N of Valid Cases	309		

a 3 cells (20.0%) have expected count less than 5. The minimum expected count is 2.97.

			sexual orientation			Total
			heterosexual	homosexual	bi-sexual	1.00
How do you feel about - It is biologically easier for woman to get HIV/AIDS than it is for men	strongly agree	Count	22	7	3	32
		Expected Count	15.0	13.5	3.5	32.0
		% within statements	68.8%	21.9%	9.4%	100.0%
		% of Total	7.1%	2.3%	1.0%	10.4%
	agree	Count	19	10	6	35
		Expected Count	16.4	14.7	3.9	35.0
		% within statements	54.3%	28.6%	17.1%	100.0%
		% of Total	6.1%	3.2%	1.9%	11.3%
	neither agree nor disagree	Count	56	47	12	115
		Expected Count	54.0	48.4	12.7	115.0
		% within statements	48.7%	40.9%	10.4%	100.0%
		% of Total	18.1%	15.2%	3.9%	37.2%
	disagree	Count	23	32	9	64
		Expected Count	30.0	26.9	7.0	64.0
		% within statements	35.9%	50.0%	14.1%	100.0%
		% of Total	7.4%	10.4%	2.9%	20.7%
	strongly disagree	Count	25	34	4	63
		Expected Count	29.6	26.5	6.9	63.0
		% within statements	39.7%	54.0%	6.3%	100.0%
		% of Total	8.1%	11.0%	1.3%	20.4%

Total	Count	145	130	34	309
	Expected Count	145.0	130.0	34.0	309.0
	% within statements	46.9%	42.1%	11.0%	100.0%
	% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.908(a)	8	.031
Likelihood Ratio	17.302	8	.027
Linear-by-Linear Association	3.753	1	.053
N of Valid Cases	309		

a 2 cells (13.3%) have expected count less than 5. The minimum expected count is 3.52.

**CROSSTABS:
TREATMENTS KNOWN AND DEMOGRAPHIC VARIABLES**

TREATMENTS KNOWN VS. SEXUAL ORIENTATION

		sexual orientation			Total	
			Heterosexual	Homosexual	Bi-sexual	1.00
treatments that you have heard of - Chelation-IV	not selected	Count	143	122	34	299
		Expected Count	140.3	125.8	32.9	299.0
		% within treatments	47.8%	40.8%	11.4%	100.0%
		% of Total	46.3%	39.5%	11.0%	96.8%
	selected	Count	2	8	0	10
		Expected Count	4.7	4.2	1.1	10.0
		% within treatments	20.0%	80.0%	.0%	100.0%
		% of Total	.6%	2.6%	.0%	3.2%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.268(a)	2	.044
Likelihood Ratio	7.075	2	.029
Linear-by-Linear Association	.580	1	.446
N of Valid Cases	309		

a 3 cells (50.0%) have expected count less than 5. The minimum expected count is 1.10.

		sexual orientation			Total	
		Heter	Homo	Bi-sexual	1.00	
treatments that you have heard of - Nutritional supplements	not selected	Count	121	84	25	230
		Expected Count	107.9	96.8	25.3	230.0
		% within treatments	52.6%	36.5%	10.9%	100.0%
		% of Total	39.2%	27.2%	8.1%	74.4%
	selected	Count	24	46	9	79
		Expected Count	37.1	33.2	8.7	79.0
		% within treatments	30.4%	58.2%	11.4%	100.0%
		% of Total	7.8%	14.9%	2.9%	25.6%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.792(a)	2	.002
Likelihood Ratio	12.945	2	.002
Linear-by-Linear Association	6.739	1	.009
N of Valid Cases	309		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.69.

		sexual orientation			Total	
		Heter	Homo	Bi-sexual	1.00	
treatments that you have heard of – AZT (Azidothymidine)	not selected	Count	82	46	17	145
		Expected Count	68.0	61.0	16.0	145.0
		% within treatments	56.6%	31.7%	11.7%	100.0%
		% of Total	26.5%	14.9%	5.5%	46.9%
	selected	Count	63	84	17	164
		Expected Count	77.0	69.0	18.0	164.0
		% within treatments	38.4%	51.2%	10.4%	100.0%
		% of Total	20.4%	27.2%	5.5%	53.1%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.476(a)	2	.002
Likelihood Ratio	12.599	2	.002
Linear-by-Linear Association	4.796	1	.029
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 15.95.

		sexual orientation			Total	
		Heter	Homo	Bi-sexual	1.00	
treatments that you have heard of - Pharmaceutical antibodies (bactrim, etc)	not selected	Count	103	67	21	191
		Expected Count	89.6	80.4	21.0	191.0
		% within treatments	53.9%	35.1%	11.0%	100.0%
		% of Total	33.3%	21.7%	6.8%	61.8%
	selected	Count	42	63	13	118
		Expected Count	55.4	49.6	13.0	118.0
		% within treatments	35.6%	53.4%	11.0%	100.0%
		% of Total	13.6%	20.4%	4.2%	38.2%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.038(a)	2	.004
Likelihood Ratio	11.091	2	.004
Linear-by-Linear Association	5.441	1	.020
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.98.

TREATMENTS KNOWN VS, STATUS

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Vitamins-Oral	not selected	Count	95	144	239
		Expected Count	87.6	151.4	239.0
		% within treatments	39.7%	60.3%	100.0%
		% of Total	32.5%	49.3%	81.8%
	selected	Count	12	41	53
		Expected Count	19.4	33.6	53.0
		% within treatments	22.6%	77.4%	100.0%
		% of Total	4.1%	14.0%	18.2%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.469(b)	1	.019		
Continuity Correction(a)	4.756	1	.029		
Likelihood Ratio	5.800	1	.016		
Fisher's Exact Test				.027	.013
Linear-by-Linear Association	5.450	1	.020		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 19.42.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Minerals-Oral	not selected	Count	100	160	260
		Expected Count	95.3	164.7	260.0
		% within treatments	38.5%	61.5%	100.0%
		% of Total	34.2%	54.8%	89.0%
	selected	Count	7	25	32
		Expected Count	11.7	20.3	32.0
		% within treatments	21.9%	78.1%	100.0%
		% of Total	2.4%	8.6%	11.0%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.376(b)	1	.066		
Continuity Correction(a)	2.700	1	.100		
Likelihood Ratio	3.622	1	.057		
Fisher's Exact Test				.080	.047
Linear-by-Linear Association	3.365	1	.067		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.73.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Peroxide-IV	not selected	Count	106	175	281
		Expected Count	103.0	178.0	281.0
		% within treatments	37.7%	62.3%	100.0%
		% of Total	36.3%	59.9%	96.2%
	selected	Count	1	10	11
		Expected Count	4.0	7.0	11.0
		% within treatments	9.1%	90.9%	100.0%
		% of Total	.3%	3.4%	3.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.738(b)	1	.053		
Continuity Correction(a)	2.606	1	.106		
Likelihood Ratio	4.574	1	.032		
Fisher's Exact Test				.060	.046
Linear-by-Linear Association	3.725	1	.054		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.03.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Peroxide-Oral	not selected	Count	106	176	282
		Expected Count	103.3	178.7	282.0
		% within treatments	37.6%	62.4%	100.0%
		% of Total	36.3%	60.3%	96.6%
	selected	Count	1	9	10
		Expected Count	3.7	6.3	10.0
		% within treatments	10.0%	90.0%	100.0%
		% of Total	.3%	3.1%	3.4%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.166(b)	1	.075		
Continuity Correction(a)	2.089	1	.148		
Likelihood Ratio	3.829	1	.050		
Fisher's Exact Test				.099	.067
Linear-by-Linear Association	3.155	1	.076		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.66.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Nutritional supplements	not selected	Count	89	127	216
		Expected Count	79.2	136.8	216.0
		% within treatments	41.2%	58.8%	100.0%
		% of Total	30.5%	43.5%	74.0%
	selected	Count	18	58	76
		Expected Count	27.8	48.2	76.0
		% within treatments	23.7%	76.3%	100.0%
		% of Total	6.2%	19.9%	26.0%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.433(b)	1	.006		
Continuity Correction(a)	6.697	1	.010		
Likelihood Ratio	7.781	1	.005		
Fisher's Exact Test				.008	.004
Linear-by-Linear Association	7.407	1	.006		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 27.85.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of – AZT (azidothymidine)	not selected	Count	68	67	135
		Expected Count	49.5	85.5	135.0
		% within treatments	50.4%	49.6%	100.0%
		% of Total	23.3%	22.9%	46.2%
	selected	Count	39	118	157
		Expected Count	57.5	99.5	157.0
		% within treatments	24.8%	75.2%	100.0%
		% of Total	13.4%	40.4%	53.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	20.377(b)	1	.000		
Continuity Correction(a)	19.293	1	.000		
Likelihood Ratio	20.543	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	20.308	1	.000		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 49.47.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - HAART (Highly active antiretroviral therapy)	not selected	Count	75	93	168
		Expected Count	61.6	106.4	168.0
		% within treatments	44.6%	55.4%	100.0%
		% of Total	25.7%	31.8%	57.5%
	selected	Count	32	92	124
		Expected Count	45.4	78.6	124.0
		% within treatments	25.8%	74.2%	100.0%
		% of Total	11.0%	31.5%	42.5%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	10.903(b)	1	.001		
Continuity Correction(a)	10.107	1	.001		
Likelihood Ratio	11.128	1	.001		
Fisher's Exact Test				.001	.001
Linear-by-Linear Association	10.866	1	.001		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 45.44.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Pharmaceutical antibodies (bactrim, etc)	not selected	Count	82	96	178
		Expected Count	65.2	112.8	178.0
		% within treatments	46.1%	53.9%	100.0%
		% of Total	28.1%	32.9%	61.0%
	selected	Count	25	89	114
		Expected Count	41.8	72.2	114.0
		% within treatments	21.9%	78.1%	100.0%
		% of Total	8.6%	30.5%	39.0%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	17.440(b)	1	.000		
Continuity Correction(a)	16.416	1	.000		
Likelihood Ratio	18.117	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	17.380	1	.000		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 41.77.

TREATMENTS KNOWN VS. ETHNIC GROUP

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
treatments that you have heard of - Vitamins-Oral	not selected	Count	7	4	111	45	93	13	6	279
		Expected Count	7.4	3.3	100.4	43.6	104.5	14.8	4.9	279.0
		% within treatments	2.5%	1.4%	39.8%	16.1%	33.3%	4.7%	2.2%	100.0%
		% of Total	2.1%	1.2%	32.7%	13.3%	27.4%	3.8%	1.8%	82.3%
	selected	Count	2	0	11	8	34	5	0	60
		Expected Count	1.6	.7	21.6	9.4	22.5	3.2	1.1	60.0
		% within treatments	3.3%	.0%	18.3%	13.3%	56.7%	8.3%	.0%	100.0%
		% of Total	.6%	.0%	3.2%	2.4%	10.0%	1.5%	.0%	17.7%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.270(a)	6	.008
Likelihood Ratio	19.226	6	.004
Linear-by-Linear Association	7.534	1	.006
N of Valid Cases	339		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is .71.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
treatments that you have heard of - Peroxide-Oral	not selected	Count	7	4	119	53	121	17	6	327
		Expected Count	8.7	3.9	117.7	51.1	122.5	17.4	5.8	327.0
		% within treatments	2.1%	1.2%	36.4%	16.2%	37.0%	5.2%	1.8%	100.0%
		% of Total	2.1%	1.2%	35.1%	15.6%	35.7%	5.0%	1.8%	96.5%
	selected	Count	2	0	3	0	6	1	0	12
		Expected Count	.3	.1	4.3	1.9	4.5	.6	.2	12.0
		% within treatments	16.7%	.0%	25.0%	.0%	50.0%	8.3%	.0%	100.0%
		% of Total	.6%	.0%	.9%	.0%	1.8%	.3%	.0%	3.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.665(a)	6	.049
Likelihood Ratio	9.998	6	.125
Linear-by-Linear Association	.212	1	.645
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .14.

		Which group do you identify with?								Total	
		american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander		
treatments that you have heard of - Porcine (pig) liver extracts-transdermal	not selected	Count	8	4	119	52	127	18	5	333	
		Expected Count	8.8	3.9	119.8	52.1	124.8	17.7	5.9	333.0	
		% within treatments	2.4%	1.2%	35.7%	15.6%	38.1%	5.4%	1.5%	100.0%	
		% of Total	2.4%	1.2%	35.1%	15.3%	37.5%	5.3%	1.5%	98.2%	
	selected	Count	1	0	3	1	0	0	1	6	
		Expected Count	.2	.1	2.2	.9	2.2	.3	.1	6.0	
		% within treatments	16.7%	.0%	50.0%	16.7%	.0%	.0%	16.7%	100.0%	
		% of Total	.3%	.0%	.9%	.3%	.0%	.0%	.3%	1.8%	
	Total		Count	9	4	122	53	127	18	6	339
			Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0

	% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.197(a)	6	.019
Likelihood Ratio	10.539	6	.104
Linear-by-Linear Association	1.430	1	.232
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .07.

		Which group do you identify with?								Total
		american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander	
treatments that you have heard of - Nutritional supplements	not selected	Count	7	4	101	44	86	9	5	256
		Expected Count	6.8	3.0	92.1	40.0	95.9	13.6	4.5	256.0
		% within treatments	2.7%	1.6%	39.5%	17.2%	33.6%	3.5%	2.0%	100.0%
		% of Total	2.1%	1.2%	29.8%	13.0%	25.4%	2.7%	1.5%	75.5%
	selected	Count	2	0	21	9	41	9	1	83
		Expected Count	2.2	1.0	29.9	13.0	31.1	4.4	1.5	83.0
		% within treatments	2.4%	.0%	25.3%	10.8%	49.4%	10.8%	1.2%	100.0%
		% of Total	.6%	.0%	6.2%	2.7%	12.1%	2.7%	.3%	24.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0

	% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.139(a)	6	.009
Likelihood Ratio	17.363	6	.008
Linear-by-Linear Association	9.726	1	.002
N of Valid Cases	339		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is .98.

TREATMENTS KNOWN VS. AGE

		Age group					Total	
		18-25	26-36	37-47	48-58	59 +	18-25	
treatments that you have heard of – AZT (Azidothymidine)	not selected	Count	37	47	42	31	8	165
		Expected Count	25.7	43.2	50.0	37.4	8.7	165.0
		% within treatments	22.4%	28.5%	25.5%	18.8%	4.8%	100.0%
		% of Total	10.9%	13.8%	12.4%	9.1%	2.4%	48.5%
	selected	Count	16	42	61	46	10	175
		Expected Count	27.3	45.8	53.0	39.6	9.3	175.0
		% within treatments	9.1%	24.0%	34.9%	26.3%	5.7%	100.0%
		% of Total	4.7%	12.4%	17.9%	13.5%	2.9%	51.5%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within treatments	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.970(a)	4	.005
Likelihood Ratio	15.229	4	.004
Linear-by-Linear Association	10.856	1	.001
N of Valid Cases	340		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.74.

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
Treatments that you have heard of - Pharmaceutical antibodies (bactrim, etc)	not selected	Count	43	59	53	49	12	216
		Expected Count	33.7	56.5	65.4	48.9	11.4	216.0
		% within treatments	19.9%	27.3%	24.5%	22.7%	5.6%	100.0%
		% of Total	12.6%	17.4%	15.6%	14.4%	3.5%	63.5%
	selected	Count	10	30	50	28	6	124
		Expected Count	19.3	32.5	37.6	28.1	6.6	124.0
		% within treatments	8.1%	24.2%	40.3%	22.6%	4.8%	100.0%
		% of Total	2.9%	8.8%	14.7%	8.2%	1.8%	36.5%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within treatments	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.938(a)	4	.007
Likelihood Ratio	14.481	4	.006
Linear-by-Linear Association	3.963	1	.046
N of Valid Cases	340		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.56.

CROSSTABS: EFFECTIVE TREATMENTS AND DEMOGRAPHIC VARIABLES

EFFECTIVE TREATMENTS VS. ETHNIC GROUP

			which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander
treatments that you think can be effective - UVBI (ultraviolet blood irradiation)	not selected	Count	5	4	115	52	122	15	6	319
		Expected Count	8.5	3.8	114.8	49.9	119.5	16.9	5.6	319.0
		% within treatments	1.6%	1.3%	36.1%	16.3%	38.2%	4.7%	1.9%	100.0%
		% of Total	1.5%	1.2%	33.9%	15.3%	36.0%	4.4%	1.8%	94.1%
	selected	Count	4	0	7	1	5	3	0	20
		Expected Count	.5	.2	7.2	3.1	7.5	1.1	.4	20.0
		% within treatments	20.0%	.0%	35.0%	5.0%	25.0%	15.0%	.0%	100.0%

	% of Total	1.2%	.0%	2.1%	.3%	1.5%	.9%	.0%	5.9%
Total	Count	9	4	122	53	127	18	6	339
	Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
	% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	30.895(a)	6	.000
Likelihood Ratio	17.748	6	.007
Linear-by-Linear Association	3.386	1	.066
N of Valid Cases	339		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is .24.

			which group do you identify with?						Total	
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial		other
treatments that you think can be effective - Selenium liver support-oral	not selected	Count	7	4	117	50	126	17	5	326
		Expected Count	8.7	3.8	117.3	51.0	122.1	17.3	5.8	326.0
		% within treatments	2.1%	1.2%	35.9%	15.3%	38.7%	5.2%	1.5%	100.0%
		% of Total	2.1%	1.2%	34.5%	14.7%	37.2%	5.0%	1.5%	96.2%
	selected	Count	2	0	5	3	1	1	1	13
		Expected Count	.3	.2	4.7	2.0	4.9	.7	.2	13.0
		% within treatments	15.4%	.0%	38.5%	23.1%	7.7%	7.7%	7.7%	100.0%
		% of Total	.6%	.0%	1.5%	.9%	.3%	.3%	.3%	3.8%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.934(a)	6	.021
Likelihood Ratio	11.141	6	.084
Linear-by-Linear Association	2.015	1	.156
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .15.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
treatments that you think can be effective - Peroxide-Oral	not selected	Count	9	4	120	52	127	17	5	334
		Expected Count	8.9	3.9	120.2	52.2	125.1	17.7	5.9	334.0
		% within treatments	2.7%	1.2%	35.9%	15.6%	38.0%	5.1%	1.5%	100.0%
		% of Total	2.7%	1.2%	35.4%	15.3%	37.5%	5.0%	1.5%	98.5%
	selected	Count	0	0	2	1	0	1	1	5
		Expected Count	.1	.1	1.8	.8	1.9	.3	.1	5.0
		% within treatments	.0%	.0%	40.0%	20.0%	.0%	20.0%	20.0%	100.0%
		% of Total	.0%	.0%	.6%	.3%	.0%	.3%	.3%	1.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.772(a)	6	.032
Likelihood Ratio	8.629	6	.196
Linear-by-Linear Association	1.021	1	.312
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .06.

		Which group do you identify with?								Total
		american indian, alaskan native, or pacific islander	asian/asian american	black/african american or negro	Hispanic	white/Caucasian	multiracial	other	american indian, alaskan native, or pacific islander	
treatments that you think can be effective - Porcine (pig) liver extracts-transdermal	not selected	Count	8	4	120	52	127	18	5	334
		Expected Count	8.9	3.9	120.2	52.2	125.1	17.7	5.9	334.0
		% within treatments	2.4%	1.2%	35.9%	15.6%	38.0%	5.4%	1.5%	100.0%
		% of Total	2.4%	1.2%	35.4%	15.3%	37.5%	5.3%	1.5%	98.5%
	selected	Count	1	0	2	1	0	0	1	5
		Expected Count	.1	.1	1.8	.8	1.9	.3	.1	5.0
		% within treatments	20.0%	.0%	40.0%	20.0%	.0%	.0%	20.0%	100.0%
		% of Total	.3%	.0%	.6%	.3%	.0%	.0%	.3%	1.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.595(a)	6	.007
Likelihood Ratio	10.074	6	.122
Linear-by-Linear Association	.808	1	.369
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .06.

		Which group do you identify with?								Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander
treatments that you think can be effective Nutritional supplements	not selected	Count	6	4	99	44	100	7	6	266
		Expected Count	7.1	3.1	95.7	41.6	99.7	14.1	4.7	266.0
		% within treatments	2.3%	1.5%	37.2%	16.5%	37.6%	2.6%	2.3%	100.0%
		% of Total	1.8%	1.2%	29.2%	13.0%	29.5%	2.1%	1.8%	78.5%
	selected	Count	3	0	23	9	27	11	0	73
		Expected Count	1.9	.9	26.3	11.4	27.3	3.9	1.3	73.0
		% within treatments	4.1%	.0%	31.5%	12.3%	37.0%	15.1%	.0%	100.0%
		% of Total	.9%	.0%	6.8%	2.7%	8.0%	3.2%	.0%	21.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.347(a)	6	.002
Likelihood Ratio	19.866	6	.003
Linear-by-Linear Association	1.756	1	.185
N of Valid Cases	339		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is .86.

EFFECTIVE TREATMENTS VS. STATUS

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - silver colloid-IV	not selected	Count	101	183	284
		Expected Count	104.1	179.9	284.0
		% within treatments	35.6%	64.4%	100.0%
		% of Total	34.6%	62.7%	97.3%
	selected	Count	6	2	8
		Expected Count	2.9	5.1	8.0
		% within treatments	75.0%	25.0%	100.0%
		% of Total	2.1%	.7%	2.7%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.212(b)	1	.022		
Continuity Correction(a)	3.652	1	.056		
Likelihood Ratio	5.019	1	.025		
Fisher's Exact Test				.055	.030
Linear-by-Linear Association	5.195	1	.023		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.93.

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - Vitamins-Oral	not selected	Count	96	148	244
		Expected Count	89.4	154.6	244.0
		% within treatments	39.3%	60.7%	100.0%
		% of Total	32.9%	50.7%	83.6%
	selected	Count	11	37	48
		Expected Count	17.6	30.4	48.0
		% within treatments	22.9%	77.1%	100.0%
		% of Total	3.8%	12.7%	16.4%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.662(b)	1	.031		
Continuity Correction(a)	3.982	1	.046		
Likelihood Ratio	4.945	1	.026		
Fisher's Exact Test				.034	.021
Linear-by-Linear Association	4.646	1	.031		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 17.59.

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - Minerals-Oral	not selected	Count	101	158	259
		Expected Count	94.9	164.1	259.0
		% within treatments	39.0%	61.0%	100.0%
		% of Total	34.6%	54.1%	88.7%
	selected	Count	6	27	33
		Expected Count	12.1	20.9	33.0
		% within treatments	18.2%	81.8%	100.0%
		% of Total	2.1%	9.2%	11.3%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.462(b)	1	.019		
Continuity Correction(a)	4.602	1	.032		
Likelihood Ratio	6.011	1	.014		
Fisher's Exact Test				.021	.013
Linear-by-Linear Association	5.443	1	.020		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.09.

		My HIV status is		Total	
		Negative	Positive	Negative	
treatments that you think can be effective Nutritional supplements	not selected	Count	92	133	225
		Expected Count	82.4	142.6	225.0
		% within treatments	40.9%	59.1%	100.0%
		% of Total	31.5%	45.5%	77.1%
	selected	Count	15	52	67
		Expected Count	24.6	42.4	67.0
		% within treatments	22.4%	77.6%	100.0%
		% of Total	5.1%	17.8%	22.9%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.611(b)	1	.006		
Continuity Correction(a)	6.835	1	.009		
Likelihood Ratio	8.046	1	.005		
Fisher's Exact Test				.006	.004
Linear-by-Linear Association	7.585	1	.006		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 24.55.

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - AZT (azidothymidine)	not selected	Count	77	106	183
		Expected Count	67.1	115.9	183.0
		% within treatments	42.1%	57.9%	100.0%
		% of Total	26.4%	36.3%	62.7%
	selected	Count	30	79	109
		Expected Count	39.9	69.1	109.0
		% within treatments	27.5%	72.5%	100.0%
		% of Total	10.3%	27.1%	37.3%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.232(b)	1	.013		
Continuity Correction(a)	5.621	1	.018		
Likelihood Ratio	6.361	1	.012		
Fisher's Exact Test				.017	.008
Linear-by-Linear Association	6.211	1	.013		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 39.94.

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - HAART (Highly active antiretroviral therapy)	not selected	Count	79	96	175
		Expected Count	64.1	110.9	175.0
		% within treatments	45.1%	54.9%	100.0%
		% of Total	27.1%	32.9%	59.9%
	selected	Count	28	89	117
		Expected Count	42.9	74.1	117.0
		% within treatments	23.9%	76.1%	100.0%
		% of Total	9.6%	30.5%	40.1%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	13.589(b)	1	.000		
Continuity Correction(a)	12.691	1	.000		
Likelihood Ratio	13.992	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	13.542	1	.000		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 42.87.

		My HIV status is		Total	
		Negative	Positive	Negative	
treatments that you think can be effective Pharmaceutical antibodies (bactrim, etc)	not selected	Count	91	109	200
		Expected Count	73.3	126.7	200.0
		% within treatments	45.5%	54.5%	100.0%
		% of Total	31.2%	37.3%	68.5%
	selected	Count	16	76	92
		Expected Count	33.7	58.3	92.0
		% within treatments	17.4%	82.6%	100.0%
		% of Total	5.5%	26.0%	31.5%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	21.445(b)	1	.000		
Continuity Correction(a)	20.251	1	.000		
Likelihood Ratio	23.056	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	21.372	1	.000		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 33.71.

EFFECTIVE TREATMENTS VS. AGE

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
treatments that you think can be effective - Peroxide-IV	not selected	Count	49	87	103	76	18	333
		Expected Count	51.9	87.2	100.9	75.4	17.6	333.0
		% within treatments	14.7%	26.1%	30.9%	22.8%	5.4%	100.0%
		% of Total	14.4%	25.6%	30.3%	22.4%	5.3%	97.9%
	selected	Count	4	2	0	1	0	7
		Expected Count	1.1	1.8	2.1	1.6	.4	7.0
		% within treatments	57.1%	28.6%	.0%	14.3%	.0%	100.0%
		% of Total	1.2%	.6%	.0%	.3%	.0%	2.1%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within treatments	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.697(a)	4	.030
Likelihood Ratio	10.044	4	.040
Linear-by-Linear Association	6.145	1	.013
N of Valid Cases	340		

a 5 cells (50.0%) have expected count less than 5. The minimum expected count is .37.

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
treatments that you think can be effective - Nutritional supplements	not selected	Count	48	75	76	52	14	265
		Expected Count	41.3	69.4	80.3	60.0	14.0	265.0
		% within treatments	18.1%	28.3%	28.7%	19.6%	5.3%	100.0%
		% of Total	14.1%	22.1%	22.4%	15.3%	4.1%	77.9%
	selected	Count	5	14	27	25	4	75
		Expected Count	11.7	19.6	22.7	17.0	4.0	75.0
		% within treatments	6.7%	18.7%	36.0%	33.3%	5.3%	100.0%
		% of Total	1.5%	4.1%	7.9%	7.4%	1.2%	22.1%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within treatments	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.873(a)	4	.012
Likelihood Ratio	13.571	4	.009
Linear-by-Linear Association	9.891	1	.002
N of Valid Cases	340		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 3.97.

EFFECTIVE TREATMENTS VS. SEXUAL ORIENTATION

			sexual orientation			Total
			Heter	Homo	Bi-sexual	
treatments that you think can be effective - Nutritional supplements	not selected	Count	124	88	26	238
		Expected Count	111.7	100.1	26.2	238.0
		% within treatments	52.1%	37.0%	10.9%	100.0%
		% of Total	40.1%	28.5%	8.4%	77.0%
	selected	Count	21	42	8	71
		Expected Count	33.3	29.9	7.8	71.0
		% within treatments	29.6%	59.2%	11.3%	100.0%
		% of Total	6.8%	13.6%	2.6%	23.0%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.313(a)	2	.002
Likelihood Ratio	12.467	2	.002
Linear-by-Linear Association	6.330	1	.012
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.81.

			sexual orientation			Total
			Heter	Homo	Bi-sexual	
treatments that you think can be effective - Pharmaceutical antibodies (bactrim, etc)	not selected	Count	113	75	23	211
		Expected Count	99.0	88.8	23.2	211.0
		% within treatments	53.6%	35.5%	10.9%	100.0%
		% of Total	36.6%	24.3%	7.4%	68.3%
	selected	Count	32	55	11	98
		Expected Count	46.0	41.2	10.8	98.0
		% within treatments	32.7%	56.1%	11.2%	100.0%
		% of Total	10.4%	17.8%	3.6%	31.7%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.972(a)	2	.002
Likelihood Ratio	13.076	2	.001
Linear-by-Linear Association	6.674	1	.010
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.78.

List of Crosstabs with No Significance

Sources

- Books
- Newspapers
- Events (seminars, workshops, conferences)
- Medical websites
- Blogs, online bulletin boards
- Emails
- Community organizations
- Religious organizations
- Alternative medical doctors
- Other

Source Credibility

- TV
- Radio
- Books
- Newspapers
- Magazines
- Out of home (billboards, bus ads, posters, flyers, brochures)
- HIV/AIDS groups websites
- Online newsletters, journals, etc
- Emails
- Social media-Facebook, Twitter, etc
- Religious organizations
- Conventional medical doctors
- Alternative medical doctors
- Other

Perception Statements

- Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS
- HIV/AIDS infections are often the result of immoral behavior
- HIV/AIDS prevention efforts often receive more funding than treatment efforts
- Young people under 25 account for almost half of new HIV/AIDS infections globally

Treatments Known

- UVBI (Ultraviolet blood irradiation)
- Silver colloid-IV
- Silver colloid-oral
- Selenium liver support-oral
- Chelation-oral
- Vitamins-IV
- Minerals-IV
- Venus flytrap-oral
- Other

List of Crosstabs with No Significance (Cont.)

Effective Treatments

Silver colloid-oral
Chelation-IV
Chelation-oral
Vitamins-IV
Minerals-IV
Venus flytrap-oral
Other

RELIABILITY STATISTICS
CRONBACH'S ALPHA ANALYSIS TABLES

Group 1: The Hedonist or the Moralist

Cronbach's Alpha	N of Items
.685	6

Item Statistics

	Mean	Std. Deviation	N
How do you feel about - Poor people are more likely to get HIV/AIDS	3.6404	1.22626	342
How do you feel about - HIV/AIDS is primarily a gay disease	4.2602	1.01577	342
How do you feel about - HIV/AIDS is God's way of punishing the wicked	4.3830	.99385	342
How do you feel about - People with HIV/AIDS deserve the same rights in the workplace as other workers	4.4561	.95168	342
How do you feel about - HIV/AIDS infections are often a result of immoral behavior	3.7222	1.23323	342
How do you feel about - Getting HIV/AIDS is usually a death sentence	3.9240	1.14623	342

Group 2: The Cautious Optimist or the Raving Pessimist

Cronbach's Alpha	N of Items
.619	6

Item Statistics

	Mean	Std. Deviation	N
How do you feel about- Globally the number of people with HIV/AIDS is decreasing	3.8830	1.08214	342
How do you feel about- Antiretroviral drugs are a cure for HIV/AIDS	3.9006	1.06479	342
How do you feel about - Giving antiretroviral drugs to people not infected prevents HIV/AIDS	3.7427	1.09565	342
How do you feel about - You cannot get HIV/AIDS during sex if condoms are always used	3.7047	1.19035	342
How do you feel about - An effective HIV/AIDS vaccine is available	3.5614	1.13361	342
How do you feel about - Alternative medical treatments for HIV/AIDS have shown promising results	2.5994	1.05580	342

Group 3: The Global Activist or the Political Ostrich

Cronbach's Alpha	N of Items
.514	7

Item Statistics

	Mean	Std. Deviation	N
How to you feel about - A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby	3.8070	1.13755	342
How do you feel about - HIV/AIDS prevention efforts often receive more funding than treatment efforts	3.0409	1.00063	342
How do you feel about - It is biologically easier for woman to get HIV/AIDS than it is for men	3.2690	1.20513	342
How do you feel about - Treating HIV/AIDS is a lucrative business for pharmaceutical companies	2.4766	1.17315	342
How do you feel about - Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact	2.8538	1.08670	342
How do you feel about - People who knowingly expose others to HIV/AIDS should be prosecuted as criminals	2.4678	1.26670	342
How do you feel about - Getting HIV/AIDS is usually a death sentence	3.9240	1.14623	342

**SOCIAL MARKETING STRATEGIES FOR COMBATING HIV/AIDS
IN RURAL AND/OR DISADVANTAGED COMMUNITIES
IN MEXICO, UGANDA, AND THE UNITED STATES**

VOLUME 2

RUTH E. MASSINGILL

**A thesis submitted in partial fulfillment
of the requirements of Teesside University
for the degree of Doctor of Philosophy**

April 2011

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APPENDIX A
A REFLECTIVE LOG

*Travelling high roads, visiting low places,
and following bunny trails
from Texas to Teesside and back home again*

Reflective Log

2005-2010

This is a personal chronicle of my research journey over towering mountains of information, past pillars of statistics, through labyrinths of opinion and theory, and across ethical minefields. At the same time, there was the academic maze to navigate, with its ironclad procedures, reams of reports, and educational conventions.

This was also an intensely personal journey that took me out of my comfort zone, where I encountered people and experiences that would never have touched my sheltered university life in Texas.

Along the way, I logged thousands of actual miles travelling from Texas to Teesside, with forays north to Canada, south to Peru and Mexico, and across the pond to a number of European cities. I met a wonderfully diverse group of individuals with fascinating—sometimes shocking—knowledge they were kind enough to share.

This arduous pursuit was undertaken with the realisation there would be dead ends and missed markers aplenty, but I hoped by journey's end logical patterns would emerge as the sanity of method came to the forefront. I admit I rambled down a goodly number of bunny trails—diversions that yielded no useful result—but isn't that part of the research process? Over the years, I experienced curiosity (which set this endeavour in motion), frustration, steep learning curves, exhilaration, and empathy. At one point, I was told that writing a PhD thesis was the '*largest and most self-indulgent thing*' I would ever do. If that is the case, this reflective log is the most hedonistic thing of all. Certainly the entire project has been self-serving in that I have received immeasurable rewards, which have more than compensated for the time, expense, and discomfort—both physical and emotional.

This, then, is my five-year chronology of milestone places and experiences, combined with my serious—and sometimes not-so-serious—musings on the mundane as well as the profound.

2005

Paris, September 2005

The inspiration for this project was my desire to go to Paris. For years, I had longed to visit France. Time was passing and I was still in Texas, although I frequently

presented academic papers in major U.S. cities. So, in the Spring of 2005, I searched the Internet for communication conferences scheduled to meet in the City of Lights.

Success! I found a call for abstracts by an organisation meeting at UNESCO. A colleague and I sent a proposal, which was accepted for presentation. In researching and writing my part of the paper, I was stunned by the scope of the HIV/AIDS epidemic. I also discovered the field of social marketing—heretofore unknown to me—and through my colleague I started to learn about the medical aspects of the disease. Our research suggested unhealthy relationships between drug companies and dissemination of information about medical issues, especially relating to diseases such as HIV/AIDS, where billions of dollars were being spent for prevention and treatment programs. We reported that companies such as Merck and Pfizer typically spent more on marketing their drugs than on research and development.

Our paper included this statement:

‘With this kind of investment at stake, it is not surprising the traditional medical establishment uses its influence and financial clout to control the dissemination of information. It does so by violating the most intrinsic human freedom and endangering the most basic of human capabilities—access to knowledge.’

The paper was controversial, some even said it was ‘incendiary,’ but my interest was sparked. I had found my PhD topic. (And, yes, Paris is now one of my favourite cities; I have returned several times since.)

MILESTONE:

11-14 September 2005—*Curing AIDS: Why Successful HIV/AIDS Treatments are Unknown to World Government Policy Makers*. Fifth International Conference on the Capability Approach, UNESCO. Paris, France (co-author: James Adams)

Teesside, September 2005

While researching the converging topics of HIV/AIDS, social marketing, and their relationship to conventional and alternative medicine, I also began looking for a PhD program that would fit my life situation and make me eligible for promotion at the university in Texas where I teach communication classes. *Bear’s Guide to Earning Degrees by Distance Learning* helped me determine that part-time distance programs in public relations/social marketing were available, especially in Europe and Australia.

Since leaving my job for a full-time research program was not feasible, I began to search for an English-language university with international GAAP certification that offered PhD marketing degrees via distance learning. Social marketing is not a common degree in the United States, so I turned my attention to universities in the UK. Staff at

Teesside Business School agreed to meet with me and discuss my proposal while I was in Europe for the UNESCO conference. In mid-September, the 6 a.m. train from London took me north to Middlesbrough and a taxi delivered me to the campus, where I found my way to the Business School for an appointment that would significantly affect the next five years of my life.

After discussing my proposed topic with faculty and staff from the Teesside Business School, a question I was to answer many times over the next few years was broached: *'Why travel so far to earn your degree and why are you specifically interested in Teesside?'* I explained that in addition to offering the kind of program and flexibility I needed to advance in my academic career, Teesside was squarely in the middle of my roots; my family originally came from Masongill, near Settle, Yorkshire. Masongill was the family seat of the Massengills during the Middle Ages. Daniel Marsingell, a sailor from nearby Whitby, immigrated to Virginia in the mid-1650s and was the forbearer for the many Massingills now living in the States. I had learned these facts years ago from a hefty book in my personal library—*The Massengills, Massengales and Variants 1472-1931*, written by Samuel Evans Massengil, M.D., and published in 1931. So, I feel a special affinity to Yorkshire and was delighted with the prospect of exploring the area while spending my annual residency at Teesside.

Beyond these personal and professional motivations, however, I was intrigued with the idea of tackling a far-ranging project that would challenge me to understand cultures outside my experience and would allow me to become constructively involved in the international dialogue about social policies to combat HIV/AIDS. Happily, Terry Robinson, Reader in Marketing, and Helen Bussell, acting Assistant Dean in the Teesside Business School, enthusiastically agreed to supervise my research and my enrolment was approved in December of 2005. So at an age when many of my contemporaries were looking forward to retirement, I was blithely committing to a project that would devour much of my spare time and money for the next five years and would require me to travel to Teesside each year for several weeks in residence at the university.

MILESTONE:

December 2005—Officially enrolled at Teesside

Huntsville, Texas, May 2006

As one requirement for moving from enrolment to registration at Teesside, I completed a graduate level research methods class through Sam Houston State University, where I have been a tenured instructor for more than 15 years. This class gave me needed background in mixed methods research, with an emphasis on the qualitative techniques that would be dominant in much of my work. This class also reminded me of the student role I had not experienced in many years; I was accustomed to being the professor who assigned, facilitated and graded. Learning to switch back and forth between being student and instructor was valuable; it gave me insights that were helpful to me as learner and as educator. Also, since I had to take the class online due to my own teaching schedule, I gained valuable insights into the pros and cons of this method of teaching, which served me well a few years later when I began teaching some of my communication classes online.

MILESTONE:

May 2006—Earned an ‘A’ in research methods and packed my bags for my first residency at Teesside

Teesside, May-June 2006

My first annual trip to Teesside was a learning experience in logistics as I figured out how to get from London Gatwick to Kings Crossing to catch the northbound train. That was also the year of too-much luggage; I mistakenly packed one massive (and extremely heavy) suitcase, thinking its wheels would make it manageable. I soon realised my error when I discovered there were no escalators in the London tube and elevators were rare and well hidden. After that experience, with each succeeding year, I would travel lighter, although a laptop computer was always mandatory, and it was the heaviest item in my luggage.

Once my luggage and I made it to Middlesbrough that first year, I settled into a rented room in a house I shared with other students, one who was a graduate business school student from China with whom I developed a continuing friendship.

With my journalism background, being curious about people’s lives and asking incisive (some might say nosy) questions comes naturally, but following a strict research protocol during the interviewing process was a departure from my experiences

as a reporter. When I became a graduate student in England, it was helpful to have recently gone through the IRB (Institutional Review Board) process for *Prison City*, a book I co-wrote about communication in the Texas criminal justice system.

Since I often presented papers at international conferences wearing the twin hats of a communication faculty member for Sam Houston State University in Texas and a graduate student at Teesside, I had to satisfy the research/ethics committees at both institutions. Of course, the applications had to be written in American English (organization, for example) for SHSU and in British English (organisation) for Teesside! Eventually I created my own ‘cheat sheet’ for the *z* words; for *horizon*, *magazine*, *size*, and *citizen*, it was okay to use *z*; in most other cases, I should convert the *z* to an *s*. The language selection in my word processing program was immensely helpful and soon all of my academic papers were written in UK English.

Also, I quickly learned the terms *thesis* and *dissertation* have opposite meanings in Europe and in the U.S. In the states one writes a thesis as a requirement for a master’s degree and a dissertation to earn a PhD. At Teesside, I would be writing a thesis for my PhD. This would cause much confusion among my colleagues back in Texas, and meant that I would have completed a thesis for my master’s degree (from the University of Wyoming) and another for my PhD. So, I began the challenge of life with one foot in British academia and the other in higher education in the U.S.

Stirling, Scotland, June 2006

While I was working on my ethics application, my research proposal, and registration paperwork at Teesside, I contacted Laura McDermott, research officer at the Institute for Social Marketing (ISM) at the University of Stirling, and asked for an interview. She agreed and I was once again on a northbound train, first to Edinburgh, where I stayed in a bed and breakfast booked over the Internet. A map of the city and questions of bus drivers and various other citizens confused me further, so I had an extended walking tour of the city before finding my room. The next day, I retraced my path and found the bus to Stirling. As with many of my first visits to a new city, getting there was an exercise in critical thinking and problem solving.

When I reached Stirling, attractively sited in the countryside, McDermott and several of her colleagues at the ISM were welcoming and encouraging. They shared case studies and behind-the-scenes strategies for some of their campaigns, including a draft report discussing which theoretical models were proving most effective in national anti-obesity campaigns.

Back at Teesside, I struggled to produce a comprehensive ethics application; since my project would involve interviews with and a survey of human subjects, *and* since my topic was HIV/AIDS, the application received careful scrutiny. My Teesside director of studies, Terry Robinson, was especially helpful as I edited and rewrote the application, which had the added benefit of helping me focus on my project's purpose and protocol. By the time I completed my 2006 residency and headed home, the ethics application was approved and my request to be accepted as an MPhil candidate at Teesside had been submitted. (At that time, Teesside, like most British universities, first accepted graduate students as MPhil candidates and, when the student's work warranted, he or she could apply to transfer to PhD status.)

MILESTONES:

Summer 2006—University of Teesside's Research Ethics Committee approved my application

September 2006—Registration as an MPhil candidate in the Teesside Business School was approved

Texas and Mexico, Summer 2006

Back in Texas, I taught summer school and attended my 25th high school reunion, in a world far removed from my experiences in the U.K. Many of the 39 people from my high school class were at the reunion, and they were mystified that I would, first of all, begin work toward a doctorate at an age when most of them were grandparents with their golden retirement years in their sights. My colleagues at Sam Houston were equally confounded at the thought of me travelling halfway around the world each year to study in Europe. Several commented, *'I can't believe you travel all that way by yourself!'* My students, on the other hand, thought it sounded like a wonderful adventure, which of course it already was proving to be. I explained to some of my colleagues that yet another reason I was pleased with my choice was the higher education culture in Europe. Everyone I encountered at Teesside and at various conferences I attended wanted me to succeed with my research and with earning my degree. I never experienced even a hint of the caste system of PhD vs. non-PhD that is so prevalent in many U.S. universities or encountered the 'academic hazing' I have frequently seen in U.S. academia.

That summer I also took my second trip to a medical clinic in Mexico, where HIV/AIDS was being treated using alternative therapies. The clinic's director was a client of The Massingill Agency, my firm that specialises in health care communication.

My research into HIV/AIDS medical issues was proving helpful in my work with this client. I summarised some of my secondary and primary research in an HIV/AIDS backgrounder for a media kit. I was surprised to learn many of the stereotypes about HIV/AIDS were false, but generally widespread, perceptions. I learned that in 2005, more new infections (13,000 daily) and deaths (8,000 daily) had occurred than during any previous year of the pandemic. I also noted that worldwide, about half of the infected were women, and heterosexual transmission was the most common means of infection. Even more frightening, I discovered that in the U.S. alone, an estimated one-third (or more) of the HIV infections were undiagnosed.

The most intriguing fact I learned while working with my Mexico clinic client was that an international team of researchers and physicians had begun IRB-sanctioned pilot programs using the latest nanotechnology and sub-nanotechnology. The early results in the summer of 2006 showed remarkable outcomes in patient blood tests measuring viral load reductions. My interest in emerging alternative treatments for HIV/AIDS was certainly captured by these statistics!

Lima, Peru, August 2006

At summer's end, I travelled to Peru to attend a communication conference where I was an invited presenter on advertising campaigns that cross cultural boundaries. I found the discussion about aspirational ads to be an intriguing question that related to my research into which behavioural change approaches were effective in combating HIV/AIDS. Although many advertising professionals were eschewing aspirational approaches as too elitist, some professionals think that is a short-sighted viewpoint, as explained in this blog:

'An aspiration is defined as "a strong desire, longing, aim or goal. To strive toward an end: to soar." If you were to ask American families what they aspire to, you are likely to hear responses about health and happiness, giving their kids a better life, making sure college is paid for, vocational fulfilment, contentedness even. You see, while American consumers have bought into the cultural narrative that "progress" is constituted by attaining the most feature-laden cell phone, the things people fundamentally care about are unchanging' (Guest Blogger: Elizabeth Paul, The Martin Agency <http://blog.communispace.com/index.php/2009/09/09/redefining-aspiration>, Sept 2009).

Aside from fulfilling a long-time desire to visit Peru, this international gathering of communicators raised some intriguing questions for me about culture and advertising, and helped me prepare for an upcoming Mexico conference on AIDS in Culture. It was

also my first bilingual (English/Spanish) conference, where simultaneous translations took place while the speakers were presenting.

MILESTONE:

3-6 August 2006—*Aspiration Advertising Campaigns as Intercultural Conduits* (invited presentation) Congress of the Americas. Lima, Peru

Banff, Canada, October 2006

I had attended many academic conferences over the years, but in October I travelled to Canada to present a poster at my first social marketing conference. This was also the first poster presentation I had done—my desktop publishing skills and my B.A. in art found a practical use. I had been to Banff before so I already knew it was breathtakingly beautiful, especially in the autumn. This conference was an excellent introduction to the international world of social marketing. I was fascinated by the research presentations, informed by their methodologies, and delighted with the variety of people I met. I returned home with a fistful of business cards and presentation handouts, some of which helped me plan the Phase 1 of my research—a content analysis of recent HIV/AIDS campaigns.

MILESTONE:

19-21 October 2006—*HIV/AIDS Social Marketing: A Comparative History* (poster session) Social Marketing Advances in Research and Theory (SMART) Conference. Banff, Canada

Mexico City, December 2006

Ciudad de México was an exciting place to be at the end of 2006. Civil unrest as a result of the recent presidential election generated all-night protests in the central zócalo, officially known as Plaza de la Constitución. I was staying in a hotel one block from the city square and could hear the protestors chanting and singing through the night. During the day, every rooftop and every street was guarded by **Policía Federal** in full riot gear. Since it was also the celebration of the Virgin of Guadalupe, a national holiday, in the evening protestors rode through the streets on bicycles, wearing white and carrying colourful posters and red roses representing the Virgin, who is said to have appeared to a poor Indian on December 12, 1531, and was a key figure in acceptance of the Catholic religion by the indigenous peoples of Mexico. This combination of political and religious history was the background for the third AIDS in Culture conference, sponsored by CENSIDA (Mexico's National Centre for Prevention and Control of

AIDS) and *Enkidu*, a gay activist magazine. At first, I was taken aback by the explicit nature of the some of the presentations, but as I talked with the organisers of the conference, I learned much about the disease's scope and political issues in the country's largest city. Once again, I collected business cards as well as personal stories from those attending the conference.

Language was a barrier, but not an impossible obstacle; the editor of *Enkidu* served as interpreter for all presentations. I sometimes had problems remembering to say several sentences and then stop for the interpreter to give my comments in Spanish. I have not had the opportunity to attend that annual conference again, but I did attend a gathering of the conference organisers and local HIV activists when I returned to Mexico City two years later (See 2008 entry.).

MILESTONE:

9-12 December 2006—*Getting the Word Out: Promoting Cures Through Social Marketing* (paper presented as part of a special panel session, 'Making History: Curing AIDS with Nanotechnology') AIDS in Culture III: Explorations in the Cultural History of AIDS. Mexico City (co-author: Lauren Maddox)

Texas, Winter 2006

What is the question, anyway?

Refining my overall research question was an ongoing challenge; much easier said than done, as the saying goes. Seasons came and went, and my overall question evaded perfection, but siren-like, invited interminable tinkering. While I tinkered, I applied for scholarships and grants, signed up for a social marketing listserv I learned about from one of my recent contacts, and submitted a proposal for a conference that would be close to home—in New Mexico, just west of my home state: only 743 miles (1195 kilometers) away. I also found myself struggling to remember to use the correct formal style for each project I was working on; I was alternatively working with Chicago style, MLA, APA, and also the official style required by Teesside: Harvard.

2007

Huntsville, Spring 2007

When (a few) funds came rolling in

Some of the applications I made paid off—literally. I was awarded the Scott Scribes Scholarship for Older Adults (I was glad to have the scholarship despite the name) by

the Writers' League of Texas, which paid most of my Teesside tuition for the year. Also, I received a bursary from the Academy of Marketing to attend its 2007 Doctoral Colloquium in Surrey later that year. I was very grateful for both, both for the votes of confidence in my work and for the financial assistance they brought.

That spring also brought to fruition my first book project, which I had been working on for over three years as the lead author. *Prison City: Life with the Death Penalty in Huntsville, Texas*, was released by Peter Lang Publishing in April. Although neither fame nor fortune came with the publication of *Prison City*, (the royalties were just enough to take a couple of friends out to dinner in Houston), completing this book about the execution capital of the world cleared the way for me to focus exclusively on my HIV/AIDS research. Also, since *Prison City* examined how communication techniques used by inmates, information officers for the prison system, and community leaders affect the political, cultural, and economic landscape, similar issues applied to my Teesside project. Additionally, the *Prison City* research revealed the incidence of HIV/AIDS in U.S. prisons was higher than among any other population in the country, which I found to be the case in other countries as well. All in all, the *Prison City* project was a good preface to my thesis work; I now knew I could do a large research and writing project that stretched over several years and required synthesising massive amounts of information.

MILESTONE:

April 2007—Massingill, Ruth and Sohn, Ardyth. *Prison City: Life with the Death Penalty in Huntsville, Texas*. New York: Peter Lang Publishing, Inc.

St. Petersburg, Florida, May 2007

Despite a broken nose (no, not as a result of asking nosey questions; I really did walk into a door—duh!), after my spring teaching term was over, my university department chair asked that I participate in a seminar, '*Teaching diversity across the curriculum*,' given at the prestigious Poynter Institute in St. Petersburg, Florida. This intensive seminar provided useful training in how to better communicate with diverse populations and offered suggestions for being more inclusive of various cultural groups, including ethnic groups and gay and transgender populations. I quickly realised this experience would help me better understand social marketing campaigns directed toward specific groups where HIV/AIDS prevalence was a problem. The seminar also made me more aware of language and cultural issues that affected messages directed to specific audiences.

Teesside, June 2007

When I returned to Texas, it was time to pack (as lightly as possible) for my annual residency at Teesside. I made arrangements for the care of my animal companions and flew to Madrid to visit a long-time Texas friend, who lived near the city centre and taught English at the Spanish police academy. From Madrid, I took an overnight sleeper train to Paris (yes, I *had* to spend a weekend eating chocolate pastries and fresh strawberries in the city where my adventures began), then boarded more trains to London and on to Middlesbrough. Along the way, I was reminded that keyboards across Europe vary, which made me glad I had hauled my Mac laptop with me, despite the bulk and weight. I was also bemused by the subtle differences of design for practical items such as lavatories (I spent a minute or so in the public restroom at the Gardens of Versailles trying to turn the water on so I could wash my hands—the lever was on the floor.)

That year, I was able to live in an on-campus residence hall, which was much more convenient as well as economical. I had a bed, a desk, a tiny bath and the shared use of a kitchen. The weeks I spent at Teesside each year were an interesting contrast to my multi-tasking life in the States. When I came to Teesside, I had no home or animals to care for, no car to maintain (I walked or took the train everywhere I went), and very few possessions that required my time. I washed my clothes by hand and dried them on the radiators. I didn't iron and I carried only a few necessities in a tiny purse. I shopped carefully for groceries, aware the items I purchased would have to be carried back to my room. I realized that, at least for those weeks, having so few 'things' was a relief and being able to focus only on my research was a wonderful luxury. It also sharpened my thinking and increased my productivity.

During that year's residence at Teesside, I completed my application requesting transfer from MPhil to PhD. This process helped further clarify and focus my study. I was honoured to be invited to present my Phase I research during the University's Post Graduate Research Students' Networking Forum. And, I was asked to write a short article for the postgraduate Business School newsletter. My article, *'From Texas to Teesside,'* began with this paragraph:

'It's a long way from Houston, Texas, to Middlesbrough, but I quickly felt welcome when I first visited the Teesside campus almost two years ago to explore the possibility of becoming a distance learning student in social marketing...'

...And ended like this:

'Now, when my colleagues and friends hear about my experiences at Teesside, they no longer ask "why"; they understand the reason I travel so far each year. In fact, I think they are a bit jealous! And, although I have resumed my "regular" life in Texas, I look forward to returning to Teesside next summer.'

Surrey, England, July 2007

The doctoral colloquium was a positive experience that came at a point in my project where advice and encouragement from the professional world was most welcome. The conference was hosted by Kingston Business School, which is organised around a quad of ancient buildings reached by forest trails. The day of the colloquium was filled with presentations by a number of the doctoral students and workshops presented by marketing professionals. Practical suggestions abounded, and each student presenter received feedback on his/her work from a panel of international experts. In an introductory talk, one speaker commented that *'most people only get one PhD, because they don't want to go through (the process) again.'* I used some of the handouts from those sessions to help me at each stage in my project, including the tips to prepare for my viva (short for viva voce—'lively discussion'), or the less poetic 'oral defence.'

The information gleaned from the colloquium and the associated conference proved helpful when it was time to respond to questions from the assessors who examined my transfer document. Not surprisingly, the assessors pointed out I should clarify/rewrite the main research question. I agreed with their assessment and noted I was about to begin the second phase of my research, which would involve a number of semi-structured interviews and should help focus my study.

MILESTONES:

2-3 July 2007—*A Practical Approach to Cultural Change: Using Social Marketing to Combat HIV/AIDS in Mexico*, Academy of Marketing 2007, Doctoral Colloquium, Surrey, England

Summer 2007—Teesside Business School approves transfer from MPhil to PhD status (later approved at the university level)

Taos, New Mexico, October 2007

During the autumn term (my Teesside director of studies asked that I learn to say *'autumn'* instead of *'fall'* as we are wont to do in Texas), I prepared materials for a 1 ½ hour workshop focusing on visual and verbal persuasion methods in some of the social marketing campaigns from my content analysis. This conference setting was an

American West version of the Surrey conference; it was in the wilderness outside of the old Indian town of Taos. I took a bus from Taos to the campus hosting the conference, arriving at dusk and promptly getting lost on the winding forest paths. Finally, the sound of flutes led me to the conference centre, where a bonfire warmed the crisp mountain air and Indian musicians were performing ancient melodies. Even though I was only a short plane ride from home, I was assuredly in another country and another culture. To add to the international scene, my assigned roommate was Tugba (pronounced Tuba) Kalafatoglu, president of a global management and public affairs consulting firm in Istanbul. Tugba told me her firm advised politicians on message development and campaign strategies and assisted business leaders with global marketing and cross-cultural leadership. Her business card joined my growing stack of international contacts.

My workshop visuals generated a lively discussion about the HIV/AIDS campaigns and provided fresh insights from an audience that was not overly familiar with the topic.

While preparing for this workshop, I had also begun work on a book chapter about social marketing in Mexico. Through the social marketing listserv I had been joined months earlier, I learned of plans for an international book of social marketing success stories and submitted a proposal. I was delighted to receive a contract to write a chapter based on my research of two Mexico initiatives.

MILESTONE:

4-6 October 2007—*Motivating Change: Visual and Verbal Persuasion in HIV-AIDS Social Marketing*, American Communication Association, Taos, New Mexico

2008

Huntsville, February 2008

2008 was to be the hardest year of my project due to injuries that made travel and even typing difficult and painful. I think of that year as being book ended with broken bones. A hard fall in the early spring broke my right shoulder and made writing or driving impossible for a number of weeks. Luckily, I was able to move some of the classes I was teaching that spring to an online format, and my next conference commitment was an Internet event.

Internet, March 2008

This was another first for me—a live online conference. It turned out to require at least as much preparation as a traditional conference presentation. I created a

PowerPoint, wrote a script to accompany the visuals, and recorded the commentary via phone prior to the conference. While the conference was in session, I monitored comments and responded to questions. The conference was sponsored by PSP-One (Private Sector Partnerships for Better Health), a USAID project to *'increase the private sector's provision of high-quality health products and services in developing countries.'* My script went through an approval process that erased any hint of criticism of the financial ties to health care in poor countries. The pro-business 'spin' was clear. Nevertheless, it was an interesting experience and one of the comments I received during the conference was from the director of Population Services International-Mexico, who provided updated information about PSI's social marketing approach in Mexico. We visited via email and phone and his input became part of the book chapter I was writing for *Global trends and success stories*.

MILESTONE:

10-15 March 2008—Taking Taboo Topics Public: How Social Marketing Partnerships Combat HIV/AIDS in Mexico (part of a panel titled: 'Partnership Based Approaches: What Works?'), *Social Marketing in the Developing World: What Have we Accomplished and What Does the Future Hold?* 2008 PSP-One on-line conference

Szeged, Hungary, June 2008

My physical therapists assured me the broken shoulder would be sufficiently healed for travel by June, but they were a bit optimistic. Nevertheless, I packed even lighter than the previous year, and set off for my conference presentation at the International Congress on Public and Nonprofit Marketing. I still am grateful to the many fellow passengers that summer who lifted my luggage in and out of the overhead bins and carried bags down flights of stairs for me. Conference organisers met my flight in Budapest and accompanied several conference attendees to our hotel in Szeged. By this point, my annual travel to different international locations had made my passport suspect to airport security and customs agents, who questioned me carefully and usually required a special security inspection of my person and my luggage. A British customs agent was particularly memorable; when she saw my U.S. passport, she sent me to the back of the line, then quizzed me at length about how long I would be in England and the exact date I would be leaving. But, for the most part, I encountered careful but cheerful people who gave me information and helped me understand travel requirements of their country.

The Szeged conference was attended by academics from universities across the EU and I added more business cards and memories to my collection. As usual, some people were intrigued by my topic and others were astonished at my choice. One colleague commented that she would not want to *'touch anyone with HIV.'*

MILESTONE:

12-13 June 2008—*Creating a Culture of Change: Social Marketing's Global Initiative Against HIV/AIDS*. VII International Congress on Public and Nonprofit Marketing. Szeged, Hungary

Teesside, June 2008

By this point, my annual return to Teesside was a homecoming of sorts. Everyone at the Business School welcomed me back and my supervisors made sure I had a desk and a computer as well as access codes for my stay. With such efficiency, I was able to settle in to work the day after I arrived and moved into my room in Parkside Residence Halls, overlooking the expansive and beautiful city park. I shared a kitchen with several other summer students, including a group of Chinese undergraduates who were studying English so they could enrol in classes in the autumn. Internet access in my room was an added bonus and made it possible for me to work at all hours, even on weekends when the library had short hours.

Amid my growing mounds of data, I began to draft chapters of my thesis. My wily director of studies insisted I begin with my methodology chapter, which he knew was the most difficult and also the chapter I was secretly dreading. By the end of my residency that year, I had several chapters in various stages.

Mexico City, August 2008

At the end of the summer, I had the opportunity to attend the International AIDS Conference in Mexico City. This biannual conference was truly a world event, drawing professionals and academics from the medical and social science areas, as well as local, national, and international organisations associated with HIV/AIDS prevention and treatment efforts. About 25,000 participants gathered in Mexico City, generating worldwide publicity. The conference was a whirlwind of demonstrations, concurrent presentations, information being dispensed in every possible medium, and informal and formal discussions about all aspects of the pandemic. Pharmaceutical sponsorship was highly visible, and 'safe sex' was a recurring theme.

Competition was stiff for presentation slots at the conference, even for poster presentations. My poster focused on three campaigns from my Phase I research that targeted women. AIDS XVII offered opportunities to make contacts with people central to some of the campaigns I examined during Phase I and to conduct interviews with key informants as a continuation of my Phase II research. I especially enjoyed my interview with the co-director of Instituto Promundo, a Brazilian NGO that partners with other Latin America organisations to create and implement HIV/AIDS social marketing campaigns.

Those contacts and interviews also allowed me to update and obtain images for my book chapter in *Social Marketing for Public Health: Global Trends and Success Stories*, which would be edited by Philip Kotler, Nancy Lee, and Hong Cheng.

MILESTONE:

3-8 August 2008 –*Until AIDS Do Us Part: Social Marketing Campaigns Empower Women At Risk in Uganda, Mexico, and the United States*. XVII International AIDS Conference. Mexico City

Huntsville, Winter 2008

After so much travel, my broken shoulder was not healing well, so I declined an invitation to return to Mexico City in October to present a paper titled *Virtual Virtuosity: How the ONE Campaign Uses Social Media to Combat Global Poverty and HIV/AIDS*, at the 2nd Congress of the Americas. Unfortunately, staying in Texas proved unsafe; in November I fell and broke my right ankle, which kept me homebound until after the first of the year. But I did finish edits and rewrites on my book chapter, parts of which would reappear in greatly shortened form as a case study in my thesis. A bright spot during that time was an email with comments from *Global Trends* editor Phil Kotler (known as the ‘father of social marketing’):

‘I am absolutely pleased with what I read. Each chapter is a treasure-trove of information, analysis, campaign description, and evaluation.’

‘My regard for the importance of the book has grown immensely. This book should have a long shelf life. The campaigns provide classic models of social marketing. Any social marketer tackling any of these issues will draw excellent guidance into developing his or her campaign.’

Huntsville, Spring 2009

This was a time when I focused on teaching my four spring term classes at Sam Houston, learned to manoeuvre on crutches and focused on getting my body back to its pre-broken condition. On the research front, I completed my Phase II work and prepared a complex poster summarising my content analysis results for a conference in Switzerland. (*All of the posters and projects mentioned in this Log are shown as subsequent appendices in this volume.*)

St. Gallen, Switzerland, June 2009

In route to Teesside that summer, I first flew to Zurich to attend the First German-Austrian Swiss AIDS-Congress SODAK 2009, '*Prepare for the Long Run.*' The conference was held in St. Gallen, an hour's train ride from the capital. In keeping with the congress theme, I had a poster presentation in the social science track that used cross tabulation matrixes summarising my content analysis research from Phase I.

This conference attracted about 800 attendees, and the second congress was already scheduled for June of 2011. Although the congress call for abstracts included both medical and social science tracks, most of the attendees were from the medical community. Several medical professionals at the congress commented to me that my research on the cultural aspects that contribute to the AIDS pandemic is equally important in the battle against the disease and should have had a more prominent role in conference discussions. I also received a number of compliments on the production of my poster, which again utilised my desktop design skills to create a poster that was more elaborate and colourful than most others on display.

Observations from attending conference sessions and from informal discussions with presenters and attendees included:

- Pharmaceutical companies were much in evidence as conference sponsors and as vendors dispensing literature and branded specialty items.
- Complacency was widely considered to be a prime enemy in the fight against HIV infection, as many people now consider that HIV/AIDS is not an automatic death sentence but can be treated with HAART therapy. (Not curable, but controllable)
- However, drug-resistant HIV is an increasing problem, fostering research and development of a host of new drugs.
- With so many drugs available, interest in CAM therapy is greatly diminished.

- However, presentations included promising reports on the efficacy of green tea extract and stem cell studies.
- Many of the new European social marketing campaigns for HIV/AIDS feature condoms as prominent elements, couples in suggestive poses, and graphic language.
- This conference primarily focused on HIV/AIDS as a biomedical problem, with culture and stigma taking a back seat.
- Condoms were repeatedly recommended as the fail-safe prevention method (and samples of various brands were available in most vendor booths).

Like AIDS XVII, this congress was a source of interesting contacts as well as the newest medical information about conventional AIDS treatments. A highlight was attending the Swiss premiere for an HIV/AIDS documentary on HIV/AIDS in Europe, *‘Blissfully Lost,’* which was created by a doctor who worked at a German HIV clinic and a filmmaker from Cape Town, South Africa. I learned about the documentary by chance—the only promotion for it was on a postcard I happened to pick up in sponsor GlaxoSmithKline’s booth. But the card’s one paragraph caught my attention:

...28 years of public discourse, TV spots, posters, celebrity-upvalued campaigns and putting condoms over bananas have left their mark on the collective psyche. What do you think of HIV/AIDS?

My interest peaked, I took a taxi to the small art theatre where the screening was scheduled. Only a handful of people attended, but I was pleased I had gone. The documentary included interviews with a diverse group of people and was designed to inform and promote dialogue about the disease. After the screening, I met the creators of the film and spent several hours at a local watering hole getting to know the two of them and learning about their lives and projects. We have kept in touch about the possibility of screening the documentary in Houston at some point.

After the conference, it was back to Zurich for a weekend as a tourist and then a flight to Manchester and the now-familiar train trip to Middlesbrough and Teesside.

MILESTONE:

24-27 June 2009—*Working Toward a World Without AIDS: How Social Marketing Inspires Long-term Cultural Change*. First German-Austrian Swiss AIDS-Congress SODAK 2009. St. Gallen, Switzerland

Teesside, June 2009

When I reached Teesside, I learned I was now attending the 2009/10 University of the Year; Teesside had been named to this prestigious honour by Times Higher Education. It was a great achievement, especially for a so-called ‘new university’ like Teesside and there were posters and pennants everywhere. Again, I moved into Parkside Residence Halls, unpacked my one small suitcase, and connected my laptop. I was ready for my annual residency. I soon wished I had brought a fan; Middlesbrough was having a heat wave—not that hot by Texas standards, but there is little or no air conditioning in Middlesbrough, certainly not in the residence halls or in the Business School offices. Sweating (‘glowing’ as Texas ladies are supposed to say) while typing was the only choice.

However, I still managed to organise and categorise my work to date. I refined and expanded my thesis outline and continued drafting (and revising) chapters. I also updated my literature review to include several articles and books that provided fresh insights as well as reinforcement of my own findings from Phases I and II. I consulted marketing texts on survey methodology to support my own research design for Phase III, using that information as background for writing the survey methodology. And, to further order my work in the coming months, I developed a status report form for tracking my thesis progress and setting goals for each chapter.

Additionally, my Director of Studies and I revisited and re-checked my original ethical approval on 9 June 2009 and determined there had been no significant change in methodology that would impact ethical approval. This was important since I was planning a survey of patients and staff at an HIV/AIDS clinic in Houston.

The ever-expanding amount of information plus the genuine interest in my research topic from people I interviewed or consulted indicated I had chosen a significant area of study with many possibilities for making contributions to knowledge. It was also heartening that the panel of experts who pilot tested my survey expressed scholarly and professional interest in my research, asking that I share the results with them.

Houston, Autumn, 2009

Creating my survey was time-consuming, but was finally accomplished thanks to a panel of experts I assembled to pilot test the instrument. Getting permission to administer the survey at a Houston HIV/AIDS clinic was more difficult and required

persistence, persuasion, patience, and numerous meetings with clinic administrators. Five months later, approval was in hand, and I began to organise the logistics of travelling to Houston to survey clinic patients and staff. I recruited several of my undergraduate students to help with data collection. Some of the students were naturally outgoing and did not hesitate to approach everyone who came into the clinic. A couple of students were actually frightened—one told me she feared to use the restroom facilities at the clinic. Another student was horrified when she learned we would be working at an AIDS clinic. *'So, some of the people might actually have AIDS?'* she asked in all seriousness.

The patients were all ages, genders (sometimes difficult to determine), and ethnic group. Their educational background ranged from high school dropout to doctorate. But HIV/AIDS was the common thread that connected them all. Some spoke very freely about their HIV/AIDS experiences; most were appreciative we were collecting information to better inform people about the disease and possible treatments. Both staff and patients commented they found information in the survey that made them realise they needed to do more research into treatment choices. Some took time to tell us their personal stories. One of my student assistants wrote this entry in his own reflective log:

'I remember one guy in particular who came in with a huge smile on his face. When we asked him to participate in our survey, the man smiled, said no problem, and took a clipboard from my hand. As he was filling out the survey, he began to converse with us about how he got AIDS when he was a kid in high school and had no knowledge of AIDS or HIV. He said he's had AIDS for about half of his life, and that he belongs to a Houston organisation that raises money for AIDS and HIV awareness. He told me he had been working for this organisation for about 13 years and last year alone, he raised over \$100,000 for HIV/AIDS education so kids could be more aware of the disease and learn to be safer about sex so they could live the life he never got to have. He then finished the survey, handed it to me, gave me a big smile and told me thanks for what we were doing. He told us that it meant a lot and that we had no clue how big of a difference we were actually making. I think I'll always remember him and that conversation because it really did touch my heart.'

Some people were intent on taking the survey. One woman did not have her reading glasses with her and asked one of the students to read the survey so she could be included. The students kept commenting, *'I can't believe people are so open.'* By contrast, a couple of patients' only question when asked to participate, was, *'Is there an incentive?'* In fact, we did have a grab bag of candy and small party favours, which the respondents seemed to find a sufficient reward. There was clearly a feeling of

community at the clinic—people knew each other and were mostly positive and upbeat in their attitude toward life.

The clinic administrators were surprised at the high rate of response to our survey—we collected more than 340 valid surveys during four days. The elements that seemed to make the process go so smoothly included:

- The ‘goodie bag’ was a fun element—the silly toys and candy made people smile.
- People responded to the students and the fact the project was education based.
- A polite but persistent approach paid off.
- We had a good location in the front foyer; everyone who came in walked past us.
- We had good signage—colourful and simple in both English and Spanish.
- People liked being asked for their opinions and wanted to help with the project.

2010

Huntsville, Spring 2010

This spring was a whirlwind of research and teaching as I prepared for my annual residency, to take place in April instead of in the summer. This schedule would allow me to complete most of my thesis while I was at Teesside, do rewrites and edits over the summer and submit the final version by the end of the year. Since I would be leaving for England in the middle of the spring term, my three classes were set up as online courses—now I could teach from anywhere in the world as long as I had an Internet connection.

The biggest challenge was all that needed to be done before I left Texas. In addition to putting all of my survey data into SPSS so I could ‘crunch the numbers,’ I needed to do my reaction interviews to the survey data.

In the odd way that serendipity had so often come to my rescue since I began this project, it happened again. This time, the catalyst was a donkey named Ricardo. I am a passionate animal lover, and I learned of a no-kill animal shelter on the outskirts of Huntsville. I went for a tour, met the owner of the shelter and decided to sponsor an animal. I chose Ricardo, a beautiful donkey who had been rescued from the Grand Canyon several years ago. My monthly contribution would help keep Ricardo in donkey vittles and apple treats. I also learned the director of the shelter had been an HIV/AIDS counsellor and activist who helped found the Center for AIDS Information and Advocacy in Houston. He provided a referral to that organisation’s director, and to an

internationally known HIV/AIDS medical doctor, both who proved to be key informants for my reaction interviews.

I was also excited to receive a copy of the *Global Trends* book, which was released internationally in soft cover that spring.

MILESTONE:

Published—‘Love, Sex, and HIV/AIDS: Using Social Marketing to Redefine Gender Norms Among Mexican Youth,’ Chapter 4, *Social Marketing for Public Health: Global Trends and Success Stories*. Eds. Hong Cheng, Philip Kotler, and Nancy Lee. Sudbury, Mass.: Jones and Bartlett

Teesside, April-May 2010

On the road again: back to Teesside for my fifth—and last—residency. I was determined to work as many hours each day as I could so I would have most of my thesis written and reviewed before I returned to Texas. I took only a few items of clothing and left my cell phone at home. No distractions. So, I struggled with the SPSS data (with the help of a faculty expert in statistics), assimilated my interview data, interpreted, edited, wrote, and rewrote. And rewrote. This time I shivered in the chill air of April and was grateful for warm water in the down-the-hall bath I shared with three computer undergrads in a rented house several blocks from the university. I also continued to teach my three online classes; I graded the students’ final projects and posted their grades from England. My only leisure time was the Friday I ‘skipped school’ and took the train to my favourite Yorkshire town—Whitby, that seaside city from which my ancestor sailed centuries ago. Sitting in the train, I enjoyed anew the verdant fields, the flocks of sheep, and the quaint train station at every village. In Whitby I bought a few gifts to take to friends back in the States and ate lunch at my favourite waterfront restaurant. Then, it was time to catch the evening train back to Middlesbrough and my waiting laptop.

Huntsville, Summer 2010

The writing and re-writing continued through the summer. I was drowning in data and some days it seemed I would never find the right words to introduce, explain, and conclude each chapter. Formatting proved to be hugely time-consuming. The thesis grew to two volumes—one for the body of the thesis, the other for the six appendices, even bulkier than the main document. A perfectionist by nature, I urged myself to

remember the advice from that doctoral colloquium in Surrey three years ago: *'The perfect is the enemy of the good.'* I was determined to create a *good* thesis even if it could never be quite perfect. By the middle of August, everything was there, from abstract and acknowledgements to references and appendices. I was ready for my supervisors to do one last 'big read' before the volumes were shipped off the examiners.

While my committee members valiantly tackled my thesis, I mined the chapter on my survey results to fashion a paper, which I submitted to the 2nd World Social Marketing Conference, to be held in Dublin in April 2011.

Huntsville, Autumn 2010

In late autumn, I received this heartening email:

'I work for the Research team at The NSMC (previously the National Social Marketing Centre) which is based in London, UK. One of our resources, which is widely used within the social marketing industry, is ShowCase, an online database of social marketing case studies. We are always looking for new and innovative examples of social marketing good practice to contribute to our growing wealth of knowledge and learning. In searching for suitable projects for ShowCase I came across 'Programme H,' which you had written about in the book 'Social Marketing Public Health: Global Trends and Success Stories'. Programme H is exactly the kind of social marketing/behaviour change project we would like to write up and publish on our website.

Would you be interested in contributing to the write up of Programme H for ShowCase? Please confirm whether you would like to be featured on ShowCase.'

Of course, my response was an enthusiastic 'yes.' The case study has since been written and edited and will appear in ShowCase in 2011.

Additionally, my Dublin proposal was accepted, so I registered for the 2nd World Social Marketing Conference and marked my calendar to be in Ireland in April of 2011. I'm honoured to be one of the presenters at this international event that will feature the social marketing giants from around the world.

Aside from completing the final edits on both volumes of my thesis, I ended 2010 with one other positive note: I learned that *Global Trends* had been published in Google Books, extending its reach and usefulness as a social marketing text.

Huntsville, December 2010

Looking back...

By the time I reached the fourth stage of this research expedition, I had crossed many borders—literally and figuratively. In a literal sense I had traversed many borders, trekking outside the ubiquitous portals of the Internet to personally visit an array of countries and speak with a diverse mix of people. My travels in pursuit of a degree led to encounters with a variety of natural and man-made disasters, but delays and minor discomfort were the only tolls I paid. These events stand out in my memory:

Hurricane: Sept 2005—My travel companions and I were stuck in London because Hurricane Rita closed the Houston airport (and the rest of the city, too). Rita was the most intense tropical cyclone ever observed in the Gulf of Mexico, coming inland with winds of 120 mph. Luckily, the B&B had vacancies for an extra three days and my plastic was up to the challenge.

Terrorism: July 2007—A bomb at the Glasgow airport filled the southbound trains with travellers trying to make their flights in London, so I wedged myself onto a train to Surrey. When I was ready to head home from London on July 4, half of Heathrow Airport was closed due to another bomb threat, but my flight made it out on schedule.

Volcano: April 2010—The Iceland volcano disrupted flights in much of Europe for several weeks. I was on the first plane out of Houston to Frankfurt after five days of closures. Arriving in Frankfurt, I became part of an ocean of people. I saw rooms of cots where people had been sleeping for days, and learned there were no flights to England. By mere chance I discovered my airline, Lufthansa, was running a few buses to major European airports. I managed to get the last seat on a bus headed for London. For 12 hours we rolled across Europe with two 10-minute rest stops. At midnight, we crossed the channel at Dover, and then were deposited at Heathrow at 2 a.m. to make our way to our final destination. I spent the rest of the night sitting in Heathrow airport and visiting with a journalist from Birmingham who was on same bus. When morning came, we took the underground to the central train station, where I purchased a ticket to Middlesbrough. I was immensely grateful to be in England and not sleeping on a cot in the Frankfurt airport.

But most of all, I am grateful to the many people who offered encouragement, advice, information, and insights. I met supportive and interesting people on trains, planes, and buses. Helpful people showed up at my office door in Texas, at my work

cubicle in Teesside, and at each conference I attended; my casual reading provided important links to people with diverse perspectives on my topic.

On a personal level, I travelled beyond my comfort level and was prompted to extend my range of empathy and tolerance in ways I never before contemplated. Through it all, life went on, with its large and small triumphs and tribulations: financial problems, divorce, death of a parent, work crises, and losses of long-time friends and pets.

On an academic level, I had journeyed across continents of knowledge previously unknown to me, emerging with a fuller understanding of just how much I still did not comprehend.

When I called a temporary halt in my travels to reflect and record, I realized I had only charted a miniscule region; there are worlds more to explore.

APPENDIX B
CONTENT ANALYSIS AND INTERVIEW DOCUMENTS

- B.1** Questionnaire to assess campaigns for content analysis
- B.2** Summary fact sheet for content analysis campaign (sample)
- B.3** Summary of the 18 campaigns used for content analysis
- B.4** Question bank for pre-survey interviews – Mexico
- B.5** Question bank for pre-survey interviews – Houston
- B.6** Question bank for reaction interviews (post-survey)
- B.7** List of exploratory research interviews
- B.8** List of key informants interviewed – pre-survey
- B.9** List of key informants interviewed – post-survey

APPENDIX B.1 Content Analysis

Social Marketing Campaign Name:

Description:

Year Began:

Country:

- Mexico
 Uganda
 United States

Specifically Disseminated: _____

Sponsorship:

- Government dept (s) _____
 International organization(s): _____
 for –profit corporation / business(s): _____
 industry association (s): _____
 pharmaceutical company (s): _____
 educational institution(s): _____

Specific intended target group:

- no, campaign is aimed at a mass audience
 yes, campaign is aimed at a very specific group

Is a specific group being targeted?

- men who have sex with men
 teens/young adults
 sex workers
 people living with AIDS
 mature adults (30-64)
 parents
 at-risk groups
 other: _____

Is a specific gender being targeted?

- no; n/a
 males specifically
 females specifically

Are there any other identifying characteristics of the group being targeted?

- n/a; no other identifying characteristics
 yes – Specifically: _____

Type of Mixed Media Used:

- billboards
 banners
 cartoon / comics
 discussion groups
 forums
 literature / printed materials
 postcards

NAME

FALL 2006

- posters
- radio commercials (Length: _____)
- television ads (Length: _____)
- training
- videos
- workshops
- other: _____

Messages Presented:

Slogan/Tag Line:

Message Recommendations / Purpose (check all that apply):

- none
- "safe sex"
- protect yourself/take care of yourself
- use condom
- fewer partners/avoid multiple partners
- monogamy/one partner
- abstinence
- get tested
- don't share needles
- don't be afraid of getting AIDS through casual contact situations
- take responsibility
- learn the facts/know the facts
- write for info
- phone for info
- pick up information/brochure/pamphlet
- get help/counseling/treatment
- see your doctor
- talk to your parents
- talk to your kids
- give money/donation
- other: _____

Other Notes on Purpose:

Call to Action Present:

- no
- yes

Role of Spokesperson:

- n/a/not sure
- announcer
- singer
- average/neutral person
- first-hand experience
- victim/survivor/friend of victim
- expert

NAME

FALL 2006

- authority figure
- government / political official
- community leader
- celebrity
- cartoon figure
- other: _____

Name of Celebrity(s): _____

If authority figure, expert, community leader, or government official, what occupation?

- n/a
- police officer
- fire fighter
- judge
- teacher/professor
- minister/priest
- doctor
- nurse
- Other: _____

Spokesperson Characteristics:

Sex:

- n/a or not sure
- male
- female

Age:

- n/a or not sure
- child
- teenager
- young adult (18-30)
- mature adult (30-64)
- elderly (65+)

Race:

- n/a or not sure
- white
- black
- Hispanic
- Asian
- Other: _____

Reference to Cultural Roots:

- No/not sure
- Yes

If yes, cite specific examples:

- Language
- Country/area flag or seal
- Clothing / style

NAME

FALL 2006

- Music
- Lifestyle
- Other: _____

Product Promotion:

- No/not sure
- Yes

If yes, what is the product(s)?

- Book/literature
- Condoms – male
- Condoms – female
- Treatment Kits
- Video
- Other: _____

Types of Appeals Present (Check all that apply): Evidence of Appeals on Page 5

- Decision-making
- Fear
- Positive / rational
- Self-interest
- Social-cognitive
- Sustainable development
- Two-step flow

Overall Tone of Message:

- Negative (threat, fear, sad)
- Neutral
- Positive (up-beat, humor)
- Not sure

Social Marketing Elements:

Product / Solutions: Is there a clear social marketing product being offered?

- No
- Yes – Specifically: _____

Is there an “actual product” being offered?

- No
- Yes – Specifically: _____

Is there an ‘augmented product’ being offered

- No
- Yes - Specifically: _____

Price / Value: Are issues of price addressed?

- No
- Yes – Specifically: _____

Promotion / Information: Is adequate information being offered?

- No
- Yes – Specifically: _____

NAME

FALL 2006

Placement / Access: Are place and placement issues addressed?

No

Yes – Specifically: _____

Other Campaign Notes:

Evidence of Appeals:

Appeal:

- _____
- _____
- _____
- _____

Appeal:

- _____
- _____
- _____
- _____

Appeal:

- _____
- _____
- _____

APPENDIX B.2

Sugar Daddies

Description:	Working to stop cross-generational sex, which is sex with a person at least 10 years older
Currency:	Began in 2004 - 2005
Int'l Orgs:	PSI, National AIDS Committee
Pharm Co.:	None Mentioned
Purpose:	Sugar Daddy relationships are a major reason why HUV infection rates are up to 6 times higher for teenage girls than their male counterparts. Also to break the silence, raise public awareness of dangers involved, and change societal views (PSI Profile)
Target Audience:	Young women (15 – 24), their parents, and older male partners
Where Dissem.:	Uganda, Cameroon, Kenya, in schools
Media Mix Used:	Television, radio, print, seminars (with media coverage of the seminars) (PSI Profile). Government-sponsored posters, offering chastity scholarships, radio soap opera (CSM).
Msgs Present:	Sugar Daddy + Young Girl = Danger (PSI Profile). Golden Rule approach (CSM). Also, saving yourself for marriage is the right thing to do (GHF)
Use of Celebrities:	Yes, Tim Lwanga, Uganda's Minister of Ethics and Integrity. Also Archbishops (PSI)
Refs to Roots:	Having a sugar daddy could be a root, as it is a societal norm
Prod. Promotion:	Deemphasize condoms

APPENDIX B.3

Summary of the 18 campaigns used for content analysis

MEXICO

1. *Investing in People*

This five-year initiative to reduce barriers to behaviour change and care seeking began in 2003. It was a localised version of a series of similar campaigns that were underway in several countries. Focused in Mexico City, where the largest number of HIV/AIDS cases were found, *Investing in People* was the joint effort of a half-dozen international, national, and local organizations. A key technique was personal communication through workshops and conference presentations conducted by trained female advocates and local HIV/AIDS leaders (<http://www.usaid.gov/policy/budget/cbj2006/lac/pdf/mx523-023.pdf>).

2. *VIDA Menos Etiquetas*

Sponsored by Population Services International-Mexico, this gender-equity initiative incorporated the research and successful techniques of *Programas H* and *M* to reach young people at risk. *Menos Etiquetas* used peer educators to initially broach themes that included gender norms, HIV/AIDS, and stigma. A traditional media mix including posters, postcards, stickers and flyers was teamed with below-the-line social media such as blogs and Bluetooth viral marketing (<http://www.psi.org/mexico>).

3. *Programa Hombres (Project H)*

Links between traditional gender attitudes and the spread of AIDS prompted a partnership of NGOs to develop *Programa Hombres*. This five-year initiative has been used in more than twenty countries, including Mexico, to persuade young Latino men to question traditional norms related to manhood. An extensive media mix included educational videos available in three languages—Spanish, English, and Portuguese—interactive workshops, and collateral materials as well as radio, outdoor media, and direct mail. The campaign slogan, '*In the Heat of the Moment*,' urged use of the Hora H condom brand, manufactured by the makers of Durex condoms and distributed in non-traditional venues such as funk balls and cafes (www.promundo.org.br).

4. *Programa Mujeres (Project M)*

Building on their success in educating young men about the costs of traditional macho culture, in 2005 the Program H partners and World Education launched *Programa Mujeres* to encourage young women to take control of their sexual and reproductive health. This social marketing campaign was based on research that included a review of Latin American literature to define the concept of female empowerment, focus group discussions with groups of young women aged 14-24 who lived in marginalised communities outside Queretaro, Mexico, and interviews with empowered young women (www.promundo.org.br).

5. *Tú No Me Conoces (You Don't Know Me)*

The *Tú No Me Conoces* social marketing campaign promoted awareness of HIV risk and testing of Latinos living on the California-Mexico border. The 8-week campaign included Spanish-language radio, print media, a website, and a toll-free HIV-testing referral hotline. Campaign results included an increase in HIV testing at partner clinics; 28% of testers who heard or saw an HIV advertisement specifically identified the campaign. (<http://www.docstoc.com/docs/43661964/Southern-California-Border-HIVAIDS-Project-TU-NO-ME-CONOCES>).

6. *VIDA Digna (Life with Dignity)*

Reducing stigma and discrimination experienced by sex workers, gay men, men who have sex with men, drug users, and people living with AIDS was the central purpose of the three-year *Vida Digna* campaign, launched in 2005 by the Colectivo Sol alliance and funded by GlaxoSmithKline. The campaign was centred in the central states of Mexico, a conservative area characterised as having '*the weakest civil society response to AIDS.*' *Vida Digna* used anonymous testimonials to urge tolerance and acceptance of people's differences (<http://www.aidsalliance.org/sw45511.asp>).

UGANDA

1. *ABCs (Abstinence, Being Faithful and Condoms)*

This campaign took a moralistic approach—'*Sex can wait until marriage*'—and used outdoor media as well as local spokespeople such as community leaders and ministers to urge abstinence before marriage and fidelity to spouses. Practical AIDS information was provided and condom use was also advocated to reduce risk of infection. This program and others like it have generated international controversy about whether condoms are effective in reducing HIV prevalence and raising associated concerns about increased promiscuity (<http://www.pbs.org/now/science/aidsdebate.html>).

2. *Afford Good Life*

AFFORD was a five-year health marketing initiative led by the Johns Hopkins Bloomberg School of Public Health and funded by the U.S. Agency for International Development. Designed to increase accessibility and affordability of AIDS products and services, the campaign promoted Protector brand condoms, Pilpan oral contraceptives, and Inject injectable contraceptives. Consumers were encouraged to use these products properly and could access them at subsidised rates. A centrepiece of the campaign was '*The Good Life Gameshow,*' an entertainment education quiz show using an integrated multimedia approach, including community interaction, and radio and television shows (<http://www.jhuccp.org/africa/uganda/afford.shtml>).

3. *Be a Man*

Targeted primarily to young men 15 to 24, this campaign was launched in 2006 to prompt reflection on the costs of traditional male attitudes and behaviours, which research has shown contribute to an increase in HIV infections. '*Society's expectations of men are setting them up for failure,*' according to Vincent Kiwanuka, the *Be a Man* campaign's coordinator. The media mix heavily utilised radio drama and television, including broadcasts during the World Cup. The goal was to encourage sexual relationships based on mutual respect and love (<http://www.hcpartnership.org/Press/press2006-06-21.php>).

4. *Onelove*

Launched in January 2009, the South African *Onelove* campaign aimed to reduce new HIV infections in South Africa by 10% by 2011. The focus of the campaign, led by Soul City Institute for Health and Development Communication, was on multiple concurrent partnerships (MCP), one of the key drivers of the HIV pandemic in Southern Africa. The campaign's goal was to shift social norms away from multiple sexual partnerships and encourage monogamous relationships. *Onelove* challenged gender stereotypes and cultural norms that reinforce MCP and highlighted the risks associated with transactional, drunk, and intergenerational sex. The campaign used

mass media, including the Soul City television drama series, a radio drama, print materials, and social mobilisation and advocacy (<http://www.comminit.com/en/node/286237/347>).

5. PMTCT (Prevention of Mother to Child Transmission)

'*The Social Marketing Approach to PMTCT*' is a Population Services International [PSI] project that used a branded franchise network of trained midwives to help pregnant women reduce transmission risk during birth. The midwives were also trained on HIV testing procedures and counselling skills. The central message of this campaign was it is possible to have an HIV-negative baby even when both parents are HIV positive. Since 2003, a broad media mix has disseminated this message to male partners of pregnant women 25-45, primarily in low-income, low-literary, peri-urban, and rural areas of Uganda (<http://www.psiwash.org/resources/pubs/Uganda2004.pdf>).

6. Sugar Daddies

Addressing the widespread problem of cross-generational sex (sex with a person at least 10 years older), this campaign, begun in 2004, sought to raise awareness of the dangers of 'sugar daddy' relationships. This practice is a major reason HIV infection rates have been six times higher for teenage girls than for their male counterparts. Target audiences include young women 15 to 24, their parents (who often encourage such relationships), and older male partners. The PSI-sponsored initiative features recognised male role models such as Uganda's Minister of Ethics and Integrity Tim Lwanga urging men to '*stop preying on young girls*' (<http://psi.org/resources/pubs/cross-gen.pdf>).

UNITED STATES

1. Be the Generation

This program aimed to create a supportive environment for HIV vaccine research by mobilizing existing community partnerships and networks to educate key communities about this research in 20 U.S. cities where HIV vaccine clinical trials were ongoing or planned. Coordinated media and collateral materials segment targeted audiences by gender, ethnicity, and lifestyle, showing images of two people, one older and one younger. Extensive educational materials were available online. The uniform message was the young generation's '*great cause*' is to end AIDS and that a vaccine is the best hope of accomplishing that goal (www.bethegeneration.org).

2. I am African / (Keep a Child Alive)

This campaign, heavily saturated with celebrities, promoted the idea that everyone has some DNA with connections to an African heritage, so all people should work together to help with the AIDS problem. Begun in 2005, donations for AIDS drugs were particularly sought. *I am African* was linked with the *Keep a Child Alive* campaign, which sought to help AIDS orphans in Africa by providing them with ARVs [treatment cocktails]. The *I am African* images of celebrities such as Gwyneth Paltrow and Sting wearing 'war paint' with the campaign slogan beneath sparked controversy about the use of eye-catching visuals that '*insensitively perpetuate stereotypical ways of thinking about AIDS or Africa*' ([www.keepachildalive.org; http://percipere.typepad.com/media/2006/08/cause_celebre_o.html](http://percipere.typepad.com/media/2006/08/cause_celebre_o.html)).

3. *MTV Think*

This award-winning public information campaign began in 2006 and was notable for bringing MTV on board as a major sponsor. The goal was to reach sexually active 16- to 24-year-olds with information about HIV and related issues, since according to UNAIDS, half of new HIV infections worldwide are among people under the age of 25. Discussion of safe-sex issues, condom use, and HIV testing were urged through television and web media. According to sponsor The Kaiser Family Foundation, this was a *'multi-platform, interactive community for the first generation of Americans who have lived their entire lives during the AIDS epidemic'* (<http://www.kff.org/hivaids/hip060506nr.cfm>).

4. *The New Faces of HIV in Houston*

Due to HIV high prevalence among African Americans in Houston, in 2002 the Harris County Hospital District and the Houston Department of Health and Human Services launched a social marketing campaign to raise awareness and increase testing among this population. Media included radio, public transit, direct mail, and brochures targeting women. Images of both men and women were featured in the materials, with the slogan, *'We look just like you, but you don't have to be like us. Do the right thing. Get tested'* (<http://www.hchdonline.com/HIV/newfaces.htm>).

5. *ONE*

With more than 60 partners, this campaign was set up to rally Americans one by one to push for increased donations to fight poverty and AIDS. The campaign had a broad target audience, ranging from students to ministers to punk rockers to soccer moms. The call to action was *'We're not asking for your money, we're asking for your voice.'* In line with this approach, on June 11, 2007, ONE launched ONE Vote '08, its *'largest and boldest initiative ever,'* vowing to make extreme poverty and global disease an issue in the 2008 U.S. elections (www.one.org).

6. *We all have AIDS*

Launched in 2005 on World AIDS Day, this campaign created by American designer Kenneth Cole was heavily supported by celebrities and prominent AIDS activists. The message was to reduce stigma associated with AIDS to prevent, contain, and eradicate the disease. The consistent theme for all ads was *'We all have AIDS...if one of us does.'* International celebrities participating included President Nelson Mandela, Arch Bishop Desmond Tutu, Sharon Stone, Will Smith, and Sir Elton John (www.WeAllHaveAIDS.com).

APPENDIX B.4

Using Social Media as a Health Promotion Tool: The Mexican Experience

Date: _____

Code: _____

1. What is your academic or professional background?
2. Describe the health organization you work for.
3. What health campaigns have you been involved with?
4. What has been your role in those campaigns?
5. Background and rationale behind the campaign approach?
6. Can you describe those campaigns?
 - a. What was the target audience or target market? Describe its characteristics.
 - b. When was the campaign executed? Scope/timeframe of campaign?
 - c. What kind of research was conducted before designing the campaign?
 - d. Who designed the campaign?
 - e. What have you learned by executing this campaign?
 - f. What were this campaign's objectives?
 - g. What were the messages disseminated? Why did you choose those messages?
 - h. Who were the sponsors/partners? How were they selected?
 - i. Were there medical advisers/image consultants, etc?
 - j. Campaign strategies—which were most effective? (might include policies, internal PR, etc)
 - k. What media outlets were used to disseminate information? Which were more effective?
 - l. Was social media used? If so, who decided to use it? Have anybody assessed the used of social media?
 - m. Who sponsored the campaign?
 - n. Budget/funding sources?
 - o. How do recipients of information perceive their choices as regards prevention techniques and treatment modalities?
 - p. What are their unanswered questions, gaps in knowledge?
 - q. How is campaign evaluation conducted? (Is there a written report available?)
 - r. Role of controversy/political concerns in getting funding/approval for campaigns?
 - s. The most important lessons learned? What will you do differently in future campaigns?
 - t. Trends you see in the use of social marketing campaigns for disease preventions/information?
 - u. Possible to get samples of materials? (Okay to reproduce images?)

APPENDIX B.5
Question bank for pre-survey interviews (Houston)

1. Briefly, please talk about your professional background as it relates to HIV/AIDS.
2. How long have you been working with fundraising/communications efforts to combat HIV/AIDS in Houston?
3. Which techniques have you found are most effective in gaining the support of Houston policymakers/upstream audiences?
4. Did you participate in developing the rationale behind the campaign approach for *New Faces of Houston*?
5. Was it difficult to make the decision to be pictured in the campaign literature? (Only addressed to interviewees who were pictured in the campaign)
6. What kinds of problems has being a spokesperson for the campaign created for you? (Same as #5)
7. How important are sponsors/partners to successful HIV/AIDS campaigns?
8. Which kinds of campaign media strategies do you think are most effective in Houston?
9. How do recipients of HIV/AIDS information perceive their choices as regards prevention techniques and treatment modalities in this city?
10. What are their unanswered questions, gaps in knowledge?
11. In your experience, what is the role of controversy/political concerns in getting funding/approval for campaigns in Houston?
12. What do you think were the most important lessons learned in this campaign?
13. What would you like to see done differently in future HIV/AIDS campaigns?
14. What trends do you see in the use of social marketing campaigns for HIV/AIDS prevention/information?
15. Is there anything you would like to add that I have not asked?

APPENDIX B.6
Question bank for reaction interviews (post survey)

1. Briefly, please talk about your professional background as it relates to HIV/AIDS.
2. What are your initial reactions to the Legacy Clinic survey results? (Interviewer summarises highlights of results and shows charts of result trends).
3. Regarding HIV/AIDS in Houston: What kinds of support have been provided by local or national policymakers?
4. What techniques/approaches have been most effective in getting support?
5. How important are sponsorships/partnerships in combating HIV/AIDS?
6. Do those sponsorships influence which products and treatments are considered mainstream? If so, how?
7. What is the role of controversy in getting messages out about HIV/AIDS?
8. After 30 years, what are the most important things we have we learned in the area of (medical, marketing, advocacy) for prevention and treatment of HIV/AIDS?
9. Where do we go from here? What would you like to see done differently in the future regarding (medical, marketing, advocacy?)
10. In general, how effective do you think social marketing campaigns are in motivating people to change their behaviour regarding preventing HIV/AIDS?
11. Can social marketing campaigns motivate lifestyle changes regarding treatments for HIV/AIDS?
12. Is there anything you would like to add that I have not asked?

APPENDIX B.7
List of exploratory research interviews
2005-2010

Dr. S.K. Banerjee, Homeopathic Physician, Kolkata, West Bengal, India. *Email and telephone communication, June 2007.*

Kemper B. Crabb, Director of the Order of Servants of the King, a charity organisation that builds churches, schools, orphanages, and hospitals in remote areas of India, Nepal, and Uganda. *Personal interview, March 2007.*

Sameer Deshpande, PhD, Assistant Professor, Marketing, University of Wisconsin, and Faculty member, Centre for Socially Responsible Marketing, Lethbridge, Alberta, Canada. *Personal communication, October 2006.*

Tugba Kalafatoglu, Tugba Kalafatoglu and Associates, Istanbul, Turkey. *Personal communication, October 2007.*

Dr. Susan Kern, Principle investigator, 'Lazarus Study: HIV/AIDS Interaction with HIV/AIDS.' *Personal interview, June 2006.*

James Kiwanuka-Tondo, Assistant Professor, Department of Communication, North Carolina State University, Raleigh, NC. *Personal and email communication, October 2006.*

Dr. Jesus Meza Lueza, Profesor- Investigador, Comunicadio Y Periodismo, Campus Ciudad de Mexico. *Personal communication, August 2006.*

Laura McDermott, Research Officer, Institute for Social Marketing, University of Stirling & The Open University, Stirling, Scotland. *Personal interview, June 2006.*

John Harold Estrada Montoya, Profesor Investigador, Salud Pública, VIH/SIDA, Ciudad Universitaria, Bogota, Colombia. *Personal communication, August 2006.*

David Olson, Director of Public Affairs, Population Services International, Washington, DC. *Personal communication, August 2008.*

Lars Ivar Owesen-Lein Borge, HIV/AIDS Activist and conference organiser, Mexico City. *Personal interview, December 2006.*

Andrew Waldhausen, Director, Gay & Lesbian Network, South Africa. *Personal interview, August 2008.*

Agustín Villalpando, Editor, *Enkidu Magazine*, Mexico City. *Personal communication, December 2006.*

APPENDIX B.8
List of key informants interviewed—pre-survey

TEXAS/USA

Françoise Armand, Social Marketing and Pharmaceutical Partnerships Director, Private Sector Partnerships One, Bethesda, MD. *Email communication, March 2008.*

Dr. Carlos Arreola, a long-time HIV/AIDS counsellor and activist in the Houston area. Helped found the CFA (see glossary). *Personal interview, March 2009.*

Barbara Bijelic, Research Assistant, PSP-One Program, International Health Division, Bethesda, MD. *Email communication, January 2008.*

Susan Diemont-Conwell of Torma Communications in Houston helped design the campaign, *New Faces of HIV in Houston*. *Telephone and email interviews, January 2008.*

Dena Gray, a Houston activist and administrator for Houston's Housing and Community Development Department, an agency that locates housing for people living with HIV/AIDS. She is responsible for public service funds totalling approximately \$12 million annually. Gray was also pictured in the *New Faces of HIV in Houston* campaign. *Email interview, January 2008.*

Maria de la Luz Martinez, Translation consultant, Austin, Texas. *Email and telephone communication, May 2008.*

Beau J. Mitts, Manager, HIV Prevention Program, City of Houston. *Personal interview, January 2008.*

Ken Malone, HIV Testing Project Coordinator, Thomas Street Health Centre, Houston, TX. *Personal interview, September 2009.*

Eric Roland, Senior Director of Marketing, Legacy Community Health Services, Houston, TX. *Telephone and email interviews, February 2008.*

Karen Russell, Incremental Marketing, Inc., Clear Lake Shores, TX. *Email interview, February 2008.*

Dr. Blair Winegar, Conventional medical doctor who completed his training in Texas. *Personal communication, October 2009.*

Sandy Won, International Center for Research on Women (ICRW), Washington, DC. *Email communication, February 2009.*

EUROPE

Dr. Nele Jensen, who worked at an HIV/AIDS clinic in Germany, co-directed a documentary of interviews with HIV-positive people from all walks of life. *Personal interview, June 2009.*

Daréll Lourens, a South African filmmaker who filmed and edited The HIV/AIDS documentary, *Blissfully Lost*, which was financed by GlaxoSmithKline and was screened at the 2009 German-Austrian-Swiss AIDS Congress in St.Gallen. *Personal interview, June 2009.*

Elizabeth Sutherland, PhD, Associate Scientist II, Health Services Research, Family Health International, Durham, NC. *Personal communication, June 2009.*

MEXICO/LATIN AMERICA

Pepe Aguilar, Director, DEMYSEX, Mexico. *Email communication, May 2008.*

Hilda Peñaloza Andaluz, Coordinadora Administrativa, Population Services International, México. *Email communication, February 2009.*

Gerardo Ayala, Salud y Genero, Mexico. *Email communication, February 2009.*

Gary Barker, PhD, Executive Director/Diretor Executivo, Instituto Promundo, Rio de Janeiro, Brasil. *Email communication, April 2008.*

Alejandro Brito, Director, LETRA S, Mexico. *Email communication, May 2008.*

Oliver LeTouzé, Director, PSI México. *Email and telephone communication, April 2008.*

Anna Luiza, Promundo Instituto, Brasil. *Email communication, February 2009.*

Alejandra Megloli, Director, Mexfam, Mexico. *Email communication, May 2008.*

Marcos Nascimento, Co-Director, Promundo Instituto, Brasil. *Email and telephone communication, May 2008.*

Lars Ivar Owesen-Lein Borge, HIV/AIDS Activist and conference organiser, Mexico City. *Personal interview, August 2008.*

Christine Ricardo, Co-Director, Promundo Instituto, Brasil, *Email and personal interviews, August 2008.*

Agustín Villalpando, Editor, *Enkidu Magazine*, Mexico City. *Personal communication, August 2008.*

APPENDIX B.9

List of key informants interviewed post-survey (reaction interviews)

Dr. Jacques Clermont, Collaborator for INSERM, France's National Institute of Health and Medical Research, commented from the perspective of an alternative medical doctor doing research and working with HIV/AIDS patients.

Tina Megdal, Senior Director of Client Services, Legacy Clinic in Houston, provided observations on the results of the survey at Legacy.

Amy Leonard, Health Educator for Legacy Clinic in Houston, provided observations on the results of the survey at Legacy.

Dr. Mark Nichols, Vice President of Clinical Affairs for the Bering Dental Clinic in Houston, commented from the perspective of a conventional medical doctor working with HIV/AIDS patients.

Paul Simmons, Executive Director of the Center for AIDS Information and Advocacy (CFA) in Houston, commented from the perspective of a long-time HIV/AIDS activist.

Note: All were personal interviews, which took place in Houston in March and April of 2010.

APPENDIX C
SURVEY DOCUMENTS

- C.1** Research Subject Informed Consent Form
- C.2** HIV/AIDS Knowledge and Perceptions Survey (English)
- C.3** Survey: Versions 9.2, 9.3, and 9.4 of Page 2
- C.4** HIV/AIDS Knowledge and Perceptions Survey (Spanish)
- C.5** Survey Consultants
- C.6** Guidelines for Survey Data Collection
- C.7** Facsimiles of the Survey Signs (English) (Spanish)
- C.8** Comments from Legacy Survey Respondents

APPENDIX C.1
Research Subject Informed Consent Form

Title of Project:

Social Marketing Strategies for Combating HIV/AIDS in Rural and Disadvantaged Communities in Uganda, Mexico, and the Southern United States

Prospective Research Subject:

Read this consent form carefully and ask as many questions as you like before you decide whether you want to participate in this research study. You are free to ask questions at any time before, during, or after your participation in this research. There will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate.

Purpose and Procedures:

You are being asked to participate in a research study designed to evaluate your knowledge and perceptions about HIV/AIDS. Your responses will help guide the design of a model for effectively disseminating information about HIV/AIDS.

This survey is being administered to a sample of people whose principal commonality is that they are all receivers of information about prevention techniques and treatment modalities available for HIV/AIDS. You should not experience any discomfort as a result of participating in this study and you can decline to answer any question. Your responses will be strictly anonymous; they cannot be connected to you in any way. If this research is published, no information that would identify you will be written. You may stop the survey at any time.

This survey is part of a research project being conducted by a Ph.D. candidate at the University of Teesside in Middlesbrough, England. For questions or concerns regarding this research, contact Ruth Massingill at 80 Waterwood, Huntsville, Texas 77320, or at 1-936-581-1322.

Authorization:

I have read and understand this form, and I consent to voluntarily participate in this research study. I understand I will receive a copy of this form. I realize I am free to withdraw my consent and to withdraw from this study at any time without negative consequences.

Participant Name (printed): _____

Participant Signature:

Date:

HIV/AIDS Knowledge and Perceptions Survey

This is part of a research study regarding knowledge and perceptions about HIV, HIV/AIDS, and/or AIDS (referred to as HIV/AIDS in this survey). Your responses will help guide the design of a model for effectively informing people about HIV/AIDS.

- I. Are you 18 or older? (If not, stop survey.)**
- II. Have you seen or heard information about prevention and treatment of HIV/AIDS? (If no, stop survey; if yes, proceed.)**

A. From which of these sources have you learned about HIV/AIDS in the past 4-5 years? Check ALL that apply.

- | | |
|--|--|
| <input type="checkbox"/> 1. TV
<input type="checkbox"/> 2. Radio
<input type="checkbox"/> 3. Books
<input type="checkbox"/> 4. Newspapers
<input type="checkbox"/> 5. Magazines
<input type="checkbox"/> 6. Out of home (billboards, transit ads, posters, flyers, brochures)
<input type="checkbox"/> 7. Events (seminars, workshops, conferences)
<input type="checkbox"/> 8. Medical websites
<input type="checkbox"/> 9. HIV/AIDS groups' websites
<input type="checkbox"/> 10. Blogs, online bulletin boards | <input type="checkbox"/> 11. Online newsletters, journals, etc
<input type="checkbox"/> 12. Emails
<input type="checkbox"/> 13. Social media (Facebook, Twitter, etc)
<input type="checkbox"/> 14. Community organizations
<input type="checkbox"/> 15. Religious organizations
<input type="checkbox"/> 16. Educational institutions
<input type="checkbox"/> 17. Conventional medical doctors
<input type="checkbox"/> 18. Alternative medical doctors
<input type="checkbox"/> 19. Friends or family members
<input type="checkbox"/> 20. People you work with
<input type="checkbox"/> 21. Other (Specify) _____ |
|--|--|

B. Using the scale below, rate each of these sources of HIV/AIDS information according to how credible (believable) they have been in your experience.

	Not at all credible	Somewhat credible	Undecided	Credible	Extremely credible
1. TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Radio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Newspapers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Magazines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Out of home (billboards, bus ads, posters, flyers, brochures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Events (seminars, workshops, conferences)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Medical websites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. HIV/AIDS groups' websites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Blogs, online bulletin boards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Online newsletters, journals, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Emails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Social media-Facebook, Twitter, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Community organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Religious organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Educational institutions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Conventional medical doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Alternative medical doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Friends or family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. People you work with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Other (Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Please check the response that best represents how you feel about these statements:

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Sure
1. Poor people are more likely to get HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Globally, the number of people with HIV/AIDS is decreasing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. HIV/AIDS is primarily a gay disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Getting HIV/AIDS is usually a death sentence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Antiretroviral drugs are a cure for HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. People who knowingly expose others to HIV/AIDS should be prosecuted as criminals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. You cannot get HIV/AIDS during sex if condoms are always used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. HIV/AIDS is God's way of punishing the wicked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. An effective HIV/AIDS vaccine is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Alternative medical treatments for HIV/AIDS have shown promising results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. People with HIV/AIDS deserve the same rights in the workplace as other workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Treating HIV/AIDS is a lucrative business for pharmaceutical companies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. HIV/AIDS infections are often the result of immoral behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. It is biologically easier for women to get HIV/AIDS than it is for men.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. HIV/AIDS prevention efforts often receive more funding than treatment efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Young people under 25 account for almost half of new HIV/AIDS infections globally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I am not personally worried about getting HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Please mark ALL of the following HIV/AIDS treatments that you have heard of.

- | | |
|--|---|
| <input type="checkbox"/> 1. UVBI (Ultraviolet blood irradiation) | <input type="checkbox"/> 11. Peroxide-IV |
| <input type="checkbox"/> 2. Silver colloid-IV | <input type="checkbox"/> 12. Peroxide-oral |
| <input type="checkbox"/> 3. Silver colloid-oral | <input type="checkbox"/> 13. Venus flytrap-oral |
| <input type="checkbox"/> 4. Selenium liver support-oral | <input type="checkbox"/> 14. Porcine (pig) liver extracts-transdermal |
| <input type="checkbox"/> 5. Chelation-IV | <input type="checkbox"/> 15. Nutritional supplements |
| <input type="checkbox"/> 6. Chelation-oral | <input type="checkbox"/> 16. AZT (Azidothymidine) |
| <input type="checkbox"/> 7. Vitamins-IV | <input type="checkbox"/> 17. HAART (Highly active antiretroviral therapy) |
| <input type="checkbox"/> 8. Vitamins-oral | <input type="checkbox"/> 18. Pharmaceutical antibiotics (Bactrim, etc) |
| <input type="checkbox"/> 9. Minerals-IV | <input type="checkbox"/> 19. Other (Specify) _____ |
| <input type="checkbox"/> 10. Minerals-oral | |

E. Based on your own knowledge or experience, please mark ALL of the following HIV/AIDS treatments that you think can be effective in treating HIV/AIDS.

- | | |
|--|---|
| <input type="checkbox"/> 1. UVBI (Ultraviolet blood irradiation) | <input type="checkbox"/> 11. Peroxide-IV |
| <input type="checkbox"/> 2. Silver colloid-IV | <input type="checkbox"/> 12. Peroxide-oral |
| <input type="checkbox"/> 3. Silver colloid-oral | <input type="checkbox"/> 13. Venus flytrap-oral |
| <input type="checkbox"/> 4. Selenium liver support-oral | <input type="checkbox"/> 14. Porcine (pig) liver extracts-transdermal |
| <input type="checkbox"/> 5. Chelation-IV | <input type="checkbox"/> 15. Nutritional supplements |
| <input type="checkbox"/> 6. Chelation-oral | <input type="checkbox"/> 16. AZT (Azidothymidine) |
| <input type="checkbox"/> 7. Vitamins-IV | <input type="checkbox"/> 17. HAART (Highly active antiretroviral therapy) |
| <input type="checkbox"/> 8. Vitamins-oral | <input type="checkbox"/> 18. Pharmaceutical antibiotics (Bactrim, etc) |
| <input type="checkbox"/> 9. Minerals-IV | <input type="checkbox"/> 19. Other (Specify) _____ |
| <input type="checkbox"/> 10. Minerals-oral | |

F. Demographics (For statistical purposes only—your responses are anonymous.)

1. Age Group: 18-25 26-36 37-47 48-58 59+
2. Which gender do you most identify with? Male Female
3. Sexual orientation: Heterosexual Homosexual Bisexual Prefer not to say
4. Which of the following groups do you most identify with? (Check only one.)
- | | |
|--|--|
| <input type="checkbox"/> American Indian, Alaska Native
or Pacific Islander | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Asian/Asian American | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Black/African American or Negro | <input type="checkbox"/> Multi-racial |
| | <input type="checkbox"/> Other (Specify) _____ |
5. Which of the following best describes your education level? (Check only one.)
- 8th grade or less
- Some high school
- Graduated high school/have my GED
- Graduated from college
- Master's degree or above
6. Religious affiliation: _____ Prefer not to say
7. Are you in a paid position with an organization involved with HIV/AIDS? Yes No
8. Are you an unpaid volunteer with an organization involved with HIV/AIDS? Yes No
9. My HIV status is: Negative Positive Don't know Prefer not to say

G. Other comments (Use back of page if needed)

Thanks for your participation!

C. Please check the response that best represents how you feel about these statements: (V9.2)

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Sure
1. HIV/AIDS is God's way of punishing the wicked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Getting HIV/AIDS is usually a death sentence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Globally, the number of people with HIV/AIDS is decreasing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor people are more likely to get HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. HIV/AIDS prevention efforts often receive more funding than treatment efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. HIV/AIDS is primarily a gay disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I am not personally worried about getting HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Alternative medical treatments for HIV/AIDS have shown promising results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Antiretroviral drugs are a cure for HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. An effective HIV/AIDS vaccine is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. You cannot get HIV/AIDS during sex if condoms are always used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People with HIV/AIDS deserve the same rights in the workplace as other workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. People who knowingly expose others to HIV/AIDS should be prosecuted as criminals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Young people under 25 account for almost half of new HIV/AIDS infections globally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. It is biologically easier for women to get HIV/AIDS than it is for men.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. HIV/AIDS infections are often the result of immoral behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Treating HIV/AIDS is a lucrative business for pharmaceutical companies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Please check the response that best represents how you feel about these statements: (V9.3)

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Sure
1. Alternative medical treatments for HIV/AIDS have shown promising results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Young people under 25 account for almost half of new HIV/AIDS infections globally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. People with HIV/AIDS deserve the same rights in the workplace as other workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. HIV/AIDS infections are often the result of immoral behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. HIV/AIDS prevention efforts often receive more funding than treatment efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. HIV/AIDS is primarily a gay disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. HIV/AIDS is God's way of punishing the wicked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Getting HIV/AIDS is usually a death sentence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. An effective HIV/AIDS vaccine is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Poor people are more likely to get HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I am not personally worried about getting HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Globally, the number of people with HIV/AIDS is decreasing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Antiretroviral drugs are a cure for HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. It is biologically easier for women to get HIV/AIDS than it is for men.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. People who knowingly expose others to HIV/AIDS should be prosecuted as criminals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. You cannot get HIV/AIDS during sex if condoms are always used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Treating HIV/AIDS is a lucrative business for pharmaceutical companies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Please check the response that best represents how you feel about these statements: (V9.4)

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Not Sure
1. An effective HIV/AIDS vaccine is available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Alternative medical treatments for HIV/AIDS have shown promising results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Young people under 25 account for almost half of new HIV/AIDS infections globally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Getting HIV/AIDS is usually a death sentence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. HIV/AIDS prevention efforts often receive more funding than treatment efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. People with HIV/AIDS deserve the same rights in the workplace as other workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Antiretroviral drugs are a cure for HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. HIV/AIDS is God's way of punishing the wicked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. HIV/AIDS is primarily a gay disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. You cannot get HIV/AIDS during sex if condoms are always used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Poor people are more likely to get HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Globally, the number of people with HIV/AIDS is decreasing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I am not personally worried about getting HIV/AIDS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. It is biologically easier for women to get HIV/AIDS than it is for men.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. HIV/AIDS infections are often the result of immoral behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Treating HIV/AIDS is a lucrative business for pharmaceutical companies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. People who knowingly expose others to HIV/AIDS should be prosecuted as criminals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Encuesta sobre conocimiento y percepción sobre VIH/SIDA (APP C.4)

Esta encuesta es parte de una investigación sobre el conocimiento y las percepciones que tienen las personas sobre el VIH y el Síndrome de Inmunodeficiencia Adquirida (SIDA). Para acortar la información, esta encuesta menciona SIDA en lugar de Síndrome de Inmunodeficiencia Adquirida. Sus respuestas ayudarán a diseñar un modelo de educación para informar a las personas sobre la prevención y el tratamiento del VIH/SIDA.

I. ¿Es usted mayor de 18 años? (Si no, encuesta sobre la parada.)

II. ¿Ha visto información sobre prevención y el tratamiento del VIH/SIDA? (Si no, encuesta sobre la parada.)

A. ¿De cuáles de estos es recursos usted ha aprendido sobre VIH/SIDA en los pasados 4-5 años? Seleccione todas las respuestas que apliquen.

- | | |
|---|---|
| <input type="checkbox"/> 1. Televisión
<input type="checkbox"/> 2. Radio
<input type="checkbox"/> 3. Libros
<input type="checkbox"/> 4. Periódicos
<input type="checkbox"/> 5. Revistas
<input type="checkbox"/> 6. Anuncios fuera de la casa (carteleros, letreros, hojas sueltas)
<input type="checkbox"/> 7. Eventos (seminarios, talleres, conferencias)
<input type="checkbox"/> 8. Páginas Web escritas por personal médico
<input type="checkbox"/> 9. Páginas en la Web creadas por personas que tienen VIH/SIDA
<input type="checkbox"/> 10. Blogs, tableros de anuncios en línea | <input type="checkbox"/> 11. Periódicos en línea
<input type="checkbox"/> 12. Correos electrónicos
<input type="checkbox"/> 13. Facebook, Twitter, My Space, etc.
<input type="checkbox"/> 14. Organizaciones comunitarias
<input type="checkbox"/> 15. Organizaciones religiosas
<input type="checkbox"/> 16. Instituciones educativas
<input type="checkbox"/> 17. Doctores convencionales
<input type="checkbox"/> 18. Doctores en medicina alternativa
<input type="checkbox"/> 19. Amigos o familiares
<input type="checkbox"/> 20. Personas con las que trabaja
<input type="checkbox"/> 21. Otro (Especifique) _____ |
|---|---|

B. Seleccione la respuesta que mejor represente cuán creíble (verosímil) usted piensa que son los siguientes recursos que hablan sobre VIH/SIDA.

	No lo encuentro creíble	Algo creíble	Inseguro	Creíble	Extremadamente creíble
1. Televisión	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Radio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Libros	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Periódicos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Revistas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Anuncios fuera de la casa (carteleros, letreros, hojas sueltas)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Eventos (seminarios, talleres, conferencias)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Páginas Web escritas por personal médico	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Páginas en la Web creadas por personas que tienen VIH/SIDA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Blogs, tableros de anuncios en línea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Periódicos en línea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Correos electrónicos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Facebook, Twitter, MySpace, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Organizaciones comunitarias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Organizaciones religiosas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Instituciones educativas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Doctores convencionales	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Doctores en medicina alternativa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Amigos o familiares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Personas con las que trabaja	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Otro (Especifique) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Haga una marca a lado de los tratamientos de VIH/SIDA de los que haya escuchado o leído.

- | | |
|---|--|
| <input type="checkbox"/> 1. UVBI (la irradiación ultravioleta de la sangre) | <input type="checkbox"/> 11. Peróxido – IV (intravenoso) |
| <input type="checkbox"/> 2. Plata coloidal –IV (intravenoso) | <input type="checkbox"/> 12. Peróxido –oral |
| <input type="checkbox"/> 3. Plata coloidal–oral | <input type="checkbox"/> 13. Atrapamoscas –oral |
| <input type="checkbox"/> 4. Selenium apoyo de hígado–oral | <input type="checkbox"/> 14. Extractos de hígado de cerdo– transdérmico |
| <input type="checkbox"/> 5. Quelación – IV (intravenoso) | <input type="checkbox"/> 15. Suplementos nutricionales |
| <input type="checkbox"/> 6. Quelación –oral | <input type="checkbox"/> 16. AZT (Azidothymidine) |
| <input type="checkbox"/> 7. Vitaminas – IV (intravenoso) | <input type="checkbox"/> 17. HAART (Terapia antiretroviral altamente activa) |
| <input type="checkbox"/> 8. Vitaminas –oral | <input type="checkbox"/> 18. Farmacéutico antibióticos (Bactrim, etc) |
| <input type="checkbox"/> 9. Minerales – IV (intravenoso) | <input type="checkbox"/> 19. Otro (Especifique)_____ |
| <input type="checkbox"/> 10. Minerales –oral | |

E. De acuerdo con su propio conocimiento o experiencia, por favor marque TODOS los casilleros de los siguientes tratamientos del VIH / SIDA que cree que puede ser eficaz en el tratamiento del VIH / SIDA.

- | | |
|---|--|
| <input type="checkbox"/> 1. UVBI (la irradiación ultravioleta de la sangre) | <input type="checkbox"/> 11. Peróxido – IV (intravenoso) |
| <input type="checkbox"/> 2. Plata coloidal –IV (intravenoso) | <input type="checkbox"/> 12. Peróxido –oral |
| <input type="checkbox"/> 3. Plata coloidal–oral | <input type="checkbox"/> 13. Atrapamoscas –oral |
| <input type="checkbox"/> 4. Selenium apoyo de hígado–oral | <input type="checkbox"/> 14. Extractos de hígado de cerdo– transdérmico |
| <input type="checkbox"/> 5. Quelación – IV (intravenoso) | <input type="checkbox"/> 15. Suplementos nutricionales |
| <input type="checkbox"/> 6. Quelación –oral | <input type="checkbox"/> 16. AZT (Azidothymidine) |
| <input type="checkbox"/> 7. Vitaminas – IV (intravenoso) | <input type="checkbox"/> 17. HAART (Terapia antiretroviral altamente activa) |
| <input type="checkbox"/> 8. Vitaminas –oral | <input type="checkbox"/> 18. Farmacéutico antibióticos (Bactrim, etc) |
| <input type="checkbox"/> 9. Minerales – IV (intravenoso) | <input type="checkbox"/> 19. Otro (Especifique)_____ |
| <input type="checkbox"/> 10. Minerales –oral | |

F. Información demográfica (Sus repuestas serán confidenciales.)

1. Edad: 18-25 26-36 37- 47 48-58 59+
2. ¿Con qué género se identifica mejor? Masculino Femenino
3. Orientación sexual: Heterosexual Homosexual Bisexual Prefiero no decir
4. ¿Con cuál de los siguientes grupos usted se identifica más? (Seleccione sólo una contestación.)
- | | |
|--|--|
| <input type="checkbox"/> Indio Americano, Original de Alaska | <input type="checkbox"/> Hispano |
| <input type="checkbox"/> O de las islas del Pacífico | <input type="checkbox"/> Blanco/Caucasico |
| <input type="checkbox"/> Asiático/Asiático Americano | <input type="checkbox"/> Mezcla de razas |
| <input type="checkbox"/> Negro/Africano Americano | <input type="checkbox"/> Otro (Especifique)_____ |
5. ¿Cuál de las siguientes opciones mejor describe su educación académica? (Seleccione sólo una contestación.)
- El grado octavo o menos
- Algún instituto
- Instituto/tiene graduado mi GED
- Graduado colegial
- Maestría o doctorado
6. Afiliación religiosa: _____ Prefiero no decir
7. ¿Trabaja usted en alguna organización que se encargue de educar, tratar personas que tienen HIV/AIDS, o que enseñe a prevenir la enfermedad? Sí No
8. ¿Es usted un voluntario en alguna organización sobre HIV/AIDS? Sí No
9. Mi HIV estatus es: Negativo Positivo No sé Prefiero no decir

G. Otros comentarios (Use la parte de atrás de la página si necesita más espacio.)

APPENDIX C.5 SURVEY CONSULTANTS

Jacques Clermont, Doctor of Naturopathic Medicine and collaborator for INSERM, France's National Institute of Health and Medical Research

Solly Diaz, MHA, Division Manager-Southwest Region, City of Houston Department of Health and Human Services, Houston, Texas

Hugh Fullerton, PhD., Researcher and retired educator, Texas

Amy Leonard, Health Educator, Legacy Clinic, Houston, Texas

Ken Malone, HIV Test Project Coordinator, HIV Services, Harris County Hospital District, Houston, Texas

Tina Megdal, Senior Director of Client Services, Legacy Clinic, Houston, Texas

Beau J. Mitts, MPH, Technical Assistance Manager, HIV/AIDS Care, Treatment, and Houston Program, Bureau of HIV/AIDS Prevention and Control, New York City Department of Health and Mental Hygiene. (Formerly Manager, HIV Prevention Program, City of Houston Health and Human Services, Houston, Texas)

Wanda Reyes, PhD, Assistant Professor of Mass Communication, Sam Houston State University, Huntsville, Texas

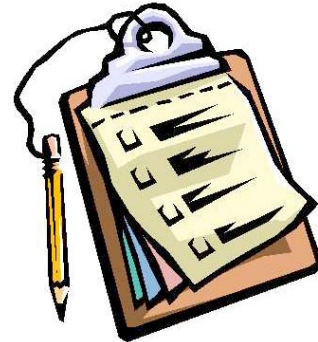
Ardyth Broadrick Sohn, PhD., Professor and Director, Hank Greenspun School of Journalism and Media Studies, University of Nevada Las Vegas, Las Vegas, Nevada

Christopher White, PhD., Associate Professor of Mass Communication, Sam Houston State University, Huntsville, Texas

APPENDIX C.6: Guidelines for Survey Data Collection

- 1) Preparing—Read the consent form and the survey before going into the field. Take the survey and think about what questions respondents might have.
- 2) Organize copies of the blank consent forms and the five versions of the survey in separate folders. Be sure to have separate folders for the five different versions of the surveys. All folders should be clearly labelled. Have several pens for respondents' use.
- 3) Have separate folders for completed surveys and signed consent forms. At no time should the consent forms be filed with the corresponding surveys.
- 4) Approaching possible respondents—Greet the person, give your name and explain that you are asking people to take a brief survey about their knowledge and perceptions about HIV/AIDS. This is part of a research project to help find effective ways to inform people about HIV/AIDS.
- 5) Time frame/anonymity—Explain that taking the survey will only take about 10-15 minutes and will be anonymous—names will never be used but their information will be important and useful.
- 6) Filter questions—
 - a. *Are you 18 or older?* (No minors can take the survey.)
 - b. *Have you seen or heard information about prevention and treatment of HIV/AIDS?*
If NO, say thank you, and do not distribute a survey. If YES, continue.
- 7) Distribution of different survey versions—Distribute version 1 of the survey to the first respondent, version 2 to the second respondent, and so on. After five surveys have been completed, begin the cycle over again.
- 8) Getting consent forms signed—There must be a signed consent form for the survey to be valid. Give a copy of the consent form to the respondent and ask him/her to sign and return a copy. Stress again that surveys and consent forms will be kept separate and will not be linked in anyway. The person's name will NEVER be used in any way. (If the person requests a copy of the consent form, give him/her a copy.)
- 9) Answering questions respondents might ask:
 - Q: Can I decline to answer a question? YES
 - Q: Can I stop the survey at any time? YES
 - Q: Whom can I contact if I have a question? Contact and phone # on the form.
 - Q: Why must I sign a form? For a survey to be valid, respondents must give consent.
- 10) Coding—At the end of the collection period, code the surveys and the consent forms using the collection site and date codes provided. Do NOT code the surveys in the presence of the respondents.
- 11) Transporting the surveys—Surveys should be kept in a secure place while being transported to the site where they will be edited, coded, and tabulated.

Take a ^{quick} survey



Grab a ^{funny} gift

If you are 18 or older, please take a few minutes to fill out our HIV/AIDS survey. Your anonymous responses will help us find better ways to inform people about HIV/AIDS prevention and treatment.

Thanks for your help!



This research project has IRB approval from the University of Teesside.

**Participar en
una encuesta**



Recibir un regalo!

**Si usted tiene 18 años o más, por favor,
tómese unos minutos para participar en un
encuesta sobre VIH/SIDA. Su respuesta
anónima nos ayudará a informar a gente
sobre el tratamiento y la prevención
de VIH / SIDA.**

Gracias por tu ayuda!



Este proyecto de investigación aprobado por la Universidad de Teesside.

APPENDIX C.8
Comments from Legacy Survey (Nov/Dec 2009)

Taking this survey made me realize how much I don't know about HIV/AIDS.

Great work by everyone pulling together.

I've been infected for 23 years.

I am not very familiar with HIV/AIDS and its treatments or lack thereof. New to Houston and have never been face to face with HIV/AIDS and its effects and or the amount of people that have it. I suppose it's ok to say that I am not very educated in this matter.

Having 4 friends with HIV, I still don't know much about what they go through to stay well every day. I feel maybe that it's not a open subject to talk about.

We need more help to get good service.

Thanks for your help.

Thanks for all you do for the HIV community.

I am transgender.

Positive for 30 years and have never taken any drugs ever for the illness.

Nice to participate.

Answered "not sure" on items I don't know, #16, yes! But only if the other party is unaware of the infected person's condition; #19, depends on the person (ex are they rapists, cheating or just dating) question was too broad.

Lots of treatments.... I didn't know any of them.

I know that my God is good. I've been exposed since 1992 till now. I'm still here.

All the best on your research project. Happy and safe Holidays and 2010.

More education in schools; many people believe the #'s are going down drastically and there is a readily available cure.

If it was not for the good doctors and caseworkers, I would have been very ill. This is a good clinic and I love how you all work with me and let me know I am not in the dark.

The people helping out are doing a wonderful job.

Part D: Some of these therapies used together can be effective treatments.

I have been negative for the last 4 years of my life, and was HIV in 1987.

Knowledge is power!

Work as LVN for HCHD.

There are some religious teachings that I disagree with in regard to HIV education. I believe a full dissemination of scientifically proven HIV prevention methods should be mandatory for any organization funded for such efforts. The censorship of this education based on “beliefs” is ethically challenged. While some religious organizations are beneficial in their teaching method, others try to enforce their beliefs on those in need.

I myself have 2 sons with AIDS. Thanks for your support.

I feel that people with no insurance is treated unfairly and results are not always correct.

Thanks.

Hoping for a cure.

The research being done in vector treatment looks promising.

I have had a family member living with AIDS for almost 10 years. In that time I have seen her almost die 5 times. With the meds she always got better. She is living a full life and is very healthy. I believe given funding a cure could be found. I have to hope.

Good luck with your school project.

I think it's sad that we have gotten comfortable with these diseases and to really educate yourself, you have to make the effort. There needs to be awareness.

I am a Leeper graduate of 2007.

My daughter is HIV, possibly AIDS, age 33, contracted HIV at 21 from husband-Now ex.

DCA Drug will cure Cancer & AIDS/HIV, but we can't get it in the USA as a legal treatment. Availability in Canada only.

My boyfriend is HIV positive.

I have some thoughts that I am infected with HIV one time and it was horrible.

Thanks and good luck.

I didn't check any treatments because I have never heard of any of them.

APPENDIX D

PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

- D.1** Presentation, *Taking taboo topics public: how social marketing partnerships combat HIV/AIDS in Mexico* (2008).
- D.2** Paper, *Creating a culture of change: social marketing's global initiative against HIV/AIDS* (2008).
- D.3** Abstract, *Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States* (2008).
- D.4.1** Poster, *Working toward a world without AIDS: how social marketing inspires long-term cultural change* (2009).
- D.4.2** Abstract, *Working toward a world without AIDS: how social marketing inspires long-term cultural change* (2009).
- D.5** Book chapter, *Love, sex, and HIV/AIDS: using social marketing to redefine gender norms among Mexican youth* (2011).

PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

D.1 Presentation Title: *Taking taboo topics public: how social marketing partnerships combat HIV/AIDS in Mexico* (part of a panel titled: Partnership Based Approaches: What Works?)

Presented at: 2008 PSP-*One* Online Social Marketing Conference: *Social marketing in the developing world: what have we accomplished and what does the future hold?*

Conference website with list of presenters:

<http://www.icohere-presentations.com/Assist/PSP-OneReg08/PSP1conference.htm>

Dates: 10-15 March 2008

Publication: Recorded online script with accompanying PowerPoint, plus on-line participation during the conference.

Presentation published at:

www.psp-one.com/files/4986_file_Massingill__presentation_p1.pdf

Note: PSP-*One* (Private sector partnerships for better health) is USAID's flagship project to increase the private sector's provision of high-quality reproductive health and family planning and other health products and services in developing countries (<http://www.psp-one.com>).



**Taking Taboo Topics Public:
How Social Marketing Partnerships Combat HIV/AIDS in Mexico**

Introduction

- ❑ Social marketing influences low-income, high-risk populations to make healthy behaviour changes.
- ❑ Key tactic for combating HIV/AIDS
- ❑ Spread of infection can be managed: level and prevalence of HIV/AIDS are altered by human intervention/decisions.



Social marketing has been widely used to influence low-income, high-risk populations to make healthy behaviour changes. This application of marketing principles has also become an important tool for persuading upstream audiences to make long-term policy changes that achieve socially desirable goals.

As the human, social, and economic costs of the HIV/AIDS pandemic mount, social marketing is now a key tactic for combating the disease.

This is particularly appropriate since the spread of the infection can be managed. Passive contagion, a core tenet of classic disease diffusion models, is not appropriate for HIV/AIDS since human intervention and human decision-making can alter both the level and the prevalence of the disease.

A Case for Social Marketing in Mexico

- ❑ Increase in HIV/AIDS cases each year since early 1980s
- ❑ Affecting youngest and most productive populations as well as poor and marginalized
- ❑ #4 cause of death for men 25-34
- ❑ Diverting resources from other health, welfare, and education priorities



As the human, social, and economic costs of the HIV/AIDS pandemic mount, policymakers worldwide are earmarking funds and forming alliances to combat the spread of the disease. Mexico, where the first AIDS case was diagnosed in 1983, faces serious threats to social sustainability as infections steadily multiply. Recent reports show the disease is increasingly affecting the youngest and most productive populations as well as poor and marginalized groups.

Mexico ranks 13th globally and third in the Americas in the total number of HIV cases reported; unfortunately, the increase in new cases has been continuous since the early 1980s. With an estimated average of 4,000 new cases annually in Mexico, AIDS has become the No. 4 cause of death for men in the 25 to 34 age group. Higher rates of HIV infection are also being documented among injecting drug users and women.

Overall Research Question

How have alliances of government decision makers, the health care community, and AIDS activists allowed social marketers to bring about voluntary behavioural changes in Mexico?



How have alliances of government decision makers, the health care community, and AIDS activists allowed social marketers to bring about voluntary behavioural changes in Mexico?

A Population of Campaigns

- ❑ Six campaigns selected for comparison
- ❑ Examined purpose, sponsors, audience, where disseminated, media mix, messages, product promotion, and appeals
- ❑ Commonalities and unique characteristics identified
- ❑ Research methods: content analysis, semi-structured interviews with key decision makers



This presentation analyses six recent HIV/AIDS campaigns in Mexico, examining their ability to motivate change and their potential for informing target audiences about new health choices. Analysis of the campaigns identified the commonalities and unique characteristics as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used. Semi-structured interviews with opinion leaders were used to explore the rationale behind the content choices, cultural influences, and economic factors influencing the public dissemination of HIV/AIDS information. The six campaigns share a number of common concerns and objectives although each has a unique theme and a distinctive focus and approach. All campaigns, however, rely heavily on partnerships and present messages that openly discuss once-taboo topics.

Finding #1: Collaboration is Essential

- ❑ Social marketers do not have infrastructure/marketplace environment of commercial marketers
- ❑ Build network of groups with common goals, varied resources.
- ❑ Good example: “Investing in People” in Mexico City, with largest number of AIDS cases ...
- ❑ Taboo topic: Sex before marriage

Recognizing that expanding HIV/AIDS populations will devastate the global economy, governments in both developing and industrialized countries, often in conjunction with pharmaceutical companies, have launched organized offensives, which include political commitment, law enforcement, government policy, social marketing, and community mobilization.

This global cooperation encourages alliances such as those forged to support the campaigns in this study. From a practical standpoint, these partnerships are essential because social marketers “do not have the infrastructure and the marketplace environment commercial marketers take for granted.” Rather than “divide and conquer,” in social marketing the strategy is to build a network of groups and individuals with common goals and varied resources.

The “Investing in People” campaign is a good example of such alliances...

Partnership Lesson #1:

Build local, nat'l & internat'l alliances with common goals

Investing in People

Purpose:	Reduce barriers to behavior change & care seeking, and increase access to services that facilitate safer behavior. Diminish stigma.
Timeframe:	2003-2008
Sponsors:	USAID, CENSIDA, Mexico City AIDS Program, Futures Group International, Mexican National Institute for Public Health, PSI
Audiences:	Vulnerable populations, at-risk groups
Where:	Mexico City
Media Mix:	Trained 40 women advocates, workshops, condom marketing
Messages:	Safe behaviors: Abstinence, fidelity, and delay of sexual debut
Speakers:	Local HIV/AIDS leaders deliver conference presentations
Products:	Condoms
Appeals:	Self-interest, sustainable development

...This five-year initiative, which began in 2003, is centered in Mexico City, where the largest number of HIV/AIDS cases are found. "Investing in People" is the joint effort of a half-dozen international, national, and local organizations. A key technique is personal communication through workshops and conferences conducted by trained female advocates and local HIV/AIDS leaders, who openly discuss sex before marriage, a once-forbidden topic in this strongly Roman Catholic country.

Finding #2: Focus on Prevention

- ❑ Messages usually focus on prevention
- ❑ Social marketing involves procuring, distributing pharmaceuticals, OTC drugs, condoms
- ❑ Condom Social Marketing (CSM)
- ❑ Mexico: largest consumer of pharmaceuticals in Latin America
- ❑ Taboo topic: Use of condoms

Most HIV/AIDS campaigns have a stronger focus on prevention messages than treatment information, so social marketing assistance usually involves procuring and distributing pharmaceuticals, over-the-counter drugs, and condoms. For example, PSI [Population Services International], the principal contractor for USAID's 2005 behavioural change campaign in Mexico, emphasizes prevention messages and brand-specific advertising, especially of condoms. Under this "manufacturer's model," partnerships are negotiated with commercial manufacturers, suppliers, and distributors of health products, and products are made available at lower than market costs. Brand-name condoms and related products are always sold rather than given away, albeit at reduced prices, because PSI's policy is "when products are given away... the recipient often does not value them or even use them." In fact, promoting the use of condoms is such an integral part of HIV/AIDS social marketing that the practice has its own acronym: Condom social marketing [CSM], which is central to the Vida campaign strategy...

Partnership Lesson #2: Recruit commercial sponsors for additional resources

VIVE Condoms

Purpose:	Make condoms socially acceptable
Timeframe:	2004-2005
Sponsors:	PSI, USAID
Audiences:	Men who have sex with men, female sex-workers, truckers, migrants, prisoners, young adults (15-24) people living with AIDS, men in uniform
Where:	Southern and Central Mexico, non-traditional outlets in high-risk areas--bars, markets, parks, bus stations
Media Mix:	Commercial distribution of condoms, discussion and interactive activities
Messages:	Appropriate condom use, testing results confidential, required treatment is guaranteed, Vive tu Vida
Products:	VIVE condom brand
Appeals:	Sustainable development, self-interest

The VIVE condom brand, popular in several Latin American countries, is the centerpiece of recent "Vida" educational efforts directed to prisoners and other high-risk groups in southern and central Mexico. A recent survey reported that Mexican society has become the largest consumer of pharmaceuticals in Latin America and the ninth largest worldwide. Pharmaceutical sales jumped from US\$6.83 billion in 2002 to an estimated US\$11.3 billion in 2005. Given these numbers, it seems safe to say that major pharmaceutical companies will continue to vie for partnership status in social marketing initiatives and that condoms will continue to be more accessible and socially acceptable.

Finding #3: Stigma Goes Underground

- ❑ “Underground epidemic”
- ❑ People living with AIDS, esp. women fear rejection by families and loss of jobs.
- ❑ “Vida Digna” in central Mexico, with “weakest civil response to AIDS”...
- ❑ Taboo topic: Alternative lifestyles

HIV has been called an “underground epidemic” because of the stigma and discrimination associated with the disease.

USAID, whose infectious disease objectives in Mexico are designed “to contain and reduce HIV/AIDS in vulnerable populations,” focuses on reducing barriers to behavior change and thereby preventing the HIV/AIDS epidemic in Mexico from becoming generalized to the population at large.

Reducing stigma and discrimination experienced by sex workers, gay men, men who have sex with men, drug users, and people living with AIDS is the central purpose of the three-year Vida Digna [Life with Dignity] campaign, launched in 2005 by the Colectivo Sol alliance and funded by GlaxoSmithKline...

Partnership Lesson #3: ***Involve the target audience from the outset***

Vida Digna (Life with Dignity)

Purpose:	Reduce stigma and discrimination of AIDS
Timeframe:	2005-2008
Sponsors:	AIDS Alliance, Colectivo, Sol, Positive Action, GlaxoSmithKline
Audiences:	People living with AIDS, sex workers, drug users, men who have sex with men
Where:	Mexico - Aguascalientes, Guanajuato, Queretaro, San Luis Potosi
Media Mix:	Training, literature, commercials, community leaders
Messages:	Equality begins with accepting people's differences
Speakers:	Community leaders, key decision makers, media
Appeals:	Social cognitive, sustainable development

...The campaign is centered in the central states of Mexico, a conservative area characterized as having “the weakest civil society response to AIDS.” Vida Digna uses anonymous testimonials to urge tolerance and acceptance of people’s differences. The International HIV/AIDS Alliance’s research indicates people living with AIDS, especially women, are fearful of rejection by their families and dismissal from their jobs if their HIV status is revealed.

Finding #4: Cultural/Gender Norms

- ❑ Machismo and homophobia fueling Mexico's AIDS epidemic
- ❑ Young men often control how and when young women have sex
- ❑ Changing gender norms: "Programa Hombres" and
- ❑ "Programa Mujeres"--female empowerment
- ❑ Taboo topics: Women's rights and homophobia

According to Mexico's National Center for the Prevention and Control of HIV/AIDS [Censida], changing how Mexicans view gender roles and erasing widespread prejudice against gays will be necessary to effectively combat the disease. Speaking at a conference in February of 2006, Censida's director, Jorge Saavedra, said machismo and homophobia are fueling the country's HIV/AIDS epidemic. Saavedra was quoted in *Dominican Today* as saying machismo undermines prevention messages and "puts women, as well as men, at risk," and that "fighting homophobia is one of the best ways to fight HIV."

Links between traditional gender attitudes and the spread of AIDS prompted a partnership of NGOs to develop Programa Hombres [often called Program H]...

Partnership Lesson #4: Initiatives must be multimedia & multilingual

Programa Hombres (Project H)

Purpose:	Help young men question traditional social norms related to manhood, reflect on the advantages of more gender-equitable behaviors and re-think what it means to be a man. Develop strategic relationships at the macro-policy level.
Timeframe:	1999-2004
Sponsors:	Began with Brazil's Instituto Promundo. Partners include PAPA! Institute, ECOS, and Salud Y Genero, PAPA/WHO, USAID, UNAIDS, IPPF/WHO, UNFPA, The Population Council, PATH, SSL International
Audiences:	Young men, 15-24
Where:	Mexico -Tested in more than 20 countries
Media Mix:	Educational videos, manuals, and workshops, information folders, radio spots, billboards, postcards, banners
Messages:	Chega Junta Cara, "In the Heat of the Moment"
Speakers:	Workshops facilitated by young men
Products:	Hora H condoms
Appeals:	Self-interest, decision-making

...This five-year initiative has been used in more than 20 countries, including Mexico, to persuade young Latino men to question traditional norms related to manhood since the male youth often control how and when young women have sex. An extensive media mix included educational videos available in three languages—Spanish, English, and Portuguese—interactive workshops, and collateral materials, as well as radio, outdoor media, and direct mail. The campaign slogan, "In the Heat of the Moment," urged use of the Hora H condom brand, manufactured by the makers of Durex condoms and distributed in non-traditional venues such as funk balls and cafes.

Partnership Lesson #5: Utilize global support for women

Programa Mujeres (Project M)

Purpose:	Promote young women's reflections on gender norms, and their self-efficacy and empowerment
Timeframe:	2005-
Sponsors:	Began with Brazil's Instituto Promundo. Partners include PAPAI Institute, ECOS, and Salud Y Genero, MacArthur Foundation, World Education (USA), OAK Foundation and the Special Secretariat of Womens Policies (Brazil)
Audiences:	Young women, 15-24
Where:	Brazil, Mexico, and soon India
Media Mix:	"Once upon a Girl" educational cartoon, discussion guide
Messages:	Sexual and reproductive health, educational, professional development, community involvement
Products:	Video for sale on website
Appeals:	Social-cognitive

Building on their success in educating young men about the costs of traditional macho culture, in 2005 the Program H partners and World Education launched Programa Mujeres [Project M] to encourage young women to take control of their sexual and reproductive health. This social marketing campaign was based on research that included a review of Latin American literature to define the concept of female empowerment, focus group discussions with groups of young women aged 14-24 who lived in marginalized communities outside Queretaro, Mexico, and interviews with empowered young women.

Finding #5: Population Mobility Danger

- ❑ Travel or migration factor in AIDS prevalence
- ❑ Risk to partners at home
- ❑ U.S./Mexico: Border health initiative to make testing and care more accessible and acceptable...
- ❑ Taboo topics: Sex outside of marriage, prostitution

Studies of highly mobile groups such as truck drivers, seasonal employees, and sex workers have identified travel or migration as a factor related to increased HIV/AIDS prevalence. Higher rates of infection are also frequently found along transport routes and in border regions. In addition, migration and mobility also increase vulnerability to HIV/AIDS for the partners at home.

Not surprisingly then, HIV/AIDS is a significant problem along the 2,000-mile border between the United States and Mexico, where mobility, poverty, and lack of access to health care complicate prevention and care. The SPNS [Special Projects of National Significance] Border Health Initiative is administered by the U.S. Department of Health and Human Services to raise awareness about HIV and to make testing and care more accessible...

Partnership Lesson #5: Construct trans-border alliances

SPINS Border Health Initiative

Purpose:	Identify infected people and refer to primary care, raise awareness, make testing more accessible, advance skills in delivering health and social services to people with AIDS
Timeframe:	2004-
Sponsors:	U.S. Department of Health and Human Services, CARE Act
Audiences:	Migrant farm workers, trans-border populations, sex workers
Where:	2,000-mile border between U.S. and Mexico, truck stops and border crossings, and communities
Media Mix:	One-to-one outreach, radio, TV, promotores (volunteer health workers), printed materials
Messages:	Bold messages that HIV is a community problem, identify testing and clinical resources, reverse cultural norms (use of Spanish language, culturally specific)
Speakers:	Local, well-known media personalities
Appeals:	Decision-making, social cognitive

...In many of the rural border communities people are reluctant and embarrassed to openly discuss HIV/AIDS or the sex worker industry. Relying heavily on social marketing, SPNS utilizes Spanish language media to blanket the transient communities with “bold” HIV messages designed to “reverse the cultural norm that topics related to sexuality, including HIV, are not discussed in public” and to educate Latinos about the risk of the disease. SPINS border outreach initiatives are designed to be culturally sensitive to the Latino culture, which values trust and relationship building.

Conclusions

- ❑ Communications about AIDS is complex and highly political
- ❑ HIV/AIDS crosses all boundaries; no one unaffected
- ❑ Social marketing is able to create upstream and downstream behaviour changes
- ❑ Partnerships are crucial
- ❑ Taboo topics must be discussed



As demonstrated by these six Mexico-based campaigns, the content of social marketing messages about HIV/AIDS, the role of stigma and culture, and the economic realities of the global medical market created by the epidemic form a complex and politically charged environment that influences public dissemination of information.

As HIV/AIDS social marketing establishes a track record in Mexico, organizations using such initiatives can begin to analyze long-term results. Nevertheless, it already seems clear that the power of social marketing is a strong tool for motivating change and informing target audiences about new health choices. Over a period of less than two decades, alliances of HIV/AIDS social marketers have been able to operate successfully in the maelstrom of cultural, political, economic, and social concerns while bringing about voluntary behavioral changes among both downstream and upstream audiences.

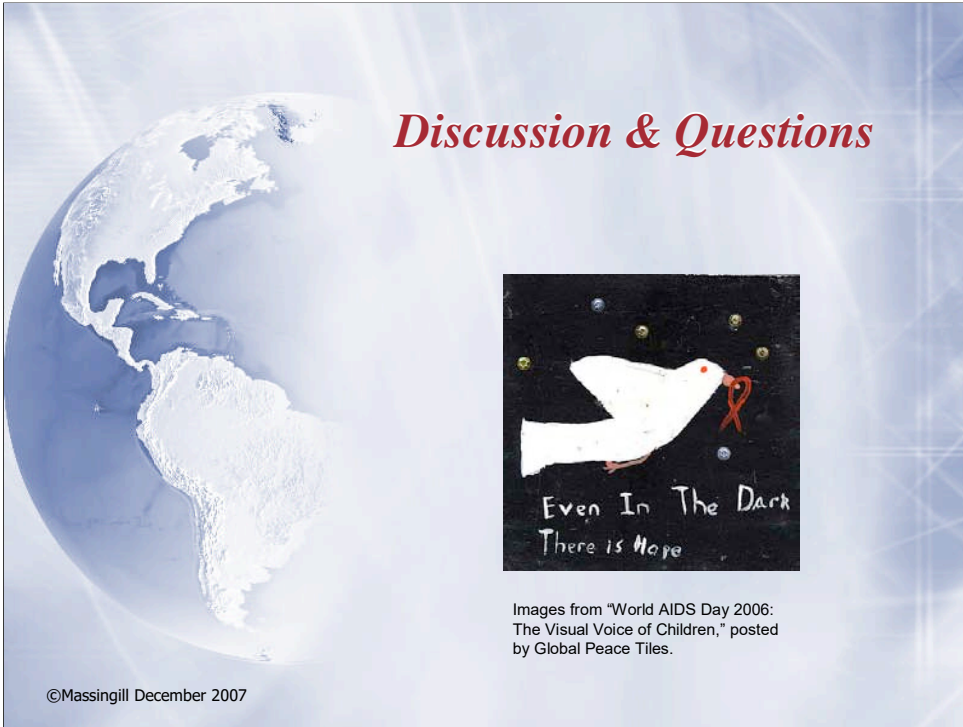
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Discussion & Questions



Images from "World AIDS Day 2006:
The Visual Voice of Children," posted
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**CREATING A CULTURE OF CHANGE:
SOCIAL MARKETING'S GLOBAL INITIATIVE AGAINST HIV/AIDS**

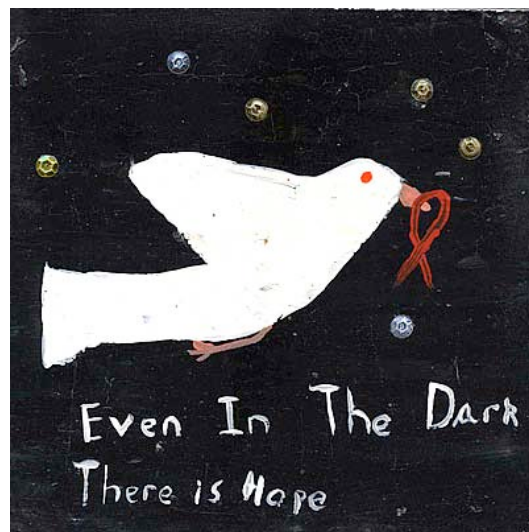
RUTH MASSINGILL

PH.D. CANDIDATE

UNIVERSITY OF TEESSIDE, MIDDLESBROUGH, ENGLAND, UK

MASS COMMUNICATION FACULTY

SAM HOUSTON STATE UNIVERSITY, HUNTSVILLE, TEXAS, USA



ABSTRACT

Social marketing [SM] is a key tactic for combating HIV/AIDS. When SM builds successful partnerships with upstream audiences who focus on downstream targets, a community's social fabric can be permanently altered.

This paper scrutinises how SM techniques are used to disseminate HIV/AIDS information, often with conventional medicine's sponsorship and alternative medicine's increasing influence.

Analysis of eighteen SM campaigns from Uganda, Mexico, and the U.S. indicates public communication revolves around 1) cultural content of SM messages about HIV/AIDS, 2) political expediency, and 3) economic realities of the global marketplace, forming a complex environment that influences dissemination of information about health care options. Semi-structured interviews with opinion leaders involved in designing, sponsoring, and implementing selected campaigns provide insights into lesson learned so far from these initiatives.

Image from "World AIDS Day 2006: The Visual Voice of Children," posted by Global Peace Tiles.

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INTRODUCTION

For more than three decades, social marketing, “the application of the principles and tools of marketing to achieve socially desirable goals,” (Kotler and Zaltman, 1971: 5) has been widely used to influence low-income and high-risk populations to make healthy behaviour changes. Although these campaigns often created awareness among specific target audiences and even persuaded members of at-risk groups to adopt lifestyle changes, it became increasingly obvious that the burden of deep societal change could not rest exclusively on these downstream targets (Andreasen, 2006). As a result, social marketing has come to be seen as a tool for social change on all levels. When social marketing can build partnerships that include governments, non-government organizations [NGOs], international agencies, and private businesses—so-called upstream audiences—working in conjunction with downstream targets, then the entire social fabric of a community can be permanently altered (Andreasen, 2006).

Therefore, social marketing has been a key tactic in combating HIV/AIDS, both in developing and in industrialized countries, for the past 20 years. These campaigns typically define a purpose relating to a specific target audience, use a variety of media to disseminate the campaign message, and are based on a recognized behavioural change model (McDermott, *et al.*, 2005). Numerous international organizations now have a track record of designing and implementing social marketing campaigns in countries where infection rates are on the rise. As the human, social, and economic costs of the HIV/AIDS pandemic mount, policymakers worldwide are earmarking funds and forming alliances to combat the spread of the disease.

This research explores links between social marketing and HIV/AIDS while mapping connections to the conventional and alternative medical communities. It is not unusual to find literature relating to any two of these terms, but rarely are all woven together. This project defines and contextualises social marketing, then it scrutinises how dissemination of HIV/AIDS information uses social marketing techniques, usually in partnership with conventional medicine. Alternative medicine's increasing influence and the consequent ramifications for audiences of HIV/AIDS social marketing campaigns are also investigated. This combination of topics—social marketing for HIV/AIDS as related to conventional and alternative medicine—is one that has not been explored in the manner outlined in this study, so the potential for contributing to the current body of knowledge is significant.

RESEARCH QUESTIONS

1. What is social marketing? What can it accomplish? How does it work?
2. How has social marketing been used to combat HIV/AIDS in both developing and industrialised countries?

3. What political and economic factors affect dissemination of information about HIV/AIDS treatment and prevention? What role do the media play?
4. What are specific examples of recent HIV/AIDS social marketing campaigns?
5. What commonalities and unique characteristics can be identified in this population of campaigns as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used? What lessons have been learned so far?

METHODOLOGY

To answer these questions, this study began with a comprehensive literature review, followed by content analysis of a population of 18 social marketing campaigns selected from three countries that represent diverse situations regarding the disease. This analysis provided context for semi-structured interviews with key informants from selected campaigns. The ethical guidelines of the U.K. Market Research Society Code of Conduct were examined and adhered to throughout the course of this study.

Literature Review: Areas of literature reviewed included social marketing [history, theory, and practice], HIV/AIDS [history, scope, and projections], social marketing as a tactic for combating HIV/AIDS, health communications and pharmaceutical-dominated marketing, health activism, Complementary and Alternative Medicine (CAM) and conventional medical approaches to HIV/AIDS, criminal justice concerns as relating to prisoner health care, and an overview of media coverage of these issues.

Content Analysis: A population of six HIV/AIDS social marketing campaigns was selected for each of the three countries targeted for this study—Mexico, Uganda, and the southern United States. The HIV/AIDS initiatives that were included each contained the recognized elements of social marketing campaigns, as well as several additional criteria selected by the researcher. Previous literature review revealed widespread agreement that social marketing combines a mix of several essential components: Behavioural change, informed by research, is the purpose behind any social marketing intervention. Also required is consumer orientation, in which the social marketer segments and profiles the target audience with the aim of building a long-term interactive relationship. Another common ingredient is facilitating a voluntary exchange from which both parties derive benefits. Finally, the successful social marketer thinks strategically, setting specific and measurable long-term objectives, using the marketing mix, and considering the appeal of competing behaviours (Andreasen, 2006; McDermott *et al.*, 2005).

Beyond meeting this definition for social marketing, criteria for campaign selection included currency—active as recently as 2004— implementation by a recognized international organization, and participation of a major medical organization or pharmaceutical company. The points of analysis were easily comparable aspects: purpose, target audience segmentation, where the campaign was disseminated, media mix used, messages presented, and types of appeals employed. The most common social marketing appeals to motivate health-related behaviour

change were determined through extensive literature review and informal interviews with social marketing researchers at the Institute for Social Marketing at Stirling University in Scotland.

Semi-structured Interviews: Interviews to date have included representatives from sponsoring organizations Population Services International, Instituto Promundo, Mexfam, Democracy and Sexuality (DEMYSEX) and LETRA S, as well as campaign spokespeople, health agency officials, medical practitioners, and community HIV/AIDS activists.

FINDINGS

I. CONVERGENCE OF SOCIAL MARKETING, HIV/AIDS, AND MEDICAL COMMUNITIES

The areas where social marketing, HIV/AIDS communications, and the conventional and alternative medical establishments overlap were of particular interest. Societal issues such as evolving public perceptions, the changing political landscape, international economics, and media agendas related to these topics are pertinent since they affect the global HIV/AIDS situation on a daily basis.

Research question 1: What is social marketing? What can it accomplish? How does it work?

Social marketing was first defined as a discipline 35 years ago, but has rapidly gained recognition as a “bridging mechanism” between behavioural science and the “socially useful implementation of what that knowledge allows” (Kotler and Zaltman, 1971:12). Social marketing's roots in commercial marketing are undisputed, with a strong influence by the 4Ps of marketing—product, promotion, price, and placement—although this model is sometimes viewed as insufficiently customer-based for social marketing’s framework (Niblett, 2005).

Social marketing ideally combines several elements. Behavioural change, informed by research, lies behind any social marketing intervention. Also required is consumer orientation, which segments audiences and builds long-term interactive relationships. Facilitating a voluntary exchange with mutual benefits is necessary. Successful social marketers think strategically, set long-term objectives, use the marketing mix, and consider the competition (Andreasen, 2006; McDermott *et al.*, 2005; Dev and Schultz, 2005).

As early as the 1960s, commercial marketing was incorporated into health education campaigns in developing countries (Ling *et al.*, 1992) and continued to play an important role in influencing behaviours of populations at risk for diseases such as HIV/AIDS, malaria, and alcoholism (Rogers *et al.*, 1991). When the effort extends beyond informing to persuading, it is called “health activism” and involves “attempts to change the status quo, including social norms, embedded practices, policies, and power relationships”(Zoller, 2005:361).

In 1981, however, Bloom and Novelli found many social marketing campaigns lacked rigor and theory. They recommended using research to segment audiences, design programs, and create strategic campaigns. Social marketing's popularity grew when its potential was publicised by Lefebvre and Flora (1988) and Hastings and Haywood (1991) in medical journals. As the

link between public health and commerce (Hastings and Soren, 2003), social marketing is the primary method international organisations such as UNAIDS use to combat global health issues.

Hastings and Donovan (2002) as well as Andreasen argue social marketing should be repositioned as an “approach to social change that reaches both upstream and downstream” (Andreasen, 2006: viii). However, Niblett cautions partnerships are key to this process because social marketers lack “infrastructure and the marketplace environment commercial marketers take for granted” (2005:3).

Although social marketing is not a theory, it informs and structures its framework using psychology, sociology, anthropology, and communications (Kotler and Zaltman, 1971). Social marketers may employ the health belief model (Basu, 2003), the transtheoretical model of health behaviour change [stages of change], diffusion of innovation, social cognitive theory, or theory of reasoned action (McDermott *et al.*, 2006; Lefebvre, 2001: 507-515). Nevertheless, many disregard theoretical approaches, preferring to be “broadly eclectic and intuitive tinkers” (Walsh *et al.*, 1993: 115). Despite criticisms of manipulation, overuse of fear appeals (Hastings *et al.*, 2004), and improper use of incentives (Dholakia and Dholakia, 2001), social marketing demonstrably effects social change.

Research question 2: How has social marketing been used to combat HIV/AIDS in both developing and industrialised countries?

Perhaps the most highly visible social problem in the world today is HIV/AIDS. Since it was first diagnosed 25 years ago, HIV/AIDS has become one of the most deadly health issues worldwide, with an estimated 40 million people—2.3 of them children—now living with the disease. Contrary to popular perception, about half of the infected are women and heterosexual transmission is now the most common means of infection (UNAIDS, 2006). HIV/AIDS is called an “underground epidemic” because of associated stigma and discrimination, which discourage people from getting tested or accessing care (HIV infection, 2003).

Where HIV/AIDS is rampant, social marketing is widely used to motivate low-income and high-risk audiences to adopt healthy behaviours. Population Services International, the first organisation to use social marketing to combat AIDS, uses targeted Behaviour Change Communications (BCC) to focus on prevention messages. Brand-specific advertising is often an integral part of HIV/AIDS campaigns, representing a major expense for drug companies, which spend on average two-and-a-half times more on marketing than on research (Hamber, 2005). With this kind of investment at stake, critics say the conventional medical establishment uses influence and financial clout (Moynihan and Cassels, 2005) to shape dissemination of health information.

Research Question 3: What political and economic factors affect dissemination of information about HIV/AIDS treatment and prevention? What role do the media play?

Additionally, in the wake of widespread media coverage about selective reporting of clinical drug trials, U.S. political leaders have questioned “whether the pharmaceutical industry has systematically misled physicians and patients by suppressing important data on their drugs”

(Graham, 2004: 21). These concerns, combined with reports documenting the deplorable state of public health care, are spurring public interest in complementary and alternative medicine [CAM], creating a more positive climate for alternative treatments in general (Tindel, 2005; Abraham, 2007). Likewise, in the UK, recent media coverage of controversial public funding for CAM, which is strongly supported by Prince Charles, has brought the topic to the forefront of public attention (Booth and Henderson, 2006).

Examining the media's role from a dissemination standpoint, clearly new interactive methods of building social networking communities have revolutionised how target audiences access and use information, significantly altering the international dialogue about HIV/AIDS. Many of the campaigns analysed rely heavily on online media, especially if they are targeting young, politically active, or well-educated audiences.

In toto, these factors form a complex and politically charged environment that influences dissemination of information about health care options and offers a multitude of possibilities for fresh interpretations of the cross-disciplinary relationships and concepts involved.

II. DECONSTRUCTING 18 HIV/AIDS SOCIAL MARKETING CAMPAIGNS

Research question 4: What are specific examples of recent HIV/AIDS social marketing campaigns?

Dozens of social marketing HIV/AIDS campaigns are underway in the three countries targeted for this study. Campaigns from Mexico, Uganda, and the U.S. demonstrate how NGOS and government leaders use social marketing to motivate changes in cultural attitudes and health-related behaviours. The campaigns selected for study:

MEXICO

1. Investing in People

This five-year initiative to reduce barriers to behaviour change and care seeking began in 2003. It is a localised version of a series of similar campaigns currently underway in several countries. Focused in Mexico City, where the largest number of HIV/AIDS cases is found, "Investing in People" is the joint effort of a half-dozen international, national, and local organizations. A key technique is personal communication through workshops and conference presentations conducted by trained female advocates and local HIV/AIDS leaders.

2. VIVE Condoms

The VIVE condom brand, popular in several Latin American countries, is the centrepiece of recent "Vida" educational campaigns directed to prisoners as well as other high-risk groups in southern and central Mexico. Population Services International, the primary sponsor for this campaign, uses both traditional [pharmacies, health clinics] and non-traditional [bars, hotels, brothels, salons] sales outlets to make condoms accessible and socially acceptable. The slogan is "Vive to mejor momento" or "live your best moment."

3. VIDA Digna (Life with Dignity)

Reducing stigma and discrimination experienced by sex workers, gay men, men who have sex with men, drug users, and people living with AIDS is the central purpose of the three-year “Vida Digna” campaign, launched in 2005 by the Colectivo Sol alliance and funded by GlaxoSmithKline. The campaign is centred in the central states of Mexico, a conservative area characterised as having “the weakest civil society response to AIDS.” Vida Digna uses anonymous testimonials to urge tolerance and acceptance of people’s differences.

4. *Programa Hombres (Project H)*

Links between traditional gender attitudes and the spread of AIDS prompted a partnership of NGOs to develop Programa Hombres. This five-year initiative has been used in more than twenty countries, including Mexico, to persuade young Latino men to question traditional norms related to manhood. An extensive media mix includes educational videos available in three languages—Spanish, English, and Portuguese—interactive workshops, and collateral materials as well as radio, outdoor media, and direct mail. The campaign slogan, “In the Heat of the Moment,” urges use of the Hora H condom brand, manufactured by the makers of Durex condoms and distributed in non-traditional venues such as funk balls and cafes.

5. *Programa Mujeres (Project M)*

Building on their success in educating young men about the costs of traditional macho culture, in 2005 the Program H partners and World Education launched Programa Mujeres to encourage young women to take control of their sexual and reproductive health. This social marketing campaign was based on research that included a review of Latin American literature to define the concept of female empowerment, focus group discussions with groups of young women aged 14-24 who lived in marginalised communities outside Queretaro, Mexico, and interviews with empowered young women.

6. *SPNS Border Initiative*

The SPNS [Special Projects of National Significance] Border Health Initiative is administered by the U.S. Department of Health and Human Services to raise awareness about HIV and to make testing and care more accessible. Relying heavily on social marketing, SPNS utilises Spanish language media to blanket the transient communities with “bold” HIV messages designed to “reverse the cultural norm that topics related to sexuality, including HIV, are not discussed in public” and to educate Latinos about the risk of the disease. SPNS border outreach initiatives are designed to be culturally sensitive to the Latino culture.

UGANDA

1. *ABCs (Abstinence, Being Faithful and Condoms)*

This campaign takes a moralistic approach—“Sex can wait until marriage”—and uses outdoor media as well as local spokespeople such as community leaders and ministers to urge abstinence before marriage and fidelity to spouses. Practical AIDS information is provided and condom use is also advocated to reduce risk of infection. This program and others like it have generated international controversy about whether condoms are effective in reducing HIV prevalence and raising associated concerns about increased promiscuity.

2. *Afford*

AFFORD is a five-year health marketing initiative led by the Johns Hopkins Bloomberg School of Public Health and funded by the U.S. Agency for International Development. Designed to increase accessibility and affordability of AIDS products and services, the campaign promotes Protector brand condoms, Pilpan oral contraceptives, and Inject injectable contraceptives. Consumers are encouraged to use these products properly and have access to them at subsidised rates. A centrepiece of the campaign is “The Good Life Gameshow,” an entertainment education quiz show using community interaction, and radio and television shows.

3. *PMTCT (Prevention of Mother to Child Transmission)*

“The Social Marketing Approach to PMTCT” is a Population Services International [PSI] project that uses a branded franchise network of trained midwives to help pregnant women reduce transmission risk during birth. The midwives are also trained on HIV testing procedures and counselling skills. The central message is that it is possible to have an HIV-negative baby even when both parents are HIV positive. Since 2003, a broad media mix has disseminated this message to male partners of pregnant women 25-45, primarily in low-income, low-literary, rural areas.

4. *Trust Condoms*

Designed to reach people in rural, isolated areas of the country, particularly women, this campaign’s central purpose is to launch a new condom brand. The stated rationale for the effort, which began in 2006, is that combating the AIDS pandemic must go hand-in-hand with sensitising those who live in outlying areas. The British and Norwegian governments contributed funds for the campaign.

5. *Be a Man*

Targeted primarily to young men 15 to 24, this campaign was launched in 2006 to prompt reflection on the costs of traditional male attitudes and behaviours, which recent research has shown are contributing to an increase in HIV infections. “Society’s expectations of men are setting them up for failure,” according to Vincent Kiwanuka, the “Be a Man” campaign’s coordinator. The media mix heavily utilises radio drama and television, including broadcasts during the World Cup. The goal is to encourage sexual relationships based on mutual respect.

6. *Sugar Daddies*

Addressing the widespread problem of cross-generational sex (sex with a person at least 10 years older), this campaign, begun in 2004, seeks to raise awareness of the dangers of “sugar daddy” relationships. This practice is a major reason HIV infection rates are six times higher for teenage girls than for their male counterparts. Target audiences include young women 15 to 24, their parents (who often encourage such relationships), and older male partners. The PSI-sponsored initiative features recognised male role models such as Uganda’s Minister of Ethics and Integrity Tim Lwanga urging men to “stop preying on young girls.”

UNITED STATES

1. *We all have AIDS*

Launched in 2005 on World AIDS Day, this campaign created by American designer Kenneth Cole is heavily supported by celebrities and prominent AIDS activists. The message is to reduce stigma associated with AIDS to prevent, contain, and eradicate the disease. The consistent theme for all ads is “We all have AIDS...if one of us does.” International celebrities participating include President Nelson Mandela, Arch Bishop Desmond Tutu, Sharon Stone, Will Smith, and Sir Elton John.

2. ONE

With more than sixty partners, this campaign’s purpose is to rally Americans one by one to push for increased donations to fight poverty and AIDS. The campaign has a broad target audience, ranging from students to ministers to punk rockers to soccer moms. The call to action is “We’re not asking for your money, we’re asking for your voice.” In line with this approach, June 11, 2007, ONE launched ONE Vote ’08, its “largest and boldest initiative ever,” vowing to make extreme poverty and global disease an issue in the 2008 election.

3. *I am African /Keep a Child Alive*

This campaign, also heavily saturated with celebrities, promotes the idea that everyone has some DNA with connections to an African heritage, so all people should work together to help with the AIDS problem. Begun in 2005 and updated every year since, donations for AIDS drugs are particularly sought. “I am African” is linked with the “Keep a Child Alive” campaign, which seeks to help AIDS orphans in Africa by providing them with ARVs [treatment cocktails]. Images of celebrities such as Gwyneth Paltrow and Sting wearing “war paint” with the campaign slogan beneath has sparked controversy about the use of eye-catching visuals that “insensitively perpetuate stereotypical ways of thinking about AIDS or Africa.”

4. *Be the Generation*

This program seeks to create a supportive environment for HIV vaccine research by mobilizing existing community partnerships and networks to educate key communities about this research in twenty U.S. cities where HIV vaccine clinical trials are ongoing or planned. Coordinated media and collateral materials segment target audiences by gender, ethnicity, and lifestyle, showing images of two people, one older and one younger. Extensive educational materials are available online. The uniform message is that the young generation’s “great cause” is to end AIDS and that a vaccine is the best hope of accomplishing that goal.

5. *MTV Think*

This award-winning public information campaign began in 2006 and is notable for bringing MTV on board as a major sponsor. The goal is to reach sexually active 16- to 24-year-olds with information about HIV and related issues, since according to UNAIDS, half of new HIV infections worldwide are among people under the age of 25. Discussion of safe-sex issues, condom use, and HIV testing are urged through television and web media. According to sponsor The Kaiser Family Foundation, this is a “multi-platform, interactive community for the first generation of Americans who have lived their entire lives during the AIDS epidemic.”

6. *The New Faces of HIV in Houston*

Due to high HIV prevalence among African Americans in Houston, in 2002 the Harris County Hospital District and the Houston Department of Health and Human Services launched a social marketing campaign to raise awareness and increase testing among this population. Media include radio, public transit, direct mail, and brochures targeting women. Images of both men and women are featured in the materials, with the slogan, “We look just like you, but you don’t have to be like us. Do the right thing. Get tested.”

Research question 5: What commonalities and unique characteristics can be identified in this population of campaigns as regards purpose, sponsors, target audience, dissemination methods, media mix, messages, product promotion, and appeals used? What lessons have been learned so far?

The campaigns share a number of common concerns and objectives although each has a unique theme and a distinctive focus and approach. Each uses a customised media mix to disseminate messages to selected audience(s), but core commonalities are evident throughout. Behavioural models underlying the campaigns were carefully examined.

First and foremost, collaboration is essential; each campaign involves multiple organisations and community groups designed to build participation in and acceptance for individual and policy change. From a worldview, each country’s HIV/AIDS problem has far-reaching implications. Recognising that expanding HIV/AIDS populations will devastate the global economy, governments in both developing and industrialised countries, in conjunction with pharmaceutical companies such as Pfizer, have launched a variety of organised offensives, which include political commitment, law enforcement, government policy, social marketing, and community mobilisation (Pfizer, 2006). This global cooperation encourages alliances such as those forged to support the campaigns in this study.

Secondly, the campaigns all incorporate prevention strategies, with condom use being a frequent tactic. In keeping with its inclusive approach, social marketing assistance usually involves procuring and distributing pharmaceuticals, over-the-counter drugs, and condoms. It also supports capacity building and financial sustainability programs for non-government organisations [NGOs] or for-profit companies (USAID, 2005).

In recognition of cultural obstacles, the campaigns each address aspects of stigma and traditional cultural norms. USAID, whose infectious disease objectives are designed “to contain and reduce HIV/AIDS in vulnerable populations,” focuses on reducing barriers to behaviour change and thereby preventing the HIV/AIDS epidemic in countries such as Mexico from becoming generalised to the population at large (USAID *Health Profile*, 2005). It is generally recognised that changing how people view gender roles and erasing widespread prejudice against gays will be necessary to effectively combat HIV/AIDS.

A number of social marketing campaigns draw on research showing that in many cultures, young men often control how and when young women have sex. Some of the traditional gender norms the campaigns were designed to change are 1) Men should initiate sexual activity early in

life, 2) Men should have multiple sexual partners, 3) Men should maintain control over their female partners, and 4) Unsafe sex is more enjoyable than safer sex. Addressing these gender norms, especially among young people, is increasingly recognised as a vital strategy to prevent the spread of HIV infection (Promoting, 2006).

Modern-day mobility and lifestyle patterns are also considerations in crafting social marketing campaigns for at-risk populations, especially for migrant populations or in border areas. Studies of highly mobile groups such as truck drivers, seasonal employees, and sex workers have identified travel or migration as a factor related to increased HIV/AIDS prevalence. Higher rates of infection are also frequently found along transport routes and in border regions. In addition, migration and mobility also increase vulnerability to HIV/AIDS for the partners at home (*Population Mobility*, 2001: 4).

Persuasive messages for the campaigns are informed by the tenets of one or more established behavioural models. Early generations of HIV social marketing campaigns frequently built their messages around the health belief model, which uses fear or anxiety-arousing messages. In the long term, however, the use of fear appeals draws mixed responses, both from observers and from the targeted audiences. Hastings and colleagues noted fear appeals have been “embraced with enthusiasm by social marketers” (2004: 962), but cautions fear appeals, in addition to encouraging “health fatalism,” may actually have negative long-term effects on the brand. A more effective appeal, especially for young people, according to Backer, Rogers, and Sopory, is the positive rational/emotional approach, which uses fear to grab attention, then relates the fear to a positive outcome (Backer, *et al.*, 1992). The use of external incentives, central to most social marketing approaches, also has potential pitfalls because they can be interpreted as coercion or bribery and not deliver the long-term behavioural change desired (Dholakia and Dholakia, 2001: 498). The personal benefits inherent in self-interest appeals, however, are frequently used to advantage. Based on the well-established Maslow’s hierarchy of needs, self-interest appeals target common human needs ranging from physiological to safety, social, ego, and self-fulfilment (Wilcox, 2002).

Consequently, the current generation of social marketing campaigns is usually grounded in theoretical models other than fear or short-term benefits. In a report prepared for the UK’s National Social Marketing Strategy for Health, McDermott and colleagues (2006) found nutrition social marketing interventions were most frequently based on social cognitive theory, which emphasises observational learning and self-efficacy and is frequently used in campaigns where individuals have choices of how to respond to their environments (Lefebvre, 2001). A somewhat similar appeal is the behavioural decision making model, which uses risk comparisons and probability (Maibach and Parrott, 1995).

Another popular approach, according to McDermott’s report, was the transtheoretical model, known as “stages of change,” which assumes few people are ready to take action and must be moved through early stages of indecision. Lefebvre pointed out one of the few population-based models available to social marketers is diffusion of innovation, which segments any target into

types of adopters (innovator, early adopter, early majority, late majority, and laggard) and suggests the marketer begin with one or two segments (2001:507-515). On a broader policy level, upstream appeals often reference the goal of sustainable development, which takes a generational view and focuses on people's power to make decisions about the future of their society (Dubois, 2003). Typically, each social marketing initiative in this study combines aspects from several of these approaches to ensure acceptance and motivate lasting social change.

SUMMARY OF LESSONS LEARNED

Interviews with key informants revealed important lessons from campaign implementation. Most important are that successful campaigns: 1) Build local, national, and international alliances with common goals, 2) Recruit commercial sponsors for additional support, 3) Involve the target audiences from the outset, 4) Incorporate multimedia and multilingual tactics, 5) Utilize global support for women, 6) Construct trans-border alliances, and 7) Tackle once-taboo topics openly and candidly.

ANALYSIS AND EVALUATION

PRELIMINARY REFLECTIONS

After literature review, content analysis, and a number of semi-structured interviews were completed, it became clear that public communication about HIV/AIDS essentially revolves around three factors: culture, politics, and economics. The specifics of these issues vary from one country to the next, but the global implications cross all physical and conceptual boundaries.

Cultural:

Although categorised as an underground epidemic because of stigma and discrimination associated with the disease, HIV/AIDS has become everyman's—and everywoman's—problem. The actual prevalence numbers are uncertain because of reluctance to seek testing and treatment, but it is certain the global pandemic has spread each year since the first diagnosis in 1981. HIV/AIDS is now both a horizontal epidemic—affecting both sexes—as well as a vertical epidemic—being transferred from mothers to children.

Social marketing has gained widespread acceptance among international organisations as the tool of choice to motivate healthy lifestyle choices and to promote long-term policy changes. These initiatives typically use culturally sensitive approaches to build rapport and persuade. However, the visual/verbal presentation varies widely, depending on the target audience, and appeals vary from personal fear to altruistic concern. HIV/AIDS campaigns are typically targeted to audiences segmented by such factors as demographics [often using ethnicity, gender, or age], behaviour [such as sex workers], or lifestyle [frequently the gay community]. The Mexico and U.S. campaigns share many commonalities, but each reflects the audience's cultural differences. Finally, the phenomenon of complacency, sometimes called “disinhibition”(Abraham, 2007), may be driving a decline in safe sex practices, especially in Western countries where anti-retroviral drugs [ARVs] are widely available and considered a

kind of “cure” for the disease. This may be an example of misperceptions arising out of media and social marketing messages. Regardless, such a trend toward increased risky sexual behaviour among some groups calls into question the way HIV/AIDS information has been presented and perceived.

Political

Politics, the universal tactic of negotiation and compromise, comes into play at every level of human discourse and HIV/AIDS is no exception, as policymakers pursue agendas with a wide range of goals. Therefore, communication about the disease is invariably shaped by political concerns and people live or die as a result of those decisions.

From a practical standpoint, most campaigns emphasise prevention over treatment since there is no known “cure” for the disease and the primary political directive is to reduce rates of infection. It follows, then, that the downstream audience is often the target, with a focus on short-term behavioural change. Additionally, campaign evaluation is difficult, so measurement of effectiveness is frequently based on product successes such as increased condom sales.

As previously explained, collaboration is essential, but “communication by committee” is time-consuming and fraught with dissention. Still, most social marketing initiatives rely on partnerships that cross all boundaries—cultural, political, and geographical—but those partners may have differing viewpoints and aims. For example, in 2003 U.S. President Bush approved a five-year African aid package, saying his country had a “moral duty to act...[since] every day of delay means 8,000 more AIDS deaths in Africa and 14,000 more infections” (Campaigners, 2003). Bush’s plan was criticised because a third of the money slated for prevention had to promote abstinence rather than safer sex. Similarly, in countries like Mexico, which is predominately Roman Catholic, earmarking funds for a disease often associated with lifestyles or practices that conflict with the teachings of the church is a political hurdle.

An intriguing political response to the problem of attracting substantial support is the “positioning” of women as the primary victims— “the innocents”—in the battle against AIDS. This widespread rhetoric is designed to gain broad political support from faith-based organisations as well as from political leaders looking for the most acceptable route to public approval. Since women comprise about half of those infected worldwide, this marketing approach lends itself to a wide range of emotional/rational appeals. On the eve of the June 2007 EU summit, Bill Gates, a major contributor of funds to fight AIDS, appealed to the G8 countries to pledge new resources to “beat AIDS.” Gates said in part, “A top priority must be to address the prevention needs of women and girls...biologically, women are twice as likely as men to contract HIV. And many women—including those who are married—have little power to ensure their partners are faithful or use condoms” (Gates, 2007).

Financial

Whether the focus of the discussion is on individual health care, allotment of national resources, or international business, economics is a principal catalyst for action. AIDS represents both crisis and opportunity in the world of finance.

On the global scale, concern about projected costs of AIDS treatment is spurring policymakers to look for far-reaching solutions to avoid a future collapse of their health care systems. In terms of opportunity, the disease offers possibilities of massive profits for aggressive marketers. Promoting the use of condoms is such an integral part of HIV/AIDS social marketing that the practice has its own acronym: condom social marketing [CSM] (Condom, 2006). After realising sales in Mexico of 19 million condoms in 2004, the charitable organisation DKT International noted “dynamic social marketing” was essential to its success (DKT, 2005).

Even greater opportunities abound when it comes to conventional drug treatments for AIDS victims. In industrialised countries such as the United States, Americans with adequate insurance or personal funds can receive HAART [Highly Active Anti-retroviral Treatment] and monitoring for about £5,000/year. The cost of current treatments clearly separates the haves from the have-nots; only one-fifth of infected people in developing countries are receiving anti-retroviral therapy, primarily due to cost constraints.

In this rush to find effective treatments and ultimately a cure, there have been many stumbles and some documented deceits, such as selective reporting of clinical drug trials, as acknowledged by the International Committee of Medical Journal Editors (Graham, 2004:18). In 2003, the Panos Institute, a global network based in London that focuses on “amplifying the voices of the poor and marginalised,” issued a report examining how communication has been used to respond to the AIDS pandemic and calling for media to support informed debate rather than merely disseminating information (Missing, 2003).

Finally, some critics claim that medical innovations such as nanotechnology are changing the landscape of possibilities regarding treatment and new discoveries about the cause of AIDS are not being published in medical journals or pursued by conventional medicine (Siegal, 2003). The conventional medicine community, on the other hand, cites the benefits of international alliances and increased life expectancies for those receiving HAART (Sepkowitz, 2006).

As the international debate continues, these three factors—cultural content of social marketing messages about HIV/AIDS, the role of political expediency, and the economic realities of the global medical market created by the epidemic—form a complex and politically charged environment that influences public dissemination of information about health care options. The deeper beneath the surface one looks, the more relationships, conflicts, and knowledge gaps are uncovered, justifying further study.

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PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

D.3 Abstract Title: *Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States*

Presented at: AIDS 2008 - XVII International AIDS Conference, Mexico City

Dates: 3-8 August 2008

Publication: Abstract no. WEPE0802

<http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200719099>

Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States

R. Massingill

Issues: When world leaders completed their 25th annual tally of the unrelenting progress of the AIDS pandemic, it was sadly apparent women have achieved global infection equity. Women are biologically twice as likely to contract HIV as men and now make up more than 50 percent of adults living with the disease (UNAIDS, 2007). From the cradle to the grave, women's health destinies are often linked to cultural traditions of female acquiescence and powerlessness, as well as gender norms that give men control of when and how women have sex.

Description: To combat these too-common circumstances, alliances of local, national, and international groups are designing social marketing campaigns to empower women.

This study tells the human stories behind recent successful initiatives that targeted women at risk in three countries:

- Sugar Daddies addressed the widespread problem of cross-generational sex in Uganda, where HIV infection rates are six times higher for teenage girls than for their male counterparts.
- The New Faces of HIV in Houston was launched to increase testing among African American women, who account for 70 percent of the newly diagnosed HIV-positive women in the United States.
- Programa Mujeres encouraged Mexican women aged 14-24 to take control of their sexual and reproductive health in a society where traditional gender roles fuel annual increases in HIV infections.

Lessons learned: Although these empowerment projects were worlds apart in language and culture, each targeted highly vulnerable groups. Relying on global support for the HIV prevention needs of women, the campaigns demonstrated important lessons for future initiatives: forging collaborative partnerships with common goals and varied resources; involving the target audience at every stage; and crafting culturally sensitive multimedia, multilingual messages.

Next steps: Examples of materials and experiences from participants in these campaigns will inspire audiences to contribute ideas for continuing this worldwide empowerment of women.

PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

D.4.1 Poster Title: *Working toward a world without AIDS: how social marketing inspires long-term cultural change*

Presented at: First German-Austrian Swiss AIDS-Congress SODAK 2009, St. Gallen, Switzerland

Dates: 24-27 June 2009

Poster published at www.soedak2009.com

Actual Size of Poster: 32" x 48"

D.4.2 Abstract Title: *Working toward a world without AIDS: how social marketing inspires long-term cultural change*

Published in: *European Journal of Medical Research*, 14.1 (2009) p. 32

Working Toward a World Without AIDS:

How Social Marketing Inspires Long-Term Cultural Change

Ruth Massingill, University of Teesside (England), Sam Houston State University (USA)

From the machismo mindset of Latin America to the Sugar Daddy tradition of African countries to the widespread acceptance of casual sex in the United States, cultural norms are recognized as complicit in the global HIV/AIDS epidemic. Preventing the continued spread of AIDS infections requires permanently altering the social fabric

of such societies. Social marketing—using marketing techniques to achieve social goals—is widely used to motivate high-risk groups to adopt healthy behaviors, which often requires altering generations-long cultural traditions relating to sex and gender.

For more than two decades, social marketing has been a vital tool in this cultural battle against HIV/AIDS.

RESEARCH QUESTION:

Which social marketing approaches have been successfully used to motivate long-term changes in cultural norms that contribute to the spread of HIV/AIDS?

From content analysis and interviews with key informants, 18 campaigns in three countries were compared using cross-tabulation matrices.



Almost 30 years after the onset of HIV/AIDS, the pandemic is a political, economic and health crisis. Public events such as World AIDS Day urge increased political action.

Matrix A: Crafting the Campaign

	NAME	DATES	MESSAGE	PURPOSE*	AUDIENCE*	SPONSORS*	FRAMES*	THEORY	ROOTS	REF	ADAPTED
Mexico	Border Initiative	2004	Tu No Me Conoces	1, 2	D, FM2, 3 MSM, farmers	1, 2, G	1, 4	Health Belief	Yes	No	
	Investing in People	2003-8	Abstinence, fidelity	2, 4	D, FM at risk groups	1, 2, 3, G N P	2, 4	Health Belief	No	No	
	Menos Etiquetas	2008-	Gender equity	3, 4	D, FM1	2, 3, G N P	2, 3	Stages of Change	Yes	No	
	Programa Hombres	1999-04	Rethink masculinity	4	U/D, M1	1, 2, 3, N P	3, 5	Social Cognitive	Yes	Yes	
	Programa Mujeres	2005-	Change gender norms	4	U/D, F1	2, 3, G N P	3, 6	Social Cognitive	Yes	Yes	
Uganda	VIDA Digna	2005-8	Accept differences	2	D, PLWHA, CSW, MSM	1, 2, N P	3, 6	Diffusion of Innovation	Yes	Yes	
	ABCs	2002-6	Abstain, Be Faithful, Condom	2, 3	D, FM1, 2, general pop	1, 2, 3, G N P	2, 5	Health Belief	Yes	Yes	
	Afford Good Life	2006-	Affordable products	2, 3	D, FM, sexually active pop	2, 3, C G N P	2, 3, 5	Diffusion of Innovation	No	No	
	Be a Man	2006-	Stop transactional sex	4	D, FM1	1, 2, 3, C G N	2, 3	Social Cognitive	Yes	No	
	One Love	2006-	"Zero-grazing"	3, 4	D, FM, sexually active pop	2, 3, C G N	2, 3	Social Cognitive	Yes	Yes	
USA	PMTCT	2002-	Protect babies from HIV	3, 4	D, M2 w/ pregnant partners	2, 3, G N P	2, 4	Reasoned Action	Yes	Yes	
	Sugar Daddies	2004-	Stop cross-gen sex	3, 4	U/D, F1, M3	1, 2, G P	1, 4	Reasoned Action	Yes	Yes	
	Be the Generation	2005-6	HIV vaccine best hope	5, 6	U/D, Broad target	2, N P	2	Social Cognitive	Yes	No	
	I am African	2005	We are all African	2, 6	U/D, FM2, 3 parents	3, C N	2, 5	Social Cognitive	Yes	No	
	MTV Think	2001-	Be safe, get tested	1, 3	D, FM1, MSM	3, C N	2, 4	Health Belief	Yes	Yes	
USA	New Faces of HIV	2002-4	Get tested for HIV	1	D, FM2, African Americans	1, G N	2, 3	Reasoned Action	Yes	Yes	
	ONE	2002-	Change world one by one	5, 6	U/D, broad target	1, 2, 3, C N P	3, 5	Social Cognitive	Yes	Yes	
	We All Have AIDS	2005	Solidarity among mankind	2, 5, 6	U/D, broad target	3, C N	1, 4	Diffusion of Innovation	Yes	No	

*KEY: PURPOSES: 1. Seek Testing 2. Stigmatization 3. Prevention 4. Cultural Change 5. Political Mobilization 6. Donations/Volunteers AUDIENCES: Upstream Downstream, Female Male 1. 15-24 2. 25-34 3. 35+ SPONSORS: 1. Local 2. National 3. Corporate Government 4. Nonprofit Pharma FRAMES: 1. Consequences 2. Prevention 3. Self-efficacy 4. Sources of HIV/AIDS 5. Benefits 6. Barriers



Cultural norms often contribute to the spread of HIV/AIDS, many campaigns address issues such as gender equity.

Interpersonal communication that provokes thoughtful discussion is a vital component of effective campaigns.



New media reach high-risk, tech-savvy audiences, especially the 15-24 group. The ONE campaign has 100 partner organizations and two million members, many on college campuses.

Matrix B: Disseminating the Message

	NAME	TRAD. MEDIA*	NEW MEDIA*	PRODUCTS	INTERVENE	EVENTS	OUTCOME	SPEAKERS*	VISUAL	VERBAL	ACTION
Mexico	Border Initiative	1, 2, 5, 6	1	None	1-800 number	None	Quantified	Media	Realistic	2nd person	Yes
	Investing in People	3	1	Condoms	Advocacy seminars	Yes	Not tabulated	Comm leaders	Realistic	2nd person	Yes
	Menos Etiquetas	2, 3, 4	1, 3, 4	Condoms	Peer educators	Yes	Ongoing	None	Abstract	2nd person	Yes
	Programa Hombres	2, 3, 4, 5	1, 2	Hora H condoms	Peer workshops	Yes	Quantified	None	Cartoon	3rd person	Yes
	Programa Mujeres	2, 3	1, 2	Video	Peer workshops	Yes	Quantified	None	Cartoon	3rd person	Yes
Uganda	VIDA Digna	2, 6	1	Condoms	Training	Yes	Not tabulated	Leaders, Anon	Realistic	1st/3rd person	Yes
	ABCs	3, 5	1	Condoms	HIV ed in schools	Yes	Quantified	Anonymous	Realistic	1st person	Yes
	Afford Good Life	2, 3, 5, 6	1	Condoms	Hotline, discussions	Yes	Ongoing	TV personalities	Realistic	1st, 2nd per	Yes
	Be a Man	1, 2, 3, 5, 6	1	None	Games/contests	Yes	Ongoing	Anonymous	Realistic	1st person	Yes
	One Love	1, 3, 5, 6	1	None	Radio call-ins	Yes	Ongoing	TV personalities	Realistic	1st person	Yes
USA	PMTCT	2, 3, 5	1	Nevirapine, test kits	Health training	Yes	Goal not met	Actors	Realistic	1st person	Yes
	Sugar Daddies	3, 5, 6	4	None	Anti-AIDS clubs	Yes	Ongoing	Comm Leaders	Realistic	2nd person	Yes
	Be the Generation	1	1	None	No	Yes	Cancelled	Anonymous	Realistic	1st person	Yes
	I am African	1, 6	1, 4	None	No	Yes	Uncertain	Celebrities	Realistic	1st person	Yes
	MTV Think	6	1, 2, 4	None	Hotline	Yes	Ongoing	TV personalities	Realistic	1st person	Yes
USA	New Faces of HIV	2, 3, 4, 5	1	Condoms/stickers	Hotline	None	Quantified	Local PLWHA	Realistic	2nd person	Yes
	ONE	3	1, 3, 4, 5	Branded items	No	Yes	Quantified	Celebrities	Realistic	1st person	Yes
	We All Have AIDS	1, 3, 5	1	Special T-shirt	No	Yes	Uncertain	Celebrities	Realistic	1st person	Yes

*KEY: TRADITIONAL MEDIA: 1. Print Ads 2. Print Collateral 3. Out of Home 4. Direct Mail 5. Radio 6. TV NEW MEDIA: 1. Website 2. UTube 3. Email 4. Social Media 5. Other SPOKESPERSONS: 1. Celebrities 2. Community Leaders 3. Anonymous 4. Audience Members 5. Media Personalities 6. Actors



Abstinence or safe sex? Condom social marketing creates moral controversy.



Audience research and specific goals must be established in advance. Campaigns with too-broad targets and unclear calls to action are difficult to quantify.

Findings indicated successful HIV/AIDS campaigns are sensitive to the cultural context of the target audience, using multilingual and multimedia communication. Initiatives with the most lasting results involved members of the target

audience at every stage, from program design through implementation and evaluation. Also, key informants agreed building long-term partnerships and coalitions is challenging but imperative for significant behavioral changes. Overcoming social, political and economic barriers requires cooperation by policymakers across the globe.

Next, an anonymous survey will measure the target audience's knowledge and perceptions of HIV/AIDS information, with the goal of designing an effective communication model.



Celebrities and activists offer visibility to HIV/AIDS campaigns.

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**Working toward a world without AIDS:
How social marketing inspires long-term
cultural change**

Ruth E. Massingill

University of Teesside, Business School, Huntsville, United States

From the machismo mindset of Latin America to the Sugar Daddy tradition of African countries to the widespread acceptance of casual sex in the United States, cultural norms are recognized as complicit in the global HIV/AIDS epidemic. Preventing the continued spread of AIDS infections requires permanently altering the social fabric of such societies. Social marketing—using marketing techniques to achieve social goals—is widely used to motivate high-risk groups to adopt healthy behaviors, which often requires altering generations-long cultural traditions relating to sex and gender. For more than two decades, social marketing has been a vital tool in this cultural battle against HIV/AIDS.

This paper addresses the question: Which social marketing approaches have been successfully used to motivate long-term changes in cultural norms that contribute to the spread of HIV/AIDS?

Description: To answer this question, the researcher established criteria and selected 18 recent HIV/AIDS social marketing campaigns for content analysis. Follow-up consisted of semi-structured interviews with key informants connected to the campaigns. Informed by this secondary and primary information, the campaigns were compared using a cross-tabulation matrix.

Conclusions: Findings indicated that successful campaigns are sensitive to the cultural context of the target audience, using multilingual and multimedia methods of communication. Initiatives with the most lasting results were those that involved members of the target audience at every stage, from program design through implementation and evaluation. Additionally, key informants agreed that building long-term partnerships and coalitions was challenging but imperative to achieving significant behavioral changes. The complexity of overcoming social, political and economic barriers required cooperation by policymakers across the globe.

Next steps: The researcher is developing an anonymous quantitative survey to determine perceptions of AIDS treatment and prevention information as presented in recent social marketing campaigns.

2 Prävention / Prevention

P200

Abstract zurückgezogen

P201 (PW)

**Prävention für Menschen mit HIV:
Sexualverhalten und beeinflussende Faktoren**

Dunja Nicca, Synove Daneel, Pietro Verzazza

Infectious Diseases Unit, Hospital St. Gallen, St. Gallen, Switzerland

Hintergrund: Präventionsinterventionen sollten auch Menschen die bereits mit einer HIV-Infektion leben einschliessen. Während im amerikanischen Raum solche Programme bereits Erfolge zeigten, gab es in der Schweiz und vielen anderen europäischen Ländern bisher keine systematischen Programme. An einer ambulanten Sprechstunde wurde ein theoriebasiertes Pilotprogramm zur Unterstützung von präventivem Sexualverhalten von Menschen mit HIV entwickelt und umgesetzt. Erste Resultate, zu eingeschlossenen Patienten in Bezug auf deren Sexualverhalten werden präsentiert.

Methodik: Präventionsinterventionen werden alle 6 Monate durch geschulte Fachpersonen (Ärzte/Pflegende) durchgeführt. Von März bis Dezember 2008 wurde bei 332 Personen eine erste Intervention durchgeführt. Demographische und gesundheitsbezogene Variablen wurden mit dem Fragebogen der Schweizerischen HIV Kohortenstudie erfasst. Sexualverhalten und Motivation wurden mit einem für die Evaluation entwickelten Fragebogen nach jeder Intervention durch Fachpersonen erfasst. Für die Analyse wurden 3 Gruppen mit unterschiedlichem Sexualverhalten verglichen.

Resultate: Von 401 in der Sprechstunde registrierten Patienten erhielten 83% (332) eine erste Präventionsintervention. Der mittlere Alterswert war 46 Jahre (IQR 40-50), 69% davon waren Männer. 122 (37%) Patienten gaben an, keinen Sex zu haben; 193 (58%) gaben sicheres Sexualverhalten und 17 (5%) nicht präventives Sexualverhalten an. Diese drei Gruppen waren vergleichbar bezüglich: Alter, Geschlecht, Ausbildung, Ethnie, Transmissionsgruppe. Signifikante Unterschiede zwischen den Gruppen zeigten sich, in Bezug auf: sexuelle Präferenz, fester Partnerschaft, Einzelhaushalt, Alkoholkonsum, CD4 Zellzahl, und HIV-RNA. Die Gruppe mit nicht präventivem Sexualverhalten zeigte signifikant häufiger bisexuelle Präferenz, Alkoholkonsum und HIV RNA>400.

Schlussfolgerungen: In den ersten zehn Monaten konnte ein hoher Anteil der hier erfassten Patienten erreicht werden, was als gute Integration des Programms in den klinischen Alltag interpretiert werden darf. Unterschiede zwischen den Gruppen zeigten sich vor allem im Verhaltensbereich und in Bezug auf Gesundheitsfaktoren, dies sollte in der Entwicklung von Interventionen berücksichtigt werden.

PEER-REVIEWED AND PUBLISHED WORK FROM THIS THESIS

- D.5.1 Book Cover Image:** *Social marketing for public health: global trends and success stories* (2011) Cheng, H., Philip Kotler, P., and Lee, N., eds., Sudbury, Mass., Jones and Bartlett
- D.5.2** Massingill, R., Chapter 4: *Love, sex, and HIV/AIDS: using social marketing to redefine gender norms among Mexican youth*



Social Marketing for **PUBLIC HEALTH**

GLOBAL TRENDS AND SUCCESS STORIES



Hong Cheng | Philip Kotler | Nancy R. Lee

APPENDIX E

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

- E.1 Poster, *Curing AIDS: why successful HIV/AIDS treatments are unknown to world government policy makers* (2005).
- E.2 Poster, *Social marketing strategies for combating HIV/AIDS in developing countries: examining traditional campaigns* (2006).
- E.3 Abstract, *Getting the word out: promoting cures through social marketing* (2006).
- E.4 Abstract, *A practical approach to cultural change: using social marketing to combat HIV/AIDS in Mexico* (2007).
- E.5 Workshop handouts, *Motivating change: visual and verbal persuasion in HIV/AIDS social marketing* (2007).
- E.6 Poster, *Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States* (2008).
- E.7 Poster, *Positive or negative, HIV/AIDS knowledge & perceptions* (2010).

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.1 **Poster Title:** *Curing AIDS: why successful HIV/AIDS treatments are unknown to world government policy makers*

Presented at: Fifth International Conference on the Capability Approach, UNESCO, Paris, France

Dates: 11-14 September 2005

Actual Size of Poster: 33" x 21"

Curing AIDS: Why Successful HIV/AIDS Treatments are Unknown to World Government Policy Makers

Dr. James W. Adams, University of California, Los Angeles
Ruth Massingill-Pate, Sam Houston State University

INTRODUCTION

To most of the world, an AIDS diagnosis is tantamount to a death sentence. This is both tragic and unnecessary. Physician-led clinics in Uganda, Kenya, and South Africa have demonstrated successes in treating HIV/AIDS, yet few health care industry professionals know about these curative therapies. Almost none of the world's government policymakers acknowledge them. While AIDS has been growing into a global epidemic, the health communications profession has been evolving toward a more sophisticated and pharmaceutical company dominated marketing approach.



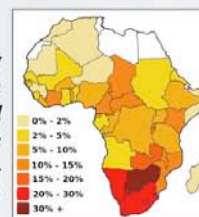
ENGAGING WITH THE CAPABILITY APPROACH

- ❑ The traditional medical establishment uses its influence and financial clout to control dissemination of health information, violating the most intrinsic human freedom and endangering the most basic of human capabilities: access to state-of-the-art, life-saving health knowledge.
- ❑ HIV/AIDS destroys people's capacity for resilience.
- ❑ Emotional appeals (*i.e.*, fear) are ignored by the public since no action can be taken to deal with vulnerabilities.
- ❑ AIDS has become an international for-profit business despite its threat to sustainable development.
- ❑ A focus on the bottom line, rather than on human welfare, represents a collision of medical ethics against economics.

Quantum medical diagnostics and treatment, such as that shown in the photograph at left, will become standard medical practice in the 21st Century. Many of these modalities should be routinely used in conjunction with HIV/AIDS treatments.

PARIS UNESCO, 11-14 Sept. 2005

The debilitating effects of AIDS on the work force and health resources are a macro-economic disaster.



The number of HIV/AIDS infected now surpasses 50 million. In many parts of Africa, AIDS is the main threat to social sustainability; half of all 15-year-olds will die of the disease.

WHAT IS HIV/AIDS?

The *Lancet* has reported for more than 12 years that people who are HIV-positive do not necessarily develop AIDS. Dr. Luc Montagnier, the discoverer of the HIV virus, has stated that HIV is "not a sufficient cause of AIDS on its own." If the definition of HIV/AIDS is incorrect, it follows then the possibility exists of successful new, "alternative" treatments.

CONCLUSION

Lack of knowledge about alternative HIV/AIDS treatments is affecting public policy decisions. Government policy makers, the international healthcare community, and AIDS victims are unable to participate in making informed choices, curtailing their capabilities and endangering future generations.



Social marketing for AIDS often focuses on prevention messages and brand-specific advertising, especially with respect to condom use.

This approach fails to inform the public that micro-viruses easily penetrate the molecular structure of latex condoms, affording minimal protection.

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.2 **Poster Title:** *Social marketing strategies for combating HIV/AIDS in developing countries: examining traditional campaigns*

Presented at: Social Marketing Advances in Research and Theory Conference (SMART), Banff, Canada

Dates: 19-21 October 2006

Actual Size of Poster: 30" x 24"

Social Marketing Strategies to Combat HIV/AIDS: Analysing Recent Campaigns in Three Countries

Ruth Massingill, University of Teesside (England) & Sam Houston State University (USA)

INTRODUCTION

For three decades, social marketing has motivated low-income and high-risk audiences to adopt healthy behaviours. Social marketing is a key tactic for combating HIV/AIDS, both in developing and industrialized countries. Campaigns often focus on prevention messages while addressing stigma and cultural concerns.

As the pandemic's death toll climbs, however, the effectiveness of some HIV/AIDS campaigns is being challenged. Critics charge social marketing messages are not always on target and voice concerns about international drug companies' involvement in product selection and information dissemination.

Nevertheless, many commonalities emerge when examining populations of social marketing campaigns in countries with widely divergent political, cultural, and economic positions in the world community.



UNITED STATES



The power of knowledge—Current U.S. campaigns feature celebrities such as Iman (left), global ambassador for Keep a Child Alive, and a host of other stars and AIDS activists to reduce ignorance and stigma. Designer Kenneth Cole created "We All Have AIDS." In 2003, CBS, Viacom and the Kaiser Family Foundation launched "Know HIV/AIDS."



MEXICO

Revising cultural norms—Programas Hombres (below) and Mujeres (below left) are designed to change how young men and women view gender roles and to urge them to consider the costs of traditional macho culture. Media include print, outdoor and video. The campaigns are sponsored by alliances of NGOs and government organizations.

METHODOLOGY

A population of six HIV/AIDS social marketing campaigns was selected in each of the three countries targeted for this study. The countries chosen represented diverse situations regarding the disease and offered convenient resources and contacts. Other criteria included currency, implementation by a recognized international organization, and sponsorship by one or more major pharmaceutical companies.

Points of analysis for the 18 campaigns included: Purpose, target audience segmentation, campaign dissemination, media mix, message presentation (defined by characteristics of text, image and sound), use of celebrities, references to localized roots, product promotion and type of appeal(s) employed.

HYPOTHESES

- International organizations, in conjunction with pharmaceutical companies, use social marketing to selectively disseminate HIV/AIDS prevention and treatment information.
- Social marketing campaigns for HIV/AIDS tend to be targeted toward specific audiences in rural and/or economically depressed communities.
- These campaigns establish conventional products and treatments as the norm, ignoring increasingly accepted alternative modalities.



UGANDA

Selling condoms and abstinence—AIDS social marketing often focuses on brand-specific advertising to rural areas, as with the Population Services International 1990s brand, Prudence, and its newest product, Trust. PSI's "Sugar Daddy" campaign uses community role models such as Tim Lwanga, Ugandan minister of ethics and integrity, to discourage cross-generational sex. Targets are older men, young women and parents of young girls.

OUTCOMES

The information from this comparative content analysis, conducted by Ruth Massingill and research assistant Lauren Maddox, will provide the basis for semi-structured interviews with opinion leaders involved in social marketing campaigns—marketers, humanitarian leaders and medical practitioners (both conventional and alternative). Interviews will explore the rationale behind the content choices, cultural influences and economic factors influencing dissemination of HIV/AIDS information.

At the conclusion of the project, the researcher will have created and tested a communication model designed to evaluate changes in perceptions and understanding regarding health choices available to prevent and treat HIV/AIDS.

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.3 **Abstract Title:** *Getting the word out: promoting cures through social marketing*

Presented at: AIDS in Culture III: Explorations in the Cultural History of AIDS, Mexico City

Dates: 9-12 December 2006

Panel Abstract for:

Explorations in the Cultural History of AIDS III, Mexico City, Dec. 9-12, 2006

MAKING HISTORY: CURING HIV/AIDS WITH NANOTECHNOLOGY

PANEL SESSION INTRODUCTION

HIV/AIDS has killed at least 28 million people since 1982 (USAID, 2006). The number of HIV/AIDS infected now surpasses 50 million. In the 25 years since the first reported cases of HIV/AIDS in 1981, the disease has become a global pandemic. Unfortunately, the epidemic's history is a story of largely unfulfilled hopes for various treatments.

However, new nanotechnology treatments are offering solutions. In 2005, silver nanoparticles were demonstrated *in vitro* to attach and inhibit HIV-1 from binding to host cells through size-dependent interaction (*see*, Elechiguerra, *et al.*, Interaction of silver nanoparticles with HIV-1, *J. Nanobiotechnology*. 2005, 3, 6.). In 2006, U.S. physicians demonstrated remarkable results in follow-up human pilot programs in Texas.

Social marketing will be a key tactic for informing both policy makers—and the public—of these successes, because social marketing can operate in the maelstrom of cultural, political, economic and social concerns.

PART I: BRIEF HISTORY OF HIV/AIDS TREATMENTS

The history of drug treatment regimens for HIV/AIDS is complex. It is complicated by problems with toxicity, compliance, side effects and cost. In 1987, AZT (zidovudine) was the first drug approved for treatment of AIDS. By the mid-1990s, a number of new drugs were being developed, such as Highly Active Anti-Retroviral Therapy (HAART). HAART treatment involves a combination of three classes of drugs: protease inhibitors, nucleoside reverse transcriptase inhibitors and non-nucleoside reverse transcriptase inhibitors, all of which interfere with the enzymes the virus uses to replicate itself. A viral load below 50—the level at which the virus is no longer detectable in blood—is the goal of therapy, but is seldom achieved.

Newer research shows, however, that the most effective drug therapies fail to prevent replication of the virus. This unfortunate result makes eliminating HIV with antiretroviral therapy unrealistic. Also, the virus often develops resistance during therapy, resulting in a steady viral load increase. Additionally, co-infections are on the rise. These co-infections include both fungal and bacterial infections, as well as common viral infections such as CMV (cytomegalovirus, which affects vision) and viral pneumonia.

Fortunately, nanotechnological solutions to HIV/AIDS hold great promise. The interaction of nano- and sub-nanoparticles with biomolecules and microorganisms is an expanding field of research (*see, e.g.*, Elechiguerra, *et al.*, Interaction of silver nanoparticles with HIV-1, *J. Nanobiotechnology*. 2005, 3, 6.).

Medical literature shows a variety of viruses have been successfully treated with silver-based drugs (Rentz, Viral pathogens and severe acute respiratory syndrome: Oligodynamic Ag⁺ for direct immune intervention, *J. Nutritional & Environmental Medicine*. 2003, Jun; 13(2): 109-18).

Emerging medical studies confirm the stellar, broad-spectrum virotoxic efficacy of oligodynamic noble metals both *in vitro* and *in vivo* (Gordon & Holtorf, A Promising Cure for URTI Pandemics, Including H5N1 and SARS: Has the Final Solution to the Coming Plagues Been Discovered? [Part II]. *Townsend Letter*, Feb/Mar 2006. This includes some of the most formidable viral organisms like HIV (including co-infections) (*Id.*; *see also*; Dean, *et al.*,

Reduction of viral load in AIDS patients with intravenous mild-silver protein—Three case reports, *Clinical Practice of Alternative Medicine*, Spring 2001; Oka, *et al.*, 1994; Hussain, *et al.*, Cystine protects Na, K-ATPase and isolated human lymphocytes from silver toxicity, *Biochem. Biophys. Res. Comm.*, 1992, 189.1444-1449; Aiken, In vitro MIC Test Against HIV-1, published account via email, AA-90 Results. Vanderbilt School of Medicine, Dec. 16, 1997; *et al.*, 2005; Zhong-Yin, *et al.*, Zinc inhibition of rennin and the protease from Human Immunodeficiency Virus Type 1, *Biochemistry*, 1991 Sept 10.30(36): 8717-21).

This portion of the panel and supporting paper will briefly discuss the 25-year history of HIV/AIDS treatments, as well as present a synopsis of current nanotechnology treatments.

PART II: U.S. CASE STUDIES (2006)

In 2006, U.S. physicians operating under Investigational Review Board (IRB) authority demonstrated highly encouraging results using silver nanoparticles to treat HIV/AIDS patients during a pilot program in Texas. This pilot program followed up a University of Texas (Austin)—University of Mexico (Monterrey) study published in 2005, which demonstrated silver nanoparticles *in vitro* attached to and inhibited HIV-1 from binding to host cells through size-dependent interaction (*see*, Elechiguerra, *et al.*, Interaction of silver nanoparticles with HIV-1, *J. Nanobiotechnology*. 2005, 3, 6.).

Under this IRB program, patients received oral-only administration of tiny silver particles set in water. HIV-infected patients, after examination and blood test, orally ingested a nanoparticle-sized solution for 30 days, then retested for improved CD4 counts and viral load. The program consisted of an initial physician examination, two blood tests (one at 15 days, the last at 30 days) to measure CD4 and viral loads, then a final analysis of results.

Patients in this pilot program were on both conventional therapy and non-conventional therapy. The best results were obtained with patients who were not on conventional therapy. One HIV-positive patient showed a remarkable drop of over 68% viral load in only 15 days.

This portion of the panel and supporting paper are based upon three case studies from the pilot program.

PART III: GETTING THE WORD OUT: PROMOTING CURES THROUGH SOCIAL MARKETING

For more than three decades, social marketing has been widely used to motivate low-income and high-risk audiences. Where successful treatments exist, social marketing should now be used to inform governmental policy makers and the public of their existence. This appears especially true with new nanotechnological treatments now in the process of being made available.

Social marketing has been a key tactic in combating HIV/AIDS, both in developing and industrialized countries, for the past 20 years. Social marketing campaigns have previously focused on prevention and treatment messages; yet, these campaigns have also addressed the cultural concerns and stigma related to the disease.

In Mexico, where the increase in new HIV cases has been continuous since 1981, social marketing is the tool of choice for promoting positive change, both for individuals (downstream audiences) and for broader social policy (upstream audiences), with the goal of preventing this “underground epidemic” from becoming generalized to the population at large (HIV Infection, 2003; USAID, 2005). Numerous campaigns address this challenge, including USAID initiatives, whose infectious disease objectives in Mexico target stigma and discrimination. The principal contractor for the USAID campaign, Population Services International [PSI], was the first organization to use social marketing to combat the AIDS epidemic. In addition to procuring and distributing pharmaceuticals, over-the-counter drugs and condoms, PSI trains government officials in marketing and communication techniques.

Mexico is a highly competitive market for products such as condoms, according to the Washington-based charitable organization DKT International. After realizing sales in Mexico of 19 million condoms in 2004, DKT noted “dynamic social marketing” was essential (DKT, 2005). Likewise, PSI, in conjunction with CENSIDA [The National Center for the Prevention and Control of HIV/AIDS] and CONASIDA [The National Council for Prevention and Control of AIDS], is using extensive condom social marketing in high-risk areas of southern Mexico (PSI, 2006).

Since HIV/AIDS is also a significant problem along the U.S.-Mexico border, programs such as the SPNS (Special Projects of National Significance) Border Health Initiative rely heavily on social marketing campaigns, using Spanish language media to blanket the transient communities with “bold” HIV messages (Innovative, 2005). Innovative media strategies also characterize Project Hombres, Project Diversity and Project Mujeres, which were developed by a partnership of Latin American NGOs to combat Mexico’s cultural, gender and lifestyle barriers (World, 2006).

As HIV/AIDS social marketing establishes a track record in Mexico, organizations using this technique can begin to analyze results. For example, PANCEA, a three-year NIH-funded research project in Mexico and four other countries, is studying the effectiveness of the eight prevention modalities commonly used to respond to the HIV epidemic (PANCEA, 2005).

Building on these self-evaluations, this portion of the panel and supporting paper use the essential elements of social marketing to compare Mexico HIV/AIDS campaigns, identifying commonalities as well as unique characteristics in purpose, targeted audience, content/focus and strategic approach. The result is a practical overview of how social marketing can successfully operate in the maelstrom of cultural, political, economic and social concerns while bringing about voluntary behavioural changes among both downstream and upstream audiences.

PANEL SPEAKERS AND MODERATOR

PART I.

Presenter: James Adams, J.D., N.M.D., PhD (cand.), is Research Director of the International Institute of Integrative Medicine. He is a 2006 Research *Collaborateur* with *INSERM*, the French National Institute of Health. Adams has directed international medical clinics and worked as a trial lawyer. He is an adjunct faculty member for UCLA.

Adams is the author of 40 professional volumes, and has edited over 90 reference volumes in law and medicine. He has presented international papers and abstracts on HIV/AIDS research at UNESCO (Paris Conference, 2005), ICASA Conference (Abuja, Nigeria, 2005), and other venues. He is currently working on his Ph.D. in bimolecular nanotechnology.

Contact information: adams.ucla@pdq.net

PART II.

Lead Presenter: Susan Kern, M.D., is a senior physician at the Family Health Group in Houston, Texas. She has practiced medicine for over 20 years. Kern graduated from the University of Texas Medical School and the University of Houston. She has served as a clinical medical director and spent several years working as a RN prior to graduating from medical school.

Kern has also trained and worked overseas with advanced international modalities and technologies. She is presently Principal Investigating Physician for a nanotechnology pilot program treating HIV/AIDS patients in the U.S.

Contact information: drsusankern@yahoo.com

Co-Presenter: James Adams (see above for biographical information)

Contact information: adams.ucla@pdq.net

PART III.

Presenter: Ruth Massingill, B.A., M.A., Ph.D. (cand.) has more than 20 years experience in public relations, advertising and publications. She has served as a university administrator and is presently a tenured faculty member at Sam Houston State University. Recent awards include Outstanding Educator (American Advertising Federation, 2002) and Outstanding Faculty (University of Phoenix-Houston, 2003). Ms. Massingill is lead author for a book on communication issues (Peter Lang Publishing, Inc., 2007).

She founded The Massingill Agency, a public relations firm specializing in social marketing and media relations for alternative health care organizations. She regularly presents papers dealing with communications topics at national and international conferences (*e.g.*, ICA/ACA, Peru, 2006; *UNESCO*, Paris Conference 2005). Currently, she is earning her Ph.D. in social marketing from the University of Teesside, Middlesbrough, England.

Contact information: ruthmassingill@yahoo.com

PANEL SESSION MODERATOR/CHAIR:

Charles Wallace, M.D., currently practices medicine in the U.S. Dr. Wallace earned his B.A. in chemistry/biology from Gustavus Adolphus College in 1973. He received his medical degree from Howard University School of Medicine in Washington, D.C., in 1978. In 1994, he received a fellowship from the National Cancer Institute to study paediatric HIV disease and oncology. He is an Associate Investigating Physician for a nanotechnology pilot program treating HIV/AIDS patients in the U.S.

His post-graduate medical training included a surgical internship and a urologic residency at Howard University Hospital and affiliated hospitals, including Walter Reed Army Hospital, Children's Hospital, and D.C. General Hospital. He was a chief resident at D.C. General Hospital in his final year as a resident.

Wallace has practiced urologic medicine and integrative medicine for 22 years. He is a Fellow with the International College of Surgeons. Wallace has testified on health care issues before the U.S. Senate. He presently is affiliated with the Methodist Hospital/University of Tennessee. Wallace is a member of the Academy for the Advancement of Medicine. Dr. Wallace has received the distinguished Physician Recognition Award from the American Medical Association.

Contact information: Telephone: 901.272.3200

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.4 **Abstract Title:** *A practical approach to cultural change: using social marketing to combat HIV/AIDS in Mexico*

Presented at: Academy of Marketing 2007 Doctoral Colloquium, Surrey, England

Dates: 2-3 July 2007

**A PRACTICAL APPROACH TO CULTURAL CHANGE:
USING SOCIAL MARKETING TO COMBAT HIV/AIDS IN MEXICO**

SUBMITTED TO:

**ACADEMY OF MARKETING 2007
DOCTORAL COLLOQUIUM
2-3 JULY 2007**

ABSTRACT

Social marketing has been widely used to influence low-income, high-risk populations to make healthy behaviour changes. This application of marketing principles has also become an important tool for persuading upstream audiences to make long-term policy changes that achieve socially desirable goals. As the human, social, and economic costs of the HIV/AIDS pandemic mount, social marketing is now a key tactic for combating the disease. This paper analyses six recent HIV/AIDS campaigns in Mexico, examining their ability to motivate change and their potential for informing target audiences about new health choices. Although each campaign has a unique theme and a distinctive focus, all share common objectives. Collaboration is essential; each campaign involves multiple organizations, thereby building acceptance for change at all levels. The campaigns all incorporate prevention strategies, and in recognition of Mexico's cultural obstacles, each addresses aspects of stigma and traditional cultural norms. Persuasive messages are informed by the tenets of established behavioural models. As a result, alliances of HIV/AIDS social marketers in Mexico have been able to operate successfully in the maelstrom of cultural, political, economic, and social concerns while bringing about voluntary behavioural changes among both downstream and upstream audiences.

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.5 **Workshop Title:** *Motivating change: visual and verbal persuasion in HIV-AIDS Social Marketing*

Presented at: American Communication Association, Taos, New Mexico

Handouts from Workshop:

- a. Controversial ads
- b. Every generation
- c. I am African
- d. Miscellaneous campaigns
- e. One campaign

Dates: 4-6 October 2007



“Friendly fire” is a term that has been used to describe social marketing campaigns aimed at shooting down the enemy-AIDS-but that do some collateral damage by either reinforcing negative stereotypes or creating an environment that makes people not want to acknowledge they are at risk. Les Pappas of Better World Advertising, which created the “HIV is a gay disease” and “HIV (not fabulous)” campaigns, says we don’t like social marketing when it “challenges our denial, shocks us, makes us feel uncomfortable, airs our dirty laundry, or makes us think too much.”

www.social-marketing.com/blog/2006/10/friendly-fire-stigma-social-marketing.html

Every generation has its great cause.

mine was civil rights
ours is ending AIDS

An HIV vaccine is our best hope of ending the AIDS epidemic.

Right now, there is no vaccine to prevent HIV infection, but scientists are working to find one. To succeed, they will need thousands of people from all walks of life to support HIV vaccine studies and encourage those who volunteer. You can't get HIV from a vaccine study, but you can help end the AIDS epidemic. Learn more about how you can do your part. Visit www.bethegeneration.org. Together, we can be the generation that ends the AIDS epidemic. Call 1-800-449-0240 for more information.

[bethegeneration.org](http://www.bethegeneration.org)

HIV VACCINE RESEARCH

Every generation has its great cause.

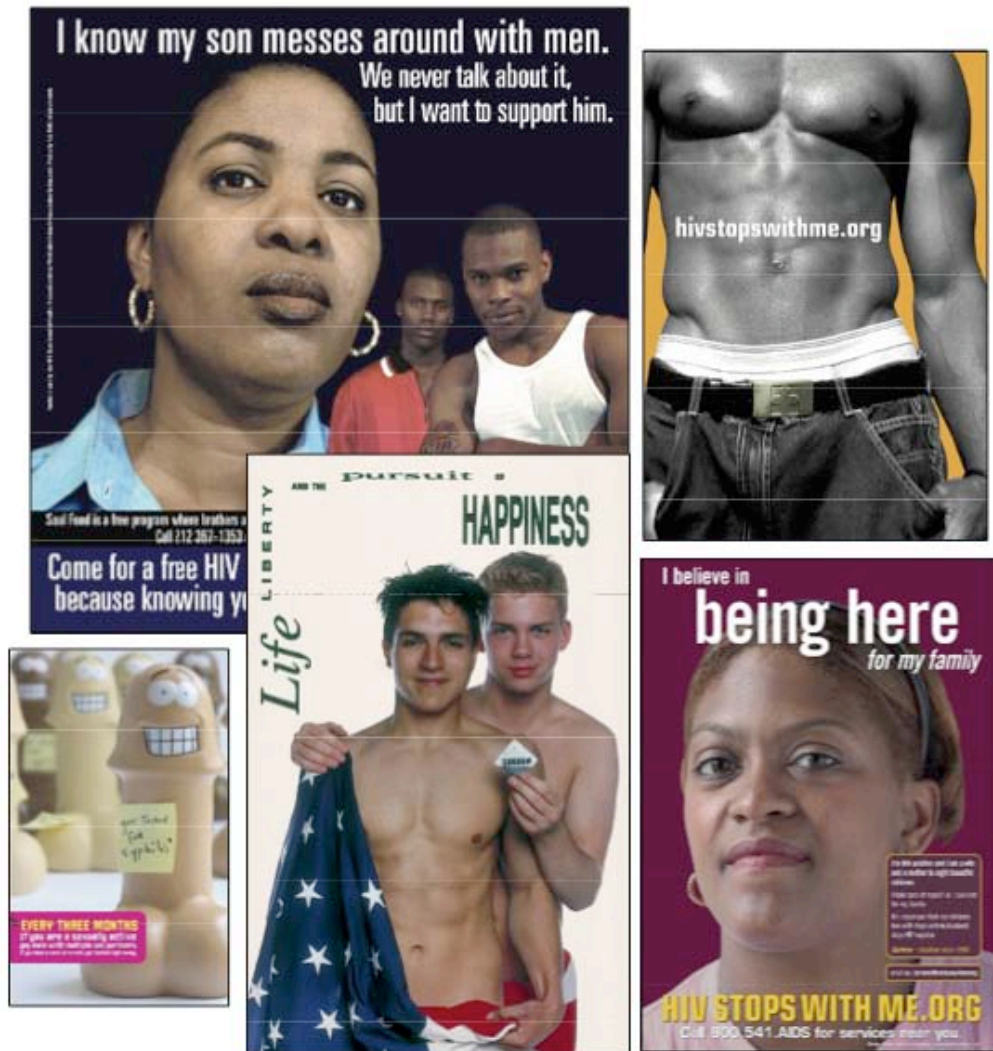
mine was a
better life for my family
ours is ending AIDS

Every generation has its great cause.

mine was starting
the fight against AIDS
ours is ending it

This program seeks to create a supportive environment for HIV vaccine research by mobilizing existing community partnerships and networks to educate key communities about this research in twenty U.S. cities where HIV vaccine clinical trials are ongoing or planned. Coordinated media and collateral materials segment target audiences by gender, ethnicity, and lifestyle, showing images of two people, one older and one younger. Extensive educational materials are available online. The uniform message is that the young generation's "great cause" is to end AIDS and a vaccine is the best hope of accomplishing that goal.

www.bethegeneration.org



Social marketers aim at the unique needs and experiences of their target audiences. But campaigns that target particular groups are often seen as reinforcing stereotypes. It has also been suggested that American HIV/AIDS campaigns are stymied by Puritanism about the body and sexuality. Most HIV/AIDS campaigns are serious in tone, although Europeans are not adverse to injecting humor into the topic. "How do you balance out the criticisms over the larger issue of effectiveness?" asked one public official who oversees San Francisco's policies for preventing HIV/AIDS.

ONE THE CAMPAIGN TO MAKE POVERTY HISTORY



With more than sixty partners, this campaign's purpose is to rally Americans one by one to push for increased donations to fight poverty and AIDS. The campaign has a broad target audience, ranging from students to ministers to punk rockers to soccer moms. The call to action is "We're not asking for your money, we're asking for your voice." In line with this approach, June 11, 2007, ONE launched ONE Vote '08, its "largest and boldest initiative ever," vowing to make extreme poverty and global disease an issue in the 2008 election.

www.one.org

PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.6 **Poster Title:** *Until AIDS do us part: social marketing campaigns empower women at risk in Uganda, Mexico, and the United States*

Presented at: XVII International AIDS Conference, Mexico City

Dates: 3-8 August 2008

Actual Size of Poster: 48" x 42"

Until AIDS Do Us Part

Social Marketing Campaigns Empower Women At Risk in Mexico, Uganda and the United States

Ruth Massingill, Sam Houston State University (USA), Teesside University (England)

When world leaders completed their 25th annual tally of the unrelenting progress of the AIDS pandemic, it was sadly apparent women have achieved global infection equity.

Women, biologically twice as likely to contract HIV as men, now account for half of the adults living with the disease worldwide. Young women are at great risk, with an estimated 45 percent of new infections globally occurring among 15- to 24-year-olds.

From the cradle to the grave, women's health destinies are often linked to cultural traditions of female acquiescence and powerlessness, as well as gender norms that give men control of when and how women have sex.

To combat these too-common circumstances, alliances of local, national and international groups are designing social marketing campaigns to empower women.

These three case studies examine initiatives that targeted women at risk in three countries. Each campaign focused on a contributing factor—gender equality, cross generational sex and stigma, but the lessons learned are applicable to all cultures and countries.



Addressing gender norms—societal messages that dictate appropriate or expected behavior for males and females—is increasingly recognized as a key strategy to prevent the spread of HIV infection, particularly among young people.

Programa Mujeres

Encouraged young Mexican women (15-24) to take control of their sexual and reproductive health in a society where machismo fuels annual increases in HIV/AIDS infections.



WHO WAS INVOLVED?

- Instituto Promundo
- PAPA Institute, ECOS and Salud y Genero
- MacArthur and OAK Foundations
- World Education
- Special Secretariat of Women's Policies

HOW WAS IT IMPLEMENTED?

- Began in Brazil, then adapted for other countries
- Target audience developed campaign materials
- Used "social technologies"
- Peer-promoters led small discussion groups
- No-words cartoon about Maria

WHAT WERE THE RESULTS?

- Changing attitudes/behaviors, building sense of self-efficacy and empowerment
- Positive response led to use in India



Cultural traditions in many developing countries have created an environment in which girls as young as 15 are encouraged to exchange their bodies for modest financial support, entering empty sexual relationships with men who are a generation or more older.



Sugar Daddies

Addressed the widespread problem of cross-generational sex in Uganda, where HIV infection rates are six times higher for teenage girls than for their male counterparts.

WHO WAS INVOLVED?

- Population Services International
- Uganda Ministry of Health
- YouthAIDS
- Straight Talk Foundation

HOW WAS IT IMPLEMENTED?

- Theme: "Cross Generational Sex Stops With You"
- Seminars with media coverage
- Extensive use of billboards
- Radio talk shows, soap opera
- Chastity scholarships

WHAT WERE THE RESULTS?

- Extensive media publicity
- Public dialogue, awareness
- Community involvement



To help counteract the detachment of anonymous billboards and posters, eight HIV-positive African-Americans in Houston put their faces on a citywide HIV prevention and education campaign with the theme, "You don't have to be like us."

New Faces of HIV

Launched in Houston, Texas, to decrease stigma and increase testing among African American women, who account for 77 percent of the HIV-positive women in Harris County.



WHO WAS INVOLVED?

- The Harris County Hospital District
- Houston Dept. of Health & Human Services
- Local HIV/AIDS advocacy groups

HOW WAS IT IMPLEMENTED?

- Posters and stickers in music shops, public restrooms
- Radio spots on local African-American stations
- Brochures in beauty salons
- Transit placards
- 24-hour HIV hotline

WHAT WERE THE RESULTS?

- Extensive media publicity
- Public dialogue, awareness
- Advocacy by campaign participants
- Additional budget allocation



Although these empowerment projects were worlds apart in language and culture, each targeted highly vulnerable groups. Relying on global support for the HIV prevention needs of women, the campaigns demonstrated important lessons for future initiatives:

- Forge collaborative partnerships with common goals and varied resources;
- Recruit commercial sponsors for additional resources;
- Involve the target audience at every stage;
- Craft culturally sensitive multimedia, multilingual messages; &
- Utilize global support for women.

In-depth examination of these three campaigns confirms that communication about HIV/AIDS is complex and highly political. But, facilitating open dialogue is crucial since the disease crosses all boundaries, creating dramatic shifts in the world economy, affecting global politics and uprooting generations of cultural traditions.

As a result, once-taboo topics such as explicit discussions about sexual practices and alternative lifestyles, use of condoms, and gender equity are now part of the international dialogue.



PEER-REVIEWED AND PRESENTED WORK FROM THIS THESIS

E.7 **Poster Title:** *Positive or negative, HIV/AIDS knowledge & perceptions*

Presented at: 1st Annual College of Humanities & Social Science Research
Conference, Sam Houston State University, Huntsville, Texas

Dates: 9 April 2010

Actual Size of Poster: 48" x 36"

POSITIVE OR NEGATIVE

HIV/AIDS Knowledge and Perceptions

RUTH MASSINGILL
Sam Houston State University (USA)
Teesside University (England)

This quantitative survey was designed to gather baseline information establishing the perceived knowledge level of a high-risk, high-interest downstream audience regarding HIV/AIDS issues and concerns. It is part of a larger project that examines HIV/AIDS social marketing campaigns in Mexico, Uganda and the United States. The overall aim is to understand which appeals and approaches are most effective in motivating lifestyle changes to prevent infection and improve treatment results. Information collected will be used to help guide the design of a model for effectively informing similar audiences about HIV/AIDS.

RESearch QUESTIONS:
The survey was designed to answer four questions:
1. Where do recipients of HIV/AIDS information learn about the disease?
2. How credible do these recipients consider their information sources to be?
3. What perceptions and knowledge do these recipients have about the disease?
4. How do recipients of HIV/AIDS information perceive their choices as regards prevention techniques and treatment modalities?

METHODOLOGY:
Anonymous surveys with separate signed consent forms were administered at the Legacy Clinic in Houston over a four-day period. Respondents were not necessarily HIV/AIDS patients; their principal commonality was they were all receivers of information about HIV/AIDS. Sample selection was by consent and convenience.
Demographic highlights of the 342 valid responses: 66% male; 42% heterosexual, 38% homosexual and 10% bisexual; 37% White, 36% Black and 16% Hispanic; 48% high school grads, 33% college grads. Regarding HIV status, 31% were negative and 54% were positive.

"Taking this survey made me realize how much I don't know about HIV/AIDS."
—Straight woman HIV-negative

"Positive for 30 years and have never taken any drugs ever for the illness."
—Bisexual man HIV-positive

"I know my God is good. I've been exposed since 1992 until now. I'm still here."
—Straight man HIV-negative

"Some of these therapies used together can be effective."
—Gay man HIV-positive

"We need more education in schools. Many people believe the numbers are going down drastically and there is a readily available cure."
—Straight woman HIV-negative

"Knowledge is power!"
—Gay man HIV-positive

"It's sad we have gotten comfortable with these diseases. To really educate yourself, you have to make an effort."
—Bisexual man HIV-positive

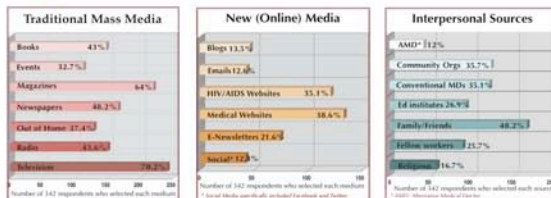
"Lots of treatments. I didn't know any of them."
—Gay man HIV-negative

"I have had a family member living with AIDS for 10 years. I have seen her almost die five times. I believe given funding a cure could be found. I have to hope."
—Straight woman HIV-negative

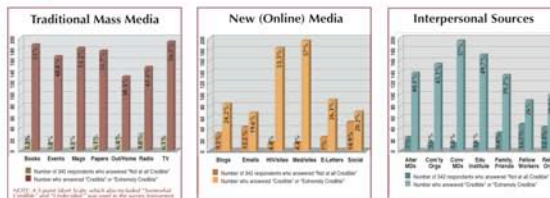
"If not for the good doctors and case workers, I would have been very ill. I love how they let me know I am not in the dark."
—Straight woman HIV-positive

"Having four friends with HIV, I still don't know what they go through to stay well every day. I feel it's not an open subject to talk about."
—Gay man HIV-negative

1 FROM WHICH SOURCES HAVE YOU LEARNED ABOUT HIV/AIDS IN THE PAST 4-5 YEARS?
Twenty choices included mass media, new media, and personal sources, but were not so labeled. Respondents were asked to select all media sources that applied to the question.



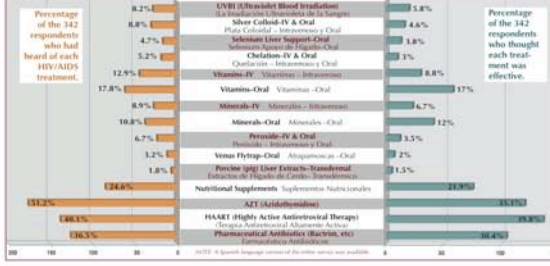
2 RATE EACH OF THESE SOURCES OF HIV/AIDS INFORMATION ACCORDING TO HOW CREDIBLE (BELIEVABLE) THEY HAVE BEEN IN YOUR EXPERIENCE.



3 PLEASE CHECK THE RESPONSE THAT BEST REPRESENTS HOW YOU FEEL ABOUT THESE STATEMENTS: These were arranged in a random manner but fell into categories relating to cultural stereotypes, prevention and treatment, and global socio-political issues.



4 A) MARK ALL OF THESE HIV/AIDS TREATMENTS YOU HAVE HEARD OF, B) BASED ON YOUR EXPERIENCE, MARK ALL TREATMENTS YOU THINK CAN BE EFFECTIVE IN TREATING HIV/AIDS.



APPENDIX F
SPSS TABLES FROM CHAPTER 7

F.1	Cross Tabulation Tables with Significance Or a Tendency toward Significance Using Pearson’s Chi-Square Test of Association	
F.1.a.	Crosstabs: Sources and Demographic Variables	F1
F.1.b.	Crosstabs: Source Credibility and Demographic Variables	F18
F.1.c.	Crosstabs: Perception Statements and Demographic Variables	F29
F.1.d.	Crosstabs: Treatments Known and Demographic Variables	F71
F.1.e.	Crosstabs: Effective Treatments and Demographic Variables	F93
F.2	List of Crosstabs with No Significance	F114
F.3	Reliability Statistics: Cronbach’s Alpha Analysis Tables	F116

CROSSTABS: SOURCES AND DEMOGRAPHIC VARIABLES

SOURCES VS. GENDER

			Which gender do you identify yourself with		Total
			male	female	
sources you have learned about HIV/AIDS in the last 4-5 years- TV	not selected	Count	77	18	95
		Expected Count	63.0	32.0	95.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-TV	81.1%	18.9%	100.0%
		% of Total	23.8%	5.6%	29.3%
	selected	Count	138	91	229
		Expected Count	152.0	77.0	229.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-TV	60.3%	39.7%	100.0%
		% of Total	42.6%	28.1%	70.7%
Total		Count	215	109	324
		Expected Count	215.0	109.0	324.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-TV	66.4%	33.6%	100.0%
		% of Total	66.4%	33.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	13.001(b)	1	.000		
Continuity Correction(a)	12.086	1	.001		
Likelihood Ratio	13.850	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	12.961	1	.000		
N of Valid Cases	324				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 31.96.

			Which gender do you identify yourself with		Total
			male	female	
sources you have learned about HIV/AIDS in the last 4-5 years- Radio	not selected	Count	133	48	181
		Expected Count	120.1	60.9	181.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	73.5%	26.5%	100.0%
		% of Total	41.0%	14.8%	55.9%
	selected	Count	82	61	143
		Expected Count	94.9	48.1	143.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	57.3%	42.7%	100.0%
		% of Total	25.3%	18.8%	44.1%
Total		Count	215	109	324
		Expected Count	215.0	109.0	324.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	66.4%	33.6%	100.0%
		% of Total	66.4%	33.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	9.320(b)	1	.002		
Continuity Correction(a)	8.611	1	.003		
Likelihood Ratio	9.301	1	.002		
Fisher's Exact Test				.003	.002
Linear-by-Linear Association	9.291	1	.002		
N of Valid Cases	324				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 48.11.

			Which gender do you identify yourself with		Total
			male	female	
sources you have learned about HIV/AIDS in the last 4-5 years- Magazine	not selected	Count	66	47	113
		Expected Count	75.0	38.0	113.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Magazine	58.4%	41.6%	100.0%
		% of Total	20.4%	14.5%	34.9%
	selected	Count	149	62	211
		Expected Count	140.0	71.0	211.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Magazine	70.6%	29.4%	100.0%
		% of Total	46.0%	19.1%	65.1%
Total		Count	215	109	324
		Expected Count	215.0	109.0	324.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Magazine	66.4%	33.6%	100.0%
		% of Total	66.4%	33.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.914(b)	1	.027		
Continuity Correction(a)	4.382	1	.036		
Likelihood Ratio	4.849	1	.028		
Fisher's Exact Test				.036	.019
Linear-by-Linear Association	4.898	1	.027		
N of Valid Cases	324				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 38.02.

			Which gender do you identify yourself with		Total
			male	female	male
sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	not selected	Count	144	57	201
		Expected Count	133.4	67.6	201.0
		% within Sources	71.6%	28.4%	100.0%
		% of Total	44.4%	17.6%	62.0%
	selected	Count	71	52	123
		Expected Count	81.6	41.4	123.0
		% within Sources	57.7%	42.3%	100.0%
		% of Total	21.9%	16.0%	38.0%
Total		Count	215	109	324
		Expected Count	215.0	109.0	324.0
		% within Sources	66.4%	33.6%	100.0%
		% of Total	66.4%	33.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.621(b)	1	.010		
Continuity Correction(a)	6.013	1	.014		
Likelihood Ratio	6.552	1	.010		
Fisher's Exact Test				.011	.007
Linear-by-Linear Association	6.601	1	.010		
N of Valid Cases	324				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 41.38.

SOURCES VS. STATUS

			My HIV status is		Total
			Negative	Positive	
sources you have learned about HIV/AIDS in the last 4-5 years- TV	not selected	Count	24	65	89
		Expected Count	32.6	56.4	89.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- TV	27.0%	73.0%	100.0%
		% of Total	8.2%	22.3%	30.5%
	selected	Count	83	120	203
		Expected Count	74.4	128.6	203.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- TV	40.9%	59.1%	100.0%
		% of Total	28.4%	41.1%	69.5%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- TV	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.164(b)	1	.023		
Continuity Correction(a)	4.582	1	.032		
Likelihood Ratio	5.311	1	.021		
Fisher's Exact Test				.025	.015
Linear-by-Linear Association	5.147	1	.023		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 32.61.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- Radio	not selected	Count	50	118	168	
		Expected Count	61.6	106.4	168.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	29.8%	70.2%	100.0%	
		% of Total	17.1%	40.4%	57.5%	
	selected	Count	57	67	124	
		Expected Count	45.4	78.6	124.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio	46.0%	54.0%	100.0%	
		% of Total	19.5%	22.9%	42.5%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
% within sources you have learned about HIV/AIDS in the last 4-5 years- Radio			36.6%	63.4%	100.0%	
% of Total			36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.071(b)	1	.004		
Continuity Correction(a)	7.388	1	.007		
Likelihood Ratio	8.046	1	.005		
Fisher's Exact Test				.005	.003
Linear-by-Linear Association	8.043	1	.005		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 45.44.

			My HIV status is		Total		
			Negative	Positive			
sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	not selected	Count	55	119	174		
		Expected Count	63.8	110.2	174.0		
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	31.6%	68.4%	100.0%		
		% of Total	18.8%	40.8%	59.6%		
	selected	Count	52	66	118		
		Expected Count	43.2	74.8	118.0		
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	44.1%	55.9%	100.0%		
		% of Total	17.8%	22.6%	40.4%		
		Total		Count	107	185	292
				Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Out of Home, billboards, transit ads,posters,flyers,brochures	36.6%	63.4%	100.0%		
		% of Total	36.6%	63.4%	100.0%		

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.701(b)	1	.030		
Continuity Correction(a)	4.180	1	.041		
Likelihood Ratio	4.676	1	.031		
Fisher's Exact Test				.035	.021
Linear-by-Linear Association	4.685	1	.030		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 43.24.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites	not selected	Count	78	108	186	
		Expected Count	68.2	117.8	186.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites	41.9%	58.1%	100.0%	
		% of Total	26.7%	37.0%	63.7%	
	selected	Count	29	77	106	
		Expected Count	38.8	67.2	106.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites	27.4%	72.6%	100.0%	
		% of Total	9.9%	26.4%	36.3%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
% within sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites			36.6%	63.4%	100.0%	
% of Total			36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.180(b)	1	.013		
Continuity Correction(a)	5.568	1	.018		
Likelihood Ratio	6.316	1	.012		
Fisher's Exact Test				.016	.009
Linear-by-Linear Association	6.159	1	.013		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 38.84.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- Online newsletter,journals,ect	not selected	Count	77	153	230	
		Expected Count	84.3	145.7	230.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Online newsletter, journals	33.5%	66.5%	100.0%	
		% of Total	26.4%	52.4%	78.8%	
	selected	Count	30	32	62	
		Expected Count	22.7	39.3	62.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Online newsletter, journals	48.4%	51.6%	100.0%	
		% of Total	10.3%	11.0%	21.2%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Online newsletter, journals	36.6%	63.4%	100.0%	
		% of Total	36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.676(b)	1	.031		
Continuity Correction(a)	4.055	1	.044		
Likelihood Ratio	4.565	1	.033		
Fisher's Exact Test				.038	.023
Linear-by-Linear Association	4.660	1	.031		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 22.72.

			My HIV status is		Total		
			Negative	Positive			
sources you have learned about HIV/AIDS in the last 4-5 years- Social media,facebook, Twitter, ect	not selected	Count	86	167	253		
		Expected Count	92.7	160.3	253.0		
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Social media, facebook, Twitter	34.0%	66.0%	100.0%		
		% of Total	29.5%	57.2%	86.6%		
	selected	Count	21	18	39		
		Expected Count	14.3	24.7	39.0		
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Social media facebook, Twitter	53.8%	46.2%	100.0%		
		% of Total	7.2%	6.2%	13.4%		
		Total		Count	107	185	292
				Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Social media facebook, Twitter	36.6%	63.4%	100.0%		
		% of Total	36.6%	63.4%	100.0%		

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.737(b)	1	.017		
Continuity Correction(a)	4.914	1	.027		
Likelihood Ratio	5.535	1	.019		
Fisher's Exact Test				.020	.014
Linear-by-Linear Association	5.718	1	.017		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.29.

			My HIV status is		Total
			Negative	Positive	
sources you have learned about HIV/AIDS in the last 4-5 years-Educational institutions	not selected	Count	68	144	212
		Expected Count	77.7	134.3	212.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Edu institutions	32.1%	67.9%	100.0%
		% of Total	23.3%	49.3%	72.6%
	selected	Count	39	41	80
		Expected Count	29.3	50.7	80.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Edu institutions	48.8%	51.3%	100.0%
		% of Total	13.4%	14.0%	27.4%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years-Edu institutions	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.956(b)	1	.008		
Continuity Correction(a)	6.256	1	.012		
Likelihood Ratio	6.820	1	.009		
Fisher's Exact Test				.010	.007
Linear-by-Linear Association	6.932	1	.008		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 29.32.

			My HIV status is		Total	
			Negative	Positive		
sources you have learned about HIV/AIDS in the last 4-5 years- Friends or family members	not selected	Count	44	106	150	
		Expected Count	55.0	95.0	150.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Friends or family members	29.3%	70.7%	100.0%	
		% of Total	15.1%	36.3%	51.4%	
	selected	Count	63	79	142	
		Expected Count	52.0	90.0	142.0	
		% within sources you have learned about HIV/AIDS in the last 4-5 years- Friends or family members	44.4%	55.6%	100.0%	
		% of Total	21.6%	27.1%	48.6%	
	Total		Count	107	185	292
			Expected Count	107.0	185.0	292.0
% within sources you have learned about HIV/AIDS in the last 4-5 years- Friends or family members			36.6%	63.4%	100.0%	
% of Total			36.6%	63.4%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.101(b)	1	.008		
Continuity Correction(a)	6.468	1	.011		
Likelihood Ratio	7.127	1	.008		
Fisher's Exact Test				.011	.005
Linear-by-Linear Association	7.076	1	.008		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 52.03.

			My HIV status is		Total		
			Negative	Positive			
sources you have learned about HIV/AIDS in the last 4-5 years- People you work with	not selected	Count	68	149	217		
		Expected Count	79.5	137.5	217.0		
		% within sources you have learned about HIV/AIDS in the last 4-5 years- People you work with	31.3%	68.7%	100.0%		
		% of Total	23.3%	51.0%	74.3%		
	selected	Count	39	36	75		
		Expected Count	27.5	47.5	75.0		
		% within sources you have learned about HIV/AIDS in the last 4-5 years- People you work with	52.0%	48.0%	100.0%		
		% of Total	13.4%	12.3%	25.7%		
		Total		Count	107	185	292
				Expected Count	107.0	185.0	292.0
		% within sources you have learned about HIV/AIDS in the last 4-5 years- People you work with	36.6%	63.4%	100.0%		
		% of Total	36.6%	63.4%	100.0%		

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	10.251(b)	1	.001		
Continuity Correction(a)	9.380	1	.002		
Likelihood Ratio	10.009	1	.002		
Fisher's Exact Test				.002	.001
Linear-by-Linear Association	10.216	1	.001		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 27.48.

SOURCES VS. SEXUAL ORIENTATION

		sexual orientation			Total	
		heterosexual	homosexual	bi-sexual	1.00	
sources you have learned about HIV/AIDS in the last 4-5 years- HIV/AIDS groups' websites	not selected	Count	109	73	16	198
		Expected Count	92.9	83.3	21.8	198.0
		% within sources	55.1%	36.9%	8.1%	100.0%
		% of Total	35.3%	23.6%	5.2%	64.1%
	selected	Count	36	57	18	111
		Expected Count	52.1	46.7	12.2	111.0
		% within sources	32.4%	51.4%	16.2%	100.0%
		% of Total	11.7%	18.4%	5.8%	35.9%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within sources	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.578(a)	2	.000
Likelihood Ratio	15.750	2	.000
Linear-by-Linear Association	14.892	1	.000
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.21.

SOURCES VS. AGE

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
sources you have learned about HIV/AIDS in the last 4-5 years- Social media, facebook, Twitter, ect	not selected	Count	42	67	98	74	17	298
		Expected Count	46.5	78.0	90.3	67.5	15.8	298.0
		% within sources	14.1%	22.5%	32.9%	24.8%	5.7%	100.0%
		% of Total	12.4%	19.7%	28.8%	21.8%	5.0%	87.6%
	selected	Count	11	22	5	3	1	42
		Expected Count	6.5	11.0	12.7	9.5	2.2	42.0
		% within sources	26.2%	52.4%	11.9%	7.1%	2.4%	100.0%
		% of Total	3.2%	6.5%	1.5%	.9%	.3%	12.4%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within sources	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	27.230(a)	4	.000
Likelihood Ratio	27.492	4	.000
Linear-by-Linear Association	17.841	1	.000
N of Valid Cases	340		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 2.22.

SOURCES VS. ETHNIC GROUP

			which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/african american or negro	hispanic	White / caucasian	multiracial	other	
sources you have learned about HIV/AIDS in the last 4-5 years- Conventional medical doctors	not selected	Count	6	3	88	42	66	10	6	221
		Expected Count	5.9	2.6	79.5	34.6	82.8	11.7	3.9	221.0
		% within sources	2.7%	1.4%	39.8%	19.0%	29.9%	4.5%	2.7%	100.0%
		% of Total	1.8%	.9%	26.0%	12.4%	19.5%	2.9%	1.8%	65.2%
	selected	Count	3	1	34	11	61	8	0	118
		Expected Count	3.1	1.4	42.5	18.4	44.2	6.3	2.1	118.0
		% within sources	2.5%	.8%	28.8%	9.3%	51.7%	6.8%	.0%	100.0%
		% of Total	.9%	.3%	10.0%	3.2%	18.0%	2.4%	.0%	34.8%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within sources	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.106(a)	6	.002
Likelihood Ratio	23.099	6	.001
Linear-by-Linear Association	5.224	1	.022
N of Valid Cases	339		

a 5 cells (35.7%) have expected count less than 5. The minimum expected count is 1.39.

**CROSSTABS:
SOURCE CREDIBILITY AND DEMOGRAPHIC VARIABLES**

SOURCE CREDIBILITY VS. STATUS

			My HIV status is		Total
			Negative	Positive	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-events, seminars, workshops, conferences	not at all credible	Count	1	8	9
		Expected Count	3.4	5.6	9.0
		% within Sources	11.1%	88.9%	100.0%
		% of Total	.5%	3.7%	4.1%
	somewhat credible	Count	5	14	19
		Expected Count	7.2	11.8	19.0
		% within Sources	26.3%	73.7%	100.0%
		% of Total	2.3%	6.5%	8.8%
	undecided	Count	12	30	42
		Expected Count	15.9	26.1	42.0
		% within Sources	28.6%	71.4%	100.0%
		% of Total	5.5%	13.8%	19.4%
	credible	Count	27	42	69
		Expected Count	26.1	42.9	69.0
		% within Sources	39.1%	60.9%	100.0%
		% of Total	12.4%	19.4%	31.8%
	extremely credible	Count	37	41	78
		Expected Count	29.5	48.5	78.0
		% within Sources	47.4%	52.6%	100.0%
		% of Total	17.1%	18.9%	35.9%
Total		Count	82	135	217
		Expected Count	82.0	135.0	217.0
		% within Sources	37.8%	62.2%	100.0%
		% of Total	37.8%	62.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.447(a)	4	.077
Likelihood Ratio	9.022	4	.061
Linear-by-Linear Association	8.171	1	.004
N of Valid Cases	217		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 3.40.

			My HIV status is		Total
			Negative	Positive	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-community organizations	not at all credible	Count	0	8	8
		Expected Count	2.9	5.1	8.0
		% within Sources	.0%	100.0%	100.0%
		% of Total	.0%	3.5%	3.5%
	somewhat credible	Count	15	14	29
		Expected Count	10.5	18.5	29.0
		% within Sources	51.7%	48.3%	100.0%
		% of Total	6.5%	6.1%	12.6%
	undecided	Count	17	38	55
		Expected Count	19.8	35.2	55.0
		% within Sources	30.9%	69.1%	100.0%
		% of Total	7.4%	16.5%	23.9%
	credible	Count	26	51	77
		Expected Count	27.8	49.2	77.0
		% within Sources	33.8%	66.2%	100.0%
		% of Total	11.3%	22.2%	33.5%
	extremely credible	Count	25	36	61
		Expected Count	22.0	39.0	61.0
		% within Sources	41.0%	59.0%	100.0%
		% of Total	10.9%	15.7%	26.5%
Total		Count	83	147	230
		Expected Count	83.0	147.0	230.0
		% within Sources	36.1%	63.9%	100.0%
		% of Total	36.1%	63.9%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.045(a)	4	.060
Likelihood Ratio	11.565	4	.021
Linear-by-Linear Association	.456	1	.500
N of Valid Cases	230		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 2.89.

			My HIV status is		Total
			Negative	Positive	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-educational institutions	not at all credible	Count	1	7	8
		Expected Count	3.0	5.0	8.0
		% within Sources	12.5%	87.5%	100.0%
		% of Total	.5%	3.2%	3.6%
	somewhat credible	Count	11	13	24
		Expected Count	9.0	15.0	24.0
		% within Sources	45.8%	54.2%	100.0%
		% of Total	5.0%	5.9%	10.8%
	undecided	Count	8	33	41
		Expected Count	15.3	25.7	41.0
		% within Sources	19.5%	80.5%	100.0%
		% of Total	3.6%	14.9%	18.5%
	credible	Count	34	47	81
		Expected Count	30.3	50.7	81.0
		% within Sources	42.0%	58.0%	100.0%
		% of Total	15.3%	21.2%	36.5%
	extremely credible	Count	29	39	68
		Expected Count	25.4	42.6	68.0
		% within Sources	42.6%	57.4%	100.0%
		% of Total	13.1%	17.6%	30.6%
Total		Count	83	139	222
		Expected Count	83.0	139.0	222.0
		% within Sources	37.4%	62.6%	100.0%
		% of Total	37.4%	62.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.976(a)	4	.041
Likelihood Ratio	10.886	4	.028
Linear-by-Linear Association	2.611	1	.106
N of Valid Cases	222		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 2.99.

			My HIV status is		Total
			Negative	Positive	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-people you work with	not at all credible	Count	7	31	38
		Expected Count	14.7	23.3	38.0
		% within Sources	18.4%	81.6%	100.0%
		% of Total	3.3%	14.5%	17.8%
	somewhat credible	Count	13	25	38
		Expected Count	14.7	23.3	38.0
		% within Sources	34.2%	65.8%	100.0%
		% of Total	6.1%	11.7%	17.8%
	undecided	Count	25	39	64
		Expected Count	24.8	39.2	64.0
		% within Sources	39.1%	60.9%	100.0%
		% of Total	11.7%	18.2%	29.9%
	credible	Count	18	24	42
		Expected Count	16.3	25.7	42.0
		% within Sources	42.9%	57.1%	100.0%
		% of Total	8.4%	11.2%	19.6%
	extremely credible	Count	20	12	32
		Expected Count	12.4	19.6	32.0
		% within Sources	62.5%	37.5%	100.0%
		% of Total	9.3%	5.6%	15.0%
Total		Count	83	131	214
		Expected Count	83.0	131.0	214.0
		% within Sources	38.8%	61.2%	100.0%
		% of Total	38.8%	61.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.848(a)	4	.005
Likelihood Ratio	15.338	4	.004
Linear-by-Linear Association	13.554	1	.000
N of Valid Cases	214		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.41.

SOURCE CREDIBILITY VS. AGE

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	18-25
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-Medical Websites	not at all credible	Count	6	1	5	3	0	15
		Expected Count	2.2	4.7	4.6	2.9	.6	15.0
		% within Sources	40.0%	6.7%	33.3%	20.0%	.0%	100.0%
		% of Total	2.3%	.4%	2.0%	1.2%	.0%	5.9%
	somewhat credible	Count	2	2	3	4	2	13
		Expected Count	1.9	4.1	4.0	2.5	.5	13.0
		% within Sources	15.4%	15.4%	23.1%	30.8%	15.4%	100.0%
		% of Total	.8%	.8%	1.2%	1.6%	.8%	5.1%
	undecided	Count	6	7	11	9	1	34
		Expected Count	5.0	10.6	10.4	6.6	1.3	34.0
		% within Sources	17.6%	20.6%	32.4%	26.5%	2.9%	100.0%
		% of Total	2.3%	2.7%	4.3%	3.5%	.4%	13.3%
	credible	Count	7	41	31	15	2	96
		Expected Count	14.3	30.0	29.3	18.8	3.8	96.0
		% within Sources	7.3%	42.7%	32.3%	15.6%	2.1%	100.0%
		% of Total	2.7%	16.0%	12.1%	5.9%	.8%	37.5%
	extremely credible	Count	17	29	28	19	5	98
		Expected Count	14.5	30.6	29.9	19.1	3.8	98.0
		% within Sources	17.3%	29.6%	28.6%	19.4%	5.1%	100.0%
		% of Total	6.6%	11.3%	10.9%	7.4%	2.0%	38.3%

Total	Count	38	80	78	50	10	256
	Expected Count	38.0	80.0	78.0	50.0	10.0	256.0
	% within Sources	14.8%	31.3%	30.5%	19.5%	3.9%	100.0%
	% of Total	14.8%	31.3%	30.5%	19.5%	3.9%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	29.176(a)	16	.023
Likelihood Ratio	28.049	16	.031
Linear-by-Linear Association	.015	1	.902
N of Valid Cases	256		

a 13 cells (52.0%) have expected count less than 5. The minimum expected count is .51.

SOURCE CREDIBILITY VS. ETHNIC GROUP

			which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	hispanic	white/ caucasian	multiracial	other	american indian, alaskan native, or pacific islander
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience- blogs, online bulletin boards	not at all credible	Count	0	0	7	2	19	1	1	30
		Expected Count	.6	.4	10.4	4.6	11.8	1.7	.5	30.0
		% within Sources	.0%	.0%	23.3%	6.7%	63.3%	3.3%	3.3%	100.0%
		% of Total	.0%	.0%	3.0%	.8%	8.1%	.4%	.4%	12.7%
	somewhat credible	Count	1	0	8	3	14	2	2	30
		Expected Count	.6	.4	10.4	4.6	11.8	1.7	.5	30.0

		% within Sources	3.3%	.0%	26.7%	10.0%	46.7%	6.7%	6.7%	100.0%
		% of Total	.4%	.0%	3.4%	1.3%	5.9%	.8%	.8%	12.7%
	undecided	Count	2	2	28	13	42	5	1	93
		Expected Count	2.0	1.2	32.3	14.2	36.6	5.1	1.6	93.0
		% within Sources	2.2%	2.2%	30.1%	14.0%	45.2%	5.4%	1.1%	100.0%
		% of Total	.8%	.8%	11.9%	5.5%	17.8%	2.1%	.4%	39.4%
	credible	Count	1	0	20	14	11	3	0	49
		Expected Count	1.0	.6	17.0	7.5	19.3	2.7	.8	49.0
		% within Sources	2.0%	.0%	40.8%	28.6%	22.4%	6.1%	.0%	100.0%
		% of Total	.4%	.0%	8.5%	5.9%	4.7%	1.3%	.0%	20.8%
	extremely credible	Count	1	1	19	4	7	2	0	34
		Expected Count	.7	.4	11.8	5.2	13.4	1.9	.6	34.0
		% within Sources	2.9%	2.9%	55.9%	11.8%	20.6%	5.9%	.0%	100.0%
		% of Total	.4%	.4%	8.1%	1.7%	3.0%	.8%	.0%	14.4%

Total	Count	5	3	82	36	93	13	4	236
	Expected Count	5.0	3.0	82.0	36.0	93.0	13.0	4.0	236.0
	% within Sources	2.1%	1.3%	34.7%	15.3%	39.4%	5.5%	1.7%	100.0%
	% of Total	2.1%	1.3%	34.7%	15.3%	39.4%	5.5%	1.7%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	37.884(a)	24	.036
Likelihood Ratio	38.451	24	.031
Linear-by-Linear Association	15.108	1	.000
N of Valid Cases	236		

a 21 cells (60.0%) have expected count less than 5. The minimum expected count is .38.

SOURCE CREDIBILITY VS. SEXUAL ORIENTATION

			sexual orientation			Total
			heterosexual	homosexual	bi-sexual	
Rate each of these sources of HIV/AIDS information according to how credible they have been in your experience-friends or family members	not at all credible	Count	13	8	7	28
		Expected Count	12.6	12.4	3.0	28.0
		% within Sources	46.4%	28.6%	25.0%	100.0%
		% of Total	5.1%	3.1%	2.7%	11.0%
	somewhat credible	Count	24	15	5	44
		Expected Count	19.8	19.5	4.7	44.0
		% within Sources	54.5%	34.1%	11.4%	100.0%
		% of Total	9.4%	5.9%	2.0%	17.3%
	undecided	Count	19	35	4	58
		Expected Count	26.2	25.7	6.1	58.0
		% within Sources	32.8%	60.3%	6.9%	100.0%
		% of Total	7.5%	13.7%	1.6%	22.7%
	credible	Count	34	36	7	77
		Expected Count	34.7	34.1	8.2	77.0
		% within Sources	44.2%	46.8%	9.1%	100.0%
		% of Total	13.3%	14.1%	2.7%	30.2%
	extremely credible	Count	25	19	4	48
		Expected Count	21.6	21.3	5.1	48.0
		% within Sources	52.1%	39.6%	8.3%	100.0%
		% of Total	9.8%	7.5%	1.6%	18.8%
Total		Count	115	113	27	255
		Expected Count	115.0	113.0	27.0	255.0
		% within Sources	45.1%	44.3%	10.6%	100.0%
		% of Total	45.1%	44.3%	10.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.345(a)	8	.038
Likelihood Ratio	15.050	8	.058
Linear-by-Linear Association	.924	1	.337
N of Valid Cases	255		

a 2 cells (13.3%) have expected count less than 5. The minimum expected count is 2.96.

**CROSSTABS:
PERCEPTION STATEMENTS AND DEMOGRAPHIC VARIABLES**

PERCEPTION STATEMENTS VS. STATUS

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about-Poor people are more likely to get HIV/AIDS	strongly agree	Count	1	10	11
		Expected Count	4.0	7.0	11.0
		% within Statements	9.1%	90.9%	100.0%
		% of Total	.3%	3.4%	3.8%
	agree	Count	21	24	45
		Expected Count	16.5	28.5	45.0
		% within Statements	46.7%	53.3%	100.0%
		% of Total	7.2%	8.2%	15.4%
	neither agree nor disagree	Count	29	33	62
		Expected Count	22.7	39.3	62.0
		% within Statements	46.8%	53.2%	100.0%
		% of Total	9.9%	11.3%	21.2%
	disagree	Count	24	48	72
		Expected Count	26.4	45.6	72.0
		% within Statements	33.3%	66.7%	100.0%
		% of Total	8.2%	16.4%	24.7%
	strongly disagree	Count	32	70	102
		Expected Count	37.4	64.6	102.0
		% within Statements	31.4%	68.6%	100.0%
		% of Total	11.0%	24.0%	34.9%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.845(a)	4	.043
Likelihood Ratio	10.574	4	.032
Linear-by-Linear Association	1.374	1	.241
N of Valid Cases	292		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 4.03.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about - HIV/AIDS is primarily a gay disease	strongly agree	Count	2	6	8
		Expected Count	2.9	5.1	8.0
		% within Statements	25.0%	75.0%	100.0%
		% of Total	.7%	2.1%	2.7%
	agree	Count	8	4	12
		Expected Count	4.4	7.6	12.0
		% within Statements	66.7%	33.3%	100.0%
		% of Total	2.7%	1.4%	4.1%
	neither agree nor disagree	Count	6	23	29
		Expected Count	10.6	18.4	29.0
		% within Statements	20.7%	79.3%	100.0%
		% of Total	2.1%	7.9%	9.9%
	disagree	Count	28	51	79
		Expected Count	28.9	50.1	79.0
		% within Statements	35.4%	64.6%	100.0%
		% of Total	9.6%	17.5%	27.1%
	strongly disagree	Count	63	101	164
		Expected Count	60.1	103.9	164.0
		% within Statements	38.4%	61.6%	100.0%
		% of Total	21.6%	34.6%	56.2%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.576(a)	4	.073
Likelihood Ratio	8.674	4	.070
Linear-by-Linear Association	.146	1	.703
N of Valid Cases	292		

a 2 cells (20.0%) have expected count less than 5. The minimum expected count is 2.93.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about - Getting HIV/AIDS is usually a death sentence	strongly agree	Count	2	7	9
		Expected Count	3.3	5.7	9.0
		% within Statements	22.2%	77.8%	100.0%
		% of Total	.7%	2.4%	3.1%
	agree	Count	14	9	23
		Expected Count	8.4	14.6	23.0
		% within Statements	60.9%	39.1%	100.0%
		% of Total	4.8%	3.1%	7.9%
	neither agree nor disagree	Count	19	26	45
		Expected Count	16.5	28.5	45.0
		% within Statements	42.2%	57.8%	100.0%
		% of Total	6.5%	8.9%	15.4%
	disagree	Count	38	55	93
		Expected Count	34.1	58.9	93.0
		% within Statements	40.9%	59.1%	100.0%
		% of Total	13.0%	18.8%	31.8%
	strongly disagree	Count	34	88	122
		Expected Count	44.7	77.3	122.0
		% within Statements	27.9%	72.1%	100.0%
		% of Total	11.6%	30.1%	41.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.982(a)	4	.017
Likelihood Ratio	11.916	4	.018
Linear-by-Linear Association	5.289	1	.021
N of Valid Cases	292		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 3.30.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about-Antiretroviral drugs are a cure for HIV/AIDS	strongly agree	Count	1	10	11
		Expected Count	4.0	7.0	11.0
		% within Statements	9.1%	90.9%	100.0%
		% of Total	.3%	3.4%	3.8%
	agree	Count	2	7	9
		Expected Count	3.3	5.7	9.0
		% within Statements	22.2%	77.8%	100.0%
		% of Total	.7%	2.4%	3.1%
	neither agree nor disagree	Count	29	40	69
		Expected Count	25.3	43.7	69.0
		% within Statements	42.0%	58.0%	100.0%
		% of Total	9.9%	13.7%	23.6%
	disagree	Count	42	53	95
		Expected Count	34.8	60.2	95.0
		% within Statements	44.2%	55.8%	100.0%
		% of Total	14.4%	18.2%	32.5%
	strongly disagree	Count	33	75	108
		Expected Count	39.6	68.4	108.0
		% within Statements	30.6%	69.4%	100.0%
		% of Total	11.3%	25.7%	37.0%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.332(a)	4	.053
Likelihood Ratio	10.208	4	.037
Linear-by-Linear Association	.027	1	.870
N of Valid Cases	292		

a 2 cells (20.0%) have expected count less than 5. The minimum expected count is 3.30.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about - People who knowingly expose others to HIV/AIDS should be prosecuted as criminals	strongly agree	Count	40	43	83
		Expected Count	30.4	52.6	83.0
		% within Statements	48.2%	51.8%	100.0%
		% of Total	13.7%	14.7%	28.4%
	agree	Count	33	43	76
		Expected Count	27.8	48.2	76.0
		% within Statements	43.4%	56.6%	100.0%
		% of Total	11.3%	14.7%	26.0%
	neither agree nor disagree	Count	24	55	79
		Expected Count	28.9	50.1	79.0
		% within Statements	30.4%	69.6%	100.0%
		% of Total	8.2%	18.8%	27.1%
	disagree	Count	5	22	27
		Expected Count	9.9	17.1	27.0
		% within Statements	18.5%	81.5%	100.0%
		% of Total	1.7%	7.5%	9.2%
	strongly disagree	Count	5	22	27
		Expected Count	9.9	17.1	27.0
		% within Statements	18.5%	81.5%	100.0%
		% of Total	1.7%	7.5%	9.2%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.249(a)	4	.004
Likelihood Ratio	15.945	4	.003
Linear-by-Linear Association	14.376	1	.000
N of Valid Cases	292		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.89.

			My HIV status is		Total
			Negative	Positive	Negative
How do you feel about - HIV/AIDS is God's way of punishing the wicked	strongly agree	Count	2	5	7
		Expected Count	2.6	4.4	7.0
		% within Statements	28.6%	71.4%	100.0%
		% of Total	.7%	1.7%	2.4%
	agree	Count	7	3	10
		Expected Count	3.7	6.3	10.0
		% within Statements	70.0%	30.0%	100.0%
		% of Total	2.4%	1.0%	3.4%
	neither agree nor disagree	Count	6	18	24
		Expected Count	8.8	15.2	24.0
		% within Statements	25.0%	75.0%	100.0%
		% of Total	2.1%	6.2%	8.2%
	disagree	Count	14	39	53
		Expected Count	19.4	33.6	53.0
		% within Statements	26.4%	73.6%	100.0%
		% of Total	4.8%	13.4%	18.2%
	strongly disagree	Count	78	120	198
		Expected Count	72.6	125.4	198.0
		% within Statements	39.4%	60.6%	100.0%
		% of Total	26.7%	41.1%	67.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.424(a)	4	.051
Likelihood Ratio	9.413	4	.052
Linear-by-Linear Association	.173	1	.678
N of Valid Cases	292		

a 3 cells (30.0%) have expected count less than 5. The minimum expected count is 2.57.

		My HIV status is		Total	
			Negative	Positive	Negative
How do you feel about - People with HIV/AIDS deserve the same rights in the workplace as other workers	strongly agree	Count	0	8	8
		Expected Count	2.9	5.1	8.0
		% within Statements	.0%	100.0%	100.0%
		% of Total	.0%	2.7%	2.7%
	agree	Count	3	4	7
		Expected Count	2.6	4.4	7.0
		% within Statements	42.9%	57.1%	100.0%
		% of Total	1.0%	1.4%	2.4%
	neither agree nor disagree	Count	9	10	19
		Expected Count	7.0	12.0	19.0
		% within Statements	47.4%	52.6%	100.0%
		% of Total	3.1%	3.4%	6.5%
	disagree	Count	29	28	57
		Expected Count	20.9	36.1	57.0
		% within Statements	50.9%	49.1%	100.0%
		% of Total	9.9%	9.6%	19.5%
	strongly disagree	Count	66	135	201
		Expected Count	73.7	127.3	201.0
		% within Statements	32.8%	67.2%	100.0%
		% of Total	22.6%	46.2%	68.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.914(a)	4	.018
Likelihood Ratio	14.388	4	.006
Linear-by-Linear Association	.054	1	.817
N of Valid Cases	292		

a 3 cells (30.0%) have expected count less than 5. The minimum expected count is 2.57.

		My HIV status is		Total	
		Negative	Positive	Negative	
How do you feel about - Treating HIV/AIDS is a lucrative business for pharmaceutical companies	strongly agree	Count	17	58	75
		Expected Count	27.5	47.5	75.0
		% within Statements	22.7%	77.3%	100.0%
		% of Total	5.8%	19.9%	25.7%
agree		Count	34	44	78
		Expected Count	28.6	49.4	78.0
		% within Statements	43.6%	56.4%	100.0%
		% of Total	11.6%	15.1%	26.7%
neither agree nor disagree		Count	38	50	88
		Expected Count	32.2	55.8	88.0
		% within Statements	43.2%	56.8%	100.0%
		% of Total	13.0%	17.1%	30.1%
disagree		Count	12	15	27
		Expected Count	9.9	17.1	27.0
		% within Statements	44.4%	55.6%	100.0%
		% of Total	4.1%	5.1%	9.2%
strongly disagree		Count	6	18	24
		Expected Count	8.8	15.2	24.0
		% within Statements	25.0%	75.0%	100.0%
		% of Total	2.1%	6.2%	8.2%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.662(a)	4	.020
Likelihood Ratio	12.139	4	.016
Linear-by-Linear Association	1.485	1	.223
N of Valid Cases	292		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.79.

		My HIV status is		Total	
		Negative	Positive	Negative	
How do you feel about - I am not personally worried about getting HIV/AIDS	strongly agree	Count	8	14	22
		Expected Count	8.1	13.9	22.0
		% within Statements	36.4%	63.6%	100.0%
		% of Total	2.7%	4.8%	7.5%
agree		Count	26	10	36
		Expected Count	13.2	22.8	36.0
		% within Statements	72.2%	27.8%	100.0%
		% of Total	8.9%	3.4%	12.3%
neither agree nor disagree		Count	24	57	81
		Expected Count	29.7	51.3	81.0
		% within Statements	29.6%	70.4%	100.0%
		% of Total	8.2%	19.5%	27.7%
disagree		Count	23	40	63
		Expected Count	23.1	39.9	63.0
		% within Statements	36.5%	63.5%	100.0%
		% of Total	7.9%	13.7%	21.6%
strongly disagree		Count	26	64	90
		Expected Count	33.0	57.0	90.0
		% within Statements	28.9%	71.1%	100.0%
		% of Total	8.9%	21.9%	30.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within Statements	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	23.678(a)	4	.000
Likelihood Ratio	22.979	4	.000
Linear-by-Linear Association	6.726	1	.010
N of Valid Cases	292		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.06.

PERCEPTION STATEMENTS VS. ETHNIC GROUP

			which group do you identify with?						
			american indian, alaskan native, or pacific islander	asian/asian american	black/african american or negro	hispanic	White / caucasian	multiracial	other
How do you feel about - Alternative medical treatments for HIV/AIDS have shown promising results	strongly agree	Count	3	1	27	9	9	7	2
		Expected Count	1.5	.7	20.9	9.1	21.7	3.1	1.0
		% within statements	5.2%	1.7%	46.6%	15.5%	15.5%	12.1%	3.4%
		% of Total	.9%	.3%	8.0%	2.7%	2.7%	2.1%	.6%
	agree	Count	1	1	38	10	35	3	1
		Expected Count	2.4	1.1	32.0	13.9	33.3	4.7	1.6
		% within statements	1.1%	1.1%	42.7%	11.2%	39.3%	3.4%	1.1%
		% of Total	.3%	.3%	11.2%	2.9%	10.3%	.9%	.3%
	neither agree nor disagree	Count	2	2	44	22	62	7	3
		Expected Count	3.8	1.7	51.1	22.2	53.2	7.5	2.5
		% within statements	1.4%	1.4%	31.0%	15.5%	43.7%	4.9%	2.1%
		% of Total	.6%	.6%	13.0%	6.5%	18.3%	2.1%	.9%
	disagree	Count	2	0	8	7	13	0	0
		Expected Count	.8	.4	10.8	4.7	11.2	1.6	.5
		% within statements	6.7%	.0%	26.7%	23.3%	43.3%	.0%	.0%
		% of Total	.6%	.0%	2.4%	2.1%	3.8%	.0%	.0%
	strongly disagree	Count	1	0	5	5	8	1	0
		Expected Count	.5	.2	7.2	3.1	7.5	1.1	.4
		% within statements	5.0%	.0%	25.0%	25.0%	40.0%	5.0%	.0%
		% of Total	.3%	.0%	1.5%	1.5%	2.4%	.3%	.0%

Total	Count	9	4	122	53	127	18	6
	Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0
	% within statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.366(a)	24	.097
Likelihood Ratio	36.283	24	.052
Linear-by-Linear Association	1.664	1	.197
N of Valid Cases	339		

a. 21 cells (60.0%) have expected count less than 5. The minimum expected count is .24.

		Which group do you identify with?							Total	
		american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander	
How do you feel about- Poor people are more likely to get HIV/AIDS	strongly agree	Count	2	0	6	3	4	2	0	17
		Expected Count	.5	.2	6.1	2.7	6.4	.9	.3	17.0
		% within Statements	11.8%	.0%	35.3%	17.6%	23.5%	11.8%	.0%	100.0%
		% of Total	.6%	.0%	1.8%	.9%	1.2%	.6%	.0%	5.0%
	agree	Count	2	0	13	13	24	2	1	55
		Expected Count	1.5	.6	19.8	8.6	20.6	2.9	1.0	55.0
		% within Statements	3.6%	.0%	23.6%	23.6%	43.6%	3.6%	1.8%	100.0%
		% of Total	.6%	.0%	3.8%	3.8%	7.1%	.6%	.3%	16.2%
	neither agree nor disagree	Count	3	1	33	7	25	4	0	73

		Expected Count	1.9	.9	26.3	11.4	27.3	3.9	1.3	73.0
		% within Statements	4.1%	1.4%	45.2%	9.6%	34.2%	5.5%	.0%	100.0%
		% of Total	.9%	.3%	9.7%	2.1%	7.4%	1.2%	.0%	21.5%
	disagree	Count	0	3	31	12	34	6	0	86
		Expected Count	2.3	1.0	30.9	13.4	32.2	4.6	1.5	86.0
		% within Statements	.0%	3.5%	36.0%	14.0%	39.5%	7.0%	.0%	100.0%
		% of Total	.0%	.9%	9.1%	3.5%	10.0%	1.8%	.0%	25.4%
	strongly disagree	Count	2	0	39	18	40	4	5	108
		Expected Count	2.9	1.3	38.9	16.9	40.5	5.7	1.9	108.0
		% within Statements	1.9%	.0%	36.1%	16.7%	37.0%	3.7%	4.6%	100.0%
		% of Total	.6%	.0%	11.5%	5.3%	11.8%	1.2%	1.5%	31.9%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	35.416(a)	24	.062
Likelihood Ratio	37.491	24	.039
Linear-by-Linear Association	.952	1	.329
N of Valid Cases	339		

a 20 cells (57.1%) have expected count less than 5. The minimum expected count is .20.

		Which group do you identify with?								Total
		american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander	
How do you feel about- Globally the number of people with HIV/AIDS is decreasing	strongly agree	Count	2	0	9	1	1	1	1	15
		Expected Count	.4	.2	5.4	2.3	5.6	.8	.3	15.0
		% within Statements	13.3%	.0%	60.0%	6.7%	6.7%	6.7%	6.7%	100.0%
		% of Total	.6%	.0%	2.7%	.3%	.3%	.3%	.3%	4.4%
	agree	Count	1	0	6	4	4	0	0	15
		Expected Count	.4	.2	5.4	2.3	5.6	.8	.3	15.0
		% within Statements	6.7%	.0%	40.0%	26.7%	26.7%	.0%	.0%	100.0%
		% of Total	.3%	.0%	1.8%	1.2%	1.2%	.0%	.0%	4.4%

	neither agree nor disagree	Count	1	3	35	15	25	5	2	86
		Expected Count	2.3	1.0	30.9	13.4	32.2	4.6	1.5	86.0
		% within Statements	1.2%	3.5%	40.7%	17.4%	29.1%	5.8%	2.3%	100.0%
		% of Total	.3%	.9%	10.3%	4.4%	7.4%	1.5%	.6%	25.4%
	disagree	Count	2	1	35	12	48	4	0	102
		Expected Count	2.7	1.2	36.7	15.9	38.2	5.4	1.8	102.0
		% within Statements	2.0%	1.0%	34.3%	11.8%	47.1%	3.9%	.0%	100.0%
		% of Total	.6%	.3%	10.3%	3.5%	14.2%	1.2%	.0%	30.1%
	strongly disagree	Count	3	0	37	21	49	8	3	121
		Expected Count	3.2	1.4	43.5	18.9	45.3	6.4	2.1	121.0
		% within Statements	2.5%	.0%	30.6%	17.4%	40.5%	6.6%	2.5%	100.0%
		% of Total	.9%	.0%	10.9%	6.2%	14.5%	2.4%	.9%	35.7%
Total	Count	9	4	122	53	127	18	6	339	
	Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0	
	% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%	
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	36.290(a)	24	.051
Likelihood Ratio	37.135	24	.042
Linear-by-Linear Association	9.076	1	.003
N of Valid Cases	339		

a 20 cells (57.1%) have expected count less than 5. The minimum expected count is .18.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about - HIV/AIDS is primarily a gay disease	strongly agree	Count	3	0	5	0	2	1	0	11
		Expected Count	.3	.1	4.0	1.7	4.1	.6	.2	11.0
		% within Statements	27.3%	.0%	45.5%	.0%	18.2%	9.1%	.0%	100.0%
		% of Total	.9%	.0%	1.5%	.0%	.6%	.3%	.0%	3.2%
	agree	Count	0	0	6	2	5	1	0	14
		Expected Count	.4	.2	5.0	2.2	5.2	.7	.2	14.0
		% within Statements	.0%	.0%	42.9%	14.3%	35.7%	7.1%	.0%	100.0%
		% of Total	.0%	.0%	1.8%	.6%	1.5%	.3%	.0%	4.1%
	neither agree nor disagree	Count	3	1	11	4	13	2	0	34
		Expected Count	.9	.4	12.2	5.3	12.7	1.8	.6	34.0
		% within Statements	8.8%	2.9%	32.4%	11.8%	38.2%	5.9%	.0%	100.0%
		% of Total	.9%	.3%	3.2%	1.2%	3.8%	.6%	.0%	10.0%
	disagree	Count	1	1	38	14	39	3	1	97

		Expected Count	2.6	1.1	34.9	15.2	36.3	5.2	1.7	97.0
		% within Statements	1.0%	1.0%	39.2%	14.4%	40.2%	3.1%	1.0%	100.0%
		% of Total	.3%	.3%	11.2%	4.1%	11.5%	.9%	.3%	28.6%
	strongly disagree	Count	2	2	62	33	68	11	5	183
		Expected Count	4.9	2.2	65.9	28.6	68.6	9.7	3.2	183.0
		% within Statements	1.1%	1.1%	33.9%	18.0%	37.2%	6.0%	2.7%	100.0%
		% of Total	.6%	.6%	18.3%	9.7%	20.1%	3.2%	1.5%	54.0%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	43.208(a)	24	.009
Likelihood Ratio	28.976	24	.221
Linear-by-Linear Association	7.353	1	.007
N of Valid Cases	339		

a 22 cells (62.9%) have expected count less than 5. The minimum expected count is .13.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about- Antiretroviral drugs are a cure for HIV/AIDS	strongly agree	Count	3	0	5	5	2	1	0	16
		Expected Count	.4	.2	5.8	2.5	6.0	.8	.3	16.0
		% within Statements	18.8%	.0%	31.3%	31.3%	12.5%	6.3%	.0%	100.0%
		% of Total	.9%	.0%	1.5%	1.5%	.6%	.3%	.0%	4.7%
	agree	Count	1	0	7	2	2	0	0	12
		Expected Count	.3	.1	4.3	1.9	4.5	.6	.2	12.0
		% within Statements	8.3%	.0%	58.3%	16.7%	16.7%	.0%	.0%	100.0%
		% of Total	.3%	.0%	2.1%	.6%	.6%	.0%	.0%	3.5%
	neither agree nor disagree	Count	1	1	30	13	24	6	3	78
		Expected Count	2.1	.9	28.1	12.2	29.2	4.1	1.4	78.0
		% within Statements	1.3%	1.3%	38.5%	16.7%	30.8%	7.7%	3.8%	100.0%
		% of Total	.3%	.3%	8.8%	3.8%	7.1%	1.8%	.9%	23.0%
	disagree	Count	2	3	39	18	48	6	0	116
		Expected	3.1	1.4	41.7	18.1	43.5	6.2	2.1	116.0

		Count								
		% within Statements	1.7%	2.6%	33.6%	15.5%	41.4%	5.2%	.0%	100.0%
		% of Total	.6%	.9%	11.5%	5.3%	14.2%	1.8%	.0%	34.2%
	strongly disagree	Count	2	0	41	15	51	5	3	117
		Expected Count	3.1	1.4	42.1	18.3	43.8	6.2	2.1	117.0
		% within Statements	1.7%	.0%	35.0%	12.8%	43.6%	4.3%	2.6%	100.0%
		% of Total	.6%	.0%	12.1%	4.4%	15.0%	1.5%	.9%	34.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	40.546(a)	24	.019
Likelihood Ratio	35.501	24	.061
Linear-by-Linear Association	7.045	1	.008
N of Valid Cases	339		

a. 22 cells (62.9%) have expected count less than 5. The minimum expected count is .14.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about - You cannot get HIV/AIDS during sex if condoms are always used	strongly agree	Count	4	0	8	7	4	1	0	24
		Expected Count	.6	.3	8.6	3.8	9.0	1.3	.4	24.0
		% within Statements	16.7%	.0%	33.3%	29.2%	16.7%	4.2%	.0%	100.0%
		% of Total	1.2%	.0%	2.4%	2.1%	1.2%	.3%	.0%	7.1%
	agree	Count	0	0	17	6	15	1	0	39
		Expected Count	1.0	.5	14.0	6.1	14.6	2.1	.7	39.0
		% within Statements	.0%	.0%	43.6%	15.4%	38.5%	2.6%	.0%	100.0%
		% of Total	.0%	.0%	5.0%	1.8%	4.4%	.3%	.0%	11.5%
	neither agree nor disagree	Count	2	0	23	4	12	2	1	44
		Expected Count	1.2	.5	15.8	6.9	16.5	2.3	.8	44.0
		% within Statements	4.5%	.0%	52.3%	9.1%	27.3%	4.5%	2.3%	100.0%
		% of Total	.6%	.0%	6.8%	1.2%	3.5%	.6%	.3%	13.0%
	disagree	Count	1	3	40	20	64	6	3	137
		Expected	3.6	1.6	49.3	21.4	51.3	7.3	2.4	137.0

		Count								
		% within Statements	.7%	2.2%	29.2%	14.6%	46.7%	4.4%	2.2%	100.0%
		% of Total	.3%	.9%	11.8%	5.9%	18.9%	1.8%	.9%	40.4%
	strongly disagree	Count	2	1	34	16	32	8	2	95
		Expected Count	2.5	1.1	34.2	14.9	35.6	5.0	1.7	95.0
		% within Statements	2.1%	1.1%	35.8%	16.8%	33.7%	8.4%	2.1%	100.0%
		% of Total	.6%	.3%	10.0%	4.7%	9.4%	2.4%	.6%	28.0%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	45.213(a)	24	.005
Likelihood Ratio	39.125	24	.026
Linear-by-Linear Association	7.517	1	.006
N of Valid Cases	339		

a. 19 cells (54.3%) have expected count less than 5. The minimum expected count is .28.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about - An effective HIV/AIDS vaccine is available	strongly agree	Count	2	0	11	4	3	1	0	21
		Expected Count	.6	.2	7.6	3.3	7.9	1.1	.4	21.0
		% within Statements	9.5%	.0%	52.4%	19.0%	14.3%	4.8%	.0%	100.0%
		% of Total	.6%	.0%	3.2%	1.2%	.9%	.3%	.0%	6.2%
	agree	Count	0	0	16	7	5	2	0	30
		Expected Count	.8	.4	10.8	4.7	11.2	1.6	.5	30.0
		% within Statements		.0%	53.3%	23.3%	16.7%	6.7%	.0%	100.0%
		% of Total	.0%	.0%	4.7%	2.1%	1.5%	.6%	.0%	8.8%
	neither agree nor disagree	Count	1	1	50	16	30	5	4	107
		Expected Count	2.8	1.3	38.5	16.7	40.1	5.7	1.9	107.0
		% within Statements	.9%	.9%	46.7%	15.0%	28.0%	4.7%	3.7%	100.0%
		% of Total	.3%	.3%	14.7%	4.7%	8.8%	1.5%	1.2%	31.6%
	disagree	Count	5	3	22	16	47	6	0	99
		Expected	2.6	1.2	35.6	15.5	37.1	5.3	1.8	99.0

		Count								
		% within Statements	5.1%	3.0%	22.2%	16.2%	47.5%	6.1%	.0%	100.0%
		% of Total	1.5%	.9%	6.5%	4.7%	13.9%	1.8%	.0%	29.2%
	strongly disagree	Count	1	0	23	10	42	4	2	82
		Expected Count	2.2	1.0	29.5	12.8	30.7	4.4	1.5	82.0
		% within Statements	1.2%	.0%	28.0%	12.2%	51.2%	4.9%	2.4%	100.0%
		% of Total	.3%	.0%	6.8%	2.9%	12.4%	1.2%	.6%	24.2%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	50.452(a)	24	.001
Likelihood Ratio	54.079	24	.000
Linear-by-Linear Association	14.490	1	.000
N of Valid Cases	339		

a. 20 cells (57.1%) have expected count less than 5. The minimum expected count is .25.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ African American or negro	Hispanic	White / Caucasian	multiracial	other	
How do you feel about - Treating HIV/AIDS is a lucrative business for pharmaceutical companies	strongly agree	Count	2	0	33	6	35	6	2	84
		Expected Count	2.2	1.0	30.2	13.1	31.5	4.5	1.5	84.0
		% within Statements	2.4%	.0%	39.3%	7.1%	41.7%	7.1%	2.4%	100.0%
		% of Total	.6%	.0%	9.7%	1.8%	10.3%	1.8%	.6%	24.8%
	agree	Count	2	0	25	16	45	3	1	92
		Expected Count	2.4	1.1	33.1	14.4	34.5	4.9	1.6	92.0
		% within Statements	2.2%	.0%	27.2%	17.4%	48.9%	3.3%	1.1%	100.0%
		% of Total	.6%	.0%	7.4%	4.7%	13.3%	.9%	.3%	27.1%
	neither agree nor disagree	Count	3	3	45	13	33	7	3	107
		Expected Count	2.8	1.3	38.5	16.7	40.1	5.7	1.9	107.0
		% within Statements	2.8%	2.8%	42.1%	12.1%	30.8%	6.5%	2.8%	100.0%
		% of Total	.9%	.9%	13.3%	3.8%	9.7%	2.1%	.9%	31.6%
	disagree	Count	1	1	10	8	10	0	0	30
		Expected	.8	.4	10.8	4.7	11.2	1.6	.5	30.0

		Count								
		% within Statements	3.3%	3.3%	33.3%	26.7%	33.3%	.0%	.0%	100.0%
		% of Total	.3%	.3%	2.9%	2.4%	2.9%	.0%	.0%	8.8%
	strongly disagree	Count	1	0	9	10	4	2	0	26
		Expected Count	.7	.3	9.4	4.1	9.7	1.4	.5	26.0
		% within Statements	3.8%	.0%	34.6%	38.5%	15.4%	7.7%	.0%	100.0%
		% of Total	.3%	.0%	2.7%	2.9%	1.2%	.6%	.0%	7.7%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	39.433(a)	24	.025
Likelihood Ratio	42.250	24	.012
Linear-by-Linear Association	4.052	1	.044
N of Valid Cases	339		

a. 21 cells (60.0%) have expected count less than 5. The minimum expected count is .31.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
How do you feel about - I am not personally worried about getting HIV/AIDS	strongly agree	Count	4	0	9	0	9	3	1	26
		Expected Count	.7	.3	9.4	4.1	9.7	1.4	.5	26.0
		% within Statements	15.4%	.0%	34.6%	.0%	34.6%	11.5%	3.8%	100.0%
		% of Total	1.2%	.0%	2.7%	.0%	2.7%	.9%	.3%	7.7%
	agree	Count	0	0	10	10	17	2	2	41
		Expected Count	1.1	.5	14.8	6.4	15.4	2.2	.7	41.0
		% within Statements	.0%	.0%	24.4%	24.4%	41.5%	4.9%	4.9%	100.0%
		% of Total	.0%	.0%	2.9%	2.9%	5.0%	.6%	.6%	12.1%
	neither agree nor disagree	Count	2	1	33	13	43	5	0	97
		Expected Count	2.6	1.1	34.9	15.2	36.3	5.2	1.7	97.0
		% within Statements	2.1%	1.0%	34.0%	13.4%	44.3%	5.2%	.0%	100.0%
		% of Total	.6%	.3%	9.7%	3.8%	12.7%	1.5%	.0%	28.6%
	disagree	Count	1	2	31	11	27	4	1	77
		Expected Count	2.0	.9	27.7	12.0	28.8	4.1	1.4	77.0

		% within Statements	1.3%	2.6%	40.3%	14.3%	35.1%	5.2%	1.3%	100.0%
		% of Total	.3%	.6%	9.1%	3.2%	8.0%	1.2%	.3%	22.7%
	strongly disagree	Count	2	1	39	19	31	4	2	98
		Expected Count	2.6	1.2	35.3	15.3	36.7	5.2	1.7	98.0
		% within Statements	2.0%	1.0%	39.8%	19.4%	31.6%	4.1%	2.0%	100.0%
		% of Total	.6%	.3%	11.5%	5.6%	9.1%	1.2%	.6%	28.9%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	39.077(a)	24	.027
Likelihood Ratio	36.587	24	.048
Linear-by-Linear Association	1.067	1	.302
N of Valid Cases	339		

a 19 cells (54.3%) have expected count less than 5. The minimum expected count is .31.

		Which group do you identify with?								Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander
How do you feel about - Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact	strongly agree	Count	1	0	15	8	6	2	0	32
		Expected Count	.8	.4	11.5	5.0	12.0	1.7	.6	32.0
		% within Statements	3.1%	.0%	46.9%	25.0%	18.8%	6.3%	.0%	100.0%
		% of Total	.3%	.0%	4.4%	2.4%	1.8%	.6%	.0%	9.4%
	agree	Count	0	2	23	5	13	1	0	44
		Expected Count	1.2	.5	15.8	6.9	16.5	2.3	.8	44.0

		% within Statements	.0%	4.5%	52.3%	11.4%	29.5%	2.3%	.0%	100.0%
		% of Total	.0%	.6%	6.8%	1.5%	3.8%	.3%	.0%	13.0%
	neither agree nor disagree	Count	2	2	52	27	50	8	4	145
		Expected Count	3.8	1.7	52.2	22.7	54.3	7.7	2.6	145.0
		% within Statements	1.4%	1.4%	35.9%	18.6%	34.5%	5.5%	2.8%	100.0%
		% of Total	.6%	.6%	15.3%	8.0%	14.7%	2.4%	1.2%	42.8%
	disagree	Count	2	0	22	9	39	5	1	78
		Expected Count	2.1	.9	28.1	12.2	29.2	4.1	1.4	78.0
		% within Statements	2.6%	.0%	28.2%	11.5%	50.0%	6.4%	1.3%	100.0%
		% of Total	.6%	.0%	6.5%	2.7%	11.5%	1.5%	.3%	23.0%
	strongly disagree	Count	4	0	10	4	19	2	1	40
		Expected Count	1.1	.5	14.4	6.3	15.0	2.1	.7	40.0
		% within Statements	10.0%	.0%	25.0%	10.0%	47.5%	5.0%	2.5%	100.0%
		% of Total	1.2%	.0%	2.9%	1.2%	5.6%	.6%	.3%	11.8%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within Statements	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	39.799(a)	24	.022
Likelihood Ratio	39.215	24	.026
Linear-by-Linear Association	5.690	1	.017
N of Valid Cases	339		

a 19 cells (54.3%) have expected count less than 5. The minimum expected count is .38.

PERCEPTION STATEMENTS VS. AGE

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
How do you feel about - HIV/AIDS is primarily a gay disease	strongly agree	Count	1	6	3	1	0	11
		Expected Count	1.7	2.9	3.3	2.5	.6	11.0
		% within Statements	9.1%	54.5%	27.3%	9.1%	.0%	100.0%
		% of Total	.3%	1.8%	.9%	.3%	.0%	3.2%
	agree	Count	5	1	5	2	1	14
		Expected Count	2.2	3.7	4.2	3.2	.7	14.0
		% within Statements	35.7%	7.1%	35.7%	14.3%	7.1%	100.0%
		% of Total	1.5%	.3%	1.5%	.6%	.3%	4.1%
	neither agree nor disagree	Count	10	5	11	5	2	33
		Expected Count	5.1	8.6	10.0	7.5	1.7	33.0
		% within Statements	30.3%	15.2%	33.3%	15.2%	6.1%	100.0%
		% of Total	2.9%	1.5%	3.2%	1.5%	.6%	9.7%
	disagree	Count	15	17	31	29	5	97
		Expected Count	15.1	25.4	29.4	22.0	5.1	97.0
		% within Statements	15.5%	17.5%	32.0%	29.9%	5.2%	100.0%
		% of Total	4.4%	5.0%	9.1%	8.5%	1.5%	28.5%
	strongly disagree	Count	22	60	53	40	10	185
		Expected Count	28.8	48.4	56.0	41.9	9.8	185.0
		% within Statements	11.9%	32.4%	28.6%	21.6%	5.4%	100.0%
		% of Total	6.5%	17.6%	15.6%	11.8%	2.9%	54.4%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within Statements	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	28.254(a)	16	.029
Likelihood Ratio	27.695	16	.034
Linear-by-Linear Association	1.894	1	.169
N of Valid Cases	340		

a 11 cells (44.0%) have expected count less than 5. The minimum expected count is .58.

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
How do you feel about - Alternative medical treatments for HIV/AIDS have shown promising results	strongly agree	Count	11	14	17	17	0	59
		Expected Count	9.2	15.4	17.9	13.4	3.1	59.0
		% within Statements	18.6%	23.7%	28.8%	28.8%	.0%	100.0%
		% of Total	3.2%	4.1%	5.0%	5.0%	.0%	17.4%
	agree	Count	11	19	34	20	4	88
		Expected Count	13.7	23.0	26.7	19.9	4.7	88.0
		% within Statements	12.5%	21.6%	38.6%	22.7%	4.5%	100.0%
		% of Total	3.2%	5.6%	10.0%	5.9%	1.2%	25.9%
	neither agree nor disagree	Count	24	44	45	25	5	143
		Expected Count	22.3	37.4	43.3	32.4	7.6	143.0
		% within Statements	16.8%	30.8%	31.5%	17.5%	3.5%	100.0%
		% of Total	7.1%	12.9%	13.2%	7.4%	1.5%	42.1%
	disagree	Count	4	8	1	11	6	30
		Expected Count	4.7	7.9	9.1	6.8	1.6	30.0
		% within Statements	13.3%	26.7%	3.3%	36.7%	20.0%	100.0%
		% of Total	1.2%	2.4%	.3%	3.2%	1.8%	8.8%
	strongly disagree	Count	3	4	6	4	3	20
		Expected Count	3.1	5.2	6.1	4.5	1.1	20.0
		% within Statements	15.0%	20.0%	30.0%	20.0%	15.0%	100.0%
		% of Total	.9%	1.2%	1.8%	1.2%	.9%	5.9%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within Statements	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	37.986(a)	16	.002
Likelihood Ratio	39.001	16	.001
Linear-by-Linear Association	1.318	1	.251
N of Valid Cases	340		

a 7 cells (28.0%) have expected count less than 5. The minimum expected count is 1.06.

PERCEPTION STATEMENTS VS. SEXUAL ORIENTATION

			sexual orientation			Total
			Heterosexual	Homosexual	Bi-sexual	
How do you feel about - A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby	strongly agree	Count	12	5	1	18
		Expected Count	8.4	7.6	2.0	18.0
		% within Statements	66.7%	27.8%	5.6%	100.0%
		% of Total	3.9%	1.6%	.3%	5.8%
	agree	Count	8	12	0	20
		Expected Count	9.4	8.4	2.2	20.0
		% within Statements	40.0%	60.0%	.0%	100.0%
		% of Total	2.6%	3.9%	.0%	6.5%
	neither agree nor disagree	Count	19	31	9	59
		Expected Count	27.7	24.8	6.5	59.0
		% within Statements	32.2%	52.5%	15.3%	100.0%
		% of Total	6.1%	10.0%	2.9%	19.1%
	disagree	Count	55	36	17	108
		Expected Count	50.7	45.4	11.9	108.0
		% within Statements	50.9%	33.3%	15.7%	100.0%
		% of Total	17.8%	11.7%	5.5%	35.0%
	strongly disagree	Count	51	46	7	104
		Expected Count	48.8	43.8	11.4	104.0
		% within Statements	49.0%	44.2%	6.7%	100.0%
		% of Total	16.5%	14.9%	2.3%	33.7%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within Statements	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.908(a)	8	.031
Likelihood Ratio	17.302	8	.027
Linear-by-Linear Association	3.753	1	.053
N of Valid Cases	309		

a 2 cells (13.3%) have expected count less than 5. The minimum expected count is 3.52.

			Heterosexual	Homosexual	Bi-sexual	1.00
How do you feel about - Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact	strongly agree	Count	15	12	0	27
		Expected Count	12.7	11.4	3.0	27.0
		% within Statements	55.6%	44.4%	.0%	100.0%
		% of Total	4.9%	3.9%	.0%	8.7%
	agree	Count	17	18	6	41
		Expected Count	19.2	17.2	4.5	41.0
		% within Statements	41.5%	43.9%	14.6%	100.0%
		% of Total	5.5%	5.8%	1.9%	13.3%
	neither agree nor disagree	Count	60	53	21	134
		Expected Count	62.9	56.4	14.7	134.0
		% within Statements	44.8%	39.6%	15.7%	100.0%
		% of Total	19.4%	17.2%	6.8%	43.4%
	disagree	Count	39	26	4	69
		Expected Count	32.4	29.0	7.6	69.0
		% within Statements	56.5%	37.7%	5.8%	100.0%
		% of Total	12.6%	8.4%	1.3%	22.3%

	strongly disagree	Count	14	21	3	38
		Expected Count	17.8	16.0	4.2	38.0
		% within Statements	36.8%	55.3%	7.9%	100.0%
		% of Total	4.5%	6.8%	1.0%	12.3%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within Statements	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.307(a)	8	.102
Likelihood Ratio	16.158	8	.040
Linear-by-Linear Association	.024	1	.878
N of Valid Cases	309		

a 3 cells (20.0%) have expected count less than 5. The minimum expected count is 2.97.

			sexual orientation			Total
			heterosexual	homosexual	bi-sexual	1.00
How do you feel about - It is biologically easier for woman to get HIV/AIDS than it is for men	strongly agree	Count	22	7	3	32
		Expected Count	15.0	13.5	3.5	32.0
		% within statements	68.8%	21.9%	9.4%	100.0%
		% of Total	7.1%	2.3%	1.0%	10.4%
	agree	Count	19	10	6	35
		Expected Count	16.4	14.7	3.9	35.0
		% within statements	54.3%	28.6%	17.1%	100.0%
		% of Total	6.1%	3.2%	1.9%	11.3%
	neither agree nor disagree	Count	56	47	12	115
		Expected Count	54.0	48.4	12.7	115.0
		% within statements	48.7%	40.9%	10.4%	100.0%
		% of Total	18.1%	15.2%	3.9%	37.2%
	disagree	Count	23	32	9	64
		Expected Count	30.0	26.9	7.0	64.0
		% within statements	35.9%	50.0%	14.1%	100.0%
		% of Total	7.4%	10.4%	2.9%	20.7%
	strongly disagree	Count	25	34	4	63
		Expected Count	29.6	26.5	6.9	63.0
		% within statements	39.7%	54.0%	6.3%	100.0%
		% of Total	8.1%	11.0%	1.3%	20.4%

Total	Count	145	130	34	309
	Expected Count	145.0	130.0	34.0	309.0
	% within statements	46.9%	42.1%	11.0%	100.0%
	% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.908(a)	8	.031
Likelihood Ratio	17.302	8	.027
Linear-by-Linear Association	3.753	1	.053
N of Valid Cases	309		

a 2 cells (13.3%) have expected count less than 5. The minimum expected count is 3.52.

**CROSSTABS:
TREATMENTS KNOWN AND DEMOGRAPHIC VARIABLES**

TREATMENTS KNOWN VS. SEXUAL ORIENTATION

		sexual orientation			Total	
			Heterosexual	Homosexual	Bi-sexual	1.00
treatments that you have heard of - Chelation-IV	not selected	Count	143	122	34	299
		Expected Count	140.3	125.8	32.9	299.0
		% within treatments	47.8%	40.8%	11.4%	100.0%
		% of Total	46.3%	39.5%	11.0%	96.8%
	selected	Count	2	8	0	10
		Expected Count	4.7	4.2	1.1	10.0
		% within treatments	20.0%	80.0%	.0%	100.0%
		% of Total	.6%	2.6%	.0%	3.2%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.268(a)	2	.044
Likelihood Ratio	7.075	2	.029
Linear-by-Linear Association	.580	1	.446
N of Valid Cases	309		

a 3 cells (50.0%) have expected count less than 5. The minimum expected count is 1.10.

		sexual orientation			Total	
		Heter	Homo	Bi-sexual	1.00	
treatments that you have heard of - Nutritional supplements	not selected	Count	121	84	25	230
		Expected Count	107.9	96.8	25.3	230.0
		% within treatments	52.6%	36.5%	10.9%	100.0%
		% of Total	39.2%	27.2%	8.1%	74.4%
	selected	Count	24	46	9	79
		Expected Count	37.1	33.2	8.7	79.0
		% within treatments	30.4%	58.2%	11.4%	100.0%
		% of Total	7.8%	14.9%	2.9%	25.6%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.792(a)	2	.002
Likelihood Ratio	12.945	2	.002
Linear-by-Linear Association	6.739	1	.009
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.69.

		sexual orientation			Total	
		Heter	Homo	Bi-sexual	1.00	
treatments that you have heard of – AZT (Azidothymidine)	not selected	Count	82	46	17	145
		Expected Count	68.0	61.0	16.0	145.0
		% within treatments	56.6%	31.7%	11.7%	100.0%
		% of Total	26.5%	14.9%	5.5%	46.9%
	selected	Count	63	84	17	164
		Expected Count	77.0	69.0	18.0	164.0
		% within treatments	38.4%	51.2%	10.4%	100.0%
		% of Total	20.4%	27.2%	5.5%	53.1%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.476(a)	2	.002
Likelihood Ratio	12.599	2	.002
Linear-by-Linear Association	4.796	1	.029
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 15.95.

		sexual orientation			Total	
		Heter	Homo	Bi-sexual	1.00	
treatments that you have heard of - Pharmaceutical antibodies (bactrim, etc)	not selected	Count	103	67	21	191
		Expected Count	89.6	80.4	21.0	191.0
		% within treatments	53.9%	35.1%	11.0%	100.0%
		% of Total	33.3%	21.7%	6.8%	61.8%
	selected	Count	42	63	13	118
		Expected Count	55.4	49.6	13.0	118.0
		% within treatments	35.6%	53.4%	11.0%	100.0%
		% of Total	13.6%	20.4%	4.2%	38.2%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.038(a)	2	.004
Likelihood Ratio	11.091	2	.004
Linear-by-Linear Association	5.441	1	.020
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.98.

TREATMENTS KNOWN VS, STATUS

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Vitamins-Oral	not selected	Count	95	144	239
		Expected Count	87.6	151.4	239.0
		% within treatments	39.7%	60.3%	100.0%
		% of Total	32.5%	49.3%	81.8%
	selected	Count	12	41	53
		Expected Count	19.4	33.6	53.0
		% within treatments	22.6%	77.4%	100.0%
		% of Total	4.1%	14.0%	18.2%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.469(b)	1	.019		
Continuity Correction(a)	4.756	1	.029		
Likelihood Ratio	5.800	1	.016		
Fisher's Exact Test				.027	.013
Linear-by-Linear Association	5.450	1	.020		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 19.42.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Minerals-Oral	not selected	Count	100	160	260
		Expected Count	95.3	164.7	260.0
		% within treatments	38.5%	61.5%	100.0%
		% of Total	34.2%	54.8%	89.0%
	selected	Count	7	25	32
		Expected Count	11.7	20.3	32.0
		% within treatments	21.9%	78.1%	100.0%
		% of Total	2.4%	8.6%	11.0%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.376(b)	1	.066		
Continuity Correction(a)	2.700	1	.100		
Likelihood Ratio	3.622	1	.057		
Fisher's Exact Test				.080	.047
Linear-by-Linear Association	3.365	1	.067		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.73.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Peroxide-IV	not selected	Count	106	175	281
		Expected Count	103.0	178.0	281.0
		% within treatments	37.7%	62.3%	100.0%
		% of Total	36.3%	59.9%	96.2%
	selected	Count	1	10	11
		Expected Count	4.0	7.0	11.0
		% within treatments	9.1%	90.9%	100.0%
		% of Total	.3%	3.4%	3.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.738(b)	1	.053		
Continuity Correction(a)	2.606	1	.106		
Likelihood Ratio	4.574	1	.032		
Fisher's Exact Test				.060	.046
Linear-by-Linear Association	3.725	1	.054		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.03.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Peroxide-Oral	not selected	Count	106	176	282
		Expected Count	103.3	178.7	282.0
		% within treatments	37.6%	62.4%	100.0%
		% of Total	36.3%	60.3%	96.6%
	selected	Count	1	9	10
		Expected Count	3.7	6.3	10.0
		% within treatments	10.0%	90.0%	100.0%
		% of Total	.3%	3.1%	3.4%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.166(b)	1	.075		
Continuity Correction(a)	2.089	1	.148		
Likelihood Ratio	3.829	1	.050		
Fisher's Exact Test				.099	.067
Linear-by-Linear Association	3.155	1	.076		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.66.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Nutritional supplements	not selected	Count	89	127	216
		Expected Count	79.2	136.8	216.0
		% within treatments	41.2%	58.8%	100.0%
		% of Total	30.5%	43.5%	74.0%
	selected	Count	18	58	76
		Expected Count	27.8	48.2	76.0
		% within treatments	23.7%	76.3%	100.0%
		% of Total	6.2%	19.9%	26.0%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.433(b)	1	.006		
Continuity Correction(a)	6.697	1	.010		
Likelihood Ratio	7.781	1	.005		
Fisher's Exact Test				.008	.004
Linear-by-Linear Association	7.407	1	.006		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 27.85.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of – AZT (azidothymidine)	not selected	Count	68	67	135
		Expected Count	49.5	85.5	135.0
		% within treatments	50.4%	49.6%	100.0%
		% of Total	23.3%	22.9%	46.2%
	selected	Count	39	118	157
		Expected Count	57.5	99.5	157.0
		% within treatments	24.8%	75.2%	100.0%
		% of Total	13.4%	40.4%	53.8%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	20.377(b)	1	.000		
Continuity Correction(a)	19.293	1	.000		
Likelihood Ratio	20.543	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	20.308	1	.000		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 49.47.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - HAART (Highly active antiretroviral therapy)	not selected	Count	75	93	168
		Expected Count	61.6	106.4	168.0
		% within treatments	44.6%	55.4%	100.0%
		% of Total	25.7%	31.8%	57.5%
	selected	Count	32	92	124
		Expected Count	45.4	78.6	124.0
		% within treatments	25.8%	74.2%	100.0%
		% of Total	11.0%	31.5%	42.5%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	10.903(b)	1	.001		
Continuity Correction(a)	10.107	1	.001		
Likelihood Ratio	11.128	1	.001		
Fisher's Exact Test				.001	.001
Linear-by-Linear Association	10.866	1	.001		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 45.44.

			My HIV status is		Total
			Negative	Positive	
treatments that you have heard of - Pharmaceutical antibodies (bactrim, etc)	not selected	Count	82	96	178
		Expected Count	65.2	112.8	178.0
		% within treatments	46.1%	53.9%	100.0%
		% of Total	28.1%	32.9%	61.0%
	selected	Count	25	89	114
		Expected Count	41.8	72.2	114.0
		% within treatments	21.9%	78.1%	100.0%
		% of Total	8.6%	30.5%	39.0%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	17.440(b)	1	.000		
Continuity Correction(a)	16.416	1	.000		
Likelihood Ratio	18.117	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	17.380	1	.000		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 41.77.

TREATMENTS KNOWN VS. ETHNIC GROUP

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
treatments that you have heard of - Vitamins-Oral	not selected	Count	7	4	111	45	93	13	6	279
		Expected Count	7.4	3.3	100.4	43.6	104.5	14.8	4.9	279.0
		% within treatments	2.5%	1.4%	39.8%	16.1%	33.3%	4.7%	2.2%	100.0%
		% of Total	2.1%	1.2%	32.7%	13.3%	27.4%	3.8%	1.8%	82.3%
	selected	Count	2	0	11	8	34	5	0	60
		Expected Count	1.6	.7	21.6	9.4	22.5	3.2	1.1	60.0
		% within treatments	3.3%	.0%	18.3%	13.3%	56.7%	8.3%	.0%	100.0%
		% of Total	.6%	.0%	3.2%	2.4%	10.0%	1.5%	.0%	17.7%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.270(a)	6	.008
Likelihood Ratio	19.226	6	.004
Linear-by-Linear Association	7.534	1	.006
N of Valid Cases	339		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is .71.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
treatments that you have heard of - Peroxide-Oral	not selected	Count	7	4	119	53	121	17	6	327
		Expected Count	8.7	3.9	117.7	51.1	122.5	17.4	5.8	327.0
		% within treatments	2.1%	1.2%	36.4%	16.2%	37.0%	5.2%	1.8%	100.0%
		% of Total	2.1%	1.2%	35.1%	15.6%	35.7%	5.0%	1.8%	96.5%
	selected	Count	2	0	3	0	6	1	0	12
		Expected Count	.3	.1	4.3	1.9	4.5	.6	.2	12.0
		% within treatments	16.7%	.0%	25.0%	.0%	50.0%	8.3%	.0%	100.0%
		% of Total	.6%	.0%	.9%	.0%	1.8%	.3%	.0%	3.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.665(a)	6	.049
Likelihood Ratio	9.998	6	.125
Linear-by-Linear Association	.212	1	.645
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .14.

		Which group do you identify with?								Total	
		american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander		
treatments that you have heard of - Porcine (pig) liver extracts-transdermal	not selected	Count	8	4	119	52	127	18	5	333	
		Expected Count	8.8	3.9	119.8	52.1	124.8	17.7	5.9	333.0	
		% within treatments	2.4%	1.2%	35.7%	15.6%	38.1%	5.4%	1.5%	100.0%	
		% of Total	2.4%	1.2%	35.1%	15.3%	37.5%	5.3%	1.5%	98.2%	
	selected	Count	1	0	3	1	0	0	1	6	
		Expected Count	.2	.1	2.2	.9	2.2	.3	.1	6.0	
		% within treatments	16.7%	.0%	50.0%	16.7%	.0%	.0%	16.7%	100.0%	
		% of Total	.3%	.0%	.9%	.3%	.0%	.0%	.3%	1.8%	
	Total		Count	9	4	122	53	127	18	6	339
			Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0

	% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.197(a)	6	.019
Likelihood Ratio	10.539	6	.104
Linear-by-Linear Association	1.430	1	.232
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .07.

		Which group do you identify with?								Total
		american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander	
treatments that you have heard of - Nutritional supplements	not selected	Count	7	4	101	44	86	9	5	256
		Expected Count	6.8	3.0	92.1	40.0	95.9	13.6	4.5	256.0
		% within treatments	2.7%	1.6%	39.5%	17.2%	33.6%	3.5%	2.0%	100.0%
		% of Total	2.1%	1.2%	29.8%	13.0%	25.4%	2.7%	1.5%	75.5%
	selected	Count	2	0	21	9	41	9	1	83
		Expected Count	2.2	1.0	29.9	13.0	31.1	4.4	1.5	83.0
		% within treatments	2.4%	.0%	25.3%	10.8%	49.4%	10.8%	1.2%	100.0%
		% of Total	.6%	.0%	6.2%	2.7%	12.1%	2.7%	.3%	24.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0

	% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.139(a)	6	.009
Likelihood Ratio	17.363	6	.008
Linear-by-Linear Association	9.726	1	.002
N of Valid Cases	339		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is .98.

TREATMENTS KNOWN VS. AGE

		Age group					Total	
		18-25	26-36	37-47	48-58	59 +	18-25	
treatments that you have heard of – AZT (Azidothymidine)	not selected	Count	37	47	42	31	8	165
		Expected Count	25.7	43.2	50.0	37.4	8.7	165.0
		% within treatments	22.4%	28.5%	25.5%	18.8%	4.8%	100.0%
		% of Total	10.9%	13.8%	12.4%	9.1%	2.4%	48.5%
	selected	Count	16	42	61	46	10	175
		Expected Count	27.3	45.8	53.0	39.6	9.3	175.0
		% within treatments	9.1%	24.0%	34.9%	26.3%	5.7%	100.0%
		% of Total	4.7%	12.4%	17.9%	13.5%	2.9%	51.5%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within treatments	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.970(a)	4	.005
Likelihood Ratio	15.229	4	.004
Linear-by-Linear Association	10.856	1	.001
N of Valid Cases	340		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.74.

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
Treatments that you have heard of - Pharmaceutical antibodies (bactrim, etc)	not selected	Count	43	59	53	49	12	216
		Expected Count	33.7	56.5	65.4	48.9	11.4	216.0
		% within treatments	19.9%	27.3%	24.5%	22.7%	5.6%	100.0%
		% of Total	12.6%	17.4%	15.6%	14.4%	3.5%	63.5%
	selected	Count	10	30	50	28	6	124
		Expected Count	19.3	32.5	37.6	28.1	6.6	124.0
		% within treatments	8.1%	24.2%	40.3%	22.6%	4.8%	100.0%
		% of Total	2.9%	8.8%	14.7%	8.2%	1.8%	36.5%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within treatments	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.938(a)	4	.007
Likelihood Ratio	14.481	4	.006
Linear-by-Linear Association	3.963	1	.046
N of Valid Cases	340		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.56.

CROSSTABS: EFFECTIVE TREATMENTS AND DEMOGRAPHIC VARIABLES

EFFECTIVE TREATMENTS VS. ETHNIC GROUP

			which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander
treatments that you think can be effective - UVBI (ultraviolet blood irradiation)	not selected	Count	5	4	115	52	122	15	6	319
		Expected Count	8.5	3.8	114.8	49.9	119.5	16.9	5.6	319.0
		% within treatments	1.6%	1.3%	36.1%	16.3%	38.2%	4.7%	1.9%	100.0%
		% of Total	1.5%	1.2%	33.9%	15.3%	36.0%	4.4%	1.8%	94.1%
	selected	Count	4	0	7	1	5	3	0	20
		Expected Count	.5	.2	7.2	3.1	7.5	1.1	.4	20.0
		% within treatments	20.0%	.0%	35.0%	5.0%	25.0%	15.0%	.0%	100.0%

	% of Total	1.2%	.0%	2.1%	.3%	1.5%	.9%	.0%	5.9%
Total	Count	9	4	122	53	127	18	6	339
	Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
	% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
	% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	30.895(a)	6	.000
Likelihood Ratio	17.748	6	.007
Linear-by-Linear Association	3.386	1	.066
N of Valid Cases	339		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is .24.

			which group do you identify with?						Total	
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial		other
treatments that you think can be effective - Selenium liver support-oral	not selected	Count	7	4	117	50	126	17	5	326
		Expected Count	8.7	3.8	117.3	51.0	122.1	17.3	5.8	326.0
		% within treatments	2.1%	1.2%	35.9%	15.3%	38.7%	5.2%	1.5%	100.0%
		% of Total	2.1%	1.2%	34.5%	14.7%	37.2%	5.0%	1.5%	96.2%
	selected	Count	2	0	5	3	1	1	1	13
		Expected Count	.3	.2	4.7	2.0	4.9	.7	.2	13.0
		% within treatments	15.4%	.0%	38.5%	23.1%	7.7%	7.7%	7.7%	100.0%
		% of Total	.6%	.0%	1.5%	.9%	.3%	.3%	.3%	3.8%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.934(a)	6	.021
Likelihood Ratio	11.141	6	.084
Linear-by-Linear Association	2.015	1	.156
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .15.

			Which group do you identify with?							Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/ african american or negro	Hispanic	white/ Caucasian	multiracial	other	
treatments that you think can be effective - Peroxide-Oral	not selected	Count	9	4	120	52	127	17	5	334
		Expected Count	8.9	3.9	120.2	52.2	125.1	17.7	5.9	334.0
		% within treatments	2.7%	1.2%	35.9%	15.6%	38.0%	5.1%	1.5%	100.0%
		% of Total	2.7%	1.2%	35.4%	15.3%	37.5%	5.0%	1.5%	98.5%
	selected	Count	0	0	2	1	0	1	1	5
		Expected Count	.1	.1	1.8	.8	1.9	.3	.1	5.0
		% within treatments	.0%	.0%	40.0%	20.0%	.0%	20.0%	20.0%	100.0%
		% of Total	.0%	.0%	.6%	.3%	.0%	.3%	.3%	1.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.772(a)	6	.032
Likelihood Ratio	8.629	6	.196
Linear-by-Linear Association	1.021	1	.312
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .06.

		Which group do you identify with?								Total
		american indian, alaskan native, or pacific islander	asian/asian american	black/african american or negro	Hispanic	white/Caucasian	multiracial	other	american indian, alaskan native, or pacific islander	
treatments that you think can be effective - Porcine (pig) liver extracts-transdermal	not selected	Count	8	4	120	52	127	18	5	334
		Expected Count	8.9	3.9	120.2	52.2	125.1	17.7	5.9	334.0
		% within treatments	2.4%	1.2%	35.9%	15.6%	38.0%	5.4%	1.5%	100.0%
		% of Total	2.4%	1.2%	35.4%	15.3%	37.5%	5.3%	1.5%	98.5%
	selected	Count	1	0	2	1	0	0	1	5
		Expected Count	.1	.1	1.8	.8	1.9	.3	.1	5.0
		% within treatments	20.0%	.0%	40.0%	20.0%	.0%	.0%	20.0%	100.0%
		% of Total	.3%	.0%	.6%	.3%	.0%	.0%	.3%	1.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.595(a)	6	.007
Likelihood Ratio	10.074	6	.122
Linear-by-Linear Association	.808	1	.369
N of Valid Cases	339		

a 8 cells (57.1%) have expected count less than 5. The minimum expected count is .06.

		Which group do you identify with?								Total
			american indian, alaskan native, or pacific islander	asian/asian american	black/african american or negro	Hispanic	white/ Caucasian	multiracial	other	american indian, alaskan native, or pacific islander
treatments that you think can be effective Nutritional supplements	not selected	Count	6	4	99	44	100	7	6	266
		Expected Count	7.1	3.1	95.7	41.6	99.7	14.1	4.7	266.0
		% within treatments	2.3%	1.5%	37.2%	16.5%	37.6%	2.6%	2.3%	100.0%
		% of Total	1.8%	1.2%	29.2%	13.0%	29.5%	2.1%	1.8%	78.5%
	selected	Count	3	0	23	9	27	11	0	73
		Expected Count	1.9	.9	26.3	11.4	27.3	3.9	1.3	73.0
		% within treatments	4.1%	.0%	31.5%	12.3%	37.0%	15.1%	.0%	100.0%
		% of Total	.9%	.0%	6.8%	2.7%	8.0%	3.2%	.0%	21.5%
Total		Count	9	4	122	53	127	18	6	339
		Expected Count	9.0	4.0	122.0	53.0	127.0	18.0	6.0	339.0
		% within treatments	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%
		% of Total	2.7%	1.2%	36.0%	15.6%	37.5%	5.3%	1.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.347(a)	6	.002
Likelihood Ratio	19.866	6	.003
Linear-by-Linear Association	1.756	1	.185
N of Valid Cases	339		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is .86.

EFFECTIVE TREATMENTS VS. STATUS

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - silver colloid-IV	not selected	Count	101	183	284
		Expected Count	104.1	179.9	284.0
		% within treatments	35.6%	64.4%	100.0%
		% of Total	34.6%	62.7%	97.3%
	selected	Count	6	2	8
		Expected Count	2.9	5.1	8.0
		% within treatments	75.0%	25.0%	100.0%
		% of Total	2.1%	.7%	2.7%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.212(b)	1	.022		
Continuity Correction(a)	3.652	1	.056		
Likelihood Ratio	5.019	1	.025		
Fisher's Exact Test				.055	.030
Linear-by-Linear Association	5.195	1	.023		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.93.

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - Vitamins-Oral	not selected	Count	96	148	244
		Expected Count	89.4	154.6	244.0
		% within treatments	39.3%	60.7%	100.0%
		% of Total	32.9%	50.7%	83.6%
	selected	Count	11	37	48
		Expected Count	17.6	30.4	48.0
		% within treatments	22.9%	77.1%	100.0%
		% of Total	3.8%	12.7%	16.4%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.662(b)	1	.031		
Continuity Correction(a)	3.982	1	.046		
Likelihood Ratio	4.945	1	.026		
Fisher's Exact Test				.034	.021
Linear-by-Linear Association	4.646	1	.031		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 17.59.

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - Minerals-Oral	not selected	Count	101	158	259
		Expected Count	94.9	164.1	259.0
		% within treatments	39.0%	61.0%	100.0%
		% of Total	34.6%	54.1%	88.7%
	selected	Count	6	27	33
		Expected Count	12.1	20.9	33.0
		% within treatments	18.2%	81.8%	100.0%
		% of Total	2.1%	9.2%	11.3%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.462(b)	1	.019		
Continuity Correction(a)	4.602	1	.032		
Likelihood Ratio	6.011	1	.014		
Fisher's Exact Test				.021	.013
Linear-by-Linear Association	5.443	1	.020		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.09.

		My HIV status is		Total	
		Negative	Positive	Negative	
treatments that you think can be effective Nutritional supplements	not selected	Count	92	133	225
		Expected Count	82.4	142.6	225.0
		% within treatments	40.9%	59.1%	100.0%
		% of Total	31.5%	45.5%	77.1%
	selected	Count	15	52	67
		Expected Count	24.6	42.4	67.0
		% within treatments	22.4%	77.6%	100.0%
		% of Total	5.1%	17.8%	22.9%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.611(b)	1	.006		
Continuity Correction(a)	6.835	1	.009		
Likelihood Ratio	8.046	1	.005		
Fisher's Exact Test				.006	.004
Linear-by-Linear Association	7.585	1	.006		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 24.55.

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - AZT (azidothymidine)	not selected	Count	77	106	183
		Expected Count	67.1	115.9	183.0
		% within treatments	42.1%	57.9%	100.0%
		% of Total	26.4%	36.3%	62.7%
	selected	Count	30	79	109
		Expected Count	39.9	69.1	109.0
		% within treatments	27.5%	72.5%	100.0%
		% of Total	10.3%	27.1%	37.3%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.232(b)	1	.013		
Continuity Correction(a)	5.621	1	.018		
Likelihood Ratio	6.361	1	.012		
Fisher's Exact Test				.017	.008
Linear-by-Linear Association	6.211	1	.013		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 39.94.

			My HIV status is		Total
			Negative	Positive	
treatments that you think can be effective - HAART (Highly active antiretroviral therapy)	not selected	Count	79	96	175
		Expected Count	64.1	110.9	175.0
		% within treatments	45.1%	54.9%	100.0%
		% of Total	27.1%	32.9%	59.9%
	selected	Count	28	89	117
		Expected Count	42.9	74.1	117.0
		% within treatments	23.9%	76.1%	100.0%
		% of Total	9.6%	30.5%	40.1%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	13.589(b)	1	.000		
Continuity Correction(a)	12.691	1	.000		
Likelihood Ratio	13.992	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	13.542	1	.000		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 42.87.

		My HIV status is		Total	
		Negative	Positive	Negative	
treatments that you think can be effective Pharmaceutical antibodies (bactrim, etc)	not selected	Count	91	109	200
		Expected Count	73.3	126.7	200.0
		% within treatments	45.5%	54.5%	100.0%
		% of Total	31.2%	37.3%	68.5%
	selected	Count	16	76	92
		Expected Count	33.7	58.3	92.0
		% within treatments	17.4%	82.6%	100.0%
		% of Total	5.5%	26.0%	31.5%
Total		Count	107	185	292
		Expected Count	107.0	185.0	292.0
		% within treatments	36.6%	63.4%	100.0%
		% of Total	36.6%	63.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	21.445(b)	1	.000		
Continuity Correction(a)	20.251	1	.000		
Likelihood Ratio	23.056	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	21.372	1	.000		
N of Valid Cases	292				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 33.71.

EFFECTIVE TREATMENTS VS. AGE

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
treatments that you think can be effective - Peroxide-IV	not selected	Count	49	87	103	76	18	333
		Expected Count	51.9	87.2	100.9	75.4	17.6	333.0
		% within treatments	14.7%	26.1%	30.9%	22.8%	5.4%	100.0%
		% of Total	14.4%	25.6%	30.3%	22.4%	5.3%	97.9%
	selected	Count	4	2	0	1	0	7
		Expected Count	1.1	1.8	2.1	1.6	.4	7.0
		% within treatments	57.1%	28.6%	.0%	14.3%	.0%	100.0%
		% of Total	1.2%	.6%	.0%	.3%	.0%	2.1%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within treatments	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.697(a)	4	.030
Likelihood Ratio	10.044	4	.040
Linear-by-Linear Association	6.145	1	.013
N of Valid Cases	340		

a 5 cells (50.0%) have expected count less than 5. The minimum expected count is .37.

			Age group					Total
			18-25	26-36	37-47	48-58	59 +	
treatments that you think can be effective - Nutritional supplements	not selected	Count	48	75	76	52	14	265
		Expected Count	41.3	69.4	80.3	60.0	14.0	265.0
		% within treatments	18.1%	28.3%	28.7%	19.6%	5.3%	100.0%
		% of Total	14.1%	22.1%	22.4%	15.3%	4.1%	77.9%
	selected	Count	5	14	27	25	4	75
		Expected Count	11.7	19.6	22.7	17.0	4.0	75.0
		% within treatments	6.7%	18.7%	36.0%	33.3%	5.3%	100.0%
		% of Total	1.5%	4.1%	7.9%	7.4%	1.2%	22.1%
Total		Count	53	89	103	77	18	340
		Expected Count	53.0	89.0	103.0	77.0	18.0	340.0
		% within treatments	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%
		% of Total	15.6%	26.2%	30.3%	22.6%	5.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.873(a)	4	.012
Likelihood Ratio	13.571	4	.009
Linear-by-Linear Association	9.891	1	.002
N of Valid Cases	340		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 3.97.

EFFECTIVE TREATMENTS VS. SEXUAL ORIENTATION

			sexual orientation			Total
			Heter	Homo	Bi-sexual	
treatments that you think can be effective - Nutritional supplements	not selected	Count	124	88	26	238
		Expected Count	111.7	100.1	26.2	238.0
		% within treatments	52.1%	37.0%	10.9%	100.0%
		% of Total	40.1%	28.5%	8.4%	77.0%
	selected	Count	21	42	8	71
		Expected Count	33.3	29.9	7.8	71.0
		% within treatments	29.6%	59.2%	11.3%	100.0%
		% of Total	6.8%	13.6%	2.6%	23.0%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.313(a)	2	.002
Likelihood Ratio	12.467	2	.002
Linear-by-Linear Association	6.330	1	.012
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.81.

			sexual orientation			Total
			Heter	Homo	Bi-sexual	
treatments that you think can be effective - Pharmaceutical antibodies (bactrim, etc)	not selected	Count	113	75	23	211
		Expected Count	99.0	88.8	23.2	211.0
		% within treatments	53.6%	35.5%	10.9%	100.0%
		% of Total	36.6%	24.3%	7.4%	68.3%
	selected	Count	32	55	11	98
		Expected Count	46.0	41.2	10.8	98.0
		% within treatments	32.7%	56.1%	11.2%	100.0%
		% of Total	10.4%	17.8%	3.6%	31.7%
Total		Count	145	130	34	309
		Expected Count	145.0	130.0	34.0	309.0
		% within treatments	46.9%	42.1%	11.0%	100.0%
		% of Total	46.9%	42.1%	11.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.972(a)	2	.002
Likelihood Ratio	13.076	2	.001
Linear-by-Linear Association	6.674	1	.010
N of Valid Cases	309		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.78.

List of Crosstabs with No Significance

Sources

- Books
- Newspapers
- Events (seminars, workshops, conferences)
- Medical websites
- Blogs, online bulletin boards
- Emails
- Community organizations
- Religious organizations
- Alternative medical doctors
- Other

Source Credibility

- TV
- Radio
- Books
- Newspapers
- Magazines
- Out of home (billboards, bus ads, posters, flyers, brochures)
- HIV/AIDS groups websites
- Online newsletters, journals, etc
- Emails
- Social media-Facebook, Twitter, etc
- Religious organizations
- Conventional medical doctors
- Alternative medical doctors
- Other

Perception Statements

- Giving antiretroviral drugs to people who are not infected is a good way to prevent HIV/AIDS
- HIV/AIDS infections are often the result of immoral behavior
- HIV/AIDS prevention efforts often receive more funding than treatment efforts
- Young people under 25 account for almost half of new HIV/AIDS infections globally

Treatments Known

- UVBI (Ultraviolet blood irradiation)
- Silver colloid-IV
- Silver colloid-oral
- Selenium liver support-oral
- Chelation-oral
- Vitamins-IV
- Minerals-IV
- Venus flytrap-oral
- Other

List of Crosstabs with No Significance (Cont.)

Effective Treatments

Silver colloid-oral
Chelation-IV
Chelation-oral
Vitamins-IV
Minerals-IV
Venus flytrap-oral
Other

RELIABILITY STATISTICS
CRONBACH'S ALPHA ANALYSIS TABLES

Group 1: The Hedonist or the Moralist

Cronbach's Alpha	N of Items
.685	6

Item Statistics

	Mean	Std. Deviation	N
How do you feel about - Poor people are more likely to get HIV/AIDS	3.6404	1.22626	342
How do you feel about - HIV/AIDS is primarily a gay disease	4.2602	1.01577	342
How do you feel about - HIV/AIDS is God's way of punishing the wicked	4.3830	.99385	342
How do you feel about - People with HIV/AIDS deserve the same rights in the workplace as other workers	4.4561	.95168	342
How do you feel about - HIV/AIDS infections are often a result of immoral behavior	3.7222	1.23323	342
How do you feel about - Getting HIV/AIDS is usually a death sentence	3.9240	1.14623	342

Group 2: The Cautious Optimist or the Raving Pessimist

Cronbach's Alpha	N of Items
.619	6

Item Statistics

	Mean	Std. Deviation	N
How do you feel about- Globally the number of people with HIV/AIDS is decreasing	3.8830	1.08214	342
How do you feel about- Antiretroviral drugs are a cure for HIV/AIDS	3.9006	1.06479	342
How do you feel about - Giving antiretroviral drugs to people not infected prevents HIV/AIDS	3.7427	1.09565	342
How do you feel about - You cannot get HIV/AIDS during sex if condoms are always used	3.7047	1.19035	342
How do you feel about - An effective HIV/AIDS vaccine is available	3.5614	1.13361	342
How do you feel about - Alternative medical treatments for HIV/AIDS have shown promising results	2.5994	1.05580	342

Group 3: The Global Activist or the Political Ostrich

Cronbach's Alpha	N of Items
.514	7

Item Statistics

	Mean	Std. Deviation	N
How to you feel about - A pregnant woman with HIV/AIDS cannot avoid having an HIV-positive baby	3.8070	1.13755	342
How do you feel about - HIV/AIDS prevention efforts often receive more funding than treatment efforts	3.0409	1.00063	342
How do you feel about - It is biologically easier for woman to get HIV/AIDS than it is for men	3.2690	1.20513	342
How do you feel about - Treating HIV/AIDS is a lucrative business for pharmaceutical companies	2.4766	1.17315	342
How do you feel about - Worldwide, more people get HIV/AIDS by heterosexual contact than by homosexual contact	2.8538	1.08670	342
How do you feel about - People who knowingly expose others to HIV/AIDS should be prosecuted as criminals	2.4678	1.26670	342
How do you feel about - Getting HIV/AIDS is usually a death sentence	3.9240	1.14623	342