MEDIA USE, HIV/AIDS KNOWLEDGE, AND SEXUAL BELIEFS:
AN EXPLORATION OF DIFFERENCES BETWEEN RACES

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DEDICATION

This thesis is dedicated to my wonderful loving parents Artee Fleming Hammond Jr., M.D., and Mary Linda Jackson-Hammond, M.D. I just want to thank both of you for all of your support and love throughout my thesis. To my mother I want to thank you for always dropping everything you are doing to speak with me. To my father I want to thank you for your words of wisdom, patience, and understanding. To my brothers I love you both. I also would like to express my love and gratitude to all of my family and friends for their unconditional love and support. I love all of you very much.
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ABSTRACT

As the numbers rise among African Americans who are contracting HIV/AIDS, it becomes evident that research is needed to examine where African Americans obtain HIV/AIDS information. This study identified where African Americans obtain HIV/AIDS information and examined how that information affects African Americans’ sexual beliefs about HIV/AIDS. The theoretical foundation for this study was the Health Belief Model (HBM). This study used a survey method. The data analysis demonstrated that race does influence the type of media an individual uses. Race does not impact an individual’s access to health information. Knowledge about HIV/AIDS impacts an individual’s sexual beliefs about HIV/AIDS. Cues from the media and physicians impact an individual’s sexual beliefs about HIV/AIDS. Perceived susceptibility impacts an individual’s sexual beliefs about HIV/AIDS. The frequency of any media does not always lead to knowledge about HIV/AIDS. African Americans are more likely to use television to obtain HIV/AIDS information than other races ($r = .161, p < 0.01$). In addition, African Americans are more likely to use radio to obtain HIV/AIDS information than other races ($r = .193, p < 0.01$). Thus, African Americans media use of radio and television increased their knowledge about HIV/AIDS.
CHAPTER 1

INTRODUCTION

Two ailments challenging the nation today that especially affect African Americans are HIV and AIDS (Braithwaite & Taylor, 2001). Centers for Disease Control and Prevention (CDC) argued, “that race and ethnicity are not, by themselves, risk factors for HIV infection. However, African Americans are more likely to face challenges associated with risk for HIV infection” (CDC, 2005, p.2).

Statistics show that African Americans are roughly 10 times more likely to be diagnosed with AIDS than European Americans (CDC, 1999; U.S. Department of Health and Human Services, 2004a, 2004c). According to the CDC (1999; U.S. Department of Health and Human Services, 2004b), roughly one in 50 African American men and one in 160 African American women are considered to be infected with HIV. Conversely, one in 250 European American men and one in 3,000 European American women are considered to be infected with the virus (CDC, 1999; U.S. Department of Health and Human Services, 2004c).

Presently, Baton Rouge, Louisiana is ranked second for having the highest number of new cases of AIDS in the nation (CDC, 2004). In addition, Baton Rouge is ranked seventh for having the highest number of new cases of HIV in the nation (CDC, 2004). According to the 2000 census, African Americans account for 40.1% of the population in Baton Rouge and 32.5% of the population in Louisiana (Louisiana Department of Health & Hospital’s Office of Public Health, 2004). Two-thirds of the people infected with HIV/AIDS in the state of Louisiana reside in the cities of Baton...
Rouge or New Orleans. Moreover, African American women residing in Baton Rouge account for the highest percentage of HIV/AIDS cases in Louisiana (Louisiana Department of Health & Hospital’s Office of Public Health, 2004).

Scholars like Steers, Elliott, Nemiro, Ditman and Oskamp (1996) argued that there are numerous socio-economic factors that explain why minorities such as African Americans and Latino Americans contract HIV/AIDS at a higher rate than their European American counterparts. First, demographic records show that minorities tend to live in impoverished communities (Steers et al., 2005). According to Scott, Gilliam, and Braxton (2005), individuals who live in impoverished areas tend to contract health ailments at a higher rate than those who do not live in impoverished areas. Statistics show that nearly 1 in 4 African Americans lives in an impoverished area (CDC, 2005). Diaz, Chu, and Buehler (1994) conducted a study that found a correlation between a high rate of AIDS and low income. As a result, African Americans and Latino Americans are more likely to face the risk of contracting HIV/AIDS (Scott et al., 2005; Steers et al., 1996). CDC (2005; Mullins, Blatt, Gbarayor, Yang & Baquet, 2005; Livingston, 2004) noted that the socio-economic problems coupled with poverty would possibly affect an individual’s access to high quality health care, HIV prevention education, and may increase his or her likelihood of contracting HIV/AIDS.

Second, minorities have unique health beliefs that ascribe to their ethnicity (Steers et al., 1996). For example, Hoffler (2005) claimed that African Americans are less likely to trust physicians due to cultural beliefs and fear of obtaining inaccurate health information. Studies show that African Americans tend to seek medical advice and/or
health information from their friends, family and religious leaders (Hoffler, 2005). Many scholars such as Prothrow-Stith (2003) and Hoffler (2005) argue that this may be a result of the historical mistreatment of African Americans dating back to slavery.

According to Prothrow-Stith (2003), enslaved African Americans were used as human guinea pigs for the advancement of medicine throughout the Antebellum Era. The mistreatment of African Americans continued into the 20th century with the Tuskegee Syphilis Study. Prothrow-Stith (2003) proposed that the Tuskegee Syphilis Study may have intensified African Americans’ distrust toward medical care and physicians (Prothrow-Stith, 2003).

Lastly, minorities such as African Americans and Latino Americans tend to have inaccurate information about the seriousness of HIV/AIDS (Steers et al., 1996). According to Hoffler (2005), inaccurate health information and medical advice about serious health ailments like HIV/AIDS may potentially lead to negative consequences for an individual. Thus, a minority may potentially be hindered if he or she possesses inaccurate information about HIV/AIDS. Studies show that many individuals misconstrue myth as being fact (Hoffler, 2005; Prothrow-Stith, 2003). Many health agencies like The New York Statewide School Health Services have tried to create ways to combat the misconceptions of HIV/AIDS. The following list of inaccurate information about HIV/AIDS was complied by the New York Statewide School Health Services Center (2006):

(1) HIV/AIDS is a gay disease.

(2) A person cannot get HIV if they use birth control methods.
(3) A person is not at risk for HIV/AIDS if they only have oral sex.

(4) A person would know if a friend or a loved one had HIV.

(5) Getting tested for HIV is pointless.

(6) HIV or AIDS can be cured.

(7) A person cannot have more than one sexually transmitted disease at a time.

Furthermore, inaccurate information on HIV/AIDS can negatively affect minorities and low income populations because minorities and/or low income population will not perceive themselves to be susceptible to contracting HIV/AIDS. Thus, minorities and low income populations will be less likely to seek HIV/AIDS information if they do not perceive themselves to be susceptible and/or perceive HIV/AIDS are seriousness health conditions. As a result, minorities and low income populations are more likely to contract HIV/AIDS because minorities do not perceive themselves as being susceptible to contracting HIV/AIDS (Lynch, 2004). Lynch (2004) argues that inaccurate information causes minorities and low income populations not to use condoms as much as other populations because their perception of HIV/AIDS is incorrect. According to Lynch (2004), inaccurate information can also affect the success of prevention initiatives like health campaigns. Therefore, it is important to examine where an individual obtains HIV/AIDS information and how his or her knowledge about HIV/AIDS affects his or her sexual beliefs about HIV/AIDS (Hawkins, Gustafson, Chewning, Bosworth, & Day, 1987).

Presently, there is a plethora of research, statistics, scholarly studies, and health
communication campaigns addressing various aspects of HIV/AIDS such as prevention, causes, intervention programs, and conspiracy theories on the origin of HIV/AIDS (Bakker, Buunk, Siero, & Van Den Eijnden, 1997; Burgoon, Berger, & Waldron, 2000; Chatterjee, 1999; Cole, 2005; Scott, Gilliam, & Braxton, 2005; Steers et al., 1996; Wheeler, 2003; Williams, 2003). However, there was only one study (Chatterjee, 1999) that identified where individuals receive HIV/AIDS information. Yet, Chatterjee’s (1999) study was limited because it only focused on Indian women. Furthermore, the past studies did not specifically address how HIV/AIDS information impacts an individual’s sexual beliefs about HIV/AIDS.

Purpose

The purpose of this study is to identify where African Americans obtain HIV/AIDS information. In addition, the researcher will investigate how HIV/AIDS information affects an individual’s sexual beliefs about HIV/AIDS.

Rationale

This study’s results may provide professionals with useful information on where African Americans obtain HIV/AIDS information. In addition, specific media will be identified as being frequent sources employed by African Americans for HIV/AIDS information.

The theoretical framework employed for this study is the Health Belief Model, HBM. The following chapter titled, “Review of Literature,” will provide a thorough explanation and a justification for using the HBM in this study.

Moreover, this study may add to academic scholarship in the fields of mass
communication, marketing, and public health. For instance, public relation practitioners, media consultants, and health professionals who create and work on prevention campaigns and programs for HIV/AIDS will be able to accurately identify the most suitable media for disseminating HIV/AIDS information. Last, this study will also add to the body of knowledge on the HBM, which will be beneficial for health professionals when implementing health campaigns and HIV/AIDS prevention programs.
CHAPTER 2
REVIEW OF LITERATURE

This literature review will center on the HBM. First, this chapter will discuss the conception of the HBM. Second, it will examine the five constructs of the HBM. Last, this chapter will discuss the sources of HIV/AIDS information.

Health Belief Model

During the early 1950s the U.S. Public Health Services primary focus was in prevention of health conditions (Rosenstock, 1974a). Thus, in an attempt to understand the widespread failure of individual acceptance of disease prevention and/or screening tests for early detection of asymptomatic diseases a theory had to be developed (Rosenstock, 1974a). In addition, this theory had to thoroughly explain why some preventive health actions were taken and others were not (Rosenstock, 1974a). As a result, Hochbaum, Leventhal, Kegeles, and Rosenstock created the HBM to in an attempt to understand why individuals did or did not engage in health prevention actions (Maiman & Becker, 1974).

According to Rosenstock (1974a) the HBM was designed to help an individual take action to avoid a medical condition. Yet, the individual must believe that he or she is susceptible to it and that the occurrence of the condition would have an impact on his or her life. In addition, the person has to believe that taking a particular action would be beneficial in reducing his or her susceptibility to the condition. “However, this is not inclusive of barriers such as cost, convenience, and embarrassment that must be overcome for desired action to occur” (Rosenstock, 1974a, p.329). According to Janz
and Becker (1984) the HBM predicts why an individual does or does not engage in
avoiding a health condition. Moreover, many studies have found the HBM to be accurate
in its predictions (Janz & Becker, 1984).

The Five Constructs of the HBM

The HBM consists of five constructs: perceived susceptibility, perceived severity,
perceived benefits, perceived barriers, and cues to action (Maiman & Becker, 1974;
Rosenstock, 1974a). Many scholars explain the HBM as an arithmetic equation where
one can calculate the level of perceived susceptibility, severity, and cues then subtract the
difference between barriers and benefits to predict the likelihood of a person doing the
positive health behavior (Janz & Becker, 1984; Rose, 1996; Rosenstock, 1974a; Turner,
Hunt, DiBrezzo, & Jones, 2004).

Perceived Susceptibility

Perceived susceptibility refers to the personal risks of contracting a condition.
Essentially, an individual must believe he or she is at risk of contracting a condition (Janz
& Becker, 1984; Maiman & Becker, 1974; McIntosh, Kubena, Jiang, Usery, & Karnei,
1996; Rosenstock, 1974 a, 1974 b). According to Rosenstock (1974a), individuals will
vary extensively in their acceptance of personal susceptibility to a health condition.
For instance, many oral diseases like “dental caries” can be prevented if an individual
believes he or she is susceptible to contracting the condition. According to the
Department of Cariology (2004) dental caries is a loss of calcium from the tooth surface
caused by bacteria. Hollister and Anema (2004) examined how perceived susceptibility
influenced prevention methods when combating an oral health condition called childhood
dental caries. The researchers found that parents and/or guardians are more likely to make use of preventive health care methods for their children if the parents perceive their children to be susceptible to dental caries (Hollister & Anema, 2004).

Susceptibility can be applied to an assortment of conditions. For example, condom usage has been proven to be a way to combat STDs, however an individual may not perceive him or herself to be susceptible to contracting an STD. STDs are a major public health concern in the United States. Data show that condoms are a primary prevention method combating the spread of STDs like HIV/AIDS (Zak-Place, 2004). Orr and Lagerfeld (1993) conducted a study that identified the predictors of condom use in a population of male adolescents at risk for contracting STDs. The researchers found that male adolescents who perceived themselves susceptible to contracting STDs were more likely to use condoms than those who did not perceive themselves to be susceptible to STDs (Orr & Langefeld, 1993).

Weinstock, Berman, and Cates (2004) estimated that 19 million new infections of STDs occur each year, and almost half are among young persons ages 15 to 24 (Zak-Place, 2004). Thus, many older adults (40 and older) in America perceive youth to be very susceptible to contracting HIV/AIDS (Rose, 1996). Rose (1996) examined how informative community outreach programs impact individual’s perception of susceptibility to a health condition like HIV/AIDS. Rose (1996) found that information about HIV/AIDS from community outreach programs impacted older adults’ perception of HIV/AIDS. Rose (1996) argued that older adults are more likely to perceive themselves to be susceptible to contracting HIV/AIDS after they receive HIV/AIDS
information from community outreach programs. As a result, before a desired action can take place an individual must perceive himself or herself to be susceptible to the health condition in which he or she is trying to avoid.

**Perceived Severity**

Perceived severity refers to how an individual identifies the seriousness of a health condition (Janz & Becker, 1984; Maiman & Becker, 1974; McIntosh et al., 1996; Rosenstock, 1974a, 1974b). For example, an individual may perceive a health condition in terms of how a particular condition will affect his or her life such as causing physical and/or mental disability and/or death. On the other hand, an individual may perceive a condition in terms of its medical importance. According to Rosenstock (1974a) individuals will perceive the severity of a health condition differently.

Perceived severity was proven to be an indicator of health beliefs and health behaviors (Orr & Lagerfeld, 1993). Orr and Lagerfeld (1993) identified the reasons for male adolescents’ condom usage. The data collected from the study showed that male adolescents used condoms to prevent contracting STDs (Orr & Langefeld, 1993). Furthermore, the study found that male adolescents who perceived STDs to be severe and deadly would increase their usage of condoms.

**Perceived Benefits**

Perceived benefits refer to the acceptance of an individual’s susceptibility to a health condition that is also perceived to be severe which will lead to an action (Rosenstock, 1974a). This action is believed to be influenced by an individual’s health beliefs regarding the effectiveness of the available alternatives in reducing the health
condition threat to which he or she feels subjected. The individual’s behavior depends on how beneficial he or she perceives the alternative to be. Rosenstock (1974a) claimed that there must be an alternative available that is possible for the individual to take.

For instance, an overweight individual who has a family history of diabetes may perceive dieting and losing weight as an alternative action for preventing diabetes. This alternative action is a benefit for the individual.

**Perceived Barriers**

Perceived barriers refer to an individual’s perception of the alternative action as an effectively way to reduce the threat of the health condition, yet the action must be convenient, inexpensive, pleasant, and painless (Rosenstock, 1974a). If these aspects are not upheld the alternative action is less likely to happen. Those aspects are potential barriers that may affect an individual from taking alternative action (Rosenstock, 1974a). For example a possible barrier challenging breast self examinations (BSE) for women who want to combat against breast cancer could be the possible fear of finding a lump. Norman and Brain (2005) attempted to combat against this precise barrier by applying perceived susceptibility, perceived severity, perceived benefits, and perceived barriers to the prediction of BSEs among women who had a family history of breast cancer. The researchers reported that perceived barriers were an effective construct when measuring an individual’s self-efficacy (Norman & Brian, 2005). Therefore, when perceived barriers are low, health behavior can change for the betterment of the individual (Norman & Brain, 2005).

However, other factors viewed as additional constructs to the HBM in order to
predict health beliefs. Many studies (Allard, 1989; Hollar & Sniek, 1996) have added factors such as self-esteem and knowledge about the health condition as new constructs to the HBM. According to Hollar and Sniek (1996), individuals who engaged in safer sex practices tend to perceive themselves to susceptible to contracting HIV/AIDS. In addition, those who practiced safe sex possessed a high level of self-esteem and knowledge about HIV/AIDS than those who did not practice safe sex. Likewise, individuals who had a low level of knowledge on HIV/AIDS were more likely to engage in risky forms of sexual behavior. Therefore, the relationship between knowledge, self-esteem, and perceived susceptibility are important to examine when promoting healthy behavior (Hollar & Sniek, 1996).

Cues to Action

Cues to action refer to a suitable action that is essential to take in order to avoid the health condition (Rosenstock, 1974a). According to Rosenstock (1974a), the combination of susceptibility and severity provides the power to act and the benefits provide for a path to the preferred action as long as the barriers are low. “Perceived susceptibility and severity have a strong cognitive component, yet both are dependent on cues to action” (Rosenstock, 1974a, p.331). In the field of health care cues can be internal or external. Internal cues are an individual’s personal perception of his or her health, while external cues come from medical advice, media, and interpersonal communication (family, friends, etc). Rosenstock (1974a) argued that the required intensity of a cue needed to prompt behavioral change will depend upon the individual’s beliefs (susceptibility and severity). For example, if an individual has a low level of perceived
susceptibility and severity towards a health condition he or she would need a high level of motivation to generate a reaction. Likewise, if an individual has a high level of perceived susceptibility and severity towards a health condition he or she would need a low level of motivation to generate a reaction (Rosenstock, 1974a).

Cues to action have proven to be useful in motivating individuals to take the preferred path of action in order to prevent a health condition (Chatterjee, 1999; Hahn, Simpson & Kidd, 1996; McIntosh et al., 1996). For instance, Hahn et al. (1996) utilized external cues to action to encourage parental involvement in a grammar school’s substance abuse program called, Alcohol, Tobacco, and Other drugs (ATOD) prevention program. Teachers motivated the students with incentives such as stickers or toy prizes for them to remind their parents to participate in school activities. Once the students were motivated then the students would tell their parents and/or guardians about the program. Hahn et al. (1996) noted that incentives work equally well for parents and teachers as it does for the students. Incentives are beneficial for motivating an individual to take the alternative path.

Likewise, McIntosh et al. (1996) reported that “cues to action” was an effective predictor of health behavior. The researchers (McIntosh et al., 1996) examined the impact of physicians’ advice along with other external cues on reducing fat and cholesterol in an individual’s diet. The researchers proposed that modifying a person’s beliefs on fat and cholesterol intake the following must happen: he or she must see the benefits in reducing his or her fat and cholesterol intake. For instance, a possible benefit to having a healthy life would be that an individual may live longer than an individual
who eats unhealthy food. However, an individual must be triggered by an external cue like medical advice in order to adapt the alternative action. McIntosh et al. (1996) reported that an individual is more likely to take the alternative action when the level of motivation (cues: physician’s advice) is high.

Last, Chatterjee (1999) also argued that an individual is more likely to take the preferred action when external cues from the media specifically television are high. Chatterjee (1999) investigated how women in India obtain information on AIDS. Health information on AIDS was disseminated through the use of the media and sex education programs in India (Chatterjee, 1999). Chatterjee (1999) like Rose (1996) both found that if an individual perceives himself or herself to be susceptible to contracting AIDS she will seek out health information on the subject. Once a woman possessed information on AIDS she would most likely discuss the matter in her social network (husband, friends, and family). However, these discussions on AIDS would only be addressed as a cultural problem and not as a personal matter (Chatterjee, 1999).

Sources for HIV/AIDS Information

Earlier HBM studies gloss over the significant role mass media play in society by disseminating health information to the masses. Therefore, it is important to understand how sexual beliefs are affected by the media (Plowden, 2000). The findings of this kind of inquiry would be useful for practitioners to develop an appropriate intervention.

Media

According to Black, Bryant, and Thompson (1997), media effects are consequences or impacts of an individual’s media use, society’s media use, and culture’s
Some studies (Guttman, 1997; Wilcox, Cameron, Ault, & Agee, 2003) have found that media affects public health issues in negative way. The word media refers to blogs, radio, television programs (entertainment and news programs), newspapers, magazines, Internet, and books. Black et al. (1997) argued that media bombard individuals with symbols and images of unhealthy behaviors and attitudes. These symbols and images could include advertisements for items such as cigarettes and alcohol consumption. Other symbols and images could include entertainment television programs that present irresponsible and/or unsafe practices in regard to sex, HIV/AIDS, drug use, and alcohol. Scholars like Black et al. (1997) argued that the media are irresponsible and careless because the media do not explain and/or educate the public on the images and attitudes that are being disseminated through the media. Consequently, the public becomes responsible for deciphering the positive and negative images and attitudes on various subjects like HIV/AIDS thus affecting an individual’s health beliefs.

According to Plowden (2000) other factors also affect an individual’s health beliefs such as education, economics, religion, family, and politics. Public relations practitioners can prevent potential barriers by developing appropriate interventions such as health campaigns and/or sex education programs. Interventions are potential sources where individuals can obtain correct information on HIV/AIDS.

**Health Campaign**

A health campaign provides information to motivate a change in attitude and/or action to promote the health of an individual (Hawkins et al., 2001; Karolevitz, 1983; Kurtz, 1980). Many health campaigns raise awareness about HIV/AIDS by using
brochures and PSAs to disseminate information to the masses (Hawkins et al., 1987). Informative materials like brochures and PSAs also provide facts, statistics, and contact information to an individual who seeks more information. For example, brochures on HIV/AIDS are used quite often in the medical profession because brochures provide vital and concise information for an individual who seeks information on HIV/AIDS (Rose, 1996).

**Research Questions and Hypotheses**

The reviewed literature provided the foundation for this thesis on the following key concepts: the HBM, applications of the HBM, and sources for HIV/AIDS information. Scandell and Wlazelek (2002) found that the HBM was ineffective as a predictor of health beliefs. Other studies found that the HBM was effective in predicting perceived susceptibility (Allard, Maticka-Tyndale, 1991; Orr & Lagerfeld, 1993; Rose, 1996; Steers et al., 1996; Wilson, Lavelle, Greenspan, & Wilson, 1990; Wilson, Manual, & Lavelle, 1991), perceived severity (Lin, Simoni, & Zemon, 2005; Lollis, Antoni, Johnson, Chitwood, & Griffin, 1995; Maiman & Becker, 1974; Malcolm, Ng, Rosen & Stone, 2003), perceived benefits (Malcolm et al., 2003; Rose, 1996; Stiles & Kaplan, 2004; Trobst, Wiggins, Coasta, Herbst, & McCrae, 2000), perceived barriers (Turner et al., 2004; Zak-Place & Stern, 2004), and cues to action (Hahn et al. 1996).

Many studies have found it beneficial to add more constructs to the HBM when predicting why individuals did or did not take preventive actions to avoid a health condition. These constructs would include variables like socio-demographics (Allard, 1989; Malcolm et al., 2003), AIDS Health Belief Scale (Scandell & Wlazelek, 2002),
perceived access to professional medical advice (Wilson et al., 1991), health knowledge (Hollar & Sniek, 1996), education programs (Malcolm et al., 2003; Rose, 1996), and cues to access for health protection (Wilson et al., 1991). The studies were supportive of adding more constructs to the HBM. By doing so the researchers could find out more in-depth information to why individuals did or did not take preventive actions to avoid a health condition.

Scandell and Wlazelek (2002) were to identify more risky sexual beliefs among college students in their study by adding the AIDS Health Belief Scale to the HBM. This information will be helpful when analyzing where African Americans obtain HIV/AIDS information.

However, the past literature did not address the focus of this study, which is to examine where African Americans obtain HIV/AIDS information. Steers et al. (1996) found that the HBM predicted sexual beliefs equally among the various races. However, Steers et al.’s (1996) study did not examine where the respondents obtained their sexual beliefs from, nor did the study examine the relationship between an individual’s knowledge about HIV/AIDS and his or her sexual beliefs. As a result the following research questions and hypotheses were developed.

R1. Does race play a role in differentiating media use patterns and health information access?

R2. Does race play a role in the type of media an individual uses to obtain HIV/AIDS information?

R3. Is HIV/AIDS information related to an individual’s sexual beliefs?

   Literature suggests that when perceived susceptibility and cues to actions are high
then an individual will seek to modify his or her health behaviors. Cues to action can predict an individual’s response to a subject depending upon how many messages that individual was exposed to the media (Janz & Becker, 1984). Therefore, the following hypotheses were formed.

H1. Cues to action are related to an individual’s sexual belief.

H2. Perceived susceptibility is related to an individual’s sexual belief.

H3. News consumption (frequency of an individual’s media use) leads to knowledge on HIV/AIDS.

H4. Media use (type of medium an individual uses) leads to knowledge on HIV/AIDS.

The popular media bombard people with symbols, images, and information. According to Black et al. (1997), a lot of the symbols and/or information may have a negative and/or positive impact on individuals who use the media. Many people seek information from the media on various subjects such as health, education, politics, etc. Media use may increase an individual’s understanding about a subject (Black et al., 1997).
CHAPTER 3
METHODS

This chapter indicates the research method employed by the researcher to test the research questions and hypotheses. The purpose of this study was to examine where African Americans obtain HIV/AIDS information. Given the selection of research questions and hypotheses used in this study, a research approach is required to solve the questions being posed. Thus, a research design is necessary to lay out the steps taken by the researcher while collecting and analyzing the data used for this study (Wimmer & Dominick, 2003).

Design

The research design for this study examines the relationships (dominant and weak relationships) among the variables (independent and dependent variables), the setting (environment) in which the survey was administered, and the instrument used for this study (Wimmer & Dominick, 2003).

Variables

According to Wimmer and Dominick (2003) a variable is an occurrence or an incident that can be measured. Variables can be tested to determine if relationships exist among them (Wimmer & Dominick, 2003). The variables used in this study were race, cues to action (a component of the HBM), sexual belief, knowledge, media use, health information access, HIV/AIDS information, perceived susceptibility, and news (see Table 1). The race variable examined the nationalities of the respondents. The variable of cues to action was inclusive of external triggers such as physician advice, PSAs,
prevention campaign commercials, news stories disseminated through the media. Sexual belief was inclusive of one’s ideas on sex, sexuality, condom usage, sexual activity, the HBM and HIV/AIDS. The variable of knowledge included items that measured an individual’s level of knowledge on HIV/AIDS. For instance, an item on the survey asked a respondent how HIV/AIDS is contracted. In addition, the media use variable incorporated items such as advertisement, prevention campaigns, PSAs, news stories, news articles, web sites, radio programs, and television programs that disseminate information about HIV/AIDS. Specifically, this variable examined the amount of time a respondent spent using a particular medium. The health information access variable measured the respondents’ access to information on health information and HIV/AIDS information. The HIV/AIDS information variable measured a respondent’s awareness of HIV/AIDS. The perceived susceptibility variable measured whether a respondent believed he or she was susceptible to contract HIV/AIDS. Last, the news variable measured a respondent’s consumption of news. Moreover, Wimmer and Dominick (2003) argued that variables can be categorized in terms of their relationship between one another. Variables can be categorized as independent and/or dependent variables. An independent variable is a variable that is systematically varied by the researcher whereas, a dependent variable is a variable that is observed and whose value is presumed to depend on the independent variable (Wimmer & Dominick, 2003).

The independent variables used in this study were race, HIV/AIDS information, cues to action, perceived susceptibility, news, and media use. Studies (Farris-Watkins, 2002; Walters, Walters, Kern-Foxworth & Hornig Priest, 1997; White, 1992; Williams,
2003) have found that an individual’s race affects the way he or she learns and/or recalls information. Thus, the researcher categorized the race variable as independent in order to measure whether a relationship exists between: race and media use; race and health information access; and race and HIV/AIDS information (see Tables 1). The researcher performed a correlation test to measure this variable.

First, the HIV/AIDS information variable was categorized as an independent variable. This variable measured whether a respondent was aware of HIV/AIDS. If a respondent was aware of HIV/AIDS a relationship would exist between an individual’s understanding of HIV/AIDS and his or her sexual belief (perceived susceptibility to contracting HIV/AIDS, perceived severity of HIV/AIDS, perceived barriers to preventing HIV/AIDS, perceived benefits practicing safe sex and/or abstinence, and cues from physician and/or media (see Table 1). A correlation test was performed in order to measure this variable.

Second, the “cues to action” variable was labeled as an independent variable. This variable measured if a relationship exists between cues to action and a respondent’s sexual belief (see Table 1). As mentioned earlier, cues to action only included external cues. Cues motivate individuals to take a preferred action to prevent a condition. However, this study only identified external cues. External cues included physician advice, brochures on HIV/AIDS, health campaigns, sex education programs on HIV/AIDS, and news stories in the media. News stories were generated from newspapers, radio, and/or television broadcast. A correlation test was performed in order to measure this variable.
Third, the perceived susceptibility variable was classified as independent variable. This variable measured if a relationship existed between perceived susceptibility and sexual belief (the HBM) [see Table 1]. A correlation test was performed in order to measure this variable.

Fourth, the news variable was identified as an independent variable. This variable measured if a relationship existed between a respondent’s news consumption and his or her level of knowledge on HIV/AIDS (see Table 1). A correlation test was performed in order to measure this variable.

Last, the media use variable was categorized as an independent variable. Typically health communication campaigns disseminate messages about issues like sex and HIV/AIDS through the use of media (Flora, 2001; Dervin & Frenette, 2001; Paisely, 2001; Synder, 2001; Valente, 2001). The media use variable was inclusive of interpersonal communications such as family and friends. The researcher included the following media to identify where African Americans obtained information on HIV/AIDS: television, radio, magazines, newspapers, radio, and Internet. This variable measured if a relationship existed between a respondent’s media use pattern and his or her knowledge on HIV/AIDS (see Table 1). A correlation test was performed in order to measure this variable.

Likewise, the following variables were categorized as dependent which were media use, health information access, HIV/AIDS information, sexual belief and knowledge.

Media use variable was classified as a dependent variable. This variable measured
if a relationship existed between the variables race and media use. In order to have a relationship exist between the two variables race must impact the type of media an individual chooses. A correlation test was performed in order to measure this variable.

Health information access variable was categorized as a dependent variable. The measurement of this variable was dependent upon an individual’s race. Thus, an individual’s access to health information may have been impacted by his or her race. A correlation test was performed in order to measure this variable.

HIV/AIDS variable was identified as a dependent variable. The measurement for this variable was dependent upon an individual’s race. Therefore, a respondent’s awareness of HIV/AIDS was dependent upon his or her race. A correlation test was performed in order to measure this variable.

Sexual belief variable was categorized as a dependent variable. Sexual beliefs included all ideas and/or thoughts on HIV/AIDS such as perceived susceptibility to contracting HIV/AIDS, perceived severity of HIV/AIDS, perceived barriers for preventing the spread of HIV/AIDS, perceived benefits for practicing safe sex, and cues to action from physicians and media about the dangers associated with risky sexual behavior such as HIV/AIDS. The measurement of this variable was dependent upon the impact of HIV/AIDS information variable, cues to action variable, and perceived susceptibility variable. A correlation test was performed in order to measure this variable. When the correlation test was performed for hypothesis 2, perceived susceptibility was only used as an independent variable.

The last variable labeled as a dependent variable was knowledge. The
measurement of this variable was dependent upon an individual’s news consumption and media use pattern. The level of an individual’s knowledge about HIV/AIDS varied based on news consumption and media use. The variable of knowledge included all questions that asked whether a fact and/or myth about HIV/AIDS were “true or false”. These questions asked a respondent if he or she understood how an individual could contract HIV/AIDS and/or prevent HIV/AIDS.

Table 1

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Dependent Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>Media Use</td>
</tr>
<tr>
<td></td>
<td>Health Information Access</td>
</tr>
<tr>
<td>Race</td>
<td>HIV/AIDS Information</td>
</tr>
<tr>
<td>HIV/AIDS Information</td>
<td>Sexual Belief</td>
</tr>
<tr>
<td>Cues to Action</td>
<td>Sexual Belief</td>
</tr>
<tr>
<td>Perceived Susceptibility</td>
<td>Sexual Belief</td>
</tr>
<tr>
<td>News</td>
<td>Knowledge</td>
</tr>
<tr>
<td>Media Use</td>
<td>Knowledge</td>
</tr>
</tbody>
</table>

Participants

In an attempt to determine the reach of HIV/AIDS knowledge among the participants specifically African Americans who reside in Baton Rouge, Louisiana, the
researcher chose to conduct a survey. Research (Hollar & Snizek, 1996) has shown that college-aged people are more likely to engage in risky sexual behavior therefore, college students are more likely to be susceptible to contracting HIV/AIDS (Hollar & Snizek, 1996). All participants for this study were students enrolled at Louisiana State University. The researcher recruited 747 students from The Manship School of Mass Communication at Louisiana State University.

A survey was developed from the relevant research on the HBM, safe-sex behaviors, and health issues surrounding African Americans (Allard, 1989; Maticka-Tyndale, 1991; Nemoto, Operario, Keatley, Han, & Soma, 2004; Oliva, Rienks, Udo, & Smith, 2005; Scandell & Wlazelek, 2002; Steers et al., 1996; Thorburn, Harvey, & Ryan, 2005). The questionnaire consisted of 78 items. The survey required approximately 15-30 minutes to complete. These items included demographic information, gender, sexuality; religious affiliation, sexual history, media usage, HIV/AIDS awareness and knowledge, STD testing, safe sex practices, condom usage, sexual partners, sexual behavior and sexual beliefs (see Appendix). This survey was voluntary. Respondents had the option to refuse to participate in the study and/or discontinue participation at any time during the survey without being penalized. All data and records collected during the study were placed in a secured locked cabinet. Only the researcher has access to the data and records. All data and records related to this study have been kept confidential. All respondents were anonymous.

The researcher telephoned and sent e-mails to all of the professors who taught courses in mass communication at the university. The e-mails explained the purpose of
this study and request their assistance by getting their students to participate in the study. Communicating via e-mail with several professors allowed the researcher to obtain access and permission to administer the survey to their classes. Allowing the researcher access to their classes ensured a larger response rate among the participants. Students were encouraged by their instructors in their classes to participate in the study. Students who participated in this study received extra credit points toward their final grade.

The survey was administered to students in three mass communication classes at Louisiana State University. These classes were MC 2000 section 1, MC 2000 section 2, and MC2020 section 2.

This study used a convenience sample. According to Wimmer and Dominick (2003) convenience samples are useful for a pilot study. This is suitable for the exploratory nature of this study (Wimmer & Dominick, 2003). The researcher employed the statistical software programs, SPSS and Excel to collect and analyze the data from the survey.

**Questionnaire**

The researcher employed questions derived from several published studies to develop the questionnaire used for this study (Allard, 1989; Maticka-Tyndale, 1991; Nemoto et al., 2004; Oliva et al., 2005; Scandell & Wlazelek, 2002; Steers et al., 1996; Thorburn et al., 2005). The design of the questionnaire derived mostly from Steers et al.’s study (1996), whose questionnaire consisted of one hundred and three questions. These items included questions and/or statements about an individual’s sexual history, religious affiliation, knowledge about HIV/AIDS, and demographics information such as race,
gender, age, and household income. Further items were derived from Allard (1989), Oliva et al. (2005), Nemoto et al. (2004), Thorburn et al. (2005), Scandell and Wlazelek (2002), and Maticka-Tyndale’s (1991) research. These items pertained to one’s sexual beliefs. Specifically, these items examined an individual’s perceived susceptibility, perceived severity, perceived benefits, perceived barriers and cues to action in regards to preventing a health ailment such as HIV/AIDS. For instance, some of the questions asked an individual about getting tested for STDs; while other questions asked an individual about his or her condom usage to protect and combat against STDs like HIV/AIDS (Allard, 1989; Maticka-Tyndale, 1991; Nemoto et al., 2004; Oliva et al., 2005; Scandell & Wlazelek, 2002; Thorburn et al., 2005). The remainder of the items asked a respondent about his or her media usage. These items were created and tested in a pilot study which was performed by the researcher (see Appendix).

The questionnaire utilized for this study was divided into 5 groupings of questions. The first grouping of questions assessed the respondent’s knowledge on HIV/AIDS. This grouping consisted of 18 items. Several questions asked the respondent if he or she understood how HIV/AIDS is contracted. Other questions asked the respondent if he or she knew what percent of new cases of HIV/AIDS accounted for African Americans and Latino Americans. Further questions asked the respondent how the city of Baton Rouge ranks in the state and nation (United States of America) among new cases of HIV/AIDS. A true/false type of question was used to measure each respondent’s knowledge level.

The second grouping of questions asked respondents about cues he or she
receives from the media and their personal physicians. This set of questions measured whether or not cues to action were present as far as if respondents’ sexual beliefs about HIV/AIDS were influenced by the media and/or their personal physician. This section consisted of 10 items. A yes/no type of question was used to measure their differences on this category.

The third grouping of questions asked a respondent about his or her personal media use. Specifically, these questions asked a respondent whether or not he or she receives information about HIV/AIDS from the media, and if so, what medium. The researcher specifically wanted to know where African Americans receive HIV/AIDS information, compared to respondents of different ethnic background. The researcher gave the respondents several types of media and interpersonal communications to choose from such as newspapers, television, magazines, radio, Internet, church, health care providers, friends and family. This set of questions also identified how often an individual used a particular medium as a news source like *The New York Times*. This grouping of questions was measured on a Likert scale. There were 30 items in this grouping.

The fourth grouping asked the respondent about his or her sexual beliefs pertaining to HIV/AIDS. This section solely measured the constructs of the HBM (perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action). There were 14 items in this grouping.

The last grouping posed 6 demographic questions to the respondent. The first question asked a respondent about his or her gender. The second question inquired about
the birth year of the respondent. The third question asked for the race of the respondent. The fourth question inquired about the frequency of respondent’s attendance to religious services. The fifth question asked the respondent about his or her religious affiliation. The last question asked the respondent about his or her household income.
CHAPTER 4

RESULTS

The previous chapter explained the method employed by this research and presented some of the questions that were used in the data collection for this study. This chapter introduces the actual results of the data analysis. This research employed quantitative research which involved collecting data from surveys and analyzing their responses with SPSS.

Response Rate

A total of 747 respondents were given a questionnaire to fill out. The response rate for the entire survey was 13.8% (103 respondents) completed all items in the questionnaire. The reason why the response rate for the entire questionnaire appeared to be low was because of the low response rate to a particular question in the demographic section of the questionnaire. That particular question asked respondents to identify their attendance at a religious service. Thus, the response rate for that one question affected the entire response rate for the study.

In reference to the previous chapter, “Methods” the questionnaire was divided into five sections. Section 1 titled, “Knowledge about HIV/AIDS” consisted of 18 “true and false” statements. Ninety-eight point nine percent (739 respondents) completed all items in this section. Section 2 titled, “Cues to Action” consisted of 10 “yes and no” statements. Ninety-eight point nine percent (739 respondents) completed all items in this section. Section 3 titled, “Media Use” consisted of 30 questions. Eighty-eight point eight percent (664 respondents) completed all items in this section. Section 4 titled, “titled,
“Sexual Beliefs” consisted of 14 statements. Ninety-four point twenty-nine percent (704 respondents) completed all items in this section. Section 5 titled, “Demographic” consisted of 5 questions. Thirteen point eight percent (103 respondents) completed all items in this section. Section 5 had the largest amount of missing data for the entire data collection. The missing data impacted this study’s entire response rate negatively because the response rate would have been in the eighties for the entire response of the survey. The researcher assumed the reason for students not completing the question on their attendance to religious services may have been related to a time constraint. Respondents may not have had enough time to finish that question. Or maybe the answer lies with the design of the survey. The questionnaire consisted of 10 pages yet, all of the demographic questions were placed on last two pages of the questionnaire. As a result, the researcher believed students were probably tried of answering the questions by that point.

Description of the Sample

The sample consisted of 747 college students who were enrolled in either MC 2000 or MC 2020 during the 2006-2007 academic school years. Seven hundred and sixteen respondents (95.9%) reported their gender in this study. Thirty-eight point three percent of the respondents were male (n = 286), 57.6% were female (n = 430) and 4.1% of the respondents (n = 31) did not identify their gender. The students’ mean age was 20 years. Eighty-eight point two percent (n = 659) were between the ages of 18 and 24, 0.9% (n = 7) between 25 and 29, 1.1% (n = 9) were between the ages of 30 and 63, and 0.4% (n = 3) were 17 years old. Six hundred and ninety-nine respondents (93.6%) identified their race in this study. The respondents were Latino American/ Latino (n = 27,
Many scholars like Plowden (2000) have argued that many factors influence an individual’s health beliefs such as education, income, family, politics, and religion. Therefore, the questionnaire used for this study asked respondents about their attendance to religious services and their religious affiliation. Thirteen point eight percent (n = 103) answered the question on their attendance to religious services; 3.9 % (n = 29) attend religious services regularly, 3.7 % (n = 28) attend religious services somewhat, 3.6 % (n = 27) attend religious services rarely, and 2.5 % (n = 19) do not attend religious services at all.

However, 747 respondents answered the question that asked about their religious affiliation. Forty-one point two percent (n = 308) of the respondents identified as Catholic (Roman Catholic), 36.8% (n = 236) were Protestants, 0.9 % (n = 7) were Jewish, 0.9 % (n = 7) were Mormon, 0.4 % (n = 3) were Muslim, 0.4 % (n = 3) were Hindu, 0.3 % (n = 2) were Buddhist, 0.1 % (n = 1) was Shamanist, 0.1 % (n = 1) was Pagan, 0.1 % (n = 1) was Nazarene, and 18.8% did not have any affiliation to a religion.

Seven hundred and thirteen respondents (95.4%) answered the question about marital status. Ninety-two point one percent (n = 688) identified as single, 1.2 % (n = 9) were Married, 0.3 % (n = 2) were Divorced, 0.3 % (n = 2) were widowed and 1.6 % (n = 12) marked other. Based on the data collected there was no correlation between religious attendance, religious affiliation and sexual beliefs on HIV/AIDS. Moreover, the questionnaire asked respondents about their families’ household income.
Six hundred and fifty-two respondents (87.3%) answered this question. Twenty-one point six percent (n = 161) of the respondents’ household income were greater than $120,000; 9.0% (n = 67) of the respondents’ household income were $100,000; 9.5% (n = 71) of the respondents’ household income were between $80,000 to $99,999; 10.7% (n = 80) of the respondents’ household income were between $60,000 to $79,999; 9.4% (n = 70) of the respondents’ household income were between $40,000 to $69,999; 7.0% (n = 52) of the respondents’ household income were between $20,000 to $39,999 and 20.2% (n = 151) of the respondents’ household income were between $0 to $19,999. A total of 95 respondents did not answer this question.

Knowledge

Seven hundred and fourteen respondents answered all of the items in this section. Respondents had knowledge of HIV/AIDS based on the questionnaire that was given to them which tested the amount of knowledge he or she had on the subject. This portion of the questionnaire measured an individual’s knowledge on HIV/AIDS. The researcher performed a crosstabulation test. This test examined the variables of race and respondents’ test score. The variable of the respondent’s test score was derived by adding all of the respondents’ answers up this section then dividing by the total number of items in this section which is 15. The results to the equation would yield the respondents score. The score was based on a grading scale 0 (grade of an “F”) to 100 (grade of “A”), 6.8% of the respondents scored 90-100 points (which would be an “A”), 41.9% of the respondents scored 80 to 89 points (which would be a “B”), 33.3% of the respondents scored between 70 to 79 points (which would be a “C”), 10.1% of the
respondents scored between 60 to 69 points (which would be a “D”), 3.4% of the respondents scored between 59 to 0 points (which would be an “F”). The mean score was 79.44% among the respondents.

The data analysis showed that minorities such as African Americans and Latino Americans scored higher than their European American counterparts on questions that tested respondents’ knowledge about HIV/AIDS (see Table 2). Moreover, African Americans scored the highest on those questions than the other races.

Results of Race, Media Use Patterns, and Access to Health Information

The first research question asked whether race plays a role in differentiating media use pattern and health information access. This study’s results showed that there was a correlation present between media use pattern and race. Specifically, African Americans are more likely to use television than other races \( (r = .96, p < 0.01) \). Moreover, African Americans are more likely to use radio than other races \( (r = .86, p < 0.05) \). Also, African Americans are more likely to use The Los Angeles Times than other races \( (r = .92, p < 0.05) \). However, African Americans are less likely to use the Internet than other races \( (r = -.106, p < 0.01) \). In addition, African Americans are less likely to use the following newspapers: The Advocate [Baton Rouge newspaper] \( (r = -.78, p < 0.05) \) and The Reveille [The Louisiana State University’s Student Newspaper] \( (r = -.116, p < 0.01) \) than other races.

Steers et al. (1996) argued that minorities such as African Americans and Latino Americans tend to live in impoverished communities. As a result, minorities are more likely to contract HIV/AIDS due to lack of access to high quality health care (Steers et
al., 1996). However, the data collected for this study found that the variable of race did not correlate with the variable of income. The study found that the various races (African Americans, Latino Americans, European Americans, Asian Americans, and Other) were roughly equal in household income. Specifically, African Americans had equal and/or similar average household income to their counterparts (European Americans, Latino Americans, Asian Americans, and Other). The average household income was $ 40,936.

Table 2

Scores on HIV/AIDS Knowledge Test by Race

<table>
<thead>
<tr>
<th>Test Score</th>
<th>Afr.Am.</th>
<th>Lat. Am.</th>
<th>A.Am</th>
<th>E.Am</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-60</td>
<td>3.8</td>
<td>0</td>
<td>0</td>
<td>3.5</td>
<td>11.1</td>
</tr>
<tr>
<td>60-80</td>
<td>28.3</td>
<td>56</td>
<td>42.2</td>
<td>46.9</td>
<td>33.3</td>
</tr>
<tr>
<td>80-100</td>
<td>68</td>
<td>44</td>
<td>57.9</td>
<td>49.5</td>
<td>55.5</td>
</tr>
</tbody>
</table>

The second part of the research question asked whether or not race affects an individual’s access to health information. The data analysis showed that race is less likely to impact an individual’s access to health information ($r = -.004, p < 0.05$). The researcher performed a correlation test. This test examined whether or not a relationship existed between race and income. Research (Braithwaite & Taylor, 2001; Adams) has shown that access to health information in minority communities is heavily determined by their household income. However, this study found that not to be the case. According
to the data analysis there was no relationship present between income and access to health information.

**Results of Race and HIV/AIDS Information**

The second research question asked respondents whether or not race makes a difference in where an individual obtains HIV/AIDS information. The data analysis demonstrated that race impacts where an individual obtains HIV/AIDS information. Specifically, African Americans are more likely to use television to get HIV/AIDS information than other races ($r = .161, p < 0.01$). In addition, African Americans are more likely to use radio to get HIV/AIDS information than other races ($r = .193, p < 0.01$). Lastly, African Americans are more likely to talk with family and friends about HIV/AIDS information than other races ($r = .137, p < 0.01$).

**Results of HIV/AIDS Information and Sexual Beliefs**

Previous research (Janz & Becker, 1984; Rose, 1966; Rosenstock, 1974a; Turner et al., 2004) noted that the HBM can be used as an arithmetic equation to analyze and predict an individual’s sexual beliefs and/or behavior. Thus, the third research question was created and asked if there was a relationship between HIV/AIDS information and an individual’s sexual beliefs. The researcher used the respondents’ knowledge scores from questions on HIV/AIDS information and the statements on sexual beliefs (perceived susceptibility, perceived severity, perceived barriers, perceived benefits, and cues to action) to investigate if there was a correlation. The results indicated that there was a correlation between HIV/AIDS information and an individual’s sexual beliefs about HIV/AIDS. Thus, an individual knowledge on HIV/AIDS impacted his or her sexual
beliefs about HIV/AIDS. Specifically, a respondent’s knowledge about HIV/AIDS correlated positively with perceived severity ($r = .122, p < 0.01$) and cues to action ($r = .125, p < 0.01$). Therefore, an individual who possessed knowledge on HIV/AIDS was more likely to perceive HIV/AIDS as a serious health condition that could affect his or her life if contracted. However, a respondent’s knowledge about HIV/AIDS correlated negatively with perceived barriers ($r = -.132, p < 0.01$). Consequently, an individual who possessed knowledge on HIV/AIDS was less likely to perceive that there were barriers hindering him or her from avoiding the contraction of HIV/AIDS.

Results of Cues to Action and Sexual Belief

Scholars like Chatterjee (1999), Hahn et al. (1996), and McIntosh et al. (1996) all reported that cues to action effectively motivate an individual to take the alternative action and/or belief. Thus, the first hypothesis was developed which states that cues to action are related to an individual’s sexual belief. Cues to action are related to an individual’s sexual beliefs (perceived susceptibility, perceived severity, perceived barriers, and perceived benefits). The results demonstrated that the construct, “cues to actions” of the HBM correlate with the other constructs of the HBM according to the Pearson correlation. Cues to action are less likely to influence an individual to take an alternative action to prevent a health condition if an individual does not perceive himself or herself susceptible to contracting the health condition ($r = -.096, p < 0.01$) and does not perceive the health condition as severe ($r = -.123, p < 0.01$). In addition, cues to action are less likely to motivate an individual to modify an action if perceived barriers are high ($r = -.095, p < 0.01$). There is a weak relationship between cues to action and
perceived benefits ($r = 0.022, p < 0.05$).

### Table 3

Cues to Action and Sexual Belief

<table>
<thead>
<tr>
<th></th>
<th>Susceptibility</th>
<th>Severity</th>
<th>Barriers</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cues to Action</td>
<td>-.096</td>
<td>-.123</td>
<td>-.095</td>
<td>.022</td>
</tr>
</tbody>
</table>

**Results of Perceived Susceptibility and Sexual Belief**

The second hypothesis stated that perceived susceptibility is related to an individual’s sexual belief. The data analysis shows the second hypothesis was supported (see Table 4). A respondent is more likely to perceive him or herself susceptible to contracting a health condition if he or she perceives the health condition severe ($r = .148, p < 0.01$). Furthermore, cues from the media and/or a physician on prevention of a health condition and/or information about a health condition are likely to impact an individual’s sexual beliefs by making the individual perceive that he or she is susceptible to that health condition ($r = .270, p < 0.01$). Once an individual perceives him or herself as being susceptible to a health condition taking the alternative action to prevent contracting the health condition must be perceived as beneficial ($r = .143, p < 0.01$).

**Results of News and Knowledge about HIV/AIDS**

The third hypothesis states that news consumption leads to knowledge on HIV/AIDS. The data collected showed that there was no significant correlation between the frequency of a type of media use and individual’s knowledge about HIV/AIDS.
Based on the data collected this hypothesis was not supported. However, the data analysis also demonstrated that the respondents who used the media to obtain news scored lower on the section of the questionnaire that tested their knowledge on HIV/AIDS than those who used the media but not specifically for news.

Table 4

Perceived Susceptibility and Sexual Belief

<table>
<thead>
<tr>
<th></th>
<th>Severity</th>
<th>Barriers</th>
<th>Benefits</th>
<th>Cues to Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susceptibility</td>
<td>.148**</td>
<td>.105**</td>
<td>.143**</td>
<td>.270**</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).

Results of Media Use and Knowledge about HIV/AIDS

The last hypothesis stated that media use leads to knowledge about HIV/AIDS. The researcher performed a correlation test between media use and knowledge (was derived from section in questionnaire that tested a respondent’s knowledge about HIV/AIDS which yielded a test score for each respondent) and found that a relationship exists between the two variables. The results showed that media use leads to knowledge on HIV/AIDS. Specifically, African Americans media use of radio and television lead to their knowledge on HIV/AIDS. Moreover, respondents who used telecommunication and personal communication networks with family and friends lead to knowledge about HIV/AIDS ($r = .098$, $p < 0.01$).

On the other hand, a correlation was present between the use of newspapers and
knowledge on HIV/AIDS. In particular, respondents who used newspapers such as *The Wall Street Journal* ($r = -0.080, p < 0.05$), *The Chicago Tribune* ($r = -0.147, p < 0.01$), *The Los Angeles Times* ($r = -0.075, p < 0.05$), and *The Southern Digest* ($r = -0.133, p < 0.01$) did not always lead to knowledge on HIV/AIDS. A negative correlation was found to exist between the above newspapers and knowledge on HIV/AIDS.

However, the data analysis showed that respondents use *The Reveille* lead to knowledge on HIV/AIDS ($r = 0.100, p < 0.01$). A positive correlation was found to exist between the use of *The Reveille* and knowledge on HIV/AIDS. Thus, this hypothesis was only partially supported by the results.
CHAPTER 5
DISCUSSION AND CONCLUSIONS

The previous chapter presented results on how race plays a role in differentiating media use patterns, HIV/AIDS information, and sexual beliefs. In this chapter, the researcher provides interpretation and discussion of findings and revisits the significance of this study.

The hypotheses and research questions posed in this study focused around the purpose of the study. This study aimed to identify exactly where African Americans obtain HIV/AIDS information from. Moreover, the researcher wanted to identify if an individual’s knowledge about HIV/AIDS information correlated with an individual’s sexual beliefs. In doing so, this study examined type of media which are frequently used by African Americans. This research adds to the general knowledge on the HBM by providing more data results that show that the HBM is a useful tool when motivating a change of action. Lastly, these findings provide a foundation for health, marketing, public relation practitioner, and government professionals on which type of media to use when disseminating HIV/AIDS information to African Americans.

Interpretation of Race, Media Use Patterns, and Access Health Information

This study found that race influences and/or impacts an individual’s media use. This finding is similar to the findings Walters et al. (1997) found in their study. Walters et al. (1997) examined how cultural factors such as ethnicity, gender, education, beliefs, values, and customs can influence one’s media use. Walters et al. (1997) also found that cultural factors such as race does impact an individual’s media use.
In addition, this study confirmed that African Americans obtain health information and news from television and radio. African Americans also are more likely to use *The Los Angeles Times* for news information than other races. Moreover, the data analysis also showed that African Americans are less likely to use the Internet, *The Advocate* and *The Reveille* to obtain news and health information than other races. The reason behind African Americans usage of *The Los Angeles Times* may be that they may be from that area and/or read specific sections out of *The Los Angeles Times*. This finding cannot be interpreted further due to the nature of this study (questionnaire). However, future research may examine in more details.

In addition, this study sampled college students which may imply that this finding reflected only a specific population within the African American race. On the other hand, this finding may also reflect the general population of college students because Black et al. (1998) also found that college students use television more often than any other media during an average day. On the other hand, one must take into consideration Black et al.’s (1998) research is nearly ten years old therefore, a lot has changed in regards to Internet usage among college students.

This study also found that race coupled with income does not impact an individual’s access to health and HIV/AIDS information. The data collected for this study found that the respondents were from financially similar backgrounds. This study refutes the claim that minorities tend to live in impoverished areas making them more susceptible to contracting HIV/AIDS (Steers et al., 1996) because the average income for
respondents who participated in this study was $40,936. This finding also reflects the average income in America. The U.S. Census Bureau found in 2004 that the average household income was $43,389. The nation’s newspapers such as the *USA Today* have classified the middle class to range from $25,000 to $99,999. Thus, the respondents in this study were from middle class families. Many studies (Adams, 1995; Braithwaite & Taylor, 2001) have found a correlation between race and health information access. Adams (1995) found that African American women do not have access health information to due their lack of funds. However, this study did not find a correlation between race and health information access. Specifically, African Americans came from equal financial backgrounds as their racial counterparts, thereby making them accessible to health information.

**Interpretation of Race and HIV/AIDS Information**

The results found that race does impact where an individual obtains HIV/AIDS information. These findings indicate that some races may have a better understanding about HIV/AIDS information than other races due to their media use. Specifically, this study found that African Americans are more likely to use television and radio to obtain HIV/AIDS information. Research (CDC, 2004; CDC, 1999) has found African Americans’ media use to negatively affect their knowledge about HIV/AIDS. Thus, studies like Steers et al. (1996) research have found that minorities specifically African Americans tend to have incorrect information about HIV/AIDS which negatively affect their perception of the severity of HIV/AIDS. However, this study refutes those claims that African Americans have incorrect information about HIV/AIDS because
African Americans scored the highest on the section in the questionnaire that measured respondents’ knowledge on HIV/AIDS.

These findings also suggest that African Americans are less likely to use the Internet, newspapers, and/or magazines to obtain HIV/AIDS information. In particular, those who use print media such as newspapers, magazines, and books to obtain HIV/AIDS information have been found to a higher level of knowledge and/or understanding on any given subject than those who use electronic media such as television and radio (Black et al., 1998). Research (Black et al., 1998) has found that print media the most credible source for information. However, this study found that radio and television are more credible sources for obtaining HIV/AIDS information.

Contrary to this study’s findings, scholars (Black et al., 1998) have found that television typically misrepresents and promotes health related behaviors and beliefs in an unrealistic way by not explaining to the public that these health related behaviors and beliefs shown on television may cause adverse affects for a person. For instance, if an individual watches a television program where the main characters always snacks on food and never gains weight he or she may believe that snacking on food does not lead weight gain. Black et al. (1998) mentioned that this type of misrepresentation is identified as a negative media effect. Many individuals are susceptible to the misconceptions depicted on television.

As a result, those who watch sexual acts on television tend not to make the connection between sexual activity and susceptibility to contracting STDs such as HIV/AIDS. This may provide insight into why African Americans are contracting
HIV/AIDS at a much higher rate than their European American counterparts (CDC, 1999) if their media use only involves television and radio. In addition, if this finding reflects those of the general population of African Americans then use of television and radio has negatively effected their population. Therefore, CDC’s (2005) argument that African Americans are more likely to face challenges associated with risk for HIV/AIDS infection has validity.

Interpretation of HIV/AIDS Information and Sexual Beliefs

This research found that a relationship exists between an individual’s knowledge about HIV/AIDS and his or her sexual beliefs. Specifically, those who scored high on this section perceived HIV/AIDS as a serious health ailment that may cause death if contracted. Stiles and Kaplan (2004) also found that individuals who possessed HIV/AIDS information understand the severity of the disease and virus which lead to discuss ideas about HIV/AIDS with friends and family. Likewise, Hollister and Anema (2004) found that the more information an individual obtained about a health condition the more it would impact his or her health beliefs. Macticka-Tyndale (1991) noted that HIV/AIDS information impacts an individual’s sexual beliefs. Mactika-Tyndale (1991) found that an individual’s knowledge of HIV/AIDS affects whether or not he or she perceives him or herself susceptible to contracting HIV/AIDS.

Moreover, this study found that those who scored high on that section also, received cues from their physicians (advice/information on safe sex and/or abstinence) and media (PSA and prevention campaigns for HIV/AIDS). Matick-Tyndale (1991) argued that an individual’s knowledge about HIV/AIDS has an impact on his or her
sexual beliefs about HIV/AIDS. However, just because an individual perceives him or herself to be susceptible to contracting HIV/AIDS does not mean he or she will modify his or her sexual beliefs about HIV/AIDS.

Furthermore, Rose (1996) discovered that HIV/AIDS information impacts an individual’s sexual beliefs. Specifically, Rose (1996) examined how adults perceived HIV/AIDS. Rose (1996) found that adults perceived HIV/AIDS to be a serious health condition. However, those adults did not perceive themselves to be susceptible to contracting HIV/AIDS because many of them perceived HIV/AIDS to be an issue for youth. Rose (1996) noted that when the adults obtained HIV/AIDS information their perception about HIV/AIDS changed. In particular, those adults perceived themselves to be susceptible to contracting HIV/AIDS. As a result, Rose (1996) concluded by stating that HIV/AIDS information does impact and/or influences an individual’s sexual beliefs.

**Interpretation of Cues to Action and Sexual Belief**

The findings revealed that cues to action are related to an individual’s sexual beliefs. The data analysis showed that cues to action have a negative correlation with sexual beliefs (perceived susceptibility, perceived severity, perceived barriers, and perceived benefits). Many scholars like Turner et al. (2004) explain the HBM as an arithmetic equation and these findings suggest that to be a logically way of explaining the HBM. Thus, the findings note that in order for cues to action to be effective in educating and advising individuals about a sexual belief other constructs of the HBM must be present. This study yielded similar findings to other studies like McIntosh et al. (1996).

McIntosh et al. (1996) found that in order to motivate an individual to change his
or her beliefs about fat and cholesterol intake the following constructs of the HBM must be present which were “cues to action” and perceived benefits. McIntosh et al. (1996) noted that cues from an individual’s physician increase individual’s health beliefs. Specifically, that individual will believe that modify his or her eating patterns will be more beneficial for his or her health. Chatterjee (1999) found that cues from the media that informed individuals about AIDS impacted individuals’ perception about AIDS. Chatterjee (1999) argued that once a woman received cues about AIDS from the media she would be more likely to perceive herself as being susceptible to AIDS. Therefore, she would seek more information in order for her to modify her behavior. Moreover, Hahn et al. (1996) found that “cues to action” was effective in motivating parents’ participation in a prevention activity. Hahn et al. (1996) discovered parents were more likely to participate in the prevention activity when cues were given to them by their children and their children’s teachers.

Interpretation of Perceived Susceptibility and Sexual Belief

This study found that relationship exists between perceived susceptibility and sexual beliefs about HIV/AIDS. Therefore, if an individual perceived himself or herself to be susceptible to a health condition than his or her beliefs about that health condition would reflect that. Researchers (Janz & Becker, 1984; Rosenstock, 1974a) have argued that an individual must perceive him or herself at risk to contracting a health aliment before a health belief and/or health behavior can change. Likewise, Maticka-Tyndale (1991) found that the HBM is dependent on an individual’s perception of susceptibility to a health condition which affects his or her sexual belief about that health condition.
The findings also suggest that in order for an individual to have knowledge about HIV/AIDS information he or she must perceive him or herself susceptible to contracting HIV/AIDS. Furthermore, the findings may indicate why African Americans scored the highest on the section that assessed respondents’ knowledge on HIV/AIDS.

**Interpretation of News and Knowledge about HIV/AIDS**

This study found that the consumption of news does not lead to an increase of knowledge on HIV/AIDS information. Thus, the frequency of a particular medium does not increase an individual’s knowledge about HIV/AIDS information. Similar, findings have been found by researchers like Black et al. (1998). Black et al. (1998) did not find a relationship between the frequency of media and an individual’s knowledge about a subject.

**Interpretation of Media Use and Knowledge about HIV/AIDS**

This research examined whether media use leads to knowledge on HIV/AIDS. This research found that media use does in fact lead to knowledge on HIV/AIDS. All respondents claimed to obtain HIV/AIDS information from media. Chatterjee (1999) also found that media use leads to knowledge about HIV/AIDS. Specifically, women who possessed a high level knowledge about HIV/AIDS were more likely to use the media as their source for HIV/AIDS information.

**Limitations**

This research was not without limitations. First, the sample size although it was a considerably large sample size, the number of African American respondents (n = 57) was low in comparison. Second, time constraints on respondents may have hindered the
outcome of this research. Many of the students did not have enough time to fill out the entire questionnaire. The researcher believed the students did not have enough time because the professor and/or instructor would start the lesson while students were trying to complete the survey. This action may have influenced students to turn in uncompleted surveys. As a result, the questionnaire was fully completed by only 103 students. Third, respondents may not have answered the questionnaire honestly because respondents may have thought their answers may be linked to them at a later time. The survey may have not been answered honestly in some parts of the survey that ask for racially driven. As a result, many respondents may have not answered honestly instead provided politically correct answers. Political correctness refers language or behavior that causes a minimum offense to various groups in society such as racial groups. Fourth, the researcher may have limited the study’s findings by choosing to perform only the following statistically test such as correlation, frequency, and cross tabulations. Fifth, the sample used for this study may limit the significance of the findings. Last, the sample of African Americans used for this study was relatively small. As a result, it may not reflect the entire race of African Americans.

**Discussion and Implications of Study**

This study is valuable to society because it offers useful findings that can be interpreted in many ways. First, let us examine the test scores on the section that measured an individual’s knowledge on HIV/AIDS. African Americans scored the highest which lead the researcher to believe that African Americans do in fact understand and are aware of the seriousness of HIV/AIDS. Second, African Americans use television
and radio as a source for obtaining HIV/AIDS information. Thus, the question becomes what are African Americans watching and/or listening to (PSAs, talk-shows, movies) in order to receive correct HIV/AIDS information? Or maybe the findings suggest that the information that is being placed on TV and radio is much more effective and thorough than what is being placed in books, magazines, and newspapers. Then again, the findings may suggest that the news directors at both the television and radio stations perceive that the HIV/AIDS epidemic is prevalent in the African American community in Baton Rouge, Louisiana. Thus, the news directors force reporters to disseminate more effective and concise information about HIV/AIDS to the public. On the other hand, the test scores may indicate the learning styles and/or recalling information for African Americans. Studies like Farris-Watkins (2002) and White (1992) found that African Americans are primarily auditory and tactile learners rather than visual learners like their European American counterparts. As a result, African Americans tend to recall PSAs in depth more than other races (Walters et al., 1997). Third, implication of this study is to understand the reasons behind African Americans use of radio and television. Specifically, why do African Americans use radio and television as their main sources for HIV/AIDS information? Lastly, African Americans’ tests scores may reflect their relationship with their physicians which would refute studies such as Hoffler (2005) and Prothrow-Stith (2003) which argue that African Americans do not have relationships with physicians.

Ramifications of Study

The findings from this can be used by health professionals and mass communication professionals like public relation practitioners. These professionals can
utilize this data from this study to effectively target African Americans for prevention campaigns for HIV/AIDS.

**Conclusion**

Race does influence an individual’s media use. As a result, race impacts where an individual obtains HIV/AIDS information. However, race does not impact an individual’s access to health information. Knowledge about HIV/AIDS influences and/or impacts an individual’s sexual beliefs about HIV/AIDS. Cues (to action) from the media and physicians impact an individual’s sexual beliefs about HIV/AIDS. Perceived susceptibility impacts an individual’s sexual beliefs about HIV/AIDS. The frequency of any media does not always lead to knowledge about HIV/AIDS. African Americans are more likely to use television and radio to obtain HIV/AIDS information than other races. Thus, African Americans media use of radio and television increased their knowledge about HIV/AIDS.

**Future Research**

Future research can examine many different areas based on the findings of this study. One area of study could be to identify the type of television and radio programming African Americans are watching and/or listening (using) to obtain HIV/AIDS information. A potential study of that nature can be beneficial to public relation practitioners when developing prevention campaigns for HIV/AIDS. For instance, let us say African Americans obtain HIV/AIDS information from their favorite radio station. A public relation practitioner can use that information to develop his or her prevention campaign for HIV/AIDS. An example of that could be that the public
relations practitioner could speak with a popular disc jockey and have him or her
disseminate prevention messages about HIV/AIDS to the African American community.
In addition, future research can examine how sexual beliefs about HIV/AIDS impact
African Americans’ sexual behavior (longitudinal study). While other future research can
examine how media use affects African Americans their sexual behaviors. Last, future
research can also examine whether or not the sample of African Americans used in this
study is reflective of all African Americans or are the findings from this study only
reflective of the African Americans who are middle-class and educated.
REFERENCES


APPENDIX

QUESTIONNAIRE

*Appendix*: Questionnaire about sexual beliefs and how it affects an individual’s sexual behaviors.
Questionnaire about HIV/AIDS information and how it affects different races’ sexual beliefs

This questionnaire asks your opinions, beliefs, and behaviors concerning Human Immunodeficiency Virus, HIV and Acquired Immune Deficiency Syndrome, AIDS. Your answers are completely anonymous and confidential. Your answers cannot be connected to you in any way. Your participation is greatly appreciated.

Primary Investigator: Tarana Hammond, Louisiana State University
**Instructions:** This is a survey conducted by a graduate student at Louisiana State University. This survey is strictly confidential and anonymous.

*Read the following and indicate your agreement with each item by coloring the appropriate bubble.*

**Knowledge about HIV/AIDS**

<table>
<thead>
<tr>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Americans account for 40% of the estimated AIDS cases diagnosed since the epidemic began.</td>
<td>① ②</td>
</tr>
<tr>
<td>Heterosexual contact is the source of almost 80% of HIV infections.</td>
<td>① ②</td>
</tr>
<tr>
<td>People who are exposed to HIV through needle sharing can transmit the virus to others during sexual intercourse.</td>
<td>① ②</td>
</tr>
<tr>
<td>African American and Latino American women together account for 83% of AIDS diagnoses.</td>
<td>① ②</td>
</tr>
<tr>
<td>Baton Rouge Ranks 2nd in the United States as the Metropolitan Area with the Highest Rate of AIDS Cases.</td>
<td>① ②</td>
</tr>
<tr>
<td>Baton Rouge Ranks 1st in the state of Louisiana with the Highest Rate of AIDS Cases.</td>
<td>① ②</td>
</tr>
<tr>
<td>Baton Rouge Ranks 7th in the United States as the Metropolitan Area with the Highest Rate of HIV Cases.</td>
<td>① ②</td>
</tr>
<tr>
<td>The number one mode of HIV transmission for females is Heterosexual activities.</td>
<td>① ②</td>
</tr>
<tr>
<td>Common ways HIV is spread by having unprotected anal, vaginal, or oral sex with someone who is infected with HIV.</td>
<td>① ②</td>
</tr>
<tr>
<td>HIV/AIDS is a gay disease.</td>
<td>① ②</td>
</tr>
<tr>
<td>A person cannot get HIV if he or she uses birth control methods.</td>
<td>① ②</td>
</tr>
<tr>
<td>A person is not at risk for HIV/AIDS if he or she only has oral sex.</td>
<td>① ②</td>
</tr>
<tr>
<td>A person would know if a friend or a loved one had HIV.</td>
<td>① ②</td>
</tr>
<tr>
<td>A person cannot have more than one sexually transmitted disease at a time.</td>
<td>① ②</td>
</tr>
<tr>
<td>HIV and AIDS can be cured.</td>
<td>① ②</td>
</tr>
</tbody>
</table>
## Knowledge about HIV/AIDS

<table>
<thead>
<tr>
<th>False</th>
<th>True</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms make intercourse completely safe.</td>
<td>1 2</td>
</tr>
<tr>
<td>A person can be exposed to HIV in one sexual contact.</td>
<td>1 2</td>
</tr>
<tr>
<td>Most people who have been exposed to HIV quickly show symptoms of serious illness.</td>
<td>1 2</td>
</tr>
</tbody>
</table>

## Cues to Action

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did your physician explain to you how you can contract HIV and AIDS?</td>
<td>1 2</td>
</tr>
<tr>
<td>Was the media the first to teach you about safe sex practices?</td>
<td>1 2</td>
</tr>
<tr>
<td>Did your physician explain to you that condoms can prevent the spread of HIV and AIDS?</td>
<td>1 2</td>
</tr>
<tr>
<td>Did your physician explain to you that HIV and AIDS are fatal diseases?</td>
<td>1 2</td>
</tr>
<tr>
<td>Have you ever seen an HIV/AIDS prevention commercial on television?</td>
<td>1 2</td>
</tr>
<tr>
<td>Have you ever heard an HIV/AIDS prevention commercial on radio?</td>
<td>1 2</td>
</tr>
<tr>
<td>Did your physician ever give you any pamphlets about HIV and AIDS?</td>
<td>1 2</td>
</tr>
<tr>
<td>Have you seen an advertisement in the newspaper about the prevention of HIV and AIDS?</td>
<td>1 2</td>
</tr>
<tr>
<td>Have you seen an advertisement in a magazine about the prevention of HIV and AIDS?</td>
<td>1 2</td>
</tr>
<tr>
<td>Have you received an e-mail message about the prevention of HIV and AIDS?</td>
<td>1 2</td>
</tr>
</tbody>
</table>
## Media Use

**How often do you get your health information from the following sources?**

<table>
<thead>
<tr>
<th>Source</th>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newspapers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Television</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Magazines</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Radio</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Internet</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Friends and family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Church</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Health Care Providers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**How often do you use the following news source?**

<table>
<thead>
<tr>
<th>Source</th>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>The New York Times</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>USA Today</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The Wall Street Journal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The Washington Post</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The Chicago Tribune</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The Los Angeles Times</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The Advocate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The Times Picayune</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The Reveille</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The Digest</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
If you chose other as your answer please specify the name of the newspaper you read in the space provided below?

In an average week, how often did you use the Internet to get news? (0-7 for number of days)

How often do you read magazines for news? (0-7 for number of days)

How often did you listen to the radio to get news? (0-7 for number of days)
How often do you get HIV/AIDS information from newspapers?

<table>
<thead>
<tr>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newspapers</td>
<td>①</td>
<td>②</td>
<td>③</td>
<td>④</td>
</tr>
</tbody>
</table>

Please write the name(s) of the newspaper(s) you read to get HIV/AIDS information.

_____________________________________________________________________________________

How often do you get HIV/AIDS information from television?

<table>
<thead>
<tr>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Television</td>
<td>①</td>
<td>②</td>
<td>③</td>
<td>④</td>
</tr>
</tbody>
</table>

Please write the name(s) of the television news station(s) you watch to get HIV/AIDS information.

_____________________________________________________________________________________

How often do you get HIV/AIDS information from magazines?

<table>
<thead>
<tr>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magazines</td>
<td>①</td>
<td>②</td>
<td>③</td>
<td>④</td>
</tr>
</tbody>
</table>

Please write the name(s) of the magazine(s) you read to get HIV/AIDS information.

_____________________________________________________________________________________

64
How often do you get HIV/AIDS information from radio?

<table>
<thead>
<tr>
<th></th>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please write the name(s) of the radio station(s) you listen to get HIV/AIDS information.

_____________________________________________________________________________________

How often do you get HIV/AIDS information from Internet?

<table>
<thead>
<tr>
<th></th>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internet</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please write the name(s) of the Internet site(s) you visit to get HIV/AIDS information.

_____________________________________________________________________________________

How often do you get HIV/AIDS information from friends and family?

<table>
<thead>
<tr>
<th></th>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends and family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please write the name(s) of your family and friend(s) you speak with to get HIV/AIDS information.

_____________________________________________________________________________________
How often do you get HIV/AIDS information from church?

<table>
<thead>
<tr>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church</td>
<td>①</td>
<td>②</td>
<td>③</td>
<td>④</td>
</tr>
</tbody>
</table>

Please write the name(s) of the church(s) you attend to get HIV/AIDS information.
____________________________________________________________________________________

How often do you get HIV/AIDS information from health care providers?

<table>
<thead>
<tr>
<th>All the Time</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Providers</td>
<td>①</td>
<td>②</td>
<td>③</td>
<td>④</td>
</tr>
</tbody>
</table>

Please write the name(s) of the Health Care Provider(s) you contact and/or see to get HIV/AIDS information.
____________________________________________________________________________________
### Sexual Beliefs (Perceived Susceptibility, Severity, Barriers, Benefits and Cues to Action in regards to HIV/AIDS)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am susceptible to HIV/AIDS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>HIV/AIDS are serious health conditions that cause death.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Practicing safe sex is a preferred action when avoiding health conditions like HIV/AIDS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Condoms are too expensive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I receive health information about HIV/AIDS from friends and family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I receive health information about HIV/AIDS from my doctor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I receive health information about HIV/AIDS from the media.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My feelings about myself would become much more negative if I got HIV.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I believe that AIDS will soon be curable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Taking safer sex precautions would require starting a new habit, which is difficult.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Using condoms interferes with the pleasure of intercourse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My chances of contracting HIV are low.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I worry a lot about contracting HIV.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Condoms protect me and my partner from contracting HIV/AIDS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Demographic

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

What is your gender? 1  2

What year were you born? ________
Race

If you have answered “Other,” please specify: ________________________________

What is your religious affiliation? _________________________________________

What is your marital status? ________
A. Single
B. Married
C. Divorced
D. Widowed
E. Other

How often do you attend religious services?

1. Regularly
2. Somewhat
3. Seldom
4. Not at all

What is your (or if you’re dependent on your parents, their) yearly income?

(1) $0 - $19,999_________  (4) $60,000 - $79,999_________
(2) $20,000 - $39,999_________  (5) $80,000 - $99,999_________
(3) $40,000 -$59,999__________  (6) $100,000 - $119,999__________
(7) >$120,000_________

Thank-you so much for taking your time to answer this survey! If you have any questions regarding HIV and/or AIDS, we encourage you to call the toll-free CDC Info at (800) CDC-INFO. The hotline is 24 hours a day. Or you can e-mail your questions to cdcinfo@cdc.gov. If you have any questions about this survey specifically, please contact the Primary Investigator, Tarana Hammond at thammo1@lsu.edu.
VITA

Tarana Hammond was born and raised in the Midwest Region of the United States of America. She attended college at her grandmother’s and great-grandmother’s almamater, Tougaloo College. She was involved in several school activities such as writing for the student newspaper, co-editor of the year book, and starting an organization that was geared toward business women. She was later accepted to an exchange program at one of the most prestigious Ivy League universities in this country, Brown University. She successfully completed a full academic semester at Brown University. Upon, her return to Tougaloo College she was given many opportunities to participate in some of the top internships in the metro area of Jackson, Mississippi such as Godwin Group, Junior Achievement, The Salvation Army and Flare Magazine. She accepted and successfully completed all of the internships. She successfully graduated Cum Laude from Tougaloo College with a Baccalaureate degree in Humanities and Journalism.

Drawing from her experience from the internships she participated in she decided to apply several Master’s Program in the area of mass communication. However, only one of the programs stood out above the rest which was the Manship School of Mass Communication at Louisiana State University. And, that is where she decided to attend where she excelled in course work and academic research. She has successfully completed her course work and thesis requirements for a Master’ Degree and is awaiting her fall commencement ceremony.