

A TALE OF TWO RISKS: THE FRAMING OF HIV TRANSMISSION RISK
IN HEALTH BROCHURES

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ABSTRACT

The framing of a health issue such as HIV transmission risk may directly impact public opinion, which plays a significant role in the formation of health policies. Brochures are an important piece of HIV treatment and prevention efforts, so it is essential to understand how HIV transmission is discussed within these commonly used educational materials. This study evaluated the framing of HIV transmission risk in 31 HIV-related health brochures gathered from county health departments in the Greater Kansas City Area. The frame analysis revealed two primary frames used to construct the larger category of HIV transmission risk: risk behaviors and “risk” groups. Further analysis revealed that the frames compete with one another to explain how HIV is transmitted. While the risk behaviors frame identifies behaviors such as injection drug use (IDU), drugs and alcohol, and unprotected sex as the culprits of HIV transmission, the risk groups frame points to specific populations, namely women, heterosexuals, African Americans and teenagers and young adults. Moreover, the frames provide contending views of who is at risk for HIV. The risk behaviors frame presents anyone who engages in “risky” behaviors as at risk for HIV/AIDS, while the

risk groups frame highlights the risk associated with being a member of a specific population. Interestingly, older adults and homosexual individuals are almost entirely excluded from the discussion of HIV transmission risk within the brochures. In addition to competing with one another to present at-risk groups, the frames overlap as an inconsistent presentation of risk-free activities within the risk behaviors frame perpetuates the misunderstanding that HIV can be transmitted via casual social contact, which has implications for groups identified as at-risk within the risk groups frame; the implications can be dire as a lack of understanding regarding how the disease is not transmitted has been directly linked to negative attitudes toward people living with HIV/AIDS (and presumably groups considered at-risk for HIV). The paper concludes with a further discussion detailing the implications of the framing of HIV transmission risk within the brochures.

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the College of Arts and Sciences have examined a thesis titled “A Tale of Two Risks: The Framing of HIV Transmission Risk in Health Brochures,” presented by Kathryn E. Fagan, candidate for the Master of Arts degree, and certify that in their opinion it is worthy of acceptance.

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To my sister, Jessica Fagan

CHAPTER 1

INTRODUCTION

Human immunodeficiency virus / acquired immune deficiency syndrome (HIV/AIDS) continues to be a relevant phenomenon in the United States and around the world. As of 2011, 1.2 million people were living with HIV in the United States, with an average of 50,000 people becoming newly infected each year (Centers for Disease Control and Prevention, 2014a). It has been posited that the HIV epidemic is actually two epidemics, one of biological significance and the other a product of cultural meaning (Treichler, 1999). The cultural meaning of an illness can be understood by investigating how it is socially constructed. As Conrad and Barker explain, “In contrast to the medical model, which assumes that diseases are universal and invariant to time and place, social constructionists emphasize how the meaning and experience of illness is shaped by cultural and social systems” (2010, p. S67). For HIV/AIDS, its designation as a sexually transmitted disease has defined how HIV positive individuals experience the illness, as well as how people living with or at risk for HIV are portrayed through media sources.

HIV/AIDS remains the most stigmatized illness in our society; the stigma associated with HIV is rooted in its classification as a venereal disease. This point is supported by comparing the construction of HIV/AIDS to Hepatitis B for example. While both illnesses are transmitted via blood, semen and other bodily fluids associated with sexual interaction, can result from sharing needles to inject drugs and can be passed from a mother to her newborn child, the difference in how they have been constructed is enormous (CDC, 2009). Hepatitis B is described as a virus which impacts the liver. HIV/AIDS, on the other hand, is characterized as a sexually transmitted disease. Allan Brandt argues that, “Medical and social

values continue to define venereal disease as a uniquely sinful disease, indeed, to transform the disease into an indication of moral decay” (1985, p. 186). The moral blanketing of HIV/AIDS is most evident in the portrayal of groups of people living with or at risk for the disease. Women and children have historically been characterized as victims of HIV/AIDS, while men, particularly injection drug users and homosexuals are often portrayed as the perpetrators of HIV (Donovan, 1993). Donovan emphasizes that an investigation into the social construction of an illness must take into account that “within a society, identifiable groups of actors are imbued with culturally constructed positive or negative images which influences the types of policy benefits and burdens lawmakers are willing to target to that given group” (1993, p. 5). More specifically, the classification of groups as guilty or innocent can directly impact policies related to HIV/AIDS. For instance, the Ryan White CARE Act, implemented in 1990, targeted women and children with AIDS designating them as a “deserving” population, while gay men, ethnic minorities, and injection drug users (IDUs) were underrepresented with regard to how and where the Act would provide health care. At the time, women and children made up a small portion of those living with AIDS, while gay men and ethnic minorities accounted for a large portion of the population living with AIDS (Patterson & Keefe, 2008).

The mass media is a powerful tool for disseminating information, particularly cultural meanings of illness. While definitions of illness may originate within medical institutions, they reach the public through media sources; in much the same way as medical authorities determine how an illness is defined, the media determines the way in which an illness is portrayed to an audience. This is done through the use of media frames which are “largely unspoken and unacknowledged, [and which] organize the world both for journalists who

report it and, in some important degree, for us who rely on their reports” (Gitlin, 1980, p. 7). Media frames are deeply embedded within the culture from which they originate and can therefore reveal the cultural meanings associated with an illness such as HIV/AIDS (de Souza, 2007). For instance, in the early years of AIDS in the United States, news sources avoided the use of “explicit” terms such as semen, condom, vaginal fluids, etc. This avoidance led to a vague and misconstrued picture of how the disease was transmitted as well as how to prevent the spread of HIV/AIDS. For instance, the use of “bodily fluids” to describe transmission, gave the impression that HIV/AIDS could be transmitted via any bodily fluid, creating a fear of even casual contact with HIV-positive individuals. Metaphors used in describing HIV/AIDS created a distinction between those that had the disease and everyone else. A commonly used phrase, “the war on AIDS” has framed the disease and those living with HIV/AIDS not only as the enemy, but as something/someone to be defeated (Cline, 2003). Along with the war metaphor, HIV/AIDS has also been described as a plague and linked to a criminal nature. These metaphors that infiltrate everyday experience further distance those living with HIV/AIDS or considered at risk for HIV/AIDS from the general population. This only heightens the need to understand how HIV/AIDS is constructed in public discourse, specifically to uncover the sources of symbolic meaning in health care and to expose how health beliefs, behaviors, and institutional practices are not inevitable but materialize from contextual and political sources (Sharf & Vanderford, 2003, p. 12).

Misinformation and stigma have plagued the cultural understanding of HIV/AIDS transmission in the United States. While research shows that individuals are competent in their knowledge of how HIV is transmitted, they are much less comfortable with how it is not transmitted (Dias, Matos, & Goncalves, 2006; Inungu, Mumford, Younis, & Langford, 2009;

Lew-Ting & Hsu, 2002). Considering that knowledge associated with HIV transmission directly impacts attitudes toward people living with the disease, it is imperative to understand how HIV transmission is presented in media sources. This is underscored by the fact that as recently as the early 2000s, one in four Americans reported that they were afraid of personal contact with a person living with HIV/AIDS, and one in three would intentionally avoid such a person (Vanable, Carey, Blair, & Littlewood, 2006). The misplaced risk associated with casual social contact can impact not only people living with HIV/AIDS, but those persons or groups perceived to be at risk for the disease. Furthermore, media frames can help determine public opinion, which in turn affects policies regarding health issues and directly impacts people living with HIV/AIDS or at risk of contracting the disease. As such, there is a critical need to understand how a prevalent health issue such as HIV transmission risk is portrayed in media sources.

Previous research has looked at how HIV/AIDS is constructed in media sources such as newspapers and academic journals, but there is limited research addressing how HIV/AIDS is framed in health brochures. Health brochures are often used as preventive tools and individuals report that brochures are a common source of health information; in response, the purpose of this study is to examine how HIV transmission risk is framed in health brochures, based on a sample gathered from county health departments in the Greater Kansas City Area.

In order to understand how the brochures presented HIV transmission risk, I conducted a frame analysis of the text and images in the brochures. The frames were developed by analyzing repeated statements addressing the transmission of HIV within the text, while examining groups presented as at-risk for HIV/AIDS through the images. The

analysis revealed that HIV transmission risk is discussed via two primary frames: risk behaviors and “risk” groups. These frames compete and overlap with one another to identify how HIV is transmitted. The risk behaviors frame emphasizes that anyone can get HIV by engaging in risky behaviors, primarily through sharing needles, the use of drugs and alcohol, and engaging in unprotected sex. Conversely, the risk groups frame highlights the risk associated with groups, namely women, heterosexuals, African Americans and teens and young adults. Ambiguity surrounding transmission related to casual social contact within the risk behaviors frame emphasizes the risk associated with the groups identified in the risk groups frame. Older adults and homosexual individuals are almost completely excluded from the discussion of HIV transmission risk within these brochures.

CHAPTER 2

REVIEW OF LITERATURE

A Social Constructionist Framework

Social construction, as a conceptual framework focuses on understanding our world from a cultural and historical standpoint. From this perspective, the meaning of social phenomena such as illness, is not fixed or “natural”, but rather “originates in our thoughts and actions, and is maintained as real by these” (Berger & Luckmann, 1966, p. 20). Berger and Luckmann argue that we live in the “reality of everyday life” and this reality is structured by language and shared by others. Berger and Luckmann specifically note that “language marks the co-ordinates of a person’s life in society and fills that life with meaningful objects” (1966, p. 22). Language discerns everything from geographic locations to everyday tools such as can openers and it is through these designations that we are able to make sense of our world. For instance, I know that I live in Kansas City, which is located in the Midwestern portion of the United States of America. I wake up every morning and make coffee using a coffee maker and feed my son using a bottle, all tools which have been designated for these specific purposes. Likewise, my husband also lives in Kansas City and understands that to feed our child, he must use a bottle. In this way, “the reality of everyday life further presents itself to me as an intersubjective world, a world that I share with others” (Berger & Luckmann, 1966, p. 23). Furthermore, the reality of everyday life is not the same for everyone. For example, my reality is not the same as someone living in Peru. Mothers in Peru almost exclusively breastfeed, many well into their child’s second year of life. This is different from the United States, where only a small percentage of babies (14%) are still exclusively breastfed at 6 months of age, and it is normal for children to be switched to cow’s

milk once they reach one year of age (World Health Organization, 2014a). Consequently, women in Peru might find bottle-feeding, which is a common part of my everyday reality, to be a strange activity; in this way their reality of everyday life is different from mine.

The reality of everyday life is situated within a specific time and place, and is impacted by the historical landscape from which it originates. As Berger and Luckmann explain, “a person cannot reverse at will the sequences imposed by the temporal structure of everyday life” (1966, p. 27). I cannot graduate without first having completed the requirements for my college degree. I cannot drive without first having passed the driving test and received my driver’s license. Likewise, I was born in a specific year which is itself part of a larger historical time and place. I was born in the early 1980s, graduated from high school in the early 2000s and had my first child in 2013. Each of these periods of time is marked by specific economic, social and political occurrences, which determine how I experience everyday life. For instance, trends in marriage and college graduation rates can be very telling of how a specific historical time period influences the reality of everyday life. I was born in 1984, when the median age at first marriage was roughly 24 years and the number of women between the ages of 26 and 28 with a bachelor’s degree outnumbered men of the same ages with bachelor’s degrees (Elliott, Krivickas, Brault, & Kreider, 2012; Russell Sage Foundation, 2013). I was born into a period of time where it was common for women to go to school, complete a degree and use that degree outside of the home. If I had been born in 1950, when the age at first marriage for women was 20 and they were less likely than men to complete a bachelor’s degree, the reality of my everyday life would have been different. I may have been more likely to marry young and exist within the household, raising children, than to attend college as a degree-seeking student. The trend continues as you move through

time; in 1942, a married woman could not be employed in an overwhelming majority (87%) of school districts within the United States. Furthermore, a substantial number of school districts (70%) would cut ties with a single woman once she married (Wright, 1991). This is very different from today, where a majority of married women work outside the home. In fact, the practice of excluding married women from working in certain positions would be considered a form of discrimination in today's society.

Language also allows “for both biographical and historical experience to be objectified, retained and accumulated” through the development of semantic fields, or “zones of meaning” (Berger & Luckmann, 1966, p. 41). A prime example of this can be seen in how an individual experiences their particular occupation. An occupation requires a specific semantic field. For instance, a bank teller will build up a vocabulary based on the requirements of their occupation, such as “deposit”, “cash drawer”, “Banking Center Control Review”, and so on and so forth. It would not be necessary to understand these terms in a different occupation such as teaching, which would then have its own semantic field. As a result, semantic fields “meaningfully order all the routine events a person encounters in their daily work” (Berger & Luckmann, 1966, p. 41). Berger and Luckmann argue that, “The accumulation of biographical and historical experience is selective, with the semantic fields determining what will be retained and what ‘forgotten’ of the total experience of both the individual and the society “(1966, p. 41). The accumulation of biographical and historical experience results in a “social stock of knowledge” which is shared by others and therefore, “interaction with others in everyday life is constantly affected by our common participation in the available social stock of knowledge” (Berger & Luckmann, 1966, p. 41). Participating in the social stock of knowledge illuminates the limits of a person's particular situation. For

instance, a homeless individual would not be able (or even allowed) to shop at a high-end department store, while a wealthy individual would likely not be found sleeping on the streets. Consequently, “participation in the social stock of knowledge permits the ‘location’ of individuals in society and the ‘handling’ of them in the appropriate manner” (Berger & Luckmann, 1966, p. 42).

The Social Construction of Illness

A social constructionist approach to illness emphasizes a difference between “disease” and “illness”; disease refers to the biological aspects of a condition, whereas illness can be understood by looking at the social meaning of a condition (Conrad & Barker, 2010). Understanding the social meaning of illness is imperative as cultural meanings can “have an impact on the way the illness is experienced, how the illness is depicted, the social response to the illness, and what policies are created concerning the illness” (Conrad & Barker, 2010, p. S69). Sociologists interested in understanding how illness is socially constructed have investigated issues such as the process through which behaviors and experiences are defined as illness, how individuals cope with and make sense of illness, and “the real and tangible social consequences of an illness label” (Conrad & Barker, 2010, p. S68). The social meaning of an illness can be seen in the way it is classified, such as a disability, or in the degree to which an illness is stigmatized. Conrad and Barker emphasize that the social meaning of a health condition can impact patients independently of the biological symptoms associated with an illness (2010). In fact, prior research found that individuals suffering from epilepsy have more difficulty dealing with the stigma associated with the illness than the actual seizures (Conrad & Barker, 2010).

The social meaning of an illness is not based on the inherent properties of an illness, but instead is the result of how we understand and pass on *understanding* of an illness. For this reason, sociologists are particularly interested in the social meanings of illness “because they bring into sharp relief the cultural landscape that ordinarily eludes us” (Conrad & Barker, 2010, p. S69). Part of understanding the cultural landscape that leads to the social meaning of illness is recognizing that illnesses such as HIV/AIDS do not impact all people in the same way. As Berger and Luckmann explain, life expectancy and types of illness vary by social location. They note that upper-class individuals live longer and are ill less frequently than their lower-class counterparts. In sum, they argue that “society determines how long and in what manner the individual shall live...Society can maim and kill. Indeed, it is in its power over life and death that it manifests its ultimate control over the individual” (Berger & Luckmann, 1966, p. 181). HIV/AIDS is no different and in fact, is rife with disparities across different populations that cannot be fully explained through medical avenues. In response to this, there is growing recognition for the social determinants of health.

Social Determinants of Health

Prior to examining the framing of an illness, it is critical to understand that health is not created equal. We see this in rates of diabetes, which have been significantly higher among African Americans than Caucasians for more than 30 years, with the gap between the two populations remaining relatively stable (CDC, 2014b). Tuberculosis also disproportionately impacts African Americans and the homeless population, while Hepatitis C is significantly more prevalent among prisoners than in the general population (CDC, 2014c). The CDC notes that “such disparities are unfair, pose a significant cost to society and are avoidable” (2010, p. 3). In order to reduce disparities in health, it is vital to understand

and address social determinants of health. The World Health Organization (WHO) defines social determinants of health as “circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics” (WHO, 2014b). HIV/AIDS is no exception to the influence of social factors. Prior research explains that environmental factors such as housing and social networks can impact the spread of HIV. One study found that homeless individuals living with HIV/AIDS were more likely to have been hospitalized, less likely to follow medication regimens and had a poorer overall health status than those living with HIV/AIDS who had housing (CDC, 2010). Furthermore, African Americans and gay and bisexual men are disproportionately impacted by HIV/AIDS in the United States. This is evidenced by the rate of HIV infection within the African American population, which was eight times the rate of HIV infection within the Caucasian population in 2010. Furthermore, gay and bisexual men represent the largest number of new infections within the African American population (CDC, 2014d). Laumann and Youm (2001) attribute the high rates of HIV infection within the African American community to the “intra-racial network effect”, a direct result of high levels of segregation. In essence, the level of segregation experienced by African Americans increases the likelihood that uninfected individuals will come into contact with those living with the virus (Cockerham, 2013, p. 17). Cockerham explains that although the public widely accepts that social factors influence health, research literature often does not encompass this view. In fact, “Usually social variables are characterized as distant or secondary influences on health and illness, not as direct causes” (Cockerham, 2013, p. 1). This finding reflects a growing need to understand how social determinants of health are reflected in the framing of health issues.

Media Frames

Mass media plays an important role in disseminating health information, highlighting the potential that media sources have to impact changes in perceptions and behavior regarding health risks (Morton & Duck, 2001). Media frames are often studied to uncover how health issues are described in media sources. Media frames “serve to close the sense making gap between what one group views as real and what another group experiences. Furthermore, media frames emerge within specific cultural contexts and in order to make stories intelligible, journalists draw on preexisting cultural frames to construct their narratives” (de Souza, 2007, pp. 257-258). Scholars have studied a number of media sources including newspapers, the internet, advertisements, and pharmaceutical literature to understand how health is constructed in the mass media. Previous studies have investigated the incomplete coverage or omission of particular health issues, the misrepresentation of certain health issues, the competition of multiple frames, and the use of negative and positive role models to either diminish or promote health behaviors (Kline, 2003).

Cancer is a commonly explored health issue within framing studies (Clarke & Everest, 2006, Clarke, 1999). Scholars have noted that fear and cancer seem to go hand in hand, and this fear is exacerbated by the idea that cancer is everywhere and can strike anyone at any time (Clarke & Everest, 2006; Clarke, 1999). Statistics concerning cancer rates, personal narratives and the association of cancer to everyday activities such as sun bathing are all ways in which magazines present cancer as something to be feared (Clarke & Everest, 2006). Scholars examining the portrayal of cancer in major U.S. and Canadian magazines also explain the overemphasis of expertise related to medical doctors, called in to support and enhance study findings. They argue that the cited expertise of doctors may not necessarily

match up to their actual medical expertise. This is accompanied by a lack of expertise from other areas involved in the understanding and prevention of cancer such as public health officials and government entities (Clarke & Everest, 2006). Clarke & Everest contend that “The unquestioning pre-eminent position of medicine may have significant deleterious consequences for the health of populations” (2006, p. 2598). They argue that understanding cancer strictly within medical terms narrows preventive efforts and detaches cancer from potential structural sources such as the environment, culture, gender, etc. (Clarke & Everest, 2006, p. 2598).

Media frames can and often do compete with one another to emphasize certain aspects of an issue. Frames compete in a variety of manners; they can present issues from entirely different vantage points, they can present issues from a similar vantage point, but for opposing outcomes, or frames can also complement one another by reinforcing the other’s message (Wise & Brewer, 2010). Scholars have identified competing frames used to present information on a number of health issues, including cancer, tobacco regulation and obesity (Wise & Brewer, 2010; Clarke & Everest, 2006; Clarke, 1999). Wise and Brewer (2010) investigated the debate surrounding the trans fat ban in New York City in 2006, as a result of the link between trans fat and heart disease. They found four primary frames used when talking about the ban: “the pro-ban public health frame, the anti-ban public health frame, the pro-ban business frame, and the anti-ban business frame”(Wise & Brewer, 2010, pp. 440-441); while the frames promoted similar goals (public health and protecting business), the methods with which to achieve these goals differed.

Contradictory and competing frames have also been found within the presentation of cancer in media sources. One study analyzing magazine articles related to breast cancer,

found the existence of conflicting information regarding the effectiveness of having women self-examine their breasts for signs of breast cancer. While the article claimed that this practice does not save lives, it also stated that women often find breast cancer on their own, a direct contradiction to their prior claim (Clarke & Everest, 2006). Another study which evaluated the presentation of breast cancer in U.S. and Canadian magazines found competing portrayals of women with cancer or at risk for cancer and medical doctors. While doctors are considered highly capable, rational individuals, women with breast cancer are presented as emotionally unstable, fearful individuals whose primary concerns are about the impact of the cancer on their physical appearance (Clarke, 1999).

The importance of understanding how health issues are framed is underscored by research that shows that frames impact public opinion (Wise & Brewer, 2010; Chong & Druckman, 2007). Wise and Brewer (2010) examined the impact that frames promoting opposing sides of the New York trans fat ban had on public opinion. They found that individuals were guided in their thinking by the particular frame they were exposed to, either for or against the ban. Individuals receiving information in favor of the ban were more likely to be for the banning of trans fat, while individuals exposed to frames that presented the ban negatively, were more likely to be against banning trans fat. Public opinion is important because it directly impacts policy change. Policy change in turn hinges upon how public health risk is framed (Lawrence, 2004). Nathanson (1999) outlines three ways in which the framing of public health risks can impact policy change. This involves whether or not individuals acquire health conditions through their own measures or involuntarily, whether a health risk impacts everyone or specific individuals or groups, and whether a health condition is a result of individual actions or environmental causes. Policy change is more likely to

come about when health risks are framed as involuntary, having the possibility of reaching everyone and resulting from environmental factors (Nathanson, 1999). Understanding that health issues are common in media sources and that they are framed in a variety of ways provides a backdrop to the next section and the focus of this study, the transmission of HIV/AIDS. The following section provides a summary of how HIV transmission risk has been framed in the United States from the onset of the epidemic in the early 1980s.

The Framing of HIV/AIDS Transmission Risk in the United States: A History Risk Groups

In the early days of HIV/AIDS in the United States, transmission was primarily understood as the result of belonging to “risk” groups, or groups more prone to the disease. Information about HIV transmission was initially disseminated through the CDC’s “Morbidity and Mortality Weekly Report”, a product of collaboration among scientists, doctors and sociologists at the CDC (Harris, 2013, p. 307). The disease was first discovered among gay males, causing them to be inextricably linked to the transmission of HIV. In fact, before the disease was known as AIDS, it was called “GRID”, or gay-related immune deficiency (Parmet & Jackson, 1997, p. 9). Gay men, as the primary stigmatized group, were soon accompanied by Haitians, heroin users and hemophiliacs, constituting the first set of risk groups associated with HIV/AIDS (Stevens & Hull, 2013). Clarke (2006) argues that the mass media’s portrayal of health issues is often a reproduction of dominant cultural ideologies. With regard to HIV/AIDS, terminology such as “GRID” and media headlines such as “New Homosexual Disorder Worries Health Officials” established a discursive link between HIV/AIDS and homosexuality. Furthermore, media emphasis on the severity of the epidemic, visible in headlines such as “Now No One is Safe from AIDS” which appeared on

a cover of Life Magazine in 1985, and “Poll Indicates Majority Favor Quarantine for AIDS Victims”, published in the New York Times in 1985, served to isolate people living with AIDS from the “innocent” general public (Clarke, 2006, p. 318; The New York Times, 1985; 2001). Today, although the CDC is careful to note that HIV risk behaviors are the same for everyone, they still pay special attention to certain populations based on the prevalence of HIV infection in their communities. The CDC includes information on risk based on racial/ethnic groups, gender, age and other groups such as those found in correctional and occupational settings (CDC, 2014e). For instance, the CDC lists African Americans, American Indians/ Alaska Natives, Asians and Hispanics/Latinos as high-risk populations (CDC, 2014e).

The cultural meaning of HIV/AIDS has been largely shaped by its designation as a sexually transmitted disease. This is important because although HIV/AIDS shares many of the same transmission routes with hepatitis B, for example, its classification as a venereal disease as opposed to a viral disease ensures that HIV/AIDS and those living with the disease become a target of moral judgment (Cao, Sullivan, Xu, Wu, and the China CIPRA Project 2 Team, 2006). As a consequence of this moral judgment, groups have been distinguished based upon how they are presumed to have contracted HIV. Skocpol (1992) argues that, “institutional and cultural oppositions between the morally ‘deserving’ and the less deserving run like fault lines through the entire history of American social provision” (p. 149). In the case of HIV/AIDS, groups have long been defined by how they contracted the disease, which in turn created a divide between the “victims” of HIV/AIDS who are described as deserving of health care, and the “perpetrators” of HIV/AIDS who are constructed as less deserving of health care. Historically, women and children have been depicted as victims of HIV/AIDS,

while gay men and injection drug users, presumed to have contracted the disease through risky behaviors, have been portrayed as less deserving of health care (Patterson & Keefe, 2008). The association of homosexuality with guilt can be seen in policies such as the Helms Amendment which was enacted in 1987. This amendment banned the use of federal funds for sex education materials that promoted homosexual activities. Although this specific portion of the amendment was later rescinded, policies such as this contributed to the stigmatization of homosexual individuals and their portrayal as perpetrators of HIV (AIDS.gov, 2011). The distinction between guilty and innocent victims of HIV/AIDS is also demonstrated in the disproportionate allocation of resources put forth by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990. The Act specified that 15% of funds be set aside for women and children, and 10% was directed at populations such as hemophiliacs and Native Americans. At the time, 90% of people living with HIV/AIDS were adult males, and cases were few among hemophiliacs and Native Americans (Donavan, 1993, pp. 14-17). While Donovan clarifies that the proposed percentages of funds did not necessarily translate into their actual implementation, his work provides an important example of how constructing groups of people as guilty or innocent can have direct implications for health policy (1993).

Certain groups have also been excluded from discussions addressing HIV transmission. Clarke (2006) discusses a distinction between the descriptions of individuals who contracted HIV through measures outside of their control and conversely individuals who are presumed to be responsible for their HIV diagnosis in her analysis of 20 of the largest magazines in the U.S. and Canada. She contrasts the elaborate, empathetic descriptions devoted to individuals who contracted the disease outside of their control (blood

transfusions and one instance of transmission through a dental procedure) with the barely present descriptions of gay men and injection drug users. Likewise, the studying of health education booklets targeting immigrants in Sweden revealed that homosexuality was discussed as a separate issue “while all other topics discussed took heterosexuality for granted” (Bredstrom, 2005, p. 527). Bredstrom also notes that transgender and transsexual individuals are completely excluded from the booklets. Furthermore, she mentions that the heteronormative trend found in the sex education booklets targeting immigrants, spills over into public education in Sweden where sex education primarily focuses on male-female relationships to the “exclusion of all other sexual and gendered identities and practices” (2005, p. 527).

African Americans and older adults have historically been excluded from media coverage of HIV transmission risk (Cohen, 1999; Stevens & Hull, 2010). Prior studies have examined the level of newspaper coverage devoted to HIV/AIDS within the African American community. This research, which spans from 1981 to 2007 revealed a gross underrepresentation of HIV/AIDS stories related to African Americans. In particular, Cohen (1999) found that just five percent of stories related to HIV/AIDS specifically addressed African Americans, while Stevens and Hull (2010) found that a mere 10 percent of stories addressing HIV risk focused specifically on the African American community. It is no secret that the African American community is disproportionately impacted by HIV/AIDS, making these findings even more alarming. In fact, scholars have attributed this lack of coverage to the increased rates of infection in the African American community (Donovan, 1993; Cohen, 1999; Stevens & Hull, 2010). Stevens and Hull (2010) found that existing newspaper coverage was primarily focused on individual level determinants of HIV, rather than societal

level determinants. This emphasis can impact how policies address HIV prevention. They argue that a focus on individual behavior change may reduce transmission rates, but in order to eliminate group disparities, it is pivotal to discuss and implement preventive efforts based on the structural factors that impact HIV transmission (Stevens & Hull, 2010).

As of 2010, persons 50 years and older constituted 19% of the population living with HIV in the United States, but these numbers are not reflected in news coverage addressing older adults and HIV/AIDS (CDC, 2014f). LaVail (2010) notes that older adults “are stereotyped as non-drug-using, straight, asexual individuals” and these stereotypes contribute to an absence of older adults in HIV risk coverage (p. 171). She prefaces her findings with the fact that very few newspapers provided information about older adults and HIV; LaVail specifically notes that on average, the 14 newspapers she examined published fewer than 10 articles related to older adults and HIV per year from 1989 to 2005 (2010). The limited coverage may lead to an underestimation of risk by older adults, increasing rates of infection in this population (LaVail, 2010). There is increased concern for older adults who may be more vulnerable to the disease as a consequence of weakened immune systems and may have less success with antiretroviral therapies than their younger counterparts due to the possibility of dangerous drug interactions (LaVail, 2010). In this way, older adults have specific needs when it comes to discussing HIV transmission risk, emphasizing concern regarding the absence of older adults from HIV/AIDS media coverage.

Risk Behaviors

By 1993, AIDS was the leading cause of death among men 24-44 years old, and in 1994, the same held true for women 24-44 years old. This discovery which emphasized the risk associated with heterosexual sex, coupled with an emphasis on modes of transmission

considered “non-risky” such as mother-to-child transmission and transmission through blood transfusions, painted a much broader picture of HIV/AIDS transmission, one that included everyone (Stevens & Hull, 2013). The idea of containing risk to certain groups did not hold up against this wider view that anyone could become infected with HIV. Thus, a discourse surrounding HIV risk behaviors was born. As Shoveller and Johnson explain, “the concept of risky behavior was particularly powerful because it could permeate across ‘group’ boundaries by focusing on what people did, rather than on group membership” (2006, p. 51). The focus on risk behaviors was intended to expand the world’s view of HIV transmission and move away from blaming groups for spreading the disease; however, the responsibility of HIV transmission still falls upon specific groups of people assumed to be engaging in said risky behaviors. This is evident in research that shows that people are less likely to see health disparities among groups as unfair if the differences are thought to be due to “individual factors” such as behaviors (Niederdeppe, Bigman, Gonzales, & Gollust, 2013, p. 12). As a result, it is not surprising that individual factors such as lifestyle choices have been the focal point of recent news coverage addressing health disparities (Niederdeppe et al., 2013). When compared to a disease such as leukemia, people are much more likely to view HIV/AIDS as the result of personal choices; as a consequence, people perceive the disease to be more dangerous and HIV-positive individuals as deserving of their fate (Logie & Gadalla, 2009).

Homosexual sex topped the list of risky behaviors in early discussions of HIV transmission risk, but the discursive link between HIV/AIDS and homosexuality has changed over time. While HIV/AIDS and homosexuality were nearly one in the same in the early years of the epidemic, more recent studies show that discussions addressing homosexuality and HIV have been replaced by a more heteronormative view of HIV transmission. Gross,

Goldsmith and Carruth (2008) explain that HIV transmission through homosexual sex is mentioned less frequently than heterosexual transmission in their analysis of young adult novels, published from 1995-2005, and homosexual transmission must generally be inferred due to a lack of “overt” statements (p. 406). This is a different finding from their first investigation into young adult novels, published from 1981 to 1994, which did not include heterosexual sex as a common avenue of transmission, but maintained a strong focus on homosexual transmission (Gross et al., 2008). Clarke (2006) discusses the guilt associated with homosexuality by comparing it to a valorization of heterosexual transmission. She specifically refers to Magic Johnson’s diagnosis and how media coverage was very open about his heterosexual transmission as well as his engagement in promiscuous sex. The focus upon Johnson’s heterosexual transmission is illuminated by a lack of coverage concerning homosexual transmission routes, noted in previous research (Clarke, 2006; Gross et al., 2008). Ironically, Magic Johnson was a case in point that anyone could get HIV/AIDS, not just through homosexual sexual activity and injection drug use, but at the same time, his diagnosis highlights a comfort in discussing heterosexual transmission and a sense of normativity regarding heterosexual sex that has not been associated with homosexuality.

Scholars investigating the framing of HIV/AIDS transmission in media sources have identified risk behaviors as drivers of HIV transmission. LaVail (2010) investigated the framing of HIV transmission risk related to older adults in highly-circulated urban newspapers. She found that bodily fluids, followed closely by unsafe sex and IV drugs most often framed HIV transmission risk related to older adults. Likewise, Gross et al. (2008) found that heterosexual sex and homosexual sex most often explained HIV transmission, when a cause could be deciphered, in their analysis of young adult novels. A focus on risk

behaviors can also be seen in the way the authors of this study speak about risks associated with HIV/AIDS. They note that “reasonable fears are related to situations and behaviors that can result in the transmission of HIV...The fears considered reasonable in this study are fears related to IV drug use, unprotected sex (both homosexual and heterosexual), multiple sex partners, concerns about future sexual encounters and positive test results” (Gross et al., 2008, p. 408). This continuing discursive link between HIV transmission and risk behaviors is perpetuated in the United States by a commonly held belief that behaviors are more influential to health outcomes “than affordable health care access, income, education, location and race/ethnicity” (Niederdeppe, et al., 2013, p. 12).

HIV/AIDS as a Chronic Condition

The introduction of protease inhibitors in 1996 drastically changed the face of HIV/AIDS in the United States, giving those living with HIV the hope for a future. These antiviral drugs reduced the levels of virus in the blood of HIV-infected individuals, almost immediately improving their health (AIDS.gov, 2011). With the use of these treatments, people now had the opportunity to live long term with HIV/AIDS. This transition of HIV/AIDS from a fatal to chronic illness was accompanied by a change in the way HIV/AIDS risk was reported in the media. Two significant occurrences during this time, the first drop in new AIDS cases since the beginning of the epidemic and a sharp decline in AIDS-related deaths, occupied media coverage (Stevens & Hull, 2010). The newly chronic disposition of HIV/AIDS also impacted the frequency with which information regarding the disease was reported in the media. Stevens and Hull (2010) cite a more than 50 percent reduction in reporting on HIV/AIDS between 1992 and 1997. The focus on HIV/AIDS risk in the United States shifted to a focus on international risk, particularly in Africa. Stevens

and Hull propose that this decline in news coverage addressing HIV/AIDS within the United States in favor of international coverage may have minimized the risk associated with HIV/AIDS in the United States (2010). This is supported by public opinion data that suggests that the number of Americans proclaiming “HIV/AIDS as the most urgent health problem domestically, fell from 68 percent in 1987, to 17 percent in 2006, and seven percent in 2011” (Stevens & Hull, 2010, p. 364). They also state that this change in public opinion regarding the seriousness of HIV/AIDS within the United States may have negatively impacted support for policies and funding aimed at HIV/AIDS prevention and treatment (Stevens & Hull, 2010). This is particularly problematic when you consider that the rate of new HIV infections has remained relatively stable throughout the years and groups such as African Americans and men having sex with men (MSM) continue to be disproportionately impacted by the disease (CDC, 2012; Stevens & Hull, 2010).

Casual Contact

HIV/AIDS remains one of the most stigmatized diseases in our society. A profound misunderstanding of how the disease is transmitted only exacerbates this stigma. Cao et al. (2010) explain that, “Much of the stigma and discrimination associated with HIV arises from fear, shame, and blame. In many cases fears are based on irrational beliefs about HIV transmission, in particular casual transmission” (p. 519). In 1988, two popular magazines, *Cosmopolitan* and *Newsweek*, declared the near impossibility of contracting HIV/AIDS through “ordinary” sexual avenues, but that HIV/AIDS might be contracted through casual sources such as a toilet seat or perspiration, respectively (Cline, 2003). The inconsistency in reporting surrounding HIV/AIDS engendered an unnecessary fear of the disease; the remnants of this fear continue to resonate in the minds of Americans, even though we know

significantly more about how HIV is spread today. Even more notably, incorrect knowledge associated with casual contact has a stronger impact on prejudicial attitudes toward people with AIDS (PWAs) than incorrect knowledge associated with transmission routes; in fact, studies show that Americans are pretty clear on how the disease is spread, but much less knowledgeable of how HIV is not transmitted (Lew-Ting & Hsu, 2002; Inungu et al., 2009; Dias, Matos, & Goncalves, 2006).

Competing Frames: HIV/AIDS

Prior research has investigated the presence of competing frames within HIV/AIDS discourse (Esacove, 2013; de Souza, 2007). Esacove (2013) analyzed 119 US global AIDS policy documents spanning the Clinton and George W. Bush presidential eras and found varying definitions of “good sex” and “bad sex” (p. 35). While policy documents formed under Clinton’s administration portray good sex as sex that prevents the transmission of HIV primarily through condom use, policy documents during the Bush era have a much more prominent focus on abstinence, while the effectiveness of condoms is downplayed. As Esacove explains, any sex other than that between married couples is portrayed as bad sex (2013). Another instance of this type of competition is seen in de Souza’s analysis of the framing of HIV/AIDS in Indian newspapers (2007). She found that the cause of the illness was addressed differently depending upon who was presenting the information. For instance, from an international standpoint, Indian culture and institutions were to blame, while those within the Indian government also looked at societal norms and structural factors, but additionally blamed Westernization for the increase in HIV infections. Furthermore, she found that non-governmental organizations (NGOs) tended to focus on all of the aforementioned causes. This was also true for discussions surrounding the severity of

HIV/AIDS in India. Government sources tended to minimize the severity of the problem, stating that the numbers were not high enough to alarm the public, while other actors such as non-governmental organizations (NGOs) reported that the government was minimizing the severity of the illness (de Souza, 2007).

It is important to identify the presence of competing frames within the presentation of health issues as they may have a different impact on public opinion than individual frames and may also elicit a greater amount of attention from readers as they evaluate where they stand among the frames (Wise & Brewer, 2010; Chong & Druckman, 2007). Wise and Brewer note that being exposed to competing frames may neutralize the impact that any one frame has on public opinion (2010). In their analysis of news coverage focusing on the New York City trans fat ban, they found that participants exposed to news coverage which elicited only one frame (for or against the ban), tended to favor the position of the frame. On the other hand, participants exposed to news coverage both for and against the ban were neither overwhelmingly for or against the ban, implying that exposure to the competing frames had actually mitigated the impact of both frames (Wise & Brewer, 2010). Another study found that, “competition between frames motivates conscious processing of information and integration of opposing viewpoints” (Chong & Druckman, 2007, p. 651). While the current study did not evaluate framing effects, understanding that there is a consequence for the way in which health issues are framed emphasizes a need to understand how they are framed in media sources.

Implications for the Framing of HIV Transmission Risk

The framing of HIV transmission risk has direct implications for those living with the disease as well as individuals considered at risk for HIV/AIDS. The association of shame and

guilt with an HIV-positive status can be dire for both preventive efforts and individuals living with HIV/AIDS. For instance, people may avoid getting tested for HIV out of fear or shame, which puts not only themselves but potential sexual partners at risk (Cao et al., 2006). The CDC estimates that approximately 14 percent of the 1.2 million people living with HIV do not know they are infected (CDC, 2014a). Additionally, people diagnosed with HIV may fear disclosing their status, which also puts potential sexual partners and those coming in contact with an infected person through needle sharing in jeopardy (Cao et al., 2006). Furthermore, friends and family may distance themselves from people living with HIV/AIDS, leaving them without a much needed support network. People have even experienced outward incidents of violence, and depression and anxiety are common outcomes of experienced stigma (Vanable et al., 2006). Research also shows that medication adherence can be impacted by the stigma that those living with HIV/AIDS experience, with higher incidents of stigmatization associated with more difficulty adhering to medication regimens (Vanable et al., 2006).

Understanding how health risks such as the transmission of HIV are framed in media sources helps inform how these social issues (and related groups) are interpreted and how people may react to them. Considering that public opinion influences the provision of policies related to HIV/AIDS, it is vital to investigate sources from which the public acquires knowledge of HIV transmission. This study attempts such a task by examining how HIV transmission risk is framed in health brochures, a common root of HIV-related knowledge.

Health Brochures

Brochures are a common tool used in health education interventions, and have proved to be important in facilitating HIV treatment and prevention. A recent study exploring

methods that successfully contributed to the retention of HIV-positive patients in primary care settings, found that along with posters and brief dialogue between patients and providers, brochures significantly improved the likelihood that patients returned for scheduled appointments (Higa, Marks, Liau, & Lyles, 2012). The CDC notes the cost-effective and convenient nature that brochures bring to HIV/AIDS prevention:

“Informational posters and patient education brochures develop patients' knowledge about HIV/AIDS, facilitate open dialogue and information exchange, and strengthen patients' ability to make healthy choices” (2014j). This point was supported in research done by Albarracin, Leeper, Earl and Durantini (2008). They discovered that persons exposed to an HIV-prevention brochure were more likely to watch a video on HIV/AIDS prevention and watching the video was more likely to lead to HIV/AIDS counseling and possible testing. An initial inexpensive outreach tool such as a brochure ensured that more in-depth prevention opportunities would be taken advantage of. Accordingly, if brochures are on the frontlines of HIV/AIDS prevention, it is important to understand the message behind these brochures. The purpose of this study is to understand how HIV/AIDS transmission risk is framed in health brochures. For this study, transmission risk encompasses both the spreading and contraction of HIV. The study draws its data from county health departments in the Kansas City Metropolitan Area, spanning across the states of Missouri and Kansas.

CHAPTER 3

METHODS

Data

My sample consists of 31 HIV/AIDS-related health brochures collected from health departments in the Kansas City Metropolitan area. As of 2013, this area consisted of 14 counties, spanning two states: Missouri and Kansas (Mid-America Regional Council, 2014). The Kansas City Metropolitan Area is a good representation of HIV/AIDS in the United States; while most counties fall below the national average for people living with HIV, Jackson County, Missouri and Wyandotte County, Kansas report a higher than average number of people living with HIV. Additionally, every county in the sample area is home to someone living with HIV (CDC: NCHHSTP ATLAS, 2014g). This high prevalence necessitates HIV/AIDS-related brochures in the community, which presents ample opportunity to understand how the transmission of this illness is framed in brochures. Health departments were chosen as a site to collect brochures once it was established that health clinics in the Kansas City area would not be able to provide a sizeable amount of brochures related to HIV. A Google search provided information on the counties included in the Kansas City Metropolitan Area. To obtain the brochures, each county health department was contacted by phone. I introduced myself as a student at the University of Missouri-Kansas City undertaking a research project and in need of brochures that dealt with HIV/AIDS. I received 60 brochures and pamphlets from eight of the 14 counties. The remaining counties did not have brochures on hand, or at least that they were willing to give out. Many of them directed me to the CDC website (CDC.gov) for HIV/AIDS-related materials. Several counties indicated that they direct people needing information on HIV/AIDS to larger

surrounding counties. The counties that provided brochures vary widely based on demographic factors, particularly population and race. Population estimates as of 2010 ranged from 674, 158 people in Jackson County, Missouri to 33, 381 people in Lafayette County, Missouri. Jackson County, Missouri (66.9% White, 23.9% Black or African American, 8.4% Hispanic or Latino) and Wyandotte County, Kansas (54.6% White, 25.5% Black or African American, 26.4% Hispanic or Latino) have the greatest racial diversity of all the counties. The remaining counties have a primarily white population, with fewer than 10% of any other race or ethnicity (US Census Bureau, 2014).

For this project, I chose to analyze single-sheet brochures folded into panels. I excluded pamphlets, a common type of brochure, because as unbound booklets they differ stylistically from the single-sheet brochures. Because I am analyzing the text and images in these brochures, I felt it necessary to maintain stylistic consistency across the brochures. To be eligible for analysis, the brochures had to provide specific information regarding HIV/AIDS beyond its characterization as a “common STD”. After applying these criteria to the brochures, six were eliminated. Additionally, 11 pamphlets and 12 duplicates were eliminated, leaving me with a final sample of 31 brochures. I received brochures by mail from four counties and physically visited the remaining four county health departments who informed me that they had brochures on hand. Of the four health departments I visited, only one (Wyandotte) had brochures available in a public area. The remaining health departments required that I ask for the brochures. Jackson County had an array of brochures spanning many topics available on the wall in their waiting area; this did not include brochures on HIV/AIDS. In this particular facility, they are kept in examination rooms or filing cabinets in an office area.

Analysis

To analyze the framing of HIV transmission risk in health brochures, I conducted a comprehensive analysis of the text and images in 31 HIV/AIDS-related brochures. Few studies have specifically looked at the framing of HIV/AIDS in health brochures; therefore a grounded theory approach was used to uncover initial concepts, categories, and themes. Grounded theory is an inductive approach that builds theory from the ground up, so to speak. It is conducive to research that seeks to understand broad research questions (Strauss, 1990). The research question for this project is: How is HIV transmission risk framed in health brochures? Prior to coding, I numbered and labeled each brochure by county. I then completed a general reading of all 31 brochures to gain a broader understanding of their content. This allowed me to group the brochures based on their main focus, which resulted in four groups: testing (four brochures), general (10 brochures), specific populations such as women, teenagers, older adults, young and gay men, and HIV positive individuals (13 brochures) and behaviors including injection drug use, condom use, oral sex and tattoos (four brochures). This was done in order to uncover whether HIV/AIDS is framed differently based on the targeted population or specific focus. The brochures were published between 1998 and 2012 and 27 of 31 brochures (87% of the total sample) were published in the last ten years. Nearly half of the sample (14 brochures) was published or reviewed within the last five years. The brochures were published by three different publishing companies: Channing Bete (10 brochures) based out of South Deerfield, Massachusetts, ETR Associates (nine brochures) based out of Scotts Valley, California and Journeyworks Publishing (12 brochures) based out of Santa Cruz, California.

I began the analysis using the method of open coding. I conducted a line-by-line reading in order to uncover concepts present in each brochure. Many of the brochures referred to HIV within a larger context of common STDs. Within these brochures, I only coded areas that specifically related to HIV/AIDS. I began coding at a basic level. Concepts common to many of the brochures include condom use, needle sharing risk and abstinence, to name a few. This initial process brought about more than 100 conceptual codes. Codes that appeared fewer than five times were eliminated from analysis, so that the data remained representative of the sample. This left a total of 53 codes. Once these codes were established, I then grouped them into larger conceptual categories based on their relationship to one another. This was done by asking questions and making statements about the data using the “constant comparison method” where I identified and compared themes across brochures (Strauss, 1990; de Souza, 2007, p. 259). I recorded extensive code notes which aided in identifying patterns in the data. This resulted in three main categories: Transmission, HIV Preventive Measures and Risk Groups. I combined the risk groups and transmission categories into one larger category: HIV transmission risk. Due to time and resources, I chose to exclusively focus on the framing of this category. I was also attentive to differences by geography and publication date of the brochures, but found no systematic differences in the analysis.

Frame Analysis

One method used to understand how an illness is presented to a public audience is frame analysis. Frame analysis, under the umbrella of discourse analysis, focuses on how “language builds – rather than mirrors – social reality” (Fletcher, 2009, p. 802). There has been great debate surrounding the methodology of frame analysis as well as defining what

exactly a frame is, but as Entman suggests, “the concept of framing consistently offers a way to describe the power of a communicating text” (1993, p. 51). The origin of frame analysis is most commonly credited to Erving Goffman and Gregory Bateson. Since that time, defining and identifying frames has been anything but simple. As such, Scheff (2005) notes, “...that Goffman’s ideas have not fared well. Most of the responses have been of three kinds: paraphrase, harsh criticism, and adopting terms from frame analysis but ignoring or misconstruing Goffman’s approach” (p. 369). Goffman’s first attempt at defining a frame, provides only a vague understanding of what he means by the term “frame”: “I assume that definitions of a situation are built up in accordance with principals of organization that govern events...and our subjective involvement in them; frame is the word I use to refer to such of these basic elements as I am able to identify” (Goffman, 1974, pp. 10-11).

Scholars who have drawn from Goffman’s (1974) methodology have explained frames in varying degrees of complexity as “principles of selection, emphasis and presentation composed of little tacit theories about what exists, what happens, and what matters” and “interpretive contexts that help us interpret messages” (Scheff, 2005, p. 369; de Souza, 2007, p. 257). Frames guide us in making sense of issues, health-related and other, by emphasizing certain pieces of information and addressing specific causes and solutions which are instrumental in determining how we understand a given problem. Entman (1993) argues that, “to frame is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described” (Entman, 1993, p. 52). Entman importantly notes that framing occurs by selecting pieces of information to formulate a problem and its solutions, meaning that there is intention

behind frames. Additionally, Entman proposes that frames exist beyond the source presenting the information; he states that they also exist within the mind of the individual receiving the information as well as within the culture, defined as “the empirically demonstrable set of common frames exhibited in the discourse and thinking of most people in a social grouping” (1993, p. 53). Furthermore, Entman (1993) argues that the “saliency of information can be guided by the placement or repetition of text as well as relating pieces of information to readily identifiable cultural symbols” (p. 53). For example, a brochure focused on preventing the transmission of sexually transmitted infections may incorporate the phrase “safer sex” continually throughout the text; this same brochure might also place the phrase “safer sex” next to a picture of a condom, which our culture identifies as a method of protection against sexually transmitted infections. Frames are not only defined by the information they provide, but just as importantly by the information they leave out, “...the omissions of potential problem definitions, explanations, evaluations, and recommendations may be as critical as the inclusions in guiding the audience” (Entman, 1993, p. 54).

Current Frame Analysis

The current frame analysis identified frames associated with HIV transmission risk in the brochures. In order to identify frames, I performed an extensive reading of each brochure with the following question in mind: “How is HIV transmission risk talked about?” (de Souza, 2007, p. 259). This initial process revealed that the transmission of HIV is explained through both risk behaviors and risk groups. I then continued the process by uncovering how risk behaviors and risk groups are presented in the brochures (i.e. what behaviors are considered risky and who is identified as being at-risk?). As Entman argues, information absent from a frame may be just as telling as information presented within a frame (1993).

For this reason, I analyzed behavior or group-specific information missing from each frame. This process revealed incomplete coverage of risk-free activities and risk groups associated with the transmission of HIV. Beyond understanding how the issues are talked about, it is important to identify resources such as metaphors or images used to frame issues (de Souza, 2007). These are referred to as “frame packages”. Frame packages are “keywords, stock phrases, stereotyped images, sources of information, and sentences that provide reinforcing clusters of facts or judgments” (Entman, 1993, p. 52). In addition to text, images are prevalent in the brochures. The images are primarily of individuals; other images include condoms, cell phones and medical equipment. I conducted a brief overview of these images but because they are not representative of the sample, they have been excluded from analysis. Images eligible for analysis were those of people that presented at least half of a person’s face (Gollust, Eboh & Barry, 2012). Several images portrayed only specific body parts such as lips or hands and because I was interested in discerning racial, age, and gendered-characteristics, I excluded these from analysis. I coded each individual pictured, for race (white, non-white, unable to tell), gender (male, female, unable to tell), age and sexual orientation (where applicable). Images of individuals identified as non-white were further analyzed to determine a specific race (African American, Caucasian, Asian, Hispanic and unable to tell), although I was unable to determine a specific race in nearly half of the images. I used the U.S. Census Bureau’s definitions of race as a guideline for this project (CDC, 2014h). Furthermore, age is rarely explicitly stated in the brochures, so the analysis of age within the images is based on broad categories (young teens, late teens to early 20s, 25 to 45, and 50+) and is the result of my interpretation. I recorded information based on the

number of images, regardless of whether or not a person was pictured more than once in a given brochure.

The frame analysis revealed two primary frames used to construct the larger category of HIV transmission risk: risk behaviors and “risk” groups. Further analysis revealed that the frames compete with one another to explain how HIV is transmitted. More specifically, the frames provide contending views of who is at risk for HIV. Additionally, the risk behaviors frame provides an incomplete explanation of how HIV is not transmitted, while the risk groups frame excludes older adults and homosexuals. These findings are discussed in detail in the following section.

CHAPTER 4

RESULTS AND FINDINGS

Introduction

The current study investigated the framing of HIV transmission risk in 31 HIV-related health brochures from county health departments in the Greater Kansas City Area. Analyses revealed two primary frames used to construct HIV transmission risk in the brochures: risk behaviors and “risk” groups. The risk behaviors frame attributes the spread of HIV to certain risk behaviors (injection drug use; alcohol use; unprotected sex; etc.); this frame further explores these risk behaviors by examining specific types of sex (vaginal; anal; oral) and the spread of HIV through bodily fluids (semen; blood; vaginal fluids; breast milk). The risk behaviors frame also presents information regarding activities that do not pose a risk of transmitting HIV/AIDS (shaking hands; coughing; dancing; etc.), although this information is often inconsistent and ambiguous. The risk groups frame, on the other hand, distinguishes certain populations as at risk for HIV infection and via absence, constructs others as risk-free.

The frames identified in this study do not simply present different dimensions of HIV transmission risk, but rather, they compete and overlap with one another to identify how the disease is transmitted. The competition between risk behaviors and risk groups provides a contending view of who is at risk for the disease as an emphasis on risk behaviors implies that anyone can get HIV by engaging in such behaviors, while a focus on risk groups implicates specific populations, namely women, heterosexuals, African Americans and teens and young adults. The risk associated with these groups is exacerbated by a vague construction of activities considered safe from the transmission of HIV, which emphasizes

risk associated with casual social contact. Even more telling than the groups presented as at risk within the brochures, are those groups missing from the discussion of HIV transmission risk. Homosexual individuals and older adults are almost non-existent in the brochures, insinuating that either they are not at risk, or they do not deserve to be a part of a discussion addressing HIV transmission. I argue that the construction of HIV transmission risk within these brochures serves to perpetuate both a misconception of HIV/AIDS, as well as the stigmatization of certain populations.

Risk Behaviors: “It’s not who you are, but what you do”

Many of the brochures emphasize “risk behaviors” as a common route of HIV transmission. Behaviors that the brochures identify as risky include: having sex without using a condom, sharing needles for reasons such as drug use and tattoos, having multiple sexual partners, exposure to prior sexually transmitted infections (STIs), mixing alcohol and drugs with sex, being unaware of your own or your partner’s HIV status and having sex with a person who injects drugs. Table 1 provides a listing of indicated risk behaviors and the frequency with which they appear in the brochures. The following examples from the brochures elucidate the framing of transmission in terms of risk behaviors:

- 6 – Having vaginal, anal or oral sex with someone who is HIV positive or whose HIV status you do not know puts you at risk for HIV – especially if you do not use a condom.
- 31 – HIV is most often passed through: sharing infected needles, syringes or other drug equipment (for example, to shoot drugs, make tattoos or pierce body parts).
- 24 – It may seem like no big deal to have oral sex with different partners. But the risk of getting HIV or another STD increases with the number of partners you have.
- 25 – Also avoid alcohol and other drugs. These can affect your judgment and lead you to putting yourself or your partner at risk.

The use of drugs and alcohol and engaging in unprotected sex appear most often as behaviors that can lead to the spread of HIV/AIDS. In addition to sharing needles, alcohol

and drugs are listed as risky behaviors because they can impair a person’s judgment, making them less likely to practice safer sex.

Table 1. Most Common Risk Behaviors

Behavior	# of brochures	% of brochures
Sharing needles	25	81
Drugs and alcohol	18	58
Unprotected sex	17	55
Multiple partners	12	39
Unknown status	12	39
Prior STIs	7	23
IDU & Sex	5	16
Mother-to-Child	10	32
Fetal	7	23
Delivery	7	23
Breastfeeding	6	19
Bodily Fluids	17	55
Blood	16	52
Semen	13	42
Vaginal Fluids	13	42
Breast milk	8	26
Types of Sex	23	74
Vaginal, oral, anal	22	71
No specific type of sex	6	19

The overconsumption of alcohol has been described as a risk factor in previous research examining the relationship between alcohol and HIV risk behaviors (Kalichman, Simbayi, Kaufman, Cain, & Jooste, 2007; Cooper, 2002). One particular study found that binge drinkers were nearly twice as likely to report having engaged in HIV risk behaviors as non-binge drinkers (Wen, Balluz, & Town, 2012). The presentation of risk behaviors in the

current study is similar to findings from LaVail's (2010) study of newspapers covering older adults and HIV/AIDS, where bodily fluids, unsafe sex and the use of illicit drugs rounded out the top three most commonly listed risk factors for HIV. One interesting departure from that study is the fact that same-sex intercourse is not mentioned as a risk behavior in these brochures. LaVail found that same-sex intercourse was the fourth most cited framing device regarding HIV transmission risk, mentioned in 11% of the study's sample of newspapers (2010).

Mother-to-child transmission is mentioned in 14 (45%) brochures. Five brochures simply state that HIV can be spread through breast milk; the remaining brochures provide varying degrees of additional information, including that a mother can pass HIV to an unborn baby in the womb, during delivery and while breastfeeding. Gross, et al. investigated the presentation of HIV transmission routes in young adult novels from 1981 to 1994 and again from 1995 to 2005. They found that vertical or mother-to-child transmission appeared less in the later novels and argued that the decrease in attention paid to mother-to-child transmission paints a more realistic picture of the disease as transmission through these routes has been significantly minimized by modern technology (2008). This finding is supported in the current study as mother-to-child transmission is found in less than half of the brochures (14; 45%), with breast milk (8; 26%) appearing fewer times than blood, semen and vaginal fluids and transmission via the womb and delivery mentioned fewer times than IDU, drugs and alcohol, unprotected sex, multiple partners and unknown HIV status. Examples of how mother-to-child transmission is presented in the brochures include:

31 - HIV can also be passed from a woman to her baby – before or during birth, or while breastfeeding.

5 - A mother with HIV can give it to her baby in the womb, during birth or while breastfeeding.

9 - If you get HIV and don't get treatment, you can pass it to your unborn baby during birth, or through breast milk.

HIV risk behaviors appear in every brochure that addresses the transmission of the disease, identifying the spread of HIV as a behavioral issue. Several previous studies have identified risk behaviors as playing a significant role in describing the transmission of HIV (Blumenreich & Siegel, 2006; Gross, et al., 2008; Prater & Sileo, 2001). The strong emphasis on risk behaviors is reflective of the current state of HIV/AIDS in the United States as risk behaviors such as having anal or oral sex with an HIV positive individual and injection drug use account for the majority of new HIV infections (CDC, 2014i).

Types of Sex

Transmission is also credited to specific sexual acts, namely vaginal, anal and oral sex. This can be seen in statements such as, "HIV is most often passed through: vaginal, anal or oral sex" and "Like vaginal or anal sex, oral sex can put you at risk for HIV, the virus that causes AIDS" (31; 24). A majority of the brochures (19; 61%) state that all three types of sex (vaginal, anal or oral) can spread HIV. An additional three brochures note all three types of sex in sections referring to proper condom use. Six brochures do not specify a type of sex, one brochure focusing on tattoos does not mention sex at all, one brochure targeting young gay men emphasizes the risk associated with anal sex, while minimizing risk associated with oral sex and one brochure mentions all three types of sex under general STI information, which was not coded for in this study (See Table 1).

In contrast to previous studies looking at the framing of HIV transmission, these brochures do not associate types of sex with certain sexual orientations. Gross, et al. (2008) found that other than unknown circumstances of transmission, respondents indicated that they were infected by HIV most often via "heterosexual sex" and "homosexual sex" (p. 407).

Prater and Sileo (2001) also reported heterosexual sex and homosexual sex as ways in which the transmission of HIV was described in their analysis of juvenile literature. Despite these findings, the term “heterosexual” is only used once in all 31 brochures, while “homosexual” never appears. There is one brochure focusing on young gay men, which references anal sex as the most risky type of sex, but never uses the phrase “homosexual sex”. In 2010, the CDC identified “MSM” (men who have sex with men) and “heterosexual sex” as the two most frequent transmission categories (see Chart 1) and interestingly, other than the single mention of heterosexual sexual contact, these transmission categories are not directly referenced in these brochures.

If we look at HIV infections by how people got the virus (*transmission category*), we see that men who have sex with men (MSM) are most at risk. In 2010, MSM had 63% of all new HIV infections, even though they made up only around 2% of the population. Individuals infected through heterosexual sex made up 25% of all new HIV infections in 2010.

New HIV Infections by Transmission Category, 2010 (n=47,500)

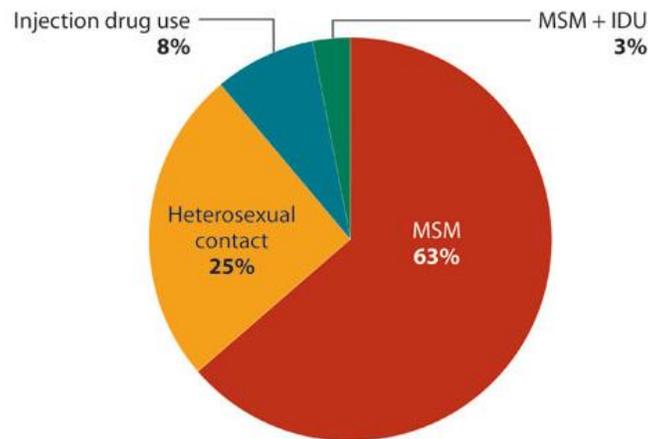


Chart 1. Common Causes of HIV Infection in the United States (CDC, 2012)

Bodily Fluids

The risk associated with certain behaviors is elaborated upon through a discussion addressing how HIV is transmitted via certain bodily fluids. The bodily fluids mentioned as potential carriers of HIV are blood, semen, vaginal fluids and less often, breast milk. This can be seen in the following examples:

26 – HIV is passed in certain body fluids. These include semen, blood and vaginal fluids. These fluids can enter through the vagina, the anus, the mouth, and any cut or open sore.

18 - Condoms keep body fluids that transmit STDs – semen, vaginal fluids and blood – from being passed during sex.

7 – You can get HIV if you have contact with the following body fluids of an infected person: Semen, vaginal fluid, blood, breast milk.

In total, 17 (55%) brochures explain the spread of HIV through one or more of these bodily fluids. Blood was listed most often, found in 16 brochures (52%), while semen and vaginal fluids were each listed in 13 brochures (42%). This finding reflects work done by Lavail (2010), who found that newspapers focusing on older adults and HIV most often listed bodily fluids when addressing transmission risk for this population. Likewise, Prater and Sileo (2001) noted that both blood and semen were stated as carriers of HIV in their investigation of how HIV is framed in books targeting a juvenile audience. Overall, a considerable portion of these brochures is devoted to explaining how HIV is transmitted. The discussion of risk behaviors is in-depth, frequent and supported by further explanations of types of sex and unsafe bodily fluids. The risk behaviors frame also includes information regarding activities that do not transmit HIV. A significant finding in this study is the comparison between the presentation of risk behaviors and risk-free activities. The thorough provision of information involving risk behaviors is counteracted by a vague presentation of risk-free activities. These activities are further explored in the following section.

Risk-free Activities

While transmission is addressed in all 31 brochures under study, only 18 (58%) of the brochures make reference to activities that do not involve a risk of contracting HIV. Moreover, these explanations vary widely and no two brochures describe how the disease cannot be transmitted in a constant way. A further analysis of these activities revealed that the brochures mention 26 different ways the disease is not transmitted. Additionally, only one of these brochures refers to safe bodily fluids (tears, saliva, sweat & urine). The following examples illustrate how the brochures address risk-free activities:

23 – HIV is not spread through casual contact. Everyday activities that do not involve contact with body fluids are considered safe. For example, you cannot get HIV by sitting next to someone, shaking hands, giving a hug or using public facilities (for example, restrooms, drinking fountains, restaurants or swimming pools). Being bitten by an insect or donating blood does not spread HIV. Dry kissing is also safe, though kissing can spread other STDs (sexually transmitted diseases), such as herpes.

4 – HIV is not passed by: Donating blood, hugging, dry kissing, sharing food, telephones, toilet seats, towels or eating utensils, tears, saliva, sweat or urine, mosquitoes or other insects . Before 1985, some people got HIV from infected blood transfusions. Now the blood supply in the United States is tested. So the chances of getting HIV this way are very, very small.

These examples present the more detailed explanations of how HIV is not spread but even within these attempts to educate readers, there is a great deal of inconsistency. To begin with, while the examples share some of the same risk-free activities, they also differ in the activities they present as risk-free. For instance, the first example references sitting next to someone and swimming pools as safe from the transmission of HIV, which are absent from the second explanation which includes towels and telephones (absent from the first explanation). The first explanation also includes an additional warning for “kissing” that is not part of the second explanation. Additionally, the first attempt defines the phrase “casual contact”, one of only two instances where this occurs, while the second attempt does not use

the phrase “casual contact” but instead alludes to it through examples. Furthermore, the second attempt makes mention of bodily fluids (tears, saliva, sweat, urine), which are completely absent from the first attempt. The examples below represent the more brief attempts to explain how the disease is not spread, which accounts for the majority of ways in which this subject is addressed. Notice that not one of the explanations is the same:

- 12 – Remind others that HIV does not spread through air, water or casual contact. (very small print)
- 3 – HIV and other STDs are not spread by casual contact, such as giving a hug, shaking hands or using restrooms.
- 20 – HIV is not passed through casual contact like shaking hands, hugging or sneezing.
- 9 – You can’t get HIV from kissing, hugging or touching.
- 2 – HIV is not spread by coughing, touching or other casual contact.

Table 2 provides a summary of all activities presented as safe from HIV transmission within the brochures. For comparison’s sake, table 1 is also presented to emphasize the difference in how risk behaviors and risk-free activities are depicted. Additionally, although conceptual codes appearing fewer than five times in the brochures were eliminated from the overall analysis, they were included in the analysis of risk-free activities. This inclusion is warranted in part because most of the risk-free activities appeared fewer than five times and this absence was a notable finding, and furthermore, to emphasize the difference in how HIV transmission and non-transmission routes are discussed within the brochures.

As table 2 shows, in contrast to the elaborate explanation of how the disease is transmitted (shown in table 1), the brochures are much more ambiguous in explaining how HIV is not transmitted. One primary concern is the lack of attention to bodily fluids, a prominent piece of the discussion of risk behaviors. While bodily fluids that are capable of transmitting HIV are mentioned in more than half (55%) of the brochures, safe bodily fluids that do not transmit the disease are mentioned once in all 31 brochures. Returning to an

earlier point, a vague construction of bodily fluids that transmit HIV early in the epidemic led to an overemphasis of casual contact as specific bodily fluids (semen, vaginal fluids, etc.) were rarely mentioned within media sources. While this is not the case in the current study, a vague construction of safe bodily fluids or fluids that do not spread HIV results in the same overemphasis of risk associated with casual social contact. Specifically, statements such as, “Avoid other people’s body fluids completely” emphasize risk associated with casual social contact as the bodily fluids (safe or unsafe) are not definitively stated. Furthermore, the most commonly cited risk-free activity (giving a hug/hugging) appears in just 26% of the brochures; on the other hand, sharing needles, the most commonly cited risk behavior, is discussed in 81% of the brochures. A comparison of the tables presenting the frequency with which risk behaviors and risk-free activities appear in the brochures is telling of the difference in how these two sides of HIV risk are discussed.

This lack of clarity around how HIV/AIDS is not transmitted has far reaching consequences as misconceptions regarding the transmission of the disease have been directly linked to attitudes toward HIV positive individuals. Individuals who have a greater understanding of both how the disease is and is not transmitted report more positive attitudes toward people living with HIV/AIDS (Dias et al., 2006). On the other hand, those who believe that the disease can be spread by “casual social contact” are more likely to fear being in close proximity to HIV positive individuals which only exacerbates the stigma these individuals experience (Dias et al., 2006, p. 208). This is even more concerning when you take into account the fact that studies investigating knowledge of HIV transmission in high school and college students, found that students were more knowledgeable about how the

Table 1. Most Common Risk Behaviors Indicated in HIV-related Brochures

Behavior	# of brochures	% of brochures
Sharing needles	25	81
Drugs and alcohol	18	58
Unprotected sex	17	55
Multiple partners	12	39
Unknown status	12	39
Prior STIs	7	23
IDU and sex	5	16
Mother-to-Child	10	32
Fetal	7	23
Delivery	7	23
Breastfeeding	6	19
Bodily Fluids	17	55
Blood	16	52
Semen	13	42
Vaginal Fluids	13	42
Breast milk	8	26
Types of Sex	23	74
Vaginal, oral, anal	22	71
No specific type of sex	6	19

Table 2. Everyday Activities That Do Not Transmit HIV

Everyday Activities	# of brochures	% of brochures
Giving a hug/ hugging	8	26
Shaking hands	8	26
Casual contact	7	23
Restrooms/ Toilet	7	23
Restaurant/ Cafeteria	6	19
Donating blood	5	16
Insect	4	13
Telephone/ payphone	4	13
Dry kissing	3	10
Sitting next to someone	3	10
Swimming pool	3	10
Food	3	10
Sneezing	2	6
Coughing	2	6
Water cooler	2	6
Air	2	6
Water	2	6
Transfusions	2	6
Water/ Drinking fountain	2	6
Hot tub	2	6
Touching	2	6
Tears	1	3
Saliva	1	3
Sweat	1	3
Urine	1	3
Kissing	1	3

disease was transmitted and less confident in how it could not be transmitted (Dias, et al., 2006; Inungu, et al., 2009). While more than 80% of students surveyed from seven public schools in Portugal correctly identified needle sharing and vertical transmission as possible routes of HIV infection, only around half of the students reported that AIDS could not be

spread through coughing, sneezing, and sharing utensils (Dias et al., 2006). A study conducted in the United States found that while more than 98% of college students correctly stated that condom use and monogamy could prevent transmission of HIV, nearly 20% were not sure whether or not the virus could be transmitted by mosquitoes and 14% reported that HIV could be transmitted by mosquitoes. Moreover, 18% of students reported that they were not sure if they would buy food from someone who they knew was HIV positive (Inungu et al., 2009). The sample of brochures in the current study might account for some of these findings as avenues through which the disease can be spread are presented in a thorough, confident manner, while by comparison activities that do not pose a transmission risk are discussed inconsistently and infrequently.

Risk Groups: “It is who you are”

The second major frame identified in this study situates certain groups as at-risk for HIV/AIDS. Risk groups were evaluated based on the appearance (or absence) of certain social characteristics within the brochures, namely gender, race, sexual orientation and age. These specific categories emerged throughout the analysis as ways in which groups were described apart from a general audience. In addition to the text and images in these brochures, risk groups were analyzed based on the targeted population of each brochure (See Table 3: Brochure Type). While the text contains some population-specific information, specific groups of people are primarily present in the images of the brochures; in fact, the images in the brochures overwhelmingly consist of people. Items such as condoms, medical personnel and equipment and phones are also pictured, but significantly less often than people. Unlike the risk behaviors frame, where anyone can become infected with HIV, the risk groups frame identifies specific groups of people as at-risk. Women (and men),

heterosexuals, African Americans, and teens and young adults are illustrated as groups at risk for HIV infection.

Women (and men...)

In this sample of brochures, women are the most commonly addressed group of people, when specific populations are mentioned. They are the primary subject matter of five brochures, more than any other population or subject.

Table 3. Brochure Type

Type of Brochure (target population or behavior)	# of brochures	Percentage of sample
General	10	32%
Women	5	16%
*African American	2	6%
*Hispanic/Latina	1	3%
Teens	4	13%
Testing	4	13%
Behavior	4	13%
*Oral sex	1	3%
*Condom use	1	3%
*Tattoos	1	3%
*Needle use	1	3%
Older adults	2	6%
Young and gay	1	3%
HIV-positive individuals	1	3%

Statements such as, “More women get HIV than ever before”, “Worldwide, 48 percent of all people with HIV are women”, and “Every woman who has unprotected sex or shares needles is at risk for HIV” underscore the risk associated with women in these brochures (9; 27; 19).

Women are also addressed within the context of mother-to-child transmission. As mentioned earlier, 14 (45%) brochures state in one way or another that HIV can be passed from a

woman to her baby. Statements such as, “If you are pregnant or thinking about having a baby, get tested” and “If you get HIV and don’t get treatment, you can pass it to your unborn baby during birth, or through breast milk”, further situate women as a risk group (19; 9).

Additionally, women, more so than any other group of people, are portrayed as victims. This is evident in the following statements:

29 – [Caption next to image of African American woman] – “No relationship is worth risking your life for. If he loved me, he would have worn a condom. Now I have HIV. I’m getting help, but I’m worried what will happen to my kids. It’s hard for them to see me like this.

27 – Why do women get STD [*sic*] more easily than men? After unprotected sex, semen stays in the woman’s body for a while. This increases the chance that STD germs will get into her body.

12 – Get support. If you’re afraid of him or if he’s doing things that could put you at risk, get help to get out.

All three of these examples depict women as innocent victims in potentially risky situations. Their actual or potential transmission risk is based on the actions of their male partner. This theme of innocence is carried through to the images in the brochures as well. Women are more likely to be pictured looking away or down, seemingly in distress and with children than their male counterparts.

While the risk associated with women is commonly addressed within the brochures, men are rarely directly stated as a risk group and the risk associated with men is implied through the discussion focused upon women. Men account for the primary subject matter in only one brochure targeting young, gay men and are only directly addressed in one additional brochure which promotes HIV/STD testing. Within this brochure, narratives of African American men and women are used to emphasize the importance of getting tested. The following examples highlight how men are portrayed as a risk group:

1 – Darnell: “I’m not going to get tested. See, I did get an STD. But I did what the doctor told me and now it’s under control. So it’s all taken care of. Isn’t it?”

1 – Tisha: “Well, I have a new man, and he used to shoot drugs. But I don’t think there’s anything to worry about. If he had a sexually transmitted disease – an STD – he’d be sick. Right?”

These statements emphasize the guilt associated with men and HIV transmission risk in the brochures. Darnell’s choice not to get tested is of his own accord and therefore his risk is based on his own actions. Tisha’s risk, however, is attributed to her male partner’s prior drug use. This idea that men are guilty of transmitting HIV carries through to the images in the brochures. Although women are pictured slightly more often than men, men are pictured more often in general HIV brochures, and images of women only outnumber those of men in one brochure. In addition, the only brochure entirely dedicated to HIV positive individuals pictures men more frequently than women in a 4:1 ratio.

The added attention given to women and the presumed guilt of men in these brochures is not a new occurrence. The increased vulnerability of women to HIV/AIDS has been a subject matter of scholars around the world. In fact, studies suggest that a man is two times more likely to pass HIV to a woman than the other way around (Dworkin, 2005). Studies often cite special concerns particular to the female genital anatomy, unequal power relations between men and women, the inability for women to negotiate safer sex in relationships and female sex work as reasons for the added vulnerability women face when it comes to HIV/AIDS (Dworkin, 2005). While Dworkin recognizes the risks women encounter with HIV/AIDS, he argues that there is another side to this story and that men are also vulnerable to HIV/AIDS. He notes that things such as migration, engaging in sex work as a means of survival and rape are all issues that can potentially put men at risk for HIV/AIDS. Dworkin belabors the need for gender studies looking at HIV/AIDS

risk to examine “women’s and men’s simultaneous privileges and inequalities in a triad made up of different groups of women, and both dominant and subordinate male groups” (2005, p. 618).

Heterosexuals

Although the term “heterosexual” is only explicitly used once in all 31 brochures, heterosexual sex and relationships are alluded to through discussions of how the disease is transmitted. For instance, the following examples of narratives discussing risk behaviors involve male-female relationships:

29 – [Caption next to African American woman] - He said if I loved him, I should trust him. So we never used a condom. I knew it was risky, but I was afraid of losing him; if you or your man can’t – or won’t – use a male condom, learn about the female condom and other options.

1 – [Caption next to African American woman] - Well I have a new man, and he used to shoot drugs. But I don’t think there’s anything to worry about. If he had a sexually transmitted disease – an STD – he’d be sick. Right?

21 – A majority of adults worldwide become infected through heterosexual sex.

Another implication that these brochures almost exclusively point to heterosexual sex can be found in how they portray types of sex as avenues of transmission. While all three types of sex, vaginal, anal and oral, are usually referenced together, anal sex and oral sex sometimes have additional warnings as seen in the following example, “Remember, you can get STDs (including HIV) from anal and oral sex, too” (25). Vaginal sex never carries this warning, further suggesting that unlike anal and oral sex, not only is it widely understood that vaginal or heterosexual sex can spread HIV, but that this type of sex is the norm. The heteronormative theme present in the text, is also apparent through the images in the brochures. Fifteen brochures (48%) contain images of couples. Of those 15 brochures, 12 (80%) strictly include images of heterosexual couples. In fact, gay male couples are only pictured in three images throughout the entire sample of brochures, and same sex couples are

completely excluded from brochures addressing a general audience, which accounts for a majority of the brochures in the sample.

African Americans

The risk associated with African Americans is primarily illustrated through the images in the brochures. African Americans are the most pictured racial group in the brochures and are referenced most often in the very brief amount of text devoted to racial-specific risk information. The following four statements account for all text specifically devoted to racial groups:

12 – Latinas and African American women are getting HIV at a faster rate than other women.

29 – Do you know the #1 killer of black women ages 25-34? It's HIV.

1 – Why get tested? African Americans have the highest rates of HIV and other STDs in the U.S.

12 – Women & HIV: A Call to Women of Color [Brochure Title]

With the exception of brochures targeting teens, older adults, and IDUs, African American's are pictured more often than any other race/ethnicity. In the general brochures, images of African Americans outnumber those of Caucasian individuals 2:1. In the testing brochures, they outnumber Caucasian individuals 3:1, although this primarily comes from a single testing brochure focused on the African American community. Images of African American women outnumber those of Caucasian women by more than 12 times in the brochures which target women. In fact, only two Caucasian women are pictured in the brochures designed for women, which is fewer than both African American and Hispanic/Latina women. It should be noted that in brochures focused on teens, this trend is actually reversed with images of Caucasian individuals outnumbering those of African Americans, 2:1.

As of 2010, African Americans accounted for 12% of the U.S. population and 44% of new HIV infections. The number of new infections for African Americans outnumbered those in Caucasian individuals by more than eight times (CDC, 2012). Within these brochures, African Americans are pictured more often than any other racial/ethnic group but they are rarely specifically addressed within the text. While three brochures do address African Americans, the references to race and issues specific to African Americans are minimal. The brochure targeting “women of color” states that “HIV isn’t a plot or punishment, and it isn’t shameful. It’s real – we need to protect ourselves” (12). A great deal of research has been dedicated to understanding conspiracy beliefs regarding HIV/AIDS in the African American community. Studies show that conspiracy beliefs associated with HIV/AIDS are more prevalent among African Americans than Caucasian individuals. These conspiracies range from the belief that the government is not telling the truth about HIV/AIDS to the belief that HIV/AIDS is a manmade weapon intended to eliminate minority races (Bird & Bogart, 2005). The brochure targeting African American women references the “down low” phenomenon in the following statement, “I had heard that my ‘ex’ was on the ‘down low’ – that he had sex with women and men” (29). Down low is an expression that refers to African American men who have sex with other men, while simultaneously involved in heterosexual relationships. Moreover, these men identify as heterosexual. This narrative shows up in HIV/AIDS discourse as a possible link to heterosexual transmission in African American women (Phillips, 2005).

Teenagers and Young Adults

Teenagers and young adults are addressed in both the text and images of these brochures. In fact, the images almost exclusively picture young adults. Continuing the trend

associated with African Americans and men, age is oftentimes not explicitly referenced in the brochures but alluded to through obscure statements such as, “Young people are at a greater risk than ever”, “Many young people are deciding to protect themselves from HIV by waiting to have sex”, and “One in every four people becoming infected with HIV today is a teenager” (21; 7). Only two statements throughout the entire sample of brochures provide a specific age range, “Do you know the #1 killer of black women ages 25-34? It’s HIV” and “More than 50% of teens over age 16 have had sex. They need to know how to protect themselves from HIV” (29; 10). Although age cannot be specifically determined, a general overview of the images in these brochures points to the following trends: young teens, late teens to early 20s, 25 to 45, and 50+. Within these categories, the group of people most often pictured falls within the age range of late teens to 45 years, with the majority of these images falling on the younger end of this spectrum. In fact, only two brochures contain images of people that come close to the 45 year mark. These categories are based on the researcher’s interpretation of the images as age is rarely specifically stated.

Who is Missing?

Homosexuals. According to the CDC, as of 2010, gay and bisexual men represented the largest number of new and existing HIV infections in the United States (CDC, 2014a). This information brings even further concern to the fact that same sex couples are almost entirely excluded from the brochures in this study. The silencing of gay men has been addressed in prior evaluations of HIV/AIDS discourse (Clarke, 2006; Prater & Sileo, 2001; Bredstrom, 2005). In particular, the findings of the current study are supported by Clarke’s analysis of the portrayal of HIV/AIDS in Canadian magazines in which she discovered that descriptions of heterosexual victims were “lengthy, warm, inspiring and heroic” while

descriptions of gay or drug using victims were “few, brief and to the point” (p. 324). Clarke argues that the lack of attention given to homosexual victims perpetuates an age old belief that homosexuality is associated with guilt and individuals acquiring HIV through homosexual measures are responsible for their disease, making them less worthy of empathy (2006). Additionally, Bredstrom (2005) maintains that “meanings sometimes are constructed through silences or implicit notions of an assumed ‘us’ by, for instance, addressing a pre-configured audience” (p. 519). The brochures under study overwhelmingly address a heterosexual audience. This heteronormative stance automatically signals to readers that homosexuality is not the norm, and in fact it is part of the “other” category, reifying the “us” (general population) verses “them” (HIV positive individuals) mentality that came about early in the epidemic. Furthermore, other than the brochure addressing young, gay men, the only two additional brochures picturing same sex couples are brochures focused on HIV positive individuals and HIV testing. The targeted audiences of these brochures are either individuals who are already HIV positive or at risk for HIV (hence the need for testing), implying a sense of guilt associated with homosexuality.

Older adults. Older adults (50+), as a risk group, only appear in the text and images of two brochures or six percent of the sample. When older adults are pictured in other brochures, they are always portrayed as doctors. The following statements describe how older adults are addressed in the brochures:

13 – Yes! People over 50 have sex; people over 50 have some special concerns when it comes to keeping sex safe; since the beginning of the HIV epidemic, around 10% people with HIV have been 50 or older; many people over 50 who get HIV through sex knew their partners.

16 – Sexually active adults in their 50s, 60s, 70s, and older need up-to-date information about HIV and other STIs; more than 10 percent of all people diagnosed with HIV or AIDS are over 50.

The absence of older adults in these brochures is alarming as adults 55 years and older accounted for 19% of people living with HIV in the United States as of 2010 (CDC, 2014f). While older adults are vulnerable to common risk behaviors such as incomplete HIV risk knowledge, multiple partners and inconsistent condom use, they also have special concerns such as a lack of communication with health care providers, increased sexual interaction due to erectile dysfunction medications, and the perceived impracticality of condoms due to associations with birth control (CDC, 2014f). Although the brochures targeting older adults cover these topics, the infrequency in comparison to the total number of brochures and the complete lack of coverage outside of these two brochures presents cause for alarm. As LaVail (2010) notes, the inefficient coverage of HIV risk behaviors in the older adult population may contribute to the frequent misconception that older adults are not at risk of contracting HIV/AIDS.

Competing Frames

The frames uncovered in this study overlap and compete with one another to identify how HIV is transmitted, either through risk behaviors or risk groups. Through this competition, a contending view of who is at risk develops as the risk behaviors frame implies that anyone is at risk if they engage in certain risk behaviors, while the risk groups frame highlights the increased risk associated with certain groups, particularly women, heterosexuals, African Americans and teens and young adults. Furthermore, an infrequent and vague presentation of activities that do not spread HIV within the risk behaviors frame, emphasizes the risk of casual social contact with the groups identified in the risk groups frame.

Within the risk behaviors frame, risk is most often attributed to a general audience, with the idea that anyone can get HIV/AIDS. This is done through a strong emphasis on risk behaviors as well as non-specific text which often uses the pronoun “you” and words such as “people”, “person”, “someone” and “partner” when addressing the reader. Furthermore, the idea that, “it’s not who you are, but what you do” is a common theme throughout the risk behaviors frame. This point is exemplified in more than 1/3 of the brochures (12; 39%) by statements such as, “Anyone can get infected with HIV. It depends on what you do – not who you are” and “...HIV doesn’t care about the color of our skin. It doesn’t care if a person’s gay or straight, man or woman, young or old. HIV spreads in the same way for all people” (31; 12). Many of the brochures (11; 36%) also make note of the fact that you cannot discern someone’s HIV status by their physical appearance. This theme is evident in statements such as, “You can’t tell by looking if someone has HIV. Anyone can have HIV and pass it on to you” and “Even people who look and feel healthy can have HIV...”(9; 11).

The message advocated within the first frame, specifically, that “anyone can get HIV by engaging in risk behaviors”, is contested by a competing perspective within the risk groups frame, which insinuates that “certain groups are at risk for contracting and spreading HIV”. The risk groups frame is primarily constructed through images, which are overwhelmingly of people. There is some group-specific text which also contributes to the implication of risk associated with certain groups. Women and heterosexuals are targeted most often, both through text and images. In addition to brochures focused upon issues related to women and HIV, a common illustration of the risk associated with mother-to-child transmission also identifies women as a risk group. The risk associated with heterosexuals is

emphasized through a primary focus upon heterosexual (vaginal) sex as well as an overwhelming representation of heterosexual couples within the images in the brochures.

In light of the previous discussion regarding how competing frames can impact public opinion, particularly that conflicting frames may in essence cancel one another out, it is certainly interesting to note that the presence of both the risk groups and risk behaviors frames may impact how readers think of HIV transmission risk (Wise & Brewer, 2010). As Chong and Druckman (2007) note, it may also facilitate a deeper reading of the brochures as individuals attempt to process the information provided by both frames. While this study is not examining the effects that these brochures have on public opinion, these findings present opportunity for future research to investigate how readers respond to the frames within the brochures and whether or not their competing nature impacts public opinion.

The Implications of the Framing of HIV Transmission Risk

The consequences of explaining HIV transmission as the result of risk groups and risk behaviors has been addressed in previous research. Stevens and Hull (2010) argue that targeting individual risk behaviors minimizes the importance of understanding how HIV/AIDS impacts certain groups, in that the public may not see “widening disparities as an important problem” (p. 354). The argument presented by Stevens and Hull (2010) highlights an important consequence of the competing frames within the current study. While certain groups are presented as at risk for HIV infection, there is little explanation for why these groups are at an increased risk for HIV. Adimora, Schoenbach, and Floris-Moore (2009) reiterate that “Exogenous factors including economic forces, demographic features, and other structural aspects of society that are beyond individual control influence sexual behaviors, sexual network features, and spread of STIs” (p. 469). Such influences are almost completely

absent from the discussion regarding HIV transmission within the brochures under study. Oftentimes, images of specific populations are presented with a discussion of risk behaviors as a backdrop. Stevens & Hull (2010) explain that discussing HIV transmission strictly as the result of individual behaviors can "...privilege prevention efforts to target individual risk behavior over efforts to influence structural determinants, even though addressing structural drivers of the disease may be more effective in slowing the epidemic" (p. 354).

The extremely limited information regarding social determinants of HIV transmission provided by these brochures, may perpetuate stigma already associated with groups such as African Americans. African Americans are pictured frequently within the brochures, but as I discussed earlier, there is very little racial specific information regarding HIV transmission. Consequently, they are seen as a risk group, but by not discussing the social determinants that make them more at risk, such as "poverty, a low male-to-female sex ratio, de facto racial segregation, and disproportionate incarceration," individuals are blamed for their engagement in risk behaviors and subsequent HIV infection (Adimora, et al., 2009, p. 469). We are reminded by Stevens and Hull (2010) that while a focus on individual behavior may slow the transmission of HIV, the lack of context regarding issues specific to the African American community and any particular group impedes the possibility of reducing health disparities related to HIV/AIDS among the most at-risk populations. The concerns addressed in the research done by Stevens & Hull (2010) are further justified by studies revealing that Americans not only tend to have little awareness of health disparities among certain groups of people but are also more likely to associate health with individual behaviors than structural determinants (Niederdeppe, et al., 2013; Rigby, Booske, Rohan & Robert, 2009). Furthermore, we are reminded by Nathanson (1999) that policy change is less likely to come

to fruition if health risks are thought to be the result of individual behaviors. This is particularly evident in Gollust and Lynch's (2011) study which revealed that American adults "are more likely to blame individuals and less likely to offer them societal support for their medical expenses when their illnesses are presented as being linked to behavioral choices" (p. 1085). According to the CDC, "evidence suggests that programs that comprehensively address health where we live, work, learn, and play can have greater impact on health outcomes at the population level than programs utilizing interventions aimed solely at individual behavioral change" (2010, p. 1). The brochures in this study do very little to disentangle HIV transmission risk from individual behaviors, which ensures that readers are not getting the full story. Consequently, the brochures may have a limited impact on the improvement of disparities in HIV infection.

Misconceptions and stigma are further established by a limited and ambiguous presentation of risk-free activities. Comparatively, risk-free activities are discussed far less than risk behaviors and when they are discussed, no two attempts to describe safe activities are the same. The importance of this finding is supported by research explaining that a lack of knowledge regarding how the disease is not transmitted directly impacts attitudes toward people living with HIV/AIDS (Dias et al., 2006). This has consequences for not only people living with the disease but groups considered at risk for HIV, as stigma can impact both the likelihood of engaging in risk behaviors as well as seeking testing and treatment for HIV/AIDS. Valdiserri (2002) references a study completed by Stokes and Peterson (1998) where they suggest that men having sex with men who have internalized stigma toward homosexuality may be more likely to have low self-esteem which can lead to HIV risk behaviors such as engaging in sex with multiple partners and the use of alcohol and drugs.

Additionally, individuals may be afraid to learn or disclose their status, creating barriers to both testing and treatment (Cao, et al., 2006). These findings suggest that HIV/AIDS educational campaigns that only focus upon modes of transmission may be missing the mark. It is equally important to ensure people are comfortable with how the disease is not spread as misconceptions based on this information have a real impact on those living with or at risk for HIV/AIDS (Dias et al., 2006).

In addition to limited information regarding group disparities, certain populations are almost entirely absent from the presentation of HIV transmission within these brochures. Older adults, a population in which HIV is a growing concern are mentioned in just two brochures or six percent of the entire sample of brochures. The CDC notes that the number of older adults (50+) living with HIV/AIDS nearly doubled from 2001 to 2005, making this population a prime candidate for HIV preventive and treatment efforts (2014f). However, the severity of the illness among older adults is not reflected within these brochures. Research shows that older adults are interested in learning about HIV, but their knowledge of HIV/AIDS is relatively limited (Small, 2010). Older adults also tend to underestimate their risk of HIV infection, which may be a direct result of being overlooked within HIV prevention efforts. While older adults do have special concerns when it comes to HIV, many of their risk factors, including barriers to disclosure of an HIV positive status, are the same as their younger counterparts and yet, by comparison, older adults are grossly underrepresented in media sources and research addressing HIV/AIDS (Emlet, 2008; Lavail, 2010). Unfortunately, the brochures in this study echo a lack of coverage concerning HIV transmission risk among older adults.

The homosexual population is also severely underrepresented in the current study. However, unlike older adults, who are stigmatized as non-sexual, risk-free beings, homosexuals appear to be silenced for different reasons. Considering the overwhelming association of homosexuality to HIV/AIDS early on, it would be difficult to assume that homosexuals are rarely addressed in the brochures because they are not considered as at-risk. Instead, a heteronormative focus in these brochures serves to stigmatize homosexuals as part of the “other”, who contradict the heterosexual status quo present in American society (Vorhis & Wagner, 2002). These findings are emulated in previous research which addressed an underrepresentation of homosexuality in social work journals. Although the authors explain that the majority of articles about homosexuals were related to HIV/AIDS, which is a departure from the current study, the total number of articles addressing homosexuals amounted to less than four percent of the total articles published in social work journals during the study period (Vorhis & Wagner, 2002). The authors of this study argue that, “Although thousands of clients that receive social work services every year are homosexual, the silence of these journals preserves the pretense that such clients do not exist or do not matter” (Vorhis & Wagner, 2002, p. 353). I argue that the brochures in the current study are sending the same message, specifically that homosexuals do not deserve the same HIV preventive and treatment efforts as their heterosexual counterparts.

CHAPTER 5

CONCLUSION

The goal of the current research was to uncover the framing of HIV transmission risk in health brochures from county health departments in the Greater Kansas City Area. Using the method of frame analysis, I uncovered two major frames used to construct HIV transmission risk: risk behaviors and risk groups. Further examination revealed that these two frames do not simply present information regarding the transmission of HIV, but compete with one another to identify the cause of HIV transmission. On the one hand, brochure discourse emphasizes risky behaviors as responsible for HIV transmission; particularly, they cite “risky” behaviors, such as injection drug use (IDU), the consumption of alcohol and unprotected sex. According to this frame, anyone who engages in these behaviors is at risk of contracting HIV. This point is emphasized through repeated statements that anyone can contract HIV regardless of their race, age, gender, etc., if they engage in such activities. This frame constructs HIV as an equal opportunity disease that has the potential to affect anyone. On the other hand, the risk groups frame constructs specific groups of people as being at greater risk of contracting (and spreading) the disease. In particular, women, heterosexuals, African Americans and teens are all considered to be at risk for HIV/AIDS. The first frame which insinuates that “it is not who you are, but what you do” is challenged by the message within the second frame: “it is who you are” that renders you at greater risk for the disease. The risk associated with these groups is intensified by the inconsistent presentation of activities that do not spread HIV, specifically activities that involve casual social contact (hugging, shaking hands, using the restroom, etc.). Furthermore, homosexuals and older

adults are almost entirely excluded from the discussion of transmission risk within the brochures.

The framing of HIV transmission risk within the brochures has implications for those living with and at risk for HIV/AIDS. A focus upon risk behaviors as the cause of transmission coupled with “risk” groups insinuates that at-risk groups engage in risky behaviors. Furthermore, a lack of group-specific risk information promotes a misconception of HIV that implicates individual behavioral choices as the primary cause of HIV transmission. In other words, these brochures do not take into account social determinants of health which are pivotal to the understanding of group disparities related to HIV/AIDS. Prior research has highlighted the relationship between structural forces such as education and income and HIV/AIDS (CDC, 2010; Adimora et al., 2009). Notably, low literacy levels in HIV positive individuals have been associated with non-adherence to HIV treatment, while lower income levels were associated with a higher likelihood that African American MSM engaged in risky sexual behaviors. Additionally, one study explains that the poverty line is significant in determining rates of HIV infection. Specifically, this study found that “heterosexual men and women in 23 major U.S. cities living below the poverty line were twice as likely to have HIV infection (2.4%) as those living above it (1.2%)” (CDC, 2010, p. 1). The CDC clarifies that, “to address this imbalance, we must complement individual-level interventions, intended to influence knowledge, attitudes, and behaviors, with new approaches that address the interpersonal, network, community, and societal influences of disease transmission and health” (2010, p. 1). They further explain that such interventions “can have greater impact on health outcomes at the population level than programs utilizing interventions aimed solely at individual behavior change” (CDC, 2010, p. 1). Health

brochures present a prime opportunity to educate individuals on the social determinants of health as research shows they are commonly used within HIV prevention, are reported as common sources of HIV information and have proved effective in encouraging individuals to participate in preventive efforts such as HIV testing (Albarracin, et al., 2008; Krauss, Wolitski, Tross, & Corby, 1999).

In addition to the absence of social determinants of HIV/AIDS, the brochures are also lacking in their presentation of risk-free activities. Although transmission routes are discussed in all 31 brochures, risk-free activities appear in significantly fewer brochures (18; 58%). The infrequent presentation of risk-free activities is accompanied by inconsistent, vague explanations for how the disease is not transmitted. This is particularly concerning considering that although Americans are generally knowledgeable of how HIV is transmitted, they are less aware of how HIV is not transmitted and incorrect knowledge regarding HIV transmission can negatively impact attitudes toward people living with HIV/AIDS (Dias et al., 2006). Dias et al. (2006) emphasize the need for HIV preventive efforts to “more effectively communicate how HIV is not transmitted, since we know that stigma is more likely to thrive in an environment of ignorance and half-truths” (p. 213). This is particularly important as stigma can dampen HIV preventive and treatment efforts; research shows that stigma can impact whether or not a person decides to get tested for HIV. One study revealed that teenagers were less likely to seek HIV testing if they felt they would be judged by their health care provider (Valdiserri, 2002). Research has also associated stigma with an inability to adhere to HIV medicine regimens (Vanable et al., 2006). The brochures in this study do very little to address the stigma associated with incorrect knowledge regarding HIV transmission; in fact, the lack of consistent explanations concerning how the disease is not

transmitted effectively emphasizes HIV transmission risk via casual social contact, which can be dire for people living with or at risk for HIV/AIDS.

A misconception of HIV/AIDS is further established by the exclusion of homosexuals and older adults from the presentation of HIV transmission risk within the brochures. Their absence is just as important as the presence of specific groups, as it insinuates that these populations are either not at-risk for HIV or they do not deserve to be a part of a discussion addressing HIV transmission; this is an alarming finding as rates of infection have increased within the MSM population, including in older adults (CDC, 2014i). Additionally, older adults are often diagnosed later than their younger counterparts due in part to a lack of interaction with health care providers, which is a direct result of the misconception that older adults are not at risk for HIV (CDC, 2013). By severely minimizing the amount of information dedicated to the transmission of HIV in the older adult population, the brochures in the current study perpetuate this misconception.

While this study has important implications, it is vital to discuss its limitations as well. The scope of the study spans 14 counties in the Greater Kansas City Area, which means these findings are only indicative of health brochures in this particular location. To expand the coverage of these findings, future research should aim to investigate a larger sample of brochures from various metropolitan areas throughout the United States. Not only will this allow for a more substantial level of representation, but it will uncover differences in geographic location, if they do exist. Additionally, the goal of this study was to explore how HIV/AIDS is constructed in health brochures; while this goal was met, it is important to also look at how other diseases are framed within health brochures to examine whether other diseases are framed similarly to or differently from HIV/AIDS. Understanding how other

diseases are framed in health brochures will add weight to the findings from the current study, particularly if these findings are limited to HIV/AIDS. Finally, although the findings in the current study are the result of an established methodology (frame analysis), they are at the mercy of one person's interpretation. To solve for this in the future, intercoder reliability checks will be conducted to ensure consistency in the coding process and the resulting findings.

It is important to understand how a health issue such as HIV/AIDS is framed, as previous work has shown us that frames can influence public opinion (Wise & Brewer, 2010). Furthermore, people may respond differently to competing frames, like the ones found in this study, than they do to individual frames, which can determine how the public views an issue such as the transmission of HIV/AIDS (Wise & Brewer, 2010). While this study did not evaluate the impact these frames have on public opinion, it provides a good basis for further research to address this very question. In light of previous findings suggesting that people tend to think differently about health issues when they are linked to specific behaviors or groups, this study provides a great basis for testing these theories as the brochures explain the transmission of HIV through both risk behaviors and risk groups (Rigby et al., 2009; Gollust & Lynch, 2011). Additionally, there is evidence to suggest that competing frames may weaken "framing effects" as the frames effectively cancel one another out (Wise & Brewer, 2010, p. 439); the current study contributes to these findings by creating an opportunity to evaluate whether presenting HIV transmission risk through both risk behaviors and risk groups mitigates the impact these brochures have on public opinion. This would have far reaching implications as brochures are commonly used to educate individuals on health issues such as HIV/AIDS and their presence on the frontlines of HIV intervention

efforts has shown to be effective in keeping individuals on course for treatment as well as furthering individual engagement in preventive measures such as HIV testing (Higa et al., 2012; Albarracin et al., 2008).

Future research should expand upon the findings of this study by interviewing recipients of these health brochures in order to understand how the presentation of HIV transmission risk within the brochures impacts public opinion. It would be particularly interesting to examine whether or not the competing view of risk impacts how individuals understand the transmission of HIV. Further research would also be served well by investigating alternative media sources dedicated to providing health information. One possible starting point would be online sources, considering that a significant portion of the U.S. population (80%) reports having previously used the internet for health information (Renahy, Parizot, and Chauvin, 2010). Furthermore, while I was collecting brochures for the current study, I was referred time and time again to the CDC's website. If health care providers are supplying patients with information directly from this website, it would be invaluable to understand how HIV/AIDS transmission risk is constructed.

Appendix A
Detailed Listing of Brochures

Brochure#	County	Brochure Title	Publisher
1	Cass	HIV/STD Testing For You	Channing Bete
2	Cass	HIV Testing - Get the facts	Channing Bete
3	Cass	Get informed not infected - HIV and other STDs	Channing Bete
4	Clay	HIV Facts	ETR Associates
5	Clay	STD Facts	ETR Associates
6	Jackson	HIV: Understanding Your Risk	Journeyworks Publishing
7	Jackson	The HIV Quiz	Journeyworks Publishing
8	Jackson	A Teen's Guide to HIV and AIDS	Journeyworks Publishing
9	Johnson	Women & HIV: Think About It	ETR Associates
10	Johnson	HIV: Talking with your Teen	ETR Associates
11	Leavenworth	Needles, HIV and Hepatitis	Journeyworks Publishing
12	Leavenworth	Women & HIV: A Call to Women of Color	Channing Bete
13	Leavenworth	HIV & STD Prevention After 50	ETR Associates
14	Leavenworth	HIV and Sex: Unsafe Safer Safest	Journeyworks Publishing
15	Leavenworth	Young and Gay: Protect Yourself from HIV	Journeyworks Publishing
16	Leavenworth	What Older Adults Need to Know About HIV and Other STIs	Journeyworks Publishing
17	Leavenworth	Tattoos and Body Piercing: Protecting Yourself from Hepatitis and HIV	Journeyworks Publishing
18	Leavenworth	How Condoms protect you from HIV and Other STDs	Journeyworks Publishing
19	Leavenworth	Women and HIV	Journeyworks Publishing
20	Leavenworth	50 Things You need to Know About STIs	Journeyworks Publishing
21	Leavenworth	HIV and AIDS: A Reality Check	Journeyworks Publishing
22	Platte	STD Testing	ETR Associates
23	Platte	HIV Prevention and protection	Channing Bete
24	Platte	Real Sex, Real risk: Oral Sex, HIV & Other STDs	Channing Bete
25	Platte	Keeping Sex Safer: HIV: Positive Choices	Channing Bete
26	Wyandotte	Safer Sex: Talking with your Partner	ETR Associates
27	Wyandotte	Women & Safer Sex	ETR Associates
28	Wyandotte	12 Reasons Get Tested for HIV	ETR Associates
29	Lafayette	Protect yourself from HIV: For Women	Channing Bete
30	Lafayette	Knowing what's true - and false: HIV and AIDS	Channing Bete
31	Lafayette	Facts about HIV and AIDS	Channing Bete

Appendix B
Code Book

HIV Risk Behaviors

Sharing needles risk – sharing needles for any purpose, i.e. drugs, hormones, tattoos, piercing, can put you at risk for HIV

Drugs and alcohol – using drugs or alcohol while engaging in sex can put you at risk for STDs, less likely to use a condom, etc.

Multiple partners – risk associated with number of sexual partners

Unknown HIV status – mentions that people are sometimes unaware of their HIV status, which can put others at risk

Prior STI risk – “Having another STI increases risk of getting HIV”

Unprotected sex risk – having unprotected sex puts you at risk for HIV

IDU and sex – brochure mentions risk of having sex with someone who has injected drugs or shared needles for any purpose

Mother to child transmission

Fetal transmission – passing HIV to a fetus

Delivery transmission – passing HIV to a baby during delivery

Breastfeeding transmission – passing HIV to a baby while breastfeeding

Type of sex – brochure specifies that HIV can be transmitted via oral/anal/vaginal sex

Oral sex warning – brochure makes special mention of transmission via oral sex

Anal sex warning – brochure makes special mention of transmission via anal sex

Bodily fluids – brochure makes mention of transmission via bodily fluids, i.e. blood, semen, vaginal fluids, breast milk

Risk-free activities – activity that does not pose a risk of HIV transmission

HIV appearance – mentions that you can't tell if someone is HIV + by looking at them

Behavior – “It's what a person does – not who a person is – that increases his or her risk of getting HIV”

Social characteristics don't matter – gender, class, etc. won't protect you from HIV, anyone can get infected

Appendix C
 Spreadsheet: Images of Race/Ethnicity by Brochure Number

Race/Ethnicity	Brochure Number																															Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
African American	14	3	3	6		2	2	3				6			2	1	2	1	3		3		2	2	1	6	1	1	16	4	3	87
Male	7	1	2	4		1	1	2				2			2	1	1		1		2		1	1	1	3				2	1	36
female	7	1	1	2		1	1	1				4					1	1	2		1		1	1		3	1	1	16	2	2	50
Caucasian		3	8	5		3	4	4			2					3	1	1	1		1		1	2	1		1	2		2		45
Male		2	3	2		1	3	3			2					1					1			1				1		1		21
female			5	3		2	1	1								2	1	1	1				1	1	1			1	1		1	23
Hispanic			1	3					5			5											1		1			1		1		18
Male			1	1					1			1											1		1			1		1		8
female				2					4			4																				10
Asian		2	2	1				1							1	1							1	1						1	1	12
Male								1							1								1	1						1		5
female		2	2	1												1															1	7
Unknown	1	2	6	3		3	9	6	3	8	3		2		3	1	4	6	2		3		6	9	11				4	6	5	106

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VITA

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