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STANDING AT THE CROSSROADS OF PROGRESS AND PESSIMISM:
HIV/AIDS COVERAGE IN AFRICAN AMERICAN MAGAZINES AND ITS
RELEVANCE FOR FEMALE READERS

by

Ashley Shiels Peterson

A thesis submitted in partial fulfillment
of the requirements for the Master of
Arts degree in Journalism
in the Graduate College of
The University of Iowa

May 2009

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CERTIFICATE OF APPROVAL

MASTER'S THESIS

This is to certify that the Master's thesis of

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ABSTRACT

African American women's HIV incidence rates are disproportionately higher than other population groups in the United States. Social cognitive theory concepts were used to perform a quantitative content analysis of the magazines *Essence*, *Ebony*, and *Jet*, which are sources of health information and vicarious learning, to evaluate the quality of the HIV/AIDS prevention messages for 2000 to 2006. The data reveal some positive reflection of health messages, but many articles focus more on dramatic risk factors and less on providing useful information and proposed behaviors for African American women. Environmental risks and gender-specific risks are not emphasized. The public health community should use the media messages that are already present to build a media advocacy campaign that provides more comprehensive information and bring about social change.

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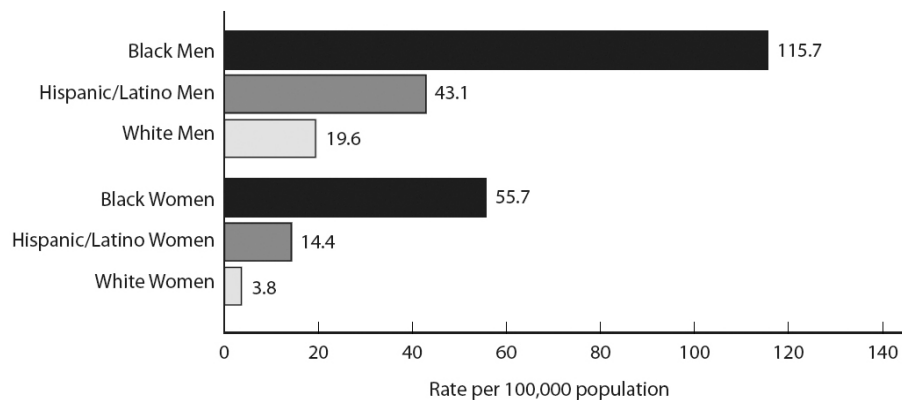
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CHAPTER I INTRODUCTION

In 2006, the United States' Centers for Disease Control and Prevention (CDC) estimated 1,185,000 people in the United States were living with HIV/AIDS, and approximately 40,000 persons will become infected each year (CDC, 2007a). Minorities bear the heaviest burden of new HIV infections. While other segments of the U.S. population are experiencing a decrease in the number of new HIV infections, African Americans account for the largest increase (Kaiser Family Foundation, 2007). Since 1995, the number of AIDS cases in African Americans has outnumbered those in whites, and the greatest disparity appeared in 2000 (CDC, 2008d). In 2006, Hispanic/Latinos and African Americans of both sexes had much higher incidence rates of HIV infections than whites (See Figure 1.) Although African Americans represented only 13% of the United States population in 2006, 45% of new infections were in African Americans, and 61% of newly infected women were African American (CDC, 2008a).

Figure 1. Estimated rates of new HIV infections, by race/ethnicity and gender, 2006.



The HIV incidence rate of African American women, which is 14.7 times that of white women and six times that of Hispanic/Latina women, represents an alarming health disparity (CDC, 2008a). Not only is the incidence rate disproportionately high, but AIDS is also the leading cause of death for African American women ages 25 to 34 and the sixth leading cause of death for African American women ages 18 to 24 (CDC, 2007b). These statistics herald a call for attention and prevention efforts for African American women from the public health community.

Since there is no known cure or vaccine for HIV/AIDS (CDC, 2008a), preventing the spread of the HIV is the only tool at the disposal of public health organizations (Airhihenbuwa & Obregon, 2000; Freimuth, 1992). Methods to address the disproportionate incidence rates should neither be small in scale nor confined to focus solely on individual behaviors. Multidisciplinary research efforts are required to craft prevention programs to address the needs of at-risk populations (Adimora & Shoenbach, 2005). Recently appointed White House officials launched an HIV/AIDS advertising campaign to address the inequality directed at African Americans and Latinos (Fox & Allen, 2009). But resources to implement prevention programs are not plentiful. In the past five years, the federal HIV/AIDS prevention budget has been slashed by 20% (The Body, 2009). Prevention programs need to target the most at-risk populations, use proven tools, and be cost effective. The media fulfill those three criteria and are a source of vicarious learning through which individuals understand health and disease (Bandura, 2001; Johnson, Flora, & Rimal, 1997).

Considering that African American women in the United States are disproportionately at risk for HIV infection, the purpose of this research is to understand which risk factors and prevention messages are being disseminated to African American women about HIV/AIDS in publications that are marketed to them. Specifically, this study examines HIV/AIDS information in three magazines produced primarily for African American women: *Ebony*, *Essence*, and *Jet*. Based on concepts derived from

social cognitive theory, the data reveal the type and quality of prevention information African American women are receiving. Social cognitive theory offers predictors and principles for health education that take into consideration contextual and individual factors (Bandura, 2004). Also, social cognitive theory-based interventions have been shown to be effective in altering individuals' behavior to reflect safer-sex practices (Amaro, 1995; Bandura, 1994; Fisher & Fisher, 2000; O'Leary & Wingwood, 2000; Sikkema, Wagner, & Bogart, 2000). This study focuses on heterosexual transmission risk factors for African American women. Intravenous (IV) drug use only accounts for 20% of HIV-transmission incidents for African American women (CDC, 2008a), and HIV/AIDS prevention messages for IV drug users require a different conceptualization and application of social cognitive theory than those presented here (Bandura, 1994). The study also examines the most effective social cognitive theoretical concepts, self-efficacy and social norms, as well as social cognitive theory's three categories of risk determinants in media messages directed at African American women. The results suggest areas of emphasis for future HIV prevention messages.

Little research is available about social cognitive theory concepts in HIV/AIDS prevention media messages. The proposed study will fill a gap in the literature not just about HIV/AIDS prevention based on social cognitive theory concepts in media messages, but also for research about HIV/AIDS coverage for African American women since 2001. The literature review reveals that historically the mainstream media have understood and reported on HIV/AIDS as a white, homosexual male disease (Brodie, Hamel, Brady, Kates, & Altman, 2004; Lupton, 1994). The impact of the virus on women and minorities has been overshadowed in the media by coverage of the impact on homosexual men and "the general public" (Cohen, 1999, p 149). In the early coverage of HIV/AIDS, both the mainstream and African American media shared the same patterns of reporting only on events and celebrities, resulting in an absence of culturally relevant material for the African American community (Hammonds, 1986; Kinsella, 1989;

Krishnan, Durrah, & Winkler, 1997). The lack of coverage has contributed to an inaccurate perception that women are not at risk for HIV/AIDS and has provided few opportunities to communicate prevention messages (Brodie et al., 2004; Hammonds, 1997; Sobo, 1995).

The African American magazines under study, *Essence*, *Jet*, and *Ebony*, state that they serve the African American community, and they have been theorized to reflect and influence health beliefs (Krishnan et al., 1997). The media, such as these magazines, hold the potential to serve as tools for social change, disseminate useful information to targeted populations, and influence attitudes and behaviors (Bandura, 2001; Wallack & Dorfman, 1996). By understanding the content of the magazines through a comprehensive, theory-based content analysis, the magazines' prevention messages can be improved to help reduce the spread of HIV via heterosexual intercourse. The study's data will be able to serve as formative research for a media advocacy campaign. Media advocacy is an issue-oriented, strategic use of media to target policy and social issues (Wallack, 1990). The first step in a media advocacy campaign is to monitor the media in order to provide an understanding of how the health issue is portrayed in the media as baseline for changing its depiction (Wallack & Dorfman, 1996). Using the results gathered from the study, a theory-based media advocacy campaign can be developed that provides effective messages and comprehensive understanding of risk factors.

Social cognitive theory's strength, the holistic understanding of health behavior influences, allows this study's approach to be adapted to other populations and other health issues. The study's method also provides a comprehensive application of social cognitive theory to media messages and serves as a confirmation of concept for how to study media messages about a disease that disproportionately affects a specific subpopulation.

CHAPTER II

LITERATURE REVIEW

The media communicate information, transmit social norms, and help shape the social construction of a disease (Bandura, 2004; Johnson et al., 1997; Krishnan et al., 1997). The social construction of a disease affects how members of society understand transmission and can hinder or help public health efforts (Herek, Widaman, & Capitanio, 2005). The media have shaped the understanding of HIV/AIDS and its meaning in complex ways (Brandt, 1988).

Bandura's (2001, 2004) social cognitive theory provides an understanding of how media messages affect individuals. Two of the theory's concepts, self-efficacy and social norms, are among the best predictors of behavior for HIV prevention interventions (Fisher & Fisher, 2000). Bandura's (2001) theory about the influence of media on individuals as a source of observational learning is also detailed. Social cognitive theory's three categories of risk determinants are used to catalog risk factors for African American women.

Media

Mainstream Media Coverage of HIV/AIDS

The spread of HIV has been cultural and linguistic as well as biological and biomedical (Treichler, 1999). The process through which Americans understood HIV/AIDS affects how the media have, do, and will report on it (Fuller, 2003). The content of the media can directly and indirectly influence individuals' health behaviors. For example, in the early 1980s the CDC classified homosexual men as the only population susceptible to the virus and overlooked the impact on heterosexuals, minority communities, and urban populations (Encyclopedia, 2005). The media picked up the CDC's original name for HIV/AIDS, gay-related immune deficiency, and have

perpetuated that HIV/AIDS is only a homosexual male disease to the public during the past two decades (Encyclopedia, 2005; Lupton, 1994). Since the beginning of the spread of HIV, media coverage has contributed to the perception that African Americans and women are not at risk (Fuller, 2003; Hammonds, 1997; Jemmott, Jemmott, & Hutchinson, 2001). In this environment, African American HIV/AIDS rates have disproportionately increased as compared to other groups (CDC, 2008a).

The early 1980s media coverage of HIV/AIDS also focused on the dramatic and moralistic characteristics of the spread of the virus. Homosexuality, promiscuity, and injection drug use were common themes (Lupton, 1994). The early news coverage portrayed HIV/AIDS as retribution for the sexual revolution, drug use, and homosexual lifestyle (Clarke, 1992). Sontag (1989) explained:

Every feared epidemic disease, but especially those associated with sexual license, generates a preoccupying distinction between the disease's putative carriers (which usually means just the poor, and in this part of the world, people with darker skins) and those defined – health professionals and other bureaucrats do the defining – as the “general population.” (p. 27)

For HIV/AIDS, the putative carriers were homosexual men, prostitutes, and injection drug users (Corea, 1992). The images invoked by the media coverage include “homophobia, fear, violence, contamination, invasion, vilification, racism, sexism, deviance, heroicness and xenophobia” (Lupton, 1994, p. 21). The number of print and television stories devoted to analyzing the spread of HIV in African American communities lagged behind those stories in which gay men were central (Cohen, 1999). The news coverage also failed to recognize socioeconomic contexts that strongly influence the spread of HIV (Swaim, 2005). More than individual behaviors contribute to HIV/AIDS risk; any social and environmental level risk factors contribute to the risk of HIV transmission (Logan, Cole, & Leukefeld, 2002). Consequently, the first reaction of the African American community was to avoid the topic in an attempt to prevent additional stigmatization (Hammonds, 1986; Kinsella, 1989; Williams, 2003). Hogan

(1998) claimed, “The adoption of a sexually conservative rhetoric may or may not be what black communities actually practice, but as a political strategy, this representation acts as a bulwark against white bigotry” (p. 173).

Bandura (1994) supports the use of the media to disseminate information about risks and increase knowledge about HIV/AIDS. Timely and responsible reporting on HIV/AIDS is important to help manage of the spread of HIV. Media coverage can increase public awareness and elicit community support that is essential to bring risks under control (Lupton, 1994; Nelkin, 1991). However, much of the coverage does not provide individuals with enough information to address their risk of contracting HIV/AIDS. The news media often focus disproportionately on titillating aspects of the spread of disease, which results in empty entertainment that is lacking in any useful information (Biddle, Conte, & Diamond, 1993; Colby & Cook, 1991). Davidson and Wallack (2004) found that in 1998, only 19% of newspaper articles in the total sample mentioned the causes, consequences, prevention, signs, symptoms, screening, transmission, treatment, trends, or rates in articles about sexually transmitted infections (STIs). The media are also responsible for perpetuating the myth that heterosexual monogamous relationships present risk-free sex (Clarke, 1992). Messages that emphasize monogamy as a way to prevent HIV transmission are not culturally sensitive and are theorized to contribute to inaccurate representations of risk for African American women (Sobo, 1995; Ratzan, 2004). Sobo (1995) found in her research that some African American women do not use a condom to affirm their relationship is monogamous and to deny they could be at risk for HIV/AIDS.

In the early 1980s, the mainstream media were slow to cover the human toll of HIV/AIDS and were not responsive to incidence rates. By the end of 1982, there had been 1,000 deaths from AIDS but only five stories in the *New York Times*, the nation’s agenda-setter (Kinsella, 1989). In 1985 there was a sharp increase in the number of stories about HIV/AIDS in the *New York Times* after the famous actor Rock Hudson

announced he had contracted HIV, and a second spike occurred later in the year when Ryan White, a teenage hemophiliac who contracted HIV through a blood transfusion, was expelled from school (Cohen, 1999; Dearing & Rogers, 1992). The three major television news networks aired six nightly news stories about HIV/AIDS in 1982. In 1983 there was a sharp increase in the number of stories, but in 1984 the number of stories declined just as incidence rate sharply increased (Colby & Cook, 1991). After 1985, HIV/AIDS became a routine topic in the print and broadcast news media that would only receive coverage if there were a newsworthy event or celebrity influence (Cohen, 1999; Colby & Cook, 1991; Lupton 1994; Swaim, 2005). More recently, the focus of HIV/AIDS coverage has been on the global epidemic. Between 1997 and 2002, the number of stories in U.S. media outlets increased 118%, but by 2001 40% of those stories focused on the global perspective, resulting in a decline in domestic coverage (Brodie et al., 2004).

However, the media can be a tool for social change by mobilizing constituencies, allowing community members to be heard, and giving influence to groups (Wallack & Dorfman, 1996). By using methods such as media advocacy, communication can be one of the most important instruments to reduce health disparities through increasing awareness and sparking public discussion and policy change (Mastin, Andsager, Choi, & Lee, 2007). The health discourse must address the medical, social, and political complexities of women and the African American community's health to be effective (Zoller, 2005).

Unfortunately, there are wide gaps in HIV/AIDS prevention communication and education between those groups most at risk and medical authorities (Williams, 2003). When African American survey participants were asked which group of people are most likely to be infected with HIV/AIDS, only 7% thought African American women were, but 32% thought of homosexuals or bisexuals (Kaiser Family Foundation, 2006). Also, 59% of African Americans think that African Americans in the United States are about equally likely to be infected with HIV/AIDS as whites, and 34% say African Americans

are more likely to be infected (Kaiser Family Foundation, 2006). However, African American women are 14.7 times more likely to become infected with HIV than white women, and African American men are six times more likely to contract HIV than white men (CDC, 2008c). For the most part, African American women and men are not recognized by the African American community to be at risk for HIV.

Mainstream Media Coverage of HIV/AIDS in the African American Community

Stories about HIV/AIDS are driven by attention-grabbing events, not incidence rates (Brodie et al., 2004; Swaim, 2005). As a result, in the early 1980s, the mainstream media were silent about the rise of HIV/AIDS in the African-American community (Hammonds, 1986). The first *New York Times* story mentioning HIV/AIDS in African Americans occurred in 1985 (Hammonds, 1986). From 1981 to 2002, only 2% of stories in national outlets focused on African Americans (Brodie et al., 2004). From 1985 to 1993, only 5% of the stories about HIV/AIDS in the *New York Times* mentioned African Americans, and of that 5%, 49% were about Earvin “Magic” Johnson, a celebrated professional basketball player, and 13% about Arthur Ashe, a famous tennis player (Cohen, 1999). Cohen (1999) reported that the mainstream press published a large number of stories when Johnson and Ashe announced their respective seropositive HIV statuses in 1991 and 1992, but the media did not highlight the high infection rates in the African-American community. The *New York Times*’ coverage of African Americans and HIV/AIDS dropped off after 1993 when there were no celebrities or events to maintain the story, but at the same time the CDC reported a large increase in incidence rate of African Americans with HIV (Cohen, 1999).

African American Media Coverage of HIV/AIDS

Little research has been published that is focused on HIV/AIDS media content specifically targeting African American women. But there have been studies about African American media's coverage of HIV/AIDS and the mainstream media's coverage of the impact of HIV/AIDS on African Americans. In general, the coverage of HIV/AIDS in both the mainstream and African American media reveals a number of news values and biases. Only celebrities and dramatic events drive media coverage of HIV/AIDS (Swaim, 2005), and the media ignore those who have the least influence in society, even if they are the most affected (Kinsella, 1989). The findings suggest that the media coverage of HIV/AIDS has many holes.

Krishnan, Durrah, and Winkler (1997) studied the coverage of HIV/AIDS in popular African American magazines from 1981 to 1994. The authors wrote: "In the face of this lingering neglect on part of the mainstream media, the role of the African American media in informing its readership and the community at large becomes extremely important" (Krishnan et al., 1997, p. 274). The first articles on HIV/AIDS in popular African American magazines were published in 1985, which is four years after the medical community named the virus (Hammonds, 1986). Most articles provided only statistics, trends, and general information about HIV/AIDS. Krishnan et al. (1997) noted the heavy use of health columns to address difficult or taboo issues like HIV/AIDS to avoid taking a moral stance or offending prevailing moral, social, and religious norms in the African American community. But the most important finding involved the questions the magazines neglected to ask:

How do we address AIDS, how must we treat people living with AIDS, how can we fund their care and treatment as AIDS becomes a chronic health issue, how best can we educate people on overcoming their fears, and how must we legislate policies to address the discrimination that people living with HIV and AIDS face? (Krishnan et al., 1997, p. 284).

In general, popular African American magazines failed to provide culturally relevant coverage of HIV/AIDS from 1981 to 1994.

As for newspapers, Kinsella (1989) reports that the *Amsterdam News* did not pay serious attention to HIV/AIDS in the African American community until 1987 and neglected to educate minorities about the disease. Pickle, Quinn, and Brown (2002) analyzed the content of the most widely circulated African American newspapers in five cities across the United States from 1991 to 1996. In contrast to the early magazine articles, most newspaper articles exhibited a critical attitude toward the government as well as skepticism about the government's commitment to saving lives, particularly the lives of minorities (Pickle et al., 2002). The articles also conveyed the message that fighting HIV first requires addressing inequities arising from the larger economic, political, and social context. However, the study's authors noted that the African American press appeared unwilling to critique African American service organizations as forcefully as it did the dominant society.

Clarke, McLellan, and Hoffman-Goetz (2006) discovered that in articles about HIV/AIDS in *Ebony* and *Essence* from January 1997 to October 2001, the discourse about HIV/AIDS differed from other studies' findings about the mainstream media. Instead of homophobia and heterosexism, the magazines depicted HIV/AIDS as a force that attacks the African American communities through racism and inequality. African Americans were described paradoxically both as powerless victims of HIV/AIDS and as members of a strong and identifiable community of "sisters" and "brothers" available to respond to prevent and cope with the disease (Clarke et al., 2006, p. 495). Another theme anomalous with mainstream media findings was that men and their risky behaviors were blamed for women's higher incidence rates (Clarke et al., 2006). This study only focused on how the disease was characterized in the media for both genders, however, and not on the quality of prevention information for African American women.

African American Magazines

Popular African-American magazines have been theorized to both reflect and influence existing values and beliefs regarding health and medicine (Krishnan et al., 1997). The media are also a source of information about health and disease. In 2006, 53% of African Americans said they received their information about HIV/AIDS from the media (Kaiser Family Foundation, 2006). African Americans tend to read more magazines than other groups. Eighty-six percent of African American adults read magazines on a regular basis, and the median number of issues read per month is 10.7 (Magazine Publishers of America, 2008). Women specifically turn to specialized magazines as a critical source of health information (Johnson, 1997; Warner & Procaccino, 2004).

Essence, *Jet*, and *Ebony* are three of the top magazines for the African American audience in the United States that have a readership that is more than 50% female (Magazine Publishers of American, 2008). The publisher of *Essence*, Essence Communications Inc. (2008a), states:

Essence is Where Black Women Come First for news, entertainment and motivation. *Essence* occupies a special place in the hearts of millions of Black women— it's not just a magazine but her most trusted confidante, a brand that has revolutionized the magazine industry and has become a cultural institution in the African-American community. (para 1)

The magazine takes on the role of serving as an information source that represents African American women's interests. Eighty-two percent of *Essence*'s readership is female and 43% is between the ages of 18 and 34, which are the ages of women most at risk for HIV/AIDS (CDC, 2006; Essence, 2008b).

Ebony magazine and *Jet* have a wider audience by gender and age, but they also serve African American women. *Ebony* has a readership that is 65% female, with 38.7% between the ages of 18 and 34 (Johnson Publishing Company, 2006a). *Jet*'s audience is

61% female, and 39% is between the ages of 18 and 34 (Johnson Publishing Company, 2006b). Johnson Publishing Company (2008), publisher of *Ebony* and *Jet*, states:

Our over 12 million monthly readers don't just read *Ebony* magazine, they live it. Between each and every page, the magazine is full of information to enrich, encourage and enlighten the entire family. *Ebony* magazine offers fresh, exciting images and perspectives on the new Black America and remains the only Black general interest and major monthly magazine that covers all of Black America. The magazine profiles successful African-American role models; discusses the issues that our community faces today; goes one-on-one with the hottest celebrities and community leaders; and brings you tips on career, relationships, health, parenting, personal finance and much more. (para 1)

Jet is the “number one” African-American newsweekly in the world, and its editorial mission “is to not only cover stories about highly recognized African-American events and individuals, but also everyday hard-hitting news that impacts lives, touches hearts and reflects the quality of life of the world we live in” (JCP, 2008, para 2).

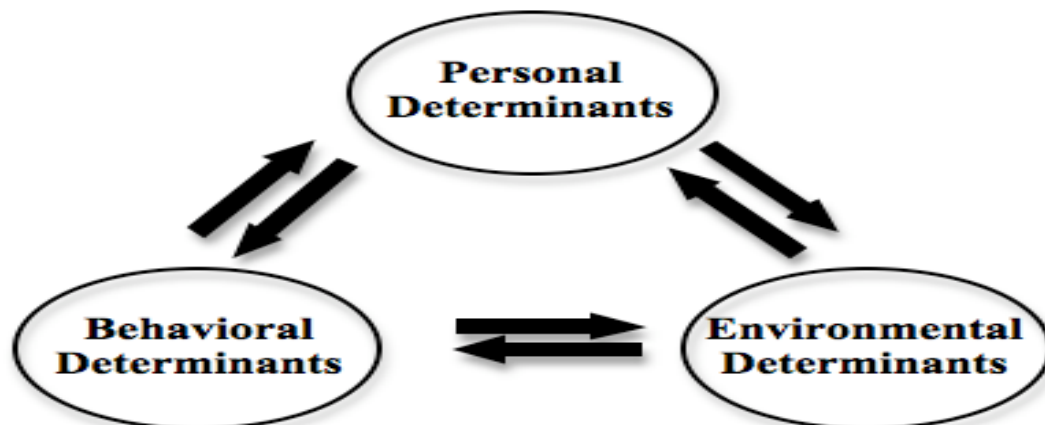
Although it is a weekly magazine and the other two are monthly, the average number of pages per month is about the same (Mastin & Campo, 2006). These three magazines, because of their purpose and audience, are part of the study evaluate the content and quality of their HIV/AIDS prevention messages based on social cognitive theory.

Social Cognitive Theory

Bandura (2004) stressed that health promotion needs to have both an individual and structural approach. Many factors that contribute to African American women’s risk for HIV/AIDS are situated within the intersection of race, gender, and social class (McNair & Prather, 2004). Social cognitive theory assumes behavior is the result of reciprocal interactions among behavioral, personal, and environment factors (Bandura, 1986). This theory does not focus on behavior in isolation, but on the individual in his or her environmental situation (Baranowski et al., 2002), which makes it a natural fit for the topic at hand. Bandura (1986) described the relationship between the three causal factors as mutually acting in a bidirectional manner. Personal determinants, which include

cognitions, emotions and biological factors, behavioral determinants, and environmental determinants, influence each other as well as health behavior decisions (see Figure 2.) In this model, individuals respond to risks as “self-organizing, proactive, self-reflecting, and self-regulating, not just reactive organisms shaped and shepherded by environmental events or inner forces” (Bandura, 2001, p. 266).

Figure 2. Schematization of triadic reciprocal causation in the causal model of social cognitive theory.



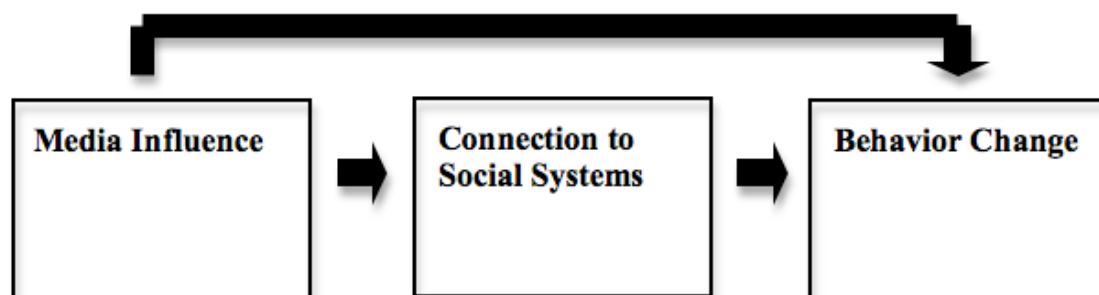
Social Learning Theory

Social learning theory, a precursor to social cognitive theory, demonstrates the process through which individuals are influenced by media messages. An individual’s social environment provides models for observational, or vicarious, learning (Baranowski et al., 2002). Bandura (2001) stressed that social modeling is not merely a process of behavior mimicry, but learning skills and customs. Four major processes lead to observational learning: First, in the attentional processes, the information for modeling is absorbed. Second, during retention processes, an individual actively restructures

information into memory. Then in the production process, the information is translated into thoughts about action. Finally, in motivational processes the action can be reinforced or punished by potential, past, or vicarious outcomes of the action and therefore acquired or not (Bandura, 1986).

The media are a source of observational learning and social norms (Bandura, 2001; Baranowski et al., 2002). Bandura (2001) conceptualized the process as media influence taking dual pathways: In the direct pathway, media messages promote change through informing, enabling, motivating, and guiding participants. In the socially mediated pathway, media influences are transfused through social networks and communities (See Figure 3.) The action of others in the media can serve as social prompts for previously learned behavior (Bandura, 2004). Role models also provide vicarious learning to help manage interpersonal situations and build self-assurance through comparison to others (Bandura, 1994). The most influential models are similar in age, sex, status, and type of problem (Bandura, 1994; Wang & Arpan, 2008). Therefore, the media are one influence on individuals that should be studied and shaped by public communicators.

Figure 3. Dual path of communication influences operating on behavior both directly and mediational through connection to influential social systems.



Self-Efficacy

For health behavior change, information is necessary, but not sufficient to inspire action. Bandura (1989) wrote, “To achieve self-directed change, people need to be given not only reasons to alter risky habits but also the means and resources to do so” (p. 128). Knowledge of health risks and benefits only creates a precondition for behavior change (Bandura, 2004). For African American women, Nyanmathi, Bennett, Leake, Lewis, and Flaskerud (1993) found that greater knowledge about HIV/AIDS was not always related to safer sex behaviors, though the authors did not explain this finding. Other social cognitive theory concepts such as self-efficacy are much more predictive for HIV risk-reduction behavior.¹

Self-efficacy is an individual’s confidence and sense of control to overcome barriers to performing a behavior (Bandura, 1977). Individuals’ belief that they can motivate themselves and regulate their behavior determines whether they will even attempt to alter their behavior (Bandura, 1994). Self-efficacy is the most important prerequisite for behavior change because it affects how much effort is invested in the behavior and what level of performance is attained (Baranowski et al., 2002). There are four information sources of self-efficacy: Performance accomplishments (e.g., participant modeling), vicarious experience (e.g., symbolic modeling), verbal persuasion (e.g., suggestions), and emotional arousal (e.g., attribution) (Bandura, 1977). Both vicarious experience and verbal persuasion self-efficacy techniques can be observed in media messages because they do not require direct interaction and are initiated by individual inferences (Bandura, 1977). Vicarious experience is developed by creating a social

¹ There are other theoretical concepts involved in Bandura’s (2004) application of social cognitive theory for health behavior change, which includes outcome expectations and perception of sociocultural facilitators and impediments, but this study focuses on those concepts that can be analyzed in media messages.

comparison between others' successful completion of a behavior and self (Bandura, 1977). Verbal persuasion is leading people to believe they can and should perform a behavior and is less successful because it is not based on experience (Bandura, 1977).

In a review of HIV-prevention interventions, Fisher and Fisher (2000) found the relationship between safer-sex practices and self-efficacy to be repeatedly supported. For example, individuals are more likely to engage in safer-sex behaviors if there is a belief in their ability to perform safer sex across a variety of situations (Noar, 2007). HIV risk-reduction behaviors that can be affected by efficacy expectations include condom use, sexual communication assertiveness, and IV drug use (Smith, McGraw, Costa, & McKinlay, 1996). Self-efficacy for condom use for African American women can be successfully increased via skill-building activities such as modeling and practice with feedback (O'Leary, Jemmott, & Jemmott, 2008). O'Leary et al. (2008) found that the perceptions of self-efficacy helped African American women attempt condom use, exert more effort to achieve the behavior, and show more persistent attempts to succeed in using condoms.

Low sexual communication self-efficacy has been associated with HIV risk-taking, and high sexual communication self-efficacy is consistent with women reporting condom use (Catania et al., 1992). Sexual communication efficacy was measured according to the health protective sexual communication scale self-response with three measures: Perceived quality of sexual communication between primary sexual partners, willingness to ask primary sexual partner to use a condom and the ability to discuss sexual histories and condom use with perspective sexual partners (Catania et al., 1989). DiClemente and Wingwood's (1995) experiment showed that African American women who received social skills training that emphasized ethnic and gender pride, HIV risk-reduction information, sexual self-control, sexual assertiveness and communication skills, proper condom use skills, and developing partner norms supportive of consistent condom use demonstrated greater sexual communication, increased condom use, and increased

sexual assertiveness. The relationship between strong self-efficacy and condom use has been supported for African American women who are at high risk for HIV/AIDS, including factors such as poverty, living in urban areas, heavy substance use, a history of sexually transmitted infections (STIs), or a history of sexual abuse (O'Leary et al., 2008). But self-efficacy is also influenced by environmental, cultural, and social factors (Campo & Mastin, 2007; Logan et al., 2002). Because of the evidence supporting the effectiveness of self-efficacy in promoting safer-sex behaviors for African American women, it should be studied to see if observational learning techniques are used in magazine articles about HIV/AIDS.

Social Norms

Social norms are perceived social pressures and an individual's motivation to follow those pressures (Bandura, 2004). Social norms correspond with expected social outcomes for a given behavior and help to generate outcome expectations for the behavior (Bandura, 2004). In the context of HIV prevention, social norms are conceptualized as an individual's perception of peers' engagement in safer sex practices combined with the belief that others want the individual to engage in safer sex and the motivation to comply (Noar, 2007).² It is the individual's sensitivity to social norms that results in developing internal standards about HIV/AIDS safer sex behavior (Fisher & Fisher, 2000). Behavior that violates social norms is often punished internally or externally (Fisher & Fisher, 2000). Because norms are based on perceived expectations for behavior, the pressure to comply with perceived expectations has an internal source

² Many of models of health behavior have overlapping theoretical concepts. The theory of planned behavior (Ajzen, 1985) states that HIV-preventive behaviors are determined by intentions, attitudes, norms, and perceived control over the performance. However, it does not take into account skill's training (Fisher & Fisher, 2000), nor can its concepts be easily translated into an understanding of media messages (Bandura, 2004).

based on either fear of disapproval or conforming to the norm to gain social approval (Rimal & Real, 2003).

Social norms are a central feature in health behaviors and decisions that predispose people to HIV risks (Airhihenbuwa & Obregon, 2000; Zimbaro & Leippe, 1991). Therefore, the influence of social norms can aid or undermine HIV/AIDS prevention education (Bandura, 2004). Adimora and Shoenbach (2005) observed that community attributes for sexual behavior affect the frequency of and risk associated with an individual's behaviors and can impede the ability of individuals to adopt preventive behaviors. However, social norms can be shaped to facilitate the adoption of risk-reduction behaviors (Bandura, 2001). Logan et al. (2002) reported that many HIV/AIDS interventions ignore the role of social norms. However, in a review of interventions that integrated social norms, the predictive power of social norms for heterosexual adults in HIV/AIDS prevention programs has been supported (Fisher & Fisher, 2000).

Social norms should be measured to see if the magazines are reinforcing strong social norms that promote safer-sex behaviors. Social norms can be separated into two categories: Distal and proximal. Sources of proximal norms have strong ties and more influence over the individual, and distal norms are less influential because the source is less tightly tied to the individual (Boer & Westoff, 2006). Proximal norm sources are peers who share identity characteristics (Rimal & Real, 2003; Wang & Arpan, 2008).

Risk Factors of HIV/AIDS

Viruses do not discriminate based on skin color or gender. But factors related to race and gender, including environmental and behavioral factors, lead to a higher prevalence of HIV/AIDS among certain populations (Sobo, 1995). African American women are more likely to contract HIV both because of factors related to their race and

their gender.³ The three reciprocal processes — environmental, behavioral, and personal — serve as categories for HIV risk factors for African American women. But the divisions are not perfect, and there is overlap among categories. An effective program for widespread change needs to take into account all three determinates as well as information to increase awareness and knowledge, skill-building modeling, and cultivating a supportive social environmental (Bandura, 1994). The public health literature described below served as a classification system applied during the content analysis. (See Table 1 in Chapter 3 for the list of risk factors coded.)

Environmental

Behavioral factors alone often fail to provide insight into the influence of pervasive sociodemographic, relational, and gender-specific factors that mediate HIV-risk behaviors (O’Leary & Wingwood, 2000). It is important to understand the environment in which HIV infection occurs in order to create effective messages. The CDC (2008b) states:

Of all racial and ethnic groups in the United States, HIV and AIDS have hit African Americans the hardest. The reasons are not directly related to race or ethnicity, but rather to some of the barriers faced by many African Americans. These barriers can include poverty (being poor), sexually transmitted diseases, and stigma. (para 1)

Both gender and race configure barriers that determine the ways in which HIV/AIDS and other diseases impact societies (Melkote, Muppidi, & Goswami, 2000). Most of the trends that contribute to HIV transmission occur in low socioeconomic status contexts, and race often reflects the underlying economic deprivation as a proxy for social class (Melkote et al., 2000; Project Hope, 2005). Being African American is not a

³ This study focuses on women’s heterosexual contact. The CDC (2006) has found no confirmed cases of female-to-female sexual transmission of HIV.

risk factor per se; it is historical forces that shape the epidemiology of a disease and how it affects different ethnic groups (Thomas & Thomas, 1995).

Populations most vulnerable to HIV/AIDS are those with the fewest resources, the least access to information, and the least amount of political and social power (Melkote et al., 2000). In 2003, nearly one in four African Americans lived in poverty (Office of the Director, 2006). Lower income, unemployment, and a lower level of education are related to reduced knowledge about HIV transmission (Melkote et al., 2000; Nyamathi et al., 2003; Williams, Ekundayo, Udezulu, & Omishakin, 2003). However, even when income is controlled for, a racial disparity between whites and blacks in health status remains (Adimora & Schoenbach, 2002).

Urban areas, where 87% of African Americans live, have the highest concentration of HIV/AIDS, which means African American women have a higher chance of contracting HIV (Office of the Director, 2005; Sobo, 1995). In the urban context, there are higher rates of IV drug use, HIV/AIDS, untreated STIs, and crack cocaine, all of which lead to an environment where unprotected sex carries an increased risk for HIV (Sikkema et al., 2000). For example, regions where there are the highest rates of HIV infections in women correspond with the highest prevalence of male injection-drug use (Wortley & Fleming, 1997). In a review of HIV/AIDS-prevention programs, Bandura (1994) noted that alcohol and drug use lowers ability to adhere to safer-sex practices in general. In the urban context, where crack cocaine is prevalent, women are less likely to use condoms, have impaired judgment, and are more likely to exchange sex for drugs or money for drugs (Sikkema et al., 2000). Also, since there are already high rates of HIV/AIDS among African American men, the sexual segregation of African Americans means that the sexual networks are more closely entwined and carry a higher risk of HIV transmission (Adimora & Schoenbach, 2002; Aral, 2002; CDC, 2008c; Sobo, 1995).

O'Leary and Wingwood (2000) state, "When conducting research with women, it is important to understand their risk and risk reduction efforts in a gender specific manner" (p. 182). Many environmental factors related to the spread of HIV are shaped by gender norms (Quinn & Overbaugh, 2005). For example, there is also a low male-to-female gender ratio in the African American community due to high mortality among young African American men, children, and infants from disease and violence.⁴ An imbalance in gender ratio combined with the prevailing imbalance in structural power between the genders produces patterns of attitude and behavior that influence the spread of HIV (Guttentag & Secord, 1983; Quinn & Overbaugh, 2005). This gender imbalance has been theorized to affect social norms, including an increase in the prevalence of concurrent partnerships, a power imbalance in relationships that is weighted in favor of men, and fewer fidelity expectations for men (Adimora & Shoenbach, 2005; Guttentag & Secord, 1983; Sobo, 1995). These circumstances contribute to the spread of HIV.

The African American community's response to the HIV/AIDS crisis is a legacy of the Tuskegee Study as well as the deeply rooted racism in the United States that affects all social institutions (Pickle et al., 2002). The Tuskegee Syphilis Study still influences the African American community's perception of messages that originate from the medical community. It has become a symbol of racism and mistreatment of African Americans by the medical establishment (Corbie-Smith & Arriola, 2001; Ross, Essien, & Torres, 2006).⁵ Within the African American community, there is a belief that HIV/AIDS was created as a form of genocide against African Americans by the United States government (Guinan, 1993; Thomas & Quinn, 1991). This notion is embedded in a social

⁴ The estimated gender ratio in 2007 is 0.464 (United States Census Bureau, 2008). Gender ratio is calculated by dividing the number of males by the total number of females and males (Wilson & Hardy, 2002).

⁵ This is a simplification of the situation. See Andsager (in press) for a full discussion.

context in which African Americans believe in conspiracy theories about whites against blacks (Thomas & Quinn, 1991). In a nonrandom study done in Houston, Texas, Ross, Essien, and Torres (2006) found that 31% of African American women and 27% of African American men believe that AIDS is an agent of genocide created by the United States government to kill minorities.

Amid the conspiracy theories are confirmed disparities in United States health care system. African Americans in general receive lower quality care than whites and are more likely to undergo less desirable procedures such as amputation of a limb than other ethnicities (Institute of Medicine, 2002; Kaiser Family Foundation, 2007). Sterilization abuse, when women are sterilized without fully informed consent, is most often done on African Americans and other minority women, and in the South it was so commonly performed on African American women it was termed the “Mississippi appendectomy” (Boston Women’s Health, 1998, p. 332). The overall death rates for African Americans remain 40% higher than for whites, which is the same difference as in 1960 (Project Hope, 2005). The leading causes of death are different for African Americans, homicide, HIV/AIDS, and septicemia, than for other ethnicities (U.S. Department of Health and Human Services, 2007). The weak relationship between African Americans and the medical community complicates HIV/AIDS education. For example, there is an association between low condom use and conspiracy beliefs (Ross, Essien, & Torres, 2006). Thomas and Quinn (1991) stated, “We must discuss the feeling within the Black community that AIDS is a form of genocide, a feeling justified by the history of the Tuskegee study. This dialogue can contribute to a better understanding of how to develop and implement HIV education programs that are scientifically sound, culturally sensitive, and ethnically acceptable” (p. 1504).

Behavioral

Women from socioeconomically disadvantaged conditions cope with many social and psychological adversities that may make it difficult for them to practice healthy behaviors in relationships. Because male partners must agree to safer-sex practices, partner characteristics and behavior patterns affect the spread of HIV (O'Leary & Wingwood, 2000). For example, survival value of immediate needs may take precedence over self-protection against long-term illnesses (Sikkema et al., 2000; Williams et al., 2003). Women living in poverty are at a disadvantage in negotiations with their partners over condom use if they are economically and emotionally dependent on their partner (Melkote et al., 2000).

Sobo (1995) reported that women may use unsafe sex as part of a psychological strategy where unprotected sex represents a trusting and mutually exclusive relationship and validates her choice for a partner. Women may even avoid condom use even if they know their partner is not monogamous (Sikkema et al., 2000). To introduce a condom into a sexual relationship is seen by some as a sign of infidelity for either partner and therefore weakens the relationship (Wingwood & DiClemente, 1998).

Women are at risk of HIV transmission even if they remain faithful because many are infected through their long-term, not casual, partner's behavior (Sikkema et al., 2000). Women may not be aware of their male partner's possible risk factors for HIV infection, such as unprotected sex with multiple partners, having sex with other men, or IV drug use (CDC, 2008a; Hader, Smith, Moore, & Holmberg, 2001; Millett, Malenbranche, Mason, & Spikes, 2005). In a meta-review, Logan et al. (2002) stated that African American men report more risky behavior such as more sexual partners in a time period and in a lifetime, younger age at first intercourse, and extramarital affairs than other ethnicities. African American men who have sex with men but are not open about their sexuality or behavior have been cited as a risk factor for African American women (Dodge, Jeffries, & Sandfort, 2008). Montgomery, Mokotoff, Gentry, and Blair (2003)

found that although more African American men reported having sex with other men, fewer African American women said that their partners were bisexual. The degree to which this contributes to African American women's risk for HIV transmission is not known (O'Leary & Jones, 2006; Siegel, Schrinshaw, Lekas, & Parsons, 2008). Worth (2003), however, stated that the "threat of a bisexual infector is more inferred than real" (p. 84).

The criminal justice system is an example of a policy-level decision that impacts behaviors that accelerate the spread of HIV/AIDS (Kaiser Family Foundation, 2008). Incarceration is a risk factor for HIV/AIDS for both men and women (McNeil & Williams, 2004). African Americans have higher rates of incarceration than other ethnicities. One in nine African American men ages 20 to 34 are incarcerated, and for African American women ages 35 to 39, the rate is one in 100 (Aizenman, 2008). Current inmates report risk behaviors such as IV drug abuse, alcohol abuse, unprotected sex, and homelessness prior to incarceration (Braithwaite & Arriola, 2003). During incarceration, some male inmates engage in unprotected same-sex encounters and IV drug use in an environment where condoms are not made available and harm-reduction strategies are only minimally endorsed (Wohl et al., 2000). It is not congruent with the criminal justice culture for correctional facilities to fund preventive health programs for inmates or acknowledge that prohibited behaviors such as sexual encounters or drug use occur in prison (Braithwaite & Arriola, 2003). Risk factors such as drug or alcohol use and sex for survival continue for some after incarceration as well (Logan et al., 2002). At the end of 2006, 1.6% of male inmates and 2.4% of female inmates in state and federal prison were known to be HIV-positive (Marischak, 2008). This is compared with less than 0.4% of the United States population living with HIV in 2006 (CDC, 2008a). Higher rates of incarceration among African American men and women introduce members who are more likely to have engaged in high-risk sexual behaviors for HIV into sexual networks.

There are other individual factors that contribute to the heterosexual spread of HIV. Multiple sexual partners increase the risk of transmission because the chance of exposure is higher (Adimora et al., 2002). Crack cocaine use has also been found to be associated with heterosexual transmission because it inhibits judgment and can be used as incentive for a sex-for-drugs exchange (CDC, 2006b). Also, trauma related to childhood physical and sexual abuse as well as intimate partner violence during adulthood is related to increased risk behaviors for women (McNair & Prather, 2004)

Other methods of HIV infection include transmission via blood. This includes sharing drug needles, blood transfusions, and mother-to-child transmission during birth and breastfeeding (CDC, 2008b). IV drug users are recommended to use only clean needles to prevent transmission (CDC, 2008b). Since 1985 all donated blood in the United States has been tested for HIV and the risk for transmission is extremely low (CDC, 2008b). Also, if the HIV-positive mother receives proper treatment during birthing and avoids breastfeeding, her chances of transmitting the virus to the child are only 2% (Kaiser Family Foundation, 2009).

Personal

Women are biologically more at risk than men for HIV transmission. The substantial mucosal exposure to seminal fluids increases women's transmission rates (Berer, 1993). Also, untreated and undiagnosed STIs increase risk of transmission (Black AIDS Institute, 2009). African Americans have higher rates of STIs than other ethnic groups (Adimora & Shoenbach, 2002). Another personal risk factor is if an individual does not perceive him- or herself to be at risk of contracting HIV (McNair & Prather, 2004). This is related to perceiving one partner is "clean" based on appearance and not practicing safer sex, and not knowing one's own HIV status. These perceptions lead to unprotected sexual contact. Most HIV infections among women, 80%, are attributed to sexual contact with an infected male partner (CDC, 2008a; Wortley & Fleming, 1997).

Sexual communication skills are a key influencer for condom use across all social strata (Catania et al., 1992). “Woman’s experience of relationship quality, trust, fidelity, and interpersonal power as she interacts with her partner influences the extent to which she discusses and negotiates condom use, as well as other HIV risks” (McNair & Prather, 2004, p. 112). If women believe that safer-sex negotiations will cause conflict in a relationship, they will be less likely to address the issue (Logan et al., 2002; O’Leary, 2000; Wingwood & DiClemente, 1998). Women whose partners disapproved of condoms are 3.5 times more likely to never use condoms than those with partners who approved of condoms (McNiel & Williams, 2004). African American and Hispanic women are less likely than white women to have partners who always use condoms (Catania et al., 1992). Inherent in traditional gender roles is a power differential between men and women where women are dependent on men for resources and may face retribution for asking for condoms (Amaro, 1995; Sikkema, et al., 2000). It is also contrary to traditional gender roles for women to be assertive in sexual communication (Amaro, 1995).

Research Questions

Identifying the content and meaning of media messages provides a window into how individuals may understand disease prevention (Clarke et al., 2006). Social cognitive theory provides concepts to understand motivational prevention messages and categories to classify risk factors and to evaluate the quality of the messages. The questions also address the sensitivity of the magazines to the spread of HIV/AIDS. The inequity of the incidence rates between Whites and African Americans peaked in 2000 (CDC, 2008d). In 2003, the incidence rates for African Americans drastically increased (Hall et al., 2008). The most recent year that the CDC has released incidence rates for is 2006. Therefore, the proposed study will seek to answer the following research questions for the time period 2000 to 2006:

RQ1: What HIV prevention behaviors are offered for African American women in the magazines' editorial content?

RQ2: To what extent do the prevention messages reflect the three types of processes of social cognitive theory: Behavioral, personal, and environmental?

RQ3: To what extent do the prevention messages reflect the two social cognitive theory concepts: Self-efficacy and social norms?

RQ4: Is there difference in content and number of articles between the time period 2000-2002, when incidence rates were lower, and the time period 2003-2006, when incidence rates for African Americans increased?

CHAPTER IV

METHODS

Latent and manifest content analyses based on social cognitive theory were conducted to identify and operationalize the processes and concepts present in the editorial content of three African American magazines: *Essence*, *Ebony*, and *Jet*. Other studies have tracked the presence of social cognitive theory concepts in the media (e.g. Agha, 2003; Cline & Young, 2004; Cohen et al., 2007; Dejong, Wolf, & Austin, 2001; Johnson et al., 1997) as well as the three processes of influence (e.g. Campo & Mastin, 2007). The magazines selected for study specifically target African American women and serve as advocates for the African American community (Campo & Mastin, 2007; Krishan et al., 1997).

The time period under study ranged from 2000 to 2006. The greatest disparity for incidence rates appeared in 2000, and the incidence rates for African Americans increased in 2003 (CDC, 2008b; 2008d). The most recent year that the CDC has released incidence rates for is 2006. The articles were found in the LexisNexis database with the index search term “HIV” from January 1, 2000, to December 31, 2006, in the publications *Essence*, *Ebony*, and *Jet* ($N = 463$).⁶ All articles that were collected were also analyzed. The unit of analysis was one article.

A second, independent coder who was unfamiliar with the topic coded articles for intercoder reliability. Three articles per year were randomly selected from the original data set to be used in the intercoder reliability sample. A Cohen’s kappa measurement of .75 or greater is acceptable (Cohen, 1960; Cohen, Shuman, & Gold, 2007). All but one variable had intercoder agreement of 1.00. The personal risk factor, the lack of risk

⁶ LexisNexis automatically includes the terms “AIDS” and “acquired immune deficiency syndrome” with the index search term “HIV.”

evaluation for HIV exposure, had a kappa of .83. When there was a disagreement for a variable, both coders reread the coding instructions and the recoded the article in which the variable disagreement occurred. This resolved the disagreements.

For RQ1, the proposed HIV-prevention behaviors were gathered from a latent content analysis of the articles in this study. A proposed behavior was operationalized as actions encouraged by the text and usually occurred in the imperative verb tense.

Proposed behaviors included: Learn more information, test for HIV, be abstinent, limit number of sexual partners, use a condom, do not share needles, and talk about sexual history with partner. Each variable was coded as present or not because it is possible to have more than one proposed behavior in each article. Learn more information was operationalized as instructions to learn more information about HIV/AIDS from a Web site, hotline, or a medical professional. Test for HIV referred to any type of HIV test proposed in the article. Be abstinent referred to endorsing celibacy to prevent HIV/AIDS. The variable use a condom included proposing both male and female condoms as well as using “protection.” The not sharing needles behavior included needle use for IV drugs, tattoos, and piercings. Talk about sexual history was defined as encouraging both partners to know each other’s sexual history prior to sex. The coding manual containing all the variables coded, their definitions, examples, and coding instructions is listed in the Appendix.

For RQ2, a review of public health literature about HIV/AIDS and African Americans as well as a latent content analysis of the articles was used to develop the list of risk factors for each of the three categories based on Bandura’s (2001, 2004) definitions of the three processes of influence. The environmental risks are society-wide, structural factors that influence the epidemiology of HIV/AIDS. Behavioral factors are patterns and individual behaviors that put an individual at risk for HIV transmission. Personal risk factors are those that deal with internal thoughts, emotions, and biology. Each risk factor was coded as present or not. The factors are listed in Table 1. Tracing

these factors demonstrates which HIV/AIDS risk factors the media portray and whether media advocacy can be used to promote more awareness of environmental risk factors.

Table 1. Risk factors by category.

Behavioral Risk Factors	Personal Risk Factors	Environmental Risk Factors
Unprotected heterosexual sexual contact	Women's biological vulnerability	Racism
Unprotected male homosexual sexual contact	No risk evaluation	Poverty
Unspecified gender of unprotected sexual contact	Self-acceptance	Social inequality
IV drug use		Conspiracy beliefs
Needle procedure		
Mother-to-child		
Crack cocaine		
Intimate trauma		
Partner infidelity		
Male partner having sex with men		
Male partner having sex with men while incarcerated		
Partner needle use while incarcerated		
Partner unwillingness		
Low sexual communication		
Multiple sexual partners		

The environmental risk factors are structural reasons the articles cited as being the cause for the prevalence of HIV/AIDS in the African American community. Racism was operationalized as unequal treatment or service that would lead to HIV/AIDS knowledge or treatment. Poverty was defined as conditions related to lacking material means such as living in a "bad" neighborhood or the inability to afford services that would prevent

HIV/AIDS. Social inequality was classified as no political or social power to change the current situation.

The three types of sexual contact variables incorporated any type of sexual contact that would transmit HIV. Unprotected heterosexual sexual contact was coded as present when it was between two people of opposite sex. Unprotected homosexual sexual contact was between two people of the same sex. Unprotected sexual contact was coded as present when the genders of the partners were not specified, such as “unprotected sex is a risk factor for HIV.”

IV drug use was coded as present when mention of IV injection use of heroin, morphine, cocaine (not crack cocaine), amphetamine, or methamphetamine, whether from needle transmission was made, or if IV drug use was cited as reason for risky behavior. The crack cocaine variable was coded as present if the use of crack cocaine was cited as the reason for the risky behavior that lead to HIV transmission.

The mother-to-child variable was defined as: If a mother passes HIV to the child during birth, pregnancy, or breastfeeding. It is often implied that happened during birth. For example, “His mother knew she was infected. She knew and she went ahead and had a baby anyway... I didn't know anything about babies with HIV” (“AIDS,” 2006, p. 215). The variable needle procedure was needle use or blood transmission not related to drugs or sexual contact. Risks cited included blood transfusions and other medical procedures as a risk for HIV transmission, as well as body piercings and tattoos.

Partner infidelity refers to the male partner having extramarital relationships with other women, getting HIV from that relationship, and then transmitting HIV to original female partner. Partner MSM was a similar concept, but dealt specifically with the male partner having sex with other men. This was often referred to as the “down low.”

Partner incarceration MSM was operationalized as a male partner being infected with HIV in prison by having sex with other men. The partner incarceration needles

variable was classified as present if male partner is cited as contracting HIV in prison from sharing needles for any reason.

Intimate trauma was coded as present if rape or partner abuse is referred to as the reason for the behavior or the cause of HIV transmission. Partner unwillingness was coded as present if the male partner is unwilling to change any type of sexual behavior. Low sexual communication assertiveness as defined as an attitude about sexual communication that leads to no communication about HIV/AIDS or HIV prevention behaviors with partner. This includes the belief that initiating conversation about condom use, sexual history, or infidelity will harm the relationship.

As personal risk factors, women's biological vulnerability to HIV includes any biological reason such as increased mucosal exposure or other STIs that make transmission more likely. No risk evaluation refers to an attitude where an individual trusts without verification that his or her partner is not a risk, own actions are not risky, or there is no need to get an HIV test. Conspiracy beliefs were coded as present if the government was thought to have caused HIV/AIDS or is keeping a vaccine from the public. Self-acceptance was operationalized as a lack of self-love, self-esteem, or self-confidence on the part of women.

For RQ3, self-efficacy was conceptualized as messages containing advice or skills in terms of two of Bandura's (1977) sources of self-efficacy: Vicarious experience and verbal persuasion. Vicarious experience was operationalized as symbolic modeling, or demonstrating how to perform the proposed behavior. Verbal persuasion included directives, such as "use a condom," to reinforce the proposed behavior. The most effective form of self-efficacy is vicarious experience (Cohen et al., 2007). Social norms were conceptualized as the proximity of the source of information, story, advice, or skills to African American women. Sources coded as distal come from the community at large, are a reporter, or are an authority figure such as a doctor or CDC employee. Proximal sources were similar to, or a peer of, an African American women. For a self-efficacy or

social norm variable to be present, there must also be a proposed behavior present. These variables were coded as present or not.

To answer RQ4, a comparison between for the time periods 2000 to 2002 and 2003 and 2006 of the number of articles as well as the frequency of the respective variables were performed. The comparison was made to see if the incidence rates among African Americans and African American women are highlighted. In the 2003 to 2006 time period, the CDC recorded higher HIV incidence rates for African Americans than in the previous three-year time frame, 2000 to 2002 (Hall et al., 2008). The number of articles and their variables from 2000 to 2002 were compared to the articles and their variables from 2003 to 2006. If the African American media are influenced by incidence rates and responding on behalf of the African American community, then coverage should increase and improve between the first three years and the last four years.

Other variables that were tracked included whether the mention of HIV/AIDS was a theme in the article or only a brief mention. For HIV/AIDS to be considered a theme, there had to be a mention of a risk factor, proposed behavior, a social cognitive theory variable, or a mention of the higher rates of HIV in the African American community. The variables relating to higher rates, for African Americans in general or for African American women, were known to be present if the disproportionate rates were directly mentioned or if a descriptive statement such as “Black women carry a heavier burden” is given. The context of the article and HIV/AIDS was also tracked. The context of the article was classified as in the United States, Africa, global, and other.

CHAPTER V
RESULTS

Between 2000 and 2006, 463 articles containing coverage of HIV/AIDS ran in *Essence* ($n = 160$), *Ebony* ($n = 119$), and *Jet* ($n = 184$). Table 2 shows the number of articles per year. The majority of the articles, 72% ($n = 334$), focused on HIV/AIDS as a domestic issue. Forty-six percent ($n = 214$) of the articles used HIV/AIDS as a theme in the story and in 54% ($n = 249$) HIV/AIDS was only a brief mention. Table 3 demonstrates the number of brief mentions and themes per magazine. There was a significant difference among the magazines ($\chi^2 = 27.75, p < .001, d = 2$). In *Jet*, 69% ($n = 126$) of the articles under study only mentioned HIV/AIDS briefly.

Table 2. Number of HIV/AIDS articles by magazine 2000-2006.

	2000	2001	2002	2003	2004	2005	2006	Total
Essence	18	19	25	25	32	14	28	161
Ebony	19	18	14	17	23	14	14	119
Jet	27	34	33	24	21	20	24	183
Total	64	71	72	66	76	48	66	463

Table 3. Number of articles containing brief mentions versus themes by magazine.

	Theme	Brief Mention
Essence	89	72
Ebony	68	51
Jet	57	126
Total	214	249

RQ1 was concerned with the frequency and relationship among the proposed HIV/AIDS prevention behaviors in the magazines. Only 17% ($n = 81$) of articles proposed at least one prevention behavior. The most prevalent proposed behaviors were to test for HIV ($n = 35$), to use a condom ($n = 30$), and to talk with partner about sexual history ($n = 23$). Table 4 presents the frequency and percentage of articles containing proposed behaviors. There was a significant difference among the magazines' coverage of the proposed behaviors for test for HIV ($\chi^2 = 10.21, p = .006, d = 2$), use a condom ($\chi^2 = 17.69, p < .001, d = 2$), and talk about sexual history with partner ($\chi^2 = 12.57, p = .002, d = 2$). *Jet* less frequently mentions the proposed behaviors for which there were significant differences. Table 5 represents the relationship among the proposed behaviors within magazine articles. The strongest correlations were between the proposed behaviors limit number of sexual partners and be abstinent ($r = .26, p < .001$), use a condom and be abstinent ($r = .26, p < .001$), and use a condom and talk about sexual history with partner ($r = .22, p < .001$).

Table 4. Frequency and percentage of articles containing proposed HIV/AIDS prevention behaviors.

Proposed Behavior	Frequency	Percentage of articles containing
Test for HIV	35	7.5%
Use a condom	30	6.5%
Talk with partner about sexual history	23	5.0%
Learn more information about HIV/AIDS	10	2.2%
Be abstinent	7	1.5%
Limit number of sexual partners	2	0.4%
Do not share needles	1	0.2%
Total	108	23.3%

Table 5. Correlations among proposed HIV/AIDS prevention behaviors.

	Learn more info	Test for HIV	Be abstinent	Limit number of partners	Use a condom	Do not share needles
Test for HIV	.13**					
Be abstinent	.10*	.16**				
Limit number of partners	-.01	.11*	.26**			
Use a condom	.02	.19**	.26**	.12*		
Do not share needles	-.01	-.01	-.01	-.01	-.01	
Talk with partner	.03	.16**	-.21	-.02	.22**	-.01

* Correlation is significant at the 0.05 level.

**Correlation is significant at the 0.01 level.

RQ2 asked the frequency of the three categories of risk factors. Twenty-five percent ($n = 118$) of articles mentioned a risk factor. Table 6 ranks each risk factor by its frequency. The three most frequently cited risk factors include unprotected heterosexual sexual contact ($n = 45$), male partner having sex with men ($n = 33$), and no HIV risk evaluation ($n = 23$). Despite the focus on male partners having sex with men, less than half of the cases paired that risk with a mention of the risk of heterosexual transmission ($n = 14$). Only 12 (36%) of the articles citing partner MSM paired the risk with proposing condom use. Also, none of the magazines talked about conspiracy beliefs during the studied period. Most of the articles focused primarily on behavioral and personal risks. The environmental factors were all in the bottom 50% of the frequency rankings.

Table 7 shows the correlations among risk factors. There were strong correlations among the environmental risks. Social inequality and poverty ($r = .54, p < .001$), poverty and racism ($r = .56, p < .001$), and social inequality and racism ($r = .56, p < .001$) were strongly correlated. Other variables with strong correlations were low sexual

communication assertiveness and partner unwillingness ($r = .64, p < .001$), partner unwillingness and self-acceptance ($r = .51, p < .001$), and partner incarceration needles and partner incarceration MSM ($r = .54, p < .001$).

There were significant differences among the magazines' inclusion of risk factors. This was evident in the coverage of the risk of heterosexual transmission. Unprotected heterosexual sexual transmission ($\chi^2 = 11.96, p = .002, d = 2$) was significantly different. *Jet* rarely mentions the risk ($n = 7$), while *Essence* ($n = 22$) and *Ebony* ($n = 16$) mention it more frequently. The same pattern occurs for non-gender-specific unprotected sexual contact transmission ($\chi^2 = 6.03, p = .049, d = 2$), IV drug use ($\chi^2 = 12.23, p = .001, d = 2$), partner infidelity ($\chi^2 = 6.03, p = .013, d = 2$), partner MSM ($\chi^2 = 14.12, p = .001, d = 2$), partner incarcerated MSM ($\chi^2 = 10.83, p = .004, d = 2$), low sexual communication assertiveness ($\chi^2 = 7.85, p = .02, d = 2$), and no risk evaluation ($\chi^2 = 6.12, p = .05, d = 2$).

RQ3 asked about the inclusion of self-efficacy and social norm variables. Only 17% ($n = 78$) of the articles used at least one of the social cognitive theory concepts. Verbal self-efficacy was used 74 times, vicarious self-efficacy 12 times, distal social norms 64 times and proximal social norms on 17 occasions. Table 8 highlights the correlations among the variables. The strongest correlation was between verbal persuasion self-efficacy and distal social norms ($r = .86, p < .001$). Table 9 shows the correlations among the self-efficacy variables and the proposed behaviors, and Table 10 shows the correlations among the social norm variables and the proposed behaviors. There were no strong correlations between vicarious self-efficacy, the more effective self-efficacy, and any of the proposed behaviors. There were also no strong correlations between proximal social norms, the more influential norm, and any of the proposed behaviors. There were moderate correlations between verbal persuasion self-efficacy and learn more information ($r = .34, p < .001$), talk about sexual history ($r = .47, p < .001$), test for HIV ($r = .59, p < .001$), and use a condom ($r = .53, p < .001$). There were also moderate correlations between proximal social norms and use a condom ($r = .42, p <$

.001); and between distal social norms and test for HIV ($r = .55, p < .001$), talk about sexual history ($r = .48, p < .001$), and condom use ($r = .43, p < .001$).

Table 6. Ranking of risk factors by frequency of mention.

Risk Factor	Frequency	Percentage of articles containing	Type of Risk
Unprotected heterosexual sexual contact	45	9.7%	Behavioral
Partner MSM	33	7.1%	Behavioral
No risk evaluation	23	5.0%	Personal
IV drug use	21	4.5%	Behavioral
Mother-to-child	17	3.7%	Behavioral
Low sexual communication assertiveness	16	3.5%	Behavioral
Self-acceptance	15	3.2%	Personal
Multiple partners	14	3.0%	Behavioral
Partner unwillingness to use condoms	12	2.6%	Behavioral
Needle procedure	12	2.6%	Behavioral
Unprotected sexual contact	12	2.6%	Behavioral
Social inequality	12	2.6%	Environmental
Poverty	10	2.2%	Environmental
Intimate trauma	8	1.7%	Behavioral
Unprotected homosexual sexual contact	8	1.7%	Behavioral
Women's biological vulnerability	7	1.5%	Personal
Partner infidelity	7	1.5%	Behavioral
Partner incarceration MSM	6	1.3%	Behavioral
Partner incarceration needles	5	1.1%	Behavioral
Racism	5	1.1%	Environmental
Crack cocaine	4	0.9%	Behavioral
Conspiracy beliefs	0	0%	Environmental
Total	292		

Table 7. Correlations among risk factors.

	Racism	Poverty	Social inequality	Unprotected heterosexual	Unprotected homosexual	Unprotected sex	IV drug use
Racism	1.00	.56**	.51**	.11*	-.15**	-.02	.18**
Poverty	.56**	1.00	.54**	.25**	.21**	.26**	.25**
Social inequality	.51**	.54**	1.00	.18**	.08	.32**	.23**
Unprotected heterosexual	.11*	.25**	.18**	1.00	.35**	.18**	.49**
Unprotected homosexual	.15**	.21**	.08	.35**	1.00	-.02	.29**
Unprotected sex	-.02	.26**	.32**	.18**	-.02	1.00	.10*
IV drug use	.18**	.25**	.23**	.49**	.29**	.10*	1.00
Needle procedure	.25**	.16**	.23**	.04	-.02	-.02	.03
Mother-to-child	.10	.05	.11*	.05	.15**	.11*	.18**
Crack cocaine	-.01	.15**	.13**	.26**	.17**	.28**	.20**
Intimate trauma	.15**	.09**	.08	.18**	.11*	-.02	.21**
Partner infidelity	-.01	.23**	-.02	.20**	.12*	-.02	.23**
Partner MSM	-.03	.19**	.17**	.31**	.29**	.27**	.30**
Partner incarceration MSM	.17**	.25**	.34**	.09*	.13**	.22**	.16**
Partner incarceration needles	.19**	.27**	.38**	.18**	.15**	.38**	.18**
Partner unwilling	-.11	.14**	.06	.27**	.19**	.14**	.29**
Low sexual communication	-.02	.14**	.12**	.26**	.07	.27**	.30**
Multiple partners	.23**	.32**	.37**	.28**	.07	.29**	.39**
Biological	.16**	.23**	.09**	.26**	.12*	.09**	.23**
No risk	.07	.38**	.28**	.33**	.12**	.40**	.33**
Self-acceptance	-.02	.14**	.05	.31**	.16**	.20**	.25**

Table 7—continued

	Partner incarcerat- ion needles	Partner unwilling	Low sexual communica- tion	Multiple partners	Biological	No risk	Self- acceptance
Racism	.19**	-.02	-.02	.23**	.16**	.07	-.02
Poverty	.27**	.14**	.14**	.32**	.23**	.38**	.14**
Social inequality	.38**	.06	.12*	.37**	.09*	.28**	.05
Unprotected heterosexual	.18**	.27**	.26**	.26**	.26**	.33**	.31**
Unprotected homosexual	.15**	.19**	.07	.12*	.12*	.12**	.16**
Unprotected sex	.38**	.14**	.27**	.09*	.09*	.40**	.20**
IV drug use	.18**	.29**	.30**	.23**	.23**	.33**	.25**
Needle procedure	-.02	-.03	-.03	.09*	.09*	-.04	-.03
Mother-to-child	.20**	.04	.09	-.02	-.02	.11*	-.04
Crack cocaine	.44**	.28**	.24**	-.01	-.01	.19**	.25**
Intimate trauma	.15**	.19**	.16**	-.02	-.02	.28**	.16**
Partner infidelity	-.01	.31**	.27**	.13**	.13*	.38**	.28**
Partner MSM	.22**	.33	.36**	.17**	-.17**	.25**	.28**
Partner incarceration MSM	.54**	-.02	.08	.20**	-.01	.24**	-.02
Partner incarceration needles	1.00	.25**	.32**	.47**	-.01	.36**	.22**
Partner unwilling	.25**	1.00	.64**	.29**	.09*	.40**	.51**
Low sexual communication	.32**	.64**	1.00	.31**	.27**	.45**	6.3**
Multiple partners	.47**	.29**	.31**	1.00	.08	.42**	.32**
Biological	-.01	.09*	.27**	.08	1.00	.05	.18**
No risk	.36**	.40**	.45**	.42**	.05	1.00	.30**
Self-acceptance	.22**	.51**	.63**	.32**	.18**	.30**	1.00

Table 7—continued

	Needle procedure	Mother-to-child	Crack cocaine	Intimate trauma	Partner infidelity	Partner MSM	Partner incarceration MSM
Racism	.25**	.09	-.01	.17**	-.01	-.03	.19**
Poverty	.16**	.05	.15**	.09	.23**	.19**	.25**
Social inequality	.23**	.11*	.13**	.08	-.02	.17**	.34**
Unprotected heterosexual	.04	.05	.29**	.18**	.12**	.31**	.09*
Unprotected homosexual	-.02	.15*	.17**	.11*	.12*	.29**	.13**
Unprotected sex	-.03	.11*	.28**	-.02	-.02	.27**	.22**
IV drug use	.03	.18**	.20**	.21**	.23**	.30**	.16**
Needle procedure	1.00	-.03	-.02	-.02	-.02	-.05	-.02
Mother-to-child	-.03	1.00	.11*	.06	-.02	.08	.18**
Crack cocaine	.06	-.11*	1.00	-.01	-.01	.25**	-.01
Intimate trauma	-.02	.06	-.01	1.00	.26**	-.04	.13**
Partner infidelity	.81	-.02	-.01	.26**	1.00	.03	-.01
Partner MSM	-.05	.08	.25**	-.04	.03	1.00	.27**
Partner incarceration MSM	-.02	.18	-.01	.13**	-.01	.27**	1.00
Partner incarceration needles	-.02	.20**	.44**	.15**	-.01	.22**	.54**
Partner unwilling	-.03	.04	.28**	.19**	.31**	.33**	-.02
Low sexual communication	-.03	.09	.24**	.16**	.27**	.36**	.08
Multiple partners	.05	.10*	.26**	.36**	.19**	.17**	.20**
Biological	.09*	-.02	-.01	-.02	.13**	.17**	-.01
No risk	-.04	.11*	.19**	.28**	.38**	.46**	.24**
Self-acceptance	-.03	-0.36	.25**	.16**	.28**	.28**	-.02

* Correlation is significant at the 0.05 level.

**Correlation is significant at the 0.01 level.

Table 8. Correlations among social cognitive theory concepts.

	Vicarious experience	Verbal persuasion	Distal social norms
Verbal persuasion	.21**		
Distal social norms	.24**	.86**	
Proximal social norms	.23**	.33**	-.04

**Correlation is significant at the 0.01 level.

Table 9. Correlations among self-efficacy concepts and proposed behaviors.

	Learn more info	Test for HIV	Be abstinent	Limit number of partners	Use a condom	Do not share needles	Talk about sexual history
Vicarious experience	.07	.16**	.09*	-.01	.23**	-.01	.28**
Verbal persuasion	.34**	.59**	.28**	.15**	.53**	.11*	.47**

* Correlation is significant at the 0.05 level.

**Correlation is significant at the 0.01 level.

Table 10. Correlations among social norm concepts and proposed behaviors.

	Learn more info	Test for HIV	Be abstinent	Limit number of partners	Use a condom	Do not share needles	Talk about sexual history
Distal social norms	.37**	.55**	.26**	.16**	.43**	.12*	.48**
Proximal social norms	-.03	.21**	.26**	-.01	.42**	-.01	.17**

* Correlation is significant at the 0.05 level.

**Correlation is significant at the 0.01 level.

RQ4 examined the differences between the two time periods to find the magazine's sensitivity to incidence rates. In total, 66 articles (14%) mentioned higher HIV incidence rates among African Americans, and 59 articles (13%) mentioned disproportionate rates for African American women. There was no significant difference between the time period and mentioning higher rates in the African American community ($\chi^2 = .44, p = .51, d = 2$) or rates among African American women ($\chi^2 = .44, p = .51, d = 2$). Table 11 shows the frequency of mentions of higher rates in each time period. There was not a significant difference between the number of articles and the time period ($t = .69, p = .52$ (one-tailed), $d = 461$). However, there were more proposed behaviors in the second time period than in the first ($t = 1.53, p = .002$ (one-tailed), $d = 461$). Table 12 shows the number of articles containing each of the proposed behaviors in each time frame. There was a significant difference between the two time periods for one risk variable: Partner MSM ($t = 2.84, p < .001$ (one-tailed), $d = 461$).

Table 11. Frequency of mention of higher HIV rates by time period.

	Time period 1 (2000-2002)	Time period 2 (2003-2006)
Higher rates for African Americans	32	24
Higher rates for African American women	34	35
Total	66	59

Table 12. Frequency of proposed behavior mentions by time period.

	Time period 1 (2000-2002)	Time period 2 (2003-2006)
Learn more info	3	7
Test for HIV	11	24
Abstinence	4	3
Limit number of partners	0	2
Condom use	10	20
Do not share needles	0	2
Talk about sexual history	8	15
Total	30	73

CHAPTER VI

DISCUSSION

This research sought to find what HIV/AIDS prevention messages were being published in magazines targeting African American women by using social cognitive theory as a framework. The data reveal both encouraging and discouraging results about the quality of information available for African American women. The magazines are disseminating some important prevention messages. Unlike what was found during the first decade of the epidemic, discussion of HIV/AIDS is not being avoided (Hammonds; 1986; Kinsella, 1989; Williams, 2003). But there are vital risks and behaviors that are not being fully discussed. Because less than half of the stories that mention HIV/AIDS elaborate on it, there were many missed opportunities to communicate prevention messages during the years covered in this study. The public health community should attempt to address the lack of elaboration in stories that mention HIV/AIDS. Out of the three magazines, *Jet* was least likely to provide useful or in-depth information. This is probably because *Jet* is a weekly publication with stories that are shorter than its monthly counterparts (Johnson Publishing Company, 2006b).

There was some positive reflection of public health messages. About three-quarters of the stories focused on HIV/AIDS as a U.S. issue. In these magazines, HIV/AIDS was portrayed as a domestic issue and was not overshadowed by the impact of HIV/AIDS around the world, unlike what Brodie et al. (2004) found in the mainstream media coverage. The number of articles proposing condom use is encouraging because 80% of new HIV infections in women are the result of unprotected heterosexual contact (CDC, 2008c). Condom use is the most efficacious and realistic means of preventing sexual HIV transmission (CDC, 2008b). Encouraging testing for HIV is a positive public health message, but it is not a successful prevention message. HIV testing is important for treatment, and knowledge of HIV status can lead to a change in behavior to protect sex or

drug-use partners from becoming infected (CDC, 2008e; Kaiser Family Foundation, 2007). But testing will not prevent HIV transmission by itself. The correlation between testing and condom use is significant, but very weak. Also, talking with partner about sexual history as a stand-alone proposed behavior is not an effective way to prevent HIV transmission. Although there was a significant correlation between talking about sexual history and use a condom, it was not very strong.

It is also positive for African American women that the magazines highlight the risk of contracting HIV through unprotected heterosexual sexual contact over other risks, such as unprotected homosexual sexual contact or IV drug use. And, the magazines are also acknowledging the risk of not knowing one is at risk for HIV/AIDS. However, the impression the magazines are perpetuating is not the full picture of epidemiology of HIV/AIDS. The content mostly focused on individual, behavioral risks. The magazines did not provide a perspective about the larger, environmental risks that influence how HIV is transmitted. This is dissimilar to what Pickle et al. (2002) found in African American newspaper coverage from 1991 to 1996, and Clark et al.'s (2006) results in *Ebony* and *Essence* from 1999 to 2001. Environmental risks are just as influential as personal or behavioral risks, according to social cognitive theory (Bandura, 2004). Without highlighting environmental risks, it is unlikely that those factors will ever be changed and the situations that increase the likelihood of HIV transmission will continue to perpetuate themselves. The correlations suggest that if one environmental risk is mentioned, it is likely paired with the other environmental risk factors. Those articles provide the larger picture, but such comprehensive articles are not common.

During the time period studied, there was a fixation on male partners having sex with other men and how that put women at risk, which was similar to what Clarke et al. (2006) found in *Ebony* and *Essence* from 1999 to 2001. The risk of the bisexual infector is still unknown (Worth, 2003). Presenting this risk alone and without a proposed behavior is not useful for women. Although there was a significant correlation between

this risk factor and unprotected heterosexual sexual contact, it was weak. It is an example of how the media dramatize certain taboo issues and do not provide useful prevention information, similar to what other researchers have discovered (Biddle et al., 1993; Colby & Cook, 1991; Lupton, 1994). But, by talking about the issue, it helps to counteract the false sense of security that a heterosexual, assumed-to-be monogamous relationship is risk-free. However, a male partner's infidelity with another woman while in a relationship is not mentioned as frequently as men having intercourse with other men at any point in time.

The magazines did not extensively explore the underlying risk factors for why women engage in risky behaviors such as unprotected sex. Discussions about risk factors related to male power in relationships were not very frequent (sexual communication assertiveness, self-acceptance, intimate trauma, and partner unwillingness). Women are warned that unprotected sex is risky, but not of the behaviors that lead to it. The coverage does not provide women with enough information to evaluate their risk of HIV or how to mitigate it. The correlations suggest that if one gender-specific risk is mentioned, so is another. These articles are providing useful information, but the occurrences are not prevalent. Women's need for information on how to prevent HIV transmission does not appear to have been met, though future studies should include interviews with female readers of these magazines to determine the extent to which they find HIV information in the magazines valuable. Future campaigns should focus on communicating risks to women that apply to them and providing effective prevention behaviors.

The magazines also did not touch on the subject of conspiracy beliefs about HIV/AIDS. Although the lack of discussion will not help to spread the beliefs, it also does not resolve them. In order to assuage fears there needs to be an open and honest discussion of them (Ross et al., 2006; Thomas & Quinn, 1991). Public health communicators should work with the magazines and other representatives who are in service to the African American community to debunk conspiracy beliefs.

The magazines also cited risk factors much more frequently than proposed behaviors that can mitigate the risks. Knowledge about risks is aroused, but information about what do to prevent HIV transmission is not always available. And, the proposed behaviors are not encouraged as effectively as possible. Although there is evidence of self-efficacy and social norms in the media messages, the more effective forms – vicarious self-efficacy and proximal social norms – were not widely used. These variables were also not strongly paired with any proposed behaviors. Including these concepts would improve the quality of information and increase the likelihood that the advice is followed.

The magazines were not overly sensitive to the 2003 rise of HIV-incidence rates for African Americans. Since AIDS was first reported, media coverage has not been driven by incidence rates, but by events and celebrities (Cohen, 1999; Colby & Cook, 1991; Kinsella, 1989; Lupton, 1994). The content and number of articles remained fairly stable over time. The magazines also did not highlight the disproportionate rates either directly by mentioning the fact that there were higher rates or increasing the number of stories in response. Without attention being paid to the issue and increasing awareness, a media advocacy campaign cannot be effective in bringing about change.

This study is limited in its scope. African American women read more magazines than just *Essence*, *Ebony*, and *Jet*, as well as pay attention to other media. These magazines are also not their only source of HIV-prevention messages, or social norms. Because this was a quantitative study, the context of prevention mentions was not fully taken into consideration. Also, African American women's interpretation of the messages and whether they acted on them is also not known. Future studies should address these issues. Men are the other factor in heterosexual transmission of HIV. Messages targeted to men should be studied to build a more complete picture of HIV/AIDS-prevention messages in African American magazines.

CHAPTER VII

CONCLUSION

Social cognitive theory provides an understanding of the many influences on health behavior. With the gap between African American and other ethnicities' HIV incidence rates widening, all tools at the disposal of public health communicators should be utilized. The media hold the potential to disseminate useful information and influence health behaviors, as well as elicit community support (Bandura, 2001, 2004; Nelkin, 1991). The three magazines under study are marketed to African American women, are read by African American women, and are a source of health information. How these magazines are reporting on HIV/AIDS and the quality of prevention messages that may be reaching African American women can serve as formative research for a media advocacy campaign.

The study's method shows another use for social cognitive theory. Theory-based content analysis provides a systematic means of assessing media messages in a comprehensive manner. The results can also be easily transferred to the practice of health communication. By using social cognitive theory's three categories of risk determinates, it creates an inclusive method of categorizing the risks pertaining to a specific population group, as demonstrated by this study. Armed with the knowledge of which type of risks are infrequently cited by the media from the content analysis, health communicators can work to strategically remedy this issue. Also, social cognitive theory concepts used in campaigns have shown to be effective in altering individual's behavior to reflect safer-sex practices (Amaro, 1995; Bandura, 1994; Fisher & Fisher, 2000; O'Leary & Wingwood, 2000; Sikkema et al., 2000). The insight into human behavior that social cognitive theory provides gives health communicators a tool to create the most effective media messages. The study's method of using social cognitive theory can be generalized to understand media messages about other diseases and for other populations.

The magazines under study touch on many important HIV-prevention messages. But, they do not fully discuss the reality of the increased spread of HIV for African American women. Environmental risk factors and gender-specific risks are not frequently mentioned. The magazines focused more on dramatic risk factors such as male partners having sex with men and less on useful information for African American women. To implement a media advocacy campaign, awareness of structural factors must be increased as well as awareness of the disproportionate HIV-incidence rates. Although mentions of the disproportionate HIV-incidence rates are occasionally present, they are not emphasized.

Self-efficacy and social norms can increase the influence of media messages and have been found to improve compliance with safer-sex behaviors (Fisher & Fisher, 2000). But the strongest forms, vicarious self-efficacy and proximal social norms, were rarely used. Further, the larger issue is that more than half of the articles did not provide any information about HIV/AIDS prevention. For the most part, these magazines lacked useful information or elaboration for prevention risks and behaviors for African American women.

Health communicators can initiate a number of tactics to address the missing information. To assure consistent and effective reporting on the issue, the relationship with the magazines should be predicated on a partnership between the health communicator and the magazine to disseminate accurate and useful information about HIV/AIDS. By asking to partner with the magazines for this cause, the communicator is engaging the magazines' mission statement. For example, *Ebony's* publisher states, "Between each and every page, the magazine is full of information to enrich, encourage and enlighten...The magazine profiles successful African-American role models; discusses the issues that our community faces today..." (JCP, 2008, para 2). As part of this goal, the health communicator should remind the magazines that elaboration about

HIV risks and behaviors whenever it is mentioned is the best way to discuss the issue and provide useful information.

Fact sheets about HIV/AIDS and African American women can serve as a reference guide for information. They should be disseminated to writers who report on health and their editors. Since condom use is the most practical and efficacious prevention method, it should be emphasized as such in the fact sheets.

How the fact sheets are written will help to guide how the virus's impact is portrayed and how behaviors are proposed. The higher incidence rates for African American women need to be emphasized to demonstrate that they are at risk for HIV transmission. Comparing the rates to other groups will show how disproportionately their risk is. The gender-specific risks should be highlighted and demonstrated, and they should always be partnered with behaviors to prevent transmission. The main focus should be on the risks that lead to unprotected sex for women, such as low sexual communication and partner unwillingness. Proposed behaviors should be explained using self-efficacy language and explicit directions. To harness the influence of self-efficacy, the health communicator should use more than just directives such as "use a condom." Explaining the safer-sex behaviors using real-life situations will provide more detail and clarification. This can be done through quotations or in a conversation format as a subsection of the fact sheet. Also, providing contacts in the public health community who are African American women and have experience with HIV or AIDS to explain the risks and behaviors will employ the influence of social norms.

The fact sheets should also emphasize environmental risk factors such as poverty, racism, and social inequality. Providing contact information for community leaders who are addressing the impact of HIV in the African American community will help to elicit community support and awareness. These discussions should emphasize that there are steps that can be taken to address these structural issues.

To increase the amount of coverage that will explain more about HIV/AIDS, health communicators should use the existing reporting tendencies of the magazines. Tying contact with the magazines about HIV/AIDS to articles about HIV/AIDS conferences, celebrity events, campaign launches, and anniversaries will improve coverage. The magazines' editorial calendars will also list which stories will be featured each month or week.

Another area that needs to be addressed is the lack of messages about HIV/AIDS conspiracy beliefs. A discussion with African American community leaders, public health leaders, government representatives, and a moderator from the magazine can be used to address common myths. The discussion should stress the importance of being honest and open about HIV/AIDS's impact on African Americans and explaining the underlying reasons. The discussion should also suggest what individuals can do to prevent HIV and help out locally.

Addressing these issues should be on the HIV/AIDS public health communicator's to-do list. Until a cure for AIDS is found, prevention programs are the only method to reduce incidence rates. The African American community requires attention from the public health community to address the disproportionately high HIV-incidence rates. The studied magazines have laid some groundwork for increasing knowledge and awareness of HIV/AIDS risks and prevention behaviors, but more work needs to be done in a more effective fashion to truly address the high HIV-incidence rates.

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APPENDIX

Coding Manual

1. Number Assigned		
2. Magazine		
Essence	0	
Ebony	1	
Jet	2	
3. Article Date	(mm/dd/ yy)	
4. Byline Name		
5. Section		
6. Page Number		
7. Word Count		

Context of HIV	Present (1) or Not (0)	
8. United States		
9. Africa		
10. Other		
11. Mention		
12. Higher rates of HIV among African Americans	Present (1) or Not (0)	
13. Higher rates of HIV among African American women	Present (1) or Not (0)	
Proposed Behavior	Present (1) or Not (0)	
14. Learn more info		
15. Test for HIV		
16. Be abstinent		
17. Limit number of sexual partners		
18. Use a condom		

19. Do not share needles		
20. Talk about sexual history with partner		

Self-efficacy	Present (1) or Not (0)	
21. Vicarious experience		
22. Verbal persuasion		

Social Norms	Present (1) or Not (0)	
23. Distal		
24. Proximal		

Environmental Risk Factors	Present (1) or Not (0)	
25. Racism		
26. Poverty		
27. Social Inequality		
28. Conspiracy beliefs		

Behavioral Risk Factors	Present (1) or Not (0)	
29. Unprotected heterosexual sexual contact		
30. Unprotected homosexual sexual contact		
31. Unprotected sexual contact		
32. IV drug use		
33. Needle procedure		
34. Mother-to-child		
35. Crack cocaine		
36. Intimate trauma		
37. Partner infidelity		
38. Partner MSM		

39. Partner incarceration MSM		
40. Partner incarceration needles		
41. Partner unwillingness		
42. Low sexual communication assertiveness		
43. Multiple partners		

Personal Risk Factors	Present (1) or Not (0)	
44. Women's biological vulnerability		
45. No risk evaluation		
46. Self-acceptance		

Subject	Present (1) or Not (0)	
47. Male		
48. Female		
49. African American		
50. Age 18 to 34		
51. Age 35 or older		

Coding Instructions

Fill in gray-shaded sections as directed.

- 1. Number Assigned:** Code as the “x” in “x of 463 documents” at the top of the page.
- 2. Magazine:** Code as number assigned to name of magazine.
- 3. Article Date:** If only month is given, code as the first of the month in format given.
- 4. Byline Name:** Code as in LexisNexis. If no name is given, then code as “none.”
- 5. Section:** Code as in LexisNexis, but do not include page numbers.
- 6. Page Number:** Page number is listed on the “Section” line.
- 7. Word Count:** Code number as listed in “Length” column. If no word count is given, code as “none.”

- 8-10. Context of HIV:** If no mention of location, code as “United States.”

- 11. Mention:** The articles for which HIV/AIDS is only a brief mention will have no other categories coded as present than variables 1-10. Code 1 if a brief mention and 0 if a theme of the article.

- 12. Higher rates of HIV among African Americans:** Example of article that would receive a present coding: “Blacks carry a heavier burden” or “Blacks have a higher percentage of new HIV infections.”

- 13. Higher rates of HIV among African American Women:** Example of article that would receive a present coding: “Black women carry a heavier burden” or “Black women have a higher percentage of new HIV infections.”

Proposed Behavior: Behavior that is encouraged by the text. Usually done in the imperative verb tense. Proposed behavior is different than risk factor in that it is a recommendation or advice.

14. Learn more info: Includes cues to Web sites or hotlines, or the need to talk about HIV/AIDS with a medical professional.

15. Test for HIV: Cues to get any sort of HIV test.

16. Be abstinent: Endorsing celibacy, usually said as the only way to prevent HIV/AIDS.

17. Limit number of sexual partners.

18. Use a condom (any type) or “protection.”

19. Do not share needles (for any reason).

20. Talk about sexual history with partner.

Self-efficacy: Cues that encourage individual’s personal sense of control over behavior.

There must be proposed behavior(s) in order for self-efficacy to be present.

21. Vicarious experience: Gives specific instructions on how to perform behavior or uses subject to show how to perform behavior. Vicarious self-efficacy would be situations in which a person modeled the behavior (diagrams or talking in the first or second person about the proposed behavior). For example: “Use language like the following...” or if a story about a person about taking a HIV test.

22. Verbal persuasion: Advice or command about the proposed behavior, such as “Take a rapid HIV test,” “women should talk to a doctor about...,” or “use a condom.”

Social Norms: For these variables, social norms are the source of information. This is whoever is creating the social rules (reporter or subject of the story) in the article. This person/organization is the source of information, quotes, advice, skills, or story. There must be proposed behavior(s) in order for social norms to be present.

23. Distal: community, reporter or authority figure (CDC or other organization).

24. Proximal: a peer to an African American women ages 18-34. Cues include the use of “us,” “ours,” or “Sisters.”

Environmental Risk Factor for HIV transmission: Includes reasons cited for prevalence of HIV/AIDS in African American community.

25. Racism: Unequal treatment or service.

26. Poverty: Conditions of experiencing poverty such as living in bad neighborhoods or unable to afford services.

27. Social Inequality: No political or social power to change the situation.

28. Conspiracy beliefs: Example of article that would receive a present coding: If write “the government is keeping a vaccine from the public,” or “AIDS is genocide against Blacks.” This is included because it is part of an inaccurate evaluation of risks.

Behavioral Risk Factor for HIV transmission: These messages can come from personal stories (“I had unprotected sex”) or general reporting.

29. Unprotected heterosexual sexual contact: Does not matter what type of sexual contact as long as it specifically mentions people of the opposite gender.

30. Unprotected homosexual sexual contact: Does not matter what type of sexual contact as long as it specifically mentions people of the same gender.

31. Unprotected sexual contact: Sexual contact with no differentiation between genders.

32. IV drug use: Includes heroin, morphine, cocaine (not crack cocaine), amphetamine or methamphetamine, whether from needle transmission or cited as reason for risky behavior.

33. Needle procedure: Includes blood transfusions and other medical procedures, or body piercings and tattoos.

34. Mother-to-child: Mother has HIV and passes it to the child during birth, pregnancy, or breastfeeding. It is often implied that happened during birth. For example, “My mother had HIV and passed it to me.”
35. Crack cocaine: The use of cocaine is cited as the reason for the risky behavior that leads to HIV transmission.
36. Intimate trauma: Rape is cited for transmission or partner/child abuse is cited as the reason for the risky behavior that leads to HIV transmission.
37. Partner infidelity: Partner was not monogamous (the individual believed her partner did not have HIV when she entered the relationship) and transmitted HIV during relationship (contracted via any route or none mentioned). For example, “My boyfriend cheated and he gave HIV to me.”
38. Partner MSM: Male partner is cited as having sex with men or on the “down low” and then transmitting HIV to female partner. It can occur either during or before relationship.
39. Partner incarceration MSM: Male partner is cited as contracting HIV in prison from having sex with other men and then transmitting to other partner either during or before relationship.
40. Partner incarceration needles: Male partner is cited as contracting HIV in prison from sharing needles (any type) and then transmitting to other partner either during or before relationship.
41. Partner unwillingness: Male partner unwilling to change sexual behavior (any type). Signifies unequal power in the relationship.
42. Low sexual communication assertiveness: An attitude about sexual communication assertiveness that leads to no communication about HIV and prevention that increases vulnerability of contracting HIV. Includes belief that initiating conversation about condom use, asking about sexual history or asking about fidelity will harm relationship.
43. Multiple partners: Having sex with many people listed as a risk for contracting HIV.

Personal Risk Factor for HIV transmission: These messages can come from personal stories (“I thought my partner is faithful”) or general reporting.

44. Women’s biological vulnerability: Includes any biological reason such as mucosal exposure or other STIs that make transmission more likely.

45. No risk evaluation: An attitude that includes trust without verification about own (female’s) risk of contracting HIV via any route or not feeling could have already contracted HIV. In general, individuals do not believe they are at risk for HIV (for any reason) or not feeling the need to get an HIV test. This includes attempting to change the perception to “anybody can have HIV.”

46. Self-acceptance: Lack of acceptance (self-love/esteem/confidence) of women or lack of respect from men. This gives control over sex and condom use to men.

Subject of the article (author or subject) used to tell the story about a person who experience the virus/disease. Code each category as present or not. There can be multiple subjects and code characteristic as present if one subject displays the characteristic.

47. Male.

48. Female.

49. African American.

50. Aged between 18 and 34.

51. Age 35 or older.