HIV / AIDS:
Prevention and Health Communication

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Edited by

Margaret U. D'Silva, Joy L. Hart,
and Kandi L. Walker

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INTRODUCTION

HIV/AIDS: COMMUNICATION AND PREVENTION

JOY L. HART, MARGARET U. D'SILVA, AND KANDI L. WALKER

To say that HIV/AIDS is a colossal public health problem is a vast understatement. Its effects extend to all reaches of the globe and its toll is enormous. The statistics on the toll of HIV/AIDS are staggering. For example, in 2007, approximately 33.2 million people across the world were living with HIV/AIDS (UNAIDS 2007). The chapters in this volume include statistical information from a number of sources and some report on specific populations or locations. Regardless of the statistics employed, however, it is clear that HIV/AIDS is having devastating impacts. Even with some leveling of cases and adjustments in projection figures, the most recent statistics on HIV infections, people living with HIV/AIDS (PLWH/A), and AIDS-related deaths are jolting. For example, UNAIDS (2007) reported 2.5 million new infections in 2007 with an infection rate of 6,800 persons each day. Further, 2007 brought 2.1 million deaths from AIDS, with more than 5,700 persons dying each day from AIDS-related reasons (UNAIDS 2007).

Looking historically sheds additional light on the devastation HIV/AIDS has wrought across the globe. In the past twenty-five years, HIV has infected almost 65 million persons, and it is believed that approximately 25 million deaths have occurred from AIDS-related causes (UNAIDS 2006). These statistics provide only an overview—examining impacts in the hardest hit areas or among the most affected populations, as some chapters in this volume will reveal, are even more sobering. And in spite of some tempering of earlier estimates (e.g., in 2007, UNAIDS lowered PLWH/A from 39.5 to 33.2 million), the number of PLWH/A is

believed to be growing (e.g., due to general population growth, new infections, and longer survival rates).

Beyond effects on individuals, HIV/AIDS affects families, communities, societies, and economies. And progression of the disease has undermined progress on a number of important social initiatives (e.g., reducing poverty, decreasing child mortality; UNAIDS 2006). According to UNAIDS (2006), "the epidemic comes in successive waves, with the first wave being HIV infection, followed several years later by a wave of opportunistic diseases, and later still by a wave of AIDS illness and then death" (80). An additional wave of social calamity follows hitting societies from the family and community levels to the economic and national ones. Further, according to UNAIDS (2006), impacts of the later waves are still unknown and in some cases unpredictable (e.g., long-term damage, ranging from psychological to social, related to the growing millions of children orphaned by HIV/AIDS).

Considering current realities, historical data, and future projections, considerably more action needs to be taken to prevent new infections and curb the effects of HIV/AIDS. Twenty-five years into the HIV/AIDS epidemic, the worldwide response is insufficient—it must become stronger and better integrated if real progress is to be made (UNAIDS 2006). Despite increases in prevention programs, too few people are reached (UNAIDS 2006). Such interventions reach only a small subset of the populations needing them. Further, considerable evidence exists regarding the effectiveness of interventions in reducing risky sex behavior (UNAIDS 2006). For example, increased use of condoms has resulted in lower HIV transmission rates in a number of places. But more educational programs are needed, and such programs need especially to be targeted to groups particularly at-risk (e.g., sex workers, men who have sex with men; UNAIDS 2006).

Although HIV/AIDS prevention programs need improvement, such education has been shown to be effective (AVERT 2008a), both to prevent new infections and to help persons already infected to live with the virus. Beyond providing factual information, prevention programming also needs to address individual strategies (e.g., navigating sexual relations and negotiating safer sex, procuring condoms; AVERT 2008a). Rather than a single global strategy for HIV/AIDS prevention, programs must be developed and implemented with an awareness of local, regional, and national conditions. According to AVERT (2008b), successful programs typically have several common features—open communication, programmatic nature, and community involvement.

With this volume, our hope is that additional insight into HIV/AIDS prevention can be garnered and that ideas included will spur new efforts and improve existing ones. In particular, the chapters in this volume explore how health communication researchers and practitioners are playing and can continue to play critical roles in lessening HIV infection and the devastating impacts of HIV/AIDS locally, regionally, and globally.

Toward this goal, the book is divided into three sections—general prevention, global context, and specific contexts. In the first section, three chapters address differing aspects of general HIV/AIDS prevention efforts. The first chapter by Noar, Palmgreen, Zimmerman, and Cupp, "Formative Research and HIV/AIDS Mass Media Campaigns: Applications and Insights from the Field," examines HIV/AIDS research from the lens of formative research. Noar et al. describe two studies about HIV/AIDS and sexually transmitted disease prevention campaigns. The first study examined is the "Safer Sex Campaign," which focuses on condom use among young adults. The second study described is the "Postponing Sex Campaign," which is an ongoing project targeted toward young adults postponing sexual intercourse. Through examination of these two studies, Noar et al. provide a rationale for formative research so that future HIV/AIDS campaign planners can create and disseminate more informed HIV/AIDS prevention mass media campaigns.

In "Promoting HIV Testing Under Low Prevalence Conditions: Deceptive Strategies in the Communication of Risk," Steinfatt examines the difficulty of communicating statistical information. In particular, Steinfatt focuses on communication regarding false positives in HIV tests. This chapter informs the reader on probabilities surrounding false positives in HIV tests, examines how healthcare personnel are likely to communicate test results and their meanings to recipients, and calls for more accurate and sensitive communication of such information. Steinfatt also examines the role of culture, fear, and sensitivity in shaping how messages are produced and interpreted. Understanding of false positives as well as the communication issues surrounding them can lead to more accurate interpretation of results and avenues of action.

The Spence and Lachlan chapter, "Hazard and Outrage: Influencing Behavior in HIV Prevention," examines how messages to prevent HIV may alert people to the risks and simultaneously reassure them. In general, the goal of such messages is to stimulate a level of outrage proportionate to the level of risk. In this chapter, Spence and Lachlan report the results of an exploratory study, which examined hazard and outrage aspects of HIV messages, participants' reported levels of hazard and outrage, and the

effects of these perceptions on self-efficacy. Their findings suggest that HIV messages resulted in perceptions of hazard; however, such perceptions did not lead to greater outrage or self-efficacy.

In the second section, global context, four chapters examine HIV/AIDS prevention efforts in four countries. The Walker and Hart chapter, "HIV/AIDS Education and Awareness Efforts in Belize, Central America: Health Education Awareness Team," describes HIV/AIDS health education using an intercultural approach in Belize, a country at a critical point in the course of the HIV/AIDS epidemic. In an effort to address the growing problem of HIV/AIDS in this Central American nation, a team of university faculty and students has begun designing and delivering educational programs to raise HIV/AIDS awareness in two rural villages, Red Bank and Gales Point. This chapter presents data from several years of prevention programs and discusses the future of the Health Education Awareness Team's efforts as well as HIV/AIDS health education in developing countries.

In "Communicating HIV/AIDS Awareness through Folk Theater and Art: Examples from India," D'Silva, Alladi, Futrell, and Gohain examine a creative method of educating the rural Indian population about HIV/AIDS. With at least 500,000 HIV/AIDS-related deaths, India faces the ongoing challenge of caring for the infected as well as containing the epidemic. Although some strategies have stemmed the spread of the virus, the stigma surrounding HIV/AIDS frequently frustrates standard mass communication and promotion activities. Folk arts and folk theater, however, represent a method of reaching populations through indigenous entertainment forms that may dispel myths and overcome taboos that often obstruct the dissemination of accurate information about HIV/AIDS. This chapter discusses how "yakshagana," an ancient theatrical form, can be used to discuss sexuality and HIV/AIDS in a non-threatening context. This innovative approach may serve as a blueprint for future empirically-based educational initiatives.

In "Corporate HIV/AIDS Efforts in South Africa: Prevention, Education, and Treatment for Employees," Rampersad and Hart examine HIV/AIDS in South Africa, a nation experiencing one of the heaviest tolls of the disease worldwide (AVERT 2006). In a country with more PLWH/A than in any other nation (UNAIDS 2007), an adult infection rate of nearly one in five (AVERT 2006), and a general prevalence rate of just under 20% (Department of Health 2007), prevention and treatment are critical. In this chapter, Rampersad and Hart focus on one sector engaged in battling HIV/AIDS—corporations. Despite myriad motivations that may be driving corporate efforts to lessen the impacts of HIV/AIDS (i.e.,

through education, prevention, and treatment), some argue that corporations play a critical role in assisting workers, their families, and members of surrounding communities. This chapter provides examples of such efforts and assesses their utility.

In her chapter, "Faith-Based Organizations and HIV/AIDS Prevention: Cultural and Communication Challenges in Jamaica," Muturi examines efforts to lessen the impact of HIV/AIDS in Jamaica. With 1.5 percent of its adult population HIV infected (UNAIDS 2006), Jamaica faces a serious health challenge. To meet the challenge, faith-based organizations (FBOs) have undertaken several measures to care for the infected and to prevent the spread of HIV. In this chapter, Muturi uses focus groups, interviews, and participant observation to analyze the role of Jamaican FBOs in dealing with HIV/AIDS. She finds that FBOs have informed people about HIV/AIDS (e.g., through sermons and seminars) and promoted strategies for behavior change to reduce HIV infections. However, cultural factors and stigmatization that contribute to the spread of the contagion impede FBOs' prevention efforts. Finally, Muturi examines the communication-related issues that FBOs face, making HIV/AIDS particularly difficult to tackle.

The final section of the volume, specific contexts, examines HIV/AIDS prevention efforts with particular subgroups—PLWH/A, later-life adults, university students, and African Americans. In their chapter "Interventions for People Living with HIV/AIDS: A Review of the Literature and Directions for Communication Research," Klein and Lapinski focus attention on prevention interventions for PLWH/A in the United States. Studies suggest that many PLWH/A engage in risky behavior and several interventions have made attempts to change such behavior; however, little is published addressing the outcomes of these efforts. Thus, work continues without the benefit of previous lessons. In order to improve such efforts, the Klein and Lapinski chapter reviews communication interventions for PLWH/A in the U.S. In particular, these authors focus on describing such efforts, examining their outcomes, and recommending strategies for improvement.

The Dickson and Walker chapter, "HIV/AIDS among Later-Life Adults," explores prevention efforts or the lack thereof in the United States for people over fifty years of age. Although society and science have an increased awareness of HIV/AIDS, there has been a general failure in recognizing the elderly as an at-risk group. Ageism, lack of information, and negative perceptions contribute to the lack of attention to HIV/AIDS education, prevention, and treatment efforts with individuals over fifty years of age (Levy-Dweck 2005). Dickson and Walker examine

issues of ageism, racism, and lack of knowledge about sexuality among older adults and how such perceptions result in a lack of HIV/AIDS efforts with this segment of society. In addition, Dickson and Walker discuss social conditions influencing the way later-life adults prevent or fail to take actions to prevent the transmission of HIV as well as methods by which health care providers can play critical roles in preventing and treating HIV/AIDS in later-life adults.

In "Compliance-Gaining Strategies for HIV/AIDS Talk: College Students' Recommendations for Initiating Conversations with Potential Sexual Partners," Webb examines messages produced by students. Although evidence indicates that university students understand HIV transmission methods, research also suggests that many continue to engage in risky sexual behavior. This fact and the frequency of sex in this age group make university students an especially important group to study. Through content analysis of messages generated by students for a potential partner, Webb identifies common approaches to soliciting information about past partners and for encouraging AIDS testing. The most frequently used strategies were ingratiating, directly requesting, hinting, and win-win.

In "Promoting HIV Testing among African Americans," Harris explores prevention efforts in a subset of the U.S. population. HIV/AIDS affects African Americans in greater numbers than it does other groups in the U.S. Although African Americans comprise approximately 13% of the U.S. population, they constitute 51% of those diagnosed with HIV/AIDS (Centers for Disease Control 2006). Because prevention efforts, including encouraging condom use, have not been particularly effective in stemming the spread of HIV/AIDS, testing for HIV/AIDS is proposed as one way to contain the infection. In her chapter, Harris examines HIV/AIDS testing and African Americans. She concludes that African Americans value testing but fear the stigma attached to the disease, envision rejection from family and friends, and, thus, often do not get tested. Communication campaigns, particularly mediated ones, are proposed in this chapter as one way to reach this population.

In the volume's conclusion, "HIV/AIDS Communication Research: Past, Present, and Future," Noar and Edgar summarize health communication efforts to prevent the spread of infection. Based on descriptions of past and present work, these authors address ways in which health communication researchers and practitioners may contribute to future efforts. Because there is currently neither a cure for HIV/AIDS nor a vaccine to prevent infection, Noar and Edgar point out that behavior change is the key to prevention and that health communication work is

crucial to achieving such change. Their chapter links ideas in previous chapters and underscores the purpose of this volume—illuminating the role of health communication in education, prevention, and treatment of HIV/AIDS.

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PART I:

GENERAL PREVENTION

CHAPTER ONE

FORMATIVE RESEARCH AND HIV/AIDS MASS MEDIA CAMPAIGNS: APPLICATIONS AND INSIGHTS FROM THE FIELD[1]

SETH M. NOAR, PHILIP C. PALMGREEN, RICK S. ZIMMERMAN, AND PAMELA K. CUPP

Formative research is a key activity thought to be associated with successful health mass media campaigns (Atkin and Freimuth 2001; Noar 2006; Rogers and Storey 1987; Salmon and Atkin 2003), including those in the HIV/AIDS area (e.g., Alstead et al. 1999; Bull et al. 2002; Witte et al. 1998). In fact, one could argue that if the formative phase of a media campaign project is not given adequate attention, subsequent choices made in campaign implementation and evaluation may not matter, as the campaign could be doomed to failure. Although there are volumes of published HIV/AIDS media campaign *evaluations* in the literature (Bertrand et al. 2006; Myhre and Flora 2000; Palmgreen, Noar, and Zimmerman 2008) as well as general treatments of formative research (Atkin and Freimuth 2001; Valente 2002), there are comparatively few published applications detailing the formative research activities of major HIV/AIDS campaign efforts.

This gap in the literature is notable, given the number of activities that take place and challenges which must be confronted when conducting formative research, including 1) developing plans for the research (e.g., selecting methods, detailing phases of the research); 2) melding ideal formative research plans with "in the field" realities (particularly with sensitive topics such as sexual behavior and HIV/AIDS); 3) implementing formative research plans effectively; 4) testing message concepts and strategies; 5) analyzing and gleaning insights from data generated by formative work; and 6) developing plans that lead to successful implementation of campaigns.

The purpose of the current chapter is to detail the formative research activities for two major National Institute of Mental Health (NIMH)-funded campaign projects focused on HIV/AIDS and sexually transmitted disease (STD) prevention (see Table 1). The first project was a successful campaign to promote condom use among young adults, or what we will refer to as the *Safer Sex Campaign* (Palmgreen et al. 2008; Zimmerman et al. 2007). The second study is an ongoing campaign project (although the formative research phase has been completed) to promote the postponement of initiation of sexual intercourse among young adolescents, or what we will refer to as the *Postponing Sex Campaign*. Both campaign projects have focused on high sensation-seeking and impulsive decision-making youth using the sensation seeking targeting (SENTAR) approach (Palmgreen and Donohew 2003; Palmgreen et al. 2001). This approach targets high sensation-seeking youth with messages high in "message sensation value"; that is, prevention messages based upon features found to be effective with this audience (see Palmgreen and Donohew 2003; Palmgreen et al. 2002). In both studies we developed, implemented, and evaluated intensive 13-week high audience saturation campaigns consisting of a mix of televised 30-second public service announcements (PSAs). Both projects also began with major (approximately two year) phases of strategic formative research. The current chapter focuses both on what those activities were as well as some of the key findings from those activities.

Table 1: *Overview of Major Elements of Two HIV/STD Prevention Mass Media Campaign Projects*

Attribute	Safer Sex Campaign	Postponing Sex Campaign
Goal	Increase condom use in sexually active young adults	Increase the age at which young adolescents initiate sexual activity (i.e., have sex for the first time)
Target Audience	Sexually active young adults aged 18-26, particularly high sensation-seekers and impulsive decision-makers	African American and white sexually inactive adolescents aged 11-14, particularly high sensation-seekers
Location	Two moderate-sized cities in the Southeastern United States	Two moderate-sized cities in the Southeastern United States

Message Design Approach	Sensation-seeking targeting (SENTAR) – messages designed to be effective with high sensation-seekers	Sensation-seeking targeting (SENTAR) – messages designed to be effective with high sensation-seekers
Use of Behavioral Theory	Integrated theoretical framework (Focus on attitudes, negative consequences, social influences, self-efficacy & skills)	Integrated theoretical framework (Focus on attitudes, negative consequences, social influences, self-efficacy & skills)
Message Delivery	30-second televised PSAs	30-second televised PSAs
Number of Unique PSAs Used	11 PSAs (5 original PSAs, 6 existing PSAs)	12 PSAs (7 original PSAs, 5 existing PSAs)
Length of Campaign	13 weeks	13 weeks
Outcome Evaluation	Two-city interrupted time series design	Two-city interrupted time series design

Formative Research and HIV/AIDS Campaigns

Atkin and Freimuth (2001) provide a detailed description of the major formative phases of campaign development. In the first phase, *preproduction research*, information is gathered regarding audience characteristics, the behavior under study, and message channels. As will be discussed, a number of activities to assess audience characteristics and achieve a broad understanding of the behavior under study were undertaken in both the *Safer Sex Campaign* and *Postponing Sex Campaign* projects. In addition, efforts were made to understand audience channels and placement of messages within those channels. In the second phase of formative research, called *production research* or *pre-testing,* initial campaign messages are tested with the target audience in order to gather feedback and revise/improve such messages (Atkin and Freimuth 2001). A number of activities related to collecting and testing existing PSAs as well as developing original PSAs were undertaken in both campaign projects. Finally, the current chapter will discuss *campaign planning* in

terms of how the PSAs developed through formative research were (or in the case of the *Postponing Sex Campaign*, will be) implemented in the campaign efforts. In particular, the sensitive nature of sexual behavior and HIV/AIDS required that concerted efforts be made to ensure that the campaign messages could, in fact, be put on the air. In addition, given that many campaigns have suffered from low message exposure (e.g., see Noar 2006; Snyder et al. 2004), significant efforts were put into ensuring high gross rating point (GRP) campaigns that would achieve high audience exposure to campaign messages in terms of both reach (i.e., how much of the audience is exposed) and frequency (i.e., how often audience members are exposed). Table 2 provides an overview of the *preproduction research*, *pre-testing research*, and *campaign planning* activities that were undertaken in the two HIV/STD prevention campaign projects. Activities are listed in chronological order within each phase such that certain activities were undertaken before others.

Table 2: *Phases of Formative Research and Associated Activities in Two Large-Scale Mass Media Campaign Projects*

Phase	Purpose	Activities
Preproduction Research	Gather information regarding audience characteristics and behavior	• Thoroughly reviewed empirical literature • Conducted focus groups (Safer Sex Campaign) and surveys (Postponing Sex Campaign) with target audience
	Gather information regarding message channels	• Conducted surveys with target audience (pre-campaign data)
Pre-testing	Test messages with target audience – Existing PSAs	• Collected large sample of existing PSAs • Rated existing PSAs on numerous dimensions • Chose most promising PSAs for focus groups • Conducted focus groups (Safer Sex Campaign) and reaction group surveys (Postponing Sex Campaign) to get reactions to PSAs • Secured permission to use PSAs rated

		most highly in focus/reaction groups for campaign
	Develop and test preliminary versions of messages with target audience – Original PSAs	• Wrote numerous scripts for original PSAs • Revised PSA scripts based on research group discussions • Chose most promising scripts for focus groups • Conducted focus groups to get reactions to scripts • Revised scripts based on focus group feedback • Brought on target audience consultants to assist with final versions of PSA scripts • Worked with trusted professional in production of televised PSAs
Campaign Planning	Create plans that will lead to successful implementation of campaign, including high message exposure	• Worked with media buyer as liaison to TV stations • Met with TV gatekeepers/decision makers very early on (in order to partner with them) • Discussed importance of health problem and need for high sensation value messages in campaign with TV gatekeepers • Showed TV gatekeepers sample PSAs • Asked TV gatekeepers for 1-1 match on media buys • Kept TV gatekeepers informed throughout the process of development of PSAs • Worked with media buyer to ensure strategic placement of PSAs • Aired PSAs in a theoretically meaningful way

Preproduction Research

The first activities undertaken with regard to the campaigns were the *preproduction research* activities associated with achieving an understanding of the target audience and behavior under study. Without such an understanding, it would be difficult to select and develop messages aimed at changing a particular audience's attitudes and behavior.

For instance, in both campaign projects, we first conducted thorough reviews of the literature on theoretical predictors of condom use (e.g., Sheeran, Abraham, and Orbell 1999) and postponement of initiation of sex (e.g., Buhi and Goodson 2007), in particular examining those factors which seemed to be the most salient to the particular target audiences under study. In addition to thorough literature reviews, we next conducted focus groups to confirm the salience of those factors found in the literature and to explore whether other important factors emerged. Focus groups were utilized because the dynamics of such groups allow for a rich discussion of the issues at hand.

In the *Safer Sex Campaign*, a set of focus groups aimed at an understanding of why young adults do and do not engage in unprotected sex were conducted. Focus groups were conducted separately according to gender, individual differences (high sensation-seekers and impulsive decision-makers), and college student status (college and non-college students), yielding eight focus groups (2 x 2 x 2 = 8). We conducted two additional focus groups with high sensation-seeking and impulsive decision-making African Americans, who made up a significant minority in the campaign cities. Each focus group consisted of approximately 8-10 individuals. Results largely confirmed the literature regarding determinants of safer sexual behavior. For instance, condoms were viewed as a kind of "catch 22" by men in that they provide protection from pregnancy and disease, but they also diminish sexual pleasure. Condoms were viewed as necessary early in a relationship, with someone one does not know very well, and/or when a female partner is not using other forms of birth control. Condoms were *not* viewed as necessary when one enters a committed relationship where partners trust one another and the female partner is using hormonal birth control.

In the *Postponing Sex Campaign*, conducting focus groups was unfortunately not possible due to the combination of two factors: 1) the sensitive nature of the topic (i.e., sex) and 2) the young age of the target audience (11-14 year olds). Instead, we developed a quantitative, close-ended survey of factors that the literature suggested were important to delaying initiation of sex, including attitudes about waiting (i.e., reasons to have and *not* have sex), refusal self-efficacy, social norms surrounding sex, situations that may lead to sex, and so forth. These surveys were distributed in classrooms to approximately 250 African American and white adolescents, resulting in important insights into reasons adolescents might wait to have sex. For instance, the three most highly ranked reasons (out of nine) to have sex were "if I had a boyfriend/girlfriend I loved," "because I am curious to know what it is like," and "to satisfy my sexual

desires." The 4 most highly ranked reasons to *not* have sex (out of nine) were "because I do not want to have a baby right now," "because I do not want to get AIDS or other diseases," "because my parents would be angry," and "because I do not want to have a bad reputation." As will be discussed later in this chapter, the data collected through these focus groups and surveys were very useful in terms of incorporating salient reasons to use condoms (*Safer Sex Campaign*) and postpone sex (*Postponing Sex Campaign*) into PSA messages.

Next, it is important in the preproduction research phase to collect data on message channels, as these data can be used to strategically place messages in contexts that are likely to be viewed by the target audience (Palmgreen and Donohew 2003). The campaigns in both studies utilize television as the sole channel, as television offers 1) wide reach to audiences, and 2) the ability to incorporate high sensation value features such as color, sound, and movement (e.g., Morgan et al. 2003). In addition, should a televised campaign be effective, such a campaign is more easily replicated and disseminated than campaigns that use multiple, diverse channels (Noar 2006). Thus, the data that were needed had to do with which specific television channels and programs (including network, cable, and satellite formats) were most watched by the target audience, and whether or not this varied by gender, race, and other factors. These data were gathered by incorporating questions about television preferences in the main outcome evaluation survey of both campaign studies. This was done because the outcome evaluation design called for several months of pre-campaign data gathered from random samples of the target population. Thus, data on channel program preferences were collected in time to make important decisions regarding the placement of PSAs within particular television programs. More on placement of PSAs will be discussed later in this chapter.

Pre-testing Research: Testing Existing PSAs

Content analyses suggest that large numbers of televised PSAs exist in the safer sex area (e.g., DeJong, Wolf, and Austin 2001; Freimuth et al. 1990; Johnson, Flora, and Rimal 1997). Thus, before developing any of our own original PSAs for the campaigns in each project, we systematically collected and evaluated as many of these PSAs as possible (see Table 2). This served two purposes. First, such PSAs can give one ideas regarding original PSA concepts. Second, should some of the existing PSAs resonate with the target audience, it might be possible to include them in the campaign itself. Televised PSAs in both projects were

gathered through contacting a number of agencies, foundations, and research groups that had knowledge of and/or access to such PSAs. In the case of both studies, this resulted in a large library of televised PSAs. In fact, the search conducted for the *Safer Sex Campaign* resulted in a collection of more than 200 condom use and HIV prevention PSAs.

Once PSAs were collected, our research group categorized them and distilled them down to a smaller set of PSAs that appeared to be directed at our target audience. These PSAs were then carefully examined and rated by the entire research team on a number of targeting dimensions, including 1) gender; 2) race; 3) safe sex determinants; 4) message sensation value; and 5) perceived effectiveness (Palmgreen et al. 2002). The ratings guided the selection of the 10-12 most appropriate and potentially effective PSAs. The next step was to gather target audience reactions to these PSA messages.

Focus groups were our preferred means of examining reactions to the PSAs. In the *Safer Sex Campaign*, a set of focus groups aimed at garnering reactions to 11 safer sex PSAs was undertaken. Eight focus groups were again conducted separately based upon combinations of gender, individual differences (high sensation-seekers and impulsive decision-makers), and college student status (college and non-college students). We again conducted two additional focus groups with high sensation-seeking and impulsive decision-making African Americans, with approximately 8-10 individuals in all focus groups. The results helped us to determine which of the PSAs the target audience thought would be most effective, as there was good agreement as to the "best" PSAs. It so happened that these more promising PSAs were all developed by the Kaiser Family Foundation, and after conversations with them we secured permission to use six of these PSAs in the campaign itself. In addition, through these focus groups we learned a great deal about features of PSAs that participants thought were (and were not) effective. For example, effective PSAs were viewed as those that were attention-getting, were realistic, used humor, invoked fear, showed negative consequences, and had a clear and understandable message. Ineffective PSAs were viewed as those that were unrealistic, were preachy, were "cheesy" (e.g., used humor poorly), used scare tactics that exaggerated the threat, and/or had an unclear or confusing message. These findings were consistent with the premises of the SENTAR approach guiding the campaign effort (Palmgreen and Donohew 2003).

In the *Postponing Sex Campaign*, focus groups were again not a viable option due to the sensitive nature of the topic and the young target audience. Thus, we instead used so-called "reaction groups" in which we played each of 10 PSAs to groups of 6^{th} , 7^{th}, and 8^{th} graders and had them

individually rate the PSAs on various dimensions. Specifically, PSAs were played one at a time and participants rated the spots on message sensation value and various facets of perceived effectiveness, including attention, liking, credibility, personal utility, and persuasiveness. In total, we collected data from approximately 250 African American and white adolescents. Again, the ratings allowed us to select five PSAs, viewed as most effective by the target audience, to use in the campaign itself. We again contacted the developers of those PSAs to secure permission to use them in the campaign. In this case, we secured permission but did have to pay some fees to "purchase" the right to air the PSAs in the campaign. In addition, what we received less insight into, however (because of the reaction group rather than focus group format), were the specific content and format features that young adolescents believe make a PSA effective.

Pre-testing Research: Developing and Testing Original PSA Concepts

In addition to the pre-testing of existing campaign PSAs, we also engaged in a systematic process to develop original televised PSAs for both campaign projects. Although some campaign developers will use advertising agencies and other creative groups to develop PSAs (e.g., Ahrens et al. 2006), we have consistently developed our own PSAs as a research team. This is a systematic process that consists of several steps (see Table 2). We start by focusing on our theoretical approach as well as the empirical data that we have gathered. As mentioned earlier, in both campaigns we have used the SENTAR approach and sought to target common determinants of safer sexual behavior in the PSAs, such as attitudes, negative consequences, self-efficacy, and social influences (Noar et al. 2006). In addition, the focus groups (for the *Safer Sex Campaign*) and surveys (for the *Postponing Sex Campaign*) gave us some empirical data that suggested which attitudes, situations, and social influences might be most salient to focus on in the PSAs. Working with such data, we then developed and circulated a template that integrated this information, circulated examples of scripts and guidelines for writing promising PSAs to the entire research team, and sent everyone off to create and write.

Our research teams have consisted of a number of faculty members and graduate research assistants. We have also typically brought in additional graduate students who wish to get experience with this interesting and creative PSA development process. Creatively-oriented graduate students are often excited about the process, understand the theoretical and creative goals, and offer unique and interesting ideas for PSAs. Everyone is

instructed to write as many PSA scripts as they wish, and these are compiled and then subsequently read by everyone on the research team. Slogans for the campaign are also developed at this time and included with the scripts. The writing process typically results in 25-50 scripts as well as a number of potential campaign slogans. A difficult task is then deciding which scripts do and do *not* have a good chance of being promising PSAs. For this task we have employed a rating sheet where, based on detailed knowledge of the project, members of the research team rate both the PSAs and slogans for potential effectiveness. Only a relatively small number of PSAs (and slogans) that are rated highly on numerous dimensions are retained. The more promising scripts are then closely scrutinized by the research team. In-depth discussions of each of the remaining PSA scripts are held and revisions are made based on these group discussions. All discussion participants are told to disregard rank, so that the opinions of the investigators are not privileged over those of the students. Investigators in particular are reminded to "leave your ego at the door!" This sometimes contentious process takes a number of weeks, as each PSA is given significant attention.

Upon completion of this process, a set of focus groups was conducted with the target audiences (in both campaign studies) to garner feedback on the near-final scripts as well as the campaign slogans. We have found that the best way to do this is to have a narrator read the scripts and record them onto a tape or CD, which can then be played to participants during the focus groups. In addition, participants are also given hard copies of the scripts (so they can follow along) and response booklets where they can rate the PSAs on various dimensions (e.g., perceived effectiveness) and write specific open-ended comments about what they did and did *not* like about each PSA. After the ratings process, the focus group members participate in a discussion of each PSA led by the group moderator. Another method that can be used is producing so called "rough cuts" of the PSAs in order to show participants an onscreen version of each PSA (Atkin and Freimuth 2001). In our experience, however, the inevitable poor quality of rough cut PSAs is distracting and inhibits discussion of the substantive content of the PSA itself.

What did the focus groups reveal in these studies? In the *Safer Sex Campaign* study, focus groups were conducted separately (as before) according to combinations of gender, individual differences, college student status, and race. The purpose was to get reactions to and suggestions for 10 PSA scripts and five potential campaign slogans, using the process described above. In each focus group, participants gave a number of suggestions for how to improve the PSAs, including important

specifics regarding what characters should look like, how to make the situations most realistic, and how to improve the dialogue. Participants also gave feedback on a number of slogans developed for the campaign. As a result of the focus groups, the slogan "Use a Condom. Every Partner. Every Time." was selected. In addition, five of the PSAs were retained and significantly revised based on focus group feedback (while the other five were discarded). To further improve these five promising PSAs, particularly the dialogue, we also recruited a small number of particularly creative and articulate individuals from the focus groups and brought them on as target audience "consultants."

In the *Postponing Sex Campaign* study, eight focus groups were conducted separately according to gender and race (African American and white) combinations (all were high sensation-seekers). The purpose of the groups was to get reactions and suggestions to seven PSA scripts and five potential campaign slogans. Participants again offered a number of suggestions for improving characters, clothing, music, situations, and dialogue. As a result of the focus groups, the slogan "Wait for Sex. Your Future is Worth It." was selected. In addition, six of the PSAs were retained and significantly revised based on focus group feedback (while one was discarded). An idea for an additional original PSA also emerged from the groups, which was subsequently developed into a script. We again recruited individuals from the focus groups to act as target audience consultants to help with final changes to the seven PSAs.

Finally, in both campaigns, once PSA scripts were ready for production, the scripts were sent to a professional producer that we have successfully collaborated with over the years, and who has a good understanding of the SENTAR approach. This producer carefully vets the scripts, meets with us to ask questions and clarify details, and then goes into production (where he often solicits further input from us). We then typically do not see the PSAs until they are in final (or near-final) form. Changes can still be made at the video editing stage, of course, and sometimes the producer presents us with more than one version of a PSA. The versions are typically edited in different ways and our input is sought on the best version.

Campaign Planning

Well-crafted PSAs can only be effective if the target audience is exposed frequently to those messages through a coordinated and intensive campaign effort (Noar 2006; Palmgreen et al. 2001; Rogers and Storey 1987). Thus, planning for the successful implementation and execution of

campaigns is vital (see Table 2). Given the sensitive nature of airing safer sex messages on television (and particularly with certain target age groups and in certain regions of the country), we have adopted a model of initiating dialogue with local television stations and cable companies early in the process in order to bring them on as partners. Alternatively, if we developed our PSAs and then went to the stations and they refused to air them, we would be in a very tough spot. Instead, we reach out to the TV gatekeepers through a media buyer who acts as a liaison. We meet with these TV gatekeepers before we have developed any PSAs and give a presentation on the need for the campaign and the rationale for the types of messages we intend to develop. We also show them a selection of PSAs that we have collected to give them a sense of what these spots will look like. At this early point, we are able to get their feedback on the campaign, respond to concerns, and move forward in a way that brings them in as partners rather than as adversaries. As we move through the process of developing the PSAs, we also share materials with them so they might react with any concerns and/or ideas. As an example, specific issues that have arisen through this process have included whether or not a condom can be shown in a PSA (and whether the condom will be in or out of the package), as well as what kinds of language (i.e., slang) they will allow on the air. In addition, the discussion includes what times of day and night certain PSAs can air as well as on which channels and programs. In this manner, any objections to certain PSAs and/or certain air times can be voiced early in the process and negotiated at that time.

In order to increase the possibility of high message exposure in the campaigns, the media buyer also discusses the possibility of a one-one match at this time. That is, because these are public service announcement campaigns designed for the public good, we ask for 1 free PSA slot for every one that we buy. Thus far, we (with the help of our media buyer) have largely been successful in getting such a one-one match, which greatly increases the gross rating points (GRPs) of the campaigns and thus increases audience exposure. We also make a plea at this time for good donated air time, so that PSAs are *not* airing at inopportune times or in programs not watched by the target audience.

As discussed earlier, during pre-campaign data collection we gather detailed information regarding the TV programs and channels watched by the target audience, and we work with the media buyer to develop a campaign plan that ensures that the PSAs are strategically placed in those particular programs (Noar 2006; Palmgreen and Donohew 2003). In fact, we target the placement of messages based upon a number of factors, including sensation-seeking, gender, and race. For instance, if high

sensation-seeking African American females watch particular types of programs, then we will place PSAs aimed at this group in those particular programs, which may differ greatly from those popular with high sensation-seeking white males. We thus work for the maximum amount of strategic placement possible throughout the process, and our data on campaign exposure suggest that we have been successful in reaching most of our target audience with multiple exposures (Palmgreen et al. 2008; Zimmerman et al. 2007).

Finally, we also air our PSA campaigns in a theoretically meaningful way. For instance, a number of behavioral theories in the safer sex area suggest that individuals need to be motivated to have safer sex *before* it is important to work on building their self-efficacy and skills to enact safer sexual behavior (see Catania, Kegeles, and Coates 1990; Fisher and Fisher 1992; Noar 2007). Thus, we have adopted an approach of airing PSAs in a sequence that showcases negative consequences of unsafe behavior and attempts to change attitudes early in the campaign, while emphasizing skills and situational factors such as refusing sex and negotiating safer sex later in the campaign. In this way, individuals are "lead" through the process of attitude and behavior change over the course of the 13-week campaign.

Conclusion

The current chapter has provided a detailed description of and rationale for the formative research phases of two large scale HIV/STD prevention mass media campaign projects. Although there are seemingly an endless number of methods and tasks that can be undertaken in the formative research phases of a campaign (Atkin and Freimuth 2001), time and resources are often limited, and the sensitive nature of some topics can constrain the choices that are made and activities that are carried out. In the end, campaign planners must carefully select and carry out a limited set of formative research activities that they deem to be most crucial to the success of the particular campaign. The current chapter provides detail on the activities and experiences of our research team over the course of two major projects, which may be useful to others in their efforts to develop and implement HIV/AIDS prevention and other health mass media campaigns.