

**CONVERSATION ABOUT AIDS AND THE MEDIA ENVIRONMENT  
IN THAILAND: Mass Media Roles in Context Building and Content  
Providing for Interpersonal Discourse**

**Yoshimi Nishino**

A DISSERTATION

IN

COMMUNICATION

Presented to the Faculties of the University of Pennsylvania in Partial Fulfillment of the  
Requirements for the Degree of Doctor of Philosophy

1995

*Robert Hornik*

---

Robert Hornik, Ph.D.

Chair, Dissertation Committee

*Charles Wright*

---

Charles Wright, Ph.D.

Graduate Group Chairperson

*Annub/P/002/1995/N724*

**COPYRIGHT**

**Yoshimi Nishino**  
**1995**

**DEDICATION**

For Michael Schunck and  
My Parents, Masako & Takeshi Nishino

## ACKNOWLEDGMENTS

I am grateful to the Japan International Corporation Agency for providing me with an opportunity to participate in their AIDS prevention project and making it possible for me to gather and analyze this data. I am grateful for help given by all officers, administrators, researchers, and advisors who helped this research, especially, Prof. Muta, Mr. Konyama, Prof. Chanuantong, Mr. Makino, Mr. Utsumi, and Ms. Tomita. I was fortunate to have the wonderful cooperation of my Thai colleagues from the Royal Thai Ministry of Public Health. I also feel a deep appreciation for all the Thai health workers who made it possible to collect data in the field.

My completing this dissertation was only possible with help of my advisor, Prof. Robert Hornik, who taught me the way to do research, every step of the way. His guidance was always encouraging, accurate and thoughtful, coming from his deep intelligence. I respect him not just as a great scholar but as an educator with endless humanity. I thank my other two committee members, Prof. Charles Wright and Prof. Zhongdan Pan, who gave insightful suggestions to my dissertation. Their comments and suggestions are reflected in my dissertation.

My dissertation work was supported by my family, Masako, Takeshi, Seiichi, Ilse, and Rainer. My parents persevered in making possible my graduate education in the United States. Michael Schunck, who has been my classmate, colleague, editor, friend, and husband has contributed greatly to my dissertation. He has supported me through my dissertation full-time, emotionally and intellectually.

## ABSTRACT

### **CONVERSATION ABOUT AIDS AND THE MEDIA ENVIRONMENT IN THAILAND: Mass Media Roles in Context Building and Content Providing for Interpersonal Discourse**

**Yoshimi Nishino**

**Robert Hornik**

This research explores the relationship between AIDS messages in the mass media and interpersonal discourse on AIDS in Thailand. This research explores which aspects, with whom, in what context, and in what ways people discuss AIDS, specifically in relation to their exposure to AIDS messages publicized by the Thai mass media. This investigation seeks to provide an understanding of the relationship between AIDS messages in the mass media and people's interpersonal discussions.

In this research, two elements of mass media roles in stimulating AIDS talk constitute the central focus of research: *context building* and *content providing*. The term *context building* describes the process of influencing people's perception of the social appropriateness of some topic and the degree of public support for the expression of certain opinions on that subject. *Content providing* here is understood to mean the process of shaping the parameters of people's presentation of AIDS by initially providing shared meanings. This study considers media content building and content providing to jointly contribute to individual discourses on AIDS.

This research employs survey research methods based on qualitative focus group research and in-depth interviews. The target population is the potentially sexually active segment of the general population (aged between 15-29). Approximately 1800 subjects, married and unmarried males and females, were sampled in four districts of Kanchanaburi

province in Thailand. Respondents were asked about the subjects and extent of their conversations about AIDS, the choice of discussion partners and their attendant levels of discomfort with this topic.

The findings of this research supported both the context and content providing roles of mass media for interpersonal discourses. The most interesting finding is that there is a strong association between conversation topics and media reception for particular AIDS issues which the media had emphasized. The implications of these findings were discussed in terms of agenda-setting and the evolution of frames.

## TABLE OF CONTENTS

|   | <b>Page</b> |
|---|-------------|
| <b>List of Tables</b>   | <b>viii</b> |
| <b>List of Figures.</b>   | <b>x</b>    |
| <b>Chapter 1: Introduction: AIDS Conversations as a Research Topic</b>                          | <b>1</b>    |
| <b>Chapter 2 Theoretical Framework</b>  | <b>10</b>   |
| <b>Chapter 3 Hypotheses and Explanation</b>   | <b>28</b>   |
| <b>Chapter 4 Methodology</b>  | <b>40</b>   |
| <b>Chapter 5 Interpersonal Discourse</b>  | <b>60</b>   |
| <b>Chapter 6 AIDS Messages Received from the Mass Media</b>                                     | <b>75</b>   |
| <b>Chapter 7 Reception of AIDS Messages and Talk about AIDS</b>                                 | <b>87</b>   |
| <b>Chapter 8 Framing of Mass Media and Interpersonal Discourse</b>                              | <b>105</b>  |
| <b>Chapter 9 Social Appropriateness as Related to AIDS Talks and Reception of AIDS Messages</b> | <b>131</b>  |
| <b>Chapter 10 Conclusion: Summary of Findings and Discussion</b>                                | <b>150</b>  |
| <b>Appendix A Survey Questionnaire</b>  | <b>166</b>  |
| <b>Appendix B Correlation Table</b>   | <b>189</b>  |
| <b>Appendix C Table of Multiple-Regression Analysis For Talking Variety and Frequency</b>       | <b>190</b>  |
| <b>Bibliography</b>   | <b>194</b>  |

## List of Tables

| Number | Title   | Page  |
|--------|---|-------|
| 1      | <b>Questionnaire Setup for Talking Partners / Conversation Topics</b>   | 49    |
| 2      | <b>Answer Categories for Constructing Talking Variety</b>   | 51    |
| 3      | <b>List of Independent Variables and Questions Asked for Variable Construction</b>  | 57-59 |
| 4      | <b>Bivariate Correlations Among TV, Radio, and Newspapers</b>   | 82    |
| 5      | <b>Linearity between Multi-channel Reception of AIDS Messages and Talking Behaviors</b>   | 90    |
| 6      | <b>Prediction of Talking by Including Contextual Effect ( Multiple Regression Analysis)</b>   | 93    |
| 7      | <b>Proposed Alternative Models and Expected Results of Correlation Tests</b>  | 100   |
| 8      | <b>Test of Five Models of Relations among Talking about AIDS, Reception of AIDS Messages and Exposure to Mass Media</b>                   | 101   |
| 9      | <b>Correlations between Talking and Exposure and Reception after controlling for SES, Political Awareness, Marital Status and Gender</b>  | 103   |
| 10     | <b>Topical Categorization of AIDS Themes into Cause, Consequence, Prevention Issues</b>   | 106   |
| 11     | <b>Comparative Summary of Perceived and Intended Frames of AIDS as an Issue in the Mass Media</b>   | 122   |
| 12     | <b>Strength of Association in Terms of Gamma between Reception Level &amp; Discussion of AIDS Topic</b>                                   | 127   |
| 13     | <b>Correlations between the Level of Perceived Social Appropriateness and the Level of AIDS Message Reception at the Individual Level</b> | 133   |

|    |  |     |
|----|--|-----|
| 14 | <b>Predicting Perceived Social Appropriateness of Talking about AIDS, including Contextual Effects ( Multiple Regression)</b>                                  | 138 |
| 15 | <b>Correlations between the Level of Perceived Social Appropriateness and Talking at the Individual Level</b>  | 140 |
| 16 | <b>Correlations between the Level of Perceived Social Appropriateness and Talking after Controlling for Gender, Marital Status, &amp; Socioeconomic Status</b> | 143 |
| 17 | <b>Multiple Regression Predicting Talking about AIDS, including Contextual and Interaction Effects of Perceived Social Appropriateness Perception</b>          | 145 |
| 18 | <b>Correlations between Reception and Talking, Controlling for Social Appropriateness</b>  | 146 |
| 19 | <b>Final Regression Model</b>  | 156 |

## List of Figures

| Number | Title   | Page |
|--------|---|------|
| 1      | Summary of Hypotheses   | 38   |
| 2      | Diagram of the Research Strategy  | 44   |
| 3      | Conversation Partners for Talking about AIDS  | 63   |
| 4      | AIDS-related Topics Discussed   | 65   |
| 5      | Prevention Topics Talked about with Friends and Spouses                                       | 66   |
| 6      | Occasions of Talking about AIDS among Thais   | 69   |
| 7      | Reasons for Difficulty in Talking (Among Those Who Found Talking about AIDS Problematic)      | 71   |
| 8      | Reasons for Talking about AIDS with Anyone (Among Those Who Have No Trouble Talking)          | 73   |
| 9      | Reported Medium for AIDS Messages   | 77   |
| 10     | Frequency of Finding AIDS Messages in the Past Month in Each Medium                           | 78   |
| 11     | Reception of AIDS Messages from Radio   | 80   |
| 12     | Reception of AIDS Messages from TV  | 81   |
| 13     | Reception of AIDS Messages from Newspapers  | 82   |
| 14     | Reception Scale of All Channels   | 83   |
| 15     | Reported Types of Programs Containing AIDS Messages   | 85   |
| 16     | Talking Frequency and Level of Reception of AIDS Messages for TV, Radio, and Newspapers       | 88   |
| 17     | Variety of Talk and Level of Reception of AIDS Messages from Radio, Television and Newspapers | 89   |
| 18     | Reception of AIDS Messages and Talking Behavior at the Individual Level                       | 91   |
| 19     | Hypothetical Non-testable Models  | 96   |

|    |   |     |
|----|---|-----|
| 20 | <b>Combinatorial Possibilities of Exposure, Reception and Talking.</b>  | 96  |
| 21 | <b>Remaining Plausible Models of Causation</b>  | 97  |
| 22 | <b>Remaining Viable models (Exposure Precedes Reception)</b>  | 98  |
| 23 | <b>Basic Statistical Models Hypothesized</b>  | 99  |
| 24 | <b>Spurious-relations-model</b>   | 102 |
| 25 | <b>Categorization of Topics</b>   | 108 |
| 26 | <b>AIDS Topics Talked about</b>   | 123 |
| 27 | <b>Reported Topics Discussed and Recalled from the Mass Media</b>   | 125 |
| 28 | <b>Level of Emphasis of Identified Media Topics and Strength of Associations between Reception of AIDS Messages and Conversation Topics</b> | 128 |
| 29 | <b>Level of Reception and Perception of Social Appropriateness (SOCIAPT)</b>  | 134 |
| 30 | <b>Level of Reception and Potential Network for Talking about AIDS (SOCINET)</b>  | 135 |
| 31 | <b>Level of Perceived Social Appropriateness and Talking Behaviors</b>  | 141 |
| 32 | <b>Level of Perceived Social Appropriateness and Talking Behaviors</b>  | 142 |
| 33 | <b>Models for Reception, Social Appropriateness and Talking</b>   | 147 |
| 34 | <b>Alternative Models for Social Appropriateness Reception, and Talking</b>   | 153 |

## **Chapter One**

### **INTRODUCTION: AIDS CONVERSATIONS AS A RESEARCH TOPIC**

For most people, AIDS is not a merely medical issue, but a serious, emotional and sensitive conversational topic. Despite the magnitude of the threat posed by it, some aspects of AIDS may not be easy to talk about, because such talk sometimes includes discussions of sexual behaviors, making some people feel uncomfortable. AIDS is a recent epidemic, which means that it may still be rare for people to have personal, experiential contexts in which to share personal experiences and concerns about this epidemic.

This dissertation examines the nature of AIDS as a conversational topic in the hopes of providing data capable of suggesting new approaches to promoting AIDS prevention by a) providing a better understanding of existing discourses about the disease in the local population, and b) exploring the conjunction of those discourses with the speaker's reception of AIDS messages from the mass media. These concerns were applied in a field work situation in Thailand, where there is a concrete and specific need for AIDS-prevention efforts.

In Thailand, AIDS is serious problems. HIV has already spread widely throughout the commercial sex industry and among intravenous drug users (Cohen, 1988; Ford and Koetswang, 1991; Ryan, 1991; Storck and Brown, 1992). As of 1991, a working group of the Thai Ministry of Public Health (MOPH), other ministries, NGOs

and the World Health Organization estimated 200,000 to 400,000 cases of HIV infection in Thailand. The MOPH revised this figure to 350,000 to 500,000 in early 1993 (Thai MOPH, 1993) and to 600,000 in late 1994 (Rojanapithayakorn, 1994). Men in Thailand frequently patronize prostitutes (Ford and Koetswang, 1991) and not only men, but also most Thai women, accept such behavior as natural (Van Landingham et al., 1993). By extrapolating from 1990 figures, with the assumption that no significant behavioral changes would occur in the population, Thai health officials estimate that two to four million people in that country will be infected with HIV by the end of the century (Rojanapithayakorn, 1994). In order to slow the spread of a disease that is not currently curable, it is imperative that infection with HIV be prevented through efficient and effective communication intervention programs, in Thailand and elsewhere.

These AIDS intervention programs need to reach a wide range of populations in an effort to dissuade individuals from certain unsafe behaviors, since AIDS can only be prevented through behavior changes. Some researchers see mass media information projects for AIDS prevention as a promising method of outreach to large populations in Thailand (Pokapanichwong, Wright, Vanichseni & Choopanya, 1991; Shah Thongthai, Leoprapai, Mundigo, Prasartikul, & Chamrathirong, 1991; Storck and Brown, 1992).

While mass media and interpersonal communication have been discussed in terms of comparative channel studies of campaign effects on behavioral changes (for example, Chaffee, 1982; Freimuth et. al., 1989; Hornik, 1989; Rogers and Kincaid, 1981), linking the larger social context of media messages to individual discussions about AIDS has been somewhat neglected.

The relationships between mass media messages and interpersonal discussions about AIDS should be given greater attention. Providing AIDS with a personal context may promote behavioral change more effectively. These AIDS-related conversations may

be encouraged by messages from the mass media. By highlighting certain aspects of AIDS issues, mass media may affect the larger social context and encourage individuals to discuss AIDS. It is therefore worthwhile to examine the mechanism of mass media influence on individual talk about AIDS. Understanding the mechanisms linking interpersonal and mass media AIDS discourses may suggest more effective AIDS education strategies.

By analyzing research data from Thailand's Kanchanaburi province, this study examines which *aspects*, *with whom*, in *what ways*, and in *what context* people discuss AIDS, *in relation to* their receiving AIDS messages from the mass media in their everyday life. The investigation of mass media influence on talking focused on two elements: *context building* and *content providing*. Context building means the process of influencing people's perception about the social appropriateness of, or public support for expressing opinions on, or concerning AIDS. Content providing means the process of shaping people's construction of AIDS by giving them shared meanings to discuss. The content provided by the mass media includes information, symbols, and frames. Both of these mass media roles in stimulating interpersonal discourses are related to asking if, in what ways, why and in what context people talk about AIDS.

The content of mass media provides people with specific meanings of AIDS, which in turn influence people's ways of making sense of the disease. Talking may be considered one manifestation of the social meanings given to AIDS. People's ways of talking about AIDS may reflect the presentation of the disease in mass media messages. For example, people may talk about the cause, consequences, or prevention of AIDS in terms of tourism, public health concerns, and/or policy issues. This endeavor tested whether the frames employed by people in their discussions are similar to those found in the mass media -- and how the possibility of such parallels is related to people's exposure to mass media messages on this subject.

As Gamson (1992) notes, people don't solely rely on mass media resources, but rather integrate them with their experience and conventional knowledge in the process of negotiating meaning with others. It should be possible to find evidence of this conjunction of interpersonal and mass media discourses in the case of AIDS. In many societies, the increased attention given to AIDS seems to have altered people's ways of thinking about sexual behaviors (Nelkin, Willis & Parris, 1990). Because AIDS was introduced to Thai society relatively recently, compared to North America or Europe, I assume that the mass media contributed -- as experiential knowledge was scarce -- to constructing socially and culturally shared meanings of AIDS for talking.

I examined individuals' ways of talking about AIDS in terms of cause, prevention, and consequences of the disease. For prevention purposes, it is hoped that people talk about AIDS as a preventable disease and express the reality that everyone is at risk of AIDS at some level, unless preventive measures are taken by everyone. To examine the contingency of people's talking with the content of mass media, I will examine to what extent their talking parallels mass media presentations of AIDS. The details of the assessment of this relationship can be found in the methodology chapter.

The mass media's context *building* role is examined in terms of whether receiving media messages about AIDS is related to people's talking about AIDS, as evidenced in how often people talk (frequency) and how varied their conversations are. This inquiry into mass media context building roles for talking about AIDS will consider norms of talking (perceptions of social appropriateness), while simultaneously looking at other influences, for example his or her political awareness, and social factors such as gender, age, and socioeconomic status.

As part of this undertaking, I investigated how AIDS messages in the mass media may be related to individual perceptions of the *appropriateness* of discussing AIDS

prevention within their respective social environments. I assume that mass media messages about AIDS can create contexts in which people are made to feel more comfortable talking about the danger of AIDS, as well as the importance of AIDS prevention behaviors. Individuals might, as a result of their media reception, begin to negotiate the tension between previously taught social appropriateness and their re-assessment of the social appropriateness of discussing AIDS-related problems. As a result of shifts in perceived social norms, people may become more likely to express their concerns about AIDS to others.

The hypothesis that those individuals who have been exposed to AIDS educational campaigns may perceive that talking about AIDS prevention is more "publicly supported" than prior to mass media exposure and therefore become more comfortable carrying on discussions about this topic, is similar to Noelle-Neuman's (1984) idea that people talk more about their opinions when they perceive themselves to be in the majority. In this study, I conceptualize the mass media's context building role as a substitute for, and an added influence on, people's evaluation of the norms within their social environment.

I regard people's perceptions of social appropriateness or public support as a continuous process of evaluation and comparison, not only with others in their immediate social environments, but also through information from the mass media. Even though people may make assumptions about others, based on their observations of others' behaviors, these observations are not necessarily accurate or consistent over time. Part of this idea is expressed by Festinger's (1968) social comparison theory, which outlines a process of uncertainty reduction necessary for the evaluation of people's own abilities as well as issues of propriety: the process of people observing and comparing themselves with others. In a supplement to Festinger, however, I also consider messages from the

mass media as part of these 'others' in a person's social environment and thus as important for this comparison process.

When a comparison with others is not obvious or accessible, the evaluation of social mores may be more strongly influenced by messages from the mass media. For example, some college students may have difficulty talking about safe-sex practices because they assume that other students do not feel comfortable with such conversations. Yet, after seeing that other students are talking about safe-sex practices on TV, they themselves may feel more comfortable talking about safe-sex practices in public because of a reevaluation of the applicable social norm.

The above statement ought not imply that this study ignores interpersonal influences. I see mass media influences on personal discussion of AIDS as a way of conceptualizing the balance between interpersonal and direct mass media influences in an individuals' social environment. As I have argued elsewhere, "the concept of the social environment does not have to be physically limited. Rather it can be the context in which people create and communicate social reality (Nishino, 1991)." A perceived social environment is created through both, interpersonal networks, and exposure to messages in the mass media. In other words, interpersonal communication networks and direct mass media exposure should be considered as jointly contributing to an individuals' evaluation of *social appropriateness* of, and *public support* for, discussing AIDS topics.

The difficulty in testing the effect of reception on talk is that (direct) individual and contextual (social) influences are hard to separate. Even when a person is not exposed to mediated AIDS messages directly, mass media messages can affect people via their social environment. In this study, I suggest that mass media influence is examined, not only at the individual, but also at the social level. The level of reception of messages at the social level is measured as the average level of reception of a community/village,

subtracting individual level of reception of AIDS messages (for details of this operationalization, see Chapter 3).

Another variable, which I felt it necessary to consider, is a person's awareness of *political issues* generally. People with a high level of interest in political issues may attend to AIDS issues and therefore may talk about AIDS. Hence, I will be using a measure of political awareness (Zaller, 1992) as a control variable, along with the standard demographic variables, such as gender, socioeconomic status and so on.

For the purposes discussed above, I employed a survey method, the questionnaire for which was designed based on focus groups and in-depth interviews. Using data collected in Thailand, I have explored associations among the following factors: 1) what aspects of AIDS people actually discuss; 2) with whom people discuss AIDS; 3) in what ways people discuss AIDS in terms of cause, prevention, and risk; 4) in what context people discuss AIDS; 5) how much people are exposed to AIDS messages from the mass media; 6) in what ways mass media present AIDS prevention messages; and 7) to what extent people perceive it to be appropriate to express ideas about AIDS.

I had the opportunity to work for an AIDS prevention and control project in Thailand<sup>1</sup>. This dissertation is based on data from this project, for which I acted as a researcher for survey design, implementation, data analysis, and recommendations for educational programs.

Thailand was a good location for this study: It has substantial past experience with public health broadcasting (mass media programs for AIDS prevention have been

---

<sup>1</sup>The division of medical cooperation of JICA (Japan International Cooperation Agency) and the Ministry of Public Health of Thailand agreed to conduct a joint project promoting AIDS prevention in Thailand. The project was financed by both JICA and the Royal Thai Ministry of Public Health. This Information Educational Communication (IEC) AIDS education program is a part of the project. As a part of the IEC program, JICA conducted a survey to investigate individuals' knowledge of and attitudes toward AIDS and AIDS prevention behaviors as well as the use of mass media for AIDS information.

broadcast over radio and television for the past several years) and many people have been exposed to this medium's messages. Rapid urbanization of Thailand has weakened traditional social networks (Tatiwiranond and Pandey, 1991), allowing mass media to play an ever-increasing, important role in distributing knowledge, as well as constructing social environments. Yet, women talking about sex and safe-sex practices is still considered socially inappropriate behavior in many contexts of Thai society (Storek and Brown, 1992), heightening reliance on media messages for content as well as a context for talking.

This dissertation is divided into two parts: The first is a description of interpersonal discourses regarding AIDS and types of AIDS messages people received. The second part is concerned with the association between mass-mediated AIDS topics and interpersonal discourses about the disease.

Part One of this dissertation thus presents important background information, which lays the groundwork for the discussion in Part Two. Part One is exploratory, without emphasizing the testing of hypotheses. The importance of this section lies in the attempt to deepen our understanding of the nature of interpersonal communication on AIDS and the media environment surrounding AIDS. In Part Two, I tested various hypothesized relationships about the relation of interpersonal and mass media discourses on AIDS. I believe studying both discourse systems together may allow me to paint a realistic picture of the relationship between interpersonal discourse and the reception of mass media AIDS messages.

The following sequence of topics is kept: In chapter 2, I will discuss the theoretical framework of content providing and context building by integrating a number of theories such as Gans's frames and Festinger's social comparison theory. In Chapter 3, hypotheses and rationales are presented. Chapter 4 covers methodology, in

which the details of this research project and the construction of variables are explained. In Chapter 5, I present findings bearing on interpersonal communication on AIDS; Chapter 6 presents a summary of perceived and intended mass media AIDS messages. Chapter 7 first tests the basic hypothesized relationship between the level of reception of AIDS messages and AIDS talk. Chapter 8 tests the content-providing role of the media by elaborating on the frames used in interpersonal discourses and in the mass media. In Chapter 9, I test that hypothesis related to perceived social appropriateness and talking behavior/reception of AIDS messages. In Chapter 10, I discuss the overall findings and implications of this research and conclude. I also present the results of regression models which elaborate on the primary relationship between level of reception and interpersonal discourses by integrating other factors, such as social appropriateness and political awareness.

## Chapter Two

### THEORETICAL FRAMEWORK

An important question in attempting to study AIDS discourse is how we learn about AIDS, and how we share the concept of AIDS and related meanings with other individuals; more importantly even, how we come to understand and talk about the prevention of AIDS. Becoming able to successfully talk about AIDS prevention and changing sexual practices may require us to develop new concepts and vocabulary to communicate. The mass media may be able to play a role in providing elements of such shareable discourses as resources for conversation. Studying how mass media materials affect people's discussions about AIDS prevention and safe-sex practices will allow a better understanding of the conversational resources used to talk about AIDS. This in turn may make efforts to communicate about AIDS prevention more effective.

I assume the process by which the mass media influence interpersonal communication to be an on-going complex process intertwined with the dynamics of society. In light of this perspective, I argue that mass media encourage people to talk about AIDS by building context and providing content for communicative interactions among people. Individuals are assumed to be better able to talk about AIDS when provided with knowledge about, and an interpretation of AIDS, through the mass media. This function of mass media is seen as a necessary -- but not sufficient -- condition for people to talk about AIDS. For example, individuals may well be unable to freely discuss AIDS if they perceive that expressing their opinions on AIDS is not socially appropriate,

and that their opinion is not publicly supported. Mass media discourses may influence people's evaluation of the social appropriateness of, and public support for, speaking about AIDS prevention.

In the following section, I will initially discuss the relationship between mass media and interpersonal communication. In this context, I will first discuss the mass media role in content-providing, followed by a discussion of mass media context building processes. I will argue that social influence models help to explain why the mass media may encourage people to talk. People's assessment of the potential support that others in their social environment may offer for their talking about AIDS, will be conceptualized based on social comparison theory (Festinger 1968) and the pluralistic ignorance model (O' Gorman 1988 referring to Katz and Allport 1928). In the following review of the literature, I will suggest a possible integration of both of these perspectives (content providing and context building), in order to explain the role of mass media in encouraging individuals' AIDS talk.

### **1. The Relation between Interpersonal Communication and the Mass Media**

Mass media and interpersonal communication networks are usually discussed in one of two ways in the literature on communications campaigns: either as competing information and influence channels, or as having distinctly different roles in diffusion and persuasion processes (Chaffee, 1982; Freimuth, 1985; Rogers, 1971). Freimuth et. al. (1989), for example, claim that "there is considerable agreement that the primary function of mass media is to create awareness and reinforce existing behavior, whereas interpersonal sources can influence change (p.17)." While these investigations examine in a comparative manner the effects of interpersonal and mass media influences on behavioral changes in the audience, there is not much discussion concerning the possibility of mutual influences

between these channels. In addition, not much attention is paid to the distinction between interpersonal agents specifically provided for the aim of effecting particular behavioral changes and 'naturally' or pre-existing interpersonal networks.

Some more careful authors have noted the need for more precise distinctions when discussing information campaigns and the use of mass media and interpersonal channels and in doing so contributed to this theoretical discussion: Hornik (1989) for example challenges the notion that interpersonal channels are to be preferred for achieving behavioral change in any circumstance, clarifying that differences do exist between naturally (pre-) existing interpersonal networks and those deployed by outside interpersonal agents (for example health educators recruited) during communication campaigns for a strictly limited purpose. Additionally, Hornik notes that discussions on the efficacy of mass media versus interpersonal communications are futile, unless the specific situational constraints under which such an effort must be conducted are taken into account. Finally, Hornik (1989) suggests that interaction effects exist between mass media and interpersonal communication on behavioral changes. In other words, much of the comparative discussion between these channels is beside the point, drawing as it does on simplifications to justify dealing separately with one or the other type of channel. Instead, joint effects from both, interpersonal and mass media, and how they reach the individual ought be the subject of attention.

Chaffee (1982), correspondingly, argues that there is no clear-cut competitive relationship between mass media and interpersonal sources. He considers different channels as "convergent" or "complementary" from a receiver's view point (while granting that these channels may be seen as competitive from a sender's view point). Surely it is the recipient's view that matters, if one is interested in communicating for a specific purpose like health. Convergence between channels emerges, according to Chaffee, in cases where these channels provide the same or overlapping information. On the other

hand, a complementary relationship may be observed in cases where only one channel is available as an information source (Chaffee, 1982). In an earlier piece (1972), the same author had noted that "neither mass communication nor interpersonal processes can be adequately understood without reference to one another." (p.96). More recently he argued that:

Normally the mass media and the people in our daily settings serve complementary roles for most of us. We absorb a great deal of information from both kinds of channels. Only on a topic of unusual importance or concern are we likely to go out of our way either to seek information or to pass it on to others. (p. 71-72, Chaffee 1982)

In the same article, Chaffee claims that mass media do influence interpersonal communication, adding that "the more people talk with one another about information from the mass media, the greater is the total impact of the media on social action (p.73)." Chaffee (1982) sees the nature of relationship between interpersonal and mass communication as cyclical and reciprocal, denying the concept of a directional "two-step" or "multi-step" flows because "social communication consists of an on-going series of transactions between people and the channels that bring them information, not a finite competition among these channels (p.72 Chaffee, 1982)." Taking an analogous stance here, I suggest that it is both possible and fruitful to consider this interrelation.

The literature on channel effects mentioned above, however, referred to the planned use of media rather than to non-dedicated media content and its relation with naturally existing interpersonal networks. Rogers et. al. (1991) studied the impact of mass media coverage on public agendas on AIDS in the United States by testing the relationship between mass media coverage and public opinion about AIDS in national surveys. They found that mass media coverage did affect the public agenda setting, leading to 1) an increased awareness of AIDS compared to the beginning of the epidemic, 2) the public gaining accurate knowledge about the transmission of AIDS; 3) the perception of AIDS as an important health issue and, 4) support for governmental

expenditures on it, and 5) lifestyle changes like increased condom use. While these findings supported the notion that messages from the mass media influence an individual's perception of some public agenda, Roger's study did not directly investigate the influence of the mass media on interpersonal discourse.

## **2. The Social Construction of AIDS**

As with other new social phenomena, AIDS as a recently-emerged health problem needed to be provided with newly constructed, culturally shared meanings for people to appropriate it as social knowledge and become able to talk about it. The short history of AIDS is a good illustration of the process through which individuals construct the meaning of an illness, based on provided knowledge and beliefs; witness the use of historical metaphors like "the plague" for AIDS in the western world. An anthropological point of view helps to explain the creation of new forms of understanding health and illness through the introduction of new knowledge, which enables the definition, classification or framing of new diseases.

Nichter (1989), in his study of the South Kanara District in India, describes language usage as a reflection of health knowledge, perception, and practices in a culture or society. He argues that the ambiguity of health language, as well as problems in categorizing illness and health practices in a traditional culture, may cause difficulties in developing an effective prevention-oriented discourse of health and illness in that society. Nichter recognizes health education projects as stimulating "code switching between traditional and popular, modern illness categories" (Nichter 1989:118). Because AIDS is a recent problem in any society, much about the discussion of the disease is based on newly established language, knowledge, and perceptions. As a result of the growing fear of AIDS, the influence of social factors and social practices on the definition of disease is

receiving more emphasis (Brandt, 1988; Crimp, 1989; Reinerman et al, 1987; Rosenberg, 1986 and 1989; Treichler, 1988). Treichler, for instance, discusses the metaphor of AIDS in relation to social discourse rather than merely in relation to biological evidence. She writes:

Our social construction of AIDS is based not upon objective, scientifically determined "reality" but upon what we are told about this reality: that is, upon prior social constructions routinely produced within the discourses of biomedical science. There is a continuum, then, not a dichotomy, between popular and biomedical discourses and these play out in language. (1988: 35)

Given the ample evidence of the power of the mass media to shape the public agenda and popular conceptions of issue, the content of mass media may be expected to tell people what AIDS is -- but it is people themselves who make sense of this information, using the mass media as a resource. I will explore this resource role of the mass media in providing the content for individuals' conversations about AIDS next.

### **3. The Mass Media's Provision of Content about AIDS**

For a theoretical position linking the content-providing role of the media to people's reconstruction of issues in their everyday lives, this research is indebted to Van Dijk (1983, 1985, 1988) and Gamson (1989, 1992), both of whose work is concerned with how people make sense of the world and how this process is related to the way issues are presented in the mass media. While these two scholars have fundamental differences in their conceptualization of the relationships between mass media and public discourses, they agree in their emphasis on the social construction and reconstruction of knowledge in conversation as sense-making tools. Van Dijk (1988) concentrates more on the structuration and transmission of values in social construction, while Gamson's (1992) focus is on the way mass media messages provide (non-exclusive) resources for

conversations. While in Van Dijk's view, the mass media may present issues as readily organized meaning structures for their audience, the recipients are engaged in continuous processes of reinterpretation and reconstruction.

Van Dijk believes that the reproduction of concepts contained within dominant ideology takes place as a top-down flow made possible by the mass media:

We assume that the media play a central role in the reproduction of racism, both because of their relation to other elite institutions and because of their structural influence in shaping and influencing the social mind (1993:243)

He sought to demonstrate the use of mass media information in everyday conversation by researching how people use such sources to express opinions on the example of the construction of ethnicity. His results indicate that, in order to convince others and present themselves well, people do use evidence from mass media messages to support their point of view.

Gamson (1992) too discusses the role of mass media in framing political issues in his study of how people think and talk about politics. He argues that while mass media messages provide resources for conversation, people use their own experiences in addition to mass media information. In other words, Gamson sees a limit to mass media influence on people's ways of perceiving politics. Of the greatest importance to this discussion is his focus on people's reconstruction of political issues, which Gamson (1992) categorizes into three conversational types: media discourse-based, experiential knowledge, and popular wisdom. Through focus groups of working-class people talking about politics, Gamson found that;

For some issues, media discourse and popular wisdom are the primary resources, and they generally do not integrate experiential knowledge in the framing process. For other issues, they generally begin with experiential knowledge and popular wisdom. Sometimes they also bring in mass media discourse in support of the same frame, but sometimes they ignore this resource (Gamson, 1992:134).

Gamson provides insight into the relationship of discourse strategy to resource use through his focus groups, of which he distinguishes three types: cultural, personal, and integrated strategies: cultural strategies are primarily reliant on discursive resources from the mass media, rather than knowledge derived from the life experience of the individual; personal strategies rely on discursive resources derived from experiential rather than mass mediated knowledge; and integrated strategies use both cultural and personal strategies.

People using cultural strategies are, according to Gamson, the most likely to be influenced by mass media discourses, while their attitudes and beliefs are inherently unstable. People who use personal strategies in contrast, are least likely to be swayed by the content of mass media discourses. People who use integrated strategies are influenced by mass media only when the frames presented are prominent and / or when these frames are similar to their conception of popular wisdom and their experiential knowledge (Gamson, 1992). In sum, this work suggests that mass media are an important resource to help construct meaning in interpersonal conversation, despite individual differences in the use of mass media.

In order to better persuade people of the importance of AIDS prevention, it is necessary to know how people come to understand AIDS in the first place. Gamson calls this understanding a frame, defined as "a central organizing idea for making sense of relevant events and suggesting what is at issue (1989: 157)." Pan and Kosicki (1993) summarize framing in these words: "The basic idea is to view news text of organized signifying elements that both indicate the advocacy of certain ideas and provide devices to encourage certain kinds of audience processing of the texts" (1993:55-56). Mass media framing may influence people's ways of understanding issues and further influence their talking with others, especially in those cases when people rely heavily on mass media information. In the case of AIDS -- where information derived from experience is limited

-- I assume that its framing is to a large extent media-derived. It is important to bear in mind here that the framing of AIDS may influence how, and whether, people will act to prevent AIDS, based on their understanding of the risk posed by the disease.

Stallings (1990) conceived of an interrelated process of discourse about risk as a process that links personal conversation and media discourses, examining the public construction of a bridge collapse in New York. Stallings commented about the relation of media influences on individual risk discourse that, "whether rejected, accepted, or modified, comments by expert risk definers contained in news accounts serve as points of departure for personal conversations (p.81)." While he admits that mass media resources are not the only influential factor shaping public discourse, Stallings defines the inconsistent nature of risk as "not the outcome of media and public discourse, but as existing *in and through* processes of discourse (p.82, *ibid.*);" that is, he sees the nature of risk as socially constructed through both mass media and personal discourses as a contingent process.

In terms of public health objectives, it is important that the issues of AIDS risk are framed in relation to the need for AIDS prevention practices, such as condom use and monogamy. Vaughan and Seifert (1992) criticize the narrowly defined at-risk-group approach to AIDS prevention (focusing on homosexuals, in their case), claiming that this conception of AIDS fails to encourage preventive behaviors. Tyler and Cook (1984) also see problems with mass media programs that raise awareness about risk perceptions by relating risk to particular populations. To get people's attention and have them take action to lower their risk, the presentation of AIDS risk in mass media messages needs to be appropriately framed, without limiting such risk to narrow sub-populations and suggesting possible preventive behaviors as being relevant only to those groups.

In any discussion of the framing of AIDS, it is necessary to note the cultural and institutional influences on its construction. Brown et. al. (1989) discuss the cultural restrictions on the content of sexuality in communication campaign messages, noting that media messages reflect cultural (or dominant group) perceptions of the social appropriateness of talking about certain issues. Discourses about AIDS prevention and risk inherently address highly regulated social practices related to sexuality, which, in many cultures (for example contraception and homosexuality) are considered taboo (Adam, 1989; Green 1992).

#### **4. Mass Media's Context Building Role for Talking about AIDS**

AIDS may be difficult for people to talk about, since doing so often involves talk about sex and death. If a society considers talking about these topics to be socially inappropriate, people may hesitate to communicate freely on this topic as a function of feeling outside of a socially supported consensus. When people, for example, perceive that talking about the importance of monogamy or about condom use is not supported by the public at large, they may find it difficult to express themselves on the matter. The relationship of individual talk to social context should always be taken into account.

This section will examine the nature of "taboo" topics, followed by a discussion of the role of mass media in influencing people's evaluation of social appropriateness and public support for discussing AIDS as a topic of everyday conversation.

##### **4.1. Social Appropriateness of Talking about AIDS**

The potential taboo dimensions of AIDS-talk are worth explaining: Certain topics are considered taboo in specific social contexts. For couples, for example, Baxter and Wilmot (1985) found that topics like the state of their relationship or the existence of

extra-relationships (those relationships outside the couple's relationship) are considered to be taboo, because they are embarrassing and threatening to both partners. This study found that people undertake impression management so as not to give negative impressions to others -- something unlikely to encourage the free discussion of promiscuity in the face of AIDS.

Similarly, the level of embarrassment in talking about AIDS-related topics seems to depend on the particular topic being discussed. For example, Cline et. al. (1990; 1992) found that talking about safe-sex is different from talking more generally about AIDS. In that author's sample, only one-fifth of the respondents were identified as 'safe-sex talkers' (those who talk about AIDS prevention including condom use, sexual history and monogamy). In contrast, almost half of those sampled (42.9%) were found to be general talkers (i.e. those who talk about AIDS abstractly, without putting such talk in the context of their personal relationships). These researchers concluded that the major reason for not talking about safe-sex practices is "embarrassment" (Cline et. al., 1990; Cline et. al., 1992). However, that research situation is U.S. specific and cultural and gender differences are not considered. While the above arguments are related to taboos expressed between couples, that is within a close interpersonal relationship, issues of embarrassment related to taboo topics also need to be considered as a social product. Not only taboo, but also the emotions and reactions following any breach of taboo-related etiquette are socially constructed. Witness the very distinct conceptions other societies hold of concepts like embarrassment, shame or "face." More generally, Edelman defines embarrassment as

a short-lived but highly unpleasant form of social anxiety experienced by most people at one time or another. The experience may in fact be so unpleasant that individuals go to great lengths to avoid or withdraw from encounters or behaviors associated with it. (1982: 359)

Fear of embarrassment may discourage particular behaviors, which may be anticipated to cause embarrassment. Even in seemingly 'private,' interpersonal interactions, behaviors are shaped by the larger social context, which determines the appropriateness of behavior within given social expectations.

When examining the influence of mass media messages on people's perceptions of support for talking about AIDS within their social environments, it is important to consider the perceived social rules or prohibitions (taboos) that might apply to such talk. AIDS as a topic of conversation may not be considered acceptable to discuss in one social environment, but it may be 'all right' in another. Social appropriateness is one aspect of the social environment in which people make assumptions about what other people will find natural to talk about. This assumption might be influenced by the mass media. Below, I review some of the research on social influence on interpersonal communication, especially individuals' perceptions of social appropriateness.

The relationship between people's talking or not talking about certain topics in terms of mass media coverage of these topics was explored by Noelle-Neuman (1984). She found a micro-macro relationship connected to people's relative fear of isolation. People evaluate the amount of social support in their environment before choosing whether or not to speak about particular concerns. Individuals evaluate the amount of support in their social environment through mass media material. When people feel their opinions to be in the minority they keep silent, only speaking up when they see their opinions being either supported or gaining support (Noelle-Neuman, 1984). That perception of the social environment created by mass media is considered a key factor in understanding appropriateness perceptions.

This theory of a fear of isolation preventing people from asserting their opinions in public brings this discussion of AIDS discourses to the social level. Pan and McLeod (1991) note that:

Noelle-Neuman's spiral of silence theory is close to the theory of social dynamics, in that it specifies not only predictions but also theoretical mechanisms. Briefly, the theory says that individuals have a quasi-statistical ability to perceive the social opinion climate. (p. 156)

However, the spiral of silence theory does not fully consider the issue of social appropriateness of talk since Noelle-Neuman's research concerned mainly politics, a topic relatively free of taboo in Western Societies. Her theory looks at social conformity in terms of how gains in perceived support lead to the expression of opinions. Research on talking about AIDS issues has to look at the social prohibitions in speaking about the issue itself, rather than about the relative support given divergent positions concerning AIDS. More importantly, this theory is not explicit about how people assess their social environment through mass media exposure.

With this in mind, the important issue is how (through what processes) people assess their social environments and how mass media messages contribute to these re-assessments. To begin exploring this issue, I will first describe the concept of pluralistic ignorance that explains individuals' tendencies to misperceive their social environment, followed by a discussion of people's evaluation of their social environments, by connecting that argument to social comparison theory.

## **4.2. People's Perception of Their Social Environments**

### **4.2.1. Pluralistic Ignorance**

Allport's concept of pluralistic ignorance suggests that one's perception of a social environment may be inaccurate: individuals tend to have incorrect ideas about how other people in their social environment think. O'Gorman et. al. (1988) ask how in-group

members' values influence the cognitive beliefs of other in-group members. From this point of view O'Gorman et. al. consider pluralistic ignorance to be related to reference group theory. They explain that:

Pluralistic ignorance is a property of a social environment within which a number of individuals are differentially located. Although it refers to misinformed individuals, pluralistic ignorance is, technically speaking, a cultural property of a plurality of individuals in a social system. (p.150, *ibid.*)

O'Gorman's work defines pluralistic ignorance as distinct from reference groups:

In short, the study of reference groups always implies knowledge of others, and the study of pluralistic ignorance always implies the perceived existence of reference groups. From this joint point of view, pluralistic ignorance is a cultural manifestation of reference group processes in which members of groups and categories acquire, maintain, and transmit false cognitive beliefs about those who do and do not share their common membership. (p.151-152, *ibid.*)

The concept of pluralistic ignorance explains constraints to social change, because a person tends to believe that certain social norms are shared by others, even though he/she does not support these particular norms. For example, one person may think that it is important to talk publicly about AIDS prevention. Yet, this same person may not talk about AIDS in public because he/she believes that others would not support this behavior. However, it is possible that in reality, most people in this context do share the same concerns about talking publicly about AIDS. What the concept of pluralistic ignorance does not adequately explain are the processes through which these perceptions are manifested. Social comparison theory may well serve to fill this gap in explanation.

#### 4.2.2. Social Comparison Theory

Festinger's (1968) social comparison theory describes persons evaluating their opinions and abilities by comparing themselves with others. While this theory has been developed further by many researchers (Goethals, Messick and Allison, 1991; Wheeler,

1991; Wills and Suls, 1991), the major concepts remain: 1) social comparison processes occur when direct testing of opinions and abilities is not possible within an environment; 2) people compare themselves with groups who are not divergent from themselves; and 3) this comparison process may result in pressure toward uniformity.

Miller and McFarland (1991) discuss the relationship between the concept of pluralistic ignorance and social comparison theory by using an example of silence in the classroom. When students are asked if they have any questions, they often hesitate to raise their hands. A student does not want to be embarrassed because he/she perceives that other students understand the material. This social situation falls under the concept of pluralistic ignorance, "a state characterized by the belief that one's private thoughts, feelings, and behaviors are different from those of others, even though one's public behavior is identical (Miller and McFarland, 1991:287)." These authors then, argue that false interpretations of situations arise even under conditions of mutual observability, which might make social comparison information available. When information is conveyed wrongly, the result may be a distorted "reality," resulting in pluralistic ignorance.

#### **4.3. The Mass Media's Role in Re-evaluating Social Environments**

While the concept of pluralistic ignorance together with social comparison theory helps explain an individual's mis-perception of his/her social environment, neither explicitly analyzes the role of mass media in influencing a person's re-evaluation of his/her social environment. Noelle-Neuman's spiral of silence theory explains conditions under which people in the majority remain silent when minority opinions were publicly misrepresented, implying that the mass media can help to break this silence by representing the "real" opinions of the majority. As Katz (1983) pointed out, it is

possible that Noelle-Neuman's concept makes clear the role of mass media in substituting for the role of reference groups. He argues that "it is strongly implicit in the Noelle-Neuman papers that people decide whether or not to be silent on the basis of the distributions reported (often incorrectly) by mass media (p.97, *ibid.*)." As discussed before, both interpersonal networks and the mass media are potential channels through which individuals are provided with information that allow a better understanding of that individuals social environment. Chaffee noted that:

when we seek information it is often for corroboration or comparison with prior construction of reality, and we seek it through those channels that are most accessible to us and are likely to have something additional to say on the subject. (1982:72)

In conclusion, it appears that it may be possible to influence people's perceptions of social appropriateness in terms of talking about taboo topics by providing social support through the mass media.

#### **4.4. Influencing Perception on Social Appropriateness or Public Support**

Some researchers have examined the reduction of social taboos surrounding certain topics once people are exposed to messages about these previously "embarrassing" topics (Greenberg and Gantz, 1976 and Gantz and Greenberg 1990). These authors believe that taboo topics can be altered and gradually be made more socially acceptable with mass media intervention. As there are few studies that deal with AIDS and talking, I will briefly review them here and discuss the implications arising from their shortcoming to my dissertation.

Greenberg and Gantz (1975) studied the impact of mass media on reducing taboos in conversations about venereal disease (VD) in the Lansing, Michigan area. One of the hypotheses in their experiment was that exposure to taboo topics presented in the mass media might reduce the communicative taboos on VD-related issues. They used two

measures to determine the extent of communicative taboos about VD: one measure was whether respondents felt embarrassed if someone talked to them about VD. The majority of their respondents did not, and this variable was not shown to be related to exposure to mass media programming.

A second measure was based on questions asking whether respondents felt "OK" about talking about VD in a number of situations. These were, for example, between husbands and wives. Additionally, respondents were asked if they felt it was "OK" for newspapers, radio and TV to cover VD topics. They found that respondents who were exposed to TV programs dealing with VD felt more comfortable talking about VD compared to non-viewers of these programs. However, multiple regression analyses did not show a statistical relationship between reducing social taboo and exposure to those TV programs.

In a later study, these same authors (Gantz and Greenberg, 1990) again examined the role of television programs in reducing taboos, this time against talking about AIDS. After the broadcast of a documentary about AIDS in adolescents, they asked college and high school students in Michigan and Bloomington, Indiana, whether they felt able to talk about AIDS with people who are not their peers, i.e. friends, parents, teachers. No effect on talking was found after this one-time exposure.

There are a number of methodological and theoretical considerations worth noting about this research. First, as the authors themselves pointed out, a ceiling effect might have intervened; for most students, talking about AIDS did not really appear that difficult. Also, short-term quasi-experimental research designs may not be ideal for assessing the effects of mass media content on talk about socially taboo subjects -- especially looking at exposure effects from only one program. Finally, there is nothing to make the reader believe that the test message managed to distinguish itself in any way

from the background “noise” of other mass media discourses about AIDS. Had the content of their TV variable actually differed substantially from previous messages, it may have allowed the measurement of a change in interpersonal discourses, should it have occurred. Given the insufficient model these authors appear to have been operating on, this research does not warrant much in the way of conclusions about mass media influences on talking. Further studies employing a variety of social science methods need to be conducted to understand mass media roles in encouraging individuals' AIDS discourse.

I have attempted to sketch out the most crucial aspects of aspects of talking about AIDS in relation to mass media messages by focusing on context building and content providing roles of mass media. Analyzing the influence of mass media AIDS messages on talking involves complex tasks. Though little work has been done in this area, it is thought that more investigations of people's talking about AIDS as it is related to mass media AIDS messages will bring about deeper insights into the influence of those AIDS messages.

## **Chapter Three**

### **HYPOTHESES AND EXPLANATION**

As discussed in the introduction (Chapter One), this dissertation consists of two parts: a descriptive part and a hypothesis testing part. Chapters 5 and 6, on talking behaviors and mass media, are descriptive, while chapters 7-9 are dedicated to hypotheses testing. The following section in contrast, is to present my hypothetical assumptions about the relationships between mass media and talking. As described in the preceding two chapters, this investigation distinguishes between two mass media roles and thus two relationships: context building and content-provision.

The mass media's role in building context for talking will be tested in terms of whether media reception is related to increased talk about AIDS, as well as whether individual perceptions of the social appropriateness of discussing AIDS in their social environment can be affected by media messages to increase interpersonal communication on AIDS. Increased AIDS messages in the mass media may affect people's evaluation of the prevailing values in their social environment concerning discussions of AIDS. Changes in this 'social environment' perception can be conceptualized as influencing individual likelihood and amount of talk.

The assumption of a content-provision role of the mass media (mass media framing) upon individual discussions of AIDS are examined across three broad aspects of

AIDS conversations as well as in received media material: 1) cause; 2) consequence; and 3) prevention. Concretely, these theses are expressed in the following statements:

## I. CONTEXT BUILDING

**HYPOTHESIS 1:** THOSE WHO ARE INTENSIVELY EXPOSED TO AIDS MESSAGES IN THE MASS MEDIA DO MORE TALKING ABOUT AIDS IN TERMS OF BOTH QUANTITY AND VARIETY THAN THOSE PERSONS WHO ARE NOT.

In this first model, the dependent variable is the behavior associated with talking about AIDS, in terms of both frequency and topical variety of talk. The frequency of talk measure is concerned with how often people talk about AIDS with one other. Measuring the variety of talk is concerned with the number of AIDS topics discussed. The independent variable in this hypothesis is individual reception of AIDS messages. The operationalization of these variables, including the use of reception rather than simply exposure, is explained in detail in the method section (Chapter 4). The central hypothesized relationship is expressed as follows:

$$\text{Talking} = a + b_1 \text{Rec} \text{ ----- Hypo 1}$$

Talking: Individuals talking about AIDS  
 Rec: Individual reception of AIDS messages  
 (Control variables are not included)

---

**HYPOTHESIS 2:** THOSE WHO BELONG TO A VILLAGE OR COMMUNITY THAT IS MORE EXPOSED TO AIDS MESSAGES TALK MORE AND ABOUT A GREATER NUMBER OF AIDS TOPICS THAN THOSE WHO BELONG TO A VILLAGE/COMMUNITY THAT IS LESS EXPOSED TO AIDS MESSAGES.

This hypothesis presumes the existence of a social-level effect analogous to the individual relationship described in hypothesis one. Talking at the social level will also be tested in terms of variety and frequency.

This hypothesis, extending the notion of individual talk about AIDS as a result of the reception of mass media AIDS messages to the social level, will attempt to take into account the differential between individual conversations as a result of individual reception and the social-level effect. The effect of individual exposure may be oversimplified if measured only as in hypothesis one, because the theoretical perspective adopted here implies that any effect is reflected in contextual effects, rather than strictly within individuals. In fact, the very nature of talk as a communicative act must involve at least two persons. Therefore, even though some person may not have been directly exposed to AIDS messages, talk about AIDS involving this non-exposed individual may be initiated by another person who has been exposed. If this sort of situation were to occur, individual results may have to be demonstrated through (and as due to) group-level (social) effects. In addition, the membership of individuals in different groups may result in different relationships between individual reception and talking. Thus, it is desirable to estimate the group effect by distinguishing individual, group, and interaction effects. In order to test these effects, Iversen's contextual analysis framework is applied to this research.

Iversen (1991) suggested a contextual analysis model that considers the "relative effects" of contextual relationships, "based on the notion that we have data on two or

more variables for several groups, and we want to study these data for the presence of individual and group effects (p. 13)." The measurement of 'absolute' individual effect estimates the effect of individual value on the dependent variable without considering the relative weight of an individual value within a group effect. However, the relative individual effect is measured by the distance of an individual score from the mean of each group. The individual effect of reception upon talking may be expressed by the following equation:

$$\text{Talking} = a + b_1 (\text{Rec}_i - \text{Rec}_{gm})$$

(a = constant;  $\text{Rec}_i$  = individual reception score;  
 $\text{Rec}_{gm}$  = group mean of reception score)

The magnitude of the relative individual effect of reception on talking is represented by  $b_1$ , the coefficient of the value based on the relative distance between the individual's value and the mean of the group effect.

The group effect is measured in the 64 geographic clusters used in this survey as potential social units. The relative group is conceptualized here as the average reception of AIDS messages by respondents living in a community/village minus the overall population mean. In other words, group effects were expressed as the distance between the mean of the group and the mean of the population sampled. Thus, both the relative individual and the group effects on talking can be expressed as follows:

$$\text{Talking} = a + b_1 (\text{Rec}_i - \text{Rec}_{gm}) + b_2 (\text{Rec}_{gm} - \text{Rec}_{pm})$$

(a = constant;  $\text{Rec}_i$  = individual reception score;  
 $\text{Rec}_{gm}$  = group mean of reception score;  
 $\text{Rec}_{pm}$  = population mean of reception score)

The group effect is represented by the coefficient  $b_2$ .

It is also important to consider the interaction effect between relative individual and group effects. All three types of effects together are conceptually expressed in the following model:

$$\text{Talking} = a + b_1(\text{Rec}_i - \text{Rec}_{gm}) + b_2(\text{Rec}_{gm} - \text{Rec}_{pm}) + b_3(\text{Rec}_i - \text{Rec}_{gm})(\text{Rec}_{gm} - \text{Rec}_{pm}) \text{----- Hypo 2}$$

This equation expresses three different hypotheses. It is assumed that individual talking behavior is predicted by relative individual level of reception (coefficient b1), relative group level of reception (coefficient b2), and individual reception effects of those two factors (coefficient b3). The interaction effect on talking is intensified as a function of higher community level reception.

---

**HYPOTHESIS 3:** THE HIGHER THE LEVEL OF SOCIAL APPROPRIATENESS OF, OR PUBLIC SUPPORT FOR TALKING ABOUT AIDS IS PERCEIVED TO BE BY INDIVIDUALS, THE MORE THEY WILL TALK ABOUT AIDS IN TERMS OF AMOUNT OF TALK AND VARIETY OF TOPICS TALKED ABOUT.

While the first two hypotheses are concerned with the direct influence of the reception of AIDS messages on talking, this third hypothesis takes as its independent variable individual perceptions of the social appropriateness of, or public support for, talking about AIDS. This concept is expressed as follows:

$$\text{Talking} = a + b_1 \text{SociPi} \text{----- Hypo 3}$$

( a = constant; SociPi: Individual perception of social appropriateness and public support )

---

**HYPOTHESIS 4:** THOSE PEOPLE IN COMMUNITIES OR VILLAGES WHERE PEOPLE PERCEIVE THERE TO BE A HIGHER LEVEL OF SOCIAL APPROPRIATENESS OF, OR PUBLIC SUPPORT FOR, TALKING ABOUT AIDS WILL TALK ABOUT AIDS MORE, IN TERMS OF THE AMOUNT OF TALKING AND THE VARIETY OF TOPICS.

Hypothesis 4 considers the influence of social perceptions on talking at the social level of effect. In order to adequately deal with both individual and group effects upon talking, those relative effects (individual and group), as well as the interaction of both factors, had to be included in the analysis (as was discussed above). The principal dependent variable is talking. The following equation expresses three different hypotheses. It is assumed that individual talking behavior is predicted by relative individual level of reception (coefficient b1), relative group level of reception (coefficient b2), and interaction effects of those two factors (coefficient b3):

$$\text{Talking} = a + b_1(\text{SociP}_i - \text{SociP}_{gm}) + b_2(\text{SociP}_{gm} - \text{SociP}_{pm}) + b_3(\text{SociP}_i - \text{SociP}_{gm})(\text{SociP}_{gm} - \text{SociP}_{pm}) \text{----- Hypo 4}$$

(a = constant; SociP<sub>i</sub>=individual score of perception on social appropriateness of talk;  
SociP<sub>gm</sub>=group mean of score of perception on social appropriateness;  
SociP<sub>pm</sub>=population mean of scores of social appropriateness)

---

**HYPOTHESIS 5:** THOSE WHO ARE INTENSIVELY EXPOSED TO AIDS MESSAGES IN THE MASS MEDIA ARE LIKELY TO PERCEIVE IT TO BE MORE SOCIALLY APPROPRIATE OR PUBLICLY SUPPORTED TO TALK ABOUT AIDS THAN THOSE WITH LESSER EXPOSURE.

This next focus, the direction of the changes in perception on the social appropriateness of, or public support for, talk about AIDS in relation to the level of exposure to mass media AIDS messages is closely related to the notions expressed in hypotheses three and four. In the model proposed in this hypothesis, people change their perceptions of the social environment's norms or the potential level of support as a result of receiving messages from the mass media which would support such a perception shift. In the statistical expression of this model, the dependent variable is the level of perceived social appropriateness of talking. The main independent variable is individual reception of AIDS messages in the mass media. Control variables to be considered in this model will relate to enduring and temporary characteristics of the individual, such as levels of education, wealth, age, and awareness of public issues, that might affect the relationship proposed here. This hypothesis will be expressed as follows:

$$\text{SociP} = a + b_1 \text{Rec} \quad \text{----- Hypo 5}$$

(a = constant; SociP = Individual perceptions of the social appropriateness of talking about AIDS)

---

**HYPOTHESIS 6:** THOSE LIVING IN COMMUNITIES OR VILLAGES WHERE PEOPLE ARE INTENSIVELY EXPOSED TO AIDS MESSAGES IN THE MASS MEDIA ARE LIKELY TO PERCEIVE IT TO BE MORE SOCIALLY APPROPRIATE OR PUBLICLY SUPPORTED TO TALK ABOUT AIDS.

As with hypotheses 2 and 4, the following equation expresses three different hypotheses. It is assumed that individual talking behavior is predicted by relative individual perception of appropriateness (coefficient  $b_1$ ), relative group level of perceived

appropriateness (coefficient b2), and interaction effects of those two factors (coefficient b3):

$$\text{SociP} = a + b_1(\text{Rec}_i - \text{Rec}_{gm}) + b_2(\text{Rec}_{gm} - \text{Rec}_{pm}) + b_3(\text{Rec}_i - \text{Rec}_{gm})(\text{Rec}_{gm} - \text{Rec}_{pm}) \text{ ----- Hypo 6}$$

( a = constant, SociP=Individual perceptions of the social appropriateness of talking about AIDS, Rec<sub>i</sub>=individual reception score; Rec<sub>gm</sub>=group mean of reception score; Rec<sub>pm</sub>=population mean of reception score)

## II. CONTENT PROVIDING

**HYPOTHESIS 7:** PEOPLE WHO ARE MORE HEAVILY EXPOSED TO AIDS MESSAGES FROM THE MASS MEDIA ARE MORE LIKELY TO TALK ABOUT AIDS USING THE FRAMES THAT WERE PRESENTED IN THE MASS MEDIA.

This hypothesis is concerned with how people organize the meaning of AIDS in terms of cause, prevention, and consequences. There are some methodological concerns in constructing the independent variable, framing of talk about AIDS in the mass media. This independent variable takes into account the quality of AIDS messages which individuals have received in past years, rather than simply measuring quantitative reception of AIDS messages. In other words, this variable should reflect the kinds of content presented in media AIDS messages over time. However, it was not feasible to conduct a systematic content analysis of one year's worth of media content on AIDS for the purposes of this research. Given the limitations of time and monetary resources set for this research project, data gathering on a sufficiently large scale to identify and content analyze mass media AIDS frames was not an option. Moreover, there are no

retrospective archival records of television or radio content available. A contemporaneous study during the period of field work would not have been able to provide an adequate description of that earlier mass media content, which is assumed to have influenced current perception and talk. As an alternative, two methods that investigate *perceived* and *intended* frames of mediated AIDS messages were utilized here.

The first method surveys respondents about what they perceive to be the framing of AIDS messages in the mass media. The second strategy consisted of interviews with people who were involved in the production and planning of AIDS messages in the mass media. That group of persons include, for example, officials from the Ministry of Health, non-governmental organizations (NGOs), and television and radio producers. Both methods have advantages and disadvantages, as outlined below:

In using this *perceived frames of AIDS messages* variable, it is important to consider what these perceived frames really represent. While content analysis relies on skilled persons to code the content of messages based on systematically selected samples, perceived frame analysis relies on audiences to code the content of some communication, based on their experiences. Because perceived frame analysis depends on individuals' reports about AIDS messages, it is expected to have been filtered through the cognitive processes of those individuals. Such filtering may be sought in whether these people agree with the framing of a message or not; whether they were interested in the issue in the first place or most fundamentally whether they comprehended the issue. When received AIDS messages conflict with an individuals' cognition, that individual may not perceive nor recall having been exposed to such a message from the mass media. In addition, it may be difficult to identify consistent frames of AIDS messages from the mass media, if the reported frames vary across individuals to such an extent that they defy classification.

One way of increasing the likelihood of attaining constant frames (representing those frames of past media AIDS messages) is to use the report of perceived frames on a survey instrument and aggregating pre-defined choices. Respondents might be asked about their recall of perceived mass media AIDS frames in an open-ended manner, with a limited number of trained interviewers systematically coding their answers, recapturing a situation more analogous to a content analysis of text. Although there are likely to be some individual differences in perceiving and reporting mass media message frames, it will be possible to label a limited number of mediated AIDS frames representing the most common answers to these survey questions. The frames of media AIDS messages thus derived will be common to many respondents, thus reducing the effects of individual biases. The crucial difference of this method from content analysis is that here the object remains the study of perceived frames as they are recognized by the research population.

The second route chosen, the *intended frame* method, identifies creators and disseminators' intentions for the contents of AIDS messages they had produced. As Neuman et. al. (1992) point out, the public discourse carried out in the mass media need not necessarily reflect either the makers', nor the audience's concerns and subsequent discussions directly. Therefore, studying what makers of mass media material intended their framing of an issue to be may enable us to see what kinds of AIDS messages had been planned to help inform the Thai people about AIDS, regardless of how these messages were perceived by their targeted populations.

The result of inquiries using this interview method may depend, both on how the intentions of these informants were reflected in the actually produced AIDS messages, and on the selection of informants for this study. In addition, the result of the interview method may further depend on how articulate these informants were. However, an overwhelming advantage of this informant-interviewing method is that these people are experts on mass media AIDS messages. This expert knowledge should be reflected in

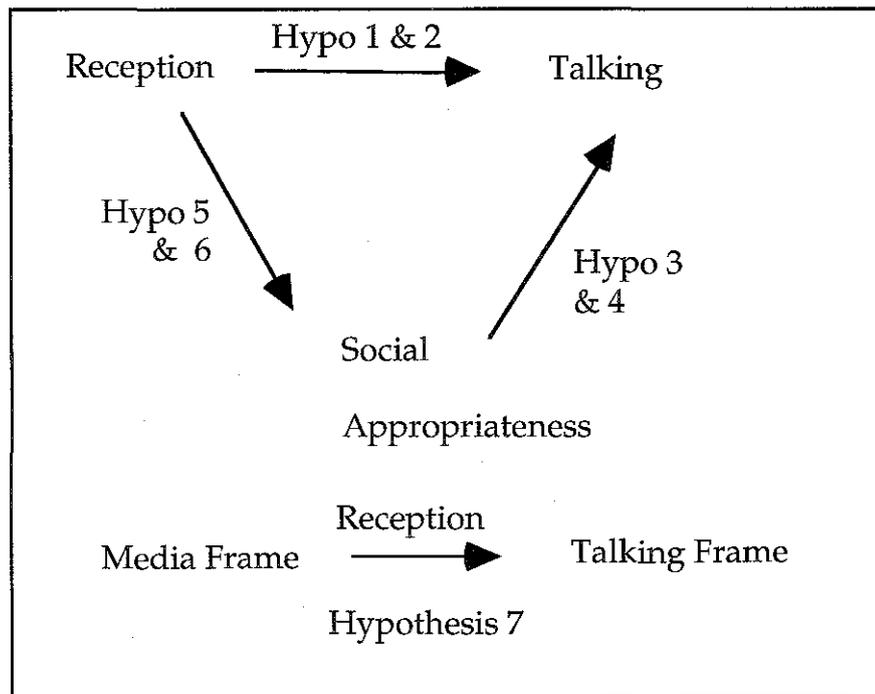
their answers, which might thus make up in quality for the shortcomings associated with inquiring into supposed intentions in terms of the contribution these answers may make to understanding audience responses. This researcher is aware of the substantial chance that audience perceptions may not match producer's intentions. I have made combined use of these two methods to get preliminary results, from which I was able to establish the fundamental frames of AIDS messages in mass media.

The hypothesis is expressed as follows:

$$\text{Talking AIDS} = a + b1\text{Rec} \quad \text{----- Hypo 7}$$

Talking AIDS: The degree to which frames of talking about topics related to cause, consequence, and prevention of AIDS match the presentation of these issues in mass media in terms of producer's intentions.

Figure 1: Summary of Hypotheses



In addition to the basic relationships between the level of reception of AIDS messages and talking outlined above, I have considered other factors, such as the individual level of political awareness, socioeconomic status, gender, marital status and age as influencing the above relationships. Zaller (1992) for example talks about “political awareness,” and refers to it as “the extent to which an individual pays attention to political issues and understands what he or she has encountered (p.21).” He found that people who have a high level of political awareness tend to receive more political information and understand it better than people who have low political awareness. In light of those findings, I decided to integrate people’s awareness of political issues into this analysis

In this chapter, I have explained the mechanism of the hypothesized roles of mass media in content providing and context building. While I have not discussed the background of the research population here, I will note that the population consists of different social groups (males, females, married and unmarried people) and that it may be important to look at communicative behaviors within these sub-groups as well as in the overall population, especially in view of the importance of social environment factors to this research.

## **Chapter Four**

### **METHODOLOGY**

The central instrument of this research effort is a survey, developed with the aid of focus groups and in-depth interviews with members of the population. In addition, interviews were conducted with expert professionals involved in Thai public information campaigns about AIDS through the mass media. The following section describes the steps taken during field work, the process of variable construction and the subsequent analytic procedures.

#### **1. SELECTION OF RESEARCH SITE AND DESCRIPTION:**

The choice of Kanchanaburi Province as the research site was made based on several considerations, namely the cooperation and competence of the local public health administration, accessibility of the site and suitability for the research agenda compared to other locations visited: the province is located well within a day's driving distance from the administrative headquarters of the project in Bangkok. The provincial public health administration was interested in cooperating with and participating in this project. Because of policy directives, as well as the obvious advantage of having the cooperation of local experts (for example in conducting interviews), the positive attitude of the provincial health officers was an important factor for this choice of site. This project was able to recruit interviewers who spoke the local dialect and were able to take the time for training sessions and the conduct of the survey through this office.

Most importantly, the province appeared to be reasonably representative of the AIDS situation in suburban and rural Thailand, outside the epicenter of the epidemic (urban centers with large sex industries like Bangkok, Chiang Mai or Pattaya). While many AIDS cases are being reported in the north of Thailand and several other research projects were at that time being conducted around that region, Kanchanaburi province had not received the same level of attention from researchers and was thus a more promising site “uncontaminated” by previous research efforts.

Kanchanaburi’s experience with AIDS seems to place it in the “mainstream” of Thailand’s provinces. While brothels exist in Kanchanaburi, they are small establishments, serving the local population. Thus this site was seen as suitable for testing the effects of previous AIDS messages from the mass media, since there was no reason to suspect that an unusually large part of the population had experiential knowledge of AIDS (again, compared to, for example, Chiang Mai with its high proportional number of infected persons). In other words, Kanchanaburi is much like other parts of Thailand in the sense that people may not yet have personally seen AIDS as a problem.

Kanchanaburi province is one of the 24 central-region provinces in Thailand, located 130 km west of Bangkok. The province shares a western border with the Union of Myanmar. The total population of Kanchanaburi is approximately six hundred forty thousand persons. Ninety percent of the over 6-year old population are literate, though the male literacy rate is slightly higher than female (92.6 and 87.8% respectively) according to the 2533 (1992) Report of the National Statistical Office, Office of the Prime Minister of Thailand.

## **2. THE IN-DEPTH INTERVIEWS**

The in-depth interviews were conducted in November of 1993. Twenty subjects were selected (stratified sampling) from the population chosen for the survey research in Kanchanaburi, including both females and males, married and unmarried people between the ages of 15 and 29 years. We visited several villages and communities to carry out interviews with those people who were selected by village health volunteers. Personnel from the Ministry of Public Health who had some experience in research, in addition to having participated in a one-day training workshop on in-depth interviewing, carried out these interviews. Each interview took between twenty and forty minutes. Subjects were asked about any interpersonal discussions they may have had about AIDS, their recall of AIDS messages in mass media, their way of thinking about AIDS, and their AIDS prevention behaviors. Due to a technical error, only 19 cases were transcribed and translated into English.

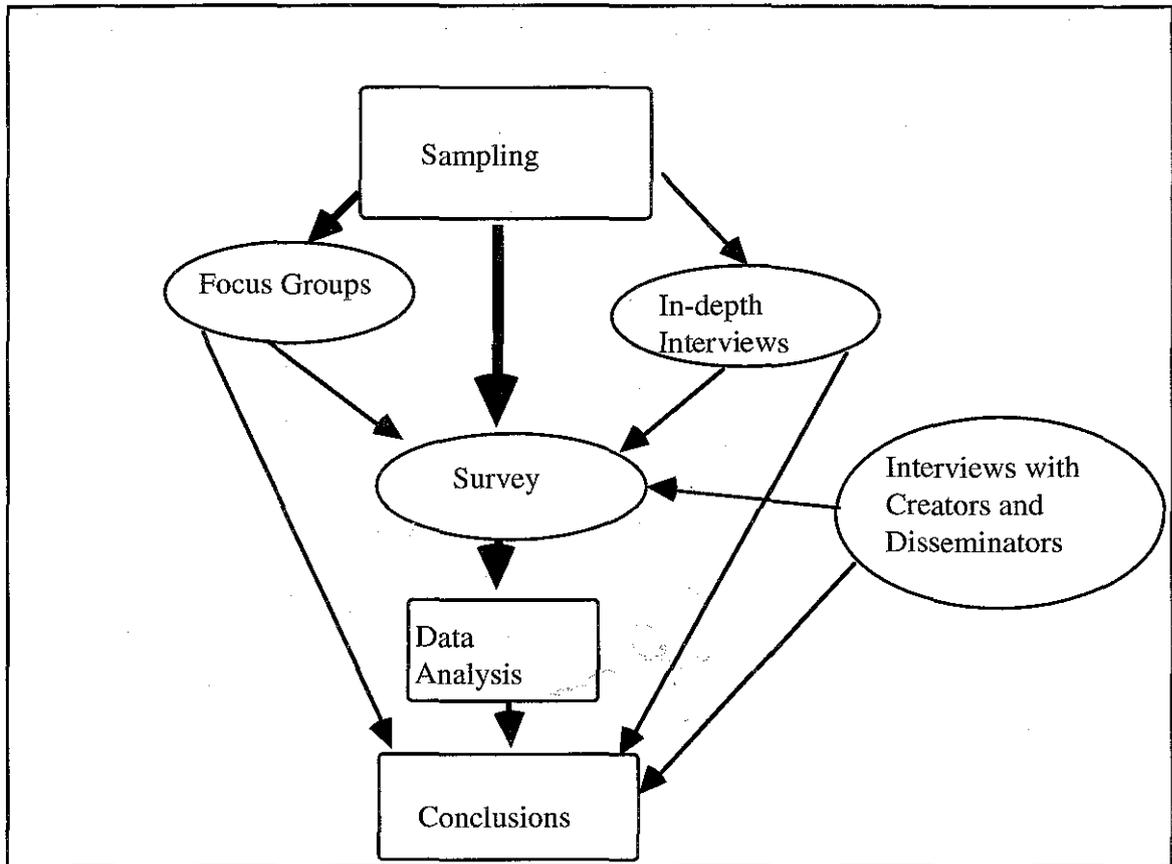
## **3. FOCUS GROUPS**

Sixteen focus groups were conducted in December of 1993. Participants were subdivided into groups based on age and gender (8 male groups and 8 female groups). Each focus group had 6-8 participants, led by one Thai moderator and one recorder for each group. Both moderators and recorders were also researchers attached to the Ministry Public Health who had previously participated in a workshop on focus groups. By stimulating free discussion among group members, the participants' ways of talking about AIDS, their attitude towards, as well as their knowledge and perceptions about AIDS were explored. Transcripts of these focus groups were made and translated into English.

#### **4. INTERVIEWS WITH CREATORS & DISSEMINATORS OF EDUCATIONAL AIDS MESSAGES**

The interviews with creators and disseminators of past AIDS messages were conducted to understand the intended messages produced in previous AIDS education campaigns in Thailand. The objective of these interviews was to gain an understanding of what the intended content and tone of the AIDS messages had been. I will discuss the methods chosen for investigating AIDS messages in mass media later in this section. Eighteen subjects, policy makers and creators of AIDS information programs, were asked about their historical involvement with AIDS educational programs (the interviews were conducted in English). Special emphasis was given to the institutional decision-making process regarding the choice of AIDS messages for media education. Officers from the Ministry of Public Health contacted the prospective interviewees, set up appointments and explained the outline of the interview format, in addition to sending follow-up letters to each interviewee detailing the overall aims of the research project and the interviews. At least one officer from the Ministry of Public Health accompanied the interviewer to each appointment. Most interview materials have been recorded and transcribed, though one interviewee objected to the use of a tape recorder and two could not be transcribed due to technical mistakes such as the destruction of tapes, leaving fifteen transcribed interviews. The other three interviews were reconstructed from notes as far as possible. The interviews with creators and disseminators began in November and continued until January of 1994.

Figure 2: **Diagram of the Research Strategy**



## 5. THE SURVEY

### 5.1. SAMPLING PROCEDURE

The survey sample was recruited from the male and female population between 15-29 years old, living in four districts of Kanchanaburi province. A multistage sampling process, combining stratified and cluster sampling was used to derive the approximately 1,800 subjects from 64 villages and communities. First, two pairs of districts with equivalent social and economic characteristics were chosen, with one urban sub-district and three rural sub-districts further selected from each of them. The next step involved the random selection of four villages/communities within each sub district.

Subsequent to the selection of districts and sub-districts, 64 villages/communities inside these administrative units were randomly chosen. Then, 26-30 males and females were sampled by health centers located in each of these villages/communities, based on registrations of residents kept by each health center. Subject's names were randomly chosen from the health center records. Health workers and volunteers affiliated with the village health centers contacted each subject one day in advance of the survey to request their cooperation. However, in cases where a selected subject was not available, for example because of work obligations, replacements were selected in their place. As it happened, this survey was conducted during the busiest time of year for this region, the sugar cane harvest, when most people worked as laborers for the sugar mill. While it may seem to have been an imposition to request these persons to take the time to participate in survey interviews, the village health volunteers made a lot of effort to convince potential interviewees to attend. I, for example, saw a high school student who had skipped his morning class because he was asked to attend an interview by a health volunteer. Despite such efforts by all participants, it was not always possible to maintain the integrity of our sample exactly as originally chosen. Indeed, since the

proportion of the targeted sample which was actually interviewed cannot be reliably estimated, the resulting sample should be treated as non-random at the village level. Seven cases had to be dropped because their age was outside the 15-29 age range. The statistical analysis is thus based on 1,783 cases.

## 5.2. CHARACTERISTICS OF THE SAMPLE

The main characteristics of samples were as follows: The mean age of this group was 23 years. Almost half (43.3%) of this sample was married, with an almost even male / female ratio (49.8% to 50.2%). Manual labor and farming/fishing were the dominant occupations (39.3% and 31.1% respectively), with white collar workers (office and government officers) accounting for only 4.3% of this group. Another 16.3% classified themselves as not working for pay (includes housewives and students).

The median educational attainment of the sample is an elementary school education (58% of the sample), with 17% percent at a lesser level or without any education. Another 14.4% completed junior high school and 10.6% attended high school or higher.

## 5.3. INTERVIEWER TRAINING

Eighteen interviewers were chosen from among the government health workers based in Kanchanaburi province, in addition to five supervisors from both, Kanchanaburi province and MOPH headquarters in Bangkok. Before starting the survey interviews, one week of training (in Thai) was conducted between January 3 and 7 of 1993. Training of the interviewers was conducted as part of the pilot phase of the research (questionnaire

design). The five day training session focused on conceptual as well as technical aspects of survey methodology. After explaining and practicing the concepts, the trainees (officers attached to the provincial offices of the Ministry of Public Health as well as village health workers) were sent out for field practice twice. Discussions were conducted and revisions to the questionnaire made after each field practice.

#### 5.4. QUESTIONNAIRE

I completed a first English-language version of the questionnaire before I went to Thailand. The questionnaire was translated into Thai prior to the interviewer training sessions. However, in response to the results of the in-depth interviews, the focus groups, and the pilot studies, several sets of modifications were made to the original form. The training and pilot project served to remove or rewrite ambiguous or difficult questions. Also, some expressions were adopted to local language use prevalent in Kanchanaburi. The interviewers were concerned that some categories of answers were beyond the conceptual abilities of interviewees and resisted inclusions of those answer choices in the final version of the questionnaire. Since I respected their opinions and knowledge of local conditions, revisions were made that reflected their concerns. In order to assure the quality of the translated Thai version of the survey instrument, the questionnaire was checked and approved by two separate translators whose mother tongues are English and Thai.

#### 5.5. FIELD WORK

The trained interviewers carried out face-to-face interviews, with the three research teams visiting an average of one village each day, starting on January 10, 1994. Every team

contained interviewers and supervisors and was assisted by health workers from the health center of the respective village or community, as well as village health volunteers. The survey completion date was February 8, 1994.

Because the subject matter of the interview included some sensitive topics, such as sexual behaviors, the interviewers were instructed to seek maximally relaxed, one-on-one interview settings, with the interviewer instructions calling for choosing a location secure from being overheard. Interviews were conducted by matching the sex of interviewers to that of respondents. It was explained to the interviewees that the questionnaire did not contain any individual identifiers, such as name, address, and birth date, to assure the anonymity of any data they volunteered. The interviewers had been cautioned about the effect of their personal appearance and therefore agreed to wear casual clothes, rather than their military-style public health staff uniforms complete with rank insignia that identify them as officers of the government.

## 5.6. VARIABLES

The construction of the variables used in this analysis is explained in the following section, beginning with the dependent variable -- talking about AIDS. The construct for talking about AIDS is measured in two dimensions: 1) the variety of talk on AIDS-related issues and 2) the frequency of such discourse by the respondent sample in the previous month.

The first variable, variety of AIDS talk, was constructed as an additive scale that represents the number of topics respondents reported as having discussed with others. Conversation partners of the respondents were grouped into the following categories for our purposes: friends, siblings, parents, co-workers and health workers (see Fig. 3).

**Table 1: Questionnaire Setup for Talking Partners/ Conversation Topics  
[Sample Case Markings in BOLDFACE]**

For each given answer in Q.3, how many times did you talk about AIDS prevention with them last month ?

| Q. 2. With whom did you talk about it?<br>(There can be more than one answer)   | Spouse<br>( Yes )                   | Parents<br>( )                       | Brothers/<br>Sisters<br>(Yes )        | Friends<br>(Yes )                     | Health-<br>workers<br>( )            | Co-<br>workers<br>( )                | Summ.                         |                    |
|---|-------------------------------------|--------------------------------------|---------------------------------------|---------------------------------------|--------------------------------------|--------------------------------------|-------------------------------|--------------------|
| How many times did you talk about AIDS?<br>1. A few times<br>2. Many times<br>3. Almost every day   | Q. 3<br>1<br>2<br>3X→               | Q. 9<br>1<br>2<br>3→                 | Q. 12<br>1X→<br>2<br>3→               | Q. 15<br>1→<br>2X→<br>3→              | Q. 21<br>1→<br>2→<br>3→              | Q. 24<br>1→<br>2→<br>3→              | 1<br>2<br>3<br><b>Total 6</b> | Freq. of<br>Talk   |
| <b>INDEX A</b><br>What did you talk about AIDS?<br>(Choose only one)<br>1. People who have AIDS<br>2. The reasons for getting AIDS<br>3. The ways one can avoid AIDS<br>4. The consequence of getting AIDS<br>8. Other (specify)  | Q. 4<br>1<br>2<br>3<br>4X→<br>8     | Q. 10<br>1<br>2<br>3<br>4→<br>8      | Q. 13<br>1<br>2X→<br>3<br>4→<br>8     | Q. 16<br>1<br>2→<br>3X→<br>4→<br>8    | Q. 22<br>1<br>2→<br>3→<br>4→<br>8    | Q. 25<br>1<br>2→<br>3→<br>4→<br>8    | X<br>X<br>X<br><b>Total 3</b> | Variety<br>of Talk |
| <b>INDEX B</b><br>What did you say about the ways one can avoid AIDS? (Choose only one)<br>1. Using condoms when having sex<br>2. Avoid going to prostitutes<br>3. Strict to monogamy<br>4. Not sharing personal belongings (e.g., razors, scissors and blades)<br>5. Using personal tools when going to the barber<br>8. Other (specify) | Q. 5<br>1X<br>2<br>3<br>4<br>5<br>8 | Q. 11<br>1→<br>2<br>3<br>4<br>5<br>8 | Q. 14<br>1X→<br>2<br>3<br>4<br>5<br>8 | Q. 17<br>1X→<br>2<br>3<br>4<br>5<br>8 | Q. 23<br>1→<br>2<br>3<br>4<br>5<br>8 | Q. 26<br>1→<br>2<br>3<br>4<br>5<br>8 | X<br><b>Total 1</b>           | Variety<br>of Talk |

In the above table, each "X" represents an answer choice for a hypothetical case. Index C (variety of talk) is not included in this table (see Appendix for this questionnaire item).

This scale of talking variety is based on three scales derived from a set of forced choice questions contained in the survey instrument (reproduced above as Table 1); these three scales are: A) an index of four AIDS-related topics across a number of conversation partners, resulting in a score between zero and three (filled-in, handwritten answers to the answer option "other" were not included in this summary and the same item checked for more than one talking partner was counted only once); B) an index of five prevention

topics respondents talked about across groups of conversation partners, resulting in a zero to five score ( As above, answers in the category "other" were excluded here as well; no category was counted more than once); and C) dichotomous answers to a 13-item list of choices as to whether respondents had conversations about causes/ prevention/ outcomes of the AIDS epidemic in Thailand in general terms.

A) and B) specified a time frame (the preceding one month before the survey was administered), including only those respondents who reported having talked with anyone in the past one month. Items on scale C) were based on a separate survey item; these questions were asked of the entire sample irrespective of a time frame for talking, and without limiting answers to specific groups of talking partners.

For A and B, each question answered with "yes" was given one point across all conversation partners for AIDS. A score of zero is given those who did not talk with anyone about AIDS in the past month (see example in Table 1 above). For C, every "yes" answer was given one point, with the score for all 13 items summed up. In order to summarize all three types of scores into one scale, the total score of each (A, B and C) was divided by the respective maximum scores (3 for A; 3 for B<sup>2</sup>; and 13 for C) . Thus, all three items used to build the overall scale were weighed equally (i.e. variable  $Talkvariety = A * 1/3 + B * 1/3 + C * 1/13$ ), resulting in a 0 to 3 scale. Reliability tested at 0.86 for the standardized alpha of these three items combined. The items used to construct the variety variable and the percentage distribution of answers are shown in Table 2 below.

---

2

The maximum score for this item ended up being three, even though there are five choices given.

Table 2: Answer Categories for Constructing Talking Variety

| Topics   | Answer Category   | % reporting having talked   |
|--|---|---|
| A)<br>General AIDS Topics                                    | 1. People who have AIDS<br>2. The reasons for getting AIDS<br>3. The ways one can avoid AIDS<br>4. The consequences of contracting HIV<br>(Number of cases each)  | 16.0 %<br>25.1 %<br>30.5 %<br>0.7 %<br><i>n=1783</i>  |
| B)<br>Ways of Avoiding Contracting AIDS                      | 1. Using condoms when having sex<br>2. Avoiding going to prostitutes<br>3. Importance of monogamy<br>4. Not sharing personal care items<br>(e.g. razors, scissors and blades)<br>5. Using personal tools when going to the barber's<br>(Number of cases each)   | 34.0 %<br>34.8 %<br>3.5 %<br>5.8 %<br>2.0 %<br><i>n=1783</i>  |
| C)<br>Thirteen General AIDS Topics (No Time Frame Specified) | 1) AIDS in Thailand is transmitted through homosexuals<br>2) AIDS is spreading because of foreign tourists<br>3) AIDS is spreading because of IV drug users<br>4) AIDS is spread by sex industry workers<br>5) AIDS is spread by men who go to prostitutes<br>6) AIDS is a threat to an individual's life and lifestyle<br>7) AIDS is a threat to a couple's relationship<br>8) AIDS is a threat to tourism in Thailand<br>9) AIDS is a threat to the health of mothers and infants<br>10) The government should be responsible for AIDS prevention campaigns<br>11) AIDS can be prevented by changing individual sexual behaviors<br>12) AIDS is prevented by using condoms<br>13) AIDS can be prevented by reducing the number of sexual partners<br>(Number of cases each) | 54.9 %<br>47.3 %<br>72.6 %<br>78.2 %<br>77.3 %<br>45.8 %<br>54.8 %<br>39.4 %<br>61.6 %<br>39.7 %<br>40.5 %<br>82.2 %<br>48.4 %<br><i>n=1783</i> |

As to the measurement of the frequency of AIDS conversation, respondents were asked (subsequent to discussing whether and, if so, with whom, they had talked about AIDS) how often they talked with each of these reported talking partners. While the former talking (variety) variable is a scale based on the sum of three variables, this frequency variable is merely a sum of frequency of talking across partners (see Table 1, above). Respondents were asked to characterize the quantity of their conversational interactions as one of four levels (0 = none, 1 = few times, 2 = many times, 3 = almost daily). These scores were summed across all talking partner categories.

The most important independent variable is the reception of AIDS messages from the mass media. The measurement of respondent's reception of AIDS messages is, however, a complex measure, since this research is interested in an individual's exposure to AIDS messages rather than their exposure to mass media messages in general. The primary concern is whether individuals received (i.e. perceived frequency and recall ability) AIDS information. This type of distinction between passive and active reception of information has been made by other researchers and expressed as "attention" (Chaffee and Schleuder, 1986) or "reception" (Price and Zaller, 1993; Zaller, 1992). While the concept of reception focuses more on the outcome than the concept of attention does, both concepts concern the audience's attention to and comprehension of the content of messages.

This scale, measuring respondents' reception of AIDS messages from television, radio and/or newspapers was based on answers to questions asking in what medium people had found information on AIDS in the past month; how often they had seen programs/articles on AIDS on radio, television or newspapers in the past month; and asking about their recall of particular programs on AIDS broadcast in the past month (a local radio program of interviews on AIDS that was produced by the Provincial Health Office and broadcast in December of 1993 as well as a television program on World AIDS Day in

December of 1993). For each channel, additive scales were created (reliability is: alpha = .71 for TV; alpha = .62 for radio; alpha = .69 for newspapers) and summarized into an overall media reception variable by summing up each channel score after dividing them by the maximum score of each channel (3 for TV; 3 for radio, 2 for newspapers). The (0 to 3) scale produced a standardized alpha of 0.68 for reliability. This scale represents the reception of mass media AIDS messages throughout the following analysis.

Two other important variables concerning AIDS messages were intended AIDS messages and perceived AIDS messages. As discussed in Chapter 3, it was not possible to conduct a content analysis of previously publicized AIDS messages for the purposes of this research. The main reasons were time and cost requirements. Another obstacle to attempting to perform a systematic content analysis was that there is no central agency handling public service health message production and distribution in all media. Rather there are many players in Thai AIDS education, including not only the government, but also non governmental organizations, foreign aid agencies and international organizations. Even within the Thai Ministry of Public Health, there were many divisions that participated in AIDS education even though the AIDS division nominally is responsible for it. Consequently, no archival resources suitable for historical content analysis exist. In addition, the distribution of such educational materials, once produced seemed to have been rather arbitrary, with media outlets airing or printing messages voluntarily and no follow-up being performed. Thus, people's exposure to programs cannot be estimated by simply analyzing the content of media programs produced. In sum, attempting a content analysis of material was not possible.

As an alternative route of investigating the content of AIDS messages, I created the above two variables, intended and perceived AIDS messages in the mass media. The first, intended AIDS messages was based on interviews with policy makers and producers. I asked questions regarding the types of messages they had chosen for their AIDS education

campaigns, the history of any content changes, and the organizational and cultural limitations they encountered in producing these campaign messages.

The second variable, perceived AIDS messages, was based on survey responses to questions which asked whether respondents had seen listed types of messages in the mass media. The types of messages were broadly categorized into three groups, covering the cause, consequence and prevention of AIDS. People were asked to answer those recall questions in terms of yes or no.

The other explanatory constructs (independent variables) this research considered as they related to variation in the frequency and variety of conversations about AIDS-related issues are measures of: age and socio-economic status, indicators of respondents' informational environment (general knowledge about AIDS and reception of mass mediated AIDS information), and a construct intended to measure respondents perceptions about the appropriateness of AIDS-related discourses (representing the context-creation aspect of the mass media).

The socioeconomic status scale was created as an index summing up respondents' equally weighted answers to questions about 1) the level of education they attained (a four point scale corresponding to elementary education, completing elementary school, attending a secondary school or graduation and post-secondary education); and whether respondents or their families own one or more of the following goods: 2) a motorcycle, 3) a telephone, 4) a radio, 5) a stereo, 6) a flush toilet, 7) an automobile, or 8) a television. For every item owned, a score of 1 is given. Four categories corresponding to levels of education were divided by the maximum score, 4 ; thus, the resulting quotient is between 0 and 1. The resulting additive socio-economic scale had a reliability of standardized alpha = 0.58. Education may appear under-represented in this scale, because self-reports favored accurate listing of possessions more than an accurate reporting of educational attainment. However,

wealth and educational levels are highly correlated, with the level of wealth already reflecting the educational level; therefore, I decided to integrate them together into one scale.

Knowledge scales were divided into two types after factor analysis and reliability tests. A scale for knowledge of mythical-beliefs represents the level of correct knowledge about mythical causes and transmission paths of the HIV virus derived from answer choices that included 1) sharing cups ("No" being the correct answer, 82.5%), 2) mosquito bites (correct answer is "No": 49.2%), 3) kissing (correct answer is "No": 59.8 %), 4) toilets (correct answer is "No": 78.7 %), and 5) shaking hands (correct answer is "No": 89.6%). One point was added to a respondent's score for every item correctly answered (for both spontaneous and responses to yes/no questions), the maximum score being four and the minimum being zero ( $\alpha = .65$  and  $\text{eigenvalue} = 2.43$ ).

The scale for general knowledge represents the level of knowledge about the cause of AIDS in general terms, including transmission of the HIV virus through 1) sex ("Yes," 99.3 %), 2) sharing needles ("Yes," 98.8 %) and 3) mother to infant (vertical) transmission ("Yes," 93.7%),, 4) sharing razors or needles ("Yes," 86.8%),and 5) blood transfusions ("Yes," 96.9 %). This scale was obtained from a forced-choice survey item. One point was given for each item correctly answered to an additive total score (maximum = 5, minimum = 0 for this scale). Due to the limited number of possible responses and the high level of knowledge (relative to what this scale sought) the distribution of answers is highly skewed. This is reflected in a very low alpha at .45 ( $\text{eigenvalue} = 1.93$ ).

Perceived social appropriateness is constructed in two ways: One measure (SOCIAPT) is based on the answers to a question asking whether respondents judge it to be socially appropriate to ask their friends whether they talked about safe-sex practices (86.5 % of people answered "yes" to this question). The second is a scale representing a person's potential communication network for AIDS-related discourses perceived as

socially appropriate (SOCINET). This additive scale was based on answers to questions asking "which people should discuss AIDS preventive practices together " for a number of people. For every possible combination of talking partners, a dichotomous choice (yes/no as to the appropriateness of conversation) was given. The survey question asked: "Who should discuss AIDS preventive practice together? " The eight possible combinations were 1) spouses, 2) boyfriend and girlfriend, 3) friends, 4) parents/children, 5) neighbors, 6) co-workers, 7) health workers and patients, and 8) prostitutes and their clients. Each pairing indicated by respondents as being appropriate was given one point. The sum of these result in a maximal score of 8 and a minimum of zero. According to reliability test and factor analysis, the alpha score is .71 and the eigenvalue is 2.68 for this item.

A political awareness scale was constructed based on questions seeking to elicit a respondent's knowledge about the specific names of dominant political parties and local politicians. Answers to these questions were scored, based on whether, and how many names of politicians respondents could correctly provide and whether they could name the currently governing party correctly. The question was asked in the following manner: "What are the names of the members of the Parliament elected from your election block?" The names of the two representatives for the appropriate district were checked and a score (0.5, and 1) was given depending on the number of correct answers. The second question asked: "What is the name of the party [that] Prime Minister Chuan Leekpai belongs to ?" If the respondent could answer "Prachathipat Party " a score of 1 was given; otherwise a 0 was marked for an incorrect response. The resulting additive scale had an alpha of 0.55.

Further independent variables included here were age, gender, and marital status. These are used as control variables for the subsequent analysis.

Table 3: **List of Independent Variables and Questions Asked for Variable Construction**

| Variable                   | Label | Explanation  |
|----------------------------|-------|--|
| Reception of AIDS Messages | RECEP | <p><b>A. In what medium did you find information about AIDS?</b><br/>(There can be more than one answer)</p> <ol style="list-style-type: none"> <li>1. newspaper (30.7%)</li> <li>2. radio (40.4%)</li> <li>3. TV (78.7%)</li> <li>4. loudspeaker (9.8%)</li> <li>5. poster (15.5%)</li> <li>6. pamphlet/brochure (6.5%)</li> <li>8. other (specify) (2.5%)</li> </ol> |
|                            | TV    | <p><b>B. How often have you seen programs about AIDS on TV in the past month?</b></p> <ol style="list-style-type: none"> <li>1) a few times (1-2 a month) (18.7%)</li> <li>2) several times (more than 2x/mo) (12.5%)</li> <li>3) many times (about once a week or more) (45.2%)</li> <li>4) every day (4.4%)</li> <li>5) never (19.3%)</li> </ol>                     |
|                            | RADIO | <p><b>C. Have you seen news reports on "WORLD AIDSDAY" on TV last December?</b></p> <ol style="list-style-type: none"> <li>1. yes (37.3%)</li> </ol>   |
|                            |       | <p><b>D. How often have you heard about AIDS during the last month on the radio?</b></p> <ol style="list-style-type: none"> <li>1) a few times (1-2 a month) (23.5%)</li> <li>2) several times (more than 2x/mo) (11.7%)</li> <li>3) many times (about once a week or more) (20.9%)</li> <li>4) every day (2.7%)</li> <li>5) never (41.2%)</li> </ol>                  |
|                            |       | <p><b>E. Have you ever heard of "Thai Family Program" in which a health officer of Kanchanaburi Provincial Medical Office interviewed AIDS experts who work on AIDS prevention on radio?</b></p> <ol style="list-style-type: none"> <li>1. yes (10.8%)</li> </ol>  |

|  |              |   |
|--|--------------|---|
|  | NEWS-PAPERS  | F. How often have you read about AIDS during the last month in newspapers?<br>1) a few times (1-2 a month) (28.2%)<br>2) several times (more than 2x/mo) (9.7%)<br>3) many times (about once a week or more) (12.4%)<br>4) every day (0.7%)<br>5) never (49.0%)                 |
| Age  | AGE          | Age of individual (15 to 29 range)<br>1) 15-19 (%)<br>2) 20-24 (%)<br>3) 25-29 (%)  |
| Knowledge of Mythical beliefs about AIDS           | KNOW-MYTH    | How do you think a person can contract AIDS?/<br>Can you contract AIDS from...? (% knowing correct answer)<br>1) sharing cups (82.5%)<br>2) mosquito bites (49.2%)<br>3) kissing (59.8%)<br>4) toilets (78.7%)<br>5) shaking hands (89.6%)                                      |
| General knowledge about AIDS                       | KNOW-GENERAL | How do you think a person can contract AIDS?/<br>Can you contract AIDS from...? (% knowing correct answer)<br>1) sex (99.3%)<br>2) sharing needles (98.8%)<br>3) mother to infant transmission (93.7%)<br>4) sharing razors or needles (86.8%)<br>5) blood transfusions (96.9%) |
| Socioeconomic status                               | SOCIOECO     | Do you have the following things at home?<br>1. radio/cassette player (85.3%)<br>2. stereo/CD (39.4%)<br>3. TV (86.8%)<br>4. phone (5.7%)<br>5. motorcycle (85.2%)<br>6. car (26.0%)<br>7. flush toilet (7.1%)<br>8. Education [1 (14.4%) 2 (62.7%) 3 (14.1%) 4 (8.8%)]         |
| Perceived social appropriateness of asking friends | SOCIAPT      | Do you agree that it is socially appropriate to ask your friends whether they have talked with their spouses about safe-sex practices?<br>yes: (86.5%)  |

|   |         |  |
|---|---------|--|
| Perceived potential communication network | SOCINET | Who should discuss AIDS preventive practices together?<br>1. wife husband (yes = 94.9%)<br>2. boy friend/ girlfriend (yes = 80.8%)<br>3. close friends (yes = 94.8%)<br>4. parents /children (yes = 90.9%)<br>5. neighbors (yes = 85.5%)<br>6. co-workers (yes = 90.9%)<br>7. health workers/patients (yes = 96.5%)<br>8. prostitutes/clients (yes = 79.7%)                  |
| Political awareness                       | POLIAW  | A. What is the name of the party, Prime Minister Chuan Leekpai belongs to? (Prachathipat Party )<br>1. correct (44.7%)<br>2. incorrect (55.3%)<br>B. What are the names of the members of Parliament elected from your election block? (2 from each district: see name list)<br>1. correct (two names) (45.7%)<br>2. correct (only one name) (20.2%)<br>3. incorrect (34.1%) |
| Gender                                    | Gender  | Male (49.8%)   |
| Marital Status                            | Mary    | Married (46.2%)  |

## **CHAPTER FIVE**

### **-- INTERPERSONAL DISCOURSE --**

In this chapter, I intend to explore interpersonal discourses on AIDS, beginning with an examination of respondent's communication networks on AIDS in terms of conversation partners and the types of topics discussed with them. This will be followed by a discussion of the social context of those conversations and the reasoning for them given by the respondents. This chapter concentrates on presenting basic descriptive findings in order to ground the subsequent discussion of the detailed relationships among talk about AIDS and mass media messages on that issue in later chapters .

#### **1. COMMUNICATION NETWORKS**

In everyday life, people carry on conversations with many people, selecting topics and conversation partners consciously or unconsciously. There are some topics we might find easy to discuss with friends, while other topics felt to be more suited to conversations with family members. The following section discusses these types of communication networks for AIDS-related topics:

### 1.1 Conversation Partners

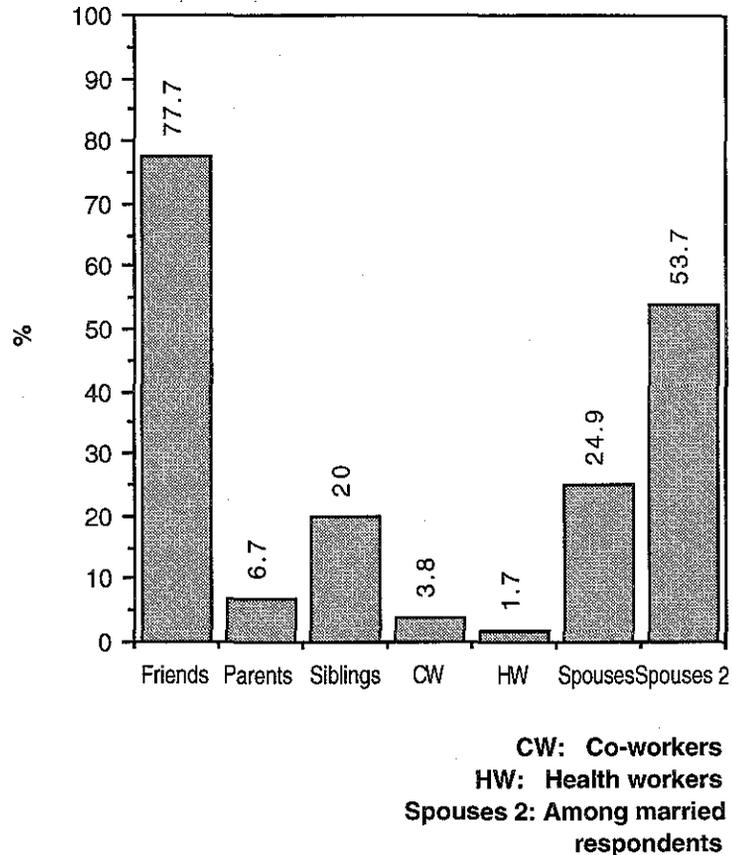
Respondents were asked with whom they talked about AIDS in the past one month ("Have you talked with anyone about AIDS in the past month?" If so, "with whom did you talk about it? "). Three-fourths of the sampled population (74.6% n=1330) reported having talked about AIDS with someone in the past month. Among those who talked about AIDS, most reported talking with their friends (77.7%). Spouses and siblings ranked as the second and third most frequently mentioned partners for talking about AIDS: 53.7% of married respondents talked with their spouses and 20% of the total sample spoke to siblings. Less than ten percent reported talking with parents, health workers, or colleagues in the past month (see Figure 3, below).

These figures reported above for conversation partners do not take into account the residential arrangements of individuals with regard to their families -- except for marital status -- because individual communication networks seem to be largely unaffected by whether the respondents live under the same roof with their parents, children, or siblings. The only variable that was associated with substantial variation was the respondent's marital status (covered in more detail below). Approximately one half of the respondents (43.6%) reported being married and a small number of respondents (9%) identified themselves as cohabiting. Two-thirds of the sample (68.6%) reported seeing their siblings every day or living with them ( half of the respondents (55.9%) were living with their siblings.) One-third of the sample live with their children (35.2% ). Most respondents (76.8%) were either living with parents or seeing them every day (66.5 % of the respondents are living with parents).

These differences in family structure do not appear to affect the availability of a ready communication network for talking about AIDS, except for marital status. No statistically significant differences in talking behaviors were observed between

respondents living with siblings (presumably seeing them on a daily basis), and those who see them everyday, but live separately from them ( $p > .05$  according to chi-square test). In the case of living arrangements respondents have with their parents or their children, their potentials as talking partners were in any case limited. There was a statistically significant difference in talking behaviors between those who lived with their parents and those who see their parents everyday but live separately. However, given that parents only functioned as talking partners for less than 10% of the overall sample, it was decided that this relationship would not be pursued. Similarly, only a small percentage of respondents reported their children as conversation partners (unsurprisingly, given the age limitation of the sample). Overall, this researcher concluded that structural factors of availability account for less than personal preferences in the choice of talking partners: People do not automatically have a larger communication network because of the availability of family members in their household.

Figure 3: **Conversation Partners for Talking about AIDS**



Note: Those who talked about AIDS in the past one month : 1330 Cases  
 Married respondents who talked with spouses about AIDS in the past month [Spouse 2]: 616 Cases

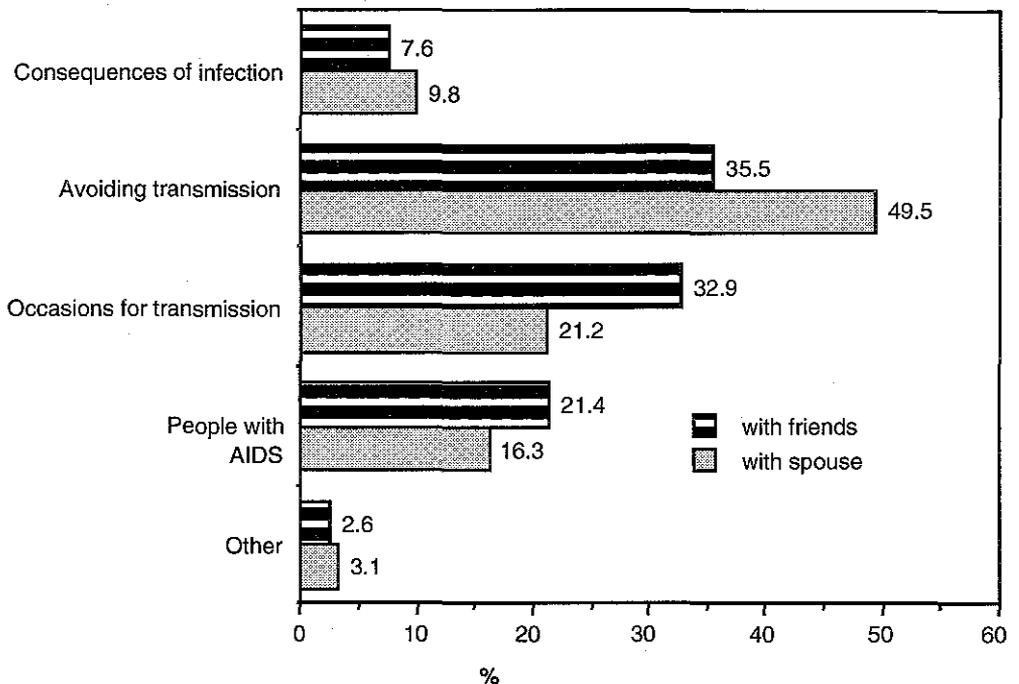
Further evidence that the communication network chosen for talking about AIDS rests on choice is the fact that friends -- people with whom affinity is chosen -- were considered the overall preferred communication partners. Whether some of this preference might also be due to some generation gap for talking about a phenomenon like AIDS is an issue for further research to consider.

## 1.2. Topics Discussed

Those who reported having talked about AIDS with their spouses or their friends in the past month were asked what particular aspects of AIDS formed the subject of their conversation ("what did you say about AIDS? "). The answers were presented in the form of a multiple-choice setup, allowing for only one answer among five choices for this question. Consequently, respondents' answers reflect the most-discussed topics, rather than a comprehensive listing of topics. The question was purposefully phrased in this way, so to encourage respondents to make a considered, forced choice among topics. It was feared that allowing any number of responses would lead to an excessive (perhaps interviewer-induced) number of "yes" choices. At the aggregate level, these responses present those AIDS topics most often discussed with either with friends or spouses.

The most frequently reported topics, both for talking with friends and -- for married people -- with their spouses, were ways of protecting oneself from infection and possible occasions of transmission. For spousal conversations, prevention was by far the most prominent topic (49.5% of reported conversations). The second most widely discussed topic, "occasions for transmission," was only answered by one fifth ( 21.2%) of these respondents. For conversations among friends, the occasions at which the virus may be transmitted (32.9%) was a high priority after prevention (35.5%). People who had contracted the virus formed the subject of conversations for 16.3% of the respondents who talked with friends and 21.4% of married people talking with their spouses. ( see Figure 4)

Figure 4: **AIDS-related Topics Discussed**

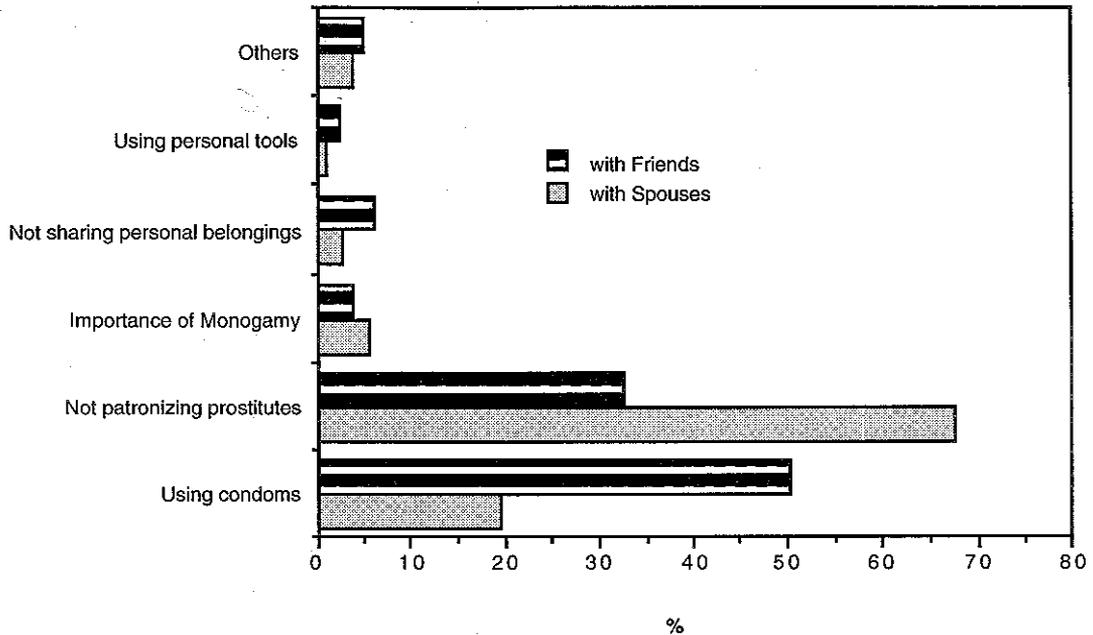


Those who talked with friends: 1033; Total cases used for this analysis: 1025  
 Missing cases: 8  
 Those who talked with spouses: 331; Total cases used for this analysis: 325  
 Missing Cases: 6

### 1.3. Aspects of AIDS Prevention:

Analogous to the above presentation, respondents who reported having talked about AIDS with either their spouses or their friends in the past month, were asked what specific prevention topics they had discussed: "What did you say about ways of avoiding AIDS?" The respondents were asked to choose one answer among 6 possible selections (See figure 6). The figure represents the types of prevention topics most often discussed with either friends or spouses.

Figure 5: **Prevention Topics Talked about with Friends and Spouses**



Those who talked about with friends: 1033

Those who talked with spouses 331; Total Cases used for this analysis : 323.

Missing Cases: 8

There are some differences in the preferred prevention topics with friends and those talked about with spouses. About half of those talking with friends reported (50.3% n=509) having talked about using condoms for sex, while one third talked about "avoiding going to prostitutes."

However, with their spouses, married respondents tend to foremost talk about avoiding patronizing prostitutes (67.5%). Only one fifth of them reported having talked about using condoms. Less than 10 percent of either category talked about the importance of monogamy. In other words, people talk about the use of condoms in a relatively less private network (with friends), while topics concerning other sexual partners are more often talked about in a quite private network (with spouses). This

difference may be explained to some extent by Thai culture, in which men are not generally censured for maintaining sexual activities outside their marital relationships; rather this is seen as the "norm." In that context it may be difficult for men to talk negatively about the practice of going to prostitutes (with same-gender-friends), and for women to explicitly talk about this topic. Condom use on the other hand is value-neutral for men, in that it pertains merely to the use of a device and not to the context of its use. The use of condoms does not necessarily imply violations of social values in regard to sexual propriety for male culture.

The topic of condom use is not value neutral among women and between spouses, however. For example, there is a gap between women's and men's ways of talking about condom use with friends. More than half of the men sampled (62.8%) reported condom use as a prevention topic, but only about one fifth (28%) of women reported condom use as prevention topic with friends. The percentage of reported talk about condom use was even lower with spouses. Only one fourth (19.3% for female and 19.7% for male) reported the use of condoms as a prevention topic. Overall, topic-related values differ, depending on the social context they occur in. There is a specific assessment of the appropriateness or inappropriateness of addressing certain issues, based on the social context.

## **2. SOCIAL CONTEXT AND TALKING**

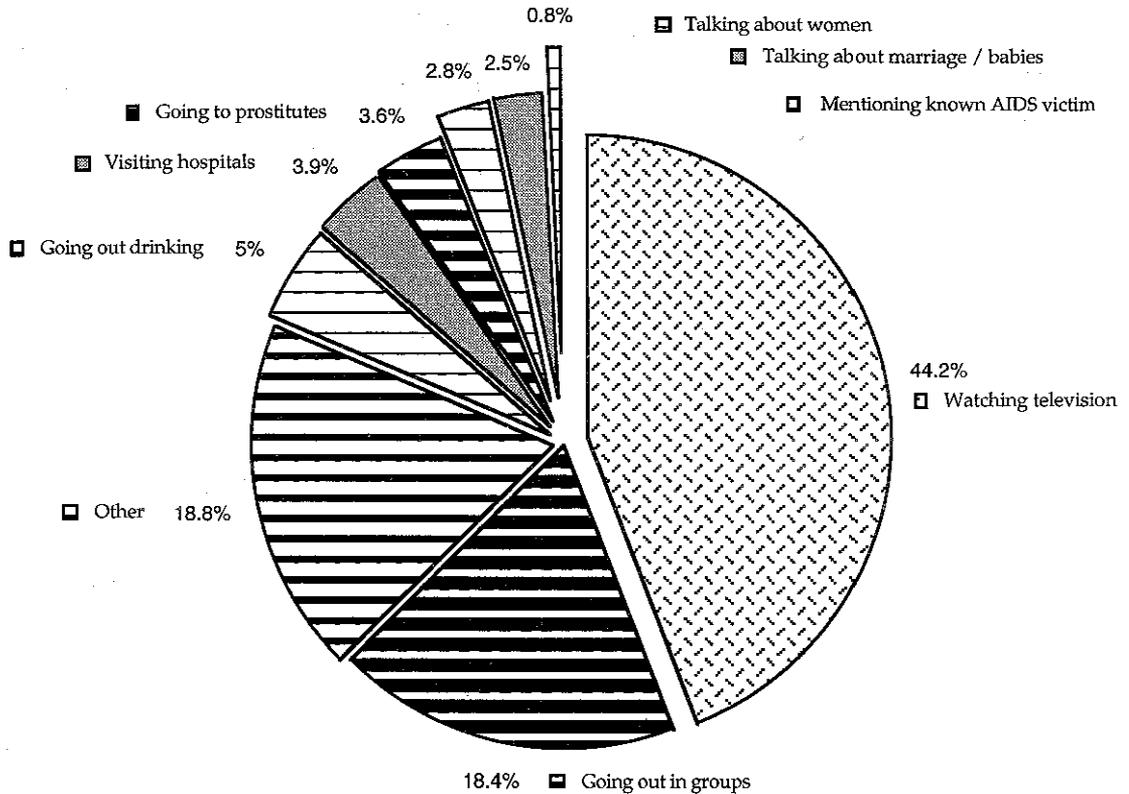
I have previously noted that the way in which people talk about AIDS may be related to these people's ways of evaluating the conversational context. In this section, questions regarding the context of AIDS talks are explored. The survey questions on which this presentation is based asked on what occasions respondents had talked about AIDS, what

reasons they perceived for difficulties encountered in talking, and the reasons motivating them to talk about AIDS.

### **2.1. Occasions for Talking**

All respondents, including those who reported not having talked with anyone in the last month were asked ("What motivated you to talk about AIDS?") about the context that occasioned their talking about AIDS. This question is concerned with those contexts in which people happened to talk about AIDS. The answer categories were developed based on the in-depth interviews and focus groups. When respondents were asked about those situations when they could recall talking about AIDS during the in-depth interviews, many responded that watching TV, as well as going out with friends, occasioned their talking about AIDS. The survey findings are consistent with these earlier findings, as well as with those from the focus groups. The answers are represented in figure 7 below:

Figure 6: Occasions of Talking about AIDS among Thais



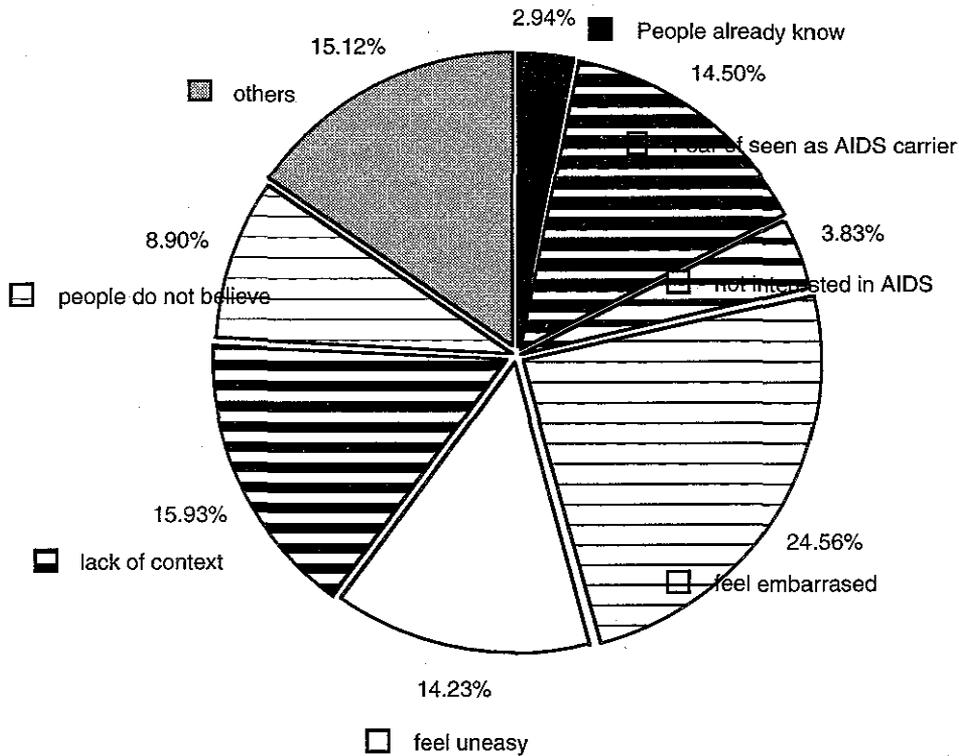
Total Cases: 1703; Missing Cases: 80

Almost half (44.2 %) of the sample, by far the largest group of respondents, reported that watching television encouraged them to talk about AIDS. A distant second choice reported by the sample was going out in groups. A notable number of responses (a total of 11.4%) expressed contexts related to sex: going to prostitutes (3.6%), going out drinking -- a typical prelude among men before buying commercial sex (5%) -- and talking about women (2.8%). While this question asked subjects about the circumstance under which they happened to talk about AIDS, the next question asked about their reasoning for not talking:

## 2. 2. Reasons for Not Talking about AIDS

While 78.0% of the total number of respondents answered that they did not have any difficulties talking about AIDS to anyone, one-fifth (22%, n=392) did. Thus the latter were asked what reasons made it difficult for them to talk about AIDS. A small number noted that they were simply not interested in AIDS (3.8%), while others said they felt that other people already knew about AIDS (3.3%). The most common set of reasons, however, was related to their evaluations of the social judgments surrounding AIDS. More than one-third of this group of respondents noted either feeling embarrassed (27.6%), or feeling uneasy (16.0%), as reasons for their difficulties in talking about AIDS. A lack of perceived appropriate context was given as a reason by 16% of the respondents. Another reason that also related to evaluations of social judgment about their talking about AIDS was reported by 14.5 % respondents as "fear of being misunderstood as being infected with AIDS." In sum, even though the majority of those people surveyed did not have any hesitation or difficulties in talking about AIDS with anyone, the obstacles for talking cited by those who did have difficulties in suggesting a need to look at and understand people's evaluation of perceived appropriate contexts for talk (Figure 7, below).

Figure 7: **Reasons for Difficulty in Talking (among Those who Found Talking about AIDS Problematic)**



Total Cases: 369; missing cases: 23

### 2.3. Reasons for AIDS-related conversations

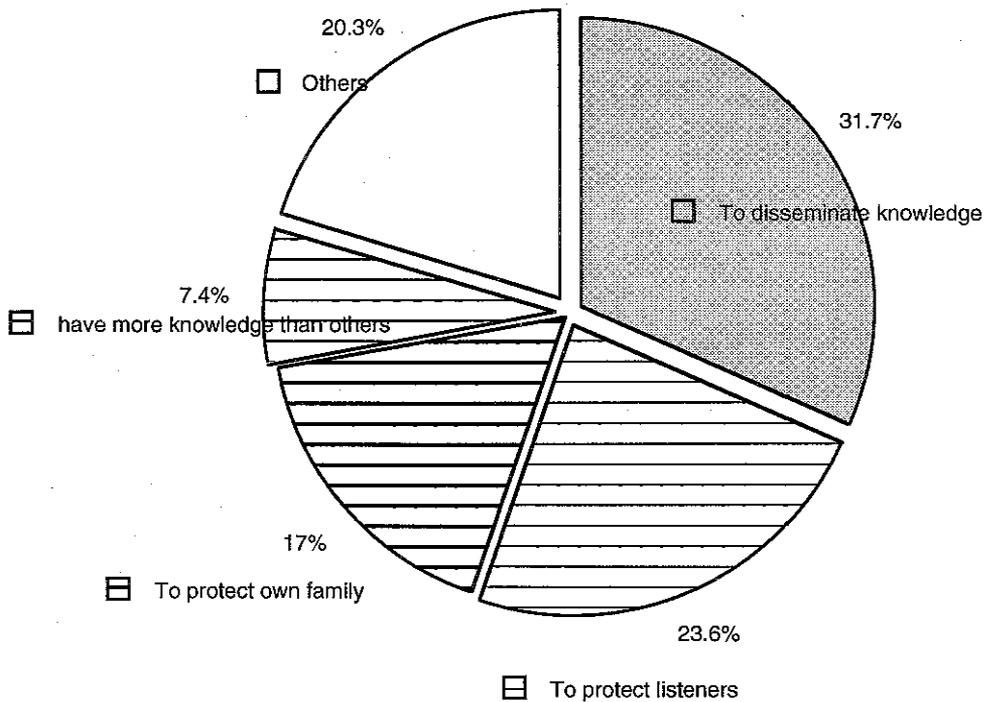
That majority of respondents who had indicated that they did not find it difficult to talk about AIDS with anyone (78%, n=1391), were asked why it was not difficult for them to talk about AIDS. This question was concerned with what makes some people feel able to talk about AIDS, while this issue is clearly difficult for some others. The answer categories were chosen based on information gathered during the in-depth interviews, as with the previous set of questions. Many of the interview partners

volunteered positive reasons for talking about AIDS; many had a desire to share information with others, and believed that sharing information is a way of preventing their friends or spouses from contracting AIDS. For example, one woman said, "I would like to protect my friends from AIDS and told them not to go to prostitutes." Another noted that "I tell my husband not to go [patronize prostitutes]..."

According to the answers to this survey question, the largest groups of people operated on the motivation to protect either their families or their listeners from AIDS. One-third (31.7 %) of the respondents indicated that they wanted to generally disseminate information to their listeners. About one-fourth (23.6%) noted that they wanted to "protect their listeners from AIDS". Less than one-fifth (17.0 %) mentioned wanting to "protect their family from AIDS." Only 7.4 % answered that they felt they knew more about AIDS than other people as a reason for talking. About 20% of respondents answers were not codeable into groups and are represented as "others" below (see Figure 8).

This set of findings is compatible with its opposite, the perceived obstacles to talking reported above: It seems that positively evaluated social contexts are an important factor in enabling people to comfortably talk about AIDS. Some people who were afraid of being embarrassed and misunderstood do not feel comfortable. On the other hand, people who are confident of their knowledge and feel a strong need to talk about AIDS do not feel it is difficult to talk about AIDS with anyone.

Figure 8: **Reasons for Talking about AIDS with Anyone  
(among those who have no trouble talking)**



Total Cases: 1355 ; Missing Cases: 36

### 3. SUMMARY

This chapter set out to add to our understanding of the social context of discussions and information-sharing about AIDS. The data show that the vast majority of the population surveyed does talk about AIDS with a range of persons they encounter in their everyday lives and constructs the issue in specific ways, highlighting areas of greatest concern or relevance to them (see Figures 4 and 5 for example). On the other hand, conversation partners for talking about AIDS were quite limited for most of the respondents to either spouses or friends. The framing of their AIDS conversation in relation to those frames promulgated through the mass media will be explored in chapter 8.

The research results presented in this chapter sought to provide a more detailed understanding of the survey respondents' ways of evaluating social contexts for talking about AIDS, such as their motivation, contexts for talking about AIDS, and possible difficulties encountered. These results do indicate that perceptions of social appropriateness or inappropriateness may make people more or less comfortable and thus able to talk about AIDS. The hypothesis positing a relationship between evaluated social appropriateness and talking about AIDS will be discussed in a later chapter.

## **Chapter Six**

### **AIDS MESSAGES RECEIVED FROM THE MASS MEDIA**

This chapter, describes the reception of mass media AIDS messages by the sampled persons. This description will include whether people received any AIDS messages from the mass media; if so, from what channel, in what programs, and how frequently.

#### **1. MEDIA RECEPTION**

In previous chapters, it was noted that many people reported watching TV as a context which motivated them to talk about AIDS. In the in-depth interviews, some interviewees also mentioned TV as an occasion to talk. From these reports, it already appeared that mass media somehow contribute to people's discussions about AIDS. While we will investigate the linkage between interpersonal discourse and discourse in mass media in a more solid way in the following chapter, for now we will proceed on the assumption that there is some attribution of respondent's talking behavior to reception of AIDS messages in the mass media. Before commencing the linkage discussion, this chapter intends to lay out the description of reported channels and types of mass media programming through which people found AIDS information.

The questionnaire included items intended to explore through what channels, from what kinds programs, and how often people receive AIDS messages. The first question

asked subjects in general terms whether they had received AIDS messages in the past month. Since it was thought to be difficult for respondents to accurately estimate their average reception of AIDS messages, the question asked only about respondent's recall of a strictly limited time frame (one month). This one-month-period for which recall was tested is considered to be representative of exposure to mass media AIDS messages over longer periods of time.

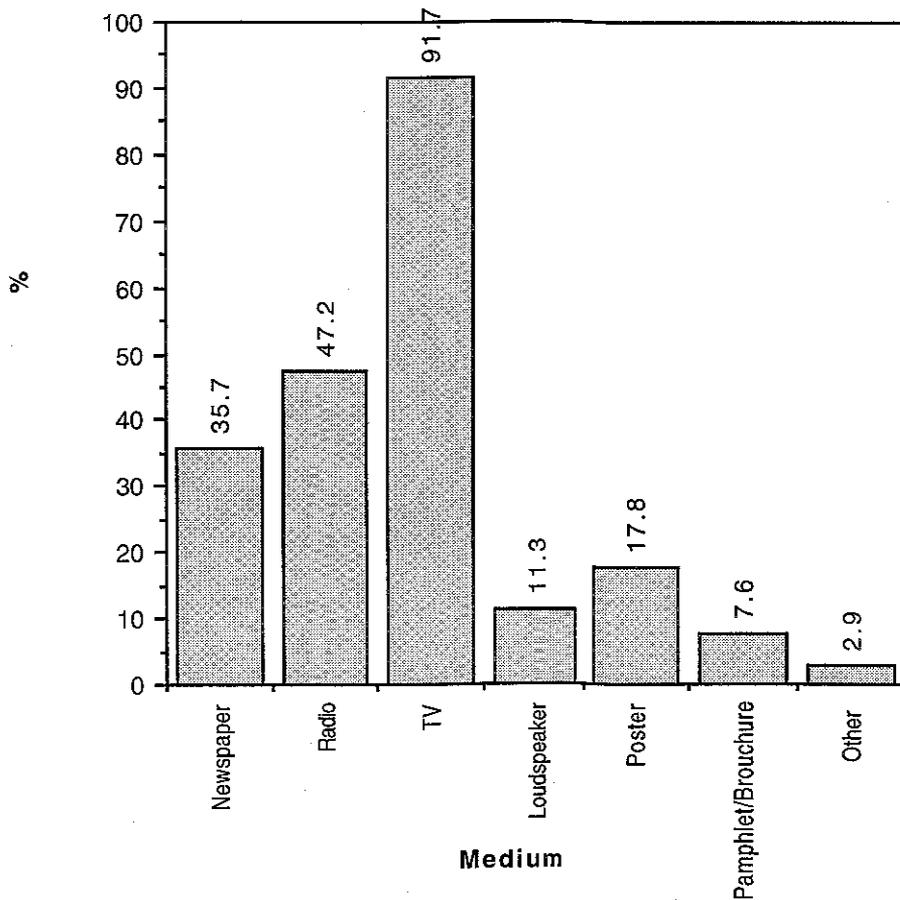
The majority of respondents (85.5%) reported having received AIDS messages within the past one month. As noted above, those people who did not receive AIDS messages according to this indicator may well have received messages prior to this time frame. Thus this indicator refers to a relative, rather than an absolute exposure value. Even among those have seen AIDS messages, however, only about a half (57.9%) could recall any program names, titles or specific subject matter when this was inquired about.

Among those who answered that they had received messages from the mass media, the majority (91.7%) reported TV as the medium for receiving AIDS information responding to a question asking "In what medium did you find information about AIDS?" About half (47.2%) of this group of respondents also reported using radio and about one-third (32.3%) reported newspapers as their medium for AIDS information. Less than one-fifth (17.7%) of this group reported having seen posters and only one-tenth (11.3%) reported public loudspeaker systems as their AIDS information medium. A further less-than-ten-percent (7.6%) of respondents reported pamphlets and brochures as information channels (see Figure 9, below).

TV, then, is the predominant medium in which the sample population finds AIDS information. Respondents were also asked how often they found AIDS messages within the one-month time frame. Less than 5% reported having received AIDS messages from any medium every day. About half of the sample however (45.2%) reported having seen

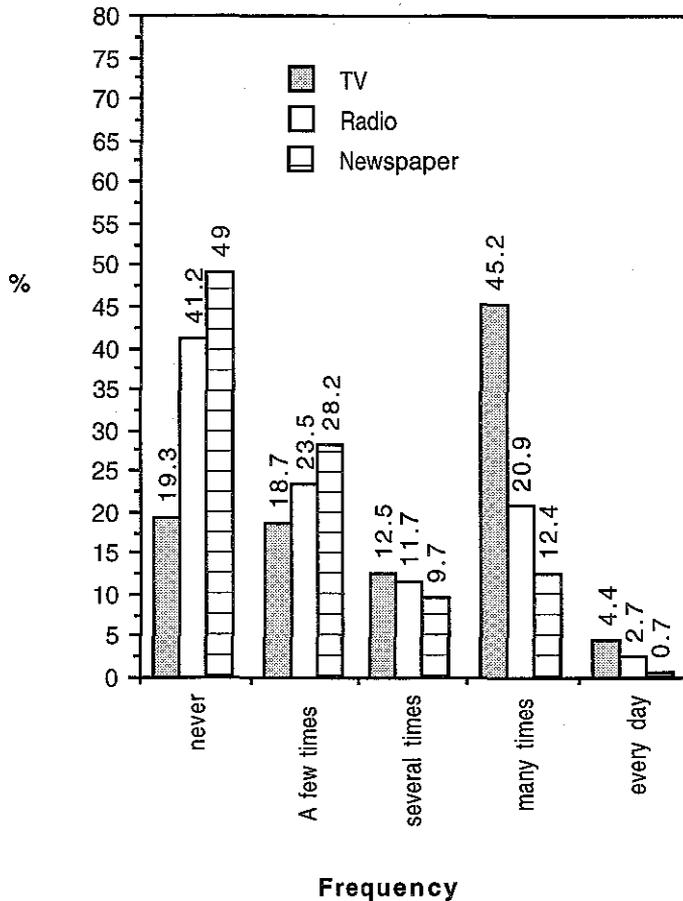
AIDS messages on TV “many times.” Only one-fifth (20.9%) reported receiving AIDS messages from the radio comparably frequently. Similarly, only about one-tenth (12.4%) noted AIDS messages appearing “many times” in newspapers. Those numbers reinforce the notion that TV seems to be most popular and most frequently attended medium for distributing AIDS information, while radio and newspapers are also reported as being important (see Figure 9, below). These survey findings are consistent with the in-depth interviews, where many interviewees also mentioned TV as an important medium of reception as well as one which motivated them to talk about AIDS.

Figure 9: **Reported Medium for AIDS Messages**



Total Cases: 1525 ( those who have received AIDS messages in the past month)

Figure 10: **Frequency of Finding AIDS Messages in the Past Month in Each Medium**



TV: Total Cases: 1764; Missing Cases: 19.

Radio: Total Cases: 1764; Missing Cases: 19.

Newspapers: Total Cases; 1765; Missing Cases: 18.

## 2. SCALE OF RECEPTION

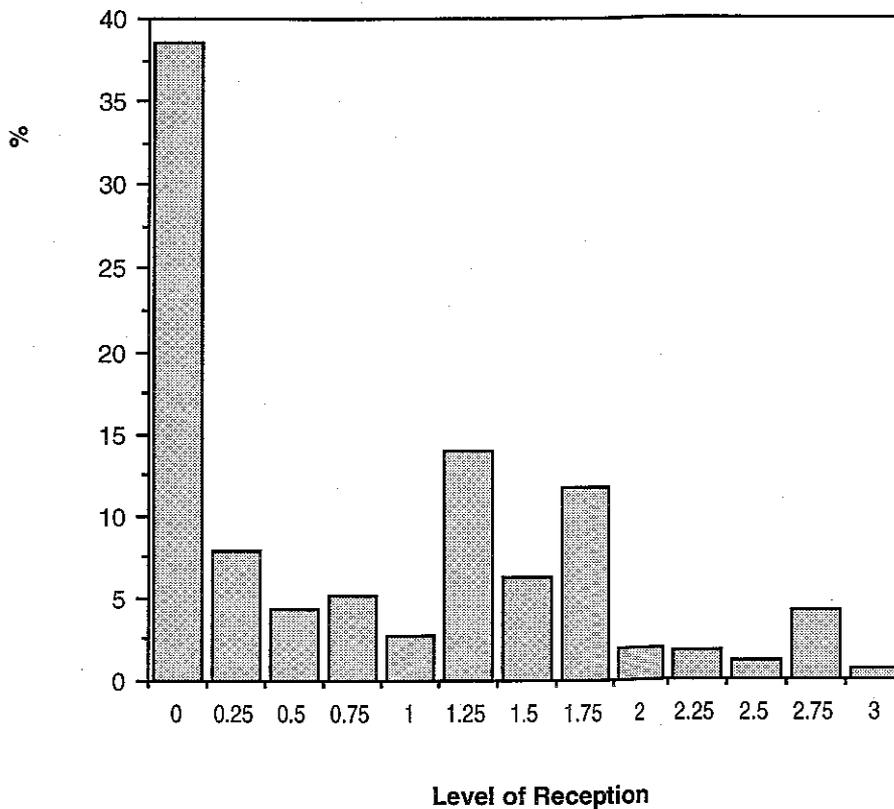
Reception scales for both, individual channels ( TV, radio, newspapers), and a total of all channels, were constructed as explained in chapter 4. The former scale consists of the sum of scored answers to questions asking in what medium people had found information on AIDS in the past month; how often they had seen programs/articles on

AIDS on radio, television or newspapers in the past month and asking about their recall of particular programs on AIDS broadcast in the past month.

The following (Figures 11, 12 and 13) show the distributions of these scores for: TV, radio and newspapers. For each channel, the mode is a score of zero. This concentration is explained by the scores for those people whose responses indicate no reception of mass media AIDS messages in the past one month (again, this zero score does not indicate that people have not received AIDS messages at all in past. Rather, it indicates that those people generally have less exposure to AIDS messages than others).

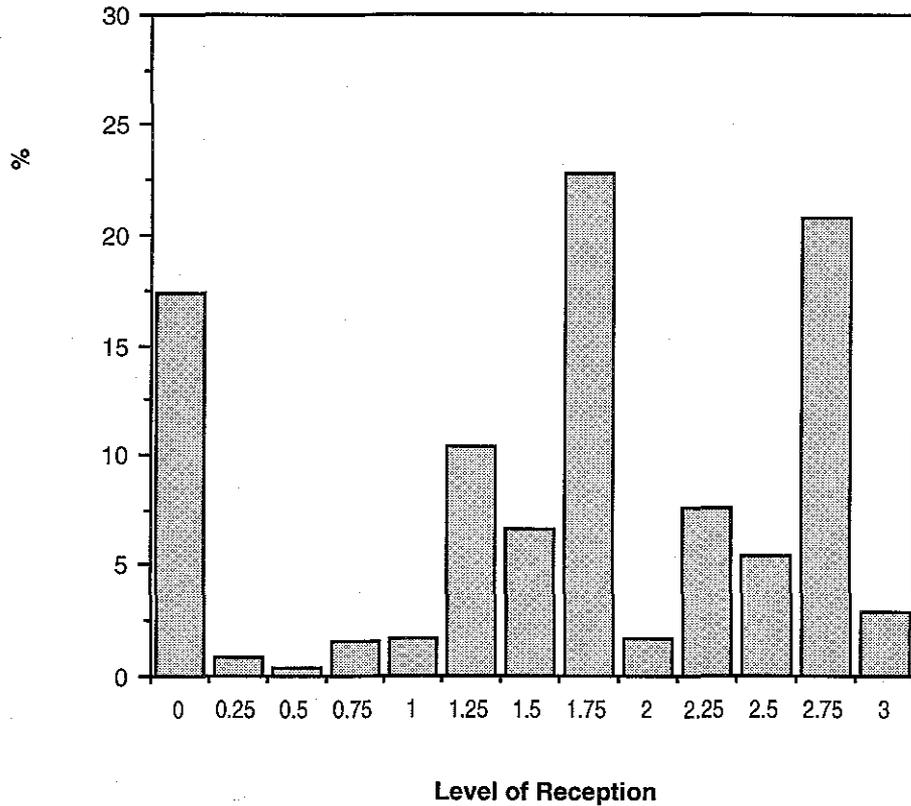
The bivariate correlation among these levels of reception from one channel to another, show that all three are reception measures are correlated at a statistically significant ( $p < .01$ ) level. In other words, people who received AIDS messages from one medium, also tend to receive it from another medium (see Table 4). Radio and newspapers showed the highest correlation to each other at  $r = .48$  ( $p < .01$ ). TV and newspapers also showed a positive correlation, though less strong than the one between radio and newspapers ( $r = .36$ ;  $p < .01$ ).

Figure 11: **Reception of AIDS Messages from Radio**



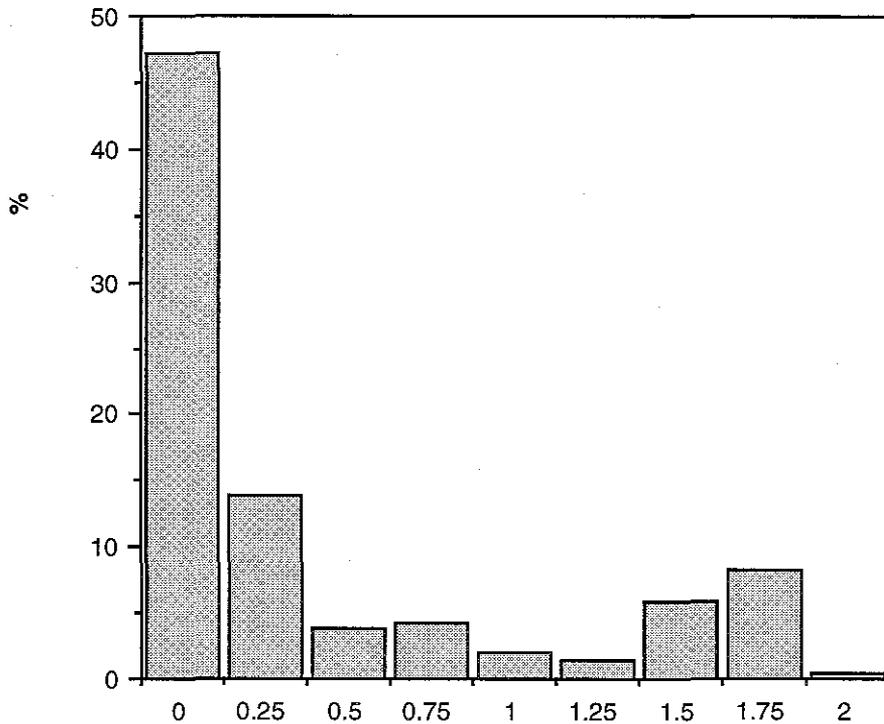
Reception Score grouped in .25 increments. Min. = 0 and max. = 3.  
Total Cases: 1759; Missing Cases: 24

Figure 12: Reception of AIDS Messages from TV



Reception Score grouped in .25 increments. Min. = 0 and max. = 3.  
Total Cases: 1751; Missing Cases: 32.

Figure 13: Reception of AIDS Messages from Newspapers



**Level of Reception**

Reception Score grouped in .25 increments. Min. = 0 and max. = 3.  
Total cases: 1765; Missing Cases: 18.

Table 4: Bivariate Correlations Among TV, Radio, and Newspapers

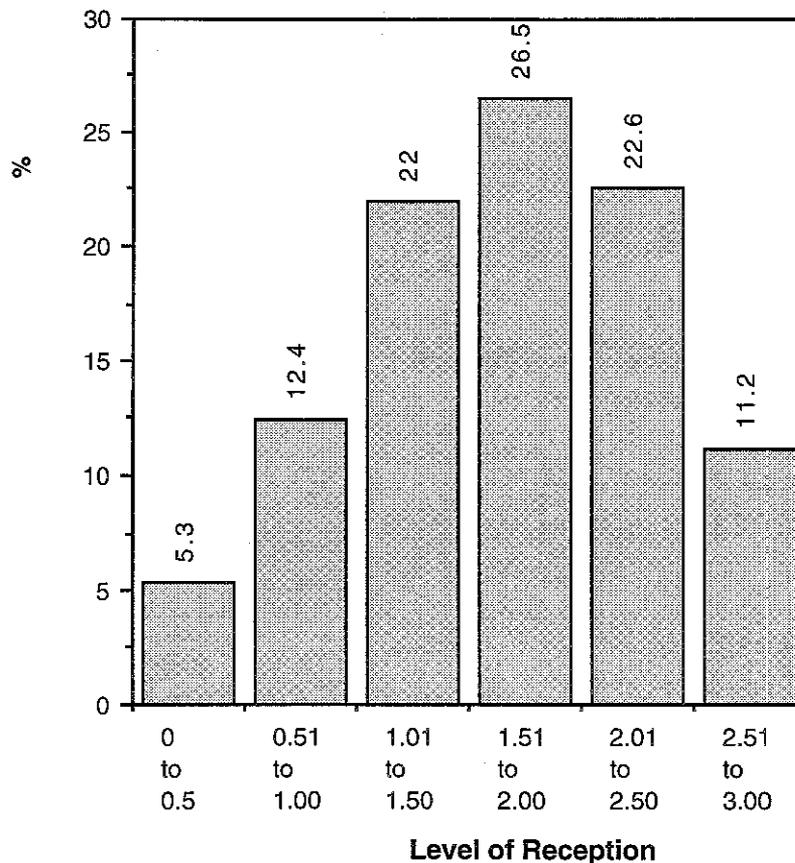
|            | TV | Radio | Newspapers |
|------------|----|-------|------------|
| TV         | -- | .41** | .36**      |
| Radio      |    | --    | .48**      |
| Newspapers |    |       | --         |

\*\*p<.01

The total reception score of all channels was created by summing up these variables for all three channels, giving them equal weight. The maximum score is three,

and the minimum score is zero<sup>3</sup> (see chapter 4 for details of the scale construction) . It is this overall scale that will be used in all subsequent analyses. The following figure (Figure 14) shows the distribution of this variable. As with the separate channel scores, the modal value is zero, representing those who did not receive any AIDS messages from any medium in the last month.

Figure 14: **Reception Scale of All Channels**



Total cases: 1737; Missing cases: 46

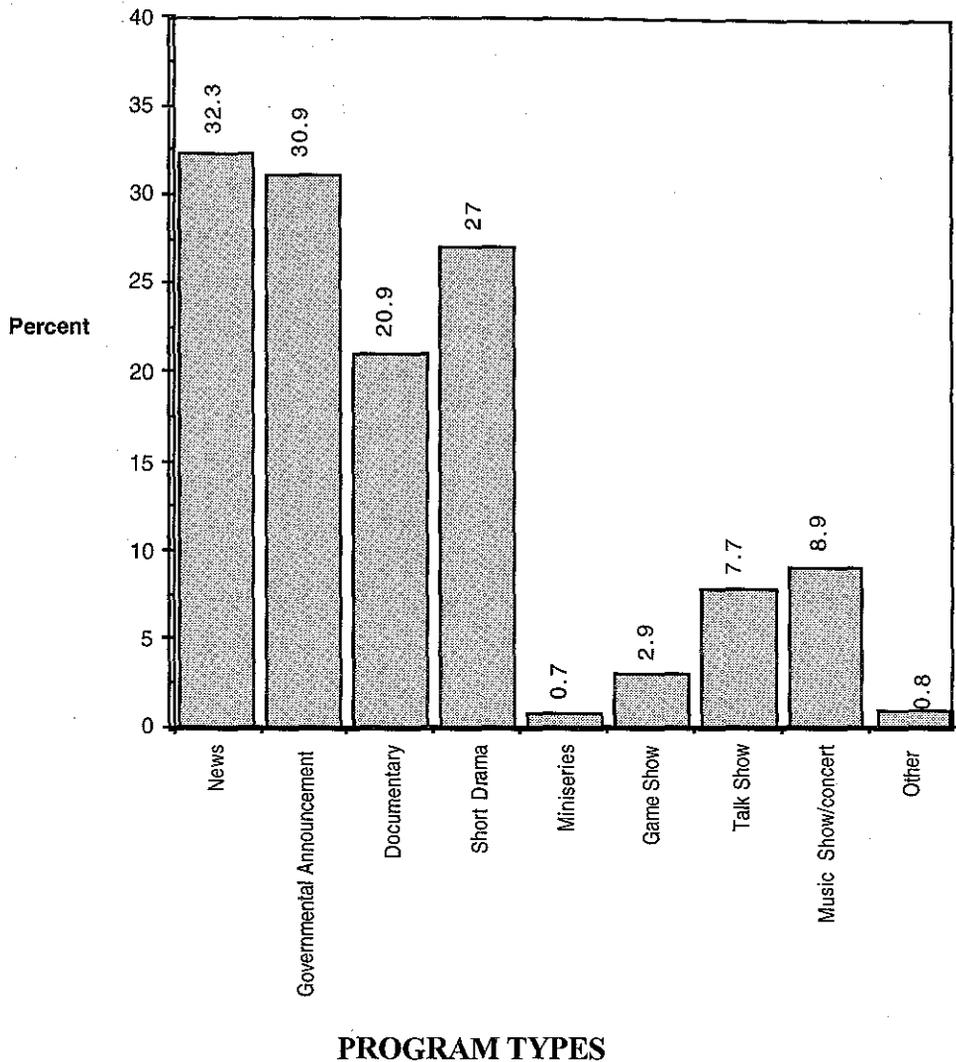
<sup>3</sup> While this original categorization of the reception variable (all channels) is used for all analyses, some subsequent figures show, for the purpose of graphic presentation a labeling of zero to five in increments of one. The underlying categorization is identical, with score ranges being translated as 0 to 0.5 = 0; 0.51 to 1.00 =1; 1.01 to 1.50 =2; 1.51 to 2.00 =3; 2.01 to 2.50 =4; 2.51 to 3.00 =5.

### 3. TYPES OF PROGRAMS

Surveyed subjects were further asked about the types of programs containing AIDS messages they had received across all media. Respondents were allowed to note any number of program type. Categories noted by them included news, governmental announcements and short dramas (32.3%, 30.9%, and 27.9%) respectively. One-fifth (20.9%) also reported seeing documentary programming regarding AIDS. Other programs like musical, talk- or game-shows and mini-series were reported by less than ten percent of respondents.

These findings might seem to point to governmental efforts at AIDS education and public outreach. The importance of the role of news in distributing AIDS information is recognized by government AIDS educators and policy makers. For example, according to interviews with officers of the Ministry of Public Health, the ministry tries to supply AIDS news to journalists to ensure public attention to this issue. Ministry officials conduct regular meetings to discuss the media coverage given to AIDS.

Figure 15: Reported Types of Programs Containing AIDS Messages



Total Cases: 1525 (those who have received AIDS messages in the past month)

#### 4. SUMMARY

This chapter summarized the types of AIDS messages respondents received in the month preceding the survey and detailed the construction of the reception scales for AIDS messages. Many respondents identified AIDS messages in the past one month from mass media channels, predominantly from TV, followed by radio and newspapers. Programs

that distribute AIDS messages were varied, including news, dramas, and governmental announcements. The reception of AIDS messages from one channel was positively correlated with the reception from the other two channels. The contents of mass media AIDS messages will be discussed in detail in Chapter 8. The next chapter will examine the relationship between interpersonal discourses on AIDS and the level of reception of AIDS messages from the mass media.

## Chapter Seven

### RECEPTION OF AIDS MESSAGES AND TALK ABOUT AIDS

In this chapter, I will examine the relationship between the level of reception of AIDS messages from the mass media and interpersonal discourses, having separately described the talking about AIDS people do, as well as the mass media messages they recall in the previous chapters. Here, I will initially examine the relationship between talking behavior and the specific level of reception of AIDS messages from each of three channels (TV, radio, and newspapers). Thereafter, the association between the overall level of reception (across these channels) and interpersonal discourses is tested at both the individual as well as at the social level. Finally, this chapter will address the question of causal direction implied in the hypotheses guiding this research.

#### 1. MEDIA RECEPTION AND TALK

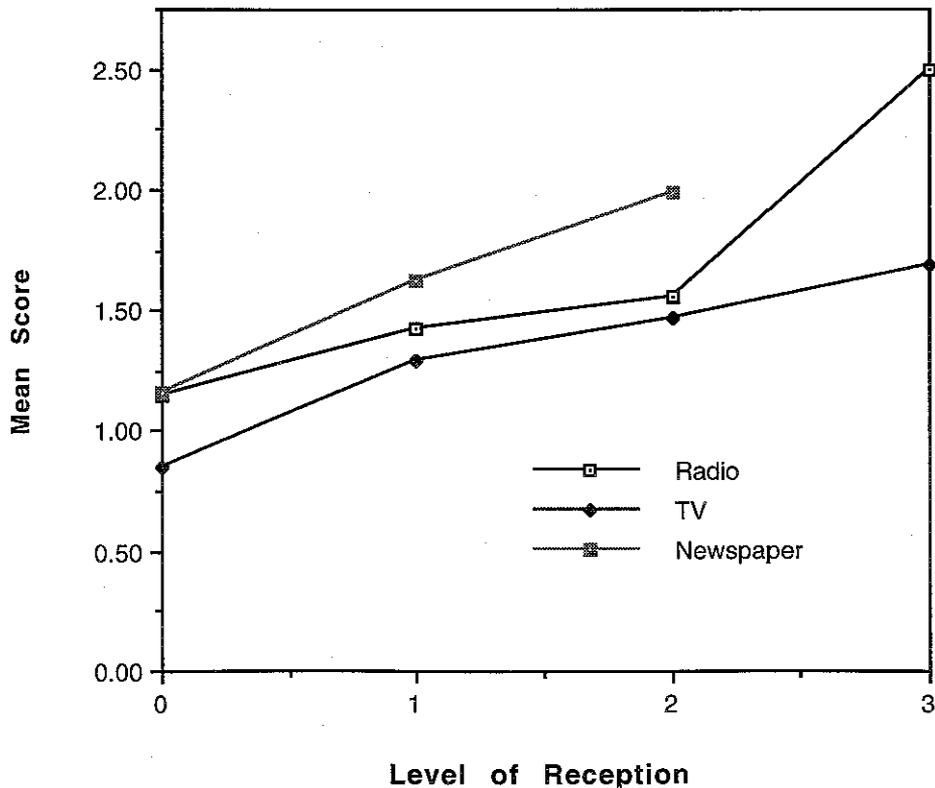
The reader will recall the hypotheses presented in chapter three. The first and most important hypothesis was stated as:

**HYPOTHESIS 1:** THOSE WHO ARE INTENSIVELY EXPOSED TO AIDS MESSAGES IN THE MASS MEDIA DO MORE TALKING ABOUT AIDS IN TERMS OF BOTH, QUANTITY AND VARIETY THAN THOSE PERSONS WHO ARE NOT.

Consequently, I tested for correlation between the level of reception of each channel and people's talking behaviors in terms of variety and frequency. Positive

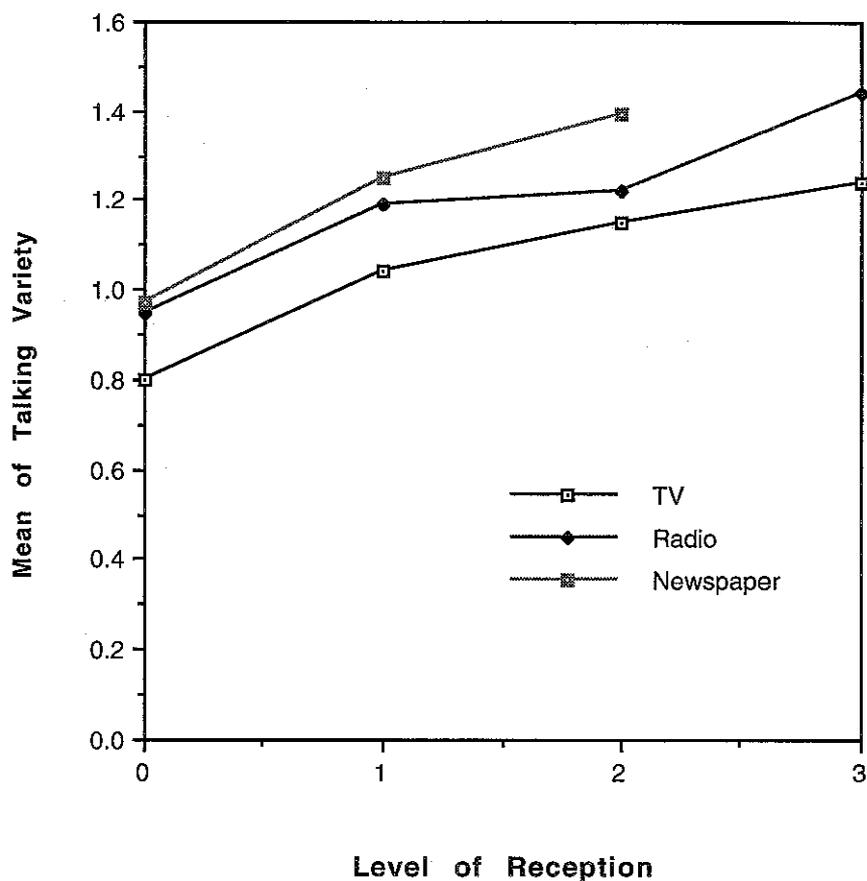
correlations were found between the reception variables for the three channels considered (TV, radio, newspaper) and the variety of talking respondents did at a statistically significant level ( $p < .01$ ; TV  $r = .20$ ; radio  $r = .21$ ; newspaper  $r = .22$ ). Those reception variables were also correlated with frequency of talking at a statistically significant level ( $r = .25$ ;  $r = .23$ ;  $r = .30$  respectively). Individuals who received more AIDS messages from any of these three media channels engage in more AIDS conversations in terms of both how often people talk about AIDS, and the number of AIDS topics conversed about. These relations are also presented in Figures 16 and 17.

Figure 16: **Talking frequency and level of reception of AIDS messages for TV, Radio, and Newspapers**



Total cases used for this analysis were 1783. Missing cases for each medium were: for TV: 32; for Radio: 24; For Newspapers: 18.

**Figure 17: Variety of Talk and Level of Reception of AIDS Messages from Radio, Television and Newspapers**



Total cases used for this analysis were 1783. Missing cases for each medium were: for TV: 50; for Radio: 42; For Newspapers: 36.

## 2. OVERALL RECEPTION AND TALKING AT THE INDIVIDUAL LEVEL

Here, the hypothesized relationship between the level of overall reception and AIDS talk in terms of frequency and variety at the individual level is tested (again, based on *Hypothesis 1*). This section, as well as subsequent analyses, use an overall index of total reception across the three channels (TV, radio, newspapers). Talking behavior as

reported by respondents is examined in terms of 1) how often people talked about AIDS with others; 2) the level of variety of AIDS topics people discussed with their talking partners (see Chapter 4 for details of this scale construction).

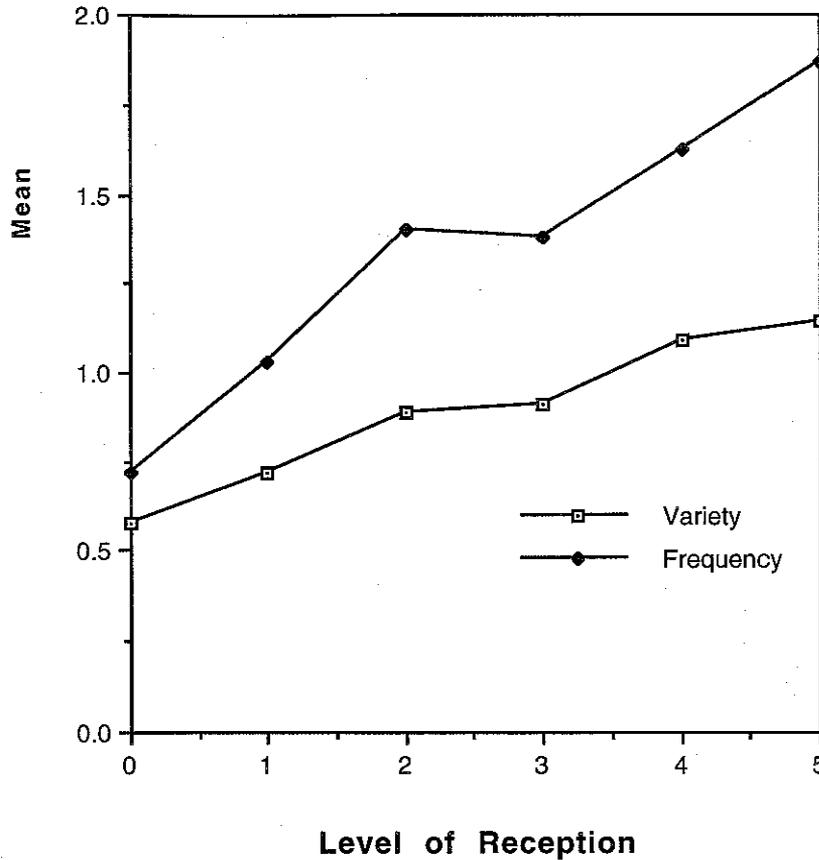
A correlation test between these two dimensions of talking behaviors and the level of mass media reception was performed, resulting in a statistically significant, positive correlation for both dimensions of talk (frequency:  $r=.27$   $p<.05$ ; and variety  $r=.33$ ;  $p<.05$ ). As shown in the table below (Table 5), the eta square values are significantly higher than those for r square; However, since the deviations from linearity did not fit into any predictable pattern for non-linearity, I have decided to treat this reception variable as linear here. The relationships between the talking variables and reception are depicted in Figure 18 below. This figure shows that the more mass media messages about AIDS an individual receives, the more likely he/she is to talk about AIDS in terms of frequency and variety.

**Table 5: Linearity between Multi-channel Reception of AIDS Messages and Talking Behaviors**

|                   |                                      |        |
|-------------------|--------------------------------------|--------|
| Talking frequency | r squared =.07**<br>eta squared=.14* | n=1732 |
| Talking variety   | r squared=.10**<br>eta squared=.16*  | n=1714 |

\*  $p<.05$  \*\* $P<.01$

Figure 18: Reception of AIDS messages and talking behavior at the individual level



This figure above is based on a reception score re-categorized into five levels for purposes of presentation. The data used for the underlying analysis was not re-categorized.

### 3. TOTAL RECEPTION AND TALKING AT THE SOCIAL LEVEL

It was hypothesized, that:

**HYPOTHESIS 2:** THOSE WHO BELONG TO A VILLAGE OR COMMUNITY THAT IS MORE EXPOSED TO AIDS MESSAGES TALK MORE AND ABOUT A GREATER NUMBER OF AIDS TOPICS THAN THOSE WHO BELONG TO A VILLAGE/COMMUNITY THAT IS LESS EXPOSED TO AIDS MESSAGES.

Having looked at this relationship at the individual level, I now turn to consideration of possible group (membership) effects on talk. Possible group effects are thought to be significant, as conversation must usually involve more than one person. This in turn may imply that there are group-level effects at work in this situation: for example, though one person may be very talkative, he or she cannot freely talk with anyone if others in this social environment are not able or willing to participate in AIDS discourses because they are not exposed to AIDS messages much. Similarly, even if one person is not particularly interested in AIDS or feels shy about initiating conversations about it, this person may nonetheless participate (or become compelled to) if everyone around him or her does discuss it as a result of others' exposure to AIDS messages. This relation is expressed in the following equation.

$$\text{Talking} = a + b_1(\text{Rec}_i - \text{Rec}_{gm}) + b_2(\text{Rec}_{gm} - \text{Rec}_{pm}) + b_3(\text{Rec}_i - \text{Rec}_{gm})(\text{Rec}_{gm} - \text{Rec}_{pm})$$

(a=constant;  $\text{Rec}_i$ =individual reception score;  
 $\text{Rec}_{gm}$ =group mean of reception score;  
 $\text{Rec}_{pm}$ =population mean of reception score)

As explained before, a social unit is conceptualized here as one of the clusters in which the survey was conducted (unit of analysis: a total of 64 of these clusters). Thus, the mean of group ( $\text{Rec}_{gm}$ ) refers to the mean of each cluster. The table below (Table 6) presents results of a multiple regression test.

Table 6: **Prediction of Talking by Including Contextual Effect ( Multiple Regression Analysis)**

|                   | Talking variety<br>Coefficient<br>( Standardized Coefficient) | Talking frequency<br>Coefficient<br>(Standardized Coefficient) |
|-------------------|---|--|
| Individual<br>b1  | .24 (.34)<br>p<.01  | .48 (.28)<br>p<.01   |
| Group<br>b2       | .22 (.11)<br>p<.01  | .28 (.06)<br>p<.05   |
| Interaction<br>b3 | —   | —  |
| Constant          | 1.10<br>p<.01   | 1.42<br>P<.01  |
| Multiple R        | .32   | .27  |
| Adjusted R square | .10   | .07  |
| N =               | 1711  | 1729   |

For both talking variety and frequency, there were both group and individual effects at statistically significant levels (  $p < .05$ ). There were however no interaction effects for both talking behaviors at statistically significant levels (coefficient p value is larger than .05). Even though the individual effects are bigger than any group effect, some influence from an individual's social environment is implied by this result. Thus, individual talking behaviors are associated with not only the individual reception of AIDS messages, but also the level of reception of other members of her/his community.

#### 4. CAUSAL INFERENCES

While the above findings tested the existence of an association between respondent's talking and the level of their reception of AIDS messages, there exist some difficulties in making any definitive statements on the causal direction within these relationships with the available data. The theoretical perspective adopted here would seem to imply that the causal direction proceeds from AIDS messages in mass media to influencing people's talk.

One reasonable argument for this kind of causal direction is a sense of logic: intuitively it is likely that people's talking about AIDS increases in terms of frequency and variety because of exposure to certain AIDS messages. It is less likely that people's talking would affect people's receiving information on AIDS to the same extent: Although attention (and thus reception) to AIDS information may be enhanced as a result of a person's familiarity with certain types of messages through talking, this effect is unlikely to equal that of the opposite causal direction. It appears somewhat unlikely that a person's media use habits, especially for the broadcast media shown to be most received for the sample, will be much influenced as a result of talking. There are limitations to watching TV. Those who watch TV for two hours would not necessarily watch (AIDS-related) TV programming for three hours now, because they have had conversations on AIDS. While, for those who receive their information generally from the mass media, the attention given to AIDS-programming may increase within the time frame they attend to TV, it is not likely that a shift in information seeking behavior will occur. In other words, not only would this require a TV-watcher to consciously search for AIDS-related programming (not a major component of broadcast time) irrespective of time-slot, but such hypothetical increases are subject to the ceiling imposed by what a broadcaster will send. Especially the (from the receiver's point of view) arbitrary distribution of AIDS messages limits the increases in the amount of reception of mass media information a

respondent may be able to seek out every day. Yet, it is possible that the reception measure may be just a measure of recall; that is those who talk are therefore more interested in AIDS, and recall such messages from the media more readily. Because this threatens my logic, I tried to look at this relationship with statistical tests.

Beyond my intuitive logical assumptions, I have attempted to ascertain the causal direction between reception and talking statistically. Below, I present the procedure and the results of testing. In order make a logically valid argument on the causal direction between reception and talking behaviors, a third (implied) variable, the level of general exposure to mass media, is included. This exposure variable is constructed based on answers to questions regarding general use of mass media, including TV, radio, newspaper. As discussed above, exposure to mass media is considered a precondition for the reception of AIDS messages.

Thus, the three core elements discussed here are 1) E: the level of exposure to mass media, 2) R: the level of reception of AIDS messages and 3) T: talking behavior (both frequency and variety). I will begin by discussing all possible models among these variables, subsequently eliminating combinations judged statistically inappropriate or logically impossible.

#### **i) Assumption of non-recursive, unidirectional models**

The most basic underlying assumption of the relations of these variables in this research is, that the model is non-recursive. Moreover it is assumed that the relations are unidirectional (not two-way models). Should the relationship between the three concepts look like those models below (Figure 19), there is no statistical resolution to the question of causal direction. In other words, these models are assumed to be non-recursive, unidirectional for the purposes of causation testing.

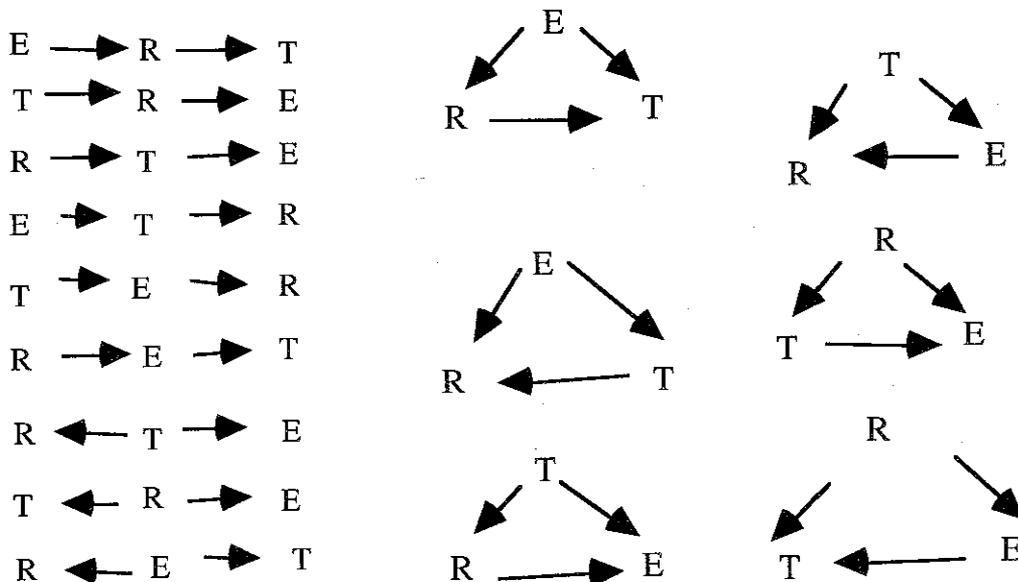
Figure 19: Hypothetical non-testable models



ii) Possible Combinations:

Based on the above assumption, the graphic presentation below (Figure 20) constitutes the list of combinatorial possibilities for our three concepts (all are both one-way and non-recursive models). However, some of these models need to be eliminated on logical grounds:

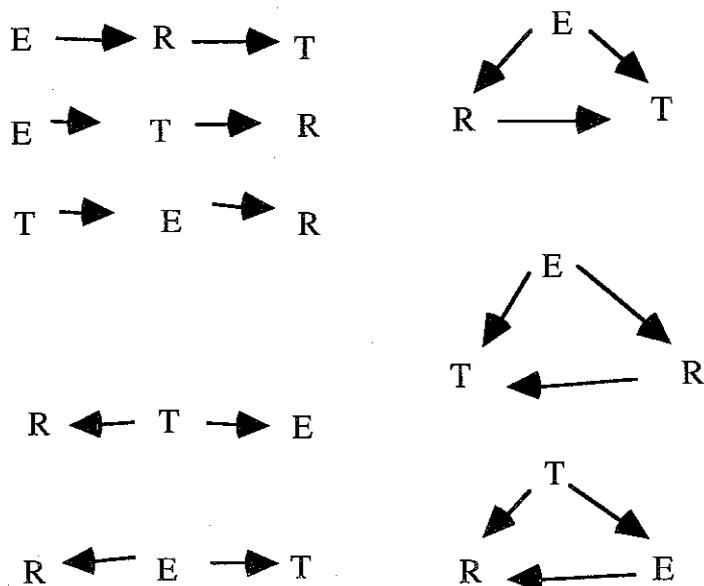
Figure 20: Combinatorial possibilities of Exposure, Reception and Talking.



### iii) Requirement for an Exposure ---> Reception sequence

Some sequence orders between variables simply cannot be justified: The obvious order between Exposure and Reception is that E has to precede R. In other words, in order for someone to receive AIDS messages from the mass media, he/she has to be exposed to mass media messages in the first place. For example, if a man is illiterate and owns neither a TV nor a radio, he can hardly be expected to receive many mass media AIDS messages (except perhaps by circumstance or accident). Based on this assumption of an E to R sequence, nine possible models remain. These are expressed in Figure 21 as follows:

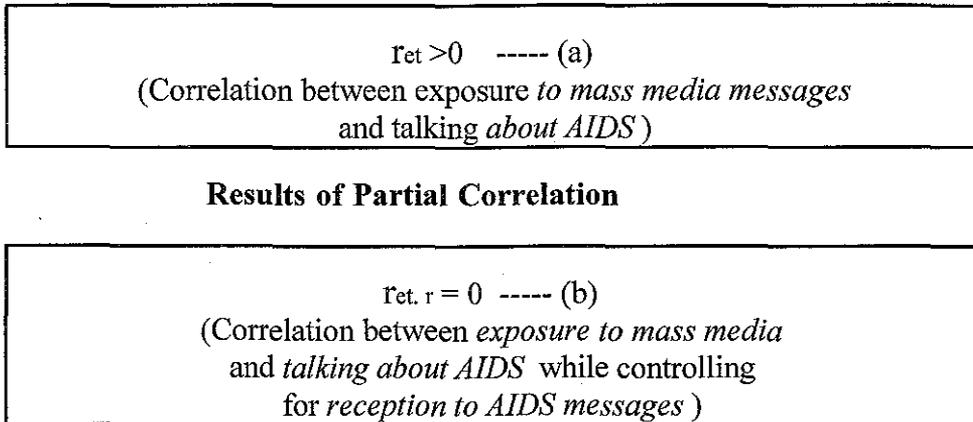
Figure 21: **Remaining Plausible Models of Causation**





of talking. The level of reception of AIDS messages is assumed to depend on an individual's exposure to mass media in general. This model, were it to be supported, needs to be capable of showing the following relations expressed in the two statistical models below:

Figure 23: **Basic Statistical Models Hypothesized for Model 1**



The relationship between the level of exposure and talking behaviors will disappear, once the correlations are controlled by reception.

Other models ( 2 through 5 ) can be tested in a same way by using both correlation and partial correlation. The expected results for models 2-4 are summarized in the table below.

Table 7: Proposed Alternative Models and Expected Results of Correlation Tests

|         | Expected Result of Correlations | Expected Result of Partial Correlations |
|---------|---------------------------------|---|
| Model 2 | $r_{er} > 0$                    | $r_{er.t} = 0$                          |
| Model 3 | $r_{rt} > 0$                    | $r_{rt.e} = 0$                          |
| Model 4 | $r_{rt} > 0$                    | $r_{rt} > r_{rt.e} > 0$                 |
| Model 5 | $r_{rt} > 0$                    | $r_{rt} > r_{rt.e} > 0$                 |

In order to show the viability of my hypothetical model by a process of elimination from the set of possible combinations listed above, I tested the partial correlation between each two variables, first alone and later controlling for each third variable (see Table 8, below). The results of the correlation analysis show, as had been assumed, a strong positive relationship between exposure to mass media and the level of reception of AIDS messages. Also, Pearsons correlations indicate that talking behaviors (both frequency and variety) and the level of exposure to mass media are positively related at a statistically significant level ( $p < .01$ ). These correlations became weaker, once the level of reception to mass media (assumed to be the intervening variable) was controlled for, though they remain significant ( $p < .01$ ). These results do not allow a claim regarding causal direction of the expected model (model 1), at least directly. On the other hand, these results are consistent with the 3-arrow models (models 4 and 5).

Table 8: **Test of Five Models of Relations among Talking about AIDS, Reception of AIDS Messages and Exposure to Mass Media**

| Model | Talking variable | Zero Order Correlations         | Expected Partial Correlations | Observed Partial Corr. | Decision      |
|-------|------------------|---------------------------------|-------------------------------|------------------------|---------------|
| 1     | freq.            | $r_{et} = .20^{**}$<br>[n=1684] | $r_{et.r} = 0$                | $.09^{**}$<br>[n=1665] | Reject        |
|       | variety          | $r_{et} = .31^{**}$<br>[n=1666] | $r_{et.r} = 0$                | $.19^{**}$<br>[1665]   | Reject        |
| 2     | freq.            | $r_{er} = .27^{**}$<br>[n=1684] | $r_{er.t} = 0$                | $.46^{**}$<br>[n=1683] | Reject        |
|       | variety          | $r_{er} = .32^{**}$<br>[n=1666] | $r_{er.t} = 0$                | $.42^{**}$<br>[n=1665] | Reject        |
| 3     | freq.            | $r_{rt} = .27^{**}$<br>[n=1684] | $r_{rt.e} = 0$                | $.20^{**}$<br>[n=1683] | Reject        |
|       | variety          | $r_{rt} = .32^{**}$<br>[n=1666] | $r_{rt.e} = 0$                | $.21^{**}$<br>[n=1665] | Reject        |
| 4     | freq.            | $r_{rt} = .27^{**}$<br>[n=1684] | $r_{rt.e} > 0$                | $.20^{**}$<br>[n=1683] | Not falsified |
|       | variety          | $r_{rt} = .32^{**}$<br>[n=1666] | $r_{rt.e} > 0$                | $.21^{**}$<br>[n=1665] | Not falsified |
| 5     | freq.            | $r_{rt} = .27^{**}$<br>[n=1684] | $r_{rt.e} > 0$                | $.20^{**}$<br>[n=1683] | Not falsified |
|       | variety          | $r_{rt} = .32^{**}$<br>[n=1666] | $r_{rt.e} > 0$                | $.21^{**}$<br>[n=1665] | Not falsified |

t: Talked about AIDS in terms of frequency and variety

e: Exposure to Mass Media

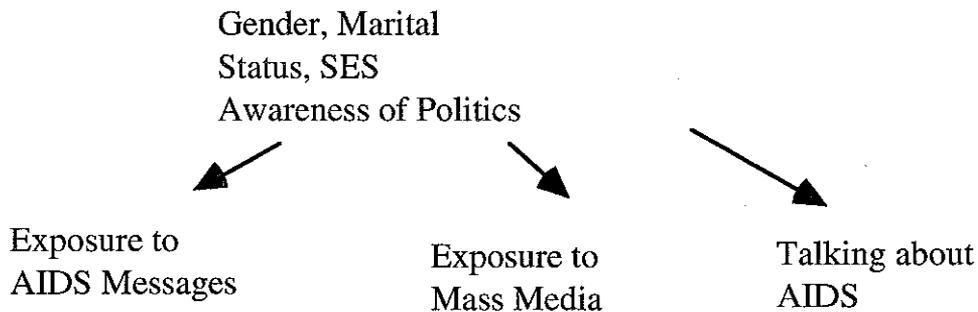
r: Reception of AIDS Messages

p<.01 \*\* p<.05 \*

Note: The correlation between exposure and reception of AIDS messages was:  $r=.48$   $p<.01$ )

The possibility that the relationships connecting the three elements of exposure, reception and talking are spurious is one special possibility. The relationship would in that case look like the one diagrammed in Figure 24 below:

Figure 24: **Spurious-relations-model**



The above figure shows one possible way in which a causal inference from the association of our three variables might be a spurious effects of other variables, such as socioeconomic status (SES), gender, marital status and awareness of political issues. These other variables might be causal factors influencing the results. In other words, the association among the variables *reception of AIDS messages*, *exposure to mass media* and *talking about AIDS* may be due to the associations of these variables with these variables. In order to explicate whether this sort of spurious relationship might exist here, a set of partial correlations between R&T or E&T controlling for SES, gender, and political awareness were tested (see Table 9 below). All of these control variables were correlated strongly with both talking and reception at statistically significant levels (see Correlation Table in Appendix 2).

Table 9: **Correlations between Talking and Exposure and Reception after controlling for SES, political awareness, marital status and gender**

|                          |   |   |
|--------------------------|---|---|
| <b>Talking Frequency</b> | $r_{rt.socioeco\ poli\ genderMar}$<br>=.23**<br>n=1705<br>( $r_{rt}=.27^{**}$ ) | $r_{et.socioeco\ poli\ genderMar}$<br>=.16**<br>(n=1710)<br>( $r_{et}=.20^{**}$ ) |
| <b>Talking Variety</b>   | $r_{rt.socioeco\ poli\ genderMar}$<br>=.25**<br>n=1687<br>( $r_{rt}=.32^{**}$ ) | $r_{et.socioeco\ poli\ genderMar}$<br>=.22**<br>(n=1692)<br>( $r_{et}=.31^{**}$ ) |

\*\* p<.01

These partial correlations between talking and the level of exposure appear to be statistically significant, even after controlling for political awareness, socioeconomic status and gender. The inference that the association between exposure and talking, or reception and talking, is merely reflection of the effects of these third variables (gender, SES, awareness of politics, marital status) is not consistent with the data and can therefore be rejected.

## **v) Conclusions**

The results above did not support the hypothesized model (Model 1). One reason for this lack of support likely is that an adequate model capable of accounting for directions of causality in the communication situation surrounding mass media material and talking about AIDS would have to be considerably more complex, including other variables not considered here. A second reason may be the limited reliability of each of the variables used in this model. Since most variables used in this analysis were constructed out of several survey measurements, the match between the variables and what they are to have represented may not be as precise as theoretically possible.

## **5. Summary**

In sum, this chapter tested hypotheses 1 and 2 in a fundamental way, so as to lay down the basis for going on to include other factors, such as social appropriateness into the analysis. These two hypotheses were generally supported: individuals who receive more AIDS messages from the mass media are more likely to talk about AIDS in terms of frequency and variety. It should also be noted that no definitive causal direction could be conclusively shown from statistical results. The presumed causal direction model was however not falsified by the analysis and was thus upheld as the most likely.

## Chapter Eight

### FRAMING OF MASS MEDIA AND INTERPERSONAL DISCOURSES

The previous chapter examined several aspects of the relationship between the level of reception of AIDS messages from the mass media and people's talking behaviors about AIDS in terms of the context-providing role of mass media. This present chapter in turn will examine the association between mass media and individual frames of AIDS messages. Hypothesis 6, positing a linkage between the framing of AIDS issues in the mass media and people's ways of talking about AIDS issues, is tested in this chapter:

*HYPOTHESIS 6: PEOPLE WHO ARE EXPOSED TO MORE AIDS MESSAGES FROM THE MASS MEDIA ARE MORE LIKELY TO TALK ABOUT AIDS, USING THOSE FRAMES PRESENTED BY THE MASS MEDIA.*

In order to test this assumed compatibility of frames, an index of 13 items was created to allow for comparisons between respondent's received frames versus those intended by the makers of media materials ( See Table 10 below). This list of items were chosen from three groups, broadly categorized as asking about causation of AIDS (five items), the consequences of AIDS (four items), and asking about preventive measures (four items). While the survey instrument allows the quantitative evaluation of this index, the intended frames are explored in a qualitative way.

Table 10: **Topical Categorization of AIDS Themes into Cause, Consequence, Prevention Issues**

| <b>Types of Topics</b> | <b>Items used for a question</b>                                  |
|------------------------|---|
| <b>Cause</b>           | AIDS in Thailand is transmitted through homosexuals               |
|                        | AIDS is spreading because of foreign tourists                     |
|                        | AIDS is spreading because of IV drug users                        |
|                        | AIDS is spread by sex industry workers                            |
|                        | AIDS is spread by men who go to prostitutes                       |
| <b>Consequence</b>     | AIDS is a threat to an individual's life and lifestyle            |
|                        | AIDS is a threat to a couple's relationship                       |
|                        | AIDS is a threat to tourism in Thailand                           |
|                        | AIDS is a threat to the health of mothers and infants             |
| <b>Prevention</b>      | the government should be responsible for AIDS prevention campaign |
|                        | AIDS can be prevented by changing individual sexual behavior      |
|                        | AIDS is prevented by using condoms                                |
|                        | AIDS can be prevented by reducing the number of sexual partners   |

## 1. PERCEIVED FRAMES IN THE MASS MEDIA

It is difficult to characterize the way AIDS issues are treated in the mass media, because of the dearth of systematic content analyses of Thai mass media messages on AIDS, as noted in earlier chapters. This research attempted to gather data in two ways: by asking respondents about their perception of media frames and by analyzing interviews with producers and creators of mass media materials on AIDS (as discussed in the Methods Chapter). A comparison of the results of both methods was attempted here.

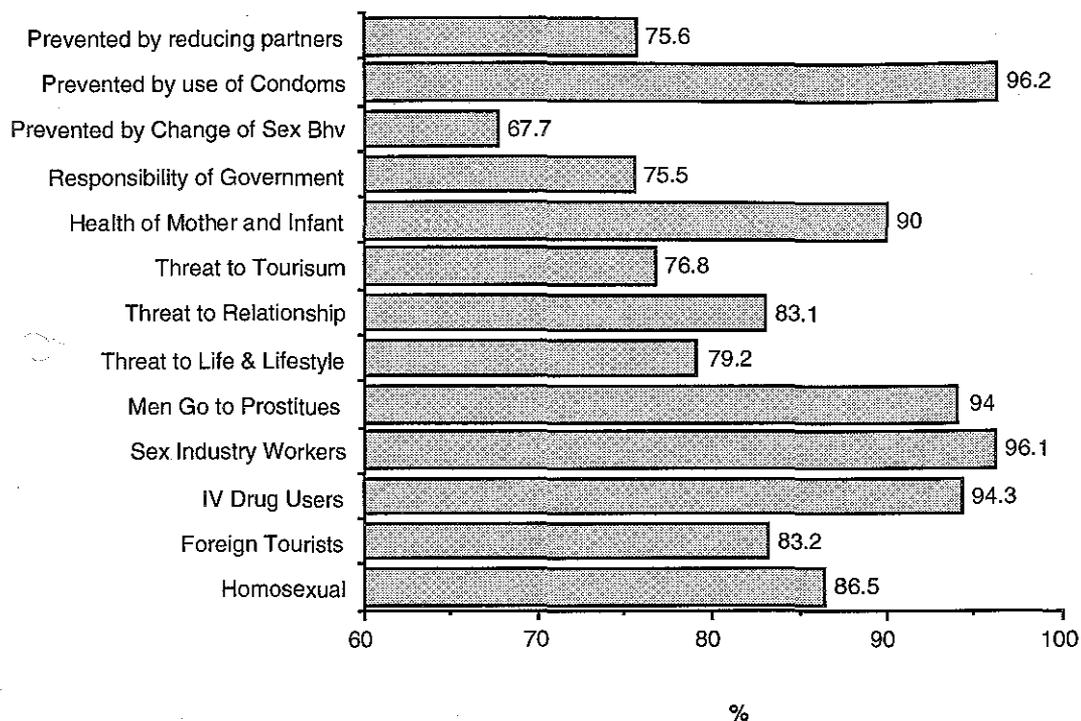
One strategy used closed-ended survey questions asking respondents about their perception of media content for a number of listed items in the table. All respondents, including those who did not report talking about AIDS in the past one month, were asked

whether they recall or have talked about the 13 mass media items listed in the questionnaire. They answered each item in terms of "yes" or "no, " in response to being asked "Do you think that the following statements describe the information concerning AIDS you have actually perceived from various kinds of mass media?"

As shown the figure below (Figure 25), reception and recall were high for all items: No item was recalled by less than 65% percent of respondents. There are differences in the reported percentages across topics. Those topics recalled by the highest percentage of respondents (equal to or more than 90 percent of respondents) were: 1) AIDS is prevented by condoms ( 96.2%); 2) AIDS is spread by sex industry workers (96.1%); 3) AIDS is spread by IV drug users (94.3%); 4) AIDS is spread by men who patronize prostitutes (94.0%) and 5) AIDS is a threat to the health of mothers and infants (90.0%). The three least recalled media topics were: 1) AIDS can be prevented by changing individual sexual behaviors (67.7%); 2) The government should be responsible for AIDS prevention campaigns (75.5%) and 3) AIDS can be prevented by reducing the number of sexual partners (65.6%).

Of the five items reported by the greatest number of respondents, three are about the cause of AIDS. One is about prevention -- condoms occupy a unique place in respondents recall as the most prominent preventive measure -- and one about a consequence of AIDS. Causation of AIDS is thus the most recalled topic of the three groups of items in the figure. All three items least reported by respondents were about the prevention of AIDS. Except for condom use, prevention of AIDS seems to be the least recognized media topic.

Figure 25: **Topics People Received in Mass Media**



Cases used for this frequency figure were total respondents: 1783. There are a few missing cases for each item but no more than 6 for any category.

## 2. INTENDED FRAMES IN THE MEDIA

The second way of characterizing the framing of AIDS messages in the mass media is based on investigating the framing intended for these materials by their creators and disseminators, for example an emphasis on certain risk groups or behaviors. The group of AIDS educators interviewed to gather data for such an interpretation includes professionals who make decisions on these messages as well those who produce them. Extensive interviews were conducted with those people, for example, governmental officers/health workers in the Ministry of Public Health, officers of non governmental organizations, and producers of public relations agencies, and the results were content analyzed.

This way of analyzing intended frames is an exploratory methodology, asking interviewees' experiences and opinions with creating and disseminating AIDS messages to the public. This data was qualitatively evaluated in terms of the same 13-item index and is discussed here in comparison with respondent's perceived frames.

It is reasoned that this construction of 'intended frames' as representative of the larger system of media messages on AIDS is justified in the Thai context, since the lack of archival sources dictated this method of data collection -- interviewing those involved in the creation of messages. The selection of interview partners as well is a reflection of the (from an American perspective) unusual set of arrangements between the government and the media characterized by a close interchange of personnel (civil service government personnel as issue-experts): Though formally (all) newspapers and some radio and TV channels (others are owned by the army or the government) are privately owned and operated in a market-oriented manner, in practice there exists a good deal of government-subsidized information on themes deemed to be of importance to policy makers. This includes the provision of information as well as government officers acting as 'experts' in their official capacities. In other words, the mass media construction of AIDS in Thailand is open to non-journalists. There is plenty of opportunity for these interviewees to directly participate in the framing of AIDS messages.

Those people interviewed, most of whom work for the government directly or indirectly in a public relations capacity, were selected because they are active participants in the creation of AIDS messages distributed to Thai audiences. Some governmental officers function not only as decision makers of whether and how to create AIDS messages but also as producers. For example, one governmental health officer, a former director of the AIDS division of the MOPH, sent his articles on AIDS to a popular newspaper at least once weekly. A director of a private public relation company also reported that she had been writing many articles on AIDS in a dominant Thai newspaper

as part of a contract for a foreign aid agency (making her a quasi-governmental voice) as part of its AIDS prevention activity in Thailand.

Overall, the Thai government is quite aware of the role of the mass media in shaping public consciousness on AIDS; as a consequence, it makes substantial efforts to distribute AIDS information, for example, through press releases, regular press conferences and the like. In other words, there is a dynamic integration of the players in the field of health and mass media, with the media being helpful in distributing information subsidized by government efforts to have it be available. This is in addition to "public service"-type programming (sometimes made by and) distributed on behalf of the government. Consequently, it seems reasonable to assume that the intentions of these decision-makers (in AIDS policy and AIDS message production) will, to some extent, be reflected in the content of AIDS messages in the mass media.

The following discussion on the intended message structure will take into account the historical description of the target of AIDS messages in Thailand, the structure of the media system as it concerns the distribution of AIDS messages, and cultural as well as organization limitations to the creation and distribution of AIDS messages. The historical description that follows is based on the information gathered from policy makers in government who are in charge of deciding the targeting of AIDS messages. Those people are aware of the epidemiological aspects of the AIDS situation in Thailand and have the political power to set the agenda for AIDS prevention education. The organizational and cultural limitations were mainly emphasized by producers and creators working for either the production component of a government agency or for outside production companies that receive government contracts. Professionals working for non-governmental organizations also were able to elaborate on the limitations placed on governmental actors. These NGO personnel contributed an added perspective on AIDS message creation and distribution limitations.

## 2.1. Historical Description of the content of AIDS messages

The historical changes in the selection of target groups and targeted (unsafe) behaviors were explained by a former director of the AIDS division of the Ministry of Public Health (MOPH). He was responsible for AIDS prevention in the late 1980s. He explained that the targeted risk groups of the AIDS epidemic had changed and were broadly divided into five waves

We actually have five different waves. The first wave was from 1984-1987, for homosexuals -- male to male transmission. From 1988-1991, we have [IV] drug users... Both groups transmitted [the] disease to sex workers... Also, heterosexual transmission from abroad, tourists, etc., [the] spread to women and then...to the public since 1989. This is [the] third wave... To prostitutes was the third wave. And then from prostitutes to male clients was the fourth wave.... [A] significant increase was observed in 1992. And I'm expecting another curve for children [I assume that he meant fifth wave].

He further described the change of AIDS education message content made in response to this view of AIDS as developing in waves.

It is very straight forward. During this period [the first wave] we want them to know [about] AIDS., how the disease is transmitted, how to prevent [it]. This is for homosexuals -- is the main [group threatened], and you can also spread [AIDS] by [IV] drug users, by heterosexuals. These figures [illustrations] sometime showed male and male together in the pamphlets, in the materials.

He continued to explain the changes in the recommended prevention behaviors to be encouraged:

During this period, [the second wave], we don't want them [IV drug users] to share needles, to avoid drug use. But the main content is AIDS still be here .. But how to prevent [it] varied. In this case how to prevent [AIDS transmission] is condom [use]. Avoid homosexual acts... And in this phase [third and fourth wave], we will have AIDS, how it is transmitted, you pay more attention to heterosexual and say don't be [promiscuous]... Don't visit prostitutes. Use condoms... this is more or less the same, the female role in preventing the disease. You can promote male condom use by women being insistent... And also, promote condom use. They have to accept this because they realize more and more among them [men] especially have the infection.

The behavioral changes sought to reduce risk behaviors were changed along with the shift in these target groups. With recognition of the migration of HIV to the heterosexual population, the use of condoms has come to be emphasized more strongly, not only in government-sponsored AIDS messages, but also in government policy: for example, the so called "100% condom policy" legitimizes prostitutes requiring their customers' using condoms and threatens to punish those who reject complying. With the recognition of the possibility of the transmission of HIV from husbands to their wives, the term "family" was emphasized as having to be protected. Most recently, youth has become the target of AIDS education. This same interviewee called the shifts in message content the direct reflection of the changing perception of target groups by policy makers.

## **2.2. The Production Process**

The influence of the constraints in the production process upon message content is more complex. While policy-level decisions described above are, by and large, reflected in the content of media messages on AIDS, the production and distribution stages do seem to filter the initial message priorities. I have, for the purpose of this presentation, divided types of production modes into five broad groups.

The first type of media production takes place within governmental organizations by members of the MOPH. For example, a government officer reported to me that he

writes a weekly column on AIDS for a major Thai newspaper, in addition to having published a book on AIDS which, according to him, was well received. Another doctor working for the rural health extension of the Ministry reported having recorded a song about AIDS, which was distributed to other local health officers. Another one of her songs, performed by a popular singer, has appeared on TV. These government officers are free to produce media products, so long as these are in line with official policy.

The second type is a cooperation between the government and private production companies. An MOPH officer responsible for video productions explained how she creates videos by subcontracting the actual production to an outside firm. She considers this contractor merely as a tool, noting that she remains in charge of decisions on the content:

"We [the Ministry] are the ones who brief the story to copywriters. They are from a private organization. We brief them on content and also the target group. They plot the story and give it back to us to proof it. After that they just write the script following the plot... they are not technical personnel enough.[meaning expertise on AIDS], so we try to put technical [information] about AIDS into the drama. At the beginning of our program it is quite obstructed. Sometimes I threw away the script and said "no, I don't want this kind of story. Write it again. Write it again." But after two months, it's OK.

She perceived there to be a lack of understanding of the medical aspect of AIDS in this production firm and expressed a strong sense of control over the content of the resulting programming. However, this seems not always be the case.

Sometimes, private production companies gain greater control over the content of messages, even though they are working under a government contract. This is the third type. The former art director of the Thai office of a large international advertisement company, for example, explained her approach to the production for AIDS messages. She said:

I created that TV commercial. It means I created the concept on the story board, about how we present the story of one man who has AIDS and what he can do if has AIDS already or how he could prevent it. That then, in brief, [is what] it means [when] the government asks us the first thing, to tell [the] Thai people that what AIDS is.

She emphasized that agency for creating a message lay with her. She further explained the content of eight commercials on AIDS she wrote the script for. One, for example, targets upper-middle-class men. She recalled the script and told the story as follows.

The message is that one guy, he is a very executive man. He is a boss and he talks about himself. The scene will open with him and a card in his hand. He go up in the lift, an elevator and he sees this crowd. The [card] is a birthday card. In the card it says "I love Papa. A Happy Birthday" and he [will] say, "this is my birthday and I can have this birthday for only 2 more years after this, because I know that I have AIDS" And in his mind he will tell about why he has AIDS... We showed [this scene] like this, because we wanted to tell businessman "don't do this, this is not right."

She said she created those TV commercials based on research data supplied by the Secretary of the Government and based on their requests. However, these requests seem to have been fairly general in this case:

In the advertising process, we have to do the brief. It's called creative brief. In the creative brief, you know what you have to say. It's called a "single-minded proposition."... and after receiving the brief [the client that is], there is one official and Dr. W.; he will tell me many things about AIDS victim and make me feel sorry [for them]...

This briefing is the occasion when producers and decision makers get together and the lead producer presents the programs these policy makers wish. Her creative process seems not have been intervened in much; however, the interaction itself appears to have influenced her understanding in the way these government officials may have sought, though not using authority. Another AIDS educator at MOPH also noted that she

preferred using private production firms rather than in-house government production offices, since she considers the creative skills of outside firms to be of a higher quality.

The fourth type of production process has non-governmental organizations creating their own AIDS messages. Here, governmental control is minimal. One executive officer of an NGO involved in AIDS education said he thought the NGOs to be much more flexible than the government, making them pioneers in AIDS education. He recalled the past of AIDS education:

...at that time, government policy didn't want to play on AIDS, because they feared it would affect tourism. So I am an NGO. I could do it. At that time the government did not understand. They feared tourists would avoid Thailand if we talked too much about AIDS. We tried explain that tourism and AIDS are not the same...

While the NGOs seem indeed to have been out in front in doing AIDS education, interviewees did not note their contradicting government policy in terms of priorities emphasized or prevention strategies advocated. For example, a female activist of a slum development NGO in Bangkok noted that her organization shifted its AIDS education emphasis from drug users to women, knowing that female sex workers were being infected with HIV. She tries to educate women not to work in the sex industry, as well as to pressure married men not to patronize prostitutes. These priorities do appear very much in line with the priorities noted by MOPH personnel.

The fifth type of production is not controlled by any of these groups of AIDS educators, but by journalists. However, these other players (the government represented mostly by the MOPH and NGOs) are well aware of the significance of media messages created by journalism and actively try to supply them with material. Several government officials, including an officer who is assigned to the public relations section of the MOPH, told me that the Ministry has a regular morning meeting, which serves to analyze mass media coverage of AIDS and to attempt to reach journalists by means of appropriate

press releases and newsletters. While ultimate 'control' over message content lies with the journalist in this case, the content of AIDS messages in the Thai mass media is constantly checked, and appropriately subsidized information is made available to reflect the government's priorities on AIDS.

### **2.3. Cultural, Organizational, Individual Limitations**

No clear division was attempted in talking about the cultural, organizational, and individual limitations on the content of AIDS messages produced. This might, in view of the interests of this research, have turned out to be a fairly pointless distinction: As described earlier, an organization may use cultural arguments for restricting certain AIDS messages -- and individuals follows these policy. Those are the explicit limitations. The more unobtrusive ones in turn may have to do with individuals having their own ways of interpreting what constitutes an appropriate message by their assessment of cultural taboos. This is an implicit limitation. The message production process is thus shaped by multiple limitations, individually as well as organizationally perceived cultural limitations, the limited capacity for creativity, and organizational decision-making processes on AIDS educational productions.

An example of cultural limitation circumscribing the creation of messages was the possibility of depicting women as dominant negotiation partners in making decisions about AIDS prevention in their sexual relationships. An interviewee working for a foreign governmental agency responsible for making AIDS messages for people in Bangkok reported that there were some difficulties in negotiating such a portrayal with the Thai government liaison; there was a hesitation on the part of one of Thai committee member to depict women as being in charge of the use of condoms. Another example was reported to me by a governmental officer, who related an instance in which he had trouble getting backing for a condom campaign. The trend seems to point to a gradual

liberalization in this respect. Another health officer recalled past experience with trying to obtain a consensus on a condom campaigns aimed at the young population:

Condom is a very good protective barrier but when we introduced the idea, people [were] concerned that we are proposing the idea to encourage people to be more promiscuous... I remember that the first proposal has been turned down because they're afraid of promoting promiscuity, especially among the young group of people, Then we tried to convince them, especially in the final session.

Condom promotion campaigns have been approved as policy since 1991 and have spread to the national level.

Not only at the policy, but also at the production level, there appear to be some limitations. Those limitations were not always explicit regulations, but often individual, voluntary restrictions. A government producer felt that Thai women are culturally limited when it came to talking about AIDS. When she was asked about her opinion about a program in which women are portrayed as talking about condoms, she responded:

It's not nice for a lady, for women, to talk about condoms or sex with men. I mean if you are a Thai lady, it's not nice to talk about sex or any kind [of thing] concerning sex with a man or strangers. You have to keep in mind that, even if you want to talk, you cannot talk. If I talk it's impolite.

Individual ways of perceiving appropriateness may be reflected in the final product of the AIDS message then. She continued, saying that

I did a television spot once. [In it] I tried to say that the wife talked to [her] husband... I tried to talk in a positive way. I didn't say exactly "use the condom!" I just said "I love you, I hope you love me, I hope you love the children. So I trust you... AIDS is a serious disease now. And I love you."

These sorts of limiting perceptions may reflect on the creative work by private agencies as well. The former art director described the final product of a commercial that was to promote condom use, referring to cultural limitation affecting its construction:

... we can't show the sex scene on TV because of the Thai tradition; and because we have the committee that will censor the story, like [for] sex, intercourse or something [like that]... The picture will open with, you see the clothes on the floor, like they put them down and you see the

brassiere, the lingerie from the woman and [the underwear] from the man. And the picture will be very close up, [so the viewer can] see many things and they [will] listen to some voice as the bed is moving and some breathing and then we [focus] close up to the trousers, the pants of a man. In his pocket, [he] has a condom but he didn't use it. [That is] like it is then. Forget it, then die!

It is not only sexual topics that may be considered difficult to print or broadcast, but also politically controversial issues. For example, a producer of a radio program reported another kind of limitation, breaking the taboo of connecting the topic of tourism to that of AIDS:

Sometimes, PR conflicts with something. Like if we talk about AIDS too much, it will affect our tourism. And this is still problematic, we cannot. It is major problem we cannot solve. If we say that PR about AIDS contradicts tourism, it means we accept that we should not do PR about AIDS, because tourism [income] might fall. Actually, it's a different issue: tourism concerns [the] sightseeing of culture and arts that they [tourists] do not have [at home]...

This producer is pessimistic about the effectiveness of informing the public about AIDS while using a format that will not offend anyone.

#### **2.4. Limits on the Distribution of Messages**

Despite the care taken by policy-makers and producers to create and select what they believe will be effective AIDS messages, the distribution system for such communications efforts may constitute a further constraint, being somewhat limited and arbitrary, especially for TV with radio being a less problematic medium. The most important reason for the difficulties in access to TV broadcasting is its high cost. Even though videos for AIDS education might be produced by the MOPH or public relations companies on a low budget, the distribution costs are not generally included in the budgeting process. Productions are generally sent to TV stations with the expectation that they will be broadcast, but there does not appear to be any mechanism in place for forcing broadcasters to air these spots without buying channel time. The public and

military-owned channels are favorably disposed to public service campaigns. However, even here, the direct influence of creators and policy makers is extremely limited. The former art director mentioned being disappointed with the limited number of TV channels which broadcast her series of AIDS commercials. She said:

We didn't make the media planing. We didn't order the TV [station to broadcast the spots]... because the government didn't give us the budget to do it. So they first told the channels "this is like a compliment, please open it." So, I think for a media plan, [this] it is not good. I think it failed. Because it's OK to one channel... but some channels didn't [broadcast it]. They just put it like, one day, one spot. It failed!

Because of this voluntary and arbitrary selection of material by the broadcasters themselves, commercials that promoted condoms (like those described above) were less frequently broadcast than others that may have been perceived as safer for broadcast. Condom commercials may be seen as too sexual. Another governmental officer reported her positive experiences:

I was lucky because the TV stations were interested in my song... I saw my song on TV channels 11 and 3. I think I am lucky because they continued airing my song. The song tells the general public about a happy family life in order not to push people to AIDS.

Radio stations were described as being more flexible in terms of distributing AIDS messages. The former art director, for example, said that about 200 radio stations broadcast her AIDS production. In other words, while TV can be a great medium for public outreach, no real media planning is possible for AIDS campaign decisions makers. Radio, on the other hand, may be easier to plan for, in terms of the distribution of AIDS messages.

### **3. Perceived Frames versus Intended Frames**

In order to compare the perceived with the intended frames, the interviews described above were examined. To make a systematic comparison possible, the 13 items used for

the survey of perceived frames were used as bases. Even though a simply checklist was used to determine which of those items were mentioned in an each interview, the details and emphases of each item were qualitatively evaluated. These topics were divided into three levels, according to the emphasis they were given by the interviewees. The highest level of intended frames were those topics that were reported across most or all of the interviews and presented with great emphasis. The lowest level of intended frames were topics that were reported by very few interviews, or, if they were mentioned by several subjects, the mention was brief and without express significance (to the interviewee). Into the middle level are categorized topics covered by some interviewees, with only a medium level of emphasis.

The ranking of perceived frames on the other hand, was simply based on a percentage ranking as described before. The highest rank was given to topics that were reported by equal to or more than 90% of respondents. The middle rank was given to those topics reported by between 80 and 89% of respondents. The lowest ranking was given to those topics mentioned by lower than 80% of respondents. The summary of perceived and intended frames are presented in the table below ( Table 11) .

This table presents a summary of the degree of overlap between the intended and the perceived framing of AIDS messages. Seven items out of 13 fell into the same level of emphasis. Only four items showed a difference of one level between intended and perceived frames. Both understandings or frames heavily emphasize the use of condoms as preventive measures. In terms of the cause of AIDS, sex industry workers and men who have sexual contact with them were reported the most for both intended and perceived (respondents) frames. While homosexuals and foreign tourists were reported in the intended frame interviews as having been included in recent AIDS messages (as contributing causes of AIDS) only at a low level, these subjects did nonetheless appear in the perceived frames (of respondents) at the medium level.

There is a slight gap between the intended original messages and what respondents perceived as AIDS messages. Large disparities were seen in regards to that aspect of messages referring to "changing individual sexual behavior," perhaps due to the influence of cultural factors on the production of AIDS messages; as a result, these messages seem to not have directly connected to males' reducing their number of sexual partners. While the messages intended by their creators emphasized (according to these people) marital fidelity for men, even the policy-makers themselves realize (and mentioned this explicitly) that this is hard or even impossible to portray. What I lump into a "cultural" constraint ranges from producers afraid to be specific (emphasizing "loving families" instead of mentioning married men's escapades) to broadcaster's reluctance to show possibly offensive messages. This particular topic (and the corresponding perception gap on the part of the audience) are indicative of a failure to communicate directly and explicitly to change sexual behaviors.

According to the interviews, the intended frames for presenting risk groups have been changing over the past decade; however, those changes were, if at all, only very selectively noticed by respondents. For example, respondents still noted homosexuals and IV drug users as groups mentioned in the mass media at the medium level, even as these agendas appear to have been phased out some time ago, according to the interviews. This finding may imply that the public may collectively retain images of the content of mass messages over some time.

Table 11: **Comparative Summary of Perceived and Intended Frames of AIDS as an Issue in the Mass Media**

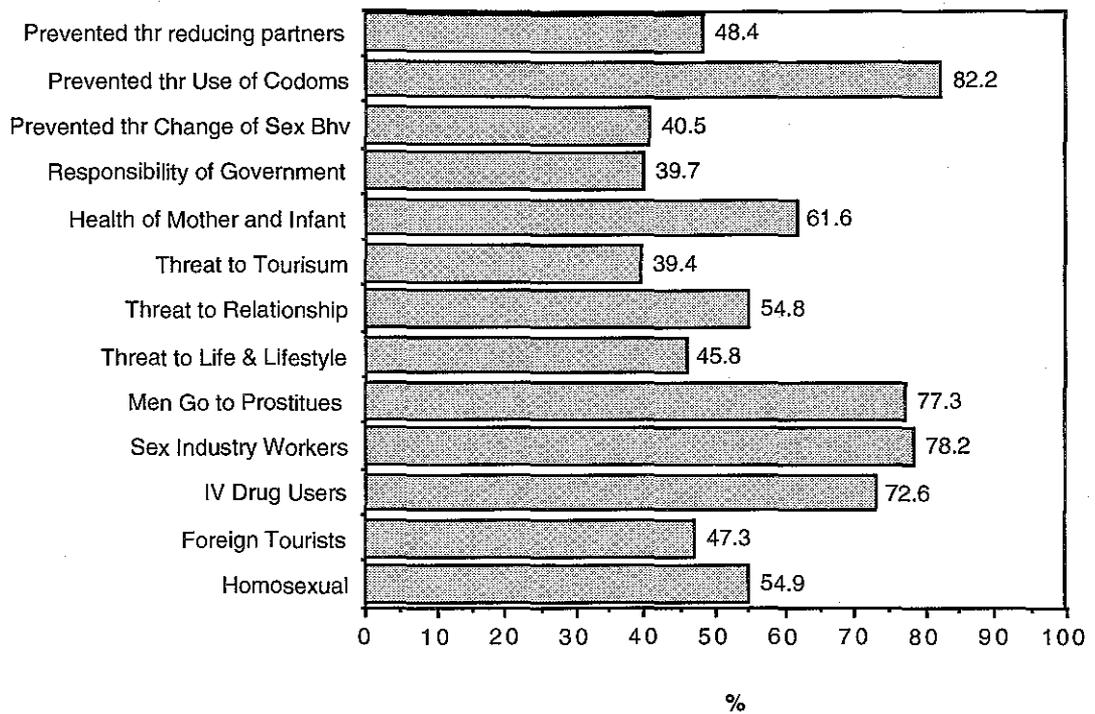
|                                      | <i>Intended</i>   |   |   |
|--------------------------------------|---|---|---|
|                                      | Lower   | Middle  | Higher  |
| <i>Perceived</i><br>Lower<br>( <80%) | -AIDS is a threat to an individual's life and lifestyle<br>-the government should be responsible for AIDS prevention campaign<br>-AIDS is a threat to tourism in Thailand |   | -AIDS can be prevented by changing individual sexual behavior<br>-AIDS can be prevented by reducing the number of sexual partners |
| Middle<br>(80%-89%)                  | -AIDS in Thailand is transmitted through homosexuals<br>-AIDS is spreading because of foreign tourists  | -AIDS is a threat to a couple's relationship  |   |
| Higher (90%+)                        |   | -AIDS is a threat to the health of mothers and infants<br>-AIDS is spreading because of IV drug users | -AIDS is prevented by using condoms<br>-AIDS is spread by sex industry workers<br>-AIDS is spread by men who go to prostitutes    |

#### 4. AIDS TOPICS DISCUSSED

The following discussion concentrates on the perceived frames, because the intended frames analysis cannot be used quantitatively. Displayed in the figure (Figure 26) below are the responses of the surveyed population to the same 13 items in answer to the question "have you ever mentioned the following topics in your conversations with anyone?" The four most commonly reported conversation topics on AIDS were: 1)

AIDS is prevented by using condoms (82.2%); 2) AIDS is spread by sex industry workers (78.2%); 3) AIDS is spread by men who go to prostitutes (77.3%); and 4) AIDS is spread through IV-drug users (72.6%). The least frequently reported AIDS topics discussed are 1) AIDS is a threat to tourism in Thailand (39.4%); 2) the responsibility of the government for AIDS prevention (39.7%); and 3) AIDS can be prevented by changing individual sexual behaviors (40.5%).

Figure 26: **AIDS Topics Talked about**

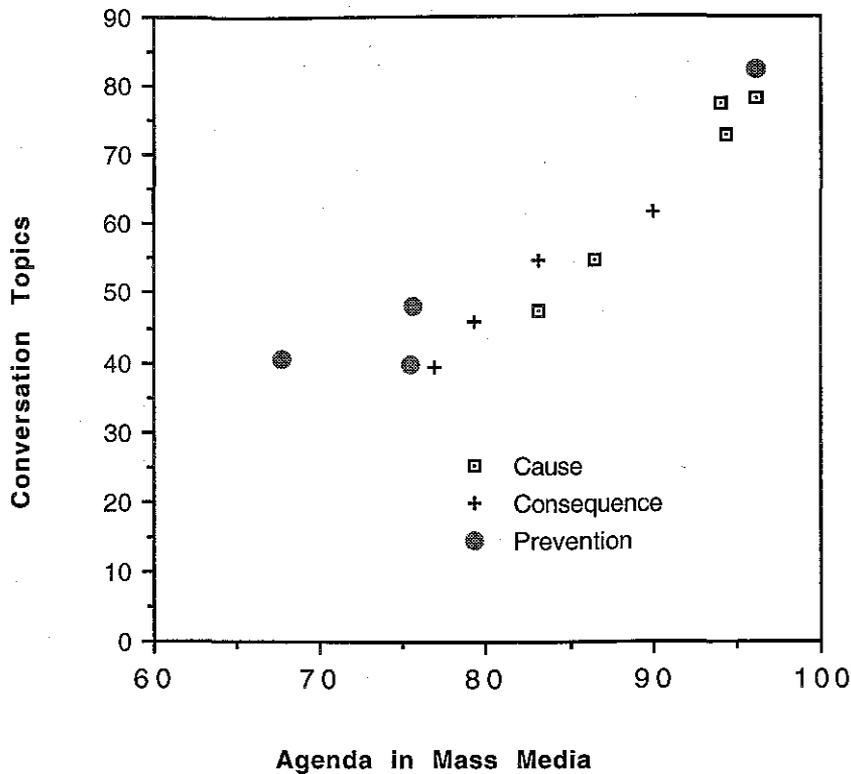


Total Cases 1783

## 5. RELATIONS BETWEEN LEVEL OF RECEPTION AND FRAMES

Perceived frames in the mass media and those topics conversed about by respondents were compared next. As seen in the figure below (Figure 27), perceived topics in the media and topics talked about are positively related as shown by the scattergram below. This figure refers to the averaged scores for perceived frames and conversed topics across individuals. Generally the percentages of conversational topics were lower than those which respondents noted as having perceived as media topics; in addition, the rank ordering of topics from most to least diverge somewhat between these two measures. The results presented in this figure indicate that the more strongly identified a topic is by respondents, the more likely it is that this same topic will be reported as a conversation topic. For example, those topics reported as having been talked about by the greatest percentage of respondents encompass three causation topics and one prevention topic -- condoms. This high-end distribution is analogous to the one reported for media topic recall. Of the three types of topics, topics concerning the prevention of AIDS were least reported, both in terms of perceived topics in mass media as well as having being conversation topics. This finding is consistent with the theoretical argument of this research, namely that mass media may provide people with the content of conversational topics about AIDS. These findings offer supportive evidence that AIDS topics identified by the majority of people as having appeared in the mass media tend to become part of the agenda of interpersonal communication.

Figure 27: **Reported Topics Discussed and Recalled from the Mass Media**



## 6. RELATIONSHIPS BETWEEN AIDS TOPICS IN THE MASS MEDIA & AIDS TOPICS DISCUSSED AT THE INDIVIDUAL LEVEL

The above section focused on the association between the types of topics frequently discussed by respondents and certain AIDS topics which the majority of respondents has identified as having been presented in the mass media. Now, the discussion moves to the study of the associations between AIDS frames contained in interpersonal discourse and those frames of AIDS messages identified as having been presented in the mass media (identified in the above discussion) as they relate to the level of reception of AIDS messages at the individual level.

It was hypothesized that people who are exposed to AIDS messages at a higher level tend to talk about AIDS in similar ways as those presented in the mass media. If this is to be supported by means of the above associations, it would mean that reportedly emphasized media topics will enjoy a stronger association between reception and the topic-specific dependent talking variable than those themes not reported as having been emphasized. The same pattern would be expected to hold for those frames interviewed makers of media material noted as being prevalent, versus others not noted.

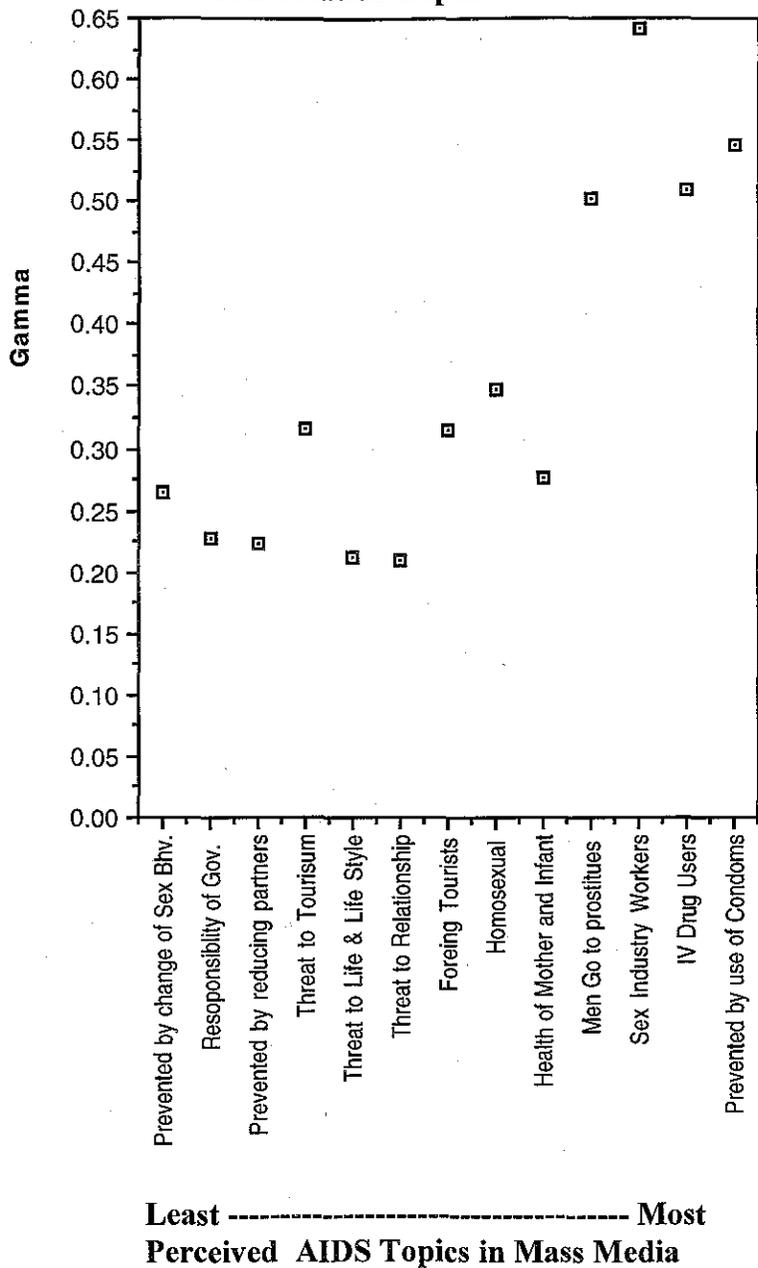
The strength of the association between the level of reception of media AIDS messages and AIDS topics discussed among respondents is shown in the table (Table 12) below in terms of the gamma values of the association. In the following figure below (Figure 28), the topics were listed on the x-axis based on the ranking order of averaged percentage of reported perceived AIDS topics in the mass media. In this graph, the further right on the graph the topic is shown, the higher the percentage of reports for that topic as a mass media theme. The differences in gamma values will allow a prediction of the difference in the likelihood of individuals talking about these topics.

The data presented in these figures provides support for hypothesis 6, namely that the association between reception and talk about AIDS topics is a function of the degree to which the topic was discussed in the mass media. For example, sex industry workers are often discussed in the mass media, as is the use of condoms for AIDS prevention. Both topics are more likely to be talked about by individuals who have a high level of reception of AIDS messages from the mass media. However, some other topics which were less reported as media frames showed less of an association between the individual reception of AIDS messages and talk about the topic -- for example most prevention frames, as well as consequences of AIDS frames such as the attribution of AIDS prevention campaigns as being a government responsibility showed a relatively lower gamma value.

Table 12: **Strength of Association in Terms of Gamma between Reception Level & Discussion of AIDS Topic**

|             | <b>AIDS-related Topics</b>                                      | <b>Gamma value</b> |
|-------------|---|--------------------|
| Cause       | Transmitted though homosexual                                   | .349               |
|             | Because of Foreign Tourists                                     | .317               |
|             | Because of IV Drug Users  | .510               |
|             | Spread by Sex Industry Workers                                  | .642               |
|             | Spread by Men who go to prostitutes                             | .502               |
| Consequence | Threat to Individuals' life and lifestyle                       | .212               |
|             | Threat to couple's relationship                                 | .210               |
|             | Threat to tourism in Thailand                                   | .212               |
|             | Threat of Health of mothers and infants                         | .277               |
|             | Government responsibility for prevention campaign               | .227               |
| Prevention  | AIDS can be prevented by changing individuals sexual behaviors  | .264               |
|             | AIDS is prevented by using condoms                              | .547               |
|             | AIDS can be prevented by reducing the number of sexual partners | .223               |

Figure 28: **Level of Emphasis of Identified Media Topics and Strength of Associations between Reception of AIDS Messages and Conversation Topics**



## 7. COMMENTS AND INTERPRETATION

This chapter was concerned with the way AIDS messages were presented in the mass media and the way these qualities and emphases (frames) relate to the way individuals talk about AIDS. Media content was examined through two sets of constructs: intended messages and perceived messages. Intended messages are operationalized as the intention and recognition of that intention in the creation and production process of AIDS prevention messages for the general public by its creators and disseminators during interviews. Perceived messages are operationalized as the recall of AIDS messages in mass media by the survey respondents. Hypothesis 6, calling for the framing of interpersonal communication of AIDS to correlate with prevalent mediated AIDS messages, was supported overall: People who have higher a level of reception of AIDS messages tend to talk about AIDS topics identified as prevalent in the mass media discourse about AIDS, including the use of condoms and attributions of the causes of AIDS.

Intended and perceived AIDS messages showed some similarity in the framing of certain topics. For example, the use of condoms for AIDS prevention, and the contribution of the sex industry to the AIDS epidemic were recognized in both frames. There is, however, a gap between the intended AIDS messages that policy makers and producers were trying to create and the messages survey respondents perceived. For example, the need to the reduce the number of one's sexual partners was recognized as an important concept for promotion by policy makers, yet respondents perceived this theme to have been one of at best light emphasis. I assume that a combination of organizational, individual and cultural limitations limited the actual production of this media message. In addition, it is assumed that individual recall of the content of messages

is filtered by the respondent's own concerns and characteristics. This aspect of recall of media messages may warrant further investigation.

The findings of this chapter also suggested support for that hypothesis concerned with the mass media role in providing content to conversations. The discussion above also provided evidence of an 'agenda-setting'-type effect of perceived media frames upon interpersonal conversations, with the effect increasing along with that person's media reception.

Another factor besides media effect that may influence people's ways of talking about AIDS should be mentioned at this time: there may be an intervening variable, experiential significance, which may explain some of the differences in the results of the associations. Gamson (1992) noted that when people talk about politics, they integrate experiential knowledge and cultural wisdom into their talk. The example of the foreign-tourist-as-cause-of-AIDS, connected to fears of declining tourism as due to fear of AIDS may exemplify this. Although there is some tourism industry in Kanchanaburi, few of these foreigners are sex tourists. There is no tourist-oriented bar and brothel industry in town. Consequently, the surveyed Kanchanaburi residents may have answered very differently than residents of Pattaya (an extremely tourist and sex-tourism-dependent seashore resort) for example -- where experiential knowledge would have made both tourist topics very relevant to talk about.<sup>4</sup> In Kanchanaburi however, the topics may lack context and cannot be connected with experiential knowledge and cultural wisdom. As Gamson (1992) also pointed out, people may rely on media resources for topics with which people do not have direct experience and thus cannot bring much experience or cultural wisdom to bear. Thus, some of the interpretations on the mass media's role in content providing may be more complex than I was able to discuss in this chapter.

---

<sup>4</sup> Majority of respondents are farmers and labors ( See Method Section).

## Chapter Nine

### SOCIAL APPROPRIATENESS AS RELATED TO AIDS TALKS AND RECEPTION OF AIDS MESSAGES

This chapter further examines the context-providing role of the mass media. First, I will examine the relationship between the level of reception and individual perceptions about the social appropriateness of talking at both the individual and social level (hypothesis 5 and 6). I then examine the individual perception of the social appropriateness of AIDS talk as it relates to talking behaviors at both the individual and the social level (expressed in hypotheses 3 and 4). The level of social appropriateness is expressed in two variables: one is a dichotomous variable measuring whether people perceive it to be socially appropriate to ask their friends about whether these had talked about safe-sex practices with their respective spouses (SOCIAPT). The other variable is a scale of respondent's perceptions on the extent of their potential communication networks for AIDS topics (SOCINET). As before, talking behavior is examined in two dimensions -- the frequency and variety of AIDS talk. Presumably, when people feel comfortable talking about AIDS-related topics, they talk about such topics more often and include a larger number of aspects of AIDS in their conversations.

## 1. RECEPTION OF AIDS MESSAGE AND PERCEPTIONS OF SOCIAL APPROPRIATENESS

**HYPOTHESIS 5:** THOSE WHO ARE INTENSIVELY EXPOSED TO AIDS MESSAGES IN THE MASS MEDIA ARE LIKELY TO PERCEIVE IT TO BE MORE SOCIALLY APPROPRIATE OR PUBLICLY SUPPORTED TO TALK ABOUT AIDS.

This hypothesis examines the role of the mass media in building the social context for AIDS talk. The hypothesis calls for levels of mass media AIDS message reception to be associated with the perception that it is socially appropriate to talk about AIDS. The underlying assumption is that the mass media may be able to influence people's evaluation of social norms relating to talk about AIDS by providing a virtual social environment for interpersonal communication. This concept is related to my earlier discussion on mass media roles in re-evaluating social environments (found in Chapter 2). As Noelle Neuman's spiral of silence theory implied, it is possible that the mass media may simulate an image suggestive of the presence of support from others in a social environment. If some persons have sufficient exposure to AIDS messages from the mass media, s/he may be more likely to have a perception of AIDS talk being socially appropriate. This hypothesis is, however, limited to the level of perception. Later in this chapter the relationship between such perceptions and actual talking will be tested.

Here, the correlation between the various levels of reception and the two social appropriateness variables -- perceptions of appropriateness (SOCIAPT) and the perception of potential conversation partners (SOCINET) -- was tested. There is a statistically significant positive correlation between the level of reception of AIDS

messages and SOCIAPT ( $r=.180$   $p<.01$ ) and SOCINET ( $r=.155$   $p<.01$ ), These relations are shown in Table 13 and Figures 29 and 30. These findings thus support hypothesis 5: the more AIDS messages people receive from the media, the more likely they are to perceive it to be socially appropriate to talk about AIDS. This finding is consistent with my theoretical argument on the role of the mass media in providing new norms for potentially uncomfortable topics.

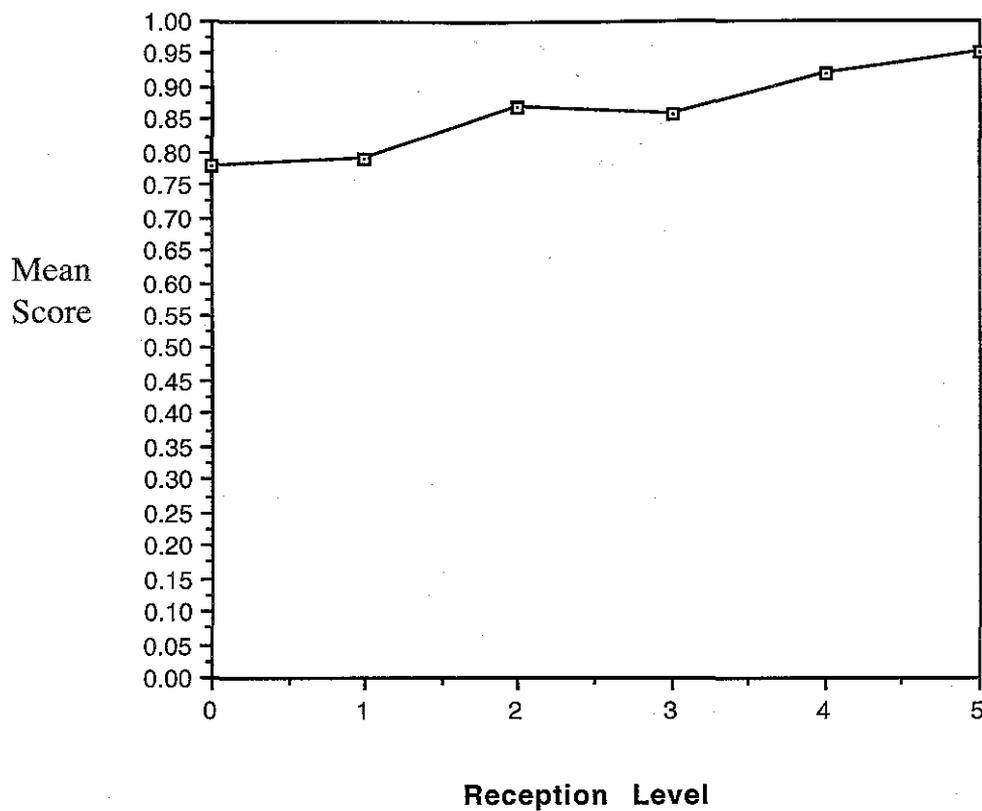
**Table 13: Correlations between the Level of Perceived Social Appropriateness and the Level of AIDS Message Reception at the Individual Level**

|                            | SOCIAPT | SOCINET |
|----------------------------|---------|---------|
| Level of Reception of AIDS | .180**  | .155**  |
| Messages                   | N=1772  | N=1732  |

$p<.01$ \*\*

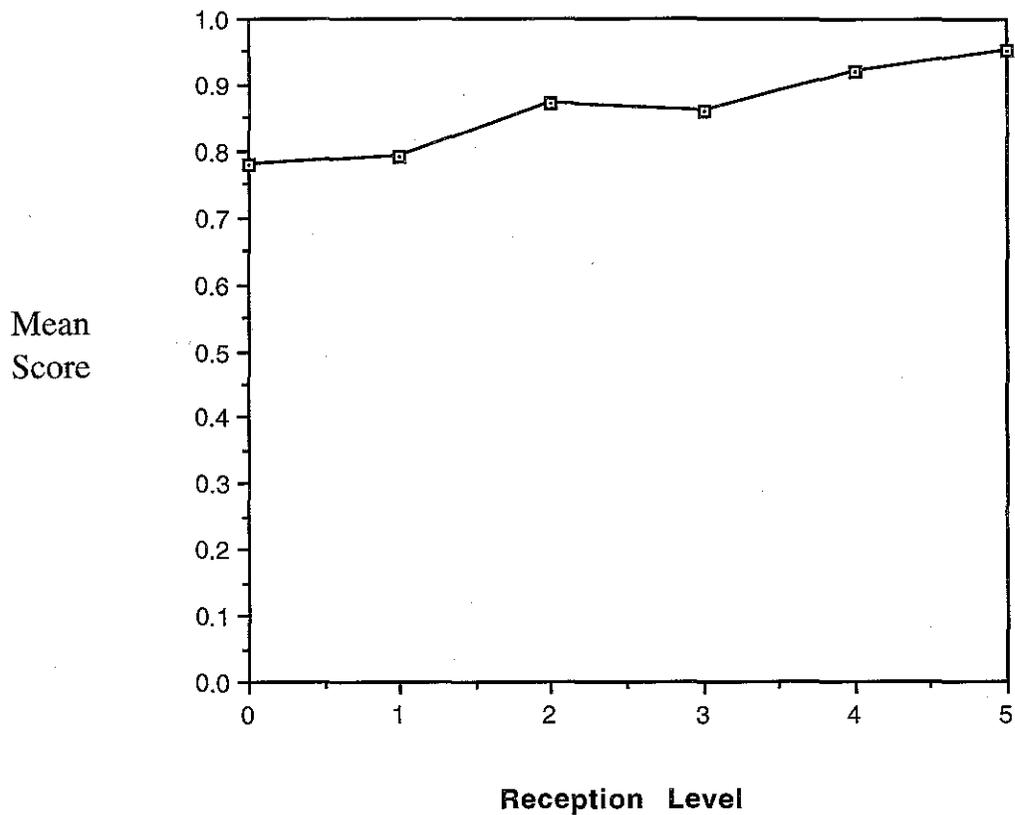
$p<.05$  \*

Figure 29: **Level of Reception and Perception of Social Appropriateness (SOCIAPT)**



In the figure above, the reception levels were categorized into five levels for purposes of presentation. The variable used for the underlying analysis was not recoded. The total number of responses (1783) was used for this analysis. Missing Cases: 62.

Figure 30: **Level of Reception and Potential Network  
for Talking about AIDS (SOCINET)**



As with the previous figure, this figure also used a recategorized level of reception for presentation purposes. All 1783 respondents were used for this analysis. Missing Cases: 51.

It was suspected that the independent and the dependent variable were related to each other, because both are correlated with other socio-demographic variables such as gender, marital status and socioeconomic status. In order to test the possibility that causal inference from the relationship between the level of reception and SOCIAPT/SOCINET would be spurious, the partial correlation between the level of reception and SOCIAPT/SOCINET were tested while controlling for gender, marital, and socioeconomic status. Both relationships remained moderately strong at a statistically significant level (SOCIAPT:  $r=.14$   $p<.01$  and SOCINET:  $r=.11$   $p<.01$ ). In other words, even among persons of the same socioeconomic status, same gender, and marital status, individuals who receive more AIDS messages appear more comfortable in talking about AIDS with a greater variety of people.

In the following section, I tested the relationship between the level of perceived social appropriateness and talking behavior at the social level. The social level of testing assumes that the reception of messages is not just directly associated with individual perceptions concerning the social appropriateness of talk, but moreover that individual perceptions about the appropriateness of talking are influenced by an individual's social environment. This hypothesis is expressed as follows:

**HYPOTHESIS 6:** THOSE LIVING IN COMMUNITIES OR VILLAGES WHERE PEOPLE ARE INTENSIVELY EXPOSED TO AIDS MESSAGES IN THE MASS MEDIA ARE LIKELY TO PERCEIVE IT TO BE MORE SOCIALLY APPROPRIATE OR PUBLICLY SUPPORTED TO TALK ABOUT AIDS

In the chapter 3, I outlined a way of examining both group and individual effects of media reception on talking behavior. The unit of analysis used to measure group effects are the 64 geographic clusters constituting the survey area. The individual relative effect is derived by computing an individual reception score minus the mean score of each

cluster. The relative group score is attained from computing the mean score of each group (cluster) minus the mean score of the entire sample. This relationship was expressed as follows.

$$\text{SociP} = a + b_1(\text{Rec}_i - \text{Rec}_{gm}) + b_2(\text{Rec}_{gm} - \text{Rec}_{pm}) + b_3(\text{Rec}_i - \text{Rec}_{gm})(\text{Rec}_{gm} - \text{Rec}_{pm}) \text{ ----- Hypo 6}$$

Results of regression tests of this hypothesized relationship were summarized in Table 14. The resulting evidence is consistent with hypothesis 5. Both coefficients of the individual effects variables of social appropriateness (SOCIAPT, SOCINET) were statistically significant ( $p < .01$ ), though the relationship for potential network was substantially stronger than for the appropriateness construct. While the coefficients of group effect for SOCIAPT showed a weak relationship at a statistically significant level ( $p < .05$ ), the relation for SOCINET was not significant at the  $p < .05$  level. The coefficient of the interaction effects of both SOCIAPT and SOCINET did not attain statistical significance ( $p > .05$ ).

Table 14: **Predicting Perceived Social Appropriateness of Talking about AIDS, including Contextual Effects ( Multiple Regression)**

|                             | SOCIAPT<br>Coefficient<br>(Standard Coefficient) | SOCINET<br>Coefficient<br>(Standard Coefficient) |
|-----------------------------|--|--|
| Individual Reception<br>b1  | .08(.19)<br>p<.01                                | .26(.16)<br>p<.01                                |
| Group Reception<br>b2       | .07 (.06)<br>p<.05                               | —  |
| Interaction Reception<br>b3 | —  | —  |
| Constant                    | .85<br>p<.01                                     | 7.17<br>p<.01                                    |
| Multiple R                  | .18  | .16  |
| Adjusted R square           | .03  | .02  |
| N                           | 1718   | 1730   |

This table presents only the final results of regression testing. Variables that are not statistically significant were omitted from the table.

Hypothesis 6 was therefore supported only for SOCIAPT but not for SOCINET: individuals in a community/village where there are more individuals exposed to (higher levels of) AIDS messages tend to hold a perception of higher social appropriateness of talking about AIDS. On the other hand, people's perceiving of their potential communication networks (SOCINET) as appropriate for talking about AIDS were associated only with individual but not with the social reception of AIDS messages. These results would indicate that the perception about potential talking partners is unaffected by social-level reception.

#### **SOCIAL APPROPRIATENESS AND TALKING AT THE INDIVIDUAL LEVEL**

While the first part of this chapter tested mass media roles in constructing the perceived social environment, this section tests the relationship between the level of perceived social appropriateness and talking behaviors in terms of frequency and variety. It is assumed that individuals constantly evaluate their social environment and monitor their own behavior to conform to their social environment. Exposure to mass media messages is considered as influencing this re-evaluation of social norms. The spiral of silence theory, for example, tested the notion that the more people perceive their own opinions to be supported, the more these same people are likely to express their opinions publicly. In addition to assuming (as stated in the theoretical discussion) that shifts in the perception of social appropriateness function as a mediating factor between media exposure and the expression of opinions about AIDS-related issues, this section will proceed to only test the association between perceived social appropriateness and talking behaviors. Analogously the following hypothesis claims that:

**HYPOTHESIS 3:** THE HIGHER THE LEVEL OF SOCIAL APPROPRIATENESS OF, OR PUBLIC SUPPORT FOR TALKING ABOUT AIDS IS PERCEIVED TO BE BY INDIVIDUALS, THE MORE THEY WILL TALK ABOUT AIDS IN TERMS OF AMOUNT OF TALK AND VARIETY OF TOPICS TALKED ABOUT.

This study therefore assumes that talking about AIDS itself is subject to appropriateness evaluations of a persons' social environment.

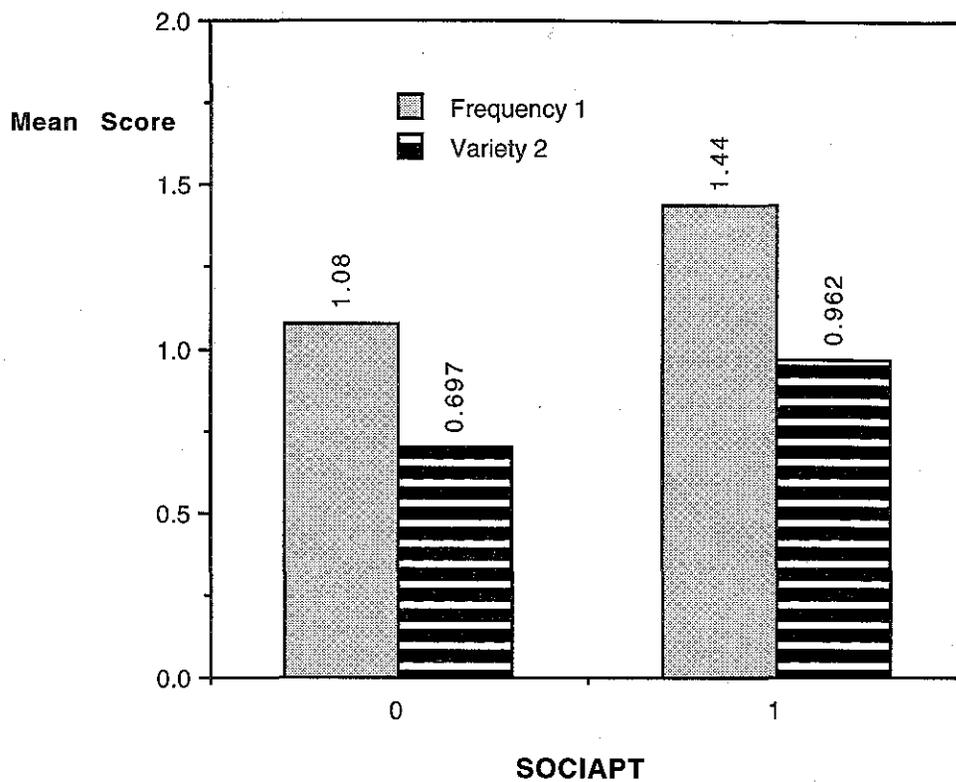
Correlation testing indicated that perceptions of social appropriateness of AIDS-related topics are positively associated with both talking behaviors (frequency and variety) at statistically significant levels ( $p < .01$ ). The results of the correlation tests are summarized in the table below (Table 15 ) and the two subsequent charts (Figures 31 and 32). Hypothesis 3 is supported, according to these results: people who perceive talking about AIDS-related topics to be more socially appropriate seem to talk about AIDS more frequently and more extensively. As noted before, no conclusions regarding causal direction are made for this data, though it is suspected that people who talk more about AIDS may have (as a previous condition) perceived talking about AIDS to be more socially appropriate than others who did not talk.

Table 15: **Correlations between the Level of Perceived Social Appropriateness and Talking at the Individual Level**

|         | Talking Frequency | Talking Variety |
|---------|-------------------|-----------------|
| SOCIAPT | .09**<br>N=1772   | .18**<br>N=1757 |
| SOCINET | .13**<br>N=1783   | .26**<br>N=1765 |

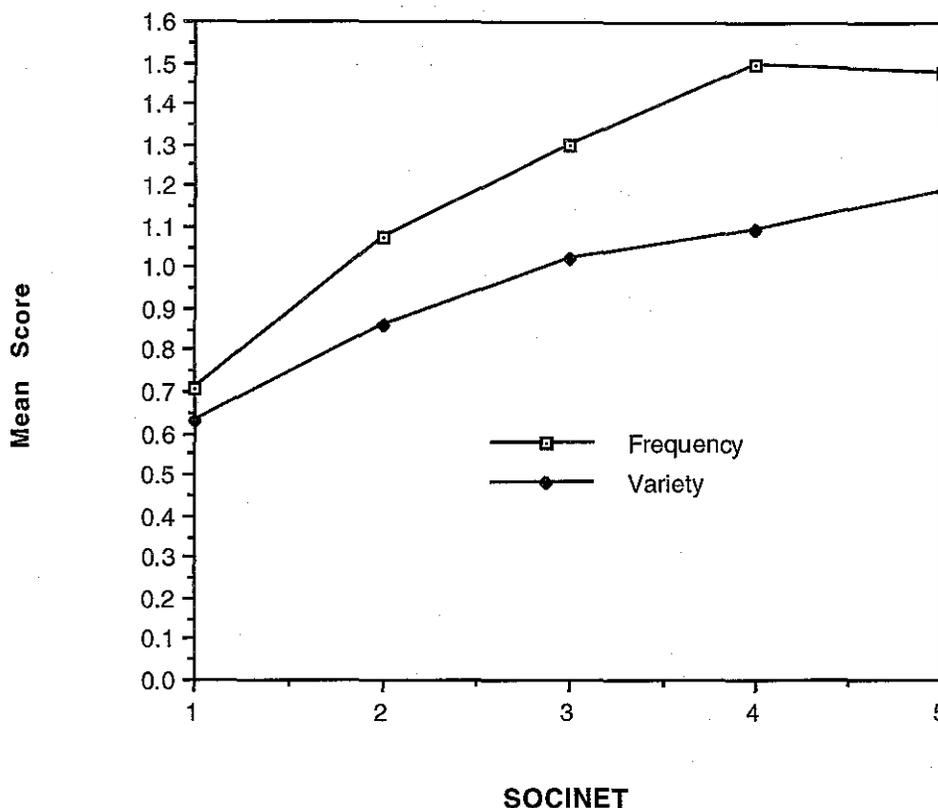
$p < .01$ \*\*

Figure 31: **Social Appropriateness Perception (SOCIAPT) and Talking Behaviors**



Total Cases for Talking Variety: 1757; Missing Cases: 26  
Total Cases for Talking Frequency: 1772; Missing Cases: 11

Figure 32: Level of Perceived Social Appropriateness and Talking Behaviors



Total cases: 1783. The figure above uses a re-categorized SOCINET with five levels for presentation purposes, while the original categorization used for the remainder of the analysis has 8 levels.

In order to check this apparent relationship for the existence of an alternative relation between talking and social appropriateness (since both of those variables are associated with other variables such as marital status, gender, and economic status) a set of partial correlations between these variables while controlling for marital status, gender, and socioeconomic status was performed. The results of the partial correlations (shown in Table 16 below) indicate that the association between talking and social appropriateness remained statistically significant even after controlling for gender, marital status, and socioeconomic status. This finding supports the contention that a causal inference for association between talking and social appropriateness is not spurious.

Table 16: **Correlations between the Level of Perceived Social Appropriateness and Talking after Controlling for Gender, Marital Status, & Socioeconomic Status**

|         | Talking Frequency   | Talking Variety   |
|---------|---|---|
| SOCIAPT | $r_{\text{soci t.socioeco poli genderMar}} = .07^{**}$<br>N=1758<br>$[r_{\text{soci t}} = .09^{**}]$  | $r_{\text{soci t.socioeco poli genderMar}} = .14^{**}$<br>N=1743<br>$r_{\text{soci t}} = .18^{**}]$ |
| SOCINET | $r_{\text{soci t.socioeco poli genderMar.}} = .12^{**}$<br>N=1769<br>$[r_{\text{soci t}} = .13^{**}]$ | $r_{\text{soci t.socioeco poli genderMar}} = .22^{**}$<br>N=1751<br>$r_{\text{soci t}} = .26^{**}]$ |

$p < .01^{**}$

$p < .05^{*}$

These findings confirm my former argument on the function of perceptions of appropriateness as they relate to (talking) behavior. Once people perceive there to be social support for certain behaviors, they are likely to adopt those behaviors as a result. In this test, the behaviors tested were talking behaviors (the frequency of talking and its topical variety). Individual assessments of social norms for these behaviors are confirmed as being associated with those behaviors.

## SOCIAL APPROPRIATENESS AND TALKING AT THE SOCIAL LEVEL

Finally, I tested the relationship between the level of perceived social appropriateness and talking behaviors at the social level. This relationship was expressed in hypothesis 4 as follows:

**HYPOTHESIS 4:** THOSE PEOPLE IN COMMUNITIES OR VILLAGES WHERE PEOPLE PERCEIVE THERE TO BE A HIGHER LEVEL OF SOCIAL APPROPRIATENESS OF, OR PUBLIC SUPPORT FOR, TALKING ABOUT AIDS WILL TALK ABOUT AIDS MORE, IN TERMS OF THE AMOUNT OF TALKING AND THE VARIETY OF TOPICS.

This statement was expressed in a regression format below:

$$\text{Talking} = a + b_1(\text{SociPi} - \text{SociP}_{gm}) + b_2(\text{SociP}_{gm} - \text{SociP}_{pm}) + b_3(\text{SociPi} - \text{SociP}_{gm})(\text{SociP}_{gm} - \text{SociP}_{pm}) \text{----- Hypo 4}$$

(a=constant; SociPi=individual score of perception on social appropriateness of talk; SociP<sub>gm</sub>=group mean of score of perception on social appropriateness; SociP<sub>pm</sub>=population mean of scores of social appropriateness)

As with the other social hypotheses, this hypothesis too is tested in a regression model that includes both the individual, the group, and their interaction effects. The results of this regression test are presented in Table 17: No group effect was found for perceptions of social appropriateness (SOCIAPT) in relation to either talking behavior (frequency and variety). Group effects were found to be supported only for perceptions of potential communication networks (SOCINET) and talking variety (but not frequency) at a statistically significant level ( $p < .05$ ). No interaction effect was found for any of these models.

Hypothesis 4 consequently received only sparse support from these results. In other words, even for people in a village in which there exists a perception of a higher level of social appropriateness for talking about AIDS, those persons will not necessarily

talk about AIDS more frequently or about a greater variety of AIDS-related topics than people from villages with a lower perception of social appropriateness of AIDS-related talk.

Table 17: **Multiple Regression Predicting Talking about AIDS, including Contextual and Interaction Effects of Perceived Social Appropriateness Perception**

|                          | Talking variety<br>Coefficient<br>(Standard<br>Coefficient) | Talking<br>frequency<br>Coefficient<br>(Standard<br>Coefficient) | Talking variety<br>Coefficient<br>(Standard<br>Coefficient) | Talking<br>frequency<br>Coefficient<br>(Standard<br>Coefficient) |
|--------------------------|---|--|---|--|
|                          | SOCIAPT   | SOCIAPT  | SOCINET   | SOCINET  |
| Individual Sociap<br>b1  | .31 (.17)<br>p<.01  | .35 (.08)<br>p<.01   | .11 (.25)<br>p<.01  | .14 (.13)<br>p<.01   |
| Group Sociap<br>b2       | —   | —  | .10 (.06)<br>p<.05  | —  |
| Interaction Sociap<br>b3 |   |  |   |  |
| Constant                 | 1.10  | 1.40   | 1.10<br>p<.01   | 1.40<br>p<.01  |
| Multiple R               | .17   | .08  | .25   | .13  |
| Adjusted R square        | .03   | .01  | .06   | .02  |
| N                        | 1755  | 1770   | 1762  | 1781   |

## SOCIAL APPROPRIATENESS AS AN INTERVENING VARIABLE

The above findings point towards an association between two sets of variables, namely 1) the reception of AIDS messages and social appropriateness, and 2) the perception of social appropriateness and talking behaviors. These associations imply the possibility that the social appropriateness variables are intervening between reception and talking behaviors. In order to test this notion, the correlation between talking variables and reception was controlled for by both social appropriateness variables (SOCINET & SOCIAPT).

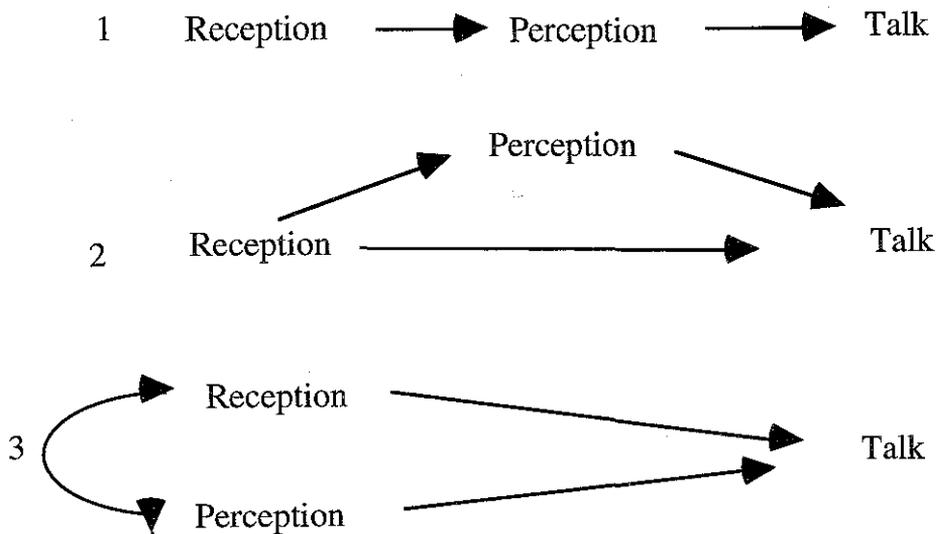
The results of tests of partial correlation are shown in the following table.

Table 18: **Correlations between Reception and Talking, Controlling for Social Appropriateness**

|         | TALKING<br>Frequency  | TALKING<br>Variety  |
|---------|---|---|
| SOCIAPT | $r_{\text{rec talk.sociapt}}=.25$<br>$p<.01$<br>[ $r_t = .27$ ] | $r_{\text{rec talk.sociapt}}=.30$<br>$p<.01$<br>[ $r_t = .32$ ] |
| SOCINET | $r_{\text{rec talk.socinet}}=.25$<br>$p<.01$<br>[ $r_t = .27$ ] | $r_{\text{rec talk.socinet}}=.29$<br>$p<.01$<br>[ $r_t = .32$ ] |

Even controlling for both social appropriateness variables, the correlations between the talking variables and reception remained statistically significant ( $p < .01$ ), though the magnitudes of association were slightly weakened. These results seem to indicate that the social appropriateness variables cannot be clearly shown to be intervening in the relationship between talking and reception. Rather, it is likely that talking and reception are (also) directly associated. As shown in the figure below, two alternative models (1 & 2) are suggested as accounting for the slight effect of appropriateness to the primary reception - talking relationship. It is possible that the influence of reception on talking may proceed both directly and indirectly through social appropriateness (Model 2), or that reception and perceptions of social appropriateness are correlated and influence talking together (Model 3).

Figure 33: **Models for Reception, Social Appropriateness and Talking**



## Summary

In sum, this chapter presented evidence seeking to support the earlier theoretical discussions on people's evaluations of the perceived appropriateness of AIDS-related topics as related to talking behaviors on the social level, as well as mass media roles in building contexts for people to construct a more positive evaluation of their social environment's supportiveness for such conversations. The above examination supported those two hypotheses relating to the media role in influencing the perception of appropriateness: At the individual level, the level of reception of AIDS messages and perceptions of social appropriateness are in fact related to people's evaluation of the social appropriateness of talking. In turn, individual evaluations of the social environment are positively associated with these persons' ways of talking about AIDS in terms of frequency and variety. However, it was not possible to establish clear evidence of the social perception on appropriateness functioning as an intervening variable between media reception and talking behaviors.

At the social level, the relationship between the level of AIDS message reception and perceptions of the social appropriateness of talking about AIDS was not completely supported. Individual reception plays a relatively more important role for talking behaviors than (contextual) group effects. The other social hypothesis -- that perceived social appropriateness at the social level is related to talking behaviors on the social level -- was not much supported either. Individual perception on social appropriateness largely determines individual talking behaviors, relatively independent from that person's social environment.

These findings, that individual reception effect exceeds group influences, gives support to my theoretical argument on the media role of providing social context as a

substitute for a person's physically immediate, social environment. The exposure to media messages provides individuals with an opportunity to re-evaluate social norms and thus should allow somewhat greater independence from the social group attitudes (which are really one kind of incarnate group norm). Both individual and group effects together do seem to demonstrate a potentially large role for mass media to provide new norms for talking about AIDS, regardless of the original norm of a social environment.

It is, however, necessary to consider alternative explanations, such as that social appropriateness by itself may not be a sufficient explanation for talking behavior: even though talking may be related to the level of perceived social appropriateness, talking behavior may be more complex than the way it was conceptualized here as being based on social perceptions. For example, a person's level of knowledge may indeed prove related to their talking behaviors if that person is already motivated to talk about AIDS in order to disseminate knowledge. The same situation may hold true for those persons concerned with political issues, who might talk about various aspects of AIDS as a political issue.

## **Chapter Ten**

### **SUMMARY OF FINDINGS AND DISCUSSION**

This study, conducted in Thailand, explored the linkages between individual conversations about AIDS and the intensive reception of AIDS messages in the mass media, as well as the kinds of AIDS-related perceptions individuals hold of their social environment and how this perception is influenced by media reception. These linkages were explored and tested in the form of hypotheses on the two roles of the mass media -- context building and content providing for personal discourses about AIDS ( See Table 34 below).

The context building role refers to media messages increasing the perceived amount of support for talking about AIDS. In order to test this context building media role, talking behaviors of the research population were investigated to try to characterize their interpersonal discourses in terms of 1) the frequency and 2) the topical variety of talking about AIDS. The concept of talking frequency referred to how often people talk about AIDS with their conversation partners. The concept of talking variety was used to characterize the breadth of AIDS-related topics these people had engaged in conversation about with others.

The other media role, that of providing content for talking about AIDS, refers to individuals taking frames from the mass media and importing them into individual discourses as a consequence of media reception. The mass media messages about AIDS used in Thailand were investigated at both the level of intended frames and that of perceived AIDS messages. Intended messages are those AIDS messages reported by

producers and disseminators as the product of their message output for the public. The analysis of perceived messages focused on those AIDS message that were reported by respondents as what they received from the mass media. Below, I will review and comment on some of the more central findings discussed in previous chapters, while seeking to summarize and extend these through multi-variate models (see Appendix C for multiple regression table). Within this presentation, I will discuss the theoretical implications of the findings of this research, the limitations inherent in the research modalities used here as well as some suggestions for future research.

## **1. Findings and Discussions**

Talking as an interpersonal communication behavior was the target of this research, originating as it did from a theoretical concern about the possibility of mutually supportive channels -- media and interpersonal discourses -- together leading to improved AIDS prevention. Consequently, it was an important aim of this investigation to gather contributing evidence for the viability of this media-interpersonal-communication connection; in other words, to demonstrate that the media may support conversations and that these conversations in turn would reinforce and extend the reach of the media messages. Certainly my inquiry into the motives that prompted the surveyed Thai communicators to engage in AIDS-related conversations shows an underlying awareness of the importance of the issue, and thus to a realistic possibility that these people's interpersonal communication about AIDS will contribute to improving the public's information about AIDS. The reader will recall that in Chapter Five, descriptive data were presented which indicated that especially TV materials were important occasions for talking about AIDS, but also that respondents were motivated to communicate about AIDS by the wish to protect their families and others from infection. It was shown that media messages encourage talking about AIDS by providing content and building contexts

for interpersonal communication. Messages highlighting AIDS issues can stimulate a dialogue on specific aspects of AIDS. Below, I discuss the results of this research and their implications in more detail, beginning with context provision at the individual and (contextual) social level and followed by content providing issues.

## **1.1. Context Building**

### **Individual Effect**

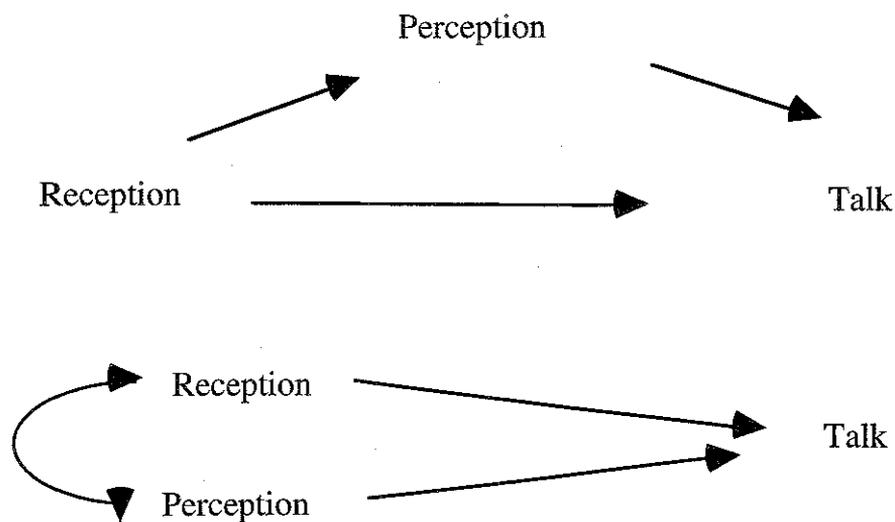
It will be recalled that the most basic inquiry of this study was whether receiving media messages about AIDS could be shown to be related to people's talking about AIDS. This talk was analyzed as evidenced in the frequency and variety of talk (expressed in hypothesis 1) at the individual level. While this basic hypothesis was supported, a further theoretical argument calling for social appropriateness to act as an intervening variable between reception and talking was falsified. The original model posited here needs to be modified based on the results obtained.

A positive association was shown for two separate sets of factors, 1) reception and social appropriateness, and 2) social appropriateness and talking. However, the association did not hold up once these two sets were combined, contrary to what had been assumed. It was shown that there is a linkage between individual assessments of social support for talking about AIDS and reported talking behaviors. This demonstrated relation reflects Festinger's social comparison theory -- that people compare themselves with others to evaluate their attitudes and actions. Expanding this question to include the role of the media in reshaping such evaluations, I also found evidence supportive of the contention that the reception of AIDS messages from the mass media affects positively the perception of the appropriateness of discussing AIDS prevention. These two

findings, combined with the rejection of social appropriateness as an intervening variable between reception and talking, call for an alternative model among reception, social appropriateness, and talking in which both reception and the perception of social appropriateness may together influence talking. These alternative models are proposed since social appropriateness is anyhow closely correlated with reception (Figure 34).

Beyond tests for the separate relations between talking, reception, perception of social appropriateness, a more complex model of testing these relationship together was assembled (see discussion below). The results of this multiple regression model indicate that the level of reception is positively associated with talking, even after controlling for social appropriateness. These results provide supporting evidence for the previous discussion on the re-constructed model on social appropriateness. The graphic representations below (also suggested in Chapter 9) show the revised role assumed to be played by perceptions of social appropriateness.

**Figure 34: Alternative Models for Social Appropriateness, Reception, and Talking**



### **Final Multiple-Regression Model for Talking Frequency and Variety**

The table below presents results of two separate final regressions models chosen among a greater number of models, after performing several regressions (See Appendix C). Some variables were excluded from the final regression models presented below. For example, SOCINET was chosen over SOCIAPT as a variable related to perceived social appropriateness. These variables are substitutes for one another in relation to talking and SOCINET has a higher correlation with talking. Educational status was used as a separate variable in a multiple regression (instead of being part of the SES variable), but the results were not significantly different from those using only SES as a control variable. Thus this variable is not contained in the final regression model (below) as a separate control variable. The final multiple regression models includes factors such as political awareness and knowledge variables, as well as demographic variables such as marital status.

For talking variety, the independent variables reception, perceived network for talk (SOCINET), general knowledge about AIDS (Know-General), political awareness (Poliaw), socioeconomic status, age, gender, and marital status were positively associated with it at a statistically significant level ( $p < .01$ ). The interaction between gender and marital status showed a statistically significant negative relationship ( $p < .01$ ).

The results indicate that people who have received more AIDS messages are likely to have reported having talked about a greater variety of AIDS topics controlling for other variables, including perception of social appropriateness, knowledge, and political awareness. Similarly, people who see talking about AIDS as more appropriate, are more aware of political issues, have a higher level of knowledge about AIDS, are older and are at a higher socioeconomic status, are also likely to engage in more varied AIDS conversations. Males and married persons were also generally advantaged in talking about

AIDS. The negative direction of the interaction effect between gender and marital status means that the gap in talking variety between unmarried and married persons is less pronounced for males -- and that the difference in taking variety between males and females is smaller among married persons (the mean scores for talking variety are: for single females = .95; single males =1.12 ; married females =1.12 ; for married males = 1.23).

For talking frequency, the pattern of the relationships for talking variety is repeated here: the level of reception of AIDS messages from the mass media substantially contributes to the frequency of talking about AIDS. People who have received more AIDS messages, tend to talk more often about AIDS even when other factors were controlled for. Also, people who have a higher level of knowledge about mythical AIDS beliefs, those who have a higher awareness of politics, perceive talking about AIDS to be more socially appropriate talk more about AIDS. Those who are older are likely to talk about AIDS more often with other in their social network. Being married is also positively related to the frequency of talk. However, gender did not appear as significant, while the interaction between gender and marital status was negatively associated with talking variable at a statistically significant level ( $p < .05$ ). This is because there is no significant gap for married, but a noticeable gender gap for single people. The mean scores of talking frequency are: for single females = 1.18; single males =1.28; married females =1.57 ; for married males = 1.59 .

An issue related to the concept of appropriateness are the cultural constraints upon AIDS talk apparent in some of the results presented: In Thai culture, talking about AIDS and AIDS-prevention subjects was more difficult for females than for males generally; this is especially true for single women. Older people also talk more about AIDS in terms of variety and frequency than younger persons do, even when this relationship is controlled for socioeconomic status, reception level, and knowledge

variables (See Table 19). The issue of respondent's "filtering" messages is taken up again below.

Table 19: **Final Regression Model**

| Variable                         | Talking variety | Talking Frequency |
|----------------------------------|-----------------|-------------------|
| Level of Reception               | .22**           | .23**             |
| Perceived Social Appropriateness | .16**           | .08**             |
| Knowledge of Myth Belief         | .12**           | .09**             |
| Knowledge general                | .11**           |                   |
| Political Awareness              | .06**           | .09**             |
| Socioeconomic status             | .09**           |                   |
| Age                              | .13**           | .14**             |
| Gender (male)                    | .11**           | 00                |
| Marital Status                   | .14**           | .10**             |
| Marital* Gender                  | -.12**          | -.08*             |
| Multiple R                       | .47             | .36               |
| Adjusted R sq.                   | .22             | .13               |
| DF                               | 10              | 8                 |
| N                                | 1662            | 1688              |

\*\*<.01; \*<.05

### **Contextual / Social Effects**

In contrast to the unambiguous support given to the individual-level hypothesis on context building, contextual media effects of community/village membership on individual talk were only partially supported: the basic relationship between reception and talking was clearly supported at the social level; however, the hypotheses involving the measures of social appropriateness were, at the social level, only partially supported. The underlying assumption of this hypothesis had been that conversation is a communicative behavior and inherently needs to involve others in an individual's social

environment. Consequently, it was assumed that talking behavior may depend on what kind of social group memberships a person maintains, with these functioning as talking partners. For example, a person who works for a hospital may talk more about diseases with their colleagues than a person who works for a restaurant, regardless of the level of reception of that individual. This relationship (expressed in hypothesis 2) was supported as showing a group effect between talking and reception. Individual talking about AIDS was not only related to individual levels of reception, but also to the social context an individual belongs to. When others in a respondent's village/community received more AIDS messages, these individuals do talk more about AIDS in terms of frequency and variety than those who belong to villages/communities having received fewer AIDS messages.

## **1.2 Content Providing**

The second mass media role this research was concerned with is the provision of content for talking about AIDS. This role was examined by testing the association between respondents talking about particular perceived topics from the mass media as these related to the level of reception. The findings related to the hypothesized positive relationship between received and talked-about topics (Hypothesis 7) were presented in detail in Chapter 8. There are five conclusions to be drawn from the Thai data:

- 1) there was a substantial conjunction shown between those framings of AIDS intended and produced by mass media message creators and disseminators, and those frames received by the public;
- 2) the data gathered from creators and disseminators shows changed constructions over time (shifts of risk-group emphasis);
- 3) instances where emphases of topics diverge between intended and received messages may be explained by these topics constituting historic artifacts sent and still recalled by the audience;

4) on the other hand some topics are filtered out by institutional and cultural constraints by both, creators and audience members.

5) the strength of association between reception and talking of specific topics is a function of media emphasis.

These findings suggest a contribution to two theoretical issues: 1) agenda-setting, and 2) framing theory. First, the above findings are notable for supporting agenda setting, the theoretical claim that media emphasis on particular topics contributes to the public consciousness of public themes. The basic question about mass media effects on the public agenda (agenda setting) is a classic question. Traditionally, most agenda setting studies seem to have focused on mass media influences on people's attitudes in terms of a kind of salience-creation and 'rank-ordering' of public issues, looking for evidence of a conjunction of media and public priorities (Protess & McCombs, 1991). While this dissertation does present evidence of such a transfer process, some important distinctions need to be made: the kind of media influence at the heart of this investigation is a rather different, micro-agenda, in that facets or frames within a single issue -- AIDS -- were investigated for the linkage of media and public constructions. Moreover, the dependent construct chosen here is reported interpersonal communication (what the respondents actually *talked* about), not merely reported attitude, a presumed capability for (communicative) action, rather than the existence of possibly merely passive attitudes (see also Price's (1992) discussion of the conceptual distinction of attitude versus expressible opinion). The findings here offer evidence of more than just agenda-setting, but also about framing effects.

The second theoretical implication is the evolution of frames over time. Public discourses on sub-topics (framing) have the potential to be changed when there are new interpretations being introduced by the media. Baumgartner and Jones (1993) discussed the potential of mass media to exercise a destabilizing effect on political discourses by elites (Congress in that case). Those authors think that political arguments are very stable

in times when these arrangements reflect the interests of dominant groups, yet leaving room for 'entrepreneurial' interpretive actions. While political arguments are almost always stable, with policies monopolized by specific groups, and incrementalism dominant, sometimes drastically new interpretations arise from the activity of new claims makers. When images of political issues do change by new elements being introduced through the mass media, existing political arguments become unstable; as a result, those issues can then be redefined and move to a new generation of discourse. This extended agenda-setting model is of some utility in explaining the findings related to the content providing role of the Thai media on AIDS, despite differences in the subject of research: Baumgartner and Jones focus on those conditions under which new information can -- through the mass media -- be brought to alter elite discourses, while this research project focused on change in public, rather than elite discourses.

The implications are as follows: Media discourses should be seen as just one type of discourse, but these represent a particularly pervasive and powerful type. The central task of media discourse is to publicize social or political events and assign them a meaning in accordance with (language) meanings and interpretations that are already commonly held in society. Media discourse is a specialized communication which extends across sub-groups to reach their widest possible distribution and has considerable effect upon the ongoing process of meaning reconstruction. Media discourses shape people's cognitive structures ( Van Dijk, 1993), the maps of meaning, serving as an integrative or dominance-promulgating force. Media discourses make things public and may in complex societies function as the de-facto public sphere reaching across divergent groups and sub-cultures. As a result, they may influence or set the public agenda for conversations, here AIDS, determine prevailing meanings and courses of action.

The framing of AIDS may become re-defined when media discourses introduce a new or revised way of framing the context of the disease. For example, the evidence

indicated that the attribution of AIDS-risk shifted from fringe groups like homosexuals and IV-drug abusers to the general heterosexual population, the current media emphasis. The fact that the audience recalled the total of these topics is evidence of an agenda-setting effect.

The latter two observations, for memory and institutional-cultural constraints, reflect on the agenda-setting tradition and the claim for active audiences. The constraints upon AIDS discourses were most apparent in relation to the need to reframe traditional sexual issues with the introduction of AIDS, as in, for example, talk about explicitly sexual imagery and the need for male monogamy. For example, it may be possible that males having multiple sexual partners was traditionally attached with a positive image of a healthy man. However, AIDS has made those practices rather dangerous and connected to the disease. Another example is condom use. This theme may originally have been discussed only in a family planning context, while now this theme appears as a conversation topic in the context of AIDS. Political reasons underlying this kind of shift in the meaning of socially shared concepts might occur (according to Baumgartner & Jones, 1993) due to new "political entrepreneurs" pushing this shift in the media, from where it affects public discourse. In the case of AIDS discourses in Thailand, these creators and disseminators of media material were sought primarily in the governmental bureaucracy into whose domain AIDS falls. However, this sort of institutional analysis is beyond the scope of this dissertation, though it would be a suitable object of future research.

It was earlier noted that intended and perceived frames share many similarities, with some exceptions, for example, the need for reducing sexual partners. The gap between intended and perceived frames were attributed to two factors, 1) retained public memory and 2) "double filtering" of information. Previous but discontinued messages such as AIDS being caused by drug users or homosexuals were apparently retained in the

memory of the public and reported when asked about *current* AIDS messages. In other words, people remember previous messages even though intended frames may have changed. This is an interesting finding, since it implies that a kind of integrative or cumulative body of information exists, rather than newer information replacing the obsolete. Thus the actual stock of "popular knowledge" may not be totally dependent upon current media or other dominant discourses; thus this knowledge may form a reservoir for active audiences creating alternative or subversive public attitudes.

The way this new audience interpretation of issues introduced by the mass media came about seems to suggest a modification of Gamson's theory of the public use of mass media resources in a limited way. Gamson emphasized the reconstruction of issues by the public through the integration of cultural knowledge and folk wisdom, as well as experiential knowledge. That view suggests that processes of reinterpretation are constant and ongoing, rather than occurring suddenly and completely. In other words, sub-group discourses (and memories) are sufficiently isolated from the broader public discourse represented in the mass media to retain something like memories out of sync with currently dominant discourses.

A process which is labeled "double filtering" here seems to account for the fact that the way that final messages on AIDS are received by the audience does, in the case of "counter-cultural" messages, not match the way these messages were intended. The first filtering system is that individuals identify the content of messages in the mass media by processing AIDS information based on the respondent's own concerns and knowledge. For example, the prevention messages regarding reducing one's number of sexual partners were identified very differently in the analysis of intended and perceived frames. This may be explained in terms of the cognitive structures of the audience (structuring the reception of information from the mass media). For example, Zaller (1992) discussed political awareness as related to the reception of political information. This research

found that the reception of AIDS information was also related to political awareness, previous AIDS knowledge, as well as socioeconomic status. Some populations were thus disadvantaged in their ability for receiving AIDS information.

Organizational structure, cultural taboos, and policy decision making can also not be ignored, as these are related to both the creation and dissemination of AIDS messages. According to Van Dijk, the construction of media discourse involves the cognitive structures (values) of the news-makers (journalists) and the institutionalized norms (i.e. inherited meanings and traditions) they work under: News discourse is a complex social interaction. Van Dijk (1983) describes it as:

" I stressed above that media discourses should to be seen merely as a 'read' product; of news-gathering activities, but as the manifestation of a complex process in which knowledge, beliefs, and opinions are matched with existing or incoming information about events, the social contexts of news production, and representations of the reading public. (p. 28) ."

Even though decisions on AIDS media messages may be made at the top level of political structure, it is unlikely that these messages reach the public without having to pass through this double filtering process. This filtering of media messages is problematic, since the content of AIDS messages distributed through the mass media does then influence public ways of talking about AIDS only insofar as it survives this selection process.

## **2. Limitations and Outlook**

While every step of this research was planned carefully, there were some limitations in carrying out the survey. First, my understanding of the Thai language is limited. Several factors made it possible for me to conduct this research in Thailand: I had support from Thai researchers as well as health workers in conducting every aspect

of this research; in addition, the translation of qualitative results and questionnaires was undertaken by a professional group of translators that included both native Thai and English speakers. They did their best to compare the translation in both languages. Although the assistance of Thai colleagues and interpreters made this kind of research feasible, it was a real limitation.

Another limitation of the design of this study was the short period of time in which to conduct research about the impact of mass media exposure on interpersonal AIDS discourses among Thai people. Ideally a longitudinal study over a long period of time should be conducted. One-point data collection is not ideal for observing change processes in talking about AIDS as affected by information disseminated by mass media campaigns. It was necessary to conduct the study as it was done under the given local conditions, but again there is a price to be paid in not being able to observe change over time.

Even though I asked questions about individuals' past exposure to mass media AIDS messages and discourses, respondents are not likely to have been able to accurately report their exposure and talking behavior for more than a very limited amount of time. Only current behaviors and attitudes are likely to be reported correctly, making any historical work with this method futile. For the validity of this research, I have to assume that currently reported exposure rates and strategies for talking about AIDS are similar to those existing throughout the longer-term periods of exposure to AIDS messages preceding this investigation as well as their earlier discourse about AIDS. Yet, I am aware of the limitations of trying to capture the relationship between exposure to AIDS messages and talking in that way. The risk is that some people may have been largely influenced by AIDS messages in the beginning of the AIDS epidemic, while other people may have been influenced by AIDS messages gradually over time. Further research content-analyzing historical mass media materials on AIDS would be productive,

especially in connection with investigations into the way recipients construct their meaning of the disease from such material and how they, in turn, discuss the subject with others.

There is a further methodological limit implied in my operationalization of groups and group effects. The operationalization of a geographic cluster as a social unit used here may simply not have been appropriate for this particular analysis, bearing in mind that communication networks for AIDS-related issues differ within the population, as was described in previous chapters: most people reported friends as talking partners and married people reported their spouses as the predominant talking partners. This may imply the existence of separate communication networks within each of the geographic clusters, segregated by gender and marital status for example.

While this study focuses on the general public, the impact of mass media AIDS messages on policy makers and health workers and under what circumstances such feedback will generate institutional changes relevant to AIDS policy is certainly a subject worth further study.

More extensive content- or framing analyses of AIDS messages may be able to further clarify the connection between mediated AIDS messages and interpersonal discourses about AIDS. The present study was unable to present a conventional message system analysis, though a series of in-depth interviews with policy makers in the public health field as well as with AIDS educators and producers of AIDS messages was carried out.

Alternative to the survey approach taken here in order to capture data about media reception and frames, I would like to encourage AIDS research with qualitative data and small samples, since much was learned about people's AIDS conversations from the preliminary focus groups and in-depth interviews conducted as part of this research.

It will be a great contribution to conduct a systematic and detailed qualitative and in-depth study of people's conversational frames of AIDS and AIDS prevention.

It was not discussed whether talking about AIDS will in fact bring about behavioral changes toward AIDS prevention, though this research assumed there to be a potential for such effect. I assume that expressed opinions in conversations reveal a person's attitudes toward certain issues and may, in the communicative interaction bring people to re-evaluate their own behaviors. Further research on the linkage of talking and behavior change would certainly be worthwhile.

Another important concept this research was not able to touch on, is how the construction of AIDS by the public may influence the understanding of AIDS messages in the mass media in turn. Whether and how public discourses may be able to bring about social actions that result in policy shifts is a fascinating question. I strongly feel that AIDS as an issue must be solved through empowerment processes like including women in AIDS prevention activities and establishing a social environment where anyone can speak out about their need for AIDS prevention in public. I believe that people can search for meanings and cooperate for prevention when they start to talk about issues without social/cultural constraints but with sufficient knowledge. I hope that other researchers will join in and continue this kind of research.

**APPENDIX A**  
**SURVEY QUESTIONNAIRE**

**A. IDENTIFICATION NUMBERS**

1. Reference number         /    /    /    /
2. District                         / ( 1. Borploy 2. Panomthun 3. Thamuang 4.  
Thamaka)
3. Sub-district                   /
4. Village ( Muban )           /    /    /    /
5. Date of Interview            /    /    /    /    /    /    /    /
6. Interviewer Number         /    /
7. Team Number                  / ( 1. Mr. Wichan 2. Mrs. Chiraporn &  
Ms. Chanpen 3 Mr. Kwanmuang & Ms. Panee)
8. Sex of Interviewee        1. male                      2. female

**B. GENERAL INFORMATION**

First, I would like to ask your background in general....

1. How old are you now?         /    /
2. What is your marital status? ( Do you have a family? )
1. single ( Go to 5)
  2. married
  3. cohabit
  4. divorced/ widowed
  5. separated
  8. others (specify) \_\_\_\_\_
3. Do you have any children? ( If single , skip Q. 3 and Q.4 )
1. yes
  2. no ( Go to Q.5)
4. How many children do you have?
5. Are you now working for pay?
1. yes
  2. no (Go to Q.7 )

6. What kind of work do you have? ( what do you do? )

1. student
2. laborer
3. farmer / fisherman
4. merchant / business owner
5. housewife
6. office worker
7. governmental officer
8. others (specify) \_\_\_\_\_

7. What is your highest level of education you attained?

0. no school
1. attended elementary school
2. completed elementary school
3. attended secondary school
4. completed secondary school
5. attended high school
6. completed high school
7. vocational diploma
8. attended university
9. received Bachelor's degree
10. higher than Bachelor's degree
88. others (specify) \_\_\_\_\_

8. I would like to ask if you have the following things at home. Please answer for each question.

1=yes 2=no

- |                                   |       |      |
|-----------------------------------|-------|------|
| 1. radio, radio / cassette player | yes 1 | no 2 |
| 2. stereo / CD                    | yes 1 | no 2 |
| 3. TV                             | yes 1 | no 2 |
| 4. phone                          | yes 1 | no 2 |
| 5. motorcycle                     | yes 1 | no 2 |
| 6. car                            | yes 1 | no 2 |
| 7. water from pipelins            | yes 1 | no 2 |
| 8. flush toilet                   | yes 1 | no 2 |

9. How many years have you lived in this place?

\_\_\_/\_\_\_ years

( if the year is fewer than the age of the interviewee, go to Q.10, otherwise go to Q12)

10. Where did you live before you came here ?

1. Bangkok
2. Another province but not BANGKOK
3. Kanchanaburi
8. Others (specify) \_\_\_\_\_

11. In what kind of community did you live before?

1. rural
2. urban

12. With whom do you live now? ( Circle as many as necessary )

0. none
1. spouse
2. grand parents
3. parents
4. brothers/sisters
5. children
8. others (specify) \_\_\_\_\_

13. If you are not living with your parents, how often do you visit them?

0. never
1. once a year
2. 2-3 times a year
3. once a month
4. once a week
5. every day

14. If you are not living with your brothers/sisters, how often do you see them?

0. never
1. once a year
2. several times a year
3. once a month
4. once a week
5. every day

15. What is the name of the party Prime Minister Chuan Leekpai belongs to ?  
(Prachathipat Party )

1. correct
2. incorrect

16. What are the names of the members of the Parliament elected from your election block? (two from each district : see the name list)

1. correct (two names)
2. correct (only one name)
3. incorrect

17. What are the names of the health volunteers of your village/community ? ( One from each village: see the list)

1. correct \_\_\_\_\_ (write down the name )
2. incorrect

## C. KNOWLEDGE

Next, I would like to ask about your knowledge of AIDS.

1. How do you think a person contracts AIDS? (Mark items which were spontaneously answered by the

interviewee first, then ask the question for each item respectively. ) Can you contract AIDS from ?

(e .g. Can you contract AIDS from having sex?)

|                                | mentioned | yes | no | do not know |
|--------------------------------|-----------|-----|----|-------------|
| a. sharing cups, plates, forks | 1         | 2   | 3  | 8           |
| b. shaking hands               | 1         | 2   | 3  | 8           |
| c. sharing toilets             | 1         | 2   | 3  | 8           |
| d. sharing razors, blades      | 1         | 2   | 3  | 8           |
| e. scissors manicure           | 1         | 2   | 3  | 8           |
| f. mosquito bites              | 1         | 2   | 3  | 8           |
| g. sharing needles             | 1         | 2   | 3  | 8           |
| h. blood transfusion           | 1         | 2   | 3  | 8           |
| i. from mother to infant       | 1         | 2   | 3  | 8           |
| j kissing                      | 1         | 2   | 3  | 8           |
| k. sex                         | 1         | 2   | 3  | 8           |
| l. other (specify) _____       | 1         | 2   | 3  | 8           |

2. Have you ever heard of condoms?

1. yes

2. no (Go to Q.6 )

3. What are they used for ? ( Do not read reasons. Let the subject answer by themselves.

There can be more than one answer.)

1. to prevent STDs in general but not AIDS
2. to prevent both STDs and AIDS
3. to prevent AIDS specifically
- 4.. to prevent pregnancy
5. 1 and 4
6. 2 and 4
7. 3 and 4
8. others (specify)
9. do not know

4. Do you know where to get condoms?

1. yes
2. no (Go to Q. 6)

5. Where do you get condoms if you want them? (There can be more than one answer)

- |                           |                     |
|---------------------------|---------------------|
| 1. hospitals              | 2. health centers   |
| 3. private clinics        | 4. markets          |
| 5. pharmacies' drugstores | 6. friends          |
| 7. bars/hotels            | 8. others (specify) |

6. Have you ever personally known someone who was infected with the AIDS virus?

1. yes
2. no (skip Q.7)

7. If yes, who was the person? ( Do not read the list ) (There can be more than one answer)

1. spouse
2. parents
3. brothers and sisters
4. children
5. relatives
6. friends
7. neighbors
8. others (specify) \_\_\_\_\_

#### D. EXPOSURE TO MASS MEDIA

1. Do you read any newspapers?

1. yes
2. no (Go to 5)

2. What are the names of daily newspapers you read ? (There can be more than one answer)

1. Thai Rat
2. Daily News
3. Matichon
4. Siam Rat
5. Siam Post
8. others (specify) \_\_\_\_\_

3. What are the names of local newspapers you read? (There can be more than one answer)

1. Chaokan
2. Putuchon
3. Lukmuang
4. Song Kwae
5. Yukmai
6. Seingtawantok
8. other (specify) \_\_\_\_\_

4. How many days per week do you read newspapers on average?

0. never
- 1-6. \_\_\_ times per week ( write down the number )
7. \_\_\_ every day

5. Do you listen to the radio?

1. yes
2. no ( Go to 10 )

6. How many times per week do you listen to the radio on average?

0. never
- 1-6. \_\_\_ times per week (write down the number )
7. \_\_\_ every day

7. How many hours a day do you listen to the radio?

\_\_\_ / \_\_\_ / hours / day

8. Which radio programs do you listen to most often? (There can be more than one answer)

1. news
2. governmental announcement
3. music
4. live programs talk shows
5. drams
6. documentary
8. other (specify ) \_\_\_\_\_

9. When do you usually listen to the radio ?
1. morning (5 - 12)
  2. afternoon(12 -4)
  3. evening (4-7)
  4. night (after 7 )
  8. others (specify) \_\_\_\_\_
10. Do you watch TV?
1. yes
  2. no (Go to. Q. 15 )
11. How many times per week do you watch TV on average?
0. never
  - 1-6. \_\_\_ times per week ( write down the number )
  7. \_\_\_ every day
12. How many hours per day do you usually watch TV?  
\_\_\_/\_\_\_/ hours /day
- 13 . What channel do you watch most often ? ( Choose only two channels)
1. Channel 3
  2. Channel 5
  3. Channel 7
  4. Channel 9
  5. Channel 11
  8. others (specify) \_\_\_\_\_
14. When do you usually watch TV?
1. morning
  2. afternoon
  3. evening
  4. night
  8. other (specify) \_\_\_\_\_
15. Do you have loudspeakers in your village/community?
1. yes
  2. no ( skip Q16 through Q.19)
16. When are village loudspeakers normally turned on?
1. morning
  2. afternoon
  3. evening
  4. night
  8. other \_\_\_\_\_

17. Do you listen to community announcement from village loudspeakers?

1. yes
2. no ( skip Q. 18 through Q. 19)

18. How many days per week do you listen to the programs made by village loudspeakers on average?

\_\_\_\_\_ days per week

19. How many hours per day do you listen to the programs made by village loudspeakers on average?

\_\_\_\_\_/\_\_\_\_\_/hours per day

20. When do you listen to village on loudspeakers?

1. morning
2. afternoon
3. evening
4. night
8. other (specify) \_\_\_\_\_

#### E. Reception of AIDS Messages

You may have received some information about AIDS in the news, entertainment, and in educational programs on TV, radio, and newspapers. I would like to ask you about your knowledge of it.

1. Have you ever seen/heard/read any programs about AIDS in the past month?

1. yes
2. no (skip Q. 2 through Q.10)

2. In what medium did you find information about AIDS ? (There can be more than one answer)

1. newspaper
2. radio
3. TV
4. loudspeaker
5. poster
6. pamphlet/brochure
8. other (specify) \_\_\_\_\_

3. What were the programs about? ( Let him/her give the names of the programs)

- 1) can recall
- 2) cannot recall ( Go to 5)

4. What types of programs were they? (There can be more than one answer)

- 1) news
- 2) governmental announcement
- 3) documentary
- 4) short drama
- 5) miniseries
- 6) game show
- 7) talk show
- 8) music show / music concerts
- 9) other (specify) \_\_\_\_\_

5. How often have you seen the programs about AIDS on TV. in the past month ?

- 1) a few times ( 1-2 a month)
- 2) several times ( more than 2)
- 3) many times ( about once a week or more )
- 4) every day
- 5) never

6. Have you ever seen the news report on " WORLD AIDS DAY" on TV last December ?

( World AIDS Day : December 1 of 1993 )

1. yes
2. no

7. How often have you heard about AIDS during the last month on the radio?

- 1) a few times ( 1-2 a month)
- 2) several times ( more than 2)
- 3) many times ( about once a week or more )
- 4) every day
- 5) never

8. Have you ever heard of "Thai Family Program" in which a health officer of Kanchanaburi Provincial Medical Office interviewing AIDS experts who work on AIDS prevention on radio?

( The interview programs were broadcast twice in December )

1. yes
2. no

9. How often have you read about AIDS during the last month in newspapers?

- 1) a few times ( 1-2 a month)
- 2) several times ( more than 2)
- 3) many times ( about once a week or more )
- 4) every day
- 5) never

10. How often have you heard about AIDS during the last month from village loudspeakers?

- 1) a few times ( 1-2 a month)
- 2) several times ( more than 2)
- 3) many times ( about once a week or more )
- 4) every day
- 5) never

#### F. Talking

I would like to ask you how you talk about AIDS in various social settings.

1. Have you ever talked with anyone about AIDS in the past month?

1. yes
2. no (Go to 2)
8. do not know/ no response ( go to 3)

## Q. 2- Q. 23

For each given answer in Q.3, how many times did you talk about AIDS prevention with them last month ?

| Q. 2. With whom did you talk about it? (There can be more than one answer) | Spouse<br>( ) | Boyfriend<br>Girlfriend<br>( ) | Parents<br>( ) | Brothers /<br>Sisters<br>( ) | Friends<br>( ) | Children<br>( ) | Health<br>workers<br>( ) | Co-workers<br>( ) |
|--|---------------|--------------------------------|----------------|------------------------------|----------------|-----------------|--------------------------|-------------------|
| How many times did you talk about AIDS?                                    | Q. 3          | Q. 6                           | Q. 9           | Q. 12                        | Q. 15          | Q. 18           | Q. 21                    | Q. 24             |
| 1. A few times   | 1             | 1                              | 1              | 1                            | 1              | 1               | 1                        | 1                 |
| 2. Many times  | 2             | 2                              | 2              | 2                            | 2              | 2               | 2                        | 2                 |
| 3. Almost every day  | 3             | 3                              | 3              | 3                            | 3              | 3               | 3                        | 3                 |
| What did you talk about AIDS?  | Q. 4          | Q. 7                           | Q. 10          | Q. 13                        | Q. 16          | Q. 19           | Q. 22                    | Q. 25             |
| 1. People who have AIDS  | 1             | 1                              | 1              | 1                            | 1              | 1               | 1                        | 1                 |
| 2. The reasons forgetting AIDS   | 2             | 2                              | 2              | 2                            | 2              | 2               | 2                        | 2                 |
| 3. The ways one can avoid AIDS   | 3             | 3                              | 3              | 3                            | 3              | 3               | 3                        | 3                 |
| 4. The consequence of getting AIDS   | 4             | 4                              | 4              | 4                            | 4              | 4               | 4                        | 4                 |
| 8. Other (specify)   | 8             | 8                              | 8              | 8                            | 8              | 8               | 8                        | 8                 |
| What did you say about the ways one can avoid AIDS?                        | Q. 5          | Q. 8                           | Q. 11          | Q. 14                        | Q. 17          | Q. 20           | Q. 23                    | Q. 26             |
| 1. Using condoms when having sex   | 1             | 1                              | 1              | 1                            | 1              | 1               | 1                        | 1                 |
| 2. Avoid going to prostitutes  | 2             | 2                              | 2              | 2                            | 2              | 2               | 2                        | 2                 |
| 3. Strict to monogamy  | 3             | 3                              | 3              | 3                            | 3              | 3               | 3                        | 3                 |
| 4. Not sharing personal belongings (e.g., razors, scissors and blades)     | 4             | 4                              | 4              | 4                            | 4              | 4               | 4                        | 4                 |
| 5. Using personal tools when going to the barbers                          | 5             | 5                              | 5              | 5                            | 5              | 5               | 5                        | 5                 |
| 8. Others (specify)  | 8             | 8                              | 8              | 8                            | 8              | 8               | 8                        | 8                 |

27. With whom do you have difficulty when talking about AIDS prevention?

( There can be more than one answer)

0. not at all
1. spouse
2. boyfriend/girlfriend
3. parents
4. brothers/sisters
5. friends
6. co-workers
7. health workers
8. other (specify) \_\_\_\_\_

28. What makes you have difficulty when you talk about AIDS?

1. feel that people already know about AIDS
2. fear of being misunderstood as carrying about AIDS
3. not interested in AIDS
4. feel embarrassed
5. feel uneasy
6. lack of context
7. afraid that people do not believe
8. other (specify) \_\_\_\_\_

29. Why not difficult for you to talk about AIDS?

1. want to disseminate AIDS knowledge to listeners
2. want to protect listeners from AIDS
3. want to protect own family from AIDS
4. more knowledgeable about AIDS more than others
8. other (specify) \_\_\_\_\_

30 What make you motivate to talk about AIDS?

0. when having known who has AIDS
1. when visiting hospitals
2. when going out drinking with friends.
3. when going out in groups with friends
4. when going to prostitutes
5. when talking about women
6. when talking about babies
7. when talking about marriage
8. when watching TV
9. others (specify) \_\_\_\_\_

31. Have you ever mentioned the following topics in your conversations topics with anyone? ( Read all and circle for each )

- |  |              |
|--|--------------|
| a) AIDS in Thailand is transmitted through homosexuals               | 1) yes 2) no |
| b) AIDS is spreading because of foreign tourists                     | 1) yes 2) no |
| c) AIDS is spreading because of IV drug users                        | 1) yes 2) no |
| d) AIDS is spread by sex industry workers                            | 1) yes 2) no |
| e) AIDS is spread by men who go to prostitutes                       | 1) yes 2) no |
| f) AIDS is a threat to an individual's life and lifestyle            | 1) yes 2) no |
| g) AIDS is a thereat to a couple's relationship                      | 1) yes 2) no |
| h) AIDS is a threat to tourism in Thailand                           | 1) yes 2) no |
| i) AIDS is a threat to the health of mothers and infants             | 1) yes 2) no |
| j) the government should be responsible for AIDS prevention campaign | 1) yes 2) no |
| k) AIDS can be prevented by changing individual sexual behavior      | 1) yes 2) no |
| l) AIDS is prevented by using condoms                                | 1) yes 2) no |
| m) AIDS can be prevented by reducing the number of sexual partners   | 1) yes 2) no |

#### G. Social Appropriateness

1. Who should discuss AIDS preventive practices together ?

(Read each item )

AIDS Prevention Practices

- |                            |              |
|----------------------------|--------------|
| 1. wife husband            | 1. yes 2. no |
| 2. boyfriend/ girlfriend   | 1. yes 2. no |
| 3. close friends           | 1. yes 2. no |
| 4. parents /children       | 1. yes 2. no |
| 5. neighbors               | 1. yes 2. no |
| 6. co-workers              | 1. yes 2. no |
| 7. health workers/patients | 1. yes 2. no |
| 8. prostitutes/clients     | 1. yes 2. no |
| 9. others (specify) _____  | 1. yes 2. no |

2. Whose opinion/advice on AIDS prevention practices do you believe in? (Read the list)

- |                           |        |       |                |
|---------------------------|--------|-------|----------------|
| 1. wife/husband           | 1. yes | 2. no | 8. do not know |
| 2. boyfriend/girlfriend   | 1. yes | 2. no | 8. do not know |
| 3. brothers/sisters       | 1. yes | 2. no | 8. do not know |
| 4. friends                | 1. yes | 2. no | 8. do not know |
| 5. relatives              | 1. yes | 2. no | 8. do not know |
| 6. neighbors              | 1. yes | 2. no | 8. do not know |
| 7. co-workers             | 1. yes | 2. no | 8. do not know |
| 8. health workers         | 1. yes | 2. no | 8. do not know |
| 9. TV                     | 1. yes | 2. no | 8. do not know |
| 10. radio                 | 1. yes | 2. no | 8. do not know |
| 11. newspapers            | 1. yes | 2. no | 8. do not know |
| 12. village loudspeakers  | 1. yes | 2. no | 8. do not know |
| 13. prostitutes           | 1. yes | 2. no | 8. do not know |
| 99. other (specify) _____ | 1. yes | 2. no | 8. do not know |

(When you speak to someone about AIDS, you may care about the person's opinion about your statements.)

3. Would you talk about AIDS prevention, when the following persons are present ?  
( Read the lists, select as many as possible )

- |                         |                 |                    |
|-------------------------|-----------------|--------------------|
| 1. wife/husband         | 1. yes, I would | 2. no, I would not |
| 2. boyfriend/girlfriend | 1. yes, I would | 2. no, I would not |
| 3. brothers/sisters     | 1. yes, I would | 2. no, I would not |
| 4. relatives            | 1. yes, I would | 2. no, I would not |
| 5. friends              | 1. yes, I would | 2. no, I would not |
| 6. neighbors            | 1. yes, I would | 2. no, I would not |
| 7. co-workers           | 1. yes, I would | 2. no, I would not |
| 8. health workers       | 1. yes, I would | 2. no, I would not |
| 9. prostitutes          | 1. yes, I would | 2. no, I would not |
| 10. drug users          | 1. yes, I would | 2. no, I would not |
| 11. others              | 1. yes, I would | 2. no, I would not |

## H. Risk

I would like to ask you some questions concerning the likelihood that either you or some other people might contract AIDS ?

1. How likely is it that the following people might contract AIDS? (Read each item)

1. people in Thailand
  1. Impossible 2. likely 3. very likely 4. Most likely
2. people in Kanchanaburi
  1. Impossible 2. likely 3. very likely 4. Most likely
3. people in your district
  1. Impossible 2. likely 3. very likely 4. Most likely
4. people in your village/ community
  1. Impossible 2 likely 3. very likely 4. most likely
5. your friends
  1. Impossible 2 likely 3. very likely 4. most likely
6. your co-workers
  1. Impossible 2 likely 3. very likely 4. most likely
7. prostitute in Kanchanaburi
  1. Impossible 2 likely 3. very likely 4. most likely
8. your spouse
  1. Impossible 2 likely 3. very likely 4. most likely
9. educated people
  1. Impossible 2 likely 3. very likely 4. most likely
10. beautiful women
  1. Impossible 2 likely 3. very likely 4. most likely
11. good-looking men
  1. Impossible 2 likely 3. very likely 4. most likely
12. yourself
  1. Impossible 2 likely 3. very likely 4. most likely

2. Do you agree that many of your female/male friends have had more than one sexual partners in the last couple of month?

1. yes, I agree or yes, I do
2. no, I don't agree
8. other or others (specify)\_\_\_\_\_

3. Do you agree that many of your female/male friends are using condoms when having sex ?

1. yes, I agree or yes, I do
2. no, I don't agree
8. other or others (specify)\_\_\_\_\_

4. Do you agree that most of your friends (or your husband's friends) have sex with a prostitutes?

1. yes, I agree or yes, I do
2. no, I don't agree
8. other or others (specify) \_\_\_\_\_

5. Do you agree that it socially appropriate to ask your friends whether they have talked with spouses about safe-sex practices?

1. yes, I agree or yes, I do
2. no, I don't agree
8. other or others (specify) \_\_\_\_\_

## I. OTHERS

Tell me if you agree or disagree with the following statements.

1. It is a good idea for men to have a lot of sexual partners.
  1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know
  
2. It is a good idea for a man to use condoms whenever he has sex with a prostitute.
  1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know
  
3. Suggesting condom use is an insult to your regular sexual partner ( who is not a prostitute).
  1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know
  
4. Using a condom reduces the enjoyment from sex.
  1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know
  
5. It is a good idea for young men to get tested for AIDS.
  1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know
  
6. It is your role to discuss safe-sex practices with your spouse.
  1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know
  
7. It is a good idea for everyone to discuss AIDS prevention with their friends.
  1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know
  
8. To avoid contracting AIDS, you should use condoms every time you have sex with your husband/wife or boyfriend/girlfriend.
  1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know

9. Do you agree that women can ask men to use condoms to avoid contracting AIDS ?
1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know

10. Do you agree that women can reject sex when her husband needs it ?
1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know

11. Do you agree that women can reject sex when her boyfriend needs it ?
1. yes, I agree or yes, I do
  2. no, I don't agree
  8. do not know or I don't know

12. Do you think that the following statement describes the information concerning AIDS you have actually perceived from various kinds of mass media ? (Read each item one by one).

- |  |              |
|--|--------------|
| a) AIDS in Thailand is transmitted through homosexuals               | 1) yes 2) no |
| b) AIDS is spreading because of foreign tourists                     | 1) yes 2) no |
| c) AIDS is spreading because of IV drug users                        | 1) yes 2) no |
| d) AIDS is spread by sex industry workers                            | 1) yes 2) no |
| e) AIDS is spread by men who go to prostitutes                       | 1) yes 2) no |
| f) AIDS is a threat to an individual's life and lifestyle            | 1) yes 2) no |
| g) AIDS is a threat to a couple's relationship                       | 1) yes 2) no |
| h) AIDS is a threat to tourism in Thailand                           | 1) yes 2) no |
| i) AIDS is a threat to the health of mothers and infants             | 1) yes 2) no |
| j) the government should be responsible for AIDS prevention campaign | 1) yes 2) no |
| k) AIDS, can be prevented by changing individuals sexual behavior    | 1) yes 2) no |
| l) AIDS is prevented by using condoms                                | 1) yes 2) no |
| m) AIDS can be prevented by reducing the number of sexual partners   | 1) yes 2) no |

## J. PRACTICES

I would like to ask you some personal questions about sex. As I said before, your identification will be confidential. Please try your best to answer each question completely.

1. Do you think that nowadays men and women have premarital sex ?
1. yes
  2. no
  8. other (specify) \_\_\_\_\_

2. Have you ever had a premarital sex ?

1. yes
2. no
8. other (specify) \_\_\_\_\_

(For males and females )

3. Do you have any kind of prevention to make sure that your spouse will not get AIDS ?

1. yes
2. no ( Skip Q.4 and go to Q.5 )

4. If yes, what do you do ? (There can be more than one answer)

1. avoid having sex
2. using condoms
3. having only one partner
4. not visiting prostitutes
8. others (specify) \_\_\_\_\_
9. nothing / don't know.

(For unmarried males and females )

3. ( For those who have boyfriends and girlfriends)

Do you have any kind of prevention to make sure that your spouse will not get AIDS ?

1. yes
2. no ( Go to Q. 10)
3. do not have boyfriend/ girlfriend ( Go to the Q 8)

4. . If yes, what do you do ?

1. avoid having sex
2. using condoms
3. having only one partner
4. not visiting prostitutes
8. others (specify) \_\_\_\_\_
9. nothing / don't know

5. When was the last time that you had sex with your husband/wife or boyfriend/girlfriend ?

1. last week
2. last month
3. last 1-2 months
4. last 3-4 months
- 5 last 5-6 months
6. more than 6 months ago
7. never
8. others (specify) \_\_\_\_\_

6. Did you use condoms during that time ?

1. yes
2. no ( Skip Q 7)

7. (If yes) How often do you use condoms when having sex with your wife ?

0. never
1. rarely
2. sometimes
3. every time

( For MEN ONLY)

8. Have you ever had sex with a prostitute ?

1. yes
2. no( skip 9, 10, 11 )

9. In the last six months, how many times have you had sex with prostitutes?

\_\_\_\_/\_\_\_\_/ number of times

77. never
- 88 don't know/ don't remember
- 99 no response

10. Did you still have sex with a prostitute in December?

- 1 yes
2. no

11. What made you feel like having sex with a prostitute ?

1. seeing nude pictures
- 2 seeing condom posters
3. quarreling with your partners
4. talking about sex with friends
5. watching love scenes in a movie
6. hearing from other friends who went to prostitutes
7. drinking
8. others (specify) \_\_\_\_\_

12. Did you use a condom the last time you had sex with a prostitute?

1. yes
2. no

13. If not, why didn't you use a condom?
1. don't know it
  2. can't get one
  3. too expensive
  4. don't like it
  5. partner didn't want it
  6. can break, or leak
  7. allergic
  8. not safe, doesn't work
  9. trust that partner doesn't have AIDS
  10. unnatural
  11. smell bad
  - 88 others (specify)

( FOR WOMEN ONLY )

14. Do you think that your husband or boyfriend had sex with a prostitute in the last one month?

1. yes ( go to the next Q)
2. no ( skip the next Q)
8. others (specify) \_\_\_\_\_

14

15. If yes, do you think that he used condoms when he had sex with a prostitute?

1. yes
2. no
8. others (specify) \_\_\_\_\_

16. Have you ever asked your husband or boyfriend not to go to prostitutes?

1. yes (skip 17)
2. no

17. If no, why didn't you ask him ?

1. he doesn't have such a behavior
2. not appropriate
3. feel too embarrassed
4. afraid of offending husband./ boyfriend
8. other (specify) \_\_\_\_\_

18. Have you ever asked your husband/ ( boyfriend) to use condoms with you?

1. yes ( Go to 20 )
2. no ( Go to 19 )

19. If not, how do you feel if you have to ask him to use a condom ?

1. not appropriate
2. too embarrassed
3. there's no need for it
4. trust that he doesn't have sex with a prostitute
8. others (specify) \_\_\_\_\_

20. Has your husband/ boyfriend ever rejected your request on using a condom?

1. yes
2. no
8. other

(EVERYONE )

21. When was the last time that you had sex with someone who is not your husband/wife or boyfriend/girlfriend ?

1. last week
2. last month
3. last 1-2 months
4. last 3-4 months
5. last 5-6 months
6. more than 6 months ago
7. never
8. other (specify) \_\_\_\_\_

22. Did you use condom when you have sex with someone who is not your spouse/boyfriend girlfriend ?

1. yes
2. no ( Skip Q 23 )
8. other

23. (If yes) how often do you use a condoms with those partners?

1. rarely
2. sometimes
3. every time

24. Have you ever been tested for HIV?

1. yes
2. no

Thank you very much for your help.

## APPENDIX B

### Correlations among Independent Variables

|                 | Talking Freq. | Talking Variety | Recept | Know-Myth | Know Gen | Socioeconomic | Sociapt | Socinet | Poliaw | Age   | Gender (male) | Marital married |
|-----------------|---------------|-----------------|--------|-----------|----------|---------------|---------|---------|--------|-------|---------------|-----------------|
| Talking Freq.   | --            | .65**           | .23**  | .13**     | .07**    | .12**         | .09**   | .13**   | .17**  | .18** | .00           | .12**           |
| Talking Variety |               | --              | .32**  | .18**     | .16**    | .21**         | .18**   | .25**   | .21**  | .16** | .10**         | .10**           |
| Recept          |               |                 | --     | .16**     | .08**    | .28**         | .18**   | .15**   | .22**  | .04** | .15**         | .00             |
| Know-myth       |               |                 |        | --        | .00      | .18**         | .02     | .10**   | .19**  | .08** | -.03          | -.10**          |
| know-General    |               |                 |        |           | --       | .10**         | .06*    | .14**   | .12**  | .16** | .05           | -.02            |
| Socioeconomic   |               |                 |        |           |          | --            | .11**   | .17**   | .21**  | .28** | .19**         | -.09**          |
| Sociapt         |               |                 |        |           |          |               | --      | .16**   | .09**  | .18** | .22**         | .03             |
| Socinet         |               |                 |        |           |          |               |         | --      | .15**  | .15** | .08**         | -.04            |
| Poliaw          |               |                 |        |           |          |               |         |         | --     | .22** | .27**         | -.03            |
| Age             |               |                 |        |           |          |               |         |         |        | --    | -.02          | .53**           |
| gender (male)   |               |                 |        |           |          |               |         |         |        |       | --            | -.19**          |
| Marital Married |               |                 |        |           |          |               |         |         |        |       |               | --              |

\*\*p<.01 \* p<.05

**APPENDIX C**  
**Table of Regression Analysis For Talking Variety and Frequency**

( Variety)

| Variable           | M 1   | M2    | M 3   | M 4   | M 5    | M6     |
|--------------------|-------|-------|-------|-------|--------|--------|
| RECEP              | .32** | .29** | .27** | .25** | .24**  | .22**  |
| SOCIAPT            |       |       | .10** | .10** | .08**  |        |
| SOCINET            |       | .21** | .19** | .17** | .17**  | .16**  |
| KNOW-MYTH          |       |       |       |       |        | .12**  |
| KNOW-GENERAL       |       |       |       | .16** | .18**  | .11**  |
| POLIAW             |       |       |       |       |        | .06**  |
| SOCIOECO           |       |       |       |       |        | .09**  |
| AGE                |       |       |       |       | .14**  | .13**  |
| GENDER             |       |       |       |       | .13**  | .11**  |
| MARITAL<br>STATUS  |       |       |       |       | .13**  | .14**  |
| MARITAL*<br>GENDER |       |       |       |       | -.11** | -.12** |
| Multiple R         | .34   | .44   | .45   | .47   | .46    | .47    |
| Adjusted R sq.     | .12   | .19   | .20   | .22   | .21    | .22    |
| DF                 | 2     | 8     | 9     | 9     | 8      | 10     |
| Residual           | 1703  | 1664  | 1655  | 1663  | 1664   | 1662   |

\*\*<.01; \*<.05

(CONTINUED)

| Variable        | M 7    | M 8   | M 9    | M 10  | M 11   |
|-----------------|--------|-------|--------|-------|--------|
| RECEP           | .24**  | .22** | .22**  | .25** | .22**  |
| SOCIAPT         |        | .09** |        |       |        |
| SOCINET         |        |       | .16**  | .17** | .16**  |
| KNOW-MYTH       |        |       |        | .12** | .12**  |
| KNOW-GENERAL    | .17**  | .17** | .16**  | .15** | .11**  |
| POLIAW          | .08**  | .08** | .07**  | --    | .06**  |
| SOCIOECO        | .10**  | .10** | .08**  | --    | .09**  |
| AGE             | .13**  | .13** | .12**  | .14** | .13**  |
| GENDER          | .13**  | .10** | .12**  | .13** | .11**  |
| Marital Status  | .13**  | .12** | .14**  | .13** | .14**  |
| Marital* Gender | -.11** | -.10  | -.12** | .11** | -.12** |
| Multiple R      | .44    | .45   | .47    | .46   | .47    |
| Adjusted R sq.  | .19    | .20   | .22    | .21   | .22    |
| DF              | 8      | 9     | 9      | 8     | 10     |
| Residual        | 1664   | 1655  | 1663   | 1664  | 1662   |

\*\*&lt;.01; \*&lt;.05

## ( Talking Frequency)

| Variable        | M 1   | M 2   | M 3   | M 4   | M 5    | M 6    |
|-----------------|-------|-------|-------|-------|--------|--------|
| RECEP           | .27** | .26** | .26** | .24** | .24**  | .23**  |
| SOCIAPT         |       |       | .04   |       |        |        |
| SOCINET         |       | .09** |       | .08** | .08**  | .07**  |
| KNOW-MYTH       |       |       |       |       |        |        |
| KNOW-GENERAL    |       |       |       | .11** | .11**  | .10**  |
| POLIAW          |       |       |       |       |        | .09**  |
| SOCIOECO        |       |       |       |       |        |        |
| AGE             |       |       |       |       | .16**  | .14**  |
| GENDER          |       |       |       |       | .02**  | .01    |
| Marital Status  |       |       |       |       | .09**  | .10**  |
| Marital* Gender |       |       |       |       | -.07** | -.08** |
| Multiple R      | .27   | .28   | .27   | .30   | .36    | .37    |
| Adjusted R sq.  | .07   | .08   | .07   | .09   | .13    | .13    |
| DF              | 1     | 2     | 2     | 3     | 7      | 8      |
| Residual        | 1688  | 1687  | 1718  | 1686  | 1682   | 1681   |

\*\*&lt;.01; \*&lt;.05

## (CONTINUED)

| Variable        | M 7   | M 8   | M 9   | M 10  |
|-----------------|-------|-------|-------|-------|
| RECEP           | .22** | .22** | .23** | .22** |
| SOCIAPT         |       |       |       |       |
| SOCINET         | .07** | .08** | .08** | .07** |
| KNOW-MYTH       |       | .08** | .09** | .08** |
| KNOW-GENERAL    | .09** | —     | —     | .03   |
| POLIAW          | .08** | .09** | .09** | .08** |
| SOCIOECO        | .03*  | .04   |       | .03   |
| AGE             | .14** | .14** | .14** | .14** |
| GENDER          | 00    | 00    | 00    | 00    |
| Marital Status  | .10** | .10** | .10** | .10** |
| Marital* Gender | -.08* | -.08* | -.08* | -.08* |
| Multiple R      | .37   | .36   | .36   | .37   |
| Adjusted R sq.  | .13   | .13   | .13   | .13   |
| DF              | 9     | 9     | 8     | 10    |
| Residual        | 1680  | 1687  | 1688  | 1679  |

\*\*&lt;.01; \*&lt;.05

## BIBLIOGRAPHY

- Adam, B. (1989). The State, public policy, and AIDS discourse. Contemporary Crisis, 13 (1), 1-14.
- Baumgartner, F., & Jones, B. (1993). Agenda and instability in American politics. Chicago: The University of Chicago Press.
- Baxter, L. A. (1984). An Investigation of compliance-gaining as politeness. Human Communication Research, 10, 427-456.
- Baxter, L., & Wilmot, W. (1985). Taboo topics in close relationships. Journal of Social and Personal Relationships, 2, 253-269.
- Brown, J., Waszak, C., & Walsh Childers, K. (1989). Family planning, abortion and AIDS: sexuality and communication campaigns. In Charles Salmon (Ed.), Information Campaigns: Balancing Social Values and Social Change (pp. 85-112). Newbury Park, CA: Sage.
- Brandt, A. M. (1988). Toward the social meaning of epidemic diseases. Social Research, 55 (3), 413-432.
- Cohen, E. (1988). Tourism and AIDS in Thailand. Annals of Tourism Research, 15 (4) 467-486.
- Crimp, D. (1989). AIDS: Cultural Analysis/Cultural Activism. Cambridge, MA: MIT Press.
- Chaffee, S. (1982). Mass media and interpersonal channels: competitive, convergent or complementary. In Gary Gumpertz and Robert Cathcart (Eds.), Inter-Media (pp. 62-80). New York/Oxford: Oxford University Press.
- Chaffee, S. (1972). The Interpersonal context of mass communication. In Gerald Kline and Phillip Tichenor (Eds.), Current Perspectives in Mass Communication Research (pp. 95-120). Beverly Hills: Sage.
- Chaffee, S., & Schleuder, J. (1986). Measurement and effects of attention to media news. Human Communication Research, 13 (1), 76-107.
- Cline, R., Freeman, K., & Johnson, S. (1990). Talk among sexual partners about AIDS: factors differentiating those who talk from those who do not. Communication Research, 17 (6), 792-808.
- Cline, R., Johnson, S., & Freeman, K. (1992). Talk among sexual partners about AIDS: interpersonal communication for risk reduction or risk enhancement? Health Communication, 4 (1), 39-56.

- Edelmann, R. (1982). The Effect of embarrassed reactions upon others. Australian Journal of Psychology, 34 (3), 359-367.
- Festinger, L. (1968). A Theory of social comparison processes. In Herbert Hyman and Eleanor Singer (Eds.) Readings in Reference Group Theory and Research (pp. 123 - 146). New York: The Free Press.
- Fields, J., & Schuman, H. (1976). Public beliefs about the beliefs of the public. Public Opinion Quarterly, 40, 427-448.
- Ford, N., & Koetswang, S. (1991). The Socio-cultural context of the transmission of HIV in Thailand. Social Science and Medicine, (33) 4, 405-414.
- Freimuth, V., Stein, J. & Kean, T. (1989). Searching for Health Information. Philadelphia: University of Pennsylvania Press.
- Gamson, W. (1992). Talking Politics. New York: Cambridge University Press.
- Gamson, W. (1989). News as framing. American Behavioral Scientist, 33 (2), 157-161.
- Gantz, W., & Greenberg, B. (1990). The Role of informative television programs in the battle against AIDS. Health Communications, 2 (4), 199-215.
- Goethals, G., Messick, D., & Allison, S. (1991). The Uniqueness bias: studies of constructive social comparison. Jerry Suls & Thomas Ashby Wils (Eds.), Social Comparison: Contemporary Theory and Research. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Green E. C. (1992). Anthropology of sexually-transmitted disease in Liberia. Social Science and Medicine, 1457-1468.
- Greenberg, B., & Gantz, W. (1976). Public television and taboo topics: the impact of "VD Blues." Public Telecommunications Review, 4, 56-59.
- Hornik, R. (1989). Channel effectiveness in development communication program. In Ronald Rice and Charles Atkins (Eds.) Public Communication Campaigns (pp. 309-330). Newbury Park, CA: Sage.
- Iversen, G. (1991). Contextual Analysis (Quantitative Applications in the Social Sciences Series, 81). Newbury Park, CA: Sage.
- Katz, E. (1983). Publicity and pluralistic ignorance: notes on "The Spiral of silence." In E. Wartella, D.C. Whitney & S. Widahl (Eds.), Mass Communication Review Yearbook (vol. 4, pp. 89-100). Newbury Park, CA: Sage.
- Miller D., & McFarland, C. (1991). When Social comparison goes awry: the case of pluralistic ignorance. In Jerry Suls & Thomas Ashby Wils (Eds.), Social

Comparison: Contemporary Theory and Research. Hillsdale, New Jersey: Lawrence Erlbaum Associates.

- Neuman, R., Just, M., & Crigler, A. (1992). Common Knowledge. Chicago: University of Chicago Press.
- Nelkin, D., Willis, D., & Parris, S. (1990). Introduction: social and cultural responses to AIDS. The Milbank Quarterly 68 (Suppl 1), 1-9.
- Nichter, Mark. (1989). Anthropology and International Health. Dordrecht/Boston/London: Kluwer Academic Publishers.
- Nishino, Y. (1991). How Social environmental conditions affect behavior changes from health communication campaigns in developing countries: a case study of a breast-feeding campaign in Jordan. Unpublished master's thesis, University of Pennsylvania, Philadelphia, PA.
- Noelle-Neuman, E. (1984). The Spiral of Silence: Public Opinion - Our Social Skin. Chicago: The University of Chicago Press.
- O'Gorman, H. (1988). Pluralistic ignorance and reference groups: the case of in-group ignorance. In O'Gorman, Hubert (Ed.), Surveying Social Life (pp. 145-173). Middletown, CT: Wesleyan University Press.
- Pan, Z., & McLeod, J. (1991). Multilevel analysis in mass communication research. Communication Research, 18 (2), 140-173.
- Pan, Z., & Kosicki, G. (1993). Framing analysis: an approach to news discourse. Political Communication 10, 55-75.
- Pokapanichwong, W., Douglas, D., Wright, N.H., Vanichseni, S., & Choopanya, K. (1991). AIDS beliefs and behaviors among intravenous drug users in Bangkok. The International Journal of the Addictions 26 (12), 1333-1347.
- Price, V. (1992). Public Opinion (Communication Concepts, 4). Newbury Park, CA, Sage.
- Price, V., & Zaller, J. (1993). Who gets the news? alternative measures of news reception and their implications for research. Public Opinion Quarterly, 57(2), 133-164.
- Protest, D., & McCombs, M. (Eds.) (1991). Agenda Setting: Readings on Media, Public Opinion and Policymaking. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Reinarman, C., & Leigh, B. C. (1987). Culture, cognition, and disinhibition: notes on sexuality and alcohol in the age of AIDS. Contemporary Drug Problems, 14 (3).

- Rogers, E., & Shoemaker, P. (1971). Communication of Innovations : A Cross -Cultural Approach. New York: Free Press.
- Rogers, E., Dearing, J., & Chang, S. (1991). AIDS in the 1980s: the agenda-setting process for a public issue. Journalism Monographs, No 126, Columbia, SC: Association for Education in Journalism and Mass Communication.
- Rogers, E. & Kincaid, L. (1981). Communication Networks: Toward a New Paradigm for Research. New York: The Free Press.
- Rojanapithayakorn, W. (1994). Evolution of the response to AIDS in Thailand. AIDScriptions, (8), 9-12.
- Rosenberg, C. (1986). Diseases and social order in America: perceptions and expectations. The Milbank Quarterly, 64, ( supplement 1).
- Rosenberg, C. (1989). Diseases in history: frames and framers. The Milbank Quarterly, (67) ( supplement 1).
- Royal Thai Ministry of Public Health, AIDS division. (1993). HIV/AIDS Situation in Thailand. Bangkok, Thailand.
- Ryan, M. (1991). AIDS in Thailand. The Medical Journal of Australia, 154, (Feb. issue) 282-284.
- Shah, I., Thongthai, V., Leoprapai, B., Mundigo, A., Prasarkul, P., & Chamrathirong, A. (1991). Knowledge and perceptions about AIDS among married women in Bangkok. Social Science and Medicine, 33 (11), 1287-1293.
- Storck, E., & Brown, N. (1992). Lack of development puts its stamp on HIV/AIDS. Population Today, 20 (9), 4-5.
- Stallings, R. (1990). Media discourse and the social construction of risk. Social Problems, 37 (1), 80-93.
- Tantiwiranond, D., & Pandey, S. R (1991). By Women, For Women: A Study of Women's Organizations in Thailand. Research Notes and Discussions Paper No.72, Social Issues in Southeast Asia, Singapore: Institute of Southeast Asian Studies.
- Treichler, P. (1988). AIDS, homophobia and biological discourse: An epidemic of signification. In Douglas Crimp (Ed.), AIDS. Cambridge, MA: Massachusetts Institute of Technology Press.
- Tyler, T., & Cook, F. L. (1984). The Mass media and judgments of risk: distinguishing impact of personal and societal level judgments. Journal of Personality and Social Psychology, 47 (4), 693-708.

- Van Dijk, T. A. (1984). Prejudice In Discourse, Amsterdam/Philadelphia: John Benjamins Publishing Company.
- Van Dijk, T. A. (1985). Introduction: Discourse analysis as a new cross-discipline. In T. Van Dijk (Ed.), Handbook of Discourse Analysis (Vol. 1. Disciplines of Discourse). London: Academic Press.
- Van Dijk, T. A. (1988). News as Discourse. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Van Dijk, T. A. (1993). Elite Discourse and Racism. Newbury Park, CA: Sage.
- Van Landingham, M., Suparasert, S., Sittitrai, W., & Vaddhanaphiti, C. (1993). Two views of risky sexual practices among northern Thai males: the health belief model and theory of reasoned action. Cincinnati, OH: Paper presented at the Annual Meeting of Population Association of America.
- Vaughan E., & Seifert, M. (1992). Validity in the framing of risk issues. Journal of Social Issues, 48 (4), 119-135.
- Wheeler, L. (1991). A Brief history of social comparison theory. In Suls and Wills (Eds.) Social Comparison. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Wills, T., & Suls, J. (1991). Commentary: neo-social comparison theory and beyond. In Suls and Wills (Eds.) Social Comparison. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Zaller, J. (1992). The Nature and Origins of Mass Opinion. New York: Cambridge University Press.