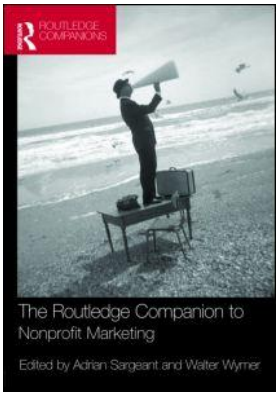

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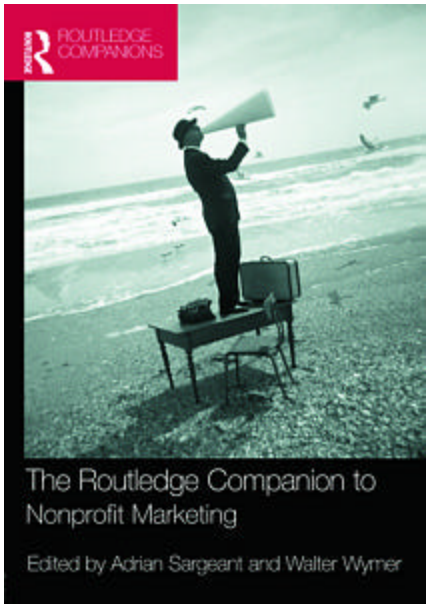

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Marketing AIDS prevention

An application of social marketing

Michael Basil

History of AIDS

In 1981, five cases of a rare pneumonia were diagnosed and almost immediately identified as a potential public health threat. During the next few years the Centers for Disease Control and Prevention (CDC) followed this 'gay pneumonia'. While the early research demonstrated that the disease was primarily associated with homosexual or bisexual males, the disease also made occurrences in intravenous (IV) drug users and Haitians. As the CDC pursued this outbreak, it eventually led to the identification of Acquired Immune Deficiency Syndrome (AIDS) as a unique disease that was very fatal (Stall and Mills 2006). Randy Shilts' (1987) book *And the Band Played on* documents the identification of AIDS in the early 1980s. After it was identified as a communicable disease, much of the response to AIDS was biomedical research attempting to understand the disease and its transmission.

Just a year after its identification, the CDC had identified 593 cases of AIDS which resulted in 243 deaths (MMWR 1982). In 1984 it was recognized that a virus, HIV, was responsible for the disease and that it was a potential epidemic that threatened to be a substantial public health burden around the world (Gallo and Montagnier 2003). By 1985 there were more stories about heterosexual transmission (including the Haitians), but these were still seen as isolated incidents (Check 1985). Subsequently, however, the infection rates began to grow at a much higher rate, especially among heterosexual women (MMWR 2006). Just twenty-five years later, in 2006, it was estimated that 40 million people around the world had AIDS (Stall and Mills 2006).

Because of its importance, its communicable nature, and the variety of means which could be applied to prevent the disease, AIDS is an excellent example of where social marketing can and should be applied. Public health practitioners have probably helped to slow the spread of the disease. Yet the potential of social marketing has not yet been fully achieved in the fight against AIDS. This chapter will demonstrate that the history of AIDS prevention efforts reveals that a number of factors have prevented social marketing from achieving its full potential.

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The social marketing approach

In 1969, Kotler and Levy suggested that the ideas of commercial marketing could be employed not only to help us to market commercial products, but also services, ideas and social needs. Only a slightly broader conceptualization of products and consumers was needed to include intangible products and other forms of consumption. Kotler (1972) went on to suggest that the marketing approach can be seen in many situations where one entity is trying to elicit a voluntary behaviour from the other entity by offering something of value (an exchange) to the other party. After a couple of uses of the term 'social marketing' seems to have caught on. Bagozzi (1975) proposed that 'social marketing' requires the creation and resolution of these voluntary exchanges.

Although none of these initial efforts mentioned applications to public health, many others have explained how the marketing approach can be used to improve public health (e.g. Andreasen 1995). Public health is probably the area that has been the most receptive to social marketing. In fact it was the application to public health that inspired Rothschild (1999) to further define what social marketing is by contrasting it with education and law. Rothschild argued that the educational approach is to get people to change their behaviour voluntarily by teaching or creating awareness without providing any reward or punishment. The legal approach tries to get people to behave by coercing them with a threat of punishment. Meanwhile, social marketing is the use of rewards, and attempts to minimize barriers to the desired behaviour. For example, making safer sex easier, more attractive or more available, and making unsafe activities harder, less attractive and less available would all be possible ways to alter sexual behaviour.

With regard to the issue of AIDS prevention, there have been many domestic educational campaigns employed, but considerably fewer legal or social marketing efforts. Next we will review the history of AIDS and some of the strategies that have been used to try to prevent, or at least reduce, the spread of HIV and AIDS in the USA. This will also be an opportunity to discuss some of the barriers to social marketing prevention programmes.

US domestic developments

Probably the most observable issue that arises from looking at the issue of AIDS is the storm that arose because of the fact that AIDS is tied to sexual behaviour. This context caused people to focus more on morality issues about sex than the public health aspects. Instead of developing a concerted effort to reduce people's risk, the sexual nature of the disease caused fight over what was the 'right' approach to trying to change people's sexual behaviour.

One outcome of AIDS being initially identified as a gay disease is that the homosexual community began getting active in AIDS education and prevention almost as soon as the disease was initially diagnosed (Shilts 1987). As early as 1982, gay men in San Francisco and New York began grass-roots preventative activities that were generally based on education that explained what the disease was, its means of transmission and how to prevent it (Dearing and Rogers 1992; MMWR 2006). Given the identification as a gay disease, this response should not be surprising. This immediate effort can be seen as evidence of the importance of self-interest and community ties. As Adam Smith would say, people typically act in their own self-interest. Because AIDS was initially identified with gays, that community was responsible for some of the first efforts. These efforts usually involved education about the disease and prevention through the use of condoms.

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The news media gave some coverage to AIDS in the early 1980s (Dearing and Rogers 1992). We know that news coverage does reach people and can sway public opinion through opinion leaders, so this was somewhat promising in educating people about AIDS. However, because the disease was most often identified with homosexuals, its effect was probably limited. First, we also know that people often make a distinction between personal risk and risk to others – called the 'impersonal impact hypothesis' (Tyler and Cook 1984). So just because the overall rates to the public were rising did not necessarily lead to people feeling personally at risk. Second, we know that people will often find ways to minimize their own risk levels, through processes such as attribution theory (Heider 1958). Attribution theory has found that people tend to blame the problems of others on internal factors (such as not being cautious enough) but see them as better able to protect themselves (because they are straight or by being better able to select partners). Because the news media generally identified AIDS as a disease among gay men (Dearing and Rogers 1992), it likely enabled people to use the fundamental attribution error and other means to minimize their own risk estimates (Heider 1958; Ross 1977). That is, people were able to think that AIDS was a risk to very sexually active gay men and ignored calls for their own action. In what is known as a 'fear control' process (Witte 1992), people found ways to minimize their own risk, largely by distancing themselves from the disease in the ways mentioned above.

In 1985, US actor Rock Hudson was diagnosed with AIDS. As a result, the number of news articles in mainstream media made a jump from fourteen stories per month to 143, a tenfold increase. Clearly, a celebrity with AIDS garnered considerably more coverage for the issue (Dearing and Rogers 1992). While this event markedly increased the number of stories about AIDS, and likely increased awareness of it, the fact that Rock Hudson was gay may have also limited the impact of this story on the general public directly. (Interestingly, however, it is possible that Rock Hudson's diagnosis affected the way a former actor colleague named Ronald Reagan perceived the disease. Since Ronald Reagan was, at the time, president of the USA, this may have had secondhand effects on the general public.) Even though the medical evidence at the time was that the disease could be spread to heterosexuals, there is evidence that the public still engaged in fear control by distancing themselves from the disease and minimizing their own risk. Again, because the initial identification of AIDS was primarily as a gay disease, this allowed heterosexual Americans to feel safe (e.g. Check 1985). Again, the fundamental attribution error, impersonal impact and fear control may have been operating to allow people to minimize their perceptions of risk, and therefore not change their behaviour (Anonymous 1987).

By 1987, the public health community noticed that the epidemic was not changing the straight community as much as they would have liked. So mainstream public health prevention efforts kicked in with a National AIDS Clearinghouse and in 1988 with the surgeon general's 'Understanding AIDS' brochure (MMWR 2006). One of the main messages was that AIDS was a sexually transmitted disease that could affect anyone, regardless of sexual orientation. The brochure was mailed to every home in the USA. Both efforts were primarily educational, explaining what the disease was, the means of transmission, and the ways in which transmission could probably be prevented, largely through abstinence or the use of condoms. However, several groups began to suggest that advocating the use of condoms encouraged sexual activity and infidelity, and perhaps even encouraged the spread of AIDS. So while his surgeon general was advocating the use of condoms, President Reagan was putting forth a message of monogamy and abstinence (*Ottawa Citizen* 1987). At the same time the US Department of Education put out a guide for parents and teachers which suggested abstinence was the only effective means of preventing AIDS (Bennett 1987). As a result, the use of condoms became a

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bit of a political football and the use of condoms was not as strongly advocated as it could have been.

In the late 1980s, despite the dilution of the condom message, there is evidence of increasing condom sales over this period (Moran *et al*. 1990). This is probably an instance of commercial marketing meshing with social marketing to increase people's ability to cope with the concern. Most of these studies tended to focus on comparing sales at the same outlets before and after these educational efforts. However, it is likely that additional channels of distribution were employed (e.g. Cohen *et al*. 1999), and therefore these studies likely underestimate the effects of these educational efforts on condom sales. Around the same time, HIV screening of the US blood supply was very effective in reducing the transmission rate from blood transfusions to about one in two million (MMWR 2006). In the case of blood transfusions, the application of a single structural change enabled by biomedical technology had a large and almost immediate effect on one form of HIV transmission.

In 1991, another important point in the story of AIDS was Earvin 'Magic' Johnson's announcement that he had HIV. Johnson was a basketball player and celebrity. Since Magic denied any homosexual activity, the public may have seen this as proof that HIV could be spread by heterosexual activity, as the surgeon general had claimed. Research suggests that this single event led to a considerable increase in calls to the AIDS hotline, from 3,000 to 40,000, a thirteenfold daily increase, and an increase in HIV tests from 30 to 146, almost a fivefold increase (Harris and Chavez 1991). In addition, the news of this story was quickly spread, largely by word of mouth (Basil and Brown 1994). Evidence suggests that men were more likely to pass this story on than were women (Basil and Brown 1994). Evidence suggests that celebrity patients result in press coverage and public awareness (Lerner 2006). In studying this phenomenon, Basil and Brown found that people identified with Magic Johnson; the notion that people felt that they knew him as a friend, led to their concern about the risk of HIV and AIDS to themselves (Basil 1996; Basil and Brown 1995, 1997). Left with a feeling of vulnerability, many people were tested for HIV. This was also an opportunity for social marketing interventions to offer the types of exchanges that Rothschild (1999) advocates to ensure safer behaviour. Later research on identification has shown that a similar feeling of identification was also important in determining people's reactions to the death of Princess Diana (Brown *et al*. 2003a) and their desire to emulate the opinions and behaviours of Mark McGwire (Brown *et al*. 2003b).

Another important time was in 1994; at an AIDS day conference, then-US Surgeon General Jocelyn Elders suggested that sexual education classes should suggest masturbation as alternative sexual outlet. An immediate negative response from religious groups erupted, and led to her resignation (Frankel 1994). This added more fuel to the fiery debate on whether abstinence or condoms should be the focus of prevention efforts and further stoked the storm still raging over what was the 'right' way to alter people's sexual activities. This fight was at least partly responsible for framing abstinence and condoms as an either–or proposition, with only one 'right' approach.

By 1996, another biomedical advance, the use of antiretroviral drugs, became common. Survival rates began to increase markedly (MMRW 2006). Again, because it did not require a change in sexual activity, this advance had a large direct impact on AIDS. While some suggest that this also may have reduced the potential threat of the disease (Kippax and Race 2003), the fact that the disease was still fatal meant that the threat could not be seen as completely ameliorated. But the face of the disease was changing. The diagnosis rates began to grow in the heterosexual community while the number of new cases actually fell in male-to-male and injection drug transmission (MMWR 2006). Another important development in

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prevention was the use of HIV testing to prevent the transmission from mother to child (MMWR 2006). Evidence shows a significant increase in HIV testing, especially among pregnant women between 1994 and 1999 (Lansky *et al*. 2001). The process of testing, coupled with antiretroviral therapy is purported to have dropped the cases of transmission from mother to child from 1,650 to a range of 144 to 236, a tenfold decrease (MMWR 2006).

In 2001, the CDC proposed a new prevention strategy which focused on reducing the number of new infections in the USA by 50 per cent (Linas *et al.* 2006). One important aspect of this effort involves increasing the number of people tested, so that people will know their HIV status. Increased federal funding was shown to result in increased levels of testing (Linas *et al.* 2006), and this finding is consistent with social marketing approaches which suggest that increasing the availability of testing or reducing the costs would lower the barriers to testing and increase compliance. If people had been more aware of testing, and that the results were anonymous, it is likely that more people would have known their HIV status, and, in theory, would have acted accordingly.

Summary of US social marketing efforts

The main debate in the USA was based on the controversial aspects of sexual behaviour. It centred on whether abstinence, limiting the number of sexual partners, or use of condoms was the 'right' approach. Some of this debate may have distracted people from the point that any and all of these behavioural changes were effective in AIDS control. In addition, most of the US interventions continued to focus on education, even though there was considerable awareness and knowledge. This means we missed other social marketing options to provide exchanges for risk reduction behaviours and disincentives for risky behaviours (DeJong 1989). The focus on education may reflect the fact that education is sometimes easier than social marketing – just putting together a brochure, information session or poster classifies as education. In addition, the news media in the West is an existing structure that is eager to seek out celebrity stories to fill its pages and attract an audience. Educational approaches were also probably less controversial than trying to alter people's sexual behaviour. It is also possible that this reflects cultural biases where we believe our own citizens are more rational or perhaps that our consumer culture is better able to deliver commercial products such as condoms to the marketplace (Ciszewski and Harvey 1995). But for whatever reasons the USA has focused more effort on educational approaches to AIDS prevention that involved information but not incentives or exchanges.

Perhaps the main reason that social marketing has been employed at all in the USA arises from the fact that AIDS initially appeared in marginalized communities and gained higher rates of prevalence in those communities (Stall and Mills 2006). The USA tends to think of social marketing approaches for people who are more marginalized. Yet it is a bit disconcerting that while educational approaches do have their use, there is plenty of evidence that people act in their own self-interest. Making condoms more available and other means of reducing the barriers to their use does result in increased use. So perhaps ethnocentrism has done the most harm, by limiting the ways in which the USA has tried to prevent the spread of HIV and AIDS to primarily educational approaches.

Yet there are some examples of social marketing programmes in the USA. One example is a programme in Louisiana which made condoms more available in clinics and in businesses in neighbourhoods with high rates of sexually transmitted diseases (STDs) (Cohen *et al.* 1999). Another is a word-of-mouth campaign for minority gay men (Silvestre *et al.* 2006). Both of these approaches were found to be successful.

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Another social marketing campaign which got some attention was the calls for abstinence among teenagers (Thomas 1999; Zipperer 1999). In addition to education efforts around social norms, the abstinence campaign asked young people to sign pledges affirming their desire to remain abstinent and by building communities where abstinence was supported. Silver rings were added as symbols. The effort, however, was met with some resistance from the American Civil Liberties Union who claimed that the financial support of the movement constituted government promotion of religion (Anonymous 2005). By delaying intercourse or reducing the number of partners this approach had potentially positive outcomes. There was some 'told-you-so' outside the religious community when research revealed that many abstinence pledges were broken (Akst 2003). More critical to the effectiveness of the programme, however, was that more than half of the pledges reported oral sex during their pledge and, further, when the pledges eventually did have sex they were not likely to use condoms (Akst 2003). Overall, the promise of the campaign was probably not as large as hoped, and ultimately may have been discredited.

Overall, then, the political and religious polarization of the issue led to competing messages about what should be done. The philosophical battle distracted from an effort that could have resulted in unified HIV prevention efforts (Rifkin 2004). Unfortunately, this can best be seen as a missed opportunity, and a lesson for social marketers to pay head to cultural norms, especially for any behaviours with strongly felt beliefs.

International efforts

While the diagnosis of AIDS arose from cases identified by the CDC in the USA, there is evidence that human retroviruses first appeared in Africa, even before AIDS was first diagnosed in the USA in 1981. Perhaps partly because of its earlier start in Africa, sub-Saharan Africa is probably the most severely affected area in the world, with six million cases, and almost a 30 per cent seroprevalance rate (Pawinski and Lalloo 2006). In Botswana this rate is an even higher 39 per cent (White 2006).

Yet for many of the same reasons that people try to deny their risks, other countries also tried to find ways to distance themselves from AIDS and HIV and this delayed their own action (Stall and Mills 2006). Typically, the first reaction was for countries to deny any cases of AIDS, or explain that it was limited to homosexuals and foreigners (Watts 1999). A typical second reaction was to control AIDS by limiting visits of people who may be HIV positive. This delay likely led to cases of HIV infection that might have been avoided. It took several years of increasing seroprevalance (blood test) before many countries confronted AIDS and HIV prevention among their own citizens (Watts 1999).

From the beginning, AIDS in Africa was primarily a heterosexual disease (Riche 1988). Perhaps this is another explanation as to why US domestic approaches have focused on educational efforts, while the rest of the world was more likely to employ social marketing approaches. When AIDS is seen primarily as a 'gay disease' or one of promiscuity (as in the USA), this may have been seen as an opportunity by many groups to 'educate' people about problems with these lifestyles. But when AIDS is primarily a heterosexual disease, people may feel less need to try to change others, and instead look to other ways of making existing sexual behaviour safer. One piece of evidence for the acceptance of social marketing can be seen in the United Nations pamphlet 'Social marketing: An effective tool in the global response to HIV/AIDS' (UNAIDS 1998). The pamphlet documents several success stories in selling condoms to low-income consumers.

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The debate on whether condoms promote promiscuity also arose in the international forum, including Canada (Byfield 2002) and the Sudan (Moszynski 2006). However, there was much greater success in combining the basic strategies of prevention into a unified 'A–B–C (abstinence, be faithful and use condoms) approach' (Rifkin 2004).

Meanwhile, the UN and the WHO have been promoting a behavioural intervention of 'no condom, no sex'. The evidence for the 'no condom, no sex' approach comes from Cambodia and Thailand where research has shown 80 per cent and 95 per cent drops in the rates of new infections (UNFPA/WHO 2006). Similar effects were found in Mozambique (Agha *et al*. 2006). So there was a considerable level of success with this approach.

Other countries have also attempted to increase the availability of condoms; back in 1991 heavily Catholic Ireland decided to lower the age limits on condom sales to make them more available to people (Anonymous 1991). China also allows sales of condoms via vending machines (Anonymous 2000). France, reversing a previously increasing trend of oral contraceptive use, increased their use of condoms (Toulemon and Leridon 1998). In Japan oral contraceptives were not legal, so baseline condom use was already high, but still showed signs of increase from concern about AIDS (Concar 1993).

Research has also demonstrated that the price of condoms affects sales (Ciszewski and Harvey 1995). So, overall, the evidence suggests that it is not just a matter of condom availability, but also price that determines the sales and frequency of use. The evidence is clear – making condoms more available and less expensive will generally increase their use. But in 2006 the USA, under the Bush administration, limited this approach by withdrawing financial support for condom distribution because of the claim that condoms may encourage promiscuity (Jack 2006).

It is interesting to note that the idea of focusing on condom availability and price is somewhat at odds with the educational approach that was seen in the USA. By some measures Africa would benefit from education. Evidence can be seen in reports that girls in Tanzania had low levels of knowledge about AIDS and that only 12 per cent of people in Botswana can explain how its transmission could be prevented (White 2006). Of course there is no reason that interventions need to be *limited* to education when other aspects of social marketing can either add to that effort or provide an additional contribution. Each approach appears to have its own contribution to behaviour (Rothschild 1999).

Other opportunities in reducing the spread of HIV and AIDS

It is clear that public health practitioners have done a good job of informing people in the West about AIDS. News stories and other information have resulted in good awareness. There is some evidence that education may have increased efforts to avoid HIV/AIDS (Moran *et al*. 1990). However, the perception of being personally at risk is harder to convey. The media may help accomplish this when a celebrity is diagnosed and his or her story is told in the press (Dearing and Rogers 1992; Lerner 2006). This appears to activate interpersonal networks of communication (Basil and Brown 1994) and result in people feeling at greater personal risk. The perception of personal risk appears to hinge on the feeling of identifying with a celebrity who has HIV (Brown and Basil 1995). This appears to affect people as if a real friend has been diagnosed (Basil and Brown 1997). Therefore it appears that efforts of personalizing the risk with the use of affected celebrities might have lasting effects.

The fight over whether condoms promoted promiscuity was also a lost opportunity. Perhaps less fighting between church and state might have led to a more cohesive integrated programme

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which did not derogate either abstinence or condoms as a viable approach. The way this was eventually combined as an A–B–C (abstinence, be faithful and use condoms) approach in the African community might also have been beneficial in other parts of the world (Rifkin 2004). Of course, this approach benefited from having evolved only in 2004. But had various factions spent less time fighting and more time reaching a compromise solution it is possible that this would have saved lives in the meantime by allowing people to use whatever risk reduction strategy suited them best.

With regard to the question of whether people have changed their behaviour, research has found that education and knowledge about AIDS are predictive of condom use. Other research has examined the barriers to condom use, yet few of these insights appear to have been fully tapped into improving the product or countering these concerns. Yet the evidence that social marketing programmes which have helped to make condoms more available result in increased use is promising (Agha *et al*. 2001; Cohen *et al*. 1999). It suggests that even with factors working against condom use, if they are available they are more likely to be used (Moran *et al.* 1990). But building a better condom, or doing a better job of destigmatizing their use could have been done. For example, some attempts at getting women to refuse sex with an unprotected partner have been tried and may have been more successful if combined with other options such as a female condom.

Despite some evidence of increased condom use, there is less evidence of other changes in people's sexual behaviour. Yet many of these other efforts might have been used to slow down the spread of HIV/AIDS. One critique of the educational approach is that previous health outbreaks have been successfully contained by interrupting the chain of transmission (Dannemeyer and Franc 1989). So another potential opportunity was to increase testing. With other diseases, positive STDs tests are required to be reported to authorities. However, HIV testing in the USA was initially done anonymously. Despite this limitation, though, some voluntary-testing efforts have been successful. The testing of pregnant women was voluntary, and yet the results of the mother-to-child interventions have been remarkably effective in lowering this means of transmission (MMWR2006).

One of the reasons for voluntary testing is to avoid stigmatization of victims, and another is to protect their health coverage. Because the USA has a private healthcare insurance system, individual carriers can drop high-risk or high-cost individuals, and can exclude existing conditions. Because retroviral therapy can be relatively expensive (especially in the early days), being dropped from coverage was a very serious risk. Therefore it was this structural factor that effectively eliminated the possibility of tests being mandatory. For mandatory reporting to be more viable, it would have been necessary to alter the laws around the insurance industry in the USA. This was probably seen as too interventionist for US lawmakers. As a result, the mandatory reporting, though potentially effective, was not used.

Another attempt to slow down the chain of transmission is laws that require the disclosure of a known positive HIV status to potential sexual partners. Failure to disclose is often framed as fraud or assault. There have been some prosecutions of people who did not disclose their HIV status to sexual partners (Wikipedia 2007).

Are there other ways we might have changed sexual behaviour to reduce AIDS risks? Because sexual behaviour is rooted in physiological needs, shaped by experience, and played out in the context of culture, attempting to alter it may be difficult and require a great deal of consideration of viable alternatives. One of the advantages of condoms is that people could still engage in their normal sexual behaviour, but do it more safely. Trying to reduce or change people's sexual behaviours raises more difficulties. One possibility was raised by former US Surgeon General Jocelyn Elders' pragmatic suggestion that sex education classes should

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mention masturbation as an alternative activity. But this comment offended religious groups who found the suggestion ran afoul of their fundamental principles (Frankel 1994). One approach that was acceptable to religious groups was the idea of abstinence. The silver ring programme attempted that, but perhaps by trying to delay and stigmatizing sex may have inadvertently raised desire, and the result appears to have resulted in unsafe alternatives. But there is some evidence that there were some spontaneous changes in sexual behaviour as a result of AIDS. This can be seen in an increase in erotic material including romance novels, pornography and sex toys (Harlib 1993). So a better consideration of the importance of sexuality to individuals, and how low-risk alternatives could be made as equivalent as possible, might have helped to design a combination of social marketing interventions that afforded the possibility of abstinence, being faithful, condoms *and* different types of safe activities.

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