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**EVALUATION OF MONTANA'S HIV
PREVENTION SOCIAL MARKETING
CAMPAIGN: A DESCRIPTIVE STUDY**

By

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B.S., University of Montana, 2001

Thesis

presented in partial fulfillment of the requirements
for the degree of

Master of Science

The University of Montana
Missoula, MT

Autumn 2006

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Evaluation of Montana's HIV Prevention Social Marketing Campaign: A Descriptive Study

Chairperson: Dr. Laura Dybdal

The purpose of this descriptive study was to evaluate Montana's 2006 HIV Prevention Social Marketing Campaign in two intervention communities: Flathead and Silver-Bow Counties and one comparison community: Lewis and Clark County. The intervention began in March 2006, and data was collected in the intervention communities for the first four months of the campaign and included four areas. First, HIV testing data was evaluated throughout the campaign to assess the number of individual's receiving HIV counseling and testing in the intervention communities. Second, a survey quantitatively evaluated the campaign among individuals receiving an HIV test at the Flathead and Silver Bow County Health Departments. A chi-square test of independence was calculated for the major trends in the data. Third, focus groups and interviews were conducted with MSM in the intervention communities to qualitatively evaluate campaign awareness, perceptions, and attitudes toward the HIV Prevention Social Marketing Campaign. Finally, the HIV testing data and survey results from the intervention communities were compared to a comparison community.

Findings from this study strongly suggest that Montana's HIV Prevention Social Marketing Campaign was effective in increasing HIV testing behaviors and HIV risk perception in the intervention communities during the first four months of the campaign. Analysis of the data revealed individuals that saw the campaign were significantly associated with getting HIV tested and becoming more aware of HIV in Montana. The campaign was successful in meeting its goals to increase HIV awareness and HIV risk perception, and HIV testing behaviors. Focus group and interview participants reported positive campaign effects and agreed with the majority of campaign messages. Recommendations for future research include: multiple measures of campaign awareness, discontinuing the use of open-ended campaign exposure assessments, measuring campaign effects, influence of the campaign on an individuals decision to test, investigating long-term effects of the campaign, investigating campaign effects in segmented populations, and utilizing a comparison group.

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“Media has the potential to influence the health of citizens of our post-industrial state, and it is imperative that we understand both the negative and positive aspects.”

(Levy & Friend, 2000)



TABLE OF CONTENTS

I. INTRODUCTION TO THE STUDY	
Introduction.....	1
Background.....	4
Statement of Purpose.....	10
Research Questions.....	11
Justification of the Study.....	12
Delimitations and Limitations.....	12
Definition of Terms.....	13
II. REVIEW OF THE LITERATURE	
Introduction.....	19
Program Evaluation.....	21
Social Marketing.....	24
Evaluation of Social Marketing Campaigns.....	26
HIV Testing.....	31
HIV Stigma.....	34
HIV Risk Perception.....	40
III. METHODOLOGY	
Purpose of the Study.....	48
Study Design.....	49
Description of the Target Population.....	50
<i>MSM</i>	51
<i>HIV Positive Populations</i>	52
<i>IDU</i>	53
<i>Down-Low</i>	53
Protection of Human Subjects.....	54
Data Collection Procedures.....	54
HIV Testing Data.....	54
<i>Selection of Sample</i>	54
<i>Data Collection and Analysis</i>	55
Survey Data.....	56
<i>Selection of Sample</i>	56
<i>Instrumentation</i>	57
<i>Data Collection and Analysis</i>	58
Focus Group Data.....	58
<i>Selection of Sample</i>	58
<i>Instrumentation</i>	59

<i>Data Collection and Analysis</i>	60
Interview Data.....	61
<i>Selection of Sample</i>	61
<i>Instrumentation</i>	61
<i>Data Collection and Analysis</i>	62
IV. RESULTS	
Introduction.....	63
Results for Intervention Communities.....	64
<i>HIV Testing Data</i>	65
<i>Survey Results</i>	68
Demographics.....	68
Campaign Awareness.....	71
Campaign Message Agreement.....	76
<i>Chi-Square Analysis</i>	78
Decision to Test.....	78
Media Channels.....	79
Type of Campaign Effects.....	79
<i>Focus Group Results</i>	80
Demographics.....	81
Results.....	81
Summary of Focus Group Results.....	104
<i>Interview Results</i>	107
Demographics.....	107
Results.....	107
Results for the Comparison Community.....	110
<i>HIV Testing Data</i>	110
<i>Survey Results</i>	111
Demographics.....	111
Campaign Awareness.....	114
Campaign Message Agreement.....	117
<i>Chi-Square Analysis</i>	118
V. DISCUSSION AND RECOMMENDATION	
Introduction.....	120
Discussion.....	121
<i>Campaign Awareness</i>	121
<i>Campaign Message Recall</i>	123
<i>Reported Campaign Effects</i>	125
<i>HIV Testing Data</i>	128
<i>Campaign Message Agreement</i>	132
<i>Segmented Audiences</i>	137
Limitations of the Study.....	139

Recommendations.....	141
<i>Campaign Media Channels</i>	141
<i>Campaign Messages</i>	142
<i>Future Campaign Messages</i>	142
<i>Recommendations for Future Research</i>	144
Conclusions.....	147

VI. REFERENCES

VII. APPENDIX

Appendix A: Commercial Message Chart.....	158
Appendix B: IRB Approval Letter.....	161
Appendix C: Survey Informed Consent.....	163
Appendix D: Survey.....	166
Appendix E: Focus Group Discussion Guide.....	171
Appendix F: Focus Group Informed Consent.....	175
Appendix G: Interview Guide.....	178
Appendix H: Survey Results for Flathead and Silver-Bow County.....	181

List of Tables

Table 1: Monthly HIV Testing Numbers for Flathead County.....	66
Table 2: HIV Monthly Testing Means for Flathead County.....	66
Table 3: Monthly HIV Testing Numbers for Silver-Bow County.....	67
Table 4: HIV Testing Means for Silver-Bow County.....	67
Table 5: Ethnicity for Kalispell and Butte.....	69
Table 6: Sexual Orientation for Kalispell and Butte.....	69
Table 7: Risk Exposure Categories for Kalispell and Butte.....	69
Table 8: Previously Tested for Kalispell and Butte.....	70
Table 9: Reasons for Not Previously Testing for Kalispell and Butte.....	70
Table 10: Length since Last Test for Kalispell and Butte.....	71
Table 11: Decision to Test for Kalispell and Butte.....	71
Table 12: Campaign Awareness for Kalispell and Butte.....	73
Table 13: Type of Campaign Effect for Kalispell and Butte.....	76
Table 14: Campaign Message Agreement for Kalispell and Butte.....	77
Table 15: Monthly HIV Testing Numbers for Lewis & Clark County.....	111
Table 16: HIV Monthly Testing Means for Lewis & Clark County.....	111
Table 17: Ethnicity for Helena.....	112
Table 18: Sexual Orientation for Helena.....	113
Table 19: Risk Exposure for Helena.....	113
Table 20: Previously Tested for Helena.....	113
Table 21: Reasons for not Previously Testing for Helena.....	114
Table 22: Length since Last Test for Helena.....	114
Table 23: Decision to Test for Helena.....	115
Table 24: Type of Campaign Effect for Helena.....	117
Table 25: Campaign Message Agreement for Helena.....	117
Table 26: Ethnicity for Kalispell.....	182
Table 27: Sexual Orientation for Kalispell.....	183
Table 28: Risk Exposure Categories for Kalispell.....	183
Table 29: Previously Tested for Kalispell.....	183
Table 30: Reasons for Not Previously Testing for Kalispell.....	184
Table 31: Length since Last Test for Kalispell.....	184
Table 32: Decision to Test for Kalispell.....	185
Table 33: Type of Campaign Effect for Kalispell.....	187
Table 34: Campaign Message Agreement for Kalispell.....	188
Table 35: Ethnicity for Butte.....	189
Table 36: Sexual Orientation for Butte.....	190

Table 37: Risk Exposure Categories for Butte.....	190
Table 38: Previously Tested for Butte.....	190
Table 39: Reasons for not Previously Testing.....	191
Table 40: Length since Last Test for Butte.....	191
Table 41: Decision to Test for Butte.....	192
Table 42: Type of Campaign Effect for Butte.....	195
Table 43: Campaign Message Agreement for Butte.....	196

List of Figures

Figure 1: Distribution of HIV/AIDS Cases by Counties.....	5
Figure 2: Timeline of Activities.....	50
Figure 3: Transmission Categories for Males given HIV Diagnosis.....	52
Figure 4: Percent Distribution of HIV cases by Exposure Categories....	53
Figure 5: Evaluation Design.....	64

List of Graphs

Graph 1: HIV Monthly Testing Numbers for Flathead County.....	66
Graph 2: HIV Monthly Testing Numbers for Silver-Bow County.....	67
Graph 3: Campaign Media Channels.....	74
Graph 4: HIV Monthly Testing Numbers for Lewis & Clark County.....	111

CHAPTER I

INTRODUCTION TO THE STUDY

Introduction

Solving social problems requires social change; changing the way individual's and groups lead their lives by transforming adverse or harmful processes into productive ones, changing attitudes and values, and creating desired social changes in order to improve the quality of people's lives (Kotler & Roberto, 1989). In the twentieth century every nation in the world is experiencing social problems that governing bodies and citizens are attempting to solve. Social change programs arise as people become intent on directing, shaping, and controlling change. Public health programs are an example of planned social change with the intention to improve the health of society (Kotler & Roberto, 1989). In order for social change to occur, programs must focus on changing individual and population level behavior and attitudes.

Current trends in the field of health promotion include community based programs that involve multiple interventions in order to achieve population based change in risk behaviors and health (Merzel & D'Affilitti, 2003). The focus on community level change represents a shift of emphasis from individual focused explanations of health behavior to a focus on social and environmental influences. This notion follows ecological models of health that are based on the belief that an individual's health behavior is influenced by the social environment, which includes influences at the interpersonal, organizational, community, and policy levels (Merzel & D'Affilitti, 2003).

Public health campaigns focus on influencing the social environment in order to produce population-wide behavior change. At various times planners, funding

organizations, policy makers, program managers, and members of the general population need to distinguish worthwhile public health campaigns from ineffective ones. The information obtained can be used to change the existing infrastructure of a health promotion program or develop a new one to achieve desirable results. The need for program evaluations is currently unprecedented as the number of public health campaigns involving a wide variety of health problems grow. Program evaluations determine the merit, worth, and value of programs and provide information on the products of processes of health promotion programs. (Rossi, Lipsey, & Freedman, 2004).

The connections between beliefs, attitudes, and behavior have well been documented for an array of health issues. Human behavior is very complex in nature and unique among certain social environments and target populations. In order to facilitate behavior change or to create a direction for change, behavioral theories such as Social Marketing are used as a basis for program planning. Social marketing is an integrated planning and action framework for programs that focuses on advances in communication technology and marketing skills in order to change behavior (Kotler & Roberto, 1989).

Social Marketing involves the design, implementation, and control of programs whose aim is to increase a social idea in one or more groups of a target audience. Social Marketing was first introduced in 1971 to describe the use of marketing principles and techniques to advance a social cause, idea, or behavior (Kotler, Roberto, 1989).

Andereasen has defined Social Marketing as “the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society” (Andereasen, 1995). Social Marketing is distinguished

from commercial marketing by its continuous focus on the target audience throughout the entire process. Social Marketing posits that in order for change to occur the target audience holds the key to success. This aspect makes all the difference between programs that should work and programs that really do work.

Currently, there is an increase in the use of mass media to transmit health related messages to the general population by a wide variety of organizations. Social Marketing Campaigns have been successful in changing the behavior of individual's on a community- wide or population-wide. Social marketing promotes behavior change by making beneficial exchanges, through media messages, so that individual does will replace their at-risk behavior for a perceived benefit (Andereasen, 1995). It is important to understand what factors contribute to an individual's risk reducing-behavior and an individual's risk-taking behavior.

Social Marketing Campaigns have been applied to a multitude of public health concerns including HIV prevention. The majority of HIV prevention programs focus on changing at-risk sexual behaviors among certain at-risk target populations. Perceptions of the prevalence of HIV risk is particularly important in influencing behavior related to at-risk sexual behaviors. The prevalence of HIV risk also plays an important role in HIV testing. If an individual does not feel susceptible to HIV they will not engage in testing or in safe behaviors (Kalichman and Cain, 2005). Periodic testing to detect early HIV infection is an important public health intervention and has been recommended by the U.S. Preventative Services Task Force and the CDC since 1996 (Takahashi, Johnson, Bradely, 2005). The CDC estimates that 25% of people infected with HIV are unaware of their status (CDC, 2005). Failure to receive HIV testing can result in delayed diagnosis

and treatment, lack of awareness of infectious risk on the part of the infected individual, and serious consequences for the individual and society as a whole (Vermund and Wilson, 2002).

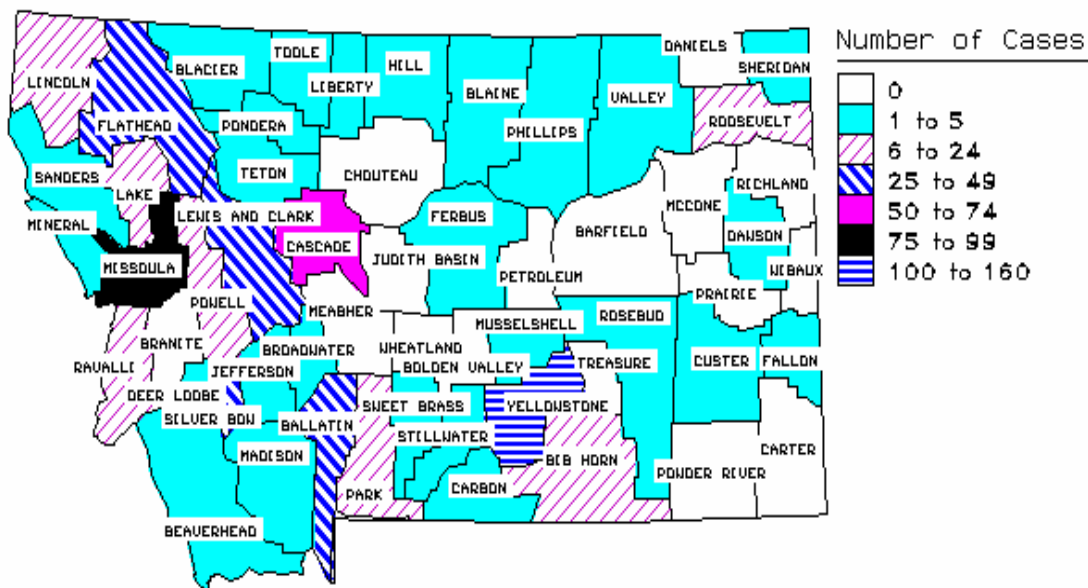
As a society it is vital to document programs that instill preventative behavior for target populations in order to prevent the spread of HIV. HIV is considered a social phenomenon because the epidemic is the outcome of human social behavior patterns and is a stimulus for human social behavior responses (Stiles & Kaplan, 2004). There are many factors that influence HIV behavior including risk perception and HIV stigma. Stigma and shame associated with HIV infection are barriers to appropriate care and treatment, prevention policy, and program development (Klien, Karchener, O'Connell, 2002). The future of the HIV epidemic in the United States will lie in the ability of our society to promote preventative behaviors that benefit individuals and society as a whole.

Background

As of June 30, 2004, a cumulative of 617 cases of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) has been reported to the Montana Departments of Public Health and Human Services (DPHHS) since 1985 (Department of Health and Human Services, 2005). In 2003, HIV/AIDS was the eighth most common reportable disease in Montana with a combined total of 29 (10 AIDS, 19 HIV) cases reported. Approximately 352 individuals aware of their infection are known to be living with HIV/AIDS in Montana. An estimated 66% of these individuals have been diagnosed with AIDS. Forty of Montana's 56 counties have reported at least one HIV/AIDS case since 1985. The geographic distribution of Montana's HIV/AIDS cases closely reflects the state's overall population distribution. Our eight largest counties

account for approximately 80% of all reported HIV/AIDS cases since 1985 (Montana Comprehensive HIV Prevention Plan, 2004).

**Figure 1: Distribution of Montana HIV/AIDS Cases by County, 1985-2003.
(Montana Comprehensive HIV Prevention Plan, 2004).**



The epidemiological and research data show a need for HIV Prevention work in three specific areas (Montana Comprehensive HIV Prevention Plan, 2004).

- 1) The need to target specific geographical areas in Montana identified as high risk counties.
- 2) The need to develop HIV prevention strategies in Montana that target specific high priority populations.
- 3) The need for HIV prevention strategies to be developed using a theoretical framework including health behavioral theory (such as Social Marketing) and needs assessment data.

Montana's HIV Prevention Social Marketing Campaign's goal is to increase awareness and perception of HIV risk in Montana's at-risk populations; to reduce sexual and drug using behaviors and maintain protective behaviors related to HIV; to establish

healthy social norms relating to HIV, HIV prevention, and sexuality. The primary objective is to increase the number of MSM, HIV positive men and women, Intravenous Drug Users (IDU) and Youth-at-risk, and Down-Low who: 1) engage in protective risk behaviors, and 2) participate in HIV counseling and testing, and 3) increase their perception of HIV risk. The HIV Prevention Social Marketing Campaign core elements are those components that are critical features of an interventions intent and design and are believed to be responsible for program effectiveness. The HIV Prevention Social Marketing Campaign's core elements include:

- 1) The HIV/AIDS prevention messages and marketing strategies are developed to increase HIV/AIDS knowledge and perceptions of risk, decrease perceptions of HIV positive stigma and sexuality stigma, decrease at-risk behaviors, and decrease barriers to HIV counseling and testing.
- 2) The HIV/AIDS prevention messages and marketing strategies are developed utilizing behavioral theory and needs assessment data from the prioritized populations.
- 3) The HIV/AIDS prevention messages and marketing strategies are developed utilizing ongoing feedback from the priority populations.
- 4) The HIV/AIDS prevention messages are disseminated through multiple communication channels/media strategies to target risk populations.

The HIV Prevention Social Marketing Campaign will continue the development, expansion, and dissemination of the on-going Montana Campaign. The campaign is based upon the Social Marketing Theory and Health Belief Model. This campaign

includes two major areas of service: 1) the development of HIV prevention commercials, posters, billboards, and theatre slides targeting at-risk populations, and 2) dissemination of media product throughout Montana.

The HIV Prevention Social Marketing Campaign was implemented in 2001 by Dr. Laura Dybdal at the University of Montana. From 2001-2003, 12 commercials/movies were developed for the MSM (men who have sex with men), HIV positive, and Youth-at-risk populations as well as posters, billboards, theatre slides, CD's, and videos. In addition, two web sites were developed for the MSM and Native youth populations. The motion design movies were developed using the Social Marketing Theory, Health Belief Model, and needs assessment data. Dissemination of the social marketing product first took place in western Montana in 2003. In 2003, an evaluation study was done to test the effects of HIV prevention motion design media on the beliefs of MSM at the University of Montana. A pre-test/post-test quasi-experimental design was used with a control group (MSM at the University of Montana) and the experimental group (MSM at the University of Idaho). The survey questions were based on the constructs of the Health Belief model including perceived susceptibility, perceived severity, perceived barriers, and perceived benefits of HIV/AIDS. A website was designed to show the motion media movies and to acquire feedback about the quality of the experimental media intervention. This study found that further establishment of HIV preventive social marketing messages for young MSM was needed. Evaluation results indicated that young rural MSM do not feel susceptible to HIV/AIDS, and that this population does not perceive HIV/AIDS to be a serious infection. The findings also

indicated that the media intervention successfully increased perceived susceptibility to HIV/AIDS, and increased the belief that HIV/AIDS is a serious issue.

In 2005, dissemination of the HIV Prevention Project Social Marketing Campaign began in central and eastern Montana in Yellowstone and Cascade Counties. Yellowstone and Cascade County show a high need for intervention strategies. Yellowstone County contains the highest total number of HIV/AIDS cases in Montana and Cascade County contains the third highest total number of HIV/AIDS cases in Montana (Montana Comprehensive HIV Prevention Plan, 2004). The campaign included the following media channels: billboards, posters, commercials for television, theatre slides in movie theatres, CD's, and videos. The campaign ran for a total of 10 months in both Yellowstone and Cascade Counties. The Social Marketing Campaign included 3 HIV Prevention commercials disseminated on six television channels and on cable in both Yellowstone and Cascade County. Most of the campaign resources went towards the airing of the HIV Prevention commercials, as television is the most efficient way to reach large portions of the population. The commercials disseminated in this campaign were developed from 2004-2005 targeting the MSM, youth-at-risk, and HIV positive individuals (see Appendix A page 158). The HIV Prevention commercials ran on four basic network channels and on Bresnan, the cable carrier, for these locations. In order to understand how many individuals saw the HIV Prevention commercials it is important to understand marketing statistics provided by television software. Marketing statistics include frequency and reach and create a way to measure how many people saw the televised campaign. The HIV Prevention Projects average reach was 74% and the average frequency was 10 for all stations in both Yellowstone and Cascade Counties.

Therefore, over the course of the media campaign the average individual saw the commercials 10 times and 74% of individuals (age 18 and over) saw the commercials at least once. Each channel averaged 2.8 commercial showings per day, and between channels commercials ran throughout all times of the day (morning rotator, prime time rotator, and late evening rotator). The HIV Prevention commercials aired on a total of eight cable channels, averaging 160 spots on each station over the course of the campaign.

In 2005, three new motion commercials were developed targeting HIV positive women, IDU (injecting drug users) population, and the Down-Low population. Therefore, six total commercials, posters, billboards, and theatre slides were disseminated targeting IDU, HIV positive men and women, MSM, Youth-at-risk, and Down-Low populations. Needs assessment data was used to develop the messages for each of the target populations. New posters were also developed specific to the messages in the new commercials.

The current campaign began in March 2006 and was disseminated in Silver-Bow and Flathead County in central and western Montana through August 2006(see PSA message chart in Appendix A, page 158). Flathead County contains the sixth highest number of HIV/AIDS cases in Montana, and Silver-Bow County contains the fifth highest number of HIV/AIDS cases in Montana (Montana Comprehensive HIV Prevention Plan, 2004). In Flathead County, Kalispell was the primary location for billboards and posters. Theatre slides were not shown in Kalispell because there is one private movie theatre which does not have local advertising. In Silver-Bow County, Butte was the primary location for billboards, posters, and theatre slides.

Dissemination for the current campaign included all three major network channels (CBS, ABC, NBC) in Kalispell and Butte. Dissemination of the campaign commercials on all three network channels in Butte will also include Bozeman viewing area also. Campaign commercials on all three network channels, were placed on daily rotators which averaged two commercials per day on each channel. The IDU and Down-Low commercial were shown on an evening rotator only. The IDU commercial was not shown on CBS because the station felt the content was unacceptable.

Statement of Purpose

The purpose of this descriptive study was to evaluate the HIV Prevention Social Marketing Campaign in two intervention communities: Flathead and Silver-Bow Counties and one comparison community: Lewis and Clark County. This study consisted of four phases. First, HIV testing data was evaluated throughout the campaign to assess the number of individual's receiving HIV counseling and testing in Flathead and Silver Bow Counties. Second, a survey quantitatively evaluated the campaign among individuals receiving an HIV test at the Flathead and Silver Bow County Health Departments. Third, focus groups and interviews were conducted with MSM in the intervention communities to qualitatively evaluate campaign awareness, perceptions, and attitudes toward the HIV Prevention Social Marketing Campaign. Finally, HIV testing data and survey results from the intervention communities were compared to a comparison community.

Evaluation is a critical component of all prevention programs, it is the only way to determine success, and improve existing programs. In addition it can be the driving force for developing new health promotion programs (McKenzie, Neiger, and Smeltzer, 2005).

Evaluation research provides insights into which messages are most effective, and through which communication channels reach the target audience the most effectively. Monitoring campaigns allows researchers to understand whether the messages are reaching the target audience and if they can recall and understand the intended messages. The information from this study will be used by the program planners to improve the effectiveness and reach of HIV Prevention Social Marketing Campaign.

Research Questions

- 1) How much did monthly HIV testing numbers change during the HIV Prevention Social Marketing Campaign in Flathead and Silver-Bow Counties?
- 2) What proportion of individuals receiving an HIV test at the Public Health Departments in Flathead and Silver-Bow Counties are aware of the HIV Prevention Social Marketing Campaign?
- 3) How frequently did individuals receiving an HIV test at the Public Health Departments in Flathead and Silver-Bow Counties report seeing the HIV Prevention Social Marketing Campaign?
- 4) What HIV Prevention Social Marketing Campaign messages are recalled by individuals receiving an HIV test at the Public Health Departments in Flathead and Silver-Bow Counties?
- 5) What media channels did individuals receiving an HIV test at the Public Health Departments in Flathead and Silver-Bow Counties report seeing most frequently?
- 6) Did individuals receiving an HIV test at the Public Health Departments in Flathead and Silver-Bow Counties report being affected by the HIV Prevention Social Marketing Campaign?

- 7) What are the reported effects on knowledge, attitudes, and behavior of the HIV Prevention Social Marketing Campaign by individuals who received an HIV test at the Public Health Departments in Flathead and Silver-Bow Counties?
- 8) What are the reported perceptions by MSM towards the HIV Prevention Social Marketing Campaign in Butte and Kalispell?

Justification of the Study

Evaluations are performed for multiple reasons such as to help managers improve a program, support advocacy by opponents or critics, gain knowledge about program effects, and provide input for program funding or to respond to political pressure (Rossi et al, 2004). Evaluations are critical to gain information about program effectiveness and to make decisions based on the information. Evaluation information can be used by planners to improve services or to see immediate outcomes of the program such as a change in knowledge, skills, or behaviors (Rossi, Lipsey, & Freedman, 2004).

The data gathered from this study will assist program planners in determining the effectiveness of the HIV Prevention Social Marketing Campaign. The data includes information about campaign awareness, campaign effects, and messages recall. The data will also assist program planners to determine if there is a need to change the program and if so, indicate what change is needed. The data will show the immediate observable affects of the HIV Prevention Social Marketing Campaign in Flathead and Silver Bow Counties. In addition, this evaluation will serve as a learning tool for what types of future evaluations are plausible when evaluating Social Marketing Campaigns.

Delimitations and Limitations

The following are the delimitations considered for this evaluation study:

- 1) This study will be delimited to descriptive data.
- 2) The study will be delimited to individuals receiving counseling and testing at the County Health Departments in Kalispell and Butte.
- 3) The study will be delimited to information gathered on a short survey.
- 4) This study will be delimited to volunteers.

The following are the limitations considered for this evaluation study:

- 1) The survey is limited to self-report. The data gathered through survey research is likely to be biased or incomplete to an unknown degree due to the reliance on the individual to report accurately. Individuals might not have the self-awareness to give accurate information. (Gall, Gall, Borg 2005). Volunteer participants were assured the confidentiality and anonymity of the survey, which is expected produce more accurate results.
- 2) This study is limited to the individual's ability to understand the questions being asked. Each individual's level of comprehension will vary, and could produce different results.

Definition of Terms

AIDS

Acquired Immunodeficiency Syndrome is a disease caused by an infection with the HIV virus and occurs when a patient has lost most of their CD4 helper T cells, so that infections with opportunistic pathogens occur (Janeway, Travers, Waldport, Shlomchik, 2001).

Descriptive Research	Descriptive research aims to provide a clear, accurate description of individuals, events, or processes (Gall, Gall, Borg, 2005).
Down-Low	This term is used to describe men who have sexual relations with other men as well as women and who do not identify as gay or bisexual (CDC, 2004).
Focus Groups	A small panel of persons selected for their knowledge or Perspective on a topic of interest that convened to discuss the topic with the assistance of a facilitator. The discussion is used to identify important themes or to construct descriptive summaries of views and experiences on the focal topic (Rossi et al, 2004).
Formative Evaluation	Any combination of measurements obtained and judgments made before or during implementation of materials, methods, activities, or programs to control, assure, or improve the quality of performance and delivery (McKenzie et al, 2005).

Frequency	The number of times the average person sees the advertisement in a specified time period (Rice, Paisley, 1981).
Gatekeepers	Individuals in the community who formally and informally control the political climate of the community (McKenzie, et al, 2005).
Health Belief Model	This theory posits that health protective behavior most likely occurs when perceived susceptibility, perceived severity, perceived barriers are low, and perceived benefits are high (Steers et al, 1996).
HIV	The human immunodeficiency virus is the virus that causes Acquired Immunodeficiency Syndrome (AIDS) by infecting helper T cells and the immune system (CDC, 2005).
HIV Stigma	The prejudice, discounting, discrediting, and discrimination that are directed towards people with HIV/AIDS (Fortenberry et al, 2002).

- HIV Counseling & Testing** The Center of Disease Control has developed HIV counseling to accompany testing in order to reduce risk of transmitting or acquiring HIV. HIV counseling includes a twenty minute session discussing reduction of risk behaviors by a trained counselor (CDC, 2005).
- IDU** A person who uses drug (heroin, cocaine, speed) administered with a needle or syringe (AIDS Foundation, 2005).
- Impact Evaluation** Focus's on the immediate observable effects of a program such as attitudes, knowledge, skills, and awareness, leading to the intended outcomes of a program (McKenzie et al, 2005).
- MSM** Men who report sexual contact with other men (homosexual contact) and men who report sexual contact with both men and women (bisexual contact) (CDC Surveillance Report, 2003 pg. 1).
- Outcome Evaluation** Focuses on the ultimate goal of a program and is generally measured by morbidity or mortality statistics in a population, vital measures, symptoms, signs, or

physiological indicators of individuals (McKenzie et al 2005).

Process Evaluation

Any combination of measurements obtained during the implementation of program activities to control, assure, or improve the quality of performance or delivery (McKenzie et al, 2005).

Program Evaluation

The use of social science methods to systematically investigate the effectiveness of social intervention programs in ways that are adapted to their political and organizational environments and are designed to inform social action in ways to improve social conditions (Rossi et al, 2004).

Reach

Percentage of the target audience reached by the campaign (Rice, Paisley, 1981).

Social Marketing

Social Marketing is a process for influencing human behavior on a large scale, using marketing principles for the purpose of societal benefit rather than commercial profit (Smith, 2000).

- Stigma** An attribute or label that sets a person apart from others and links the labeled person to undesirable characteristics (Fortenberry et al, 2002).
- Summative Evaluation** Any combination of measurements and judgments that permits conclusions to be drawn about impact, outcome, or benefits of a program or method (McKenzie et al, 2005).

CHAPTER II

REVIEW OF LITERATRE

Introduction

Social Marketing Campaigns have been shown to be a cost effective approach for public health promotion. Social Marketing Campaigns have been used to target a wide variety of public health goals such as smoking cessation, nutrition, physical activity, drinking and driving, vaccinations, and HIV prevention. However, few studies have successfully documented the success of these programs in achieving the desired behavior change. This is partially due to the fact that behavior change is extremely difficult to evaluate.

Program evaluation is an essential organizational activity in public health (CDC, 1999). Evaluation is a critical component of all prevention programs, and is the only way to determine success, improve existing programs, or can be the driving force for developing new health promotion programs (McKenzie, Neiger, and Smeltzer, 2005). It is difficult to evaluate Social Marketing Campaigns due to the complex and unpredictable nature of these interventions. There are multiple avenues evaluations can take. The various applications of evaluations are determined by the nature and goals of the program or campaign being evaluated.

One of the most common methods for the evaluation of Social Marketing Campaigns targeting HIV/STD prevention is to measure the outcome of the desired behavior change. Many Social Marketing Campaigns targeting HIV/STD prevention measure testing rates in response to a Campaign. These direct measurements are considered an indicator of change in awareness, attitudes, or beliefs (Vega and Roland,

2005). The role of testing in HIV prevention is vital to the course of the epidemic in the United States. Failure to receive an HIV test can result in delayed diagnosis and treatment, lack of awareness of infectious risk on the part of the infected individual, and serious consequences for the individual and society as a whole (Vermond & Wilson, 2002).

As we enter into the third decade of the HIV epidemic, there are multiple factors that continue to hinder the effective societal response to the epidemic. Stigma and shame associated with HIV infection are barriers to appropriate care and treatment, prevention policy, and program development (Klein, Karchener, O'Connell, 2002). Fear of stigma continues to defer individuals from being tested for HIV and from disclosing their seropositive status to sexual partners, family, and friends (Hereck, Captiano, Widaman, 2002). Another confounding factor of the HIV epidemic is perception of risk. Risk perception that an individual has about a particular health problem, predicts both the suppression of health compromising behavior and initiation of protective behaviors (Kalichman & Cain, 2005).). Perceptions of the prevalence of HIV risk is particularly important in determining behavior change related to at-risk sexual behaviors.

The review of literature is divided into six sections. The first section provides an overview of the importance and types of program evaluation. The second and third section defines Social Marketing and discusses methods for evaluation Social Marketing Campaigns. The fourth section discusses HIV testing and the fifth and sixth sections discuss the role stigma and risk perception play in response to the HIV epidemic.

Program Evaluation

Programs are evaluated in order to gain information and to make decisions. The various applications of evaluation distinguish the nature and the goals of the program being evaluated. Program evaluation is an essential organizational activity in public health. Evaluation is defined as a systematic investigation in order to determine the merit, worth, or significance of an object (CDC, 1999). Effective program evaluation is a method to improve and account for public health actions by using procedures that are useful, feasible, and accurate. Evaluation is often described as having two arms; one arm is engaged in data collection and analysis. The other arm collects, clarifies, and verifies relevant values and standards (Rossi et al, 2004).

The evaluation that program planners engage in can be classified into two categories: informal evaluation and formal evaluation. Informal evaluations lack systematic procedures and formally collected evidence and are characterized by the absence of depth. Formal evaluations are characterized by systematic well-planned procedures designed to control extraneous variables that could produce biased evaluation outcomes (McKenzie et al, 2005). Informal evaluations are adequate when program planners are interested in making minor changes to the existing program but are not recommended when major decisions will be made. Formal evaluations are necessary in order to make strong inferences about the effectiveness of a program or in order to improve existing programs.

Planners may use several types of evaluation methods when determining the value of a program. The type of evaluation chosen will reflect whether the information will be used to determine if the program has met its goals and objectives, to improve the

program, or if the program was effective. There are two sets of interrelated terms used to describe evaluation activities, the first set of terms planners use to determine the value of a program are process, impact, and outcome. Process evaluations are measurements used during the implementation of the program to control, assure, or improve the quality of performance and delivery (McKenzie et al, 2005). These measurements can be collected through short surveys or focus groups during the program delivery. Impact evaluations concentrate on the immediate observable effects and the intended outcomes of a program. These measurements look at knowledge, attitudes, skills, awareness, and behaviors. Outcome evaluations focus on the ultimate goal of the program, and are generally measured by mortality and morbidity statistics in a population, vital measures, symptoms, signs, or physiological indicators of individuals. Outcome evaluations are long term and involve a large amount of resources therefore, these types of evaluations are usually beyond the scope of most programs (McKenzie et al, 2005).

Another set of terms used by evaluators to describe evaluation activities include formative and summative. Formative evaluations are any combination of measurements obtained and judgments made during the implementation of materials, methods, activities, or programs to control, assure, and improve the quality of existing programs. Summative evaluations describe any combination of measurements and judgments in which conclusions can be drawn about impact, outcome, or benefits of a program (McKenzie et al, 2005). Although both set of terms are used to describe evaluation activities there is overlap between terms. Process evaluations occur during a program and are considered a formative evaluation. Impact and outcome evaluations occur at the end of a program and are considered summative evaluations. Despite the difference in

terminology, both sets of terms describe activities during or after implementation of a program.

Basic evaluation design employs quantitative techniques, qualitative techniques, or both for data collection. Quantitative techniques are deductive in nature and produce numerical data such as, scores, ranks, or classifications. This method is usually used when programs are well defined and compares the outcome of a particular program to other groups (Gall, Gall, Borg, 2005). Examples of quantitative data include: pre-test/post-test scores, ratings of participant satisfaction, change in knowledge, or the number of participants in a program. Quantitative researchers define their subjects of interest in terms of observable behavior and define that behavior in terms of the specific operations used to measure it. Quantitative researchers are also concerned about the probability of what they discovered occurring in a larger population from which the sample was presumably drawn (Gall, Gall, Borg, 2005).

Qualitative designs are inductive in nature and produce descriptive data. This method is used when programs are interested in emphasizing individual outcomes or when descriptive data about the program participants is needed (McKenzie et al, 2005). Carefully conducted qualitative research is important for uncovering information about how program services are configured. Qualitative research also assists researchers in understanding human behavior and human nature by exploring a particular issue more in-depth. Qualitative research can range from interviews, focus groups, or ethnographic techniques. Focus groups bring together selected individuals for a discussion on a particular topic with the aid of a facilitator. Individuals selected include gatekeepers,

community leaders, stakeholders, and individuals who are experiencing the issue at hand or have direct service needs (Rossi et al, 2004).

Evaluation assists planners when making decisions regarding the worth and the effectiveness of health promotion programs, comparing different types of programs, determining financial worth, eliminating weak programs, or providing information about programs (McKenzie et al, 2005). Evaluation typically involves one or more of five program domains: 1) the need for the program, 2) the design of the program, 3) program implementation and delivery, 4) program impact or outcomes, 5) program efficiency (Rossi et al, 2004). The evaluation process takes place before, during, and after program implementation.

Social Marketing

Behavior change theory is described as a set of interrelated concepts, definitions, and propositions that present a systematic view of events or situations by specifying relations among variables in order to explain or predict the events or situations (Thackary & Neiger, 2000). Theory, in this case, can indicate what needs to be done in order to facilitate a behavior change and provide direction on how to create change.

Social Marketing, a behavior change theory, refers to the application of basic marketing principles and community engagement to design and implement programs and informational campaigns in order to change behaviors, attitudes, or perceptions (Kotler & Roberto, 1989). The Social Marketing discipline suggests that for behavior change to be successful the appropriate marketing mix of product, price, place, and promotion must be established in context of the consumer's preference. The product describes the program decisions associated with selecting and shaping the idea, commodity, behavior, or service

that is promoted to the audience. The price in Social Marketing defines all the barriers that a person must overcome to accept the proposed social product. Price includes opportunity cost, status loss, embarrassment, and time that an individual will lose when adopting the new practice. Place refers to the system through which the products (commodities, messages, and health services) are delivered and the quality of service available. Place focuses on overcoming structural obstacles for easy access by the targeted population. Promotion, in Social Marketing, refers to the functions of outreach advertising, public relations, consumer promotions, user education, counseling, community organization, and interpersonal support. Promotion includes decisions on message content and decision on message channels (Smith, 2000). Social Marketers promote ideas as well as practices with the ultimate goal of changing behavior.

Through the integration of marketing concepts and community involvement, Social Marketing has been successful for changing the behavior of individuals on a community wide or population wide level. Social Marketing promotes behavior change by making beneficial exchanges, through media messages, so that individuals will replace their at-risk behavior for a perceived benefit (Andreasen, 1995). The ultimate objective of Social Marketing is to benefit target populations or society by influencing behavior in such a way that creates a positive behavior change in order to improve quality of life. The target population is the primary focus throughout the Social Marketing process. Social Marketing understands that individuals will only take action when it is in their best interest, therefore Social Marketing strategies always begin with an understanding of the target populations needs and wants, their values, and perceptions (Andreasen, 1995).

The goal of Social Marketing is to make a non-tangible product, such as inducing at-risk individuals to modify their behavior, appeal to a selected market, or the target populations. Marketing utilizes communication channels that the target population frequents and perceives as important (Kotler & Roberto, 1985). The strategies of Social Marketing can also target individuals who engage in risk behaviors but who do not consider themselves to be at risk. For this reason, it is essential that information be disseminated into the general population to not only influence, for example, the HIV/AIDS attitudes and perceptions of those other than the targeted at-risk population, but more importantly to target those individuals, who do not consider themselves at-risk, but still engage in the same risky behaviors.

Social Marketing campaigns generally begin when a sponsoring organization identifies a population with a health problem or threat, isolates the risk factors, and with the input of the target population creates messages to address those specific risk factors that are deemed modifiable (Winnet & Wallace, 1996). The entire process incorporates the needs, preferences, and values of the target audience which is determined from the extensive research with the population. In this sense, Social Marketing can be described as a “responsive” process of two-way communication that begins with a public health organization and is informed by the expressed needs of the audience (Winnet & Wallace, 1996).

Evaluation of Social Marketing Campaigns

Evaluation of Social Marketing Campaigns is extremely difficult and is hindered by an array of factors. These Campaigns are difficult to evaluate because they have horizontal and vertical complexity, interventions are unpredictable, context and other

factors confound outcomes, control or comparison groups are difficult to create, there is lack of knowledge and precision about outcomes, or evaluators lack the necessary tools (Harvard Family Research Project, 2005). Recently, there has been a marked increase in the use of mass media to transmit prevention related messages to the general population. Social Marketing Campaigns have included public health issues such as tobacco, sexually transmitted diseases, nutrition, physical activity, drinking and driving, and HIV prevention (Andreasen, 1995). These Campaigns have been implemented on the federal, state, or local level by a wide variety of organizations. Despite the growing number of media campaigns relatively little is known about their effectiveness (Rossi, Lipsey, Freeman, 2004). Social Marketing Campaign evaluation has included evaluation techniques such as telephone surveys, street intercept surveys, street interviews, or other experimental designs. All of these techniques have limitations and methodological flaws.

An example of Social Marketing Campaign evaluation was conducted by Vega and Roland (2005) in eight different U.S. cities in response to syphilis outbreaks. In the late 1990's syphilis outbreaks were on the rise in major metropolitan areas among gay and bisexual men. Eight cities responded with Social Marketing Campaigns to increase syphilis awareness and testing among the gay and bisexual populations. Each city developed their own campaign messages, material, and websites from the market research and need assessment data within each city

The Syphilis Campaigns were process evaluated from the first few months after launch and continued through until the end. Process evaluation questions included: (1) Is the campaign progressing towards reaching its objectives? (2) Are there enough resources? (3) Is the campaign reaching the intended audience? (4) Is the audience

satisfied with the campaign? (5) Are any obstacles hindering activities? (6) Are the materials being tested to assure quality (Vega & Roland, 2005 pg.S34)? The Campaigns were outcome evaluated with street intercept surveys in areas where gay and bisexual men are known to frequent. Street intercept surveys were sampled for a two month period in each location. Overall, the street intercept surveys reported between 70%-80% campaign awareness on the target population. Of those surveyed in the eight cities 45%-53% reported receiving syphilis testing as a result of the campaign (Vega and Roland, 2005). Overall the Social Marketing Campaign proved to be a success with high campaign awareness and an increase in syphilis testing. Each Campaign in all of the eight cities successfully addressed the local epidemic and target audience with a culturally appropriate message relevant to the needs of each city. The success of each of the campaigns is attributed to the tailoring of messages to each distinct local MSM population (Vega & Roland, 2005). This is a trademark of Social Marketing campaigns that distinguishes it from any other form of media campaign.

Another example of Social Marketing Campaign evaluation in response to a public health concern occurred in Atlanta. After an ongoing outbreak of Hepatitis A in Atlanta, the Georgia Division of Public Health launched a Hepatitis A vaccine campaign targeted towards MSM. To approximate the population, a cohort by means of convenient clusters each representing different segments of the MSM population were sampled. Because no single source of data exists on the MSM population or single means of contacting an entire group of MSM, a random sampling technique could not be used. This is a common problem encountered when evaluating Social Marketing Campaigns among specified target populations such as MSM (Friedman, Blake, Koehler, Hutwagner, and

Toomey, 2000). The survey used was a self administered anonymous questionnaire that analyzed campaign awareness and risk behaviors. A total of 210 participants completed the survey and a linear relationship was found between the number of exposures to the campaign and the likelihood of vaccination. Vaccination was independently associated with awareness of the outbreak and the vaccine from the campaign, having had sexual relations with men for 12 years or longer, having recently consulted a physician, or reading a local gay newspaper (Friedman, Blake, Koehler, Hutwagner, and Toomey, 2000). This study was the first to report the response of the MSM population to a Social Marketing Vaccination Campaign. The steady increase in vaccination rates with multiple exposures to the Campaign implies that repeated messages in a prolonged campaign can encourage individuals to perform the desired behavior (Hepatitis A vaccine). The exposure dependent relationship with the Hepatitis A campaign is consistent with the general marketing and communication literature, in which approaches to behavioral modification are part of consumer strategies (Friedman, Blake, Koehler, Hutwagner, and Toomey, 2000). In marketing literature the exposure dependent relationship is often called the area of increasing returns, which represents the fact the advertising has a minimal effect until it reaches a certain threshold. The “rule of three” states that the target audience must be exposed to the ad three times in order for it to be effective. Although keeping in mind the exact number of ads necessary will vary from situation to situation, and from target audience to target audience (Levy and Friend, 2000).

The “HIV, Live with It, Get Tested” campaign used Social Marketing to promote HIV testing to adolescents nationally. The first multi-city Campaign began in 1999 and was repeated and expanded in 2000. This study included results from its implementation

in 1999 and preliminary data from 2000. The objectives of this campaign were to change youth attitudes about HIV testing and promote more routine testing practices to health providers with the project goal of improving HIV counseling, testing, and care among at-risk youth (Futterman, Peralta, Rudy, Wolfson, Guttmacher, Rogers, 2001). The campaign development was based on Social Marketing principles and included posters, palm cards, mass-transit/outdoor advertising, testing materials distributed to providers, and radio advertising. The campaign ran for six months and an independent evaluator was contracted to conduct both process and outcome evaluations. Process evaluations included: number and type of organizations participation in each level of the local campaigns, youth participation as outreach workers or in campaign events, venues, and extent of message dissemination through community outreach and paid advertising. Outcome evaluations included the number of telephone calls to local HIV hot lines, numbers of youth receiving counseling and testing at participating sites, and numbers of positive youth identified during the campaign (Futterman, Peralta, Rudy, Wolfson, Guttmacher, Rogers, 2001). The outcome results in 1999 for five of the six cities showed a peak in telephone hot line calls in which 50% came from youth between the ages of 13-21. The majority of youth (64%) called the hot line after hearing an advertisement on the radio. The campaign emphasized a “Get Tested Week” in the middle of the six month campaign and HIV testing numbers rose significantly in all cities surrounding this week (Futterman, Peralta, Rudy, Wolfson, Guttmacher, Rogers, 2001). Community surveys were conducted by approaching youth on the streets and neighborhoods in New York City to determine the degree in which the campaign penetrated into the community. The results demonstrated an increase in the percentage of youth who had seen an

advertisement, improvements in the percentage who said the advertisement made them think testing was good, and an increase in knowledge about where to get an HIV test. There were 381 surveys completed at baseline and 565 after the “Get Tested Week”. The “HIV, live with it, get tested” campaign succeeded in promoting the visibility of the issue of youth and HIV, bringing increased numbers of at-risk youth in for HIV counseling and testing, and increased the number of HIV positive youth seeking information (Futterman, Peralta, Rudy, Wolfson, Guttmacher, Rogers, 2001).

The “HIV, Live with It, Get Tested” Campaign gives evidence to the fact that there are a number of limitless avenues for evaluators to undertake when evaluating Social Marketing Campaigns. To date, the answer to which of the numerous media campaigns or which of the evaluation techniques are the most effective is still unclear. However, Social Marketing Campaigns are recognized for their emphasis on the needs and preferences of the target audience. This provides an irreplaceable opportunity for public health organizations to change their focus towards the target audience despite the lack of a straightforward evaluation technique.

HIV Testing

HIV infection, if diagnosed early, can be treated to reduce morbidity from opportunistic infections and prolong the life of the individual. Failure to receive HIV testing can result in delayed diagnosis and treatment, lack of awareness of infectious risk on the part of the infected individual, and serious consequences for the individual and society as a whole. Failure to undergo an HIV test usually is often the result of low perceived risk of HIV by the individual (Kalichman & Cain, 2005). Other barriers to HIV testing include fear of adverse consequences, lack of expectation of benefit, no perception

of HIV risk, test is unavailable, lack of privacy in counseling, lack of guarantees of confidentiality, cost, inconvenience, personal isolation, lack or provision for testing couples or social support, and the cultural norm is not to test or is hostile to testing (Vermund and Wilson, 2002).

HIV counseling and testing has been a part of HIV prevention programs since the mid 1980's. HIV counseling and testing programs use a "client-centered" approach, which focuses on providing individualized prevention goals and strategies to individuals seeking testing (Anderson, Carey, Taveras, 2000). The HIV counseling session follows a series of six steps that identify individualized at-risk behaviors, and strategies and goals for changing those behaviors. The session involves 20 minutes with a CDC-trained HIV counselor and is completed with individual undergoing a HIV test. The goals of HIV counseling and testing have evolved over time to include delivering prevention messages to infected and uninfected individuals receiving testing, ensuring that infected persons receive appropriate treatment, testing pregnant women to prevent prenatal transmission, and encouraging persons at risk for HIV infection to be tested (Anderson, Carey, Taveras, 2000).

In 2001, the CDC published new guidelines for HIV testing and a strategic plan to decrease the incidence of HIV in the United States by at least 50% by 2005. This plan has been developed through extensive collaboration with a wide array of prevention experts and targets three specific areas: mobilization to increase the proportion of HIV-infected individuals who know their status, new prevention programs and services for individuals living with HIV combined with improved linkages to treatment and care, and

highly targeted prevention programs for HIV negative individuals at greatest risk (CDC, 2005).

The CDC currently monitors the trends of the HIV epidemic through the demographic information collected from the HIV counseling and testing programs, and through public surveys such as the Behavioral Risk Factor Surveillance System. The information collected allows the CDC and states to track the course of the epidemic among distinct populations, geographical locations, and among specified risk behaviors. In 2000, the CDC included a secondary analysis to the Behavioral Risk Factor Surveillance System to evaluate testing practices and perceptions of HIV risk among a geographically diverse population-based sample of sexually active adults who reported behaviors that could transmit HIV. The survey included additional measures of sexual activity, HIV risk, recent HIV testing, and self perceived HIV risk (Takahashi, Johnson, Bradely, 2005). Among the sexually active adults surveyed in four states, 51% who were at risk for HIV infection reported no HIV test in the past year. Among these individuals, 84% perceived their HIV risk to be low or none. Younger adults were more likely to be tested than adults over the age of 40. However, young adults also made up the largest population at risk for HIV infection who had not had a recent HIV test. Most individuals who reported HIV risk behaviors and also reported no recent HIV test, perceived their HIV risk as being low or none. This study found that most individuals who report behaviors that increase their risk for HIV do not consider themselves to be at-risk, and have not been recently tested (Takahashi, Johnson, Bradely, 2005). These findings suggest that more education is needed to increase awareness of HIV risk behaviors and the value of regular HIV testing. The findings also suggest the need to identify what

behaviors put individuals at-risk for HIV infection. In order to enhance early detection of HIV, HIV testing must be expanded and an increase in awareness of HIV infection among the general population is needed.

During the last decade the demographics of the HIV epidemic have changed. Heterosexual transmission of HIV is a rapid source of new infections in the United States and is the leading cause of HIV infection in women (CDC, 2005). Many members of the general population, especially heterosexual individuals, consider themselves at low-risk for HIV infection. It is evident that education is necessary to enhance knowledge and awareness about the course of the epidemic in the United States, and to emphasize HIV testing as a routine part of health care. Periodic testing to detect early HIV infection is an important public health intervention and has been recommended by the U.S. Preventative Services Task Force and the CDC since 1996 (Takahashi, Johnson, Bradely, 2005). However, an estimated 25% of individuals in the U.S. that are infected with HIV are unaware of their status (CDC, 2005). Therefore, despite our advances in treatment for HIV, the overall incidence of HIV has remained steady for over a decade; which emphasizes the need for regular HIV testing in order to reduce the spread of HIV.

HIV Stigma

Since its emergence the HIV/AIDS epidemic has been associated with stigma and shame. As we enter into the third decade of the HIV epidemic, the HIV stigma is considered to be the one of the greatest barriers to preventing further infections, the provision of care of people living with AIDS, and it is argued that reducing the HIV stigma is the integral component of a comprehensive approach to control the epidemic (Taylor, 2001). Stigmatizing attitudes are strongly correlated with misunderstanding of

HIV transmission and overestimating the risk of casual contact, and is associated with negative attitudes towards social groups that are disproportionately affected by the epidemic (Hereck, Capitanio, Widaman, 2002). Stigma is defined as “an attribute or label that sets a person apart from others and links that labeled person to undesirable characteristics.” Stigma related to AIDS is defined as “the prejudice, discounting, discrediting, and the discrimination that are directed at people who are perceived to have AIDS” (Fortenberry et al, 2002).

Stigma and shame associated with HIV infection are barriers to appropriate care and treatment, prevention policy, and program development (Klien, Karchener, O’Connell, 2002). Empirical data about the presence of HIV stigma in the United States can be useful in determining public health policy about HIV and other AIDS-related issues. Between 1997 and 1999, AIDS-related stigma was investigated using data from telephone surveys conducted with national probability samples of U.S. adults by Hereck, Capitanio, and Widaman (2002) at U.C. Davis. A total of 2,462 adults were interviewed with a median educational level of 1-2 years of college or post-secondary school, and a median income of \$40,000-\$50,000. To examine trends, data was compared from the 1997-1999 surveys to findings from a previously reported 1990-1991 national telephone survey. The survey included the following sections: support for coercive policies, negative feelings towards people living with AIDS (PLWA), responsibility and blame, casual contact, blood donation, trust in expert information, avoidant intentions, discomfort, and social contact (Hereck, Capitanio, Widaman, 2002). The survey trends exhibited both hopeful and disturbing findings about stigma among the U.S. adult population. The most overt expressions of HIV stigma were support for quarantine and

public identification of PLWA and have diminished since the 1990's, with fewer than 1 in 5 adults still supporting such measures by 1999. A similar trend was seen with negative feeling towards PLWA, and by 1999, few U.S. adults said they would avoid a co-worker or child with HIV/AIDS. However, it is still disturbing that in 1999 one-fifth of those surveyed still fear PLWA and one-sixth expressed disgust and suggested public naming of individuals with HIV/AIDS. Even in 1999, one-fourth of respondents felt uncomfortable having direct symbolic contact with PLWA. One-third of respondents said they would avoid shopping at a local grocery store if they were to learn that the owner had HIV/AIDS (Hereck, Capitanio, Widaman, 2002).

This survey also uncovered alarming signs of beliefs and opinions that are the foundation of HIV/AIDS stigma and thus continue to be widespread in the United States. The proportion of respondents who believe that individuals who became infected with HIV/AIDS through drug use or sexual contact deserve to have HIV/AIDS has increased over the decade. This response is disheartening because individuals with an undesirable condition, such as HIV, that are deemed personally responsible for their condition are usually subjected to greater stigma (Hereck, Capitanio, Widaman, 2002). Another area of concern is that although the majority of respondents understood how HIV is transmitted, they were less sure about how it is not transmitted. Overestimations of risks posed by social contact were higher in 1999 than in 1991. Therefore, those that believe HIV can be spread through social contact are more likely to fear contact with PLWA and support punitive policies towards them (Hereck, Capitanio, Widaman, 2002).

The survey has yielded two important findings for public health implications. First, it is apparent that the majority of U.S. adults understand how HIV is transmitted.

However, survey results do indicate a need for prevention efforts to be focused on how HIV is not transmitted. Second, public health policy should recognize that HIV stigma does still exist in the United States (Hereck, Capitnio, Widaman, 2002). Since this survey included a large number of respondents in 48 states, it is understandable that PLWA's still fear the consequences of stigma when their diagnosis becomes known to others. These fears are likely to have negative effects on PLWA and those at highest risk for HIV/AIDS. Therefore, eradicating HIV stigma should remain an important public health goal in the United States.

Over the course of their illness, PLWA encounter intense psychological and social stresses. HIV stigma occurs at all phases of the disease and creates unrelenting pressure on the management of HIV. Effective management of HIV requires timely testing to identify individuals with HIV in order to allow prompt access to care, and to benefit from available treatment. There is evidence that HIV stigma creates a delay in testing by people who are at high risk for infection. Timely testing has become more important recently, given the new evidence that antiretroviral therapy during the primary period of infection can alter the course of HIV infection (Chesney & Smith, 1999). The stigmatizing nature of HIV/AIDS is a factor that delays HIV testing by at-risk individuals. HIV stigmatization is also likely to determine what type of testing at-risk individuals are seeking. Those at highest risk are more likely to seek anonymous rather than confidential testing. Mandatory reporting of positive test results, which has been proposed as way to assist infected persons to access to care, further reduces the number of at-risk individuals getting tested for fear of their name being reported. There is also concerning evidence that individuals who are more likely to test positive are more likely

to decline testing. The primary reason for refusing testing was the fear of stigmatization (Chesney & Smith, 1999). In regard to the HIV epidemic, stigmatization has serious implications because delays in testing mean that individuals who are unaware that they are HIV positive could be unknowingly transmitting the virus to others.

Stigmatization also interferes with disclosure of HIV status, entering care, relationships with physicians, and adherence to treatment regimes. In addition to coping with the intense stress of HIV, HIV positive individuals are also confronted with stigma that can reduce livelihood and the individual's quality of life. This stigma can include rejection from family and friends, dismissal from work, financial strain, and cancellation of health and/or life insurance (Chesney & Smith, 1999). In order to protect themselves from such discrimination many HIV positive individuals conceal their status. Thus, the negative consequences of HIV stigma can become compounded as the disease progresses and concealment can become increasingly difficult.

Stigma, stereotypes, and unfounded fears by non-infected persons to distance themselves from infected individuals result in social isolation and social alienation (Shapiro, 2005). The conscious and unconscious fears that non-infected individuals have about social contact with a HIV positive individual further enhances stigmatization. In order to investigate the negative relationship between knowledge of HIV transmission routes and social distancing tendencies, a statewide random digit dialing sample of 603 Nevada residents were interviewed. Four separate dependent variables (scenarios) were created in which the geographic distance between the respondent and a hypothetical HIV positive person decreased, while physical personal contact or potential contact increased. Between 80.4% and 88.1% of Nevada residents had sufficient knowledge of HIV

transmission and the majority felt comfortable across all four social scenarios. However, multiple regression analysis indicated that respondents with sufficient knowledge of HIV transmission are significantly more comfortable with casual social interactions than those respondents' with insufficient knowledge. In each of the four scenarios presented, individuals with sufficient knowledge were more likely to feel comfortable with increasing social interaction (Shapiro, 2005). The results from this study seem to indicate that an increase in knowledge of HIV transmission routes can decrease discriminatory beliefs and social distancing. If knowledge creates comfort and if comfort results in compassion, then it is vital to increase HIV educational programs to ensure transmission knowledge.

Many individuals and communities face multiple forms of stigma and discrimination related to HIV/AIDS that impede care, treatment, and support. Coexisting factors which further confound prevention efforts include racism, sexism, homophobia, classism, and negative attitudes about drug use. Other impacts that were documented early in the epidemic but still continue to this day are: anti-homosexual bias and violence, discrimination in employment, loss of housing and inadequate or no access to social services (Klein, Karchner, O'Connell, 2002). It is imperative that steps be taken to reduce HIV stigma in order to alter the course of the epidemic. HIV stigma is often referred to as a "second epidemic" that prevents compassion and care for those living with HIV. It is necessary for our society to confront prejudices, ambivalence, and fear towards people living with HIV/AIDS. Furthermore, if we fail to do so, high-risk individuals will remain untested, HIV positive individuals will decline to disclose their status and risk infecting

others, and people living with HIV will not take advantage of treatments that can maintain their health and improve their quality of life.

HIV Risk Perception

The connection between beliefs, attitudes, and behavior has been well documented for an array of health issues including alcohol use, eating disorders, exercise, condom use, smoking, sexually transmitted disease, and HIV. Theoretical applications such as behavioral theory are often used to explain or predict how beliefs and attitudes will determine social behavior. Health behavior theories often include risk perception as an important theoretical construct and are important in motivating protective behaviors (Kalichman & Cain, 2005). The Health Belief Model is a behavioral theory that has been widely used to explain health behavior relation to risk perception.

The Health Belief Model was developed in the 1950's to explain why people would or would not use health services. This model hypothesizes that health related action depends on the simultaneous occurrence of three classes of factors: 1) the existence of sufficient motivation to make health issues relevant, 2) the belief that one is susceptible to a health problem and the health problem is serious, 3) the belief that following a particular health recommendation will be beneficial at reducing the perceived risk of the disease at a acceptable cost (McKenzie, Neiger, Smeltzer, 2005 pg. 157). The Health Belief Model posits that individuals who perceive themselves as being susceptible to a negative health outcome are more likely to reduce risky behaviors than those who do not perceive themselves to be at risk. Risk perception, or the perceived susceptibility that an individual has about the health problem, predicts both the suppression of health compromising behavior and initiation of protective behaviors (Kalichman & Cain, 2005).

HIV is considered a social phenomenon because the epidemic is the outcome of human social behavior patterns and is a stimulus for human social behavior responses (Stiles & Kaplan, 2004). Therefore, it is important to understand what factors contribute to an individual's risk-reducing behavior and an individual's risk-taking behavior. Perceived susceptibility by an individual is one factor that might contribute to one's preventive behavior or risk-taking behavior as predicted by the Health Belief Model. However, evidence that perceived susceptibility relates to changes in sexual behavior still remains inconclusive.

In a study by Zak-Place and Stern (2004), the Health Belief Model's predictive power was tested to identify which factors of the model are most predictive of safe-sex practices in a young college population. This study included both sexually transmitted diseases (STD's) and HIV as primary health threats. Intended safe-sex was operationalized as intended condom use and plan to obtain STD- and HIV-testing. The questionnaire contained Health Belief Model measures, response efficacy of condom use, response efficacy scale for STD- and HIV-testing, self-efficacy of condom use, self-efficacy of STD- and HIV-testing, STD vulnerability and severity scale, HIV vulnerability and severity scale, intention for condom use, and intention for STD- and HIV-testing. This study involved 93 male and 109 female undergraduate student participants recruited from an undergraduate level psychology class. Students choosing to participate in the study completed questionnaire packets by the end of class (Zak-Place & Stern, 2004). Self-efficacy was found to be a significant predictor for both condom use and STD- and HIV-testing intentions above and beyond all variables of the Health Belief Model (perceived severity, perceived susceptibility, perceived barriers, or perceived

benefits). The higher the perceived benefits of testing such as early detection and medical care, the greater the likelihood that college students intended to obtain testing. These results suggest that a variety of Health Belief Model factors may be important in determining health-related behaviors of college students. No single construct of the Health Belief Model proved to be a predictor of a college student's sexual behavior. This study also found that in general, college students perceive HIV as an improbable health risk (Zak-Place & Stern, 2004). This fact is alarming considering the CDC report that at least half of all new HIV cases are among those under the age of 25 (CDC, 2005). In this study, perceived susceptibility was not identified as a significant predictor of condom use or STD/HIV testing intentions (Zak-Place & Stern, 2004). This result highlights the need for increased awareness among college students about the threat of HIV for their age group. Perhaps perceived susceptibility was not a significant predictor because students were unaware of their own risks for HIV infection, and accurate statistics about the prevalence of HIV among their age group could increase their knowledge and in turn their perceived susceptibility.

Perceptions of the prevalence of HIV risk is particularly important in influencing behavior related to risks. Perceived susceptibility is directly related to an individual's perception about HIV prevalence in their city. In a study by Kalichman and Cain (2005), the association between perceived HIV/AIDS prevalence and behavioral risks for HIV was investigated in Milwaukee, Wisconsin. The investigators hypothesized that those individuals who estimate their local HIV/AIDS problem lower than other cities would demonstrate greater risk behaviors compared to individuals who perceive their local HIV/AIDS problem higher than other cities. In this study there were 487 male

participants and 236 women participants who were completed the anonymous survey at the public health clinic in the fall of 2001. Demographic and health characteristics were recorded as well as perceived HIV/AIDS burden in which participants were asked to rank a list of ten U.S. cities including Milwaukee, based on how many people are living with HIV/AIDS. Participants were also asked to estimate the number of people with sexually transmitted infections in Milwaukee in the previous year. Concern about HIV, sexual behaviors, and converging measures were also determined (Kalichman & Cain, 2005).

This study found that individuals were able to estimate relative prevalence rates of HIV and sexually transmitted infections in their city compared to other cities. There was a strong tendency to overestimate the annual incidence rates of sexually transmitted infections indicating that these individuals have a sense of intuitive epidemiology regarding their local HIV/AIDS problem, but are grossly inaccurate in overestimating the risk of disease. Perceptions of the HIV/AIDS burden were associated with sexual risk behaviors. Individuals who estimated the relative burden of HIV/AIDS in their city as lower than other cities reported more sexual partners, greater rates of unprotected sex and protected vaginal and anal sex, and greater rates of sexually transmitted infection diagnosis and current symptoms. Despite their higher risk for HIV, individuals who perceived a lower HIV/AIDS burden in their city were less likely to have been tested for HIV (Kalichman & Cain, 2005). This study is the first to investigate the association between perceived susceptibility of sexually transmitted infections and sexual risk behaviors. Estimates of disease prevalence are most likely influenced by and individuals biases and assumptions. In addition, estimates of HIV/AIDS burden may reflect an optimistic bias in risk perception that is related to risk behaviors (Kalichman & Cain,

2005). However, the results of this study do suggest that like with the Health Belief Model study of college students, perceived prevalence of a disease and conformity of normative beliefs about health behaviors do interact to influence health behavior and need to be addressed in the population.

In a study by Klein, Elifson, and Sterk (2003), HIV risk perceptions among 250 economically disadvantaged minority women was examined. This study focused on the difference between those saying that they had no chance of contracting HIV and those who indicated some chance of contracting HIV. This study was part of a larger project, the Female Atlanta Study, conducted between August 1997 and August 2000 which targeted at risk women. Most participants were African-American women with a median age of 35 years. Women were recruited by indigenous outreach workers in combination with a chain referral sampling technique. Participants were involved in a one to two hour interview and were offered a cash incentive. The independent variable was a dichotomous measure of the women's perceived risk. The eleven dependent variables were: amount of alcohol used (30 days), amount of illegal drug use (30 days), number of times having oral or vaginal sex (90 days), number of times having sex with a paying partner (90 days), total amount of sex (90 days), number of times of unprotected sex (90 days), average frequency of engaging in risky sexual behaviors (90 days), and the total number of different HIV risk behaviors practiced during the previous year (Klein, Elifson, and Sterk, 2003). This study found that women's perceptions of their levels of HIV risk reflected their behavioral practices. In general, those women who participated in the greatest levels of risky behavior were the least likely to indicate they had no risk of HIV. This indicates that women who engaged in risky behavior do have a fairly good

understanding of the risks they are taking. However, risk behaviors were fairly common among women who said they have no chance of becoming infected with HIV. More than half of the women who reported that they had no chance of contracting HIV engaged in at least one risky behavior. The authors contribute this data to two things. First, this finding is a reflection of the women's denial in which they are unable to acknowledge that their behaviors are putting them at risk for HIV. Second, this finding is also a reflection of gaps in women's HIV-related knowledge, and indicates a need for interventions that increase knowledge and awareness (Klein, Elifson, and Sterk, 2003). Significant predictors that differentiated women who thought they could become infected from those who thought they could not were: age, physical abuse experiences, self-esteem, and the number of HIV risk behaviors (Klein, Elifson, and Sterk, 2003). These findings demonstrate a need for interventions to target specific groups, especially women, and alert them of their vulnerability to HIV if they engage in risky behaviors, and what behaviors put them at risk for HIV.

The importance in understanding risk reduction factors should lie in the recognition that predictors resulting in safe behavior changes must be understood before interventions are implemented to prevent the spread of HIV. In a study by Stiles and Kaplan (2004), an analysis that extended the research on the Health Belief Model was used to recognize additional social factors that predict safer behavior change related to HIV. The analysis included additional factors such as social support and relationship status. The subjects of this study were participants in an ongoing longitudinal panel study of adaptations to stress that began in 1971, with a random selection of schools in the Houston Independent School District. There were four waves of participants from 1970-

2000, at which time 1,479 individuals from the original cohort were successfully re-interviewed as young adults (age 20). One ordinary least square regressions model was estimated in which five independent variables (vulnerability, if the individual has discussed AIDS with peers, perception of risk, cue to change behaviors, and stable relationships), six control variables (race, gender, level of education, socioeconomic status, sexual practices, and safe behavior changes), and ten interaction terms (involving risk categories: high versus low) are regressed on the dependent variable (Stiles & Kaplan, 2004).

As hypothesized, the strength of multiple independent variables was directly related to the risk category in which one belongs. Perceiving a sense of vulnerability of HIV and being black were significant predictors of general change towards safe behavior regardless of ones risk category. The results also showed that individuals in a long-term stable relationship, regardless of risk category, were significantly less likely to engage in changing their behavior (Stiles & Kaplan, 2004).

These findings imply that general behavior change increased for individuals in the high-risk category that were treated for low to medium levels of illness (sexually transmitted disease or overall health status). This indicates that the awareness of threat may lead individuals most at-risk into a state of denial, in which ones potential for contracting HIV in minimized to an acceptable level. The study also showed that individuals, who discussed AIDS with peers, have lower high risk scores and that both vulnerability and perceived susceptibility were predictive of general safe behavior change (Stiles & Kaplan, 2004).

The literature remains inconclusive in its ability to predict if perceived susceptibility actually relates to a sexual risk behavior change. Many studies are conducted in different age groups, across genders, and across different risk exposure categories. These factors make it difficult to universalize these findings to the general population, or to infer the predictive power of perceived susceptibility for behavior change. The majority of research on perceived susceptibility indicates that individuals are not aware of the behaviors that put them at risk for HIV infection, or individuals are in denial of those risks. If individuals are not aware that their behaviors place them at risk for HIV infection, then how can they feel susceptible to HIV? When individuals become informed about their personal risks for disease, they might adjust their behavior to ultimately reduce the threat (Kalichman & Cain, 2005). It is imperative that educational interventions include behavioral risk factors and highlight behaviors that put individuals at risk for HIV, in order to increase perceived susceptibility.

CHAPTER III

METHODOLOGY

Purpose of the Study

The purpose of this descriptive study was to evaluate the HIV Prevention Social Marketing Campaign in Flathead and Silver Bow Counties in Montana. Descriptive studies involve the collection and analysis of quantitative data in order to develop a precise description of the sample's behavior or personal characteristics (Gall, Gall, Borg, 2005). The media channels used for the campaign included commercials, billboards, theatre slides, and posters. The campaign specifically focused on the primary cities located within Flathead and Silver-Bow Counties and their County Health Departments. Flathead County contains the sixth largest number of HIV/AIDS cases and Silver-Bow County contains the fourth highest number of HIV/AIDS cases in the state of Montana (Montana Comprehensive HIV Prevention Plan, 2004). This descriptive study evaluated the campaign by providing a snapshot assessment of reported knowledge, attitudes, and perceptions of Montana's HIV Prevention Social Marketing Campaign in Flathead and Silver-Bow Counties.

The short term goal of the HIV Prevention Project Social Marketing Campaign is to implement Social Marketing strategies by developing innovative HIV/AIDS prevention messages and disseminating these messages among the HIV priority populations using multiple media channels. This study assisted program planners in evaluating the media channels and their effectiveness to reach the priority populations in the intervention communities. This study provided a snapshot of current campaign

awareness and perceptions, and what populations are participating in HIV Counseling and Testing in Montana.

Data from this study was collected in three different phases including disseminating surveys targeting individuals receiving an HIV Counseling and Testing in the intervention and comparison communities, conducting focus groups and interviews among MSM in the intervention communities, and assessing HIV testing data collected by the Health Departments and the state of Montana in the intervention and comparison communities. The following sections describe the methodology and procedures used for this study.

Study Design

This descriptive study used quantitative and qualitative techniques to evaluate Montana's HIV Prevention Social Marketing Campaign. Data was collected via survey research, focus groups, interviews, and HIV Counseling and Testing data. The descriptive surveys, focus groups, and interviews assessed if members of the target populations have seen the campaign, campaign message recall, and their perceptions about the campaign. The demographic profiles from the collected data will determine if the campaign is reaching high-risk populations.

The survey was voluntarily completed by individuals in the intervention communities receiving HIV Counseling and Testing at the Silver-Bow County Public Health Department and the Flathead County Health Department. Surveys were also completed by individuals receiving HIV Counseling and Testing at the Lewis and Clark County Health Department in the comparison community. The survey assessed demographic information, campaign awareness, and campaign message agreement.

Description of the Target Population

The target population for the surveys included any individual over the age of 18 receiving an HIV test at the Public Health Departments in Butte and Kalispell.

Demographic information was collected on the surveys in order to identify the populations receiving an HIV test during the campaign in Kalispell and Butte. The population receiving HIV Counseling and Testing included members of the general population and members of the target populations identified by Montana's HIV Prevention Social Marketing Campaign.

Montana's HIV Prevention Social Marketing Campaign messages specifically target the following populations: 1) MSM population, 2) HIV positive male and female population, 3) IDU population, 4) Youth-at-risk population, and 5) the "Down-Low" population.

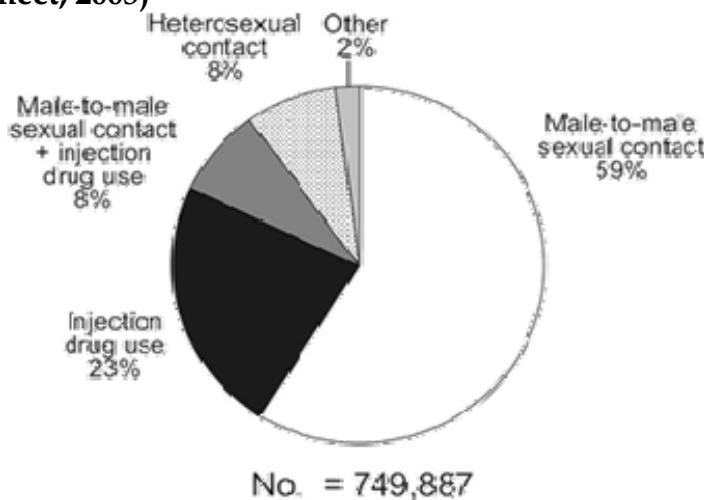
MSM Populations

In the United States, HIV/AIDS has had a tremendous effect on the MSM population. MSM accounted for approximately two thirds of all HIV infection among men in 2003, even though only 5% to 7% of men identify themselves as MSM. In 2003 MSM accounted for 67% of all men and 54% of all people who received an HIV positive diagnosis (CDC, 2005). Recent surveillance data from the young MSM population indicates an increase in HIV diagnosis and at risk sexual behavior (Valleroy et al 2000). These findings present a widespread public health problem and present a need to conduct and evaluate interventions specifically targeting young MSM.

In Montana, the MSM population accounts for approximately 63% or 383 of the 612 cumulative HIV/AIDS cases since 1985. This includes 315 reporting MSM and 68

reporting dual risk factors of MSM and infecting drug use (Montana Comprehensive HIV Prevention Plan, 2004). Sexual risk factors account for most HIV infections in MSM and include: unprotected anal sex, use of drugs and alcohol with sex, seeking sex partners on the internet, and failure to maintain preventative sexual behaviors. STD's are also included as a sexual risk factor because they are considered a marker for high risk sexual behavior that can also transmit HIV. After 25 years into the HIV epidemic, there is still evidence of an underestimation of risk, of difficulty maintaining safe sexual practices, and of a need to sustain prevention efforts for each generation of young MSM (CDC, 2005).

Figure 3: Transmission categories of male adolescents and adults given an AIDS diagnosis through 2003 in the United States (CDC HIV/AIDS Fact Sheet, 2005)



HIV Positive Populations

The HIV positive priority populations include women heterosexuals, MSM, and MSM/IDU. As of December 31, 2003, heterosexually acquired cases account for 66 (11%) of the 606 adult HIV/AIDS cases in Montana. However, if you examine HIV/AIDS cases by gender the percentage paints a different picture. While 23 of 533 (4%) of adult male HIV/AIDS cases are attributed to heterosexual content, 43 of 73

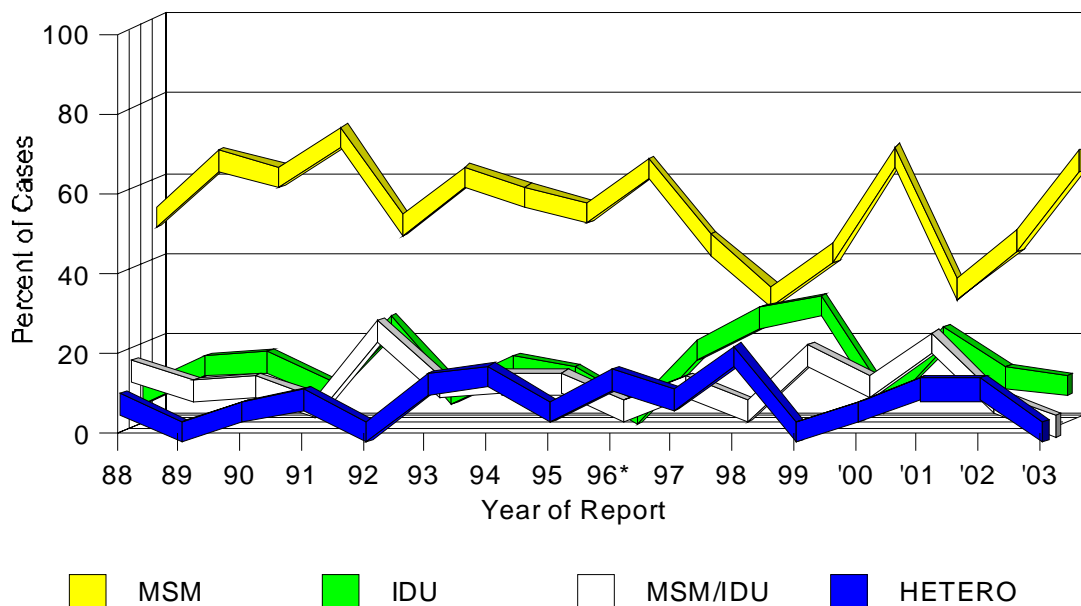
(59%) of adult female cases are attributed to heterosexual contact. Among female HIV/AIDS cases the primary exposure category continues to be heterosexual contact, accounting for about 60% of cases in women (Montana Comprehensive HIV Prevention Plan, 2004).

The other HIV positive priority population is MSM and MSM/IDU. MSM account for approximately 383 of the 612 (63%) cumulative HIV/AIDS cases reported in Montana since 1985. This total includes 315 reporting MSM and 68 reporting dual risk factors of MSM and IDU. In Montana, MSM and MSM/IDU have consistently accounted for the majority of HIV/AIDS cases and this percentage has not significantly changed over time (Montana Comprehensive HIV Prevention Plan, 2004).

IDU Populations

As of December 31, 2003, 149 of 612 (24%) cumulative HIV/AIDS cases in Montana report a direct link with injecting drug use. This total includes 81 of 612 (13%) reporting IDU as well as 68 of 612 (11%) reporting dual risk factors of MSM and IDU. In addition, 30 of 66 (45%) of heterosexual HIV/AIDS cases are linked to a partner who injects drugs (Montana Comprehensive HIV Prevention Plan, 2004).

Figure 4: Percent Distribution of HIV cases by Exposure Category in Montana (Montana HIV Prevention Comprehensive Report, 2004)



Down Low Populations

The CDC defines these populations as “men who have sex with men and women and who do not identify as gay or bisexual (CDC, 2004).” Although this term originated in the African American community, the behaviors associated with the term are not new and are not specific to African American men. Much of the media attention associated with down low has focused on the transmission bridge between bisexual men and heterosexual women. Heterosexual women have become infected through sexual contact with a bisexual man.

The Down Low behavior has gained a lot of recent media attention however, there is currently no data available to confirm or refute publicized accounts of HIV risk behavior associated with these men. Currently, CDC and its multiple research partners are exploring the HIV related sexual risks of men, including men who use the term down low to refer to themselves (CDC, 2004).

Protection of Human Subjects

The Institutional Review Board (IRB) and the University of Montana has reviewed the proposal of this study and approved the methodology used for protection of human subjects (see Appendix B page 161).

Data Collection Procedures

The selection of sample, instrumentation, and data collection analysis for each method is described below. Data was collected using four methods: HIV testing data from Montana’s Department of Health and Human Services, survey, focus groups, and interviews.

HIV Testing Data

Selection of Sample

The sample included all individuals receiving HIV Counseling and Testing in April, May, June, and July at Flathead County Health Department and Butte Silver-Bow County Health Department. The sample also included individuals receiving HIV Counseling and Testing in Helena at the Lewis and Clark City County Health Department. Helena will be used as the control because this location has not received Montana's HIV Prevention Project Social Marketing Campaign. The HIV testing data from Helena was compared to the HIV testing data from Kalispell and Butte, to look for patterns related to campaign exposure and HIV counseling and testing. Helena is comparable to both Butte and Kalispell in regards to population and mean income level. HIV testing data was collected from January through July for 2005 and 2006 in the intervention and comparison communities. The HIV testing data was compared to data from the same months during the campaign in (April through July) 2005 to look for any observable changes during Montana's HIV Prevention Social Marketing Campaign in 2006.

Data Collection and Analysis

Data gathered for the purpose of this study was obtained from the Montana Department of Health and Human Services (MDHHS). When individuals receive HIV Counseling and Testing, a trained counselor interviews the individual to determine at-risk behaviors. CDC funded HIV Counseling, Testing, and referral sites are an integral part of the national HIV prevention efforts. During the counseling sessions a specified form was completed by the counselor that is anonymous and confidential. The name or identity of

the individual were not recorded anywhere on the form. This form included demographic information (age, sex, race, ethnicity, zip code, county of residence); HIV testing information (type of test offered, and previous test outcome; risk exposure; and reason for visit).

The Montana Department of Health and Human Services provided the anonymous data for the specified time period for Kalispell, Butte, and Helena. This data was obtained at the end of the study period. The HIV testing numbers in each location included monthly totals for a period of five months. In the intervention communities, data was collected three months prior to the campaign dissemination and for the first four months of the campaign. This data allows program planners to monitor if testing numbers have increased since the beginning of the campaign in the intervention communities.

Survey Data

Selection of Sample

This study relied on a convenience sample of volunteers who are receiving HIV Counseling and Testing at the Butte-Silver Bow County Health Department, Flathead County Health Department, and Lewis and Clark County Health Department.

Convenience sampling is a form of purposeful sampling in which researchers select individuals to study because they are information rich with respect to the researcher's purposes. Convenience sampling allows researchers to select from a sample based primarily on convenience (Gall, Gall, Borg, 2005). The surveys were administered to individuals receiving HIV Counseling and Testing, the trained counselor will inform the individual about the survey and will hand the survey to them while they are waiting to be tested. After the individual read the informed consent (see Appendix C, page 163)

providing an explanation of the study, he/she decided if they were willing to participate. If so, the survey was completed and returned to a covered drop box before they left the Health Department. Individuals were not permitted to take the survey twice if they returned for testing twice during the data collection. However, this is unlikely due to the three month window period of HIV testing since the surveys will be collected for four months.

A convenience sample of high risk individuals was also included in this study. The survey will also be distributed to one outreach worker in both in Kalispell and Butte. These outreach workers, in the course of their normal prevention activities, asked individuals if they would like to complete a survey evaluating media campaigns in Montana. The surveys were voluntarily completed by high risk populations receiving HIV Counseling and Testing or another type of prevention activity outside the Public Health Departments. Surveys were collected by outreach workers and returned after three months.

Instrumentation

Descriptive data was gathered via surveys. Data included demographic information (age, gender, sexual orientation, HIV testing history, race/ethnicity, level of education, risk behaviors), perceived HIV risk, and campaign awareness (have they seen the message, what do they remember, did the message affect them, and have they changed risky behavior or received and HIV test as a result of the campaign). The third section of the survey included 16 statements developed from Montana's HIV Prevention Social Marketing Campaign messages. Participants read each statement and responded by checking one of the following statements: agree, disagree, not sure. The anonymous

survey was estimated to take around 8-10 minutes to complete and includes 30 close-ended questions and five open-ended question to assess campaign message recall and campaign exposure (see Appendix D, page 166).

The survey was tested for content validity and face validity by expert review at the University of Montana. After the survey was reviewed, it was pilot tested using a test-retest strategy among a small group of students to determine reliability. The test-retest strategy looked at each individual question as well as the survey as a whole. The survey had a 94.5% agreement over time (including demographic questions). None of the questions had less than 90% reliability and the majority of questions had 100% reliability with respondents answering the same question, with the same response over time. When each individual question was viewed, only the three questions which contained multiple answers did not have a 100% agreement over time.

Data Collection and Analysis

The surveys were collected daily for four months. At the end of each month the Health Departments would send the collected surveys to the research office at the University of Montana. After each mailing, data was coded in a SPSS database (a statistical analysis program). Survey responses were coded and descriptive statistics were used to report frequencies for each survey question. Measures of central tendency and frequency of responses were compared between the intervention communities and the comparison communities. Surveys were analyzed for relationship between campaign exposures, decision to test, reported affects of campaign, campaign message agreement. Cross tabulations and frequencies were initially run. Then data was further analyzed using chi-square test of independence between variables.

Focus Group Data

Selection of Sample

The focus group sample consisted of fourteen individuals in two focus groups. Focus groups are a crucial method of investigating individual's reactions to programs and practices. Since respondents are joined together in a group where they can talk and hear each other, they are more likely to express feelings or opinions that otherwise might not emerge in an interview or survey (Gall, Gall, Borg, 2005). The purpose of the focus groups was to explore more in-depth and build upon survey results, and to explore reactions of MSM to the campaign.

The focus groups for this study included a convenience sample of the MSM population in Kalispell and Butte. Volunteer participants were recruited by outreach workers or gatekeepers in these locations. All participants in both focus groups were over 18 years and older and lived in either Kalispell or Butte. Each focus group consisted of MSM and the Butte focus group had one woman who identified as homosexual. A time and a place were also organized by the outreach workers or gatekeeper, and in both locations the focus group took place inside someone's home. A small monetary incentive was provided for participants. Food and drink were also provided for participants.

Instrumentation

The focus group discussion guide consisted of 14 open-ended questions (see Appendix E, page 171). The focus group discussion guide was reviewed for content validity by expert review at the University of Montana. The questions explored more in depth campaign awareness, campaign perceptions, and assessed campaign message agreement. Topics included in the focus group that are not included in the survey are:

initial reactions to the campaign, campaign messages that are and are not identified with, positive and negative effects associated with the campaign, and suggestions for future campaigns targeting MSM in Montana. The focus group discussion guide contained two sections. The first section of the discussion guide included questions about what they have seen, what they have seen most frequently, message recall, and reported campaign affects. After the first seven questions, the five HIV Prevention Social Marketing Campaign commercials were shown. The five commercials shown are the same commercials that were disseminated in Butte and Kalispell for the campaign, and three of the five were developed in 2005 by the HIV Prevention Social Marketing Campaign. For a description of each commercial and the commercial messages see Appendix A (page 159). After each commercial, participants were asked to discuss their initial reactions and what messages they identified with. After all five commercials were shown, three more questions were discussed.

Data Collection and Analysis

Each focus group was lead by a moderator who initiated discussion and kept the group on track. Participants were read an informed consent form (see Appendix F, page 175) and verbal permission by all participants was received before the session began. The session was audio-taped, transcribed, and notes were taken by the moderator and an assistant. Immediately following the focus groups the researcher reviewed the notes and the audio-tape to identify areas of uncertainty, and review the overall quality of information received from the participants.

The data analysis included transcription of the session and was compared to notes recorded during the focus group. An abbreviated transcript of each focus group is

provided in chapter four. The qualitative data analysis will look for observable patterns among frequented responses in both Kalispell and Butte. The transcripts were read repeatedly to identify perceptions, general impressions, and concerns by participants. Quotes from the participants were used to support the illustrated themes in the abbreviated transcript.

Interviews

Selection of Sample

Interviews were conducted only in Kalispell by an outreach worker. A total of four interviews were conducted. After working with various gatekeepers and the Flathead County Health Department both parties thought it would be difficult to conduct a focus group with MSM in Kalispell. The MSM population is not easily accessible due to the closed community of Kalispell. After talking to several gatekeepers on the phone, interviews by the outreach worker seemed to be the only way to access this population in Kalispell. Interviews took place for two months during June and July. A convenience sample of individuals the Kalispell outreach worker conducted normal prevention activities were selected for the sample. The outreach worker asked individuals if they would participate in a brief interview about media campaigns in Montana. If the individual agreed to participate, a informed consent form (focus group informed consent form) was read by the outreach worker, and verbal permission was granted before the interview began. The outreach worker recorded the responses, and after the interview was conducted, the outreach worker completed a demographic section on the back of the survey.

Instrumentation

Interview questions were developed by the researcher from the focus group discussion guide. The interview questions consisted of the same questions used for the focus groups, however the interviewees did not view the five commercials that the focus group participants viewed and discussed. There were ten interview questions, and a brief demographic section (see Appendix G, page 178) was completed after the interview by the outreach worker. If necessary, a series of more specific questions were asked regarding in order to obtain more information regarding the interviewee's perceptions about the campaign.

Data Collection and Analysis

At the end of July the outreach worker sent the completed surveys and interview sheets to the research office at the University of Montana. The outreach worker recorded the interviews taking preliminary abbreviated notes. After the interview was over the outreach worker revisited the notes and spent time adding specifications and clarifications before completing the demographic section on the back of the interview sheet. An abbreviated transcript of the four interviews is presented in chapter four. The interviews will be qualitatively analyzed for observable patterns and themes among individual interviews.

CHAPTER IV

RESULTS

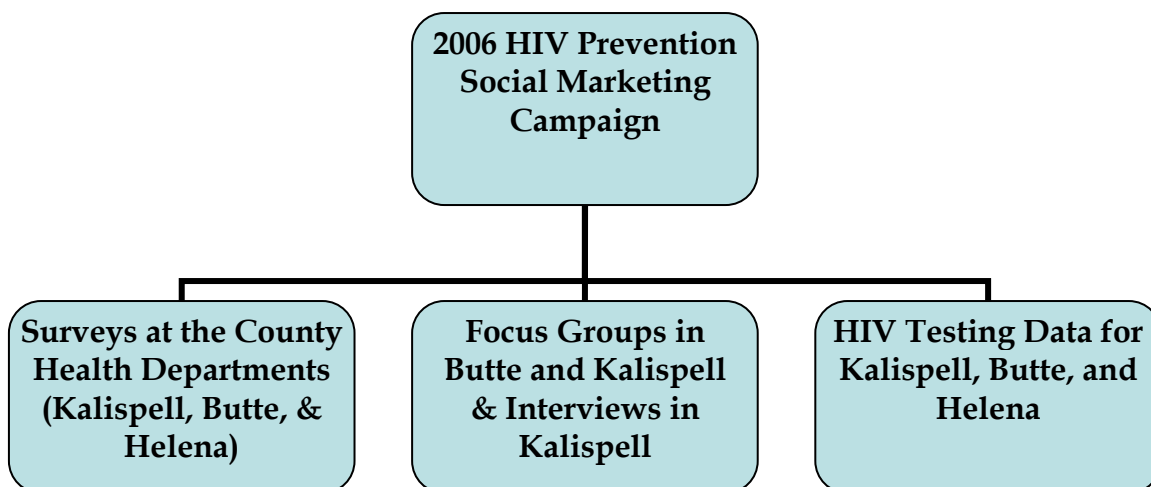
Introduction

The purpose of this descriptive study was to evaluate Montana's 2006 HIV Prevention Social Marketing Campaign in Flathead and Silver-Bow Counties. The media channels used for this campaign consisted of commercials, billboards, posters, and theatre slides. Data collection focused on the primary cities located within these counties. These cities included Kalispell in Flathead County and Butte in Silver-Bow County. Data was collected in two intervention communities which received the HIV Prevention Social Marketing Campaign and in a comparison community, Helena (Lewis and Clark County), which did not receive the HIV Prevention Social Marketing Campaign. Data collection took place the first four months of the campaign in the intervention communities, providing a snapshot of campaign awareness and perceptions.

Data collection consisted of four areas which included both quantitative and qualitative techniques. First, HIV testing data was analyzed to examine the change in monthly testing numbers during the HIV Prevention Social Marketing Campaign. The 2005 and 2006 HIV testing numbers for Flathead County and Silver-Bow County were compared for changes during the first four months of the campaign. HIV testing data from the intervention communities was compared to HIV testing data from the comparison community. Second, surveys quantitatively evaluated the campaign among individuals receiving HIV Counseling and Testing at the Flathead County and Butte Silver-Bow County Health Departments and individuals receiving HIV Counseling and Testing at the Lewis and Clark County Health Department, the comparison community.

Third, focus groups were conducted with MSM in the intervention communities to qualitatively evaluate campaign awareness, perceptions and attitudes about the campaign. Fourth, interviews were conducted in Kalispell by an outreach worker to qualitatively evaluate campaign awareness, perceptions, and attitudes about the campaign (see Figure 5 below).

Figure 5: Evaluation Design



In the following sections, the HIV testing data collected from the Montana Department of Health and Human Services is presented first for the intervention communities. Next, the survey results are presented for the two intervention communities. This includes the chi-square data analysis for the survey results. Then the focus group and interview results are presented for the intervention communities. Finally, the HIV testing data and survey results are presented for the comparison community.

Results for the Intervention Communities

In the following sections, the results for the intervention communities are presented. The intervention communities included Flathead County and Butte Silver-Bow County. The HIV Prevention Social Marketing Campaign began in mid-March and

continued through August 2006. Data was collected for the first four months of the campaign in the intervention communities.

HIV Testing Data

The Montana Department of Health and Human Services provided the monthly HIV testing data for January through July for 2005 and 2006 for Flathead County and Butte Silver-Bow County. The data was compiled in an Excel spreadsheet and graphs were composed. HIV monthly testing means are provided for January to March (the months prior to the campaign), April to July (the months during the campaign), and for the entire period of January to July. The percent increase in monthly HIV tests was also calculated. For all months that demonstrated an increase in HIV tests the percent increase was calculated and totaled for the months during the campaign. In the intervention communities, the campaign started in March 2006 and surveys started in April 2006 in both communities.

The following graph (Graph 1) compares 2005 and 2006 HIV monthly testing numbers in Flathead County. The HIV testing numbers in Flathead County decreased in the first half of 2006. The Flathead County Health Department attributed this decrease in testing to the loss of a full-time personal that did the majority of HIV testing inside and outside of the Health Department. The majority of HIV tests during 2006 were conducted as part of a routine check-up at the Family Planning Clinic, where the HIV testing takes place. The number of individuals who came to the Family Planning Clinic solely for an HIV test decreased for the entire first half of 2006. The percent increase in monthly HIV tests does indicate an increase during the campaign in 2006 compared to the same months in 2005.

Graph 1. HIV Monthly Testing Numbers for 2005 and 2006 in Flathead County

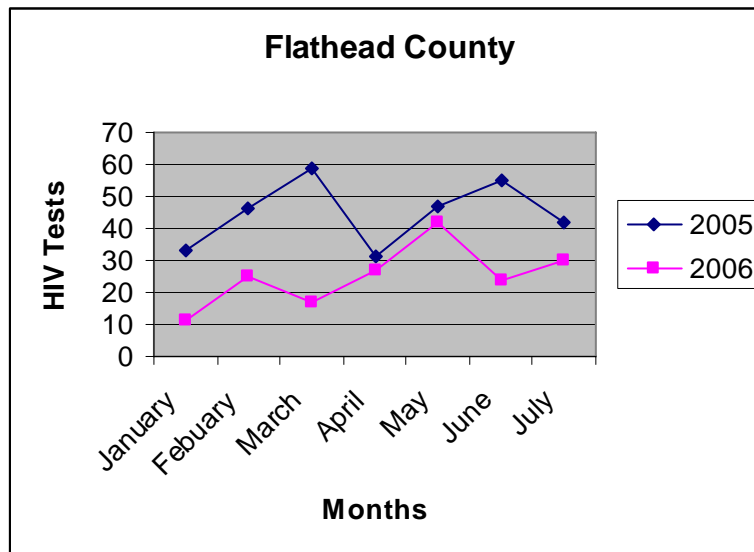


Table 1. Monthly HIV Testing Numbers and Percent Increase for Flathead County

Month	2005 HIV Tests	Percent Increase	2006 HIV Tests	Percent Increase
January	33		11	
February	46	4%	25	8%
March	59	4%	17	(-4.5%)
April	31	(-9%)	27	6%
May	47	5%	42	8.5%
June	55	2.5%	24	(-10%)
July	42	(-2%)	30	9%
Total	313	11.5%	176	23.5%

Table 2. HIV Monthly Testing Means for Flathead County

	2005	2006
January-March	46	18*
April-July	44	31*
January-July	45	25*

* The Flathead County Health Department lost their full-time HIV coordinator who did most of the HIV testing at the Health Department and at various other locations. The Flathead County Health Department did not hire a replacement until June, therefore, this contributed to the lower HIV testing numbers in the first half of 2006.

The following graph (Graph 2) compares 2005 and 2006 HIV testing numbers in Silver-Bow County. The HIV testing numbers increased in Silver-Bow County dramatically during the first two months of the campaign, overall testing levels increased during the campaign in 2006 compared to the same months in 2005. The mean increase in HIV testing numbers for the months during the campaign was 10, and the increase for the first part of the year in 2006 was 4. The percent change in monthly HIV tests also increased during the months of the campaign in 2006 compared to the same months in 2005. The Silver-Bow County Health Department has multiple individuals who are trained HIV Counselors and there were no changes in personnel that took place during this study.

Graph 2. HIV Monthly Testing Numbers in 2005 and 2006 for Butte Silver-Bow County

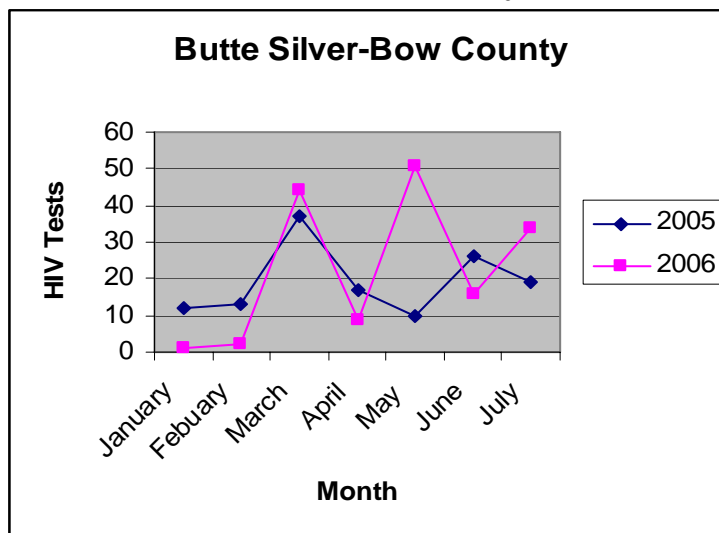


Table 3. Monthly HIV Testing Numbers and Percent increase in Silver-Bow County

Month	2005 HIV Tests	Percent Increase	2006 HIV Tests	Percent Increase
January	12		1	
February	13	.7%	2	.6%
March	37	18%	44	27%
April	17	(-15%)	9	(-22%)
May	10	(-5%)	51	27%
June	26	12%	16	(-22%)
July	19	(-7%)	34	11.5%
Total	134	30%	157	65.5%

Table 4. HIV Monthly Testing Means for Butte Silver-Bow County

	2005	2006
January-March	21	16
April-July	18	28
January-July	19	23

Survey Results

A total of 72 surveys were completed in the intervention communities. In Kalispell, a total of 18 surveys were completed by individuals receiving HIV Counseling and Testing at the Flathead County Health Department or by individuals receiving outreach prevention activities by a contracted outreach worker. In Butte, a total of 54 surveys were completed by individuals receiving HIV Counseling and Testing at the Butte Silver-Bow County Health Department or by individuals receiving outreach prevention activities by a contracted outreach worker.

Surveys were completed in the intervention communities by individuals receiving HIV Counseling and Testing at the Flathead County Health Department and the Butte Silver-Bow County Health Department or by outreach workers. Surveys in both locations were collected from April 2006 to July 2006, the first four months of the campaign. Both intervention communities received the HIV Prevention Social Marketing Campaign

starting in March 2006. The following section is a summary of the survey data for both Kalispell and Butte. (The survey data for each County can be found in Appendix H, page 181).

Demographics

This section of the survey included nine questions. Individuals were asked to provide the following demographic information: age, gender, sexual orientation, race/ethnicity, risk exposure, previously tested for HIV, reasons for not previously testing for HIV, length since last test, and decision to test.

Age and Gender

Respondents reported age as follows (n=72):

- Mean age is 31.58.
- Age ranged from 14 to 58 years old.

Respondents reported gender as follows (n=72):

- 43% were female (n=31)
- 57% were male (n=41)

Ethnicity

The ethnicity of survey respondents is listed in Table 5 below.

Table 5. Ethnicity for Kalispell and Butte (n=72)

Ethnicity	Percent of Respondents	Frequency
Native American	12%	8
Asian/Pacific Islander	1%	1
African American	0%	0
White (non-Hispanic)	83%	60
Hispanic	3%	2
Other	1%	1

Other responses included: "I do not believe in race."

Sexual Orientation

The sexual orientation of respondents is listed Table 6 below.

Table 6. Sexual Orientation for Kalispell and Butte (n=72)

Sexual Orientation	Percent of Respondents	Frequency
Heterosexual	76%	55
Homosexual	15%	11

Bisexual	9%	6
Other	0%	0

Risk Exposure Categories

Respondents were asked to check all of the risk exposure categories that applied to them. Respondents were asked to check all categories that apply, this accounts for the percent of respondents equaling more than 100%. The risk exposure categories of respondents are listed in Table 7 below. The two most frequently reported risk categories were unprotected sex (74%) and sex while using drugs or alcohol (46%).

Table 7. Risk Exposure Categories for Kalispell and Butte (n=72)

Risk Exposure Category	Percent of Respondents	Frequency
Unprotected sex	74%	53
Used injecting drugs	15%	11
Sex for money or drugs	1%	1
Sex with injecting drug user	15%	11
STD diagnosis	10%	7
Sex with a HIV positive person	7%	5
Sex with a homosexual	14%	10
Mother has HIV/AIDS	0%	0
Hemophilia/blood recipient	0%	0
Sex while using drugs or alcohol	46%	33

Previously Tested for HIV

Respondents were asked if they had previously been tested for HIV and if yes, what the results of the test were. The respondent's answers are presented in Table 8 below.

Table 8. Previously Tested for HIV for Kalispell and Butte (n=72)

Previously Tested for HIV	Percent of Respondents	Frequency
No	39%	28
Yes/Negative	60%	43
Yes/Positive	0%	0
Yes/Indeterminate	0%	0
Yes/Unknown	0%	0
Don't Know	1%	1

Reasons for Not Previously Testing for HIV

The respondents who had not been previously tested for HIV (n=28) were asked to check all the reasons for not previously testing. The respondent's answers are presented in

Table 9 below. The number of respondents who identified more than one reason for not previously testing accounts for percent of respondents equaling more than 100%.

Table 9. Reasons for Not Previously Testing for HIV for Kalispell and Butte (n=28)

Reasons for Not Previously Testing	Percent of Respondents	Frequency
Unlikely to have been exposed through sex	57%	16
Afraid to find out my HIV status	36%	10
Didn't want to think about being HIV positive	39%	11
Worried about who would learn results	21%	6
Didn't want anyone to think I was at risk	14%	4
Worried my name would be reported	11%	3
Worried friends would react badly	25%	7
Thought I was HIV negative	43%	12
Didn't have time	11%	3
Didn't want to worry family members	7%	2
Unlikely of have exposure through drug use	21%	6
Didn't want people to think I was gay	14%	4
Didn't want people to think I used drugs	11%	3
Other	14%	4

The four other responses did not explain the reason.

Length since Last Test

Those respondents that had been previously tested (n=42) were asked to specify how long it had been since their last HIV test. The respondent's length since last HIV test is reported in Table 10 below.

Table 10. Length since Last Test for Kalispell and Butte (n=42)

Length since Last Test	Percent of Respondents	Frequency
3 months	21%	9
6 months	21%	9
12 months	24%	10
More than 1 year	34%	14

Decision to Test

Respondents were asked to respond to whether or not media information about HIV contributed to their decision to get tested for HIV. The respondent's answers are reported in Table 11 below.

Table 11. Decision to Test for Kalispell and Butte (n=72)

Decision to Test	Percent of Respondents	Frequency
Agree	53%	38
Disagree	36%	26
Not Sure	11%	8

Campaign Awareness

This section of the survey assessed campaign awareness and included seven questions. Individuals were asked to answer the following questions: have you seen media information about HIV, what have you seen, campaign exposure, campaign message recall, and campaign effect.

Media Information about HIV

Survey respondents (n=72) were asked if they had seen any media information about HIV. Survey respondents reported the following about seeing media information about HIV:

- 90% (n=65) reported seeing media information about HIV.
- 10% (n=7) reported not seeing media information about HIV.

Billboards

Survey respondents (n=72) were asked if they had seen a billboard about HIV. Survey respondents reported the following about seeing a billboard about HIV:

- 78% (n=56) reported seeing a billboard about HIV.
- 22% (n=16) reported not seeing a billboard about HIV.

Survey respondents (n=56) reported the following about how many times they had seen a billboard:

- The minimum times respondents reported seeing billboards about HIV were 1 and the maximum was 120.
- The mean number of times a billboard was seen in Kalispell and Butte was 19.71.
- Of the 56 respondents who reported seeing a billboard, 23 respondents did not report how many times they had seen a billboard.

Commercials

Survey respondents (n=72) were asked if they had seen a commercial about HIV. Survey respondents reported the following about seeing a commercial about HIV:

- 74% (n=53) reported seeing a commercial about HIV.
- 26% (n=19) reported not seeing a commercial about HIV.

Survey respondents (n=53) reported the following about how many commercials about HIV they had seen:

- The maximum times respondents reported seeing commercials about HIV were 100 and the minimum was 1.
- The mean commercials seen was 15.17.
- Of the 53 respondents who reported seeing a commercial, 22 respondents did not report how many times they had seen a commercial.

Posters

Survey respondents (n=72) were asked if they had seen any posters about HIV.

Respondents reported the following about seeing posters about HIV:

- 76% (n=55) reported seeing a poster about HIV.
- 24% (n=17) reported not seeing a poster about HIV.

Survey respondents (n=55) reported the following about how many posters they have seen:

- The maximum times respondents reported seeing a poster was 40 and the minimum time was 2.
- The mean posters seen was 14.48.
- Of the 55 respondents who reported seeing posters, 24 respondents did not report how many posters they had seen.

Theatre Slides

Survey respondents (n=72) were asked if they had seen any theatre slides about HIV.

Respondents reported the following about if they had seen any theatre slides:

- 8% (n=6) reported seeing a theatre slide about HIV.
- 92% (n=67) reported not seeing a theatre slide about HIV.

Survey respondents (n=6) reported the following about how many theatre slides they have seen:

- The maximum times respondents reported seeing a theatre slide was 6 and the minimum was 1.
- The mean theatre slide seen was 3.67.
- Of the 6 respondents who reported seeing a theatre slide, 3 respondents did not report how many theatre slides they had seen.

Media Channels

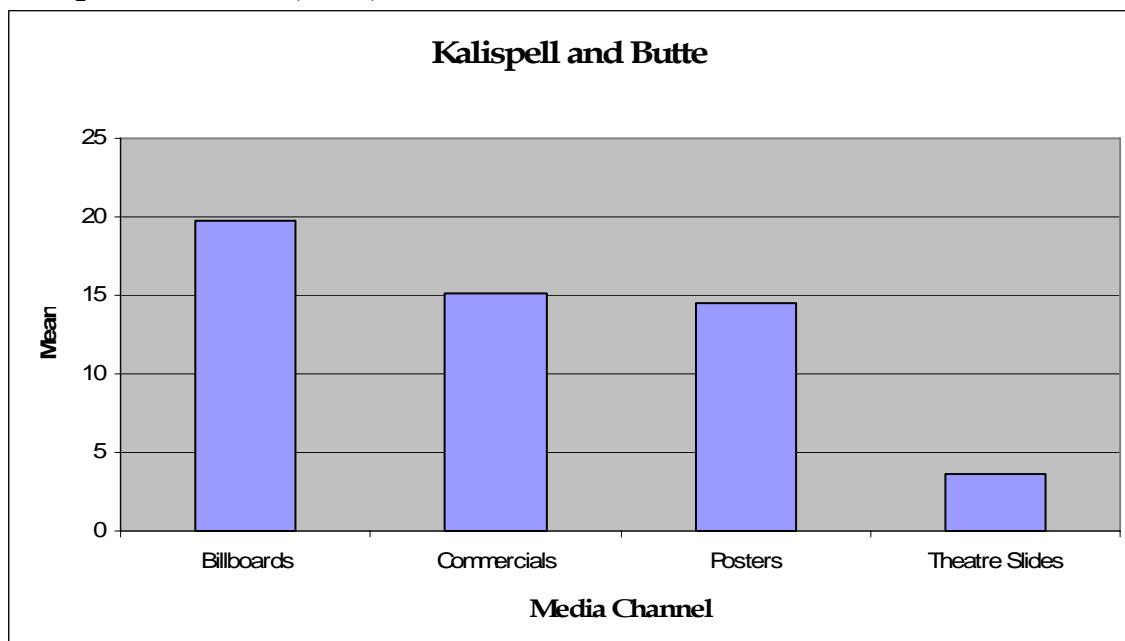
The survey data indicated between 74%-75% of individuals saw billboards, commercials, and posters. The most frequently seen media channel in Kalispell and Butte was billboards (78%) followed by posters (76%) and commercials (74%). When looking at the average times respondents reported seeing each media channel, billboards were seen most frequently (19.71 times) followed by commercials (15.17) and then posters (14.48 times). Theatre slides were only shown in Butte, and only 7% of respondent reported seeing a theatre slide.

The following table (Table 12) shows reported campaign awareness for each HIV Prevention Social Marketing Campaign media channel. Graph 3 shows reported times seen for each campaign media channel.

Table 12. Campaign Awareness for Kalispell and Butte (n=72)

Campaign Awareness	Yes	No
Media Information	90% (65)	10% (7)
Billboard	78%(56)	22% (16)
Commercial	74% (53)	26% (19)
Poster	76% (55)	24% (17)
Theatre Slide	7% (5)	93% (67)

Graph 3. Mean Times Seen Reported for the Campaign Media Channels in Kalispell and Butte (n=72)



Campaign Message Recall

All survey respondents (n=72) were asked to describe what they remember about the campaign. Not all respondents described what they recalled and duplicate responses are only noted once. The two main messages recalled most often by respondents were “to get tested” (48%) and “HIV doesn’t discriminate” (20%).

- *“Testing is available.”*
- *“HIV can lead to AIDS which is deadly. Practice safe sex. HIV and AIDS are non-discriminatory.”*
- *“Where HIV testing is done.”*
- *“Showing needles and gay.”*
- *“That it can infect anyone not just homosexuals.”*
- *“Doing a good job.”*
- *“It kills you.”*
- *“Mostly the billboard and it said the reasons to get tested and described the risks.”*
- *“The billboard caught my attention (graphics)-I drive past it everyday.”*
- *“To get tested.”*
- *“How HIV is contracted. That HIV and AIDS are not the same thing. You can be HIV positive and still not have AIDS. Although the first leads you to the second.”*
- *“That it is important to be careful, use abstinence or a condom and get tested if you think that there might be a chance that you have it.”*
- *“Why I practice safe sex.”*
- *“People crying, people of different ages, different races.”*
- *“Free confidential testing, News programs on CNN and MSNBC really have affected me as well.”*
- *“Magic Johnson.”*
- *“Scared me.”*
- *“HIV can be prevented-abstain and or use condoms.”*
- *“Encouraging safe sex, abstinence, testing the high risk homosexual men.”*
- *“Glad to see it, makes people more aware of HIV, good job.”*
- *“HIV doesn’t discriminate, it’s for life, the disease process is not fun or good, no cure.”*
- *“HIV does not discriminate, get tested.”*
- *“That it is scary because you can be an innocently infected.”*
- *“I remember a poster saying HIV doesn’t discriminate*
- *“Most people that infect others don’t know that they are infected themselves.”*
- *“To get tested often.”*
- *“Blood contact, I.V. drug users and risks.”*
- *“Practice safe sex-condoms.”*
- *“In random places/businesses, there are posters about having safe sex hanging up. I haven’t seen a billboard in this state that I can recall. The commercial I saw was awhile ago and it was about abstinence.”*
- *“How real it is in Montana, and that it is out there. It scared me.”*

- “Getting tested is the best thing to do.”
- “A commercial about the international HIV testing day.”
- “I liked the message.”
- “Need to be tested.”
- “Get tested now, HIV doesn’t discriminate.”
- “The fact that it was so simple to get tested, everyone can do it.”
- “That anyone of us can have it.”
- “Get tested with a local phone number and location.”
- “General advice about HIV.”
- “I liked all the messages.”
- “Lot’s of things, they are all over work.”
- “To get tested.”
- “Get tested, HIV does not discriminate.”
- “The importance of getting tested.”

Campaign Effect

Survey respondents (n=72) were asked if the media campaign affected them in any way. Respondent reported the following about campaign effect:

- 53% (n=38) agreed the media campaign did have an affect on them.
- 19% (n=14) felt the media campaign somewhat affected them.
- 18% (n=13) did not feel the media campaign had an affect on them.
- 10% (n=7) were not sure if the media campaign had an affect on them.

Type of Campaign Effect

Survey respondents were asked to identify the type of effect the HIV Prevention Social Marketing Campaign had on them. The respondent’s answers are reported below in Table 13. The number of respondents who identified more then one effect accounts for percent of respondents equaling more then 100%.

When asked what type of effect the campaign had on them, respondents in the intervention communities reported 159 total campaign effects. A total of 49 respondents (68%) reported the type of effect the campaign had on them. The majority of respondents (43) reported getting tested for HIV as the main effect of the campaign. Two other types of effects most frequently reported were: getting more information about HIV (20) and becoming more aware of HIV in Montana (22).

Table 13. Type of Campaign Effect for Kalispell and Butte (n=49)

Campaign Effect	Frequency of Reported Type of Effect
I got tested for HIV	43
I changed my sexual behaviors	15
I got more information about HIV	20
I am more aware of HIV in Montana	22
I use condoms more frequently	12

I know my HIV status	19
I know my Hepatitis C status	4
I no longer share needles	1
I talked to my partner about HIV	8
I asked my partner to get tested	10
Other*	5
Total Types of Effects Reported	159

*Other responses included: “media campaign had nothing to do with my testing”, “I got to school and I know I need to be careful in the medical field”, “I don’t engage in any risky behaviors”, “encouraged friends to get tested”, and “hasn’t affected me.”

Campaign Message Agreement

This section of the survey included 16 questions. Each question was a statement developed from the HIV Prevention Social Marketing Campaign messages. Participants read each statement and responded by checking one of the following: agree, disagree, or not sure. Overall campaign message agreement was 93% and higher for 10 of the 16 campaign messages. The following messages had less than 90% agreement: there is no cure for HIV/AIDS; it is important to get early treatment if infected with HIV; condoms can protect me from HIV; it is the responsibility of HIV positive individuals to protect others; in Montana, HIV positive individuals are supported by their medical community; and HIV positive individuals don’t need to apologize for having HIV.

Campaign Message Agreement

Each campaign message statement is listed below. Respondent’s answers are reported in Table 14 below.

Table 14. Campaign Message Agreement for Kalispell and Butte (n=72)

Campaign Message	Agree % (n)	Disagree % (n)	Not Sure % (n)
I can become infected with HIV in Montana	94% (68)	5% (3)	1% (1)
HIV doesn’t care what your sexual orientation is	94% (68)	3% (2)	3% (2)
HIV does not discriminate, heterosexual women are affected too	95% (69)	1% (1)	5% (3)

HIV positive people exist in Montana	99% (71)	1% (1)	0% (0)
Anyone can contract HIV/AIDS	93% (67)	6% (4)	1% (1)
Protecting myself, my family, and my friends means knowing my HIV and Hepatitis C status	98% (70)	1% (1)	1% (1)
I can help stop the spread of HIV/AIDS	94% (68)	3% (2)	3% (2)
There is no cure for HIV/AIDS	76% (55)	8% (6)	16% (11)
It is important to get early treatment if infected with HIV.	85% (61)	1% (1)	14% (10)
If I am sharing needles I am at risk for HIV	99% (71)	0% (0)	1% (1)
If I am engaging in unprotected sex I should get tested for HIV	98% (70)	0% (0)	2% (2)
Condoms can protect me from HIV/AIDS	72% (52)	11% (8)	17% (12)
It is the responsibility of HIV positive individuals to protect others	86% (62)	10% (7)	4% (3)
In Montana, free and anonymous HIV testing is available	98% (70)	0% (0)	2% (2)
In Montana, HIV positive individuals are supported by their medical community	67% (48)	4% (3)	29% (21)
HIV positive individuals don't need to apologize for having HIV	75% (54)	2% (2)	23% (16)

Chi-Square Data Analysis

Data analysis was conducted using a chi-square test for independence in a cross-tabulation of variables. The observed counts and percentages in a cross-tabulation describe the relationship between two variables in a sample. A chi-square test is a non-parametric test of statistical significance. This test indicates the level of confidence with which the study sample can be generalized to the larger population in which the sample came. The chi-square test for independence in a cross-tabulation indicates if the two variables are independent. Independence is defined as the probability that a case falls into

a particular cell of a table and occurred by chance alone (Norusis, 2005). Therefore, if the chi-square test indicates significance then there is an association between the two variables that did not occur because of chance alone. A chi-square data analysis for the intervention communities was calculated in three major areas: decision to test, campaign media channels, and type of campaign effect.

Decision to Test

The survey assessed whether or not the campaign contributed to an individuals decision to test for HIV. A chi-square test for independence was calculated comparing the frequency of the HIV Prevention Social Marketing Campaign contributing to the decision to test for HIV for individuals that had and had not been previously tested for HIV. A significant association was found ($\chi^2 (1) = 8.842, p > .05$) for individuals that had not previously tested. Individuals that had not been previously tested for HIV were more likely to get tested for HIV after seeing the campaign (80%) compared to individuals that had been previously tested (42%).

Media Channels

A chi-square test of independence was calculated comparing the frequency of being affected by the HIV Prevention Social Marketing Campaign to each of the campaign media channels (commercials, billboards, posters, and theatre slides). A significant association was found for commercials ($\chi^2 (2) = 6.500, p < .05$). Individuals that saw the HIV Prevention Social Marketing Campaign commercials (62%) were more likely to report being affected by the campaign than individuals that had not seen the campaign commercials (41%). No significant association was found for billboards ($\chi^2 (2) = 3.476, p > .05$), posters ($\chi^2 (2) = 4.974, p > .05$), or theatre slides ($\chi^2 (2) = 3.476, p > .05$).

Therefore, seeing billboards, posters, or theatre slides and the frequency of individuals reporting being affected by the campaign appear to be independent events.

Type of Campaign Effects

A chi-square test of independence was calculated comparing the most frequently reported types of campaign effects for individuals that were or were not previously tested. Survey respondents were asked to check all the types of effects the campaign had on them. The types of effects most frequently reported in the intervention communities by survey respondents were, getting tested for HIV, becoming more aware of HIV, and getting more information about HIV. A significant association was found ($\chi^2 (1) = 4.034$, $p < .05$) for getting tested for HIV. Individuals that had not been previously tested were more likely to get tested after seeing the campaign (75%) than those individuals previously tested (51%). A significant interaction was found ($\chi^2 (1) = 3.914$, $p < .05$) for becoming more aware of HIV in Montana. Individuals that had not been previously tested became more aware of HIV in Montana after seeing the campaign (43%) compared to individuals that have been previously tested (21%). No significant association was found ($\chi^2 (1) = .361$, $p > .05$) for getting more information about HIV.

A chi-square test of independence was calculated comparing the frequency of the type of campaign effect for male and female. There were two significant associations found for talking to my partner about HIV ($\chi^2 (1) = 3.746$, $p < .05$) and asking my partner to get tested ($\chi^2 (1) = 6.465$, $p < .05$). Women were more likely to report the effect of talking to their partner about HIV (19%) than men (5%). Women were also more likely to report the effect of asking their partner to get tested for HIV (26%) than men (5%). Chi-square test of independence was calculated comparing the frequency of type of campaign

effect for age and ethnicity. No significant association was found for age and type of effect of ethnicity and type of effect. Therefore, ethnicity and type of effect as well as age and type of effect appear to be independent events.

Focus Group Results

The purpose of the focus groups was to qualitatively explore more in-depth responses to the surveys questions. Focus groups were used to gather more information about opinions, perceptions, and suggestions for Montana's HIV Prevention Social Marketing Campaign in the intervention communities. Focus groups are a crucial method of investigating individual's reactions to programs and practices.

Demographics

The focus groups took place in Butte and Kalispell and included 14 participants: 13 men and one woman. All participants identified as homosexual. Age of the participants, male and female, ranged from 22-90.

The Butte focus group included nine participants' ages ranging from 22 to 58 years of age. Four of the participants were under 28 and the remaining five participants were over the age of 35. All participants in the focus group were white (non-Hispanic). All participants were from Butte and five of the nine participants were HIV positive.

The Kalispell focus group included five participants' ages ranging from 39 to 90 years of age. Three of the participants were under the age of 45 and the two remaining participants were over the age of 45. All participants were male, from Kalispell, and identified as homosexual. All participants in the focus group were white (non-Hispanic).

Results

The following information is a summary of what was discussed in the focus groups on June 30, 2006 and August 2, 2006. The information from the focus group follows the topic guided questions asked during the focus group and is presented in an abbreviated format.

Have you seen any media information about HIV recently in Kalispell or Butte?

Butte Focus Group

All of the participants agreed that they saw media information about HIV recently in Butte. Participants also said they saw media information recently in Anaconda also. Participants said they saw commercials, billboards, posters, and theatre slides.

Kalispell Focus Group:

All of the participants agreed that they have seen media information recently about HIV in Kalispell. Five of the six participants said they have seen a billboard, and four participants said they have seen commercials on television.

What do you know about Montana's HIV Prevention Social Marketing Campaign?

Butte Focus Group:

Six of the nine participants said they were familiar with Montana's HIV Prevention Social Marketing Campaign. Familiarity was based on seeing recent media information about HIV tailored to Montana, or hearing about the Campaign through social networks. When asked to describe Montana's HIV Prevention Social Marketing Campaign several participants said that the emphasis of Montana's HIV Prevention

Social Marketing Campaign is to know your HIV status and provides information about local testing sites in Butte. Quotes included the following:

- *“It’s a campaign to educate the public about HIV and provide information about getting tested.”*
- *“All the information gives a location and a number about where to get tested locally.”*
- *“It reminds the public that it is important to know your status.”*

Kalispell Focus Group:

Three of the five participants said they were familiar with Montana’s HIV Prevention Social Marketing Campaign. When asked about the campaign, participants said the campaign has funded the billboards and commercials they have seen. One participant said it is a local campaign since it provides information locally about testing sites and where you can go to get more information about HIV. Quotes included the following:

- *“The campaign emphasizes getting tested, and all the media information contains number or locations where individuals can go locally for tests or more information.”*
- *“The campaign reminds people about risks for HIV.”*

What types of media information have you seen most frequently in Kalispell or Butte?

Butte Focus Group:

Participants overwhelmingly agreed that they have seen commercial’s most often. Members agreed they have seen the two Steve commercial the most frequently in Butte. Participants said they have seen the two Steve commercials, HIV positive women commercial, and another commercial about “using needles.” There were only two participants whom reported seeing the commercial about “using needles.” Two participants mentioned that they do not have a television or that they do not watch much

television. These participants agreed that they have seen more posters than any other type of media information in Butte. They said the posters are in a lot of bathrooms in local bars, in adult bookstores, and always grab their attention.

Kalispell Focus Group:

All participants agreed they saw billboards the most frequently in Kalispell. Two participants mentioned that the billboard locations were in such central locations that they saw them daily. The four participants who had seen commercials said they have seen the HIV positive women and the Steve commercials most frequently. The two participants who had not seen any commercials mentioned they both have dish satellite; therefore they do not get the local network channels.

Campaign Message Recall

Butte Focus Group:

Most participants recalled the messages from both of the Steve commercials because they have seen them the most and because they relate to the messages. Participant's remembered that the commercials were made in Montana and that Steve identified himself as becoming HIV positive in Montana. The main message recalled by participants from Steve's commercials was, "HIV is in Montana." The female participant remembered the message from the HIV positive women commercial clearly; she said that the message "reminds us that it can be anyone." Some of the other male participants said they had seen the HIV positive female commercial but, did not pay attention to the content because it did not relate to them. Participants also remembered that the billboards in Butte displayed the risk factors associated with HIV; they said the colors grabbed their

attention. One participant also remarked that one of the posters he had seen around town says “there is no cure for HIV.” Quotes included the following:

- *“Steve’s commercial was powerful, the more you see it the more it sinks in.”*
- *“The one I saw today about HIV positive women said, we’re your neighbor, your teacher, your friend, it’s everybody, I like that part of the message. It reminds us that it can be anyone.”*
- *“On the posters, the thing that I noticed that I thought was really important is that there is no cure. I think people still have that impression that it is not as dangerous as it used to be.”*
- *“Steve’s commercial really hits home.”*
- *“The commercial with Steve stood out to me when he said that he does not apologize for having HIV.”*

Kalispell Focus Group:

All participants recalled that the billboard listed a couple of risk factors like sharing needles or unprotected sex, and had the Public Health Departments number on it. One participant also mentioned that HIV was written in the state of Montana on the billboard, which really grabbed his attention. Another participant discussed “unprotected sex” caught his attention but was surprised that the billboard did not have the typical visual cues associated with HIV, such as a ribbon or red writing. The four participants who had seen the commercials remembered the following messages: “HIV is in Montana” and “HIV does not discriminate.” Quotes included the following:

- *“The billboard listed a couple of risk factors unprotected sex and sharing needles and then said please gets tested with a number.”*
- *“The billboard has HIV in the state of Montana, which is what really grabbed my attention and is how I knew it was a local campaign for Montana.”*
- *“The two commercials with the same guy in it seemed to have similar messages saying the HIV is in Montana because he contracted HIV in Montana. I think people have forgotten about HIV especially in Montana so this is good.”*

- *“The other commercial with the women, the one message I liked and remember is HIV doesn’t discriminate, it makes you feel differently about HIV.”*

If you have seen the HIV Prevention Social Marketing Campaign, how do you feel it has affected you?

How has the Campaign affected you positively?

Butte Focus Group:

Participants agreed that Montana’s HIV Social Marketing Campaign has had an effect on them because there seems to be a lack of HIV prevention information in Butte. One participant commented that they have not seen any other media information about HIV in Butte for over ten years. Two participants commented that they have been traveling a lot in the Northwest this year and have not seen any other HIV campaigns, so they felt the Campaign is very unique to Montana. Participants agreed that the one of the positive affects of the Campaign is that it serves as a reminder that “HIV is in Montana.” Participants who were HIV positive shared this was a big contributing factor to the behaviors that put them at risk for HIV. They commented that even today, people feel “you are safe if you’re from Montana.” One participant shared that just last week, someone assumed he was safe on the internet because he was from Montana. Participants overwhelmingly agree that this is an important message to disseminate.

Another positive affect of the campaign discussed, was how the campaign generates discussion about HIV in households and in social settings. Participants also felt the media attention to HIV the campaign creates, reminds individuals that HIV still exists. Participants also commented that the Campaign message “there is no cure” is also

important to disseminate to the public. They remarked this is important because many people, especially young people, think there is a cure or will be a cure soon, so they are not as worried about contracting HIV or protecting themselves.

Another positive affect of the campaign that was discussed among participants was that it provides information about how to protect yourself against HIV and where to get tested. One participant commented that just having a reminder such as seeing a commercial, poster, or billboard makes the public think about what behaviors put them at risk. If they are at risk, the participant believes the campaign will motivate them to get tested. Quotes about the positive affects of the campaign included:

- *“I didn’t think the Campaign personally affected me, because I am already positive and protect myself. But I do appreciate the campaign because there has been a long period of time when HIV has not been discussed and I think it is really important for that discussion to take place.”*
- *“One thing that the Campaign has done for me personally is that it has caused a lot of conversation in our household about HIV, STD’s, and safe sex. It has opened a pathway for discussion with my fourteen year old son that wasn’t there before.”*
- *“It’s been a long time since I have seen any type of information about HIV in Montana, it is nice to see.”*
- *“When I would tell people I was from Montana, people would consider me safe because no one thought HIV was in Montana.”*
- *“I think the commercial has an affect on the younger generation, like me, who don’t seem to be as concerned with the threat of HIV. We were more concerned with not having sex period, which was taught to us, not with the risks associated with sex.”*
- *“The Campaign also provides a lot of information about how to protect yourself and where you can get tested, which is very useful information for the public to know.”*

Kalispell Focus Group:

Participants discussed how there is not a lot of information any more about HIV. They also mentioned since the campaign was tailored to Montana they felt like it affected them more then if it would have been a national campaign. All participants agreed that

the campaign reminds the public that “HIV is in Montana, it’s everywhere.” Another participant mentioned that a lot of people used to and might still think HIV is a gay disease; he thinks the campaign has opened a lot of peoples mind. Two participants discussed that the billboard almost served as a daily reminder about their behaviors. One participant mentioned that he got tested after seeing the billboard and the commercial a couple of months ago. Quotes included the following:

- *“There doesn’t seem to be a lot of information about HIV anymore, it seems as though people have forgotten about it. I would say the most positive affect of the campaign for me was the reminder that HIV is in Montana, it’s everywhere.”*
- *“I saw the billboard almost everyday, and everyday I thought about my behaviors and my personal risks.”*
- *“After seeing a commercial and the billboard that I pass by daily, I got tested. It had been five years since my last test and when I started thinking about it I couldn’t believe it had been that long.”*
- *“Most people used to think and some certain ones might still think, HIV is a gay disease. I think the campaign will open peoples mind and they will understand that it does not discriminate.”*

How has the Campaign affected you negatively?

Butte Focus Group:

Four participants felt negatively about several aspects of the two Steve commercials. These participants know Steve and know that he no longer lives in Montana, so they feel as if the commercial is outdated for that reason. The other reported negative effect from the Steve commercials was how healthy and happy he looked; three older HIV positive participants felt that this made the threat of HIV seem meaningless. These participants felt both the Steve commercials painted a surreal picture of the reality of living with HIV, and were concerned the public would perceive having HIV incorrectly.

The second topic debated by participants was Montana's Meth Campaign. A few older participants discussed how in the early days of HIV prevention, commercials and literature contained the same type of scare tactics as the Meth Campaign uses. The HIV media at that time depicted a skinny, frail person with lesions all over their body. Participants mentioned that two decades ago that was the "face of AIDS", and it was real. Three older participants felt that Montana's HIV Prevention Social Marketing Campaign should show the dark side of HIV because they feel this is an effective way to reach the public about the threat of HIV. The other participants commented that the face of AIDS today is much different and this approach would not work. They felt Steve is the face of AIDS today, and the other participants feel that such a healthy, happy face paints the wrong picture. However, some participants felt that this is a positive effect of the Campaign instead of a negative effect. These participants said showing a face like Steve with HIV, might make people think about how today you cannot recognize the face of AIDS. Such a message might make people think about how the happy and healthy looking person they brought home from the bar last night, could be the face for AIDS. Participants were mixed in their thoughts about how the face of AIDS should be depicted and whether or not this was a positive or negative affect of the Campaign. Quotes included about the negative effects of the Campaign included:

- *"The thing for me that was negative is knowing Steve personally, and that he doesn't even live in the state anymore. But I guess in a small state like this you are bound to everyone, no one is anonymous."*
- *"In the old days of the HIV campaigns, fear tactics were used. They showed skin and bones, lesions, and I think it was affective in the beginning but I think it also made a lot of people angry."*
- *"Maybe we need more fear tactics, because we live in a culture surrounded by death and people feel that they will die somehow anymore, and the threat of HIV isn't real anymore."*

- *“Showing a commercial with Steve looking happy and healthy instead of showing the mental effects and all the other side effects of HIV would paint a different picture. Although today, people are taking all sorts of regimens and do typically look like Steve. Having people look like that and that represent HIV might help drive the epidemic rather than preventing it.”*
- *“Steve looking healthy and happy could also be a reality check for people to. Because that guy I went home with last week from the bars looked healthy and happy and he could be positive for all I know. That could be him. And this could make people question those around them. Anyone can have HIV and today, you can’t tell by their appearance.”*
- *“Steve and those of us that appear healthy are the new face of AIDS, but there is a lot of associated effects that you cannot see and people don’t know about, and I don’t want people to forget about that.”*

Kalispell Focus Group:

When asked about negative aspects of the campaign participants agreed the only thing about the campaign which was negative was not using the typical visual cues for HIV. They felt that since the billboard did not have a ribbon or red lettering many people might pass by and read the message but not understand it was about HIV. One participant reminded the group the billboard did have HIV in the state of Montana, but participants agreed visually, even this did not stand out to them until seeing the billboard several times. Quotes included the following:

- *“I can’t think of a negative impact of the campaign.”*
- *“I guess the only thing I would say has to do with the graphics of the billboard; I think it should have had red lettering or a ribbon to signify HIV. Without these associations people might not think about HIV.”*

At this point in the focus group the HIV Prevention Social Marketing Campaign’s five commercials were shown one at a time. After each commercial participants were asked to discuss their initial reactions to the commercial and the commercial messages.

What are your initial reactions to the commercials?

Commercial 1: Steve 1

Butte Focus Group:

Participants liked the visual effects of the Steve 1 commercial, however as discussed previously half of the participants felt that the commercial paints a “fluffy picture of HIV.” They felt the commercial was very well put together, and the messages were important, but were distracted by “happy, go lucky Steve.” These members agreed that the tone of his voice and the ease of the messages rolling off his tongue leave the viewer feeling neutral about HIV. These participants agree that this aspect takes away from the importance of the messages. However, as discussed previously several members disagreed with this and believe that Steve represents how a HIV positive person looks and acts today. All participants agreed that the messages in this commercial were important and need to be disseminated.

Kalispell Focus Group:

Participants overwhelmingly agreed they liked the feel of this commercial and how the messages were presented. One participant mentioned how the colors and music create a comfortable way to present the messages, which for most people is an uncomfortable subject. Participants also discussed how most people think of Montana to be a cowboy state with no gays, therefore these messages are important to counter such believes.

Summary:

Participants in the two focus groups were mixed in their opinion about this commercial. The Butte focus group participants agreed with the messages but felt the way they were presented took away from the affect of the commercial. They felt the

music, the colors, and Steve painted a fluffy picture of HIV. However, members of the Kalispell focus group liked the comfortable way the messages were presented. They did not feel this took away from the message, but felt the commercial might make the information more comfortable for the viewer.

Commercial 2: Steve 2

Butte Focus Group:

Participants liked this commercial much better than the first, they felt Steve was more sincere and had a sense of urgency to stop the spread of HIV. All of the HIV positive participants appreciated the part of the commercial where Steve says that he does not apologize for having HIV, but does take responsibility. These individuals agree that this is an important message for the public to understand and will hopefully reduce some of the stigma's associated with being HIV positive in Montana. Some participants did not agree with the message of support from family, friends, and the medical community in the commercial. Members said support from the medical community depends on where you live, and that most family physicians do not always know how to treat HIV or they are scared to treat it. One participant mentioned that he almost feels like the medical community is judgmental and fearful of positive people and, that this prevents effective treatment and care. Participants also feel that today there is less support from friends and especially from their peers. Participants explained that being supported is a complicated issue, and most do not feel that they are supported until they were sick. Several participants also commented that being supported depends on where you live, and that their experience in Butte could be completely different than someone who is positive living in another part of Montana. An interesting issue that arose from this discussion is

that most of the rejection felt when revealing their status came from individuals in their own community. People in their own circle, engaging in the same behaviors, were the first to reject them and not to offer support. However, despite disagreement with the message that all people are supported equally my Montana's medical community, participants believe this message could potentially help gain more support for those individuals that feel they are not supported. One HIV positive individual discussed how this commercial message is an important consequence of becoming positive that most people don't understand or think of. Other participants agreed this is important message for individuals to understand.

Kalispell Focus Group:

Participants mentioned that the messages were different from the first commercial and this commercial had more of a sense of urgency. All participants mentioned they really liked the message "I did not take the risk seriously." Participants mentioned that having this message at the beginning of the commercial made it more "real" than the first Steve commercial. Two participants mentioned the message of support is important because often times in a rural state people expect to be shunned for a positive status and this is not always the case. Participants also agreed this commercial is more up close and personal than the first, and would most likely grab more people's attention. Participants also felt when Steve says he doesn't apologize for having HIV, but it is his responsibility to protect others is the strongest message in this commercial. Participants also liked how this commercial said testing was free and confidential because both of these factors are huge for gay men in Kalispell.

Summary:

All focus group participants agreed this commercial is more personal and powerful than the first Steve commercial. Participants felt Steve had more of a sense of urgency than he did in the first commercial. They also felt the messages were a lot stronger and grabbed your attention more than in the first commercial. Butte focus group participants did not necessarily agree with the message of being supported by friends, family, and medical community. However, they did discuss how this is different wherever you live in Montana. Kalispell participants felt this is an important message to disseminate in a rural state like Montana, because most people don't think this would happen in a "cowboy state."

Commercial 3: Down-Low

Butte Focus Group:

Participants were a little confused by this message and felt like the commercial was too busy to understand the message the first time they saw the commercial. After members viewed the commercial a second time, they understood the commercial was targeting the Down-Low populations. Participants thought the interaction between the two men was a little too ambiguous and did not reveal a real interaction took place between them. They felt this interaction should be stronger between the men to express the Down-Low. One participant mentioned that being on the Down-Low is all about sex, there is no foreplay or interaction, just sex. Four of the older participants discussed how they were thrown off, because Down-Low to them means in a hotel room and most men on the Down-Low would not go to a bookstore for fear they would be seen in public.

However, all participants did agree that being on the Down-Low probably means different things in different places.

The majority of participants agreed they did like how a large part of the message was focused on what these men are bringing home to their families, because that is the consequence of being on the Down-Low. This consequence is not thought of by the Down-Low man. Two participants commented on how the heterosexual HIV positive women population is growing because of men being on the Down-Low and not thinking about the consequences. These participants said that the commercial focused on the important message of knowing what you're bringing home to your family.

Kalispell Focus Group:

Participants did not understand the message of this commercial until they watched it a second time. After the second time, one participant said the commercial was about how HIV is not just a gay disease but affects families also. Two other participants identified the commercial targeting men on the Down-Low. Participants mentioned that they probably would not have gotten the messages if they were not gay men or on the Down-Low but discussed how if you were on the Down-Low the commercial would probably grab your attention. One participant mentioned that the commercial "does not scream at anyone" and might be too subtle to catch anyone's attention. Participants did agree that the spotlight's, the music, and all the scenes paint a confused, sad feeling for the viewer.

Summary:

In both focus groups, participants were a little confused about the messages of the Down-Low commercial. After seeing the commercial a second time, the majority of

participants understood who the commercial was targeting. Participants did mention the commercial does not grab your attention, and the interaction between the two men is too ambiguous for those outside the gay community to understand what is taking place. However, both focus groups discussed if you were a guy on the Down-Low you would understand the messages and the commercial would most likely grab your attention. The Butte focus group participants liked how the commercial focused on the family at the end; they felt this is an important message for the Down-Low man to consider.

Commercial 4: IDU

Butte Focus Group:

Participants really liked this commercial, the graphics, the upbeat feel, and the messages. They also liked how the commercial messages built on one another and appreciated the message of self-respect. Many members also liked how the commercial did not condone using needles but encouraged using clean needles. Participants discussed how this is an important message for Montana since the state does not have a needle exchange program, so in order to be safe you have to clean your needles. Participants also liked how the commercial combined male and female actors so that the messages targeted everyone.

Kalispell Focus Group:

Participants overwhelmingly agreed they liked the upbeat and positive feel this commercial presents. One participant described how the message of a good self-esteem stands out in this commercial. He explained that even though this guy on the commercial is doing things people might not agree with it, he believes in himself and takes care of himself. All participants agree that this message is important to disseminate to reduce

stigma associated with drug-use. Participants also discussed how they think the upbeat feel and the people in the commercial will attract a lot of youth. One suggestion for visuals on this commercial was to have “stop the spread of HIV” stand out more at the end of the commercial.

Summary:

Participants in both focus groups overwhelmingly agreed they liked the upbeat and positive feel of the commercial. Participants liked how the message of self-respect did not condone any of the behaviors associated with drug use. Participants liked the production of the commercial and how all the different faces attract everyone, even youth.

Commercials 5: HIV Positive Women

Butte Focus Group:

The only negative initial reaction to the commercial was concerning commercial production, and participants were mixed in their views. Some members felt that the women in the commercial should have been the same women at the end, in order to show her as a friend, neighbor, or mother. Other liked all the different face of women because it really brings home the message that it can be anyone of us. Participants overwhelmingly agreed this message was the strongest and the most important because it could prevent judgment if everyone believed it. Members agree that the message in the commercial emphasis how “the face of AIDS” is changing to include women. Participants liked this concept because it reminds the public that every gay man is not positive and there are many new faces of AIDS.

Kalispell Focus Group:

The participants liked how this commercial showed all the possibilities one person can be. They discussed how the commercial makes you realize how everyone is your friend, mother, or neighbor and just because you don't like them doesn't mean that you can judge them. One participant discussed how this commercial also helps people understand that the course of HIV and who it affects has changed, and it can be anyone. Participants also discussed that this message has the potential to reduce stigma against gay men and against HIV positive people.

Summary:

Participants in both focus groups really liked this commercial. Everyone agreed the message "it can be anyone of us" is important to reduce stigma associated with HIV. Participants in the Butte focus groups were mixed in their views about the production of the commercial and all the different faces it shows. However, overall participants agree this message is one of the most important messages to disseminate in Montana to reduce stigma.

Have you identified with the campaign messages?

What messages do you identify with?

Butte Focus Group:

Participants for the most part identified with most of the commercial messages. They felt all the messages were necessary and important for Montana. Members appreciated how the scenery, people, and messages were distinct to Montana and believe this plays a role in making the messages "hit home" for the public. The messages most

identified with by the group were “there is no cure”, “HIV is in Montana”, and “HIV does not discriminate”.

Kalispell Focus Group:

Participants agreed that they identified with most of the campaign messages. When asked specifically what messages they identify with, they said the messages in the Steve 2 commercial. They liked how he says he doesn't apologize, takes responsibility, and receives support because this will reduce a lot of stigmas against gay men also. They also felt like the HIV positive women commercial messages has the same effect with a different message. Three participants discussed how the responsibility message is so important for our society today. It reminds us that it is everyone's personal responsibility to take care of themselves and each other because we are all living together. Participants discussed how a lot of the stigma associated with HIV in Montana stems from the connection of HIV and gay men.

What messages do you not identify with?

Butte Focus Group:

Most of the male participants stressed the fact that they turned away from the HIV positive women commercial because it did not pertain to them. Members agreed that if a message does not pertain to them they usually do not pay attention to the content. Some participants expressed a concern for young adults who see the Campaign and might not pay attention to the messages since none of the commercials or posters they have seen contain young adults. Overall, there was not a message the participants overwhelmingly did not agree with. The message of social support was the only message that participants

expressed some disagreement with and they discussed how this is a difficult issue that is not the same for every HIV positive person living in Montana.

Kalispell Focus Group:

Half of the participants agreed they did not identify with the Down-Low messages. They mentioned that is not necessarily because of the message, but because they do not encounter men on the Down-Low in their community. Another participant mentioned that these messages would not mean anything to someone who was not gay or on the Down-Low. Participants then discussed how the campaign messages are specific to different populations and that these messages will not have the same affect on someone who is not connected to the population.

Suggestions for Future Campaign Messages Targeting MSM in Montana

Butte Focus Group:

Participants overwhelmingly agreed that future media campaigns in Montana should focus on the HIV and methamphetamine (meth) connection. The meth epidemic is a current hot topic in Montana and participants feel like there is a big connection between unsafe sex and using meth. Members feel it is important to address the risks associated with using meth, the enhanced sexual drive without consequence, and the risk of contracting HIV. Some members feel that HIV is “bare backing” meth, and this is one part of the picture that is not being addressed by Montana’s HIV Prevention Social Marketing Campaign or by the Montana’s Meth Campaign.

Participants also felt like more of the commercials and billboards should focus on the message that there is no cure for HIV. Members agree that this is a very common

myth they encounter frequently in Montana. The reality of the medicine that HIV positive people take everyday and the side effects the medicine has. Participants feel painting this picture of waking up taking 32 pills, spending half the morning in the bathroom, and spending \$1200.00 a month on “meds” is necessary. Members feel that the general public just assumes that if you’re positive and on meds that everything is normal and that there will be a cure in a few years. They don’t consider the cost or the sickness associated with the disease. One participant remarked that a commercial also showing the mental effects of being HIV positive is important because a lot of people assume that if you look healthy, you are healthy. The participant discussed how there are a lot of mental struggles associated with the disease that are often hidden from the general public and is one of the hardest things to deal with. The HIV Prevention Social Marketing Campaign does have a commercial that was developed previously addressing this message however; it was not disseminated in the current Campaign. There was a poster with the message that there is no cure disseminated with this Campaign.

Another suggestion for future messages discussed by focus group participants was bug chasers. Bug chasers are defined as individuals whom seek out HIV positive individuals and want to have sex so that they can contract HIV. All participants agree that in Montana’s gay community this is becoming a large issue, especially on the internet where bug chasers ask if you want to be the “gift giver.” Some members feel this is a huge problem because some men agree to be a gift giver in order to experience sexual security, something they have not experienced since they became positive. Every gay men in the room agreed that they know someone who has been targeted by bug chasers or have been targeted themselves.

Members also discussed that it is important for the Montana's HIV Prevention Social Marketing Campaign to target youth or young adults, participants feel that this age group is not targeted with the current campaign messages. One of the participants contracted HIV when he was 18 and discussed how before he became positive he did not know the risk associated with sex, or the behaviors that put an individual at risk for contracting HIV. Other participants mentioned that the HIV Prevention Social Marketing Campaign messages are important for youth, but the commercials or media information should have youth in them to attract them to the messages.

Kalispell Focus Group:

Two participants suggested a theme of simplicity with future campaign materials. They discussed how they are inundated with so many messages on a daily basis, that keeping the messages simple will help the campaign stand out in people's minds. Participants suggested also for future campaign materials to use the visual cues associated with HIV because our minds recall things better when we make associations with a visual cue such as the red ribbon. They also suggested using visual cues gay men might be attracted to such as the rainbow colors.

All participants agreed that the message from the IDU commercial of self-respect is a great message that should continue to be one of the campaign's main messages. They feel this positive message is an "important thing to emphasize" for any at-risk population. One participant discussed how if an individual does not have confidence and feels ashamed, the individual is more likely to engage in risky behaviors to put them more at risk for HIV.

Another suggestion for future campaigns in Montana is to include information either on a commercial or billboard about the testing procedure. Participants discussed how the general public still associates the HIV test being a blood drawn test that takes two weeks before you know your results. They feel if the public understood the rapid tests, the confidentiality, and that it is free, more people would get tested. One participant mentioned it would be great to combine this information with the message there still is no cure for HIV. They believe this is also a common misconception among the public that there is a cure, when really we haven't advanced that much further than where we were twenty years ago.

What is the best way to reach gay men with HIV prevention messages?

Butte Focus Group:

Participants suggested the internet as being the best way to reach gay men with HIV prevention messages. Most members admit to spending a significant amount of time on “gay.com”, and feel that the internet will have the highest impact with gay men. All the participants did see the campaign in Butte and feel like billboards, posters (especially in bar bathrooms and adult bookstores), and commercials are effective for reaching gay men in Montana as well.

Kalispell Focus Group:

Participants overwhelmingly agreed all the types of media the HIV Prevention Social Marketing Campaign is using are effective ways to reach gay men. Participants agreed that the billboards in Kalispell have had the most impact, and suggested spending more money on billboards than commercials especially since a lot of households might

have dish satellite. One participant suggested advertising in the local paper, because it is more personal and would reach more people in the community. Another participant suggested advertising bar bathrooms with one of the advertising companies that advertises in bathroom stalls.

When you think about your favorite media campaigns or messages, what makes these campaigns memorable for you?

Butte Focus Group:

The young participants agreed the things which grab their attention are who is in the commercial (their peers), the graphics, and the music. When asked if these factors were more important than the message the participants agreed if something does not grab their attention initially then they will not pay attention to the message. One participant described that this is why the meth campaign is so popular with youth, because the campaign uses young people and is in your face, so it grabs your attention.

Two participants believe humor has a lot to do with how memorable campaigns are. Some of their favorite campaigns contain some type of “off-the-wall” humor, which grab your attention and makes them work. They did mention that humor most likely is not an option for an HIV campaign; however this is a big factor for making a campaign memorable.

Kalispell Focus Group:

Participants said buzz words or phrases such as “I can’t believe I ate the whole thing” is what makes campaigns stand out in their mind. Catch phrases or songs help associate the product with commercial, making the slogan and the campaign memorable. They also mentioned the importance of graphics, commercials without good graphics

(like a lot of local commercials) people just laugh at and do not take seriously. When participants were asked if graphics or slogans were more important they agreed the slogan was more important overall than the graphics. One participant mentioned having one primary slogan or message that is used in every commercial or on every billboard help certain campaigns stand out.

Summary of Focus Group Results

All focus group participants reported seeing at least one type of media information about HIV recently in Butte or Kalispell. All participants identified all the media channels used in these locations by the HIV Prevention Social Marketing Campaign. Nine of the fourteen participants reported familiarity with the HIV Prevention Social Marketing Campaign. In both focus groups, familiarity was based on seeing recent media information tailored to Montana with local information about where to get tested.

Focus group participants reported differently about what type of media information they have seen most frequently. The Butte participants agreed they had seen commercials the most, while the Kalispell participants agreed they have seen billboards the most frequently. Participants who saw commercials said they saw the two Steve commercials and the HIV positive women commercial most frequently. The IDU and Down-Low commercials were the only campaign commercials on late-night rotators (10:00 pm to 12:00 am) due to their content and due to the populations the campaign was targeting.

The two messages recalled by the majority of focus group participants were “HIV is in Montana” and “HIV does not discriminate.” In both focus groups participants also mentioned that the billboards displayed the risk factors associated with HIV and

discussed how the billboards served as a reminder about what behaviors put you at-risk for HIV.

The focus group participant's unanimously agreed that the main positive effect of the campaign is the reminder that HIV is in Montana. Both focus groups discussed how there has been a lack of media information recently about HIV in Montana and feel the campaign is unique for that reason. Also, participants discussed the importance of the billboards listing the risk factors associated with HIV and how seeing these daily served as a reminder of what behaviors are risky. Both of the focus group participants believe this is another positive affect of the campaign. Another positive affect of the campaign mentioned in the Butte focus group, was how the campaign has generated discussion about HIV in household and in social settings.

The focus group participants differed in their thoughts about the negative effects of the campaign. Half of the Butte focus group participants reported being negatively affected by the two Steve commercials. These participants felt Steve appeared to "healthy and happy" and think this makes the threat of HIV seem meaningless. The other half of the participants feel this is a positive affect rather than a negative affect because, it give individuals the message that today you cannot always recognize HIV. Overall, the issues participants discussed about the negative effects of the campaign were production oriented and not the content of the campaign messages.

Focus group participant's overwhelmingly agreed they identified with all the commercial messages. When asked specifically what messages participants agreed with the following messages were mentioned: "there is no cure", "HIV is in Montana", "HIV doesn't discriminate", and Steve's message of "not apologizing for having HIV" but

“taking responsibility”. Participants appreciated how all the commercials were distinct to Montana and believe this allows the campaign to really “hit home” for the public.

Overall, in the Butte focus group there was not one message that participants did not agree. Some of the male participants discussed how they did not pay attention to the messages in the HIV positive female commercial because it did not pertain to them, not because they did not agree with the messages. In the Kalispell focus group, participants discussed how they did not relate to the message in the Down-Low commercial.

Participants said they did not relate to the message because they do not encounter men on the Down-Low in their community, and therefore do not feel it pertains to gay men in Kalispell.

Participants offered an array of suggestions for future campaign messages targeting MSM in Montana such as: HIV-meth connection, more campaign material targeting there is no cure, bug-chasers, and more campaign materials targeting young adults. Currently, the HIV Prevention Social Marketing Campaign does have posters with the message there is no cure, and a commercial targeting youth-at-risk which was not shown for the 2006 campaign. This commercial is usually aired on cable channels that youth heavily view. The Kalispell focus group had the following suggestions for future commercials or billboards targeting gay men: using visual cues associated with HIV or gay men, building upon the message of self-respect for all populations, and developing a commercial or billboard about what the current HIV testing procedure involves.

Participants in both focus groups overwhelmingly agreed the media channels the campaign is currently using are effective for reaching gay men in Montana. The other

suggestions participants had were the internet, local newspapers, and advertising in bathroom stalls.

Interview Results

Interviews were solicited by the outreach worker in Kalispell on a voluntary basis. The outreach worker conducted a total of four interviews during June and July 2006. The outreach worker, in the course of his normal activities, would ask individuals if they would complete an interview about media campaigns in Montana. The interviews were conducted in person and were transcribed by the outreach worker.

Demographics

All interviewees were from Kalispell and were homosexual men. Ages of the participants ranged from 47 to 61 years of age. The race of all the interviewees was white and all respondents identified their risk category as sex with a homosexual.

Results

The information from the interviews follows the topic guided questions asked and is presented in an abbreviated format.

**Have you seen any media information about HIV recently in Kalispell?
What do you know about Montana's HIV Prevention Campaign?**

Three of the four interviewees reported seeing both billboards and commercials in Kalispell. The other interviewee reported only seeing commercials in Kalispell.

What types of media information have you seen most frequently in Kalispell?

Three participants reported seeing billboards most frequently in Kalispell. One participant reported seeing commercials more frequently in Kalispell.

What do you remember about what you saw?

All of the interviewees recalled messages about getting tested or knowing you status. Quotes included the following:

- *“Know your status.”*
- *“To get tested for HIV.”*
- *“Everything I have seen is a little different, but each commercial or billboard suggests knowing your status and has local information on it.”*
- *“Please get tested.”*

What messages do you identify with? What messages do you not identify with?

Three interviewees said they identified with the message to know your status or get tested. One interviewee said he did not agree with any of the messages. All four interviewee’s recorded that there were not messages they did not identify with.

How do you feel the HIV Prevention Campaign has affected you?

One of the interviews said there has been “no change” after seeing the campaign. The other three interviewees feel the campaign has affected them positively because it gives the public the message that HIV is in Montana. Quotes included the following:

- *“It lets people in Montana know that HIV is here.”*
- *“Give’s Montanan’s the message that HIV is here.”*
- *“Informs the general public about HIV in Montana, and provides them with local places to go.”*

Are there any additional messages for future HIV prevention campaigns that you can suggest?

One participant said there were no new messages that he could suggest for future media campaigns. Two of the participants said to “continue with the media campaign” and that there were no new messages they could suggest. One participant suggested a

message to “tell your status to others before having sex, or to ask someone’s status before having sex.”

Please take a moment to think about past media campaigns that you have seen, what made these campaigns work for you?

Two interviewees said posters are what have made past media campaigns work for them. One respondent said “posters everywhere you look” so they are reminded continually about the campaign or the message. One respondent said “forward information” is what grabs his attention. The other respondent said “campaigns that use all media avenues” have made past campaigns stand out in his mind.

What is the most effective way to reach you with HIV prevention information?

Three respondents said television was the best way to reach them with HIV prevention information. The other respondent said “in depth information instead of thirty second commercials” would be the best way to reach him with HIV prevention information.

Results for the Comparison Community

Lewis and Clark County served as the comparison community for this study, and did not receive the HIV Prevention Social Marketing Campaign. Helena is similar in size and mean income to Kalispell and Butte. The following section includes the HIV testing data and survey results for the comparison community.

HIV Testing Data

For Lewis and Clark County, HIV testing data was collected for the same time periods as the intervention communities. Data was compiled in an Excel spreadsheet and graphs were composed. HIV monthly testing averages are provided for January to March (the months prior to the campaign), April to July (the months during the campaign), and for January to July. The HIV monthly testing numbers decreased in the first half of 2006 in Lewis and Clark Counties. For Lewis and Clark County, the 2006 HIV monthly testing means decreased for all time periods in 2006 compared to 2005 and did not exhibit any trends in the 2006 testing data. The percent increase in monthly HIV tests was higher (18%) for 2005 then in 2006 (12%). The percent change in monthly HIV tests was very similar for both 2005 and 2006 in Lewis and Clark County. The following graph (Graph 4) shows the 2005 and 2006 monthly testing numbers for Lewis and Clark County.

Graph 4. HIV Monthly Testing Numbers in 2005 and 2006 for Lewis and Clark County (Comparison Community)

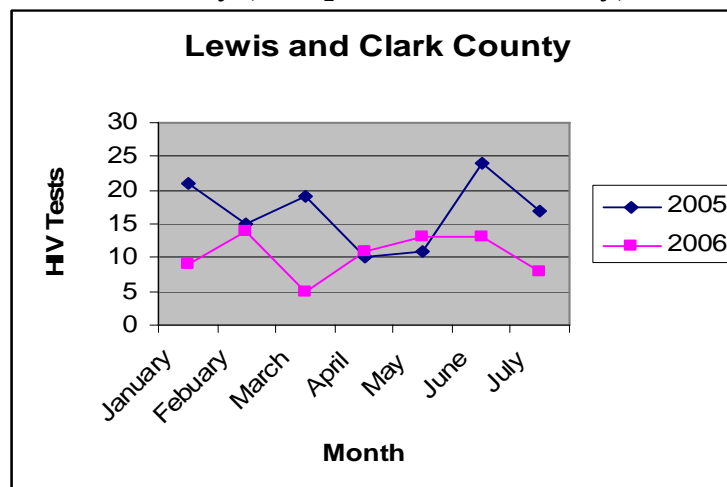


Table 15. Monthly HIV Testing Numbers and Percent Increase for Lewis and Clark County

Month	2005 HIV Tests	Percent Increase	2006 HIV Tests	Percent Increase
January	21		9	
February	15	(-6%)	14	8%
March	19	4%	5	(-14%)
April	10	(-9%)	11	9%
May	11	1%	13	3%
June	24	13%	13	0%
July	17	(-7%)	8	(-8%)
Total	100	18%	65	12%

Table 16. HIV Monthly Means Averages for Lewis and Clark County

	2005	2006
January-March	18	9
April-July	16	11
January-July	17	10

Survey Results

A total of sixteen surveys were completed in Helena at the Lewis and Clark County Health Department and by outreach workers on National HIV Testing Day on June 27, 2006. Surveys at the Lewis and Clark County Health Department were collected between April 2006 and July 2006. Helena served as a comparison group because the community did not receive the HIV Prevention Social Marketing Campaign.

Demographics

This section of the survey included nine questions. Individuals were asked to provide the following demographic information: age, gender, sexual orientation, race/ethnicity, risk exposure, previously tested for HIV, reasons for not previously testing for HIV, length since last test, and decision to test.

Age and Gender

Respondents reported age as follows (n=16):

- Mean age is 31.
- Age ranged from 19 to 54 years old.

Respondents reported gender as follows (n=16):

- 44% were female (n=7)
- 56% were male (n=9)

Ethnicity

The ethnicity of survey respondents is listed in Table 17 below.

Table 17. Ethnicity for Helena (n=16)

Ethnicity	Percent of Respondents	Frequency
Native American	6%	1
Asian/Pacific Islander	0%	0
African American	6%	1
White (non-Hispanic)	88%	4
Hispanic	0%	0
Other	0%	0

Sexual Orientation

The sexual orientation of respondents is listed Table 18 below.

Table 18. Sexual Orientation for Helena (n=16)

Sexual Orientation	Percent of Respondents	Frequency
Heterosexual	56%	9
Homosexual	44%	7
Bisexual	0%	0
Other	0%	0

Risk Exposure Categories

Respondents were asked to check all of the risk exposure categories that applied to them. Respondents were asked to check all categories that apply. This accounts for the percent of respondents equaling more than 100%. The risk exposure categories of respondents are listed in Table 19 below.

Table 19. Risk Exposure Categories for Helena (n=16)

Risk Exposure Category	Percent of Respondents	Frequency
Unprotected sex	63%	10
Used injecting drugs	0%	0
Sex for money or drugs	0%	0
Sex with injecting drug user	6%	1
STD diagnosis	6%	1

Sex with a HIV positive person	0%	0
Sex with a homosexual	38%	6
Mother has HIV/AIDS	0%	0
Hemophilia/blood recipient	0%	0
Sex while using drugs or alcohol	38%	6

Previously Tested for HIV

Respondents were asked if they had previously been tested for HIV and if yes, what the results of the test were. The respondent's answers are presented in Table 20 below.

Table 20. Previously Tested for HIV for Helena (n=16)

Previously Tested for HIV	Percent of Respondents	Frequency
No	38%	6
Yes/Negative	62%	10
Yes/Positive	0%	0
Yes/Indeterminate	0%	0
Yes/Unknown	0%	0
Don't Know	0%	0

Reasons for Not Previously Testing for HIV

The respondents who had not been previously tested for HIV (n=6) were asked to check all the reasons for not previously testing. The respondent's answers are presented in Table 21 below. The number of respondents who identified more than one reason for not previously testing accounts for percent of respondents equaling more than 100%.

Table 21. Reasons for Not Previously Testing for HIV for Helena (n=6)

Reasons for Not Previously Testing	Percent of Respondents	Frequency
Unlikely to have been exposed through sex	66%	4
Afraid to find out my HIV status	16%	1
Didn't want to think about being HIV positive	16%	1
Worried about who would learn results	0%	0
Didn't want anyone to think I was at risk	0%	0
Worried my name would be reported	0%	0
Worried friends would react badly	0%	0
Thought I was HIV negative	50%	3

Didn't have time	0%	0
Didn't want to worry family members	0%	0
Unlikely of have exposure through drug use	16%	1
Didn't want people to think I was gay	0%	0
Didn't want people to think I used drugs	16%	1
Other	0%	0

Length since Last Test

Those respondents that had been previously tested (n=10) were asked to specify how long it had been since their last HIV test. The respondent's length since last HIV test is reported in Table 22 below.

Table 22. Length since Last Test for Helena (n=10)

Length since Last Test	Percent of Respondents	Frequency
3 months	40%	4
6 months	20%	2
12 months	20%	2
More than 1 year	20%	2

Decision to Test

Respondents were asked to respond to whether or not media information about HIV contributed to their decision to get tested for HIV. The respondent's answers are reported in Table 23 below.

Table 23. Decision to Test for Helena (n=16)

Decision to Test	Percent of Respondents	Frequency
Agree	12%	2
Disagree	56%	9
Not Sure	32%	5

Campaign Awareness

This section of the survey assessed campaign awareness and included seven questions. Individuals were asked to answer the following questions: have you seen media information about HIV, what have you seen, campaign exposure, campaign message recall, and two questions about campaign effect.

Media Information about HIV

Survey respondents (n=16) were asked if they had seen any media information about HIV. Survey respondents reported the following about seeing media information about HIV:

- 63% (n=10) reported seeing media information about HIV.
- 38% (n=6) reported not seeing media information about HIV.

Billboards

Survey respondents (n=16) were asked if they had seen a billboard about HIV. Survey respondents reported the following about seeing a billboard about HIV:

- 12% (n=2) reported seeing a billboard about HIV.
- 88% (n=14) reported not seeing a billboard about HIV.

Survey respondents reported the following about how many times they had seen a billboard:

- Of the two respondents that reported seeing a billboard, one respondent reported seeing 2 billboards and the other respondent did not report a number.

Commercials

Survey respondents (n=16) were asked if they had seen a commercial about HIV. Survey respondents reported the following about seeing a commercial about HIV:

- 25% (n=4) reported seeing a commercial about HIV.
- 75% (n=12) reported not seeing a commercial about HIV.

Survey respondents (n=4) reported the following about how many commercials about HIV they had seen:

- The maximum times respondents reported seeing commercials about HIV were four and the minimum was two.
- The mean commercials seen was 2.5.

Posters

Survey respondents (n=16) were asked if they had seen any posters about HIV.

Respondents reported the following about seeing posters about HIV:

- 31% (n=5) reported seeing a poster about HIV.
- 69% (n=11) reported not seeing a poster about HIV.

Survey respondents (n=5) reported the following about how many commercials they had seen:

- The maximum times respondents reported seeing a poster were 6 and the minimum time was 2.
- The mean posters seen was 3.6.

Theatre Slides

Survey respondents (n=16) were asked if they had seen any theatre slides about HIV.

Respondents reported the following about if they had seen any theatre slides:

- 18% (n=3) reported seeing a theatre slide about HIV.
- 82% (n=13) reported not seeing a theatre slide about HIV.

Survey respondents (n=3) reported the following about how many theatre slides they had seen:

- Of the three respondents, two did not report times seen and one respondent report seeing 2 theatre slides.

Campaign Message Recall

Survey respondents (n=16) were asked to describe what they remember about what they saw. Respondents (n=6) remembered the following things about what they saw:

- *“That every person I had sexual contact with had numerous partners before. So basically I was exposed to all of them.”*
- *“MTV commercial, poster in a gay bar bathroom.”*
- *“Poster in a bar bathroom.”*
- *“About how it (HIV) was contracted and spread.”*
- *“Made me believe that HIV is prevalent but also preventable.”*
- *“Unsafe sex and drugs (intravenous needles) can pose a serious risk.”*

Campaign Effect

Survey respondents (n=16) were asked if the media campaign affected them in any way. Respondent reported the following about campaign effect:

- 12% (n=2) agreed the media campaign did have an effect on them.
- 25% (n=4) felt the media campaign somewhat affected them.
- 57% (n=9) did not feel the media campaign had an effect on them.
- 6% (n=1) were not sure if the media campaign had an effect on them.

Type of Campaign Effect

Survey respondents were asked how the media campaign affected them, 6 respondents reported what type of effect the media campaign had on them. The respondent’s answers are reported below in Table 24. The number of respondents who identified more than one effect accounts for percent of respondents equaling more than 100%.

Table 24. Type of Campaign Effect for Helena (n=6)

Type of Campaign Effect	Frequency of Reported Types of Effect
I got tested for HIV	4
I changed my sexual behaviors	3
I got more information about HIV	1
I am more aware of HIV in Montana	2
I use condoms more frequently	2
I know my HIV status	2
I know my Hepatitis C status	2
I no longer share needles	0
I talked to my partner about HIV	1

I asked my partner to get tested	1
Other	0
Total Types of Reported Effects	18

Campaign Message Agreement

This section of the survey included 17 questions. Each question was a statement developed from the HIV Prevention Social Marketing Campaign messages. Participants will read each statement and respond by checking one of the following: agree, disagree, or not sure.

Campaign Message Agreement

Each campaign message statement is listed below. Respondent's answers are reported in Table 9 below.

Table 25. Campaign Message Agreement for Helena (n=16)

Campaign Message	Agree % (n)	Disagree % (n)	Not Sure % (n)
I can become infected with HIV in Montana	94% (15)	6% (1)	0% (0)
HIV doesn't care what your sexual orientation is	100% (16)	0%(0)	0% (0)
HIV does not discriminate, heterosexual women are affected too	100% (16)	0% (0)	0%(0)
HIV positive people exist in Montana	100% (16)	0% (0)	0% (0)
Anyone can contract HIV/AIDS	94% (15)	0% (0)	0% (0)
Protecting myself, my family, and my friends means knowing my HIV and Hepatitis C status	100% (16)	0% (0)	0% (0)
I can help stop the spread of HIV/AIDS	100% (16)	0% (0)	0% (0)
There is no cure for HIV/AIDS	100% (0)	0% /(0)	0% (0)
It is important to get early treatment if infected with HIV.	94% (15)	6% (1)	0% (0)
If I am sharing needles I am at risk for HIV	94% (15)	6% (1)	0% (0)
If I am engaging in unprotected sex I should get tested for HIV	100% (0)	0% (0)	0% (0)
Condoms can protect me from HIV/AIDS	94% (15)	0% (0)	6% (1)

It is the responsibility of HIV positive individuals to protect others	81% (13)	0% (0)	19% (3)
In Montana, free and anonymous HIV testing is available	82% (13)	12% (2)	6% (1)
In Montana, HIV positive individuals are supported by their medical community	44% (7)	6% (1)	50% (8)
HIV positive individuals don't need to apologize for having HIV	94% (15)	0% (0)	6% (1)

Chi-Square Data Analysis

A chi-square test of independence was calculated comparing the intervention communities to the comparison community for campaign message agreement. The only campaign message that showed a significant association was: “in Montana, free and anonymous HIV testing is available” ($\chi^2 (2) = 9.673, p < .05$). Individuals in the intervention communities (97%) are more likely to agree with this campaign message than individuals in the comparison community (81%). This campaign message was also the most common message recalled by survey respondents in Kalispell and Butte, and the most frequently reported campaign effect (43 of 72 respondents reported getting tested for HIV after seeing the campaign).

CHAPTER V

DISCUSSION AND RECOMMENDATIONS

Introduction

Through the integration of marketing concepts and community involvement, Social Marketing has been successful for changing the behavior of individuals on a community-wide or population-wide level. The ultimate objective of Social Marketing is to benefit target populations or society, by influencing behavior to create a positive behavior change, in order to improve quality of life (Andreasen, 1995). However, evaluation of Social Marketing Campaigns is extremely difficult and hindered by an array of factors.

It is still unknown which evaluation techniques are most effective when evaluating Social Marketing Campaigns. The primary evaluation techniques demonstrated in previous studies have been telephone hot-line calls, telephone surveys, campaign awareness measures, number of tests, and recall of campaign messages (Levy and Friend, 2000). It is imperative to combine multiple evaluation methods in order to understand the observable effects and intended outcomes of Social Marketing campaigns. This study assessed: campaign awareness, campaign exposure, campaign message recall, reported effects of the campaign, HIV testing data, desired behavior change, and reported perceptions about the campaign.

The purpose of this descriptive study was to evaluate Montana's 2006 HIV Prevention Social Marketing Campaign in Flathead and Silver-Bow Counties. The information acquired from this study demonstrated the immediate observable of effects of the HIV Prevention Social Marketing Campaign in these communities. In addition, this

evaluation serves as a learning tool for what types of future evaluations are plausible when evaluating Social Marketing Campaigns.

Surveys, focus groups, interviews, and HIV testing data were used to gather information. The evaluation design employed both quantitative and qualitative techniques for data collection. The data included information about campaign awareness, campaign effects, and campaign message recall. The data collected from surveys and HIV testing data in the intervention communities was compared to similar data from a comparison community. The following chapter consists of a discussion of the key findings, conclusions, recommendations, and suggestions for further research.

Discussion

Campaign Awareness

Campaign exposure is an important component of Social Marketing Campaigns. When evaluating media campaigns, awareness of the campaign is considered one of the primary measures of campaign success or failure. Campaign awareness indicates the level of impact the campaign generated (Peetz-Schou, 1997). Campaign awareness provides the percent of individuals who reported being aware of the campaign. The HIV Prevention Social Marketing Campaign generated 90% campaign awareness in the first four months of the campaign in the intervention communities. These results are similar to what has previously been demonstrated in the literature (Vega and Roland, 2005; Futterman et al, 2001; Holzman et al, 2005; Finlay & Faulkner, 2005; Bauman, Bellow, & Owen, 2001). Previous research has shown highly targeted Social Marketing campaigns can generally reach 45% to 88% awareness of messages, with 30% campaign

awareness being generally regarded as the starting point for the behavioral change process (Vega & Roland, 2005).

Another important aspect of campaign awareness is the promotion of the messages through a mix of media channels. Montana's HIV Prevention Social Marketing Campaign used four media channels: billboards, commercials, posters, and theatre slides. This study found between 74%-75% of individuals saw billboards, commercials, and posters. The most frequently seen media channel in the intervention communities was billboards. However, individuals who reported seeing campaign commercials were more likely to report a positive campaign effect ($\chi^2 = 6.50, p < .05$). There was no association between a reported positive campaign effect and reported exposure to billboards or posters ($\chi^2 = 3.48, p > .05$ and $\chi^2 = 4.97, p > .05$). This indicated that commercials generated more positive campaign effects than billboards, posters, or theatre slides, even though they might not have been seen as frequently.

The literature has previously demonstrated that advertising must have some type of mental effect before it can affect behavior (Vakratsas & Ambler, 1999). Individual responses to advertising through a mix of media channels are mediated by factors such as motivation, and the ability to process information. Cognition, the thinking dimension of an individual's response, and affect, the feeling dimension are the two major intermediate advertising effects (Vakratsas & Ambler, 1999). This study found that individuals who saw Montana's HIV Prevention Social Marketing Campaign commercials reported being affected by the campaign the most. This finding is important to consider because it highlights the type of impact the development of complex messages targeted towards segmented audiences can have. The higher reported campaign effects by commercials are

attributed to the quality of the developed messages in the commercials. The commercial messages are more detailed and create more mental effects in thirty seconds than what is possible with a single image such as a poster or billboard. Commercials are the most costly of all the media channels, but this data indicated they also had the highest impact in the intervention communities.

After seeing Montana's HIV Prevention Social Marketing Campaign, the majority of respondents (72%) in the intervention communities reported the campaign affected them or somewhat affected them. In the comparison community, only 37% of respondents reported the campaign affected them or somewhat affected them. The majority of respondents (57%) reported the campaign did not affect them. Taken together, these results suggest that the HIV Prevention Social Marketing campaign generated high campaign awareness and high campaign effects in the intervention communities after four months. This was a promising study result given that both of these components are necessary before behavior change can be expected to take place in the target populations.

Campaign Message Recall

An additional and important measure for campaign awareness among respondents is unaided campaign message recall. Unaided campaign message recall has been shown to be the best predictor of consumer awareness by Peetz-Schou (1997). The survey given in this study purposely did not include any specific mention of Montana's HIV Prevention Social Marketing Campaign, and only indicated the subject matter (HIV) of the campaign. Respondents were asked to describe what they remember about the HIV media information they had recently seen. This assessment was shown to be an accurate

indicator of whether the HIV media information individuals reported seeing was, in fact, Montana's HIV Prevention Social Marketing Campaign. Results indicated 58% of respondents in the intervention communities recalled the HIV Prevention Social Marketing Campaign messages. Thirty percent of individuals who completed surveys did not indicate a recalled campaign message; this could be due to two factors: the individual did not remember any campaign messages or they did not take the time to write down a campaign message. In addition, with another open-ended survey question assessing how many individuals reported seeing each media channel, only 41% of individuals indicated how many times they saw each media channel. These individuals might not have remembered an exact number or did not take the time to complete the questions. Individuals completed the close-ended question indicating they had seen each media channel, but failed to complete the open-ended question indicating how many times they had seen each media channel. Therefore, even though unaided campaign awareness recall has been shown to be the best predictor of consumer awareness, it should not be the only measure for campaign awareness, because of the low completion rate or the low level of recall by respondents demonstrated by this study.

The messages most often recalled by individuals in this study were those messages which created message novelty. Message novelty allows ads to distinguish themselves from numerous other ads impacting a viewer's attention (Levy and Friend, 2000). The two main campaign messages recalled by respondents were "to get tested for HIV" and "HIV doesn't discriminate". These messages targeted the behavior change (to get tested for HIV) and targeted HIV stigma (HIV doesn't discriminate). In addition, the two messages recalled by the majority of the focus group participants were "HIV doesn't

discriminate” and “HIV is in Montana”. The message “HIV is in Montana” targets HIV risk perception, this is an important finding because previous research with in Montana indicated a low level of HIV risk perception among rural, young MSM (Dybdal & Albertson, 2004). Dybdal and Alberston’s study demonstrated that the HIV Prevention Social Marketing Campaign commercials brought about a significant change in HIV risk perception in MSM. Since this message was also recalled by the focus group participants in the current study, this signifies that Montana’s HIV Prevention Social Marketing Campaign is continuing to increase HIV risk perception among MSM.

Montana’s HIV Prevention Social Marketing Campaign demonstrated a high level of consumer awareness due to the high unaided campaign message recall in the intervention communities. These results also indicated the messages recalled by individuals belong to Montana’s HIV Prevention Social Marketing Campaign instead of another national HIV campaign. There were only four campaign messages recalled in the intervention communities which were not messages of the HIV Prevention Social Marketing Campaign. In the comparison community, all six messages recalled by individuals corresponded to posters displaying risk factors in the health department or another national campaign not necessarily related to HIV. Therefore, the unaided level of campaign message recall in the intervention communities denotes a high level of saturation of the campaign messages and the campaign in the target populations.

Reported Campaign Effects

The basic premise of Social Marketing is that, when presented with the optimal blend of behavioral, interpersonal, and environmental cues, target audiences will be persuaded to accept the product, behavior, value, belief, or idea being promoted (Winett

& Wallack, 1996). The intangible, delayed, or probabilistic health benefits that Social Marketing promotes often involve time and energy, or require a lifestyle change. This aspect of Social Marketing makes it difficult to measure the type of effect campaigns have on the target audience. The use of mass media for promotion of beneficial health practices and for the prevention of various social and health problems has long been documented. However, relatively little is still known about the effects a campaign might have. Therefore, it is imperative for evaluation techniques to determine the type of effect a campaign has within the population. This study included a survey question in which respondents were asked to identify all the types of effects the campaign had on them (risk reducing behaviors, change in knowledge, change in HIV risk perception, and communication with a partner).

The survey data from the intervention communities demonstrated the type of effect Montana's HIV Prevention Social Marketing Campaign had on individuals. When asked what type of effect the campaign had on them, respondents reported 159 total types of effects compared to 18 total types of effects reported in the comparison community. The majority of respondents reported "getting tested for HIV" as the main effect of the campaign. The two other types of effects reported most frequently were: "getting more information about HIV" and "becoming more aware of HIV in Montana". Therefore, the types of effects most often reported indicate a change in knowledge (getting more information about HIV), an increase in HIV risk perception (more aware of HIV in Montana), and a change in behavior (getting tested for HIV). Focus group and interview participants in the intervention communities also reported the main effect of the campaign was "becoming more aware of HIV in Montana". Individuals that had not been

previously tested (43%) became more aware of HIV in Montana after seeing the campaign than individuals that had been previously tested (21%) ($\chi^2 = 3.914, p < .05$). Therefore, individuals that had not been previously tested, most often reported becoming more aware of HIV in Montana as the significant type of campaign effect. During the first four months of the campaign 57% of respondents agreed the campaign contributed to their decision to get tested for HIV, and 39% of those respondents had not been previously tested. This study also found individuals that had not been previously tested for HIV were more likely to get tested for HIV after seeing the campaign compared to individuals that had been previously tested ($\chi^2 (1) = 8.842, p > .05$). Advertising must have some type of mental affect before it can affect behavior (Vakratsas & Ambler, 1999).

Previous research has shown HIV risk perception and acknowledgment of risk behaviors are the main influencing factors for an individual's decision to test for HIV (Hou & Wisenbaker, 2005; Kalichman & Cain, 2005). Health behavior theories often include risk perceptions as an important theoretical construct that is important for motivating protective behaviors. Risk perception predicts both the suppression of health compromising behavior and initiation of protective behaviors (Kalichman & Cain, 2005). When individuals are informed about their personal risks for disease, they might adjust their behavior to reduce the threat. The findings from this study support previous research and affirm that HIV risk perception contributes to an individual's decision to test.

This study found two significant associations with two different measures for the campaign contributing to an individual's decision to test. One question asked if the campaign contributed to their decision to test, individuals that had not been previously

tested were more likely to get tested after seeing the campaign ($\chi^2 (1) = 8.842, p > .05$). The other question, which addressed type of campaign effect, had 43 respondents who reported getting tested for HIV as a campaign effect. Getting tested for HIV was the most commonly reported campaign effect in the intervention communities. A significant association was found for getting tested for HIV as a campaign effect ($\chi^2 (1) = 4.034, p > .05$). Therefore, two different measures indicated Montana's HIV Prevention Social Marketing Campaign was significantly associated with contributing to an individual's decision to get tested for HIV.

Female respondents in the intervention communities, reported differently than male respondents on two different types of effects. Women were more likely to report the effect of asking their partner to get tested for HIV (26%) than men (5%) ($\chi^2 (1) = 6.465, p < .05$). Women were also more likely to report the effect of talking to their partner about HIV (19%) than men (5%) ($\chi^2 (1) = 3.746, p < .05$). These were the only gender differences found from the survey results in the intervention communities. Previous research has indicated gender differences in college students on the issue of seriousness of HIV (Opt & Loffredo, 2004). However, there has been no research at this time demonstrating gender differences in communicating to a partner about HIV as found in this study. .

HIV Testing Data

One of the most common methods for the evaluation of Social Marketing Campaigns targeting HIV/STD prevention is to measure the outcome of the desired behavior change. Many Social Marketing Campaigns targeting HIV/STD prevention measure HIV testing rates before and during a Campaign. These direct measurements are

considered to be an indicator of a change in awareness, attitudes, behavior, or beliefs (Vega and Roland, 2005). The HIV Prevention Social Marketing Campaign tracked HIV testing numbers between the intervention communities and the comparison community for January through July in 2005 and 2006 (before and during the campaign).

When analyzing testing data it is important to account for secular trends. The inconsistencies repeatedly demonstrated in HIV testing data are often a result of secular trends; these trends refer to outside influences that occur over time such as “National HIV Testing Day” or additional interventions which influence testing numbers long-term or for a specified time period. These factors cannot be controlled or discounted for their influence of HIV testing data and further complicate the ability to evaluate a specific behavior change as a result of Social Marketing campaign.

One of the intervention communities demonstrated an increase in monthly testing numbers during the first four months of the campaign. Silver-Bow County showed the largest increase in testing numbers during the first two months of the campaign. Flathead County did not demonstrate an increase during the campaign, in fact, for the first half of 2006 testing numbers decreased drastically. This was attributed to the loss of a full-time personal that performed the majority of HIV testing for their Health Department. In addition, this individual within the Health Department provided the only HIV testing site during the duration of the Social Marketing campaign. The loss of the full-time personal and the location of the HIV testing site served as barriers for HIV testing in Flathead County. HIV testing at the Flathead City County Health Department was located in the Family Planning Clinic. Primarily, HIV testing conducted in 2006 was part of a routine check-up since the full-time testing personnel were not replaced. Therefore, some

individuals did not come to the clinic solely for an HIV test. Focus group participants in Kalispell mentioned that a majority of MSM go to Missoula to get tested because they do not feel comfortable going to the Health Departments Family Planning Clinic. Therefore, during the campaign those individuals who traveled to Missoula to get tested for HIV were not counted in the HIV testing data for Flathead County. Despite these barriers, 35% of individuals who got tested for HIV at the Flathead County Health Department reported getting tested because of the campaign. This indicates that even though low HIV testing numbers were reported for Kalispell, there were still a large percentage of individuals who reported the campaign contributed to their decision to get tested for HIV. Even though testing numbers were lower in 2006, the percent increase in monthly HIV tests during the campaign indicates an increase compared to 2005. The total percent increase (only calculated for months where there was an increase in HIV tests) in HIV monthly testing numbers during the months of the campaign (March-July) in 2005 for Flathead County was 11.5% and was 23.5% for 2006. Despite the lower testing numbers in 2006, the percent increase indicates a 12% increase in HIV tests during the months of the campaign in 2006. Both of these results suggest despite the barriers encountered in Flathead County individuals reported the campaign contributing to their decision to test and there was a 12% increase in monthly HIV tests during the campaign.

The testing data from Silver-Bow County does show an increase in testing numbers during the campaign. The Butte Silver-Bow Department has three individuals on site who provide HIV testing. The researchers also worked with Butte AIDS Support Services which is another HIV testing site in Butte, and is gay friendly. Butte AIDS Support Services tends to test more high-risk individuals who do not feel comfortable

going to the Health Department to get tested for HIV. The access to HIV testing in Butte is considerably different than the access to HIV testing in Kalispell. Therefore, the higher HIV testing numbers in Butte are attributed to the access to multiple testing facilities which provide more options for individuals in Butte. The HIV testing data from Silver-Bow County indicates an increase of 23 tests for 2006, and a 35.5% increase in monthly HIV tests during the campaign compared to the same months in 2005. When the HIV testing numbers from Silver-Bow County are compared to Lewis and Clark County, the comparison community, the testing numbers indicate promising results. The comparison community demonstrated a slight decrease in monthly testing numbers for 2006 compared to 2005 and a 6% decrease in monthly HIV tests in 2006.

The HIV testing data demonstrated an increase in testing numbers during the campaign for the intervention community; however the survey results also provided an accurate indication of changes in HIV testing behavior as a result of the HIV Prevention Social Marketing Campaign. The survey results in the intervention communities demonstrated during the first four months of the campaign 57% of respondents agreed the campaign contributed to their decision to get tested for HIV, and 39% had not been previously tested. This finding is similar to what has been established in the literature. Vega and Roland (2005) found in their evaluation of eight syphilis campaigns in eight cities, 42% to 53% of individuals in street intercept surveys reported getting tested for syphilis after seeing Social Marketing campaigns. These campaigns took place in the following large cities: Atlanta, Chicago, Houston, Los Angeles, Miami, New York, and San Francisco. Most of these cities have higher populations than the entire state of Montana. In a rural state, such as Montana, it is a significant finding that the HIV

Prevention Social Marketing Campaign had similar proportions of individuals reporting the campaign contributed to their decision to get tested for HIV.

Another interesting difference that occurred between the intervention communities and the comparison community was length since last test. For individuals previously tested, a survey question asked them to indicate how long it had been since their last test: 3 months, 6 months, 12 months, or more than one year. In the intervention communities the majority of respondents (34%) indicated it had been more than one year since their last test. In the comparison community, the majority of respondents (40%) indicated it had been three months since their last test. The intervention communities demonstrated a 14% increase in testing behaviors among individuals who had not been tested for more than one year. This increase suggests the campaign was successful in increasing testing behaviors in the intervention communities among individuals who had not been tested for more than one year.

This study also found a significant association for individuals who had not been previously tested; these individuals were more likely to get tested after seeing the HIV Prevention Social Marketing Campaign than individuals who had previously been tested ($\chi^2 (1) = 8.842, p > .05$). The campaign increased testing rates more among individuals not previously tested (39%) than those individuals that had been previously tested (18%) in the intervention communities. The main barriers reported by individuals for not previously testing for HIV were: “thought I was HIV negative”, “unlikely to have been exposed through sex”, “afraid to find out my status”, and “didn’t want to think about being HIV positive”. The 1998 U.S. National Health Interview Survey found that failure to undergo HIV testing was due to: fear of adverse consequences, lack of expectation of

benefit, no perception of HIV risk, testing is unavailable, lack of privacy, lack of guarantees of confidentiality, inconvenience, and personal isolation (Vermund & Wilson, 2002). The barriers, indicated by respondents for not previously testing, in this study were related to HIV risk perception (“unlikely to have been exposed through sex”, “thought I was HIV negative”) and fear of adverse consequences (“didn’t want to think about being HIV positive”, “afraid to find out my status”). Fear of adverse consequences is directly related to the social consequences of becoming HIV positive and the stigma associated with a positive status. This data suggests the need for future HIV Prevention Social Marketing Campaign messages to continually target HIV stigma in order to reduce barriers for testing. This campaign demonstrated success in increasing HIV risk perception among individuals not previously tested, and demonstrated a need for continual targeting of HIV risk perception in Montana. Low HIV risk perception also was discussed by focus group participants. Participants reported people automatically assume you are safe from HIV infection if you are from Montana, or do not associate HIV with Montana.

The HIV testing data and the survey results both indicated the HIV Prevention Social Marketing Campaign was successful in increasing HIV monthly testing rates in the intervention communities during the first four months of the campaign. More than half of individuals agreed the campaign contributed to their decision to test. Periodic testing by individuals to detect early HIV infection is an important public health intervention and has been recommended by the U.S. Preventative Services Task Force and the CDC since 1996 (Takahashi, Johnson, Bradely, 2005). It is estimated that 25% of individuals in the United States that are infected with HIV are unaware of their status (CDC, 2005). In

order to reduce the spread of HIV it is imperative to increase HIV testing behavior in the general public.

Campaign Message Agreement

Overall message agreement was 93% or higher for all campaign messages for 10 of the 16 campaign messages, in the intervention communities. The following six messages had less than 90% agreement: “there is no cure for HIV/AIDS (76%)”; “it is important to get early treatment if infected with HIV (85%)”; “condoms can protect me from HIV (72%)”; “it is the responsibility of HIV positive individuals to protect others (86%)”; “in Montana, HIV positive individuals are supported by their medical community (67%)”; and “HIV positive individuals don’t need to apologize for having HIV (75%)”.

Message agreement in the comparison community, who did not receive the campaign, was 94% or higher for all the messages except three. Respondents reported higher campaign message agreement on all but one message. This could be due to the small sample size surveyed or the population represented by the sample. In general, the Lewis and Clark County Health Department does not test as many individuals compared to the other Health Departments, therefore, the number of surveys completed in the comparison community were a quarter of the number from the intervention communities. The population surveyed could have also been more knowledgeable about the messages, or the small sample size (n=16) did not represent the entire population. The three messages that did not have high agreement in the comparison community were: “it is the responsibility of HIV positive individuals to protect others (81%)”; “in Montana, free and anonymous HIV testing is available (82%)”; and “in Montana, HIV positive people are

supported by their medical community (44%)”. The campaign message agreement in the intervention community for this message was 67%, and was the lowest agreement reported out of all the campaign messages. However, the 23% increase in agreement from the comparison community (44%) to the intervention community (67%) does suggest this campaign message is penetrating into the community. This increase in agreement does suggest this campaign message is changing perception about HIV positive social support in the intervention communities. The message with low agreement in the comparison community, which did not correspond with the intervention community, was “in Montana, free and anonymous HIV testing is available”. Individuals in the intervention communities were more likely to agree with the campaign message in Montana, free and anonymous HIV testing is available than individuals in the comparison community ($\chi^2(2) = 9.673, p < .05$). This campaign message was also the most common message recalled by survey respondents in the intervention communities, and the targeted behavior change of the campaign. Therefore, Montana’s HIV Prevention Social Marketing Campaign was significantly associated with an increase in individuals who agreed with the message “in Montana, free and anonymous HIV testing is available” and an increase in individuals who had not been previously tested getting tested.

It is important to note the messages that did not have high agreement in the intervention communities’ targeted: HIV risk perception (85% ,72%, and 76%), HIV stigma (86%, 67%, and 75%). The message that “there is no cure for HIV” had lower agreement (76%) and also came up in the focus group discussion as a suggestion for future campaign messages to target. The HIV Prevention Social Marketing Campaign had one poster targeting “there is no cure” and one commercial previously developed, but the

commercial was not shown in the 2006 dissemination. The two other messages targeting HIV risk perception that did not have as high of agreement among intervention respondents were: “it is important to get early treatment if infected with HIV” (85%) and “condoms can protect me from HIV” (72%). The message with the highest number of respondents reporting disagreement in the intervention communities was “condoms can protect me from HIV (11%)”. This is an important knowledge-based message for sexual risk reduction; therefore this message should continue to be disseminated by the campaign. Focus group participants discussed how the public still holds many myths surrounding HIV such as there is a cure or will be soon and myths about contracting HIV. The message data and the focus group data suggest the HIV Prevention Social Marketing Campaign should continue to disseminate and emphasize messages targeting no cure, early treatment, and condoms.

The messages targeting HIV stigma with a lower level of agreement were: “HIV positive people are supported by their medical community (67%)”; “it is the responsibility of HIV positive people to protect others (81%)”, and “HIV positive people don’t need to apologize for having HIV (75%)”. The messages of social support and responsibility of HIV positive people also demonstrated lower agreement in the comparison community. In addition, the campaign message of HIV individuals being “supported by their medical community” received disagreement by focus group participants in Butte. The majority of focus group participants who disagreed with this message were HIV positive, and had not experienced support from their medical community in Butte. Participants agreed support from your medical community depends on where you live in Montana, and most family physicians do not know how to treat or

are scared to treat HIV positive patients. The campaign message of support also had the most survey respondents who reported being “not sure”, 29% reported “not sure” in the intervention communities and 50% reported “not sure” in the comparison community. The message of the responsibility of HIV positive people to protect others had the second highest disagreement (10%) of the campaign messages in the intervention communities. Three survey respondents wrote a note on their surveys saying “it is everyone’s responsibility not just the HIV positive individuals to protect themselves”. Therefore, the individuals who disagreed with this message might have done so because they felt it is also their responsibility to protect themselves, not because they felt it is not the responsibility of the HIV positive individual. The other message targeting stigma was “HIV positive people don’t need to apologize”, this message had the second highest percentage of individuals (23%) who reported being unsure of the message. Only two individuals disagreed with the message, therefore, more individuals were unsure of these messages rather than disagreeing with the content of the message. However, since these messages had lower agreement in both the intervention communities and in the comparison community, it is recommended that Montana’s HIV Prevention Social Marketing Campaign continue to target and emphasize HIV stigma in Montana.

Overall, eight out of the fourteen messages had a 94% or higher agreement and the other six messages had between 67% to 86% message agreements. These agreement percentages, which are low compared to the other eight, still exhibit high agreement in the total population. Since the majority of respondents reported being not sure of the messages rather than disagreement with the messages, perhaps these messages did not have long enough to penetrate into the community, or were not disseminated at a high

enough frequency in the first four months of the campaign to change individual knowledge or perceptions. Three of the six lower percentage agreement messages targeted HIV risk perception and the other three targeted HIV stigma. The messages that targeted stigma received the highest percentage of respondents who reported being “unsure”. Stigma is a complicated social issue, which cannot be assessed by a single survey or in a short period of four months. Many coexisting factors also contribute to a community’s stigma such as racism, sexism, homophobia, classism, and negative attitudes towards drug use making it very difficult to address in one campaign (Klein, Karchner, O’Connel, 2002).

The lower agreement with the campaign messages targeting stigma, do indicate the need for future campaign messages to continue to target stigma. The complexity of these messages, or the complex nature of stigma in society, could both be contributing factors to individuals reporting being unsure of these campaign messages. Since its emergence, the HIV epidemic has been associated with high levels of stigma and shame. HIV stigma is considered to be one of the biggest barriers to prevent further infections, for the provision of care for HIV positive individuals, and it is argued that reducing HIV stigma is the integral component of a comprehensive approach to control the epidemic (Taylor, 2001). Research indicates HIV stigma still exists in the United States and public health policy should continue to target it (Hereck, Capitino, Widaman, 2002). Stigma can also be considered a strong social norm in relation to the history of the HIV epidemic. Media campaigns have previously demonstrated the ability to change social norms as a long-term affect (Levy & Friend, 2000; Parker & Aggelton, 2003). This demonstrates the

necessity of HIV prevention campaigns to target HIV stigma in order to reduce HIV stigma and alter the course of the epidemic in the United States.

Montana's HIV Prevention Social Marketing Campaign results indicated the focus group and interview participants overwhelmingly agreed that they identified with most of the campaign's messages. However, there were two campaign messages that some focus group members did not agree. The HIV positive participants from Butte's MSM focus group did not all agree with the message of support from their medical community, but agreed support is dependent upon where you live in Montana. The Kalispell focus group participants did not relate with the Down-Low message. Lack of relevance was not based on the actual campaign messages but because they felt this message did not pertain to them since they have not encountered anyone on the Down-Low in their community. However, it is important to consider that these focus group participants did not represent the entire MSM population in Kalispell and the majority of them were in long-term relationships. Therefore, it is unlikely they would encounter men on the Down-Low in their community, making them a specific group that doesn't embody the whole of the intervention community.

Overall, Montana's HIV Prevention Social Marketing Campaign generated high campaign message agreement among focus group participants, interview participants, and survey respondents in the intervention communities. The lowest agreement was 67%, therefore, despite lower agreement among certain messages all messages still exhibit high agreement overall. The six messages with lower agreement were the most complex messages of the campaign and most likely take repeated exposure before higher agreement is reached. Recent public health media campaigns aimed at social change

have demonstrated campaigns with complex messages are more likely to require greater frequency and duration (Levy & Friend, 2000). Since this study evaluated the first four months of the campaign, a more long-term look at message agreement might exhibit higher agreement with repeated exposure.

Segmented Audiences

Social Marketing has been used in international and domestic settings for over 30 years, with primary intent to improve health and social conditions (Neiger et al, 2003). The most important aspect of Social Marketing is the continuous focus on the target audience throughout the entire planning process. Social Marketing posits that individuals will only take action when it is in their best interest, therefore, Social Marketing strategies always begin with an understanding of the target population's needs and wants, their values, and perceptions (Andreasen, 1995).

Montana's HIV Prevention Social Marketing Campaign targeted the following at-risk populations: MSM, HIV positive men and women, IDU, Youth-at-risk, and the Down-Low population. The campaign messages were developed with needs assessment data from each of the target populations. All of the campaign messages were sufficiently tailored to each of the target populations. Research has shown increased effectiveness with message tailoring to segmented audiences (Merzel & D'Affitti, 2003; Levy & Friend, 2000). By tailoring messages to segmented audiences, Social Marketing Campaigns can help change social norms and reduce at-risk behaviors among each population (Thackary & Neiger, 2000). Research has also demonstrated smaller community-level campaigns can increase effectiveness by tailoring messages to target populations in their communities (Levy & Friend, 2000). Higher effectiveness by

tailoring messages to segmented audiences also requires less frequency and duration to reach the audience. Since Montana's HIV Prevention Social Marketing Campaign messages were tailored to segmented audiences in Montana, and made in Montana, these messages have the potential to reach audiences more effectively. The results of this study indicate the campaign was successful in reaching high awareness and high message agreement in the intervention communities and among two of the segmented audiences (MSM and HIV positive individuals). Participants in the focus groups and interviews primarily recalled the messages targeting them. For example, MSM focus group participants recalled the campaign messages from the Steve commercial which targeted MSM ("HIV is in Montana" "I became positive in Montana"). The HIV positive participants also recalled more of the campaign messages from the other Steve commercial targeting HIV stigma ("don't have to apologize for having HIV" and "there is no cure"), and the one female participant recalled the message from the HIV positive women commercial ("reminds us that it can be anyone"). This study found the messages recalled by these participants were the HIV Prevention Social Marketing Campaign messages directed towards their target population.

Another important component of tailoring messages to specific audiences is the increased saturation possible when messages directly relate to a population. This topic arose in the focus group discussions. Some of the participants mentioned they had seen the HIV positive women commercial but did not pay attention because it did not pertain to them. Other participants agreed that if a commercial was on television that did not pertain to them or interest them, they would not pay attention. This study found that another important aspect of tailoring messages is the ability to grab the attention of the

target population because the messages directly relate to them. It is also important to note the majority of the messages recalled by focus group participants and interviewees were the messages which directly related to them. The majority of MSM participants recalled the messages from the two commercials targeting MSM, many mentioned they had seen the other campaign commercials but did not recall the exact message.

This evaluation found in the first four months, Montana's HIV Prevention Campaign generated high campaign awareness, and high awareness with the mix of campaign media channels in the intervention communities. More individuals reported being affected by commercials than any other campaign media channel. This study also found high unaided campaign message recall and high campaign message agreement, with the most frequently recalled message "to get tested for HIV." In the first four months, the campaign demonstrated high campaign effects, the three most frequently reported effects were an increase in HIV risk perception, increase in getting more information about HIV, and an increase in HIV testing behaviors in the intervention communities.

Limitations of the Study

This section attempts to acknowledge this study's limitations and the possible impacts the limitations may have. There is no research free of flaws or limitations, therefore it is important to acknowledge and learn from them.

- 1) The survey data was based on self-report, respondents could have concealed information they do not want others to know. Also, even if respondents wanted to provide accurate information they might not have the self awareness to do so (Gall, Gall, Borg, 2005). For these reasons, data obtained through survey research

- are likely to be incomplete to an unknown degree. Participants were guaranteed confidentiality of the survey which is expected to produce more accurate results (Berkowitz, 1999).
- 2) The focus group and interview data is subject to social desirability which can corrupt the integrity of the data. Participants in the focus groups or interviews might have responded to the questions in a way they felt was expected or acceptable. Also, social desirability can intimidate other participants from contributing for fear of responding in a way that is not socially desirable (Berkowitz, 1999). The focus group participants were volunteers who were selected by an outreach worker in the intervention communities. Therefore, the opinions and values of the focus group participants do not reflect the entire homosexual population in Montana. The participants most likely represented a portion of the gay community that is “out” and actively involved within their community.
 - 3) This study relied on a convenient sample of individual’s receiving HIV Counseling and Testing at the Public Health Departments or by an outreach worker. This form of convenience sampling is subject to sampling bias (Gall, Gall, Borg, 2005). Since a random sample was not possible, those individuals who did not participate could have different perceptions or beliefs about the campaign. This study was based on individual’s expression of willingness to participate in this study rather than systematic sampling strategies.
 - 4) This study involved a comparison group with only one quarter of the participants of the intervention community participants. Therefore, comparisons between

Helena and Kalispell and Butte may not reflect the entire population of the comparison group. A large sample size is needed to determine a small but significant difference between treatment and control groups (Holzman et al, 2005).

- 5) This study evaluated the HIV Prevention Social Marketing Campaign for the first four months of the campaign. Therefore, none of the results indicate the long-term effects of the campaign in the specified communities. This study only provides a snapshot of short-term campaign effects during the first four months of the campaign.

Recommendations

Campaign Media Channels

The HIV Prevention Social Marketing Campaign media channel most frequently seen was billboards. Billboards were seen by more respondents and billboards had the highest average times seen reported by survey respondents. Posters and commercials followed closely behind with percentage of respondents that saw them and with average times seen. Focus group participants overwhelmingly agreed all types of media channels the HIV Prevention Social Marketing Campaign uses were effective ways to reach gay men and other at-risk populations in Montana. Theatre slides did not have as high of a level of awareness as the other campaign media channels, however theatre slides were not shown in one of the intervention communities. Therefore, theatre slides might have demonstrated a higher awareness if they were shown in both of the intervention communities. All participants in the focus groups, interviewees, and survey respondents in Kalispell and Butte had seen more than one campaign media channel. It is

recommended that Montana's HIV Prevention Social Marketing Campaign continue to use the same mix of media channels for future campaigns. When participants were asked for suggestions for other media channels, the following suggestions were made: internet, local newspapers, and bathroom stall advertising companies.

Campaign Messages

The majority of the HIV Prevention Social Marketing Campaign messages had high agreement among individuals that had and had not seen the campaign. There were six campaign messages that did not have 94% or higher agreement in the intervention communities. These messages had a higher percentage of respondents reporting being "not sure" rather than message disagreement. Three of these messages targeted HIV risk perception. The number of respondents who reported being "not sure" indicate future campaign messages should continue to focus on "there is no cure", "it is important to get early treatment if infected with HIV", and "condoms can protect me from HIV". These are important HIV risk perception messages which should continue to be dispersed in Montana. It is recommended that the messages targeting HIV stigma continue to be circulated also. Stigma is a complicated social issue and is often considered the second epidemic of HIV that prevents compassion and care for individuals living with HIV. It is imperative that future campaigns target HIV stigma in order to further enhance prevention efforts.

Future Campaign Messages

Participants from the focus groups conducted in Kalispell and Butte had several recommendations for future HIV prevention campaign messages targeting gay men or other populations in Montana. The following topics and issues were recommended for

future campaigns: there is no cure, bug chasers, self-respect, HIV-methamphetamine (meth) connection, simplicity, and education about the testing procedure. The first recommendation, made by both focus groups, was for more campaign materials to focus on the message that there is no cure for HIV. Participants agree this is a common myth they encounter frequently in Montana. The HIV positive participants in the Butte focus group recommended campaign material focus on the cost and side effects of the medicine. Another recommendation made by the Butte focus group participants was for the campaign to focus on bug-chasers. Participants agreed that this is becoming an issue in Montana's gay community. Every gay man who participated in the focus group had personally been targeted or knows someone that has been targeted by a bug chaser. The HIV-meth connection was also suggested because participants feel meth induces at-risk sexual behavior, contributing to the risk for HIV.

Participants in the Kalispell focus group agreed that the message of self-respect in the IDU commercial should be more prevalent in the HIV Prevention Social Marketing Campaign materials. They felt this positive message is an important thing to disseminate for any at-risk population. The Kalispell focus group participants felt in order for individuals to remember a campaign they must see it again and again or there needs to be a specific "simple message" that appears in all the campaign materials. These participants also suggested that campaign materials use a unified message or traditional visual cues associated with HIV (red ribbon or red colors) in order for the public to associate the campaign with HIV immediately. The last recommendation from focus group participants was to educate the public about the testing procedure. Participants mentioned that a portion of the campaign material says "anonymous and confidential" but does not

indicate anything else about the testing procedure. Participants feel education about this process might motivate more individuals to engage in testing.

Recommendations for Future Research

There are limitless avenues evaluators can take when evaluating Social Marketing campaigns. The answer to which of the numerous evaluation techniques are most effective is still unknown at this time. In order for future evaluations to refine the current evaluation techniques it is important to discuss recommendations for future evaluation research for Social Marketing campaigns.

The first recommendation concerns the measure used for campaign awareness among survey respondents. This study assessed campaign awareness by asking respondents if they have seen each of the media channels and then asking them to recall how many times they have seen each media channel. More than half of the respondents did not report campaign exposure. A total of 41% to 44% of respondents reported campaign exposure for billboards, posters, and commercials. Therefore, this is not an accurate way to measure campaign exposure with self-report data. It is recommended when measuring times seen to provide a range that respondents can choose from rather than coming up with an arbitrary number themselves. This might result in a higher percentage of respondents providing data for how frequently they have seen the campaign.

It is important to evaluate if individuals reporting getting tested for HIV during the campaign got tested because of the campaign. HIV testing data will only indicate increases in testing numbers without accurately indicating if the individuals testing did so because of the campaign. Increasing in HIV testing numbers could be due to secular

trends, a national campaign, or seasonal effects rather than a Social Marketing campaign. It is suggested that future studies include the decision to test question used by this study in order to understand if the Social Marketing campaign contributed to an individual's decision to test. The HIV testing data presented multiple limitations for this study due to secular trends and incomplete data, and without investigating if the campaign did contribute to an individual's decision to test; researchers are left to assume the increase in testing numbers is due to the campaign.

Originally this study attempted to evaluate the HIV testing data among certain at-risk populations that the HIV Prevention Social Marketing Campaign targeted. However, Montana's Department of Health and Human Services was in the process of entering all the 2006 HIV testing data into a new database. None of the 2006 data had been entered into the database, so the extrapolation of HIV testing data was done manually for this study. Demographic data could not be obtained for this reason. Since Social Marketing campaigns target a segmented audience, it is important to evaluate the desired behavior change among the target populations. Therefore, when using the testing data it is recommended that future studies investigate the HIV testing patterns among the targeted populations as well as the general population to look for any observable changes within the target populations.

Most of the Social Marketing evaluation studies in the literature evaluate increase in testing numbers or hotline calls without any measure of the campaign contributing to the decision to test. Only one study by Vega and Roland (2005), directly measured if the syphilis Social Marketing Campaigns contributed to individuals decision to test in street intercept surveys. The majority of evaluation studies primarily measure the direct

behavior outcome with no indication of campaign effect, or if the campaign influenced the decision to test (Futerman et al, 2001; Holzman et al, 2005; Finlay & Faulkner, 2005; Baueman, Bellow, & Owen, 2001). Increases in HIV testing numbers can be attributed to multiple factors, as mentioned previously, therefore in order to conclude the campaign motivated individuals to get tested, it is vital to include a direct measurement of this effect. This study asked survey respondents if the campaign contributed to their decision to get tested for HIV. This measure was extremely useful for Flathead County since there were multiple barriers presented during the campaign concerning access to HIV testing. Even though the HIV testing numbers did not indicate an increase, 35% of survey respondents indicated the campaign contributed to their decision to test. This study also included a measure of type of campaign effect, and found the most commonly reported campaign effect was getting tested for HIV. Since this study included a triangulation of measurements: HIV testing data, reported campaign effects, and a measure of whether the campaign contributed to an individuals decision to get tested for HIV, conclusions were accurately drawn that Montana's HIV Prevention Social Marketing Campaign increased testing in the intervention communities. It is recommended that future studies employ multiple evaluation methods for the campaign contributing to the desired behavior outcome so accurate conclusion can be drawn.

This study used a comparison group which did not receive the HIV Prevention Social Marketing Campaign as a baseline for two communities that received the campaign. The comparison community was similar in population and annual income, however dissimilar in HIV testing numbers. Even though the comparison community did only generated a quarter of the surveys as the intervention community the percent of

individuals who completed surveys out of the total number of individuals who got tested for HIV during the campaign is similar to the intervention communities. In Silver-Bow County 49% of individuals who got tested for HIV during the campaign completed surveys. In Flathead County, 15% of individuals who got tested for HIV during the campaign completed surveys. In Lewis and Clark County, 47% of individual's who got tested for HIV during the same months completed surveys. This percent is almost identical to the survey completion rate found in Silver-Bow County. This percentage indicates the comparison community had almost an identical survey completion rate; therefore the population surveyed represented the same amount of individuals out of the total number of individuals who got tested for HIV during the months of the campaign. It is suggested for a future study employing a similar design as this study; it is recommended to use two comparison communities since two communities received the campaign. This would allow for the results of the comparison community to be more accurately compared to the intervention communities in number of respondents.

Social Marketing campaigns directed towards public health, such as Montana's HIV Prevention Social Marketing Campaign, may have more delayed effects which continue after the campaign has ended (Winnet & Wallack, 1996). The more long-term effects may arise after the campaign is over because of the time it takes to adopt the new behavior and the role of social norms (Wallack, 1981). This study evaluated the effects of the HIV Prevention Social Marketing Campaign during the first four months it was disseminated in the intervention communities and demonstrated positive short-term effects. These findings are consistent with reports of favorable short-term effects of Social Marketing on particular health behaviors (Levy & Friend, 2000). This study does

not include any indication of the long-term effects of the campaign in the target populations or if individuals will continue to get tested after the campaign has ended in the intervention communities. During a Social Marketing campaign, there are multiple opportunities for the target audiences to have contact with campaign messages, to receive feedback and reinforcement during learning phases, and to obtain support for behavior maintenance (Winnett & Wallack, 1996). All of these factors contribute to the ability of Social Marketing campaign to influence individual behavior. Evidence of positive long-term effects for Social Marketing Campaigns has been mixed (Winnett & Wallack, 1996; Levy & Friend, 2000). It is imperative to understand if Social Marketing campaigns can influence individual behavior in the long-term when environmental cues are removed; and in order to understand the ability of Social Marketing campaigns to influence social norms. Therefore, it is recommended that future research include the long-term effects after the campaign is over in order to understand the magnitude of effects possible by a Social Marketing campaign. In order to understand the long-term effects possible by a Social Marketing Campaign it is recommended future studies investigate HIV testing data and campaign message recall after the campaign has ended. Future studies could investigate HIV testing numbers after the campaign has ended to see if they decrease or continue to increase for a specified time period. Campaign message recall indicates message novelty, which are the messages that had a mental effect on the individual. It is important to understand if the same messages recalled by individuals during the campaign can be recalled after the campaign is over. This would indicate if the campaign messages changed social norms related to HIV in the intervention communities after the campaign has ended.

It is also recommended for future studies evaluating Social Marketing campaigns to use a mix of evaluation techniques, such as the techniques employed by this study, in order to understand the effects Social Marketing campaigns can have in a community. It is suggested for future studies to include multiple measures of campaign awareness and campaign effects. This study included both quantitative and qualitative measures among the general population and among two target populations. It is vital for evaluation studies to include a measure of the type of effect a campaign has in the intervention communities. This study used a checklist of multiple effects in which respondents were asked to identify the type of effect the campaign had on them. This is particularly important, because individuals might be affected by a campaign, but might not be motivated to engage in the desired behavior outcome. This study found even though, the campaign did not motivate all individuals to get tested, survey results indicate that the campaign affected individuals by making them more aware of HIV in Montana, and motivating them to get more information about HIV. Therefore, if evaluation studies only measure the desired behavior outcome, the other effects of the campaign might go unreported. This study also found unaided campaign message recall to be an accurate measure of campaign awareness and message recall. Unaided campaign message recall demonstrated the impact the messages had, and also served as another way to ensure that what campaign respondents were reporting about was Montana's HIV Prevention Social Marketing Campaign.

The primary recommendation for Montana's HIV Social Marketing Prevention Campaign is to continue the mix of media channels and the campaign messages targeting HIV risk perception and HIV stigma. Suggestions were made for future campaign

messages targeting MSM by focus group participants in the intervention communities. Recommendations for future research evaluating Social Marketing Campaigns are as follows: discontinue the use of open-ended responses for campaign exposure, measure the type of campaign effect and influences of a campaign on an individual's decision to test, investigate long-term effects of the campaign, investigate campaign effects in segmented target populations, utilize a larger comparison group, and employ a mix of evaluation techniques.

Conclusions

The connection between beliefs, attitudes, and behavior was highlighted by this study. Findings from this study strongly suggest that Montana's HIV Prevention Social Marketing Campaign was successful in increasing HIV testing behaviors and HIV risk perception in the intervention communities during the first four months of the campaign. Individuals seeing the campaign were significantly associated with getting HIV tested and becoming more aware of HIV in Montana. These results demonstrate that a large scale behavioral change is possible with a Social Marketing Campaign at the community-level. Social Marketing Campaigns are successful for changing the behavior of individuals on a community-wide or population-wide level (Andereasen, 1995). This evaluation found Montana's HIV Prevention Social Marketing Campaign has the appropriate promotion of message content and the appropriate blend of media channels. The focus group and interview results indicated the campaign messages were still effective and important to disseminate in Montana, and allowed a target population to provide their perceptions about the campaign. The focus groups allowed researchers to

retest current campaign messages among MSM and HIV positive populations, to ensure these messages are still effective.

Since HIV is considered a social phenomenon, because it is the outcome of social behavior patterns, it is imperative to understand what factors contribute to individuals preventative behaviors. Previous research in Montana, has determined that individuals living in this rural state do not feel susceptible to HIV. The HIV Prevention Social Marketing Campaign was capable of increasing risk perception which was found to be significantly associated with HIV testing behaviors. If individuals do not feel susceptible to HIV they will not engage in testing or safe behaviors (Kalichman & Cain, 2005). Therefore, Montana's HIV Prevention Social Marketing Campaign should continue campaign messages related to HIV risk perception in Montana, since it is a stimulus for social behavior responses related to HIV. The campaign should also continue messages related to HIV testing, this was the most frequently reported campaign effect and the most frequently recalled campaign message.

Social Marketing programs are often large and constantly changing, traditional evaluation design constrain the nature of the interventions, these factors along with a myriad of other factors make the evaluation of these campaigns a difficult task. The gold standard of evaluation techniques, a randomized controlled trial, answer questions with great accuracy, however, for Social Marketers they are often the wrong questions (Doner, 2003). The qualitative and quantitative evaluation techniques chosen for this study, evaluated the exposure outcome association. The results from the intervention communities with high exposure were compared to a comparison community with no exposure. This evaluation technique is called an exposure outcome evaluation, because

the desired behavior outcome is often a result of campaign exposure (Doner, 2003). The exposure outcome evaluation was strengthened by statistically examining the major trends found. This study found despite what evaluation techniques are employed, important measures should include: multiple measures of campaign awareness, a measure of the campaign's influence on the desired behavior outcome, and measure of the type of campaign effects. In addition, the use of a comparison community allows conclusions to be drawn more accurately.

This study evaluated Montana's HIV Prevention Social Marketing Campaign during the first four months and showed tremendous positive results. It is important to keep in mind, the delayed effects, which may continue after the campaign has stopped. A number of recent efforts in the United States suggest that the media could help shift cultural norms toward a healthier view of sexuality (Keller & Brown, 2002). If a campaign is capable of inducing individual level behavior change, then it has the capability of altering social norms through community level behavior change (Merzel & D'Affilitti, 2003). Since this campaign was capable of increasing HIV testing rates and HIV risk perception in four months, it is anticipated that the campaign is capable of inducing more long-term effects by increasing the social acceptance of HIV testing. The interactive relationship between health and the social environment is highlighted with Social Marketing campaigns, these campaigns highlight the importance of the social context in which health behaviors occur and have the potential to modify norms, values, and policies.

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Appendix A:

HIV Prevention Social Marketing Campaign's Commercial Message Chart

PSA Title	Target Population	Messages	Message Targets
Steve 1	MSM	No cure for HIV	HIV risk perception
Steve 1	MSM	If your having unprotected sex or sharing needles you need to get tested for HIV	HIV risk perception
Steve 1	MSM	I used to think it happened to other people in other places, but I became HIV positive in Montana	HIV risk perception
Steve 1	MSM	HIV doesn't care who you are or what your sexual orientation is	HIV stigma
Steve 2	HIV positive	I received support from family, friends, and Montana's medical community	HIV stigma
Steve 2	HIV positive	I don't apologize for having HIV, I accept that I am HIV positive	HIV stigma
Steve 2	HIV positive	I didn't take the risk seriously and as a result I am HIV positive living in Montana	HIV risk perception
Steve 2	HIV positive	It is my responsibility to protect others	HIV stigma
Youth	Youth-at-Risk	When you think about it, there is a lot to live for	Perceived benefits
Youth	Youth-at-risk	Be safe and help stop the spread of HIV	HIV risk perception
Paige	HIV positive women	I am your mother, friend, neighbor	HIV positive stigma

Paige	HIV positive women	I am living with HIV in Montana	HIV risk perception
Paige	HIV positive Women	HIV does not discriminate	HIV positive stigma
IDU	IDU	I use condoms and don't share needles	HIV risk perception
IDU	IDU	I know my HIV and Hepatitis C status	HIV risk perception
IDU	IDU	Responsibility (take care of yourself, your friends, and family)	Stigma
Down Low	Down Low	If you are engaging in high risk behaviors: protect yourself and your family by getting tested	HIV risk perception

Appendix B:
IRB Approval Letter

Appendix C:
Survey Informed Consent Form

Participant Information and Consent Form

Participant Survey

TITLE

Evaluation of the HIV Prevention Social Marketing Campaign in Montana

PROJECT DIRECTOR

Dr. Laura Dybdal: The University of Montana
McGill Hall, Missoula MT 59812
(406) 243-6988

The language in this consent form may be unfamiliar to you. If you read any words that are not clear, please contact the research assistant whose name is provided on the survey.

PURPOSE

The purpose of this research is to evaluate the HIV Prevention Social Marketing Campaign in Montana. The HIV Prevention Campaign includes billboards, posters, theatre slides, and televised commercials. By completing this survey you will assist researchers with information regarding campaign awareness and HIV testing in the state of Montana. Evaluation is a critical component of all prevention programs, it is the only way to determine success, improve existing programs, or can be the driving force for developing new health promotion programs.

PROCEDURES

You can become involved with this research by reading the rest of the informed consent form. If you agree to participate you will be asked to complete the attached survey and return it to the drop box located in the lobby. The survey should take no more than 5-10 minutes to complete. Survey completion and participation is completely **anonymous**.

RISKS/DISCOMFORTS

You might find some of the questions personal, you may feel that you do not know an answer, or some of the questions might make you uncomfortable. If you find a question uncomfortable please feel free to skip that question and proceed. You are welcome to discontinue your participation at any time.

BENEFITS

Your participation in this research will provide valuable information for the University of Montana and to the state health department. Your participation will help researchers make decisions about how to help prevent the spread of HIV in Montana.

CONFIDENTIALITY

All information collected from the surveys will be completely anonymous. Researchers will avoid recording any identifying information. They will not use your name or any other information in reports related to this study. The identities of all survey participants will remain anonymous and will not be associated with research findings in any way. Surveys will be kept in a locked office and destroyed upon completion of data analysis.

COMPENSATION FOR INJURY

Although we believe the risk of taking part in this research will be minimal, the following liability statement is required in all University of Montana consent forms.

“In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, and Chapter 9. In the event of a claim for such injury, further information may be obtained from the Universities Claims Representative or University Legal Counsel.”

VOLUNTEER PARTICIPATION/WITHDRAWAL

Your decision to take part in this research is completely **voluntary**. You are free to skip any question or discontinue participation at any time. You may refuse to take part in this study or withdraw at any time.

QUESTIONS

If you have any questions about this research please feel free to contact Dr. Laura Dybdal at (406)243-6988 or Dr. Dybdal's research assistant Helen Burnside at helenburnside@umontana.edu.

CONSENT

I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I might have will be answered by the research team. I voluntarily agree to take part in this study. I am at least 18 years of age. I understand this is my copy to keep of this consent form.

THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

Appendix D:

Survey

Section #1

This section asks you for information about yourself. The survey is completely anonymous so please do not write your name anywhere on the survey. Thank you for your time. **Please respond to these questions by checking the best answer that applies to you.**

<p>1) What is your gender?</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Transgender</p>
<p>2) What is your age? _____</p>
<p>3) What is your race/ethnicity (please check all that apply)?</p> <p><input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White (non-Hispanic)</p> <p><input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic/Latino</p> <p><input type="checkbox"/> African American <input type="checkbox"/> other (please specify) _____</p>
<p>4) What is your sexual orientation?</p> <p><input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Bisexual</p> <p><input type="checkbox"/> Homosexual/Gay <input type="checkbox"/> Other _____</p>
<p>5) Please check all of the following risk exposure categories that apply to you:</p> <p><input type="checkbox"/> Unprotected sex <input type="checkbox"/> STD Diagnosis <input type="checkbox"/> Mother has HIV/AIDS</p> <p><input type="checkbox"/> Used injecting drugs <input type="checkbox"/> Sex with person with HIV/AIDS <input type="checkbox"/> Sex with injecting drug user</p> <p><input type="checkbox"/> Sex for money/drugs <input type="checkbox"/> Hemophilia/Blood recipient</p> <p><input type="checkbox"/> Sex with a homosexual <input type="checkbox"/> Sex while using drugs/alcohol</p>
<p>6) Have you been previously tested for HIV/AIDS?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes/Positive <input type="checkbox"/> Yes, Unknown</p> <p><input type="checkbox"/> Yes/ Negative <input type="checkbox"/> Yes/ Indeterminate <input type="checkbox"/> Don't Know</p>
<p>7) If you have not been previously tested, what are the reasons you have not been previously tested for HIV (please check all that apply):</p> <p><input type="checkbox"/> Unlikely to have been exposed through sex <input type="checkbox"/> Thought I was HIV negative</p> <p><input type="checkbox"/> Afraid to find out my HIV status <input type="checkbox"/> Didn't have time</p> <p><input type="checkbox"/> Didn't want to think about being HIV+ <input type="checkbox"/> Didn't want to worry family members</p> <p><input type="checkbox"/> Worried about who would learn results <input type="checkbox"/> Unlikely to have exposure through drug use</p> <p><input type="checkbox"/> Didn't want anyone to think I was at risk <input type="checkbox"/> Didn't want people to think I was gay</p> <p><input type="checkbox"/> Worried my name would be reported <input type="checkbox"/> Didn't want people to think I used drugs</p> <p><input type="checkbox"/> Worried friends would react badly <input type="checkbox"/> Other</p> <p>_____</p>

Please see back page

8) If previously tested, how long has it been since your last test?
 3 months 6 months 12 months More than 1 year

9) Did seeing media information about HIV contribute to your decision to get tested for HIV today?
 Agree Disagree Not Sure

Section #2

This section asks you about the HIV Prevention Media Campaign. The HIV Prevention Campaign includes billboards, posters, theatre slides (advertisements before the previews begin), and televised commercials.

Please respond to the these questions by checking all the answers that apply to you.

10) Have you seen any media information about HIV?
 Yes No

11) Have you seen a billboard about HIV?
 Yes No
 If yes, approximately how many times have you seen a billboard? _____

12) Have you seen a commercial about HIV?
 Yes No
 If yes, approximately how many times have you seen a commercial? _____

13) Have you seen a poster about HIV?
 Yes No
 If yes, approximately how many times have you seen a poster? _____

14) Have you seen a theatre slides about HIV?
 Yes No
 If yes, approximately how many times have you seen a theatre slide? _____

15) What do you remember about what you saw?

16) Do you feel the media campaign has affected you in any way?
 Yes Somewhat No Not Sure

17) How has the media campaign affected you? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> I got tested for HIV | <input type="checkbox"/> I know my Hepatitis C status |
| <input type="checkbox"/> I changed my sexual behaviors | <input type="checkbox"/> I no longer share needles |
| <input type="checkbox"/> I got more information about HIV | <input type="checkbox"/> I talked to my partner about HIV |
| <input type="checkbox"/> I am more aware about HIV in Montana | <input type="checkbox"/> I asked my partner to get tested |
| <input type="checkbox"/> I use condoms more frequently | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> I know my HIV status | _____ |

Section #3

If a question makes you uncomfortable, please skip ahead to the next question. **Please respond to these questions and statements by checking the answer that best applies to you.**

18) I can become infected with HIV in Montana.

- Agree Disagree Not Sure

19) HIV doesn't care what your sexual orientation is.

- Agree Disagree Not Sure

20) HIV does not discriminate, heterosexual women are affected too.

- Agree Disagree Not Sure

21) HIV positive people exist in Montana.

- Agree Disagree Not Sure

22) Anyone can contract HIV/AIDS.

- Agree Disagree Not Sure

23) Protecting myself, my family, and my friends means knowing my HIV and Hepatitis C status.

- Agree Disagree Not Sure

24) I can help stop the spread of HIV/AIDS.

- Agree Disagree Not Sure

25) There is no cure for HIV/AIDS.

- Agree Disagree Not Sure

Please see back page

26) It is important to get early treatment if infected with HIV. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure
27) If I am sharing needles I am at risk for HIV/AIDS. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure
28) If I am engaging in unprotected sex I am at risk for HIV/AIDS. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure
29) If I am sharing needles I should get tested for HIV/AIDS. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure
30) If I am engaging in unprotected sex I should get tested for HIV/AIDS. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure
31) Condoms can protect me from HIV/AIDS. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure
32) It is the responsibility of HIV positive individuals to protect others. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure
33) In Montana, free and anonymous HIV testing is available. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure
34) In Montana, HIV positive individuals are supported by the medical community. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure
35) HIV positive individuals don't need to apologize for having HIV. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Not Sure

Thank you, your time and effort are appreciated!!

Please place the completed survey in the drop box provided.

Appendix E:
Focus Group Discussion Guide

Focus Group Discussion Guide

- 1) Introduction, Informed Consent Form, & Ice Breaker Question
- 2) Have you seen any media information about HIV recently in Kalispell?
(Please think about all the different places you have seen, heard, or read any media information about HIV recently)
- 3) What do you know about Montana's HIV Prevention Campaign?
- 4) What have you seen of Montana's HIV Prevention Campaign in Kalispell?
(Please think about all the types of media information you have seen about HIV such as billboards, posters, commercials, theatre slides)
- 5) Which part of the campaign have you seen most frequently?
- 6) What do you remember about what you saw?
(Please mention all the messages you can remember)
- 7) If you have seen the HIV Prevention Campaign in Butte, do you feel it has affected you?
 - a) Has the campaign affected you positively?
 - b) Has the campaign affected you negatively?

SHOW HIV PREVENTION CAMPAIGN COMMERCIALS

8) What are your initial reactions to the commercials and to the messages?

Steve 1

Steve 2

HIV Positive Women

IDU

Down-Low

9) Have you identified with the commercial messages?

a) Which messages do you identify with?

10) Are there any messages you do not identify with?

a) Which messages do you not identify with?

11) Do you have any ideas for future commercials or billboards targeting gay men or any other populations in Montana?

(Do you have creative ideas for visuals or graphics that would specifically target gay men in Montana? Are there missing HIV prevention messages that should be promoted for gay men in Montana?)

12) What is the best way to reach gay men with HIV prevention messages: billboards, posters, videos, commercials, or any other suggestions? Is media an effective way to reach gay men in Montana with HIV prevention messages?

13) Please take a moment to think about past media campaigns that you have seen, what made these campaigns memorable for you?

(What made them work? Grab your attention?)

14) What else would you like to mention that we have not discussed today?

Appendix F:
Focus Group Informed Consent Form

Participant Information and Consent Form

Focus Group

TITLE

Evaluation of the HIV Prevention Social Marketing Campaign in Montana

PROJECT DIRECTOR

Dr. Laura Dybdal: The University of Montana
McGill Hall, Missoula MT 59812
(406) 243-6988

The language in this consent form may be unfamiliar to you. If you read any words that are not clear, please contact the research assistant whose name is provided on the survey.

PURPOSE

The purpose of this research is to evaluate the HIV Prevention Social Marketing Campaign in Montana. The HIV Prevention Campaign includes billboards, posters, theatre slides, and televised commercials. By completing this survey you will assist researchers with information regarding media campaigns in the state of Montana. Evaluation is a critical component of all prevention programs, it is the only way to determine success, improve existing programs, or can be the driving force for developing new health promotion programs.

PROCEDURES

You can become involved with this research by reading the rest of the informed consent form. If you agree to participate you will be asked to sign the informed consent form before proceeding. After consent is given, a short demographic questionnaire will be completed and then the focus group will begin. The focus group will consist of 11 questions. All information gathered will be completely **confidential**.

RISKS/DISCOMFORTS

You might find some of the questions on the demographic survey personal, you may feel that you do not know an answer, or some of the questions might make you uncomfortable. Although all participants are told that what is said within the group stays within the group, there is a risk that a focus group member could disclose information outside the focus group discussion. You are welcome to discontinue your participation at any time.

BENEFITS

Your participation in this research will provide valuable information for the University of Montana and to the state health department. Your participation will help researchers make decisions about how to help prevent the spread of HIV in Montana

CONFIDENTIALITY

All information collected during the focus group will remain completely confidential. Researchers will avoid recording any identifying information. The identities of all focus group participants will remain confidential and will not be associated with the research findings in any way. Audio tapes from the focus group will be kept in a locked office and then destroyed immediately after transcription. All data being used will be reported as a group, not individually.

COMPENSATION FOR INJURY

Although we believe the risk of taking part in this research will be minimal, the following liability statement is required in all University of Montana consent forms.

“In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, and Chapter 9. In the event of a claim for such injury, further information may be obtained from the Universities Claims Representative or University Legal Counsel.”

VOLUNTEER PARTICIPATION/WITHDRAWAL

Your decision to take part in this research is completely **voluntary**. You are free to skip any question or discontinue participation at any time. You may refuse to take part in this study or withdraw at any time.

QUESTIONS

If you have any questions about this research please feel free to contact Dr. Laura Dybdal at (406)243-6988 or Dr. Dybdal's research assistant Helen Burnside helen.burnside@umontana.edu.

CONSENT

I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I might have will be answered by the research team. I voluntarily agree to take part in this study. I am at least 18 years of age. I understand this is my copy to keep of this consent form.

THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

Appendix G:
Interveiw Guide

Interview Questions

- 1) Have you seen any media information about HIV recently in Kalispell?

***If they have not seen any HIV media information then the interview will not continue
(Please think about all the different places you have seen, heard, or read any media information about HIV recently)***

- 2) What have you seen in Kalispell?

(Please think about all the types of media information you have seen about HIV such as billboards, posters, commercials, theatre slides)

- 3) What have you seen most frequently in Kalispell?

(Billboards, posters, commercials, or theatre slides)

- 4) What do you remember about what you saw?

(Please mention all the messages or anything else that you can recall about the campaign)

- 5) Which messages do you identify with?

a) Which messages do you not identify with?

- 6) Are there any additional messages for future campaigns that you can suggest to stop the spread of HIV in Montana?

- 7) How do you feel the HIV Prevention Campaign in Kalispell has affected you?

(Did you change any behaviors, get tested for HIV, talk about HIV with you partner, become more aware of HIV in Montana, get more information about HIV, etc.)

a) Has the campaign affected you positively?

b) Has the campaign affected you negatively?

8) Is this the most effective way to reach you with HIV prevention information?

c) If not, what is the most effective way to reach you with HIV prevention information?

9) Please take a moment to think about past media campaigns that you have seen, what made these campaigns memorable for you?

(What made them work? Grab your attention?)

10) What else would you like to mention that we have not discussed today?

DEMOGRAPHICS

Date: _____

<p>1) Current Gender:</p> <p style="text-align: center;"> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender </p>		
<p>2) Estimated Age? _____</p>		
<p>3) Risk category:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> No risk identified <input type="checkbox"/> Unprotected sex <input type="checkbox"/> STD Diagnosis <input type="checkbox"/> Sexual assault <input type="checkbox"/> Sex for drugs or money <input type="checkbox"/> Other _____ </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Injection drug use <input type="checkbox"/> Sex with injecting drug user <input type="checkbox"/> Sex with person with HIV/AIDS <input type="checkbox"/> Sex while using drugs or alcohol <input type="checkbox"/> Sex with homosexual </td> </tr> </table>	<input type="checkbox"/> No risk identified <input type="checkbox"/> Unprotected sex <input type="checkbox"/> STD Diagnosis <input type="checkbox"/> Sexual assault <input type="checkbox"/> Sex for drugs or money <input type="checkbox"/> Other _____	<input type="checkbox"/> Injection drug use <input type="checkbox"/> Sex with injecting drug user <input type="checkbox"/> Sex with person with HIV/AIDS <input type="checkbox"/> Sex while using drugs or alcohol <input type="checkbox"/> Sex with homosexual
<input type="checkbox"/> No risk identified <input type="checkbox"/> Unprotected sex <input type="checkbox"/> STD Diagnosis <input type="checkbox"/> Sexual assault <input type="checkbox"/> Sex for drugs or money <input type="checkbox"/> Other _____	<input type="checkbox"/> Injection drug use <input type="checkbox"/> Sex with injecting drug user <input type="checkbox"/> Sex with person with HIV/AIDS <input type="checkbox"/> Sex while using drugs or alcohol <input type="checkbox"/> Sex with homosexual	
<p>4) Sexual orientation:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Bisexual </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Homosexual/Gay <input type="checkbox"/> Other _____ </td> </tr> </table>	<input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Bisexual	<input type="checkbox"/> Homosexual/Gay <input type="checkbox"/> Other _____
<input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Bisexual	<input type="checkbox"/> Homosexual/Gay <input type="checkbox"/> Other _____	
<p>5) Outreach activity:</p>		

Appendix H:
Survey Results for Flathead and Silver-Bow
Counties

Kalispell

A total of 18 surveys were completed by individuals receiving HIV Counseling and Testing at the Flathead County Health Department or by outreach workers. Surveys were collected from April 2006 to July 2006. The HIV Prevention Social Marketing Campaign started in Flathead County in March 2006. The surveys were collected for the first four months of the campaign.

Demographics

This section of the survey included nine questions. Individuals were asked to provide the following demographic information: age, gender, sexual orientation, race/ethnicity, risk exposure, previously tested for HIV, reasons for not previously testing for HIV, length since last test, and decision to test.

Age and Gender

Respondents reported age as follows (n=18):

- Average age is 30.
- Age ranged from 18 to 57 years old.

Respondents reported gender as follows (n=18):

- 33% were female (n=6)
- 67% were male (n=12)

Ethnicity

The ethnicity of survey respondents is listed in Table 26 below.

Table 26. Ethnicity for Kalispell (n=18)

Ethnicity	Percent of Respondents	Frequency
Native American	11%	2
Asian/Pacific Islander	5%	1
African American	0%	0
White (non-Hispanic)	84%	15
Hispanic	0%	0
Other	0%	0

Sexual Orientation

The sexual orientation of respondents is listed Table 27 below.

Table 27. Sexual Orientation for Kalispell (n=18)

Sexual Orientation	Percent of Respondents	Frequency
Heterosexual	44%	8
Homosexual	44%	8
Bisexual	12%	2
Other	0%	0

Risk Exposure Categories

Respondents were asked to check all of the risk exposure categories that applied to them. Respondents were asked to check all categories that apply, this accounts for the percent of respondents equaling more than 100%. The risk exposure categories of respondents are listed in Table 28 below.

Table 28. Risk Exposure Categories for Kalispell (n=18)

Risk Exposure Category	Percent of Respondents	Frequency
Unprotected sex	72%	13
Used injecting drugs	22%	4
Sex for money or drugs	0%	0
Sex with injecting drug user	17%	3
STD diagnosis	0%	0
Sex with a HIV positive person	17%	3
Sex with a homosexual	50%	9
Mother has HIV/AIDS	0%	0
Hemophilia/blood recipient	0%	0
Sex while using drugs or alcohol	39%	7

Previously Tested for HIV

Respondents were asked if they had previously been tested for HIV and if yes, the results of the test. The respondent's answers are presented in Table 29 below.

Table 29. Previously Tested for HIV for Kalispell (n=18)

Previously Tested for HIV	Percent of Respondents	Frequency
No	28%	5
Yes/Negative	67%	12
Yes/Positive	0%	0
Yes/Indeterminate	0%	0
Yes/Unknown	0%	0
Don't Know	5%	1

Reasons for Not Previously Testing for HIV

The respondents who had not been previously tested for HIV (n=5) were asked to check all the reasons for not previously testing. The respondent's answers are presented in Table 30 below. The number of respondents who identified more than one reason for not previously testing accounts for percent of respondents equaling more than 100%.

Table 30. Reasons for Not Previously Testing for HIV for Kalispell (n=5)

Reasons for Not Previously Testing	Percent of Respondents	Frequency
Unlikely to have been exposed through sex	60%	3
Afraid to find out my HIV status	20%	1
Didn't want to think about being HIV positive	0%	0
Worried about who would learn results	20%	1
Didn't want anyone to think I was at risk	0%	0
Worried my name would be reported	0%	0
Worried friends would react badly	0%	0
Thought I was HIV negative	60%	3
Didn't have time	40%	2
Didn't want to worry family members	0%	0
Unlikely of have exposure through drug use	16%	0
Didn't want people to think I was gay	40%	2
Didn't want people to think I used drugs	20%	1
Other	0%	0

Length since Last Test

Those respondents that had been previously tested (n=11) were asked to specify how long it had been since their last HIV test. The respondent's length since last HIV test is reported in Table 31 below.

Table 31. Length since Last Test for Kalispell (n=11)

Length since Last Test	Percent of Respondents	Frequency
3 months	27%	3
6 months	18%	2
12 months	18%	2
More than 1 year	37%	4

Decision to Test

Respondents were asked to respond to whether or not media information about HIV contributed to their decision to get tested for HIV. The respondent's answers are reported in Table 32 below.

Table 32. Decision to Test for Kalispell (n=18)

Decision to Test	Percent of Respondents	Frequency
Agree	56%	10
Disagree	39%	7
Not Sure	5%	1

Campaign Awareness

This section of the survey assessed campaign awareness and included seven questions. Individuals were asked to answer the following questions: have you seen media information about HIV, what have you seen, campaign exposure, campaign message recall, and two questions about campaign effect.

Media Information about HIV

Survey respondents (n=18) were asked if they had seen any media information about HIV. Survey respondents reported the following about seeing media information about HIV:

- 95% (n=17) reported seeing media information about HIV.
- 5% (n=1) reported not seeing media information about HIV.

Billboards

Survey respondents (n=18) were asked if they had seen a billboard about HIV. Survey respondents reported the following about seeing a billboard about HIV:

- 72% (n=13) reported seeing a billboard about HIV.
- 28% (n=5) reported not seeing a billboard about HIV.

Survey respondents (n=8) reported the following about how many billboards they had seen:

- The minimum times respondents reported seeing billboards about HIV were 2 and the maximum was 120.
- The mean billboards seen in Kalispell were 38.87.
- Of the 13 respondents who reported seeing a billboard, 5 respondents did not report how many billboards they saw.

Commercials

Survey respondents (n=18) were asked if they had seen a commercial about HIV. Survey respondents reported the following about seeing a commercial about HIV:

- 72% (n=13) reported seeing a commercial about HIV.
- 28% (n=5) reported not seeing a commercial about HIV.

Survey respondents (n=8) reported the following about how many commercials about HIV they had seen:

- The maximum times respondents reported seeing commercials about HIV were 60 and the minimum was 2.
- The mean commercials seen were 34.25.
- Of the 13 respondents who reported seeing a commercial, 5 respondents did not report how many commercials they saw.

Posters

Survey respondents (n=18) were asked if they had seen any posters about HIV. Respondents reported the following about seeing posters about HIV:

- 72% (n=15) reported seeing a poster about HIV.
- 28% (n=3) reported not seeing a poster about HIV.

Survey respondents (n=9) reported the following about how many commercials they have seen:

- The maximum times respondents reported seeing a poster was 100 and the minimum time was 2.
- The mean posters seen were 11.55.
- Of the 15 respondents who reported seeing posters, 6 respondents did not report how many posters they had seen.

Theatre Slides

Survey respondents (n=18) were asked if they had seen any theatre slides about HIV. Respondents reported the following about if they had seen any theatre slides:

- 28% (n=3) reported seeing a theatre slide about HIV.
- 72% (n=15) reported not seeing a theatre slide about HIV.

Survey respondents (n=3) reported the following about how many theatre slides they have seen:

- Of the three respondents, one respondent reported seeing posters 4 times.

Campaign Message Recall

All survey respondents (n=18) were asked to describe what they remember about the campaign. Not all respondents described what they recalled and duplicate responses are only noted once. There were 4 respondents who recalled the message “to get tested.” Respondents remembered the following things about what they saw:

- *“The fact that it was so simple to get tested, everyone can do it.”*
- *“That anyone of us can have it.”*
- *“Get tested with a local phone number and location.”*

- “General advice about HIV.”
- “I liked all the messages.”
- “Lot’s of things, they are all over work.”
- “To get tested.”
- “Get tested, HIV does not discriminate.”
- “The importance of getting tested.”

Campaign Effect

Survey respondents (n=18) were asked if the media campaign affected them in any way. Respondent reported the following about campaign effect:

- 61% (n=11) agreed the media campaign did have an affect on them.
- 17% (n=3) felt the media campaign somewhat affected them.
- 11% (n=2) did not feel the media campaign had an affect on them.
- 11% (n=2) were not sure if the media campaign had an affect on them.

Type of Campaign Effect

Survey respondents were asked how the media campaign affected them, 15 respondents reported an effect. The respondent’s answers are reported below in Table 33. The number of respondents who identified more than one effect accounts for percent of respondents equaling more than 100%.

Table 33. Type of Campaign Effect for Kalispell (n=15)

Campaign Effect	Percent of Respondents	Frequency
I got tested for HIV	67%	10
I changed my sexual behaviors	7%	1
I got more information about HIV	27%	4
I am more aware of HIV in Montana	40%	6
I use condoms more frequently	20%	3
I know my HIV status	33%	5
I know my Hepatitis C status	7%	1
I no longer share needles	7%	1
I talked to my partner about HIV	7%	1
I asked my partner to get tested	7%	1
Other	13%	2

Other responses included: “encouraged friends to get tested” and “hasn’t affected me.”

Campaign Message Agreement

This section of the survey included 17 questions. Each question was a statement developed from the HIV Prevention Social Marketing Campaign messages. Participants will read each statement and respond by checking one of the following: agree, disagree, or not sure.

Campaign Message Agreement

Each campaign message statement is listed below. Respondents answered are reported in Table 34 below.

Table 34. Campaign Message Agreement for Kalispell (n=18)

Campaign Message	Agree % (n)	Disagree % (n)	Not Sure % (n)
I can become infected with HIV in Montana	100% (18)	0% (0)	0% (0)
HIV doesn't care what your sexual orientation is	95% (17)	5% (1)	0% (0)
HIV does not discriminate, heterosexual women are affected too	95% (17)	0% (0)	5% (1)
HIV positive people exist in Montana	100% (18)	0% (0)	0% (0)
Anyone can contract HIV/AIDS	95% (17)	0% (0)	5% (1)
Protecting myself, my family, and my friends means knowing my HIV and Hepatitis C status	100% (18)	0% (0)	0% (0)
I can help stop the spread of HIV/AIDS	95% (17)	0% (0)	5% (1)
There is no cure for HIV/AIDS	73% (13)	22% (4)	5% (1)
It is important to get early treatment if infected with HIV.	95% (17)	0% (0)	5% (1)
If I am sharing needles I am at risk for HIV	100% (18)	0% (0)	0% (0)
If I am engaging in unprotected sex I should get tested for HIV	95% (17)	0% (0)	5% (1)
Condoms can protect me from HIV/AIDS	73% (13)	16% (3)	11% (2)
It is the responsibility of HIV positive individuals to protect others	73% (13)	22% (4)	5% (1)
In Montana, free and anonymous HIV testing is available	100% (18)	0% (0)	0% (0)
In Montana, HIV positive individuals are supported by their medical community	73% (13)	5% (1)	22% (4)
HIV positive individuals don't need to apologize for having HIV	95% (17)	0% (0)	5% (1)

Butte

A total of 54 surveys were completed in Butte by individuals receiving HIV Counseling and Testing at the Butte Silver-Bow County Health Department or by outreach workers. Surveys were collected from April 2006 through July 2006. The HIV Prevention Social Marketing Campaign started March 2006 in Butte. Therefore, surveys were collected the first four months of the campaign.

Demographics

This section of the survey included nine questions. Individuals were asked to provide the following demographic information: age, gender, sexual orientation, race/ethnicity, risk exposure, previously tested for HIV, reasons for not previously testing for HIV, length since last test, and decision to test.

Age and Gender

Respondents reported age as follows (n=54):

- Average age is 32.17.
- Age ranged from 17 to 58 years old.

Respondents reported gender as follows (n=54):

- 46% were female (n=25)
- 54% were male (n=29)

Ethnicity

The ethnicity of survey respondents is listed in Table 35 below.

Table 35. Ethnicity for Butte (n=54)

Ethnicity	Percent of Respondents	Frequency
Native American	11%	6
Asian/Pacific Islander	0%	0
African American	0%	0
White (non-Hispanic)	83%	45
Hispanic	4%	2
Other*	2%	1

*Other responses included: "I do not believe in race."

Sexual Orientation

The sexual orientation of respondents is listed Table 36 below.

Table 36. Sexual Orientation for Butte (n=54)

Sexual Orientation	Percent of Respondents	Frequency
Heterosexual	87%	47
Homosexual	6%	3
Bisexual	7%	4
Other	0%	0

Risk Exposure Categories

Respondents were asked to check all of the risk exposure categories that applied to them. Respondents were asked to check all categories that apply, this accounts for the percent of respondents equaling more than 100%. The risk exposure categories of respondents are listed in Table 37 below.

Table 37. Risk Exposure Categories for Butte (n=54)

Risk Exposure Category	Percent of Respondents	Frequency
Unprotected sex	74%	40
Used injecting drugs	13%	7
Sex for money or drugs	2%	1
Sex with injecting drug user	13%	7
STD diagnosis	13%	7
Sex with a HIV positive person	17%	2
Sex with a homosexual	2%	1
Mother has HIV/AIDS	0%	0
Hemophilia/blood recipient	0%	0
Sex while using drugs or alcohol	48%	26

Previously Tested for HIV

Respondents were asked if they had previously been tested for HIV and if yes, and the results of the test. The respondent's answers are presented in Table 38 below.

Table 38. Previously Tested for HIV for Butte (n=54)

Previously Tested for HIV	Percent of Respondents	Frequency
No	43%	23
Yes/Negative	57%	31
Yes/Positive	0%	0
Yes/Indeterminate	0%	0
Yes/Unknown	0%	0
Don't Know	0%	0

Reasons for Not Previously Testing for HIV

The respondents who had not been previously tested for HIV (n=23) were asked to check all the reasons for not previously testing. The respondent's answers are presented in Table 39 below. The number of respondents who identified more than one reason for not previously testing accounts for percent of respondents equaling more than 100%.

Table 39. Reasons for Not Previously Testing for HIV for Butte (n=23)

Reasons for Not Previously Testing	Percent of Respondents	Frequency
Unlikely to have been exposed through sex	57%	13
Afraid to find out my HIV status	39%	9
Didn't want to think about being HIV positive	49%	11
Worried about who would learn results	22%	5
Didn't want anyone to think I was at risk	17%	4
Worried my name would be reported	13%	3
Worried friends would react badly	30%	7
Thought I was HIV negative	39%	9
Didn't have time	4%	1
Didn't want to worry family members	9%	2
Unlikely of have exposure through drug use	26%	6
Didn't want people to think I was gay	9%	2
Didn't want people to think I used drugs	9%	2
Other*	17%	4

*The four other responses did not explain the reason.

Length since Last Test

Those respondents that had been previously tested (n=31) were asked to specify how long it had been since their last HIV test. The respondent's length since last HIV test is reported in Table 40 below.

Table 40. Length since Last Test for Butte (n=31)

Length since Last Test	Percent of Respondents	Frequency
3 months	19%	6
6 months	23%	7
12 months	26%	8
More than 1 year	33%	10

Decision to Test

Respondents were asked to respond to whether or not media information about HIV contributed to their decision to get tested for HIV. The respondent's answers are reported in Table 41 below.

Table 41. Decision to Test for Butte (n=54)

Decision to Test	Percent of Respondents	Frequency
Agree	52%	28
Disagree	35%	19
Not Sure	13%	7

Campaign Awareness

This section of the survey assessed campaign awareness and included seven questions. Individuals were asked to answer the following questions: have you seen media information about HIV, what have you seen, campaign exposure, campaign message recall, and two questions about campaign effect.

Media Information about HIV

Survey respondents (n=54) were asked if they had seen any media information about HIV. Survey respondents reported the following about seeing media information about HIV:

- 89% (n=48) reported seeing media information about HIV.
- 11% (n=6) reported not seeing media information about HIV.

Billboards

Survey respondents (n=54) were asked if they had seen a billboard about HIV. Survey respondents reported the following about seeing a billboard about HIV:

- 80% (n=43) reported seeing a billboard about HIV.
- 20% (n=11) reported not seeing a billboard about HIV.

Survey respondents (n=25) reported the following about how many billboards they had seen:

- The minimum times respondents reported seeing billboards about HIV were 1 and the maximum was 100.
- The mean billboards seen in Kalispell were 9.73.
- Of the 43 respondents who reported seeing a billboard, 18 respondents did not report how many times they had seen a billboard.

Commercials

Survey respondents (n=54) were asked if they had seen a commercial about HIV. Survey respondents reported the following about seeing a commercial about HIV:

- 74% (n=40) reported seeing a commercial about HIV.
- 26% (n=14) reported not seeing a commercial about HIV.

Survey respondents (n=23) reported the following about how many commercials about HIV they had seen:

- The maximum times respondents reported seeing commercials about HIV were 100 and the minimum was 1.
- The mean commercials seen were 9.22.
- Of the 40 respondents who reported seeing a commercial, 17 respondents did not report how many times they had seen a commercial.

Posters

Survey respondents (n=54) were asked if they had seen any posters about HIV. Respondents reported the following about seeing posters about HIV:

- 74% (n=40) reported seeing a poster about HIV.
- 26% (n=14) reported not seeing a poster about HIV.

Survey respondents (n=22) reported the following about how many commercials they have seen:

- The maximum times respondents reported seeing a poster was 40 and the minimum time was 2.
- The mean posters seen were 5.29.
- Of the 40 respondents who reported seeing posters, 18 respondents did not report how many posters they had seen.

Theatre Slides

Survey respondents (n=54) were asked if they had seen any theatre slides about HIV. Respondents reported the following about if they had seen any theatre slides:

- 4% (n=2) reported seeing a theatre slide about HIV.
- 96% (n=52) reported not seeing a theatre slide about HIV.

Survey respondents (n=2) reported the following about how many theatre slides they have seen:

- Of the two respondents, one respondent reported seeing theatre slides 6 times and the other respondent reported seeing theatre slides 1 time.
- The mean theatre slides seen were 3.5.

Campaign Message Recall

All survey respondents (n=54) were asked to describe what they remember about the campaign. Not all respondents described what they recalled and duplicate responses are only noted once. There were 15 respondents who recalled the message “to get tested.” Respondents remembered the following things about what they saw:

- “Testing is available.”

- *“HIV can lead to AIDS which is deadly. Practice safe sex. HIV and AIDS are non-discriminatory.”*
- *“Where HIV testing is done.”*
- *“Showing needles and gay.”*
- *“That it can infect anyone not just homosexuals.”*
- *“Doing a good job.”*
- *“It kills you.”*
- *“Mostly the billboard and it said the reasons to get tested and described the risks.”*
- *“The billboard caught my attention (graphics)-I drive past it everyday.”*
- *“To get tested.”*
- *“How HIV is contracted. That HIV and AIDS are not the same thing. You can be HIV positive and still not have AIDS. Although the first leads you to the second.”*
- *“That it is important to be careful, use abstinence or a condom and get tested if you think that there might be a chance that you have it.”*
- *“Why I practice safe sex.”*
- *“People crying, people of different ages, different races.”*
- *“Free confidential testing, News programs on CNN and MSNBC really have affected me as well.”*
- *“Magic Johnson.”*
- *“Scared me.”*
- *“HIV can be prevented-abstain and or use condoms.”*
- *“Encouraging safe sex, abstinence, testing the high risk homosexual men.”*
- *“Glad to see it, makes people more aware of HIV, good job.”*
- *“HIV doesn’t discriminate, it’s for life, the disease process is not fun or good, no cure.”*
- *“HIV does not discriminate, get tested.”*
- *“That it is scary because you can be an innocently infected.”*
- *“I remember a poster saying HIV doesn’t discriminate*
- *“Most people that infect others don’t know that they are infected themselves.”*
- *“To get tested often.”*
- *“Blood contact, I.V. drug users and risks.”*
- *“Practice safe sex-condoms.”*
- *“In random places/businesses, there are posters about having safe sex hanging up. I haven’t seen a billboard in this state that I can recall. The commercial I saw was awhile ago and it was about abstinence.”*
- *“How real it is in Montana, and that it is out there. It scared me.”*
- *“Getting tested is the best thing to do.”*
- *“A commercial about the international HIV testing day.”*
- *“I liked the message.”*
- *“Need to be tested.”*
- *“Get tested now, HIV doesn’t discriminate.”*

Campaign Effect

Survey respondents (n=54) were asked if the media campaign affected them in any way. Respondent reported the following about campaign effect:

- 50% (n=27) agreed the media campaign did have an affect on them.
- 20% (n=11) felt the media campaign somewhat affected them.
- 20% (n=11) did not feel the media campaign had an affect on them.
- 10% (n=5) were not sure if the media campaign had an affect on them.

Type of Campaign Effect

Survey respondents were asked how the media campaign affected them, 34 respondents reported an effect. The respondent's answers are reported below in Table 42. The number of respondents who identified more than one effect accounts for percent of respondents equaling more than 100%.

Table 42. Type of Campaign Effect for Butte (n=34)

Campaign Effect	Percent of Respondents	Frequency
I got tested for HIV	85%	33
I changed my sexual behaviors	36%	14
I got more information about HIV	41%	16
I am more aware of HIV in Montana	41%	16
I use condoms more frequently	23%	9
I know my HIV status	36%	14
I know my Hepatitis C status	8%	3
I no longer share needles	0%	0
I talked to my partner about HIV	18%	7
I asked my partner to get tested	23%	9
Other	8%	3

Other responses included: “media campaign had nothing to do with my testing”, “I got to school and I know I need to be careful in the medical field”, “I don’t engage in any risky behaviors.”

Campaign Message Agreement

This section of the survey included 17 questions. Each question was a statement developed from the HIV Prevention Social Marketing Campaign messages. Participants will read each statement and respond by checking one of the following: agree, disagree, or not sure.

Campaign Message Agreement

Each campaign message statement is listed below. Respondents answered are reported in Table 43 below.

Table 43. Campaign Message Agreement for Butte (n=54)

Campaign Message	Agree % (n)	Disagree % (n)	Not Sure % (n)
I can become infected with HIV in Montana	93% (50)	5% (3)	2% (1)
HIV doesn't care what your sexual orientation is	94% (51)	2% (1)	4% (2)
HIV does not discriminate, heterosexual women are affected too	96% (52)	2% (1)	2% (1)
HIV positive people exist in Montana	98% (53)	2% (1)	0% (0)
Anyone can contract HIV/AIDS	93% (50)	7% (4)	0% (0)
Protecting myself, my family, and my friends means knowing my HIV and Hepatitis C status	96% (52)	2% (1)	2% (1)
I can help stop the spread of HIV/AIDS	96% (52)	4% (2)	5% (1)
There is no cure for HIV/AIDS	78% (42)	4% (2)	18% (10)
It is important to get early treatment if infected with HIV.	82% (44)	2% (1)	16% (9)
If I am sharing needles I am at risk for HIV	98% (53)	0% (0)	2% (1)
If I am engaging in unprotected sex I should get tested for HIV	98% (53)	0% (0)	2% (1)
Condoms can protect me from HIV/AIDS	72% (39)	10% (5)	18% (10)
It is the responsibility of HIV positive individuals to protect others	90% (49)	6% (3)	4% (2)
In Montana, free and anonymous HIV testing is available	96% (52)	0% (0)	4% (2)
In Montana, HIV positive individuals are supported by their medical community	65% (35)	4% (2)	31% (17)
HIV positive individuals don't need to apologize for having HIV	67% (37)	4% (2)	29% (15)