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Convenience Advertising: AIVL National Hepatitis C Education and Prevention Program (Drug Use)

Evaluation Report

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Prepared for The Commonwealth Department of Health and Aged Care

QQSR

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BUILDING INDIVIDUAL & SOCIAL CAPITAL
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THE CONVENIENCE ADVERTISING /AIVL NATIONAL HEPATITIS C EDUCATION AND PREVENTION PROGRAM

EVALUATION REPORT

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Introduction

The *AIVL National Hepatitis C Education and Prevention Program* is an innovative program designed by the Australian IV League (AIVL), the peak non-government organisation representing peer based drug user organisations in each state and territory of Australia. Drug user groups provide a unique opportunity for public health programs aimed at injecting drug users. They provide users with a voice to take part in policy discussions which greatly enhances the relevance of public health policy and strategies. They also offer an opportunity to transform users' norms and risk behaviours from within the drug scene and culture, not from without.

AIVL is a not-for-profit organisation that undertakes programs and activities that target illicit drug users in areas such as Blood Borne Viruses (BBV), overdose and drug related harm. The National Hepatitis C Education and Prevention Program for Injecting Drug Users is an AIVL program that exists to enhance illicit drug users' physical health and well being.

This report provides an evaluation of a major component of the *AIVL National Hepatitis C Education and Prevention Program* as developed and implemented by Convenience Advertising. The evaluation is based upon material gathered by interviewers in varied locations in Sydney and Melbourne. Matching the generally innovative nature of the program, the interview strategy also was innovative—using peer educators as the people trained to carry out the interviews.

While AIVL initiated the program to undertake a national hepatitis C education and prevention program for people who use drugs illicitly, it received funding from the Australian Commonwealth Department of Health and Aged Care to implement it

In August 1999 Convenience Advertising was selected to develop and implement the AIVL National Hepatitis C Education and Prevention Program, in collaboration with AIVL and the Commonwealth Department of Health and Aged Care. This programme is a comprehensive communications and resource delivery strategy, specifically designed to target the information and education needs of injecting drug users in Australia.

Convenience Advertising (CA) is an Australia based public health communications agency that has been operating since 1984. CA uses

a highly targeted placement methodology that brings select messages to specific target groups. The strategy, known as 'narrowcasting' involves the placement and maintenance of A4 framed posters in the toilet and washroom areas of selected venues.

CA uses social marketing techniques to integrate health messages into community settings. CA fosters collaborative relationships between all campaign stake holders, funding agencies, target audiences, venue managers, community educators and steering committees to produce best practice educational campaigns.

Advertising and the promotion of public health issues can be a sensitive area, particularly in the context of proscribed practices such as illicit drug use. Utilising specific venues to impact upon specific target groups requires mutual understanding and respect for the individuals and organisations involved. By placing messages into the bathroom, information can be disseminated to at-risk individuals, within a locus of risk (i.e. a public toilet) with discretion and privacy, without the deflection of a 'third-person' effect.

The CA methodology has been subjected to regular, independent testing and evaluation since their earliest inception in order to ensure that high standards of efficacy and accountability have been maintained.

The current evaluation, therefore, is in a long line of such evaluations and uses techniques—especially intercept interviewing of people using facilities—that have already been demonstrated to be robust and effective.

Health Status Background

Australia is currently in the midst of a hepatitis C epidemic. As in other developed countries, this epidemic is mainly confined to the injecting drug using population. In Australia it is estimated that the HCV prevalence is approximately 200,000 people, with a further 11,000 people becoming infected each year.

In 1997, Australia had 100,000 regular injecting drug users and 250,000 occasional injecting drug users. This provides a pool of 250,000 people either hepatitis C positive or at risk of infection. Controlling the epidemic in the injecting drug using population is vital if we are to have any impact on the level of transmission.

Aims and Main Components of the Campaign

The aims of this campaign are:

- To raise the profile and understanding of the methods of transmission of HCV amongst people who use drugs illicitly (both current and potential users) and their contacts
- To market the new nationally agreed messages: AIVL's Guide to Safer Injecting and AIVL's Guide to Cleaning Fits
- To address specific gaps in knowledge, misconceptions and risk behaviours identified by the national needs assessments

The campaign is built around two complementary components. One is a Convenience Advertising narrowcast communications campaign and the other is an innovative, integrated communications strategy involving a mix of web, text based and merchandising resources..

This evaluation concentrates upon the first component, that is the CA narrowcast communications campaign, which consists of eight key messages, supported by a range of take away information cards. These messages are A4 sized, and are placed in venues such as:

- User Groups
- Youth refuges/youth centres/crisis accommodation
- Regional Needle and Syringe Exchange Programs (NSPs)
- Tattoo and Body art venues
- Correctional Facilities
- Public Toilets in select municipalities
- Community Health Centres
- Electronic Entertainment Venues. Venues were selected using stakeholder knowledge (i.e. user groups, NSP's, local governments) and direct in-field feedback from users about where to target the campaign.

The campaign is supported by a range of innovative 'message triggers' that are designed to circulate through communities. These triggers are temporary tattoos, matchbooks and stress balls, and provide a positive identification of and with the campaign. These resources were distributed by user groups and intra-venous drug use (IDU) services in each State and Territory.

The campaign is supplemented by other education/information resources, specifically:

- A comprehensive web site
- Hepac – Health Rights For Drug Users
- Liver First
- Really Positive (6 booklets)

A logo has been developed that is intended to unify and provide a visual cue for all program resources. A range of logo options was developed, and focus tested at VIVAIDS, QUIVAA and at the Kirketon Road Centre.

8 key campaign message have been developed which address:

- Hep C awareness
- Safer Injecting
- Cleaning Fits
- Health Protection for positive users
- Re-infection
- Body art
- Hitting up in a car
- Hitting up in a toilet

These messages were developed through rigorous focus testing at VIVAIDS and QUIVAA and extensive consultation with AIVL, to ensure a series of messages that are not only visually striking and original, but which represent the communication and information needs of users in varying contexts.

Take Away Cards: These are business sized cards which are designed as a take away accompaniment to the campaign messages. These cards also serve as a referral and linking service, and provide contact details for the users groups, and www.aivl.org.au. The cards are designed to deliver more detailed information on topics such as cleaning fits and safer injecting, in a discrete take away format.

Campaign tracking data indicates that approximately 3,000 cards are distributed to users via the media mechanism per month.

Hepac is a practical guide to enable people to negotiate with services and government departments successfully, particularly in terms of making formal complaints about poor treatment (like discrimination) or poor service delivery.

Really Positive is a series of booklets which are designed to provide up-to-date information to users living with hepatitis C or HIV/AIDS, and to support and improve the health and well being of positive users. These booklets are currently in development.

Liver First informs people who inject drugs about general health, how the liver functions, and the effects hepatitis C can have on the liver, and to support people who inject drugs to reduce the potential negative health consequences of hep C.

The programme messages were implemented nationally in March 2001. The implementation of the campaign has evidenced significant demand for, and appreciation of, the key messages and resources.

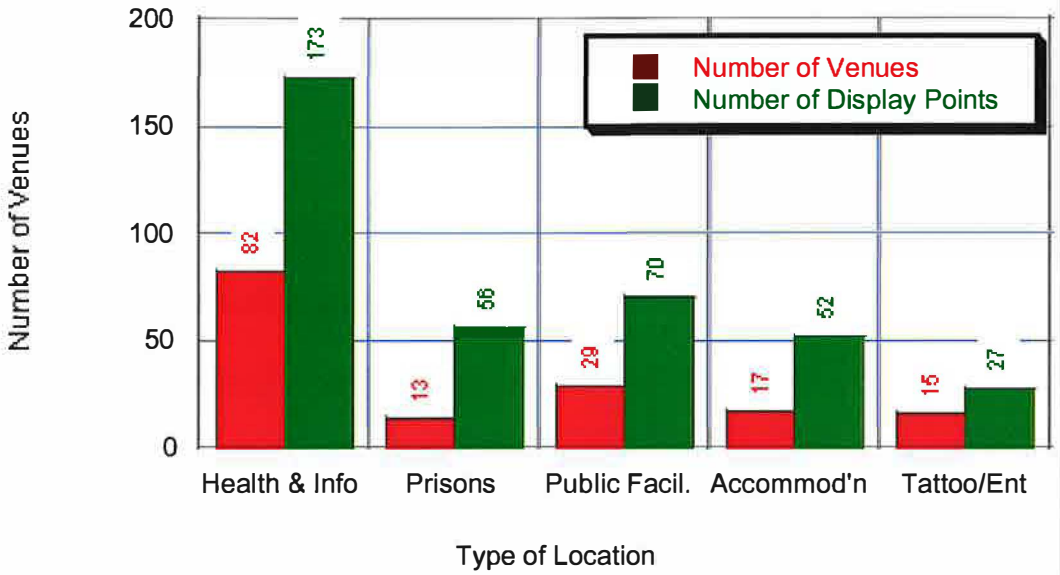
The campaign has been able to function as a model that can be applied in specific local contexts. During its implementation CA and AIVL were approached by the Brisbane City Council, who wished to customise one of the messages to be placed in all public toilets within the municipality. This built programme capacity, and enables the national campaign to be integrated with a local perspective. Currently, Wollongong City Council are considering the same local application.

Convenience Advertising manage and maintain 382 Hepatitis C message display points in 157 venues throughout Australia. Of the 382 display points, demographic information was collected on 105 venues which report an approximate patronage of 52,437 patron visits per week, in key drugs user 'hot spot' locations. Currently, there are 188 display points which deliver the take away resources at

the hand dryer location in venues. The remaining 194 display points are frame only messages located at entry/exits, cubicles and urinals.

Figure 1 provides the display point to venue ratio. In the category health and information providers, 173 display points are installed in 82 venues. Health and Information service providers include, support services, user groups, community health, needle and syringe exchange and youth services.

Fig. 1: Distribution of Venues and Display Points



Thirteen Correctional facilities are contracted for the display of 56 display points. Seventy display points are installed into 29 public toilet facilities. The accommodation category consists of both public housing estates and youth refuges. Seventeen venues were contracted for the display of 52 display points. The tattoo parlours and entertainment venues have 27 display points installed into 15 venues.

Evaluation 1: Method

In January 2002 the independent evaluation of the campaign was contracted to QQSR. QQSR designed an intercept interview schedule that covered a range of topics that were important to the stated aims of the campaign.

Overall, the evaluation sought to identify:

- Respondents levels of understanding and knowledge about hepatitis C
- Respondent's sources of information about hepatitis C
- Levels of unprompted and prompted message recall
- Levels of message comprehension
- Level of acceptance/approval of the medium
- Basic demographic information about the sample

For example, the questionnaire commenced with the question "what do you know about HepC?" Interviewers then had spaces to record whether respondents spontaneously identified HepC:

- as a disease
- as affecting the liver
- as contagious
- as blood borne
- as IV transmitted

The questionnaire then examined sources of information from which respondents obtained information about Hep C, including CA posters.

Respondents were then asked a wide range of questions about posters displayed at DPs in the venues, including a prompt for those that were uncertain about primary recall.

Finally, their sex was recorded and respondents were asked their age, their marital status and whether they considered themselves to be at risk of contracting HepC (answers included a response for those already infected).

The evaluation was carried out using an intercept interview methodology. A sample of 174 respondents was surveyed in Sydney and Melbourne. In field research was conducted by peer educators from VIVAIDS and NUAA, the Melbourne and Sydney User groups.

Research was conducted in hot spot locations, such as public toilets, NSPs (needle exchanges), user groups, youth crisis accommodation centres, health services and tattoo parlours. CA was also fortunate to be able to interview a small sample in the Safe Injecting facility in Sydney.

Evaluation 2: Principal Findings

The samples in the two cities were not identical. The Sydney sample provided a wider range of venue types than did the Melbourne sample, with the latter being more concentrated in high risk groups with larger proportions of IDUs.

In the results presented below, therefore, we examine

- the overall pattern of the data
- Sydney/Melbourne comparisons
- the Sydney data in-depth to see if there are any differences between venue types

Given the large number of tables generated, a complete presentation of every set of results would be unwieldy and also risks 'losing sight of the wood for the trees'. Therefore, in what follows we report overall patterns and comparative results that seem to show significant differences.

Analyses of the variables in the Sydney file are presented using contingency tables as the format for presentation. In each case, the

independent variable is the same, namely the type of location in which the interviews took place. The categories are:

Health Centre (29 cases)
Needle Exchange (26 cases)
Safe Injecting Facility (7 cases)
Tattoo Parlour (5 cases)
Youth Accommodation (42 cases)

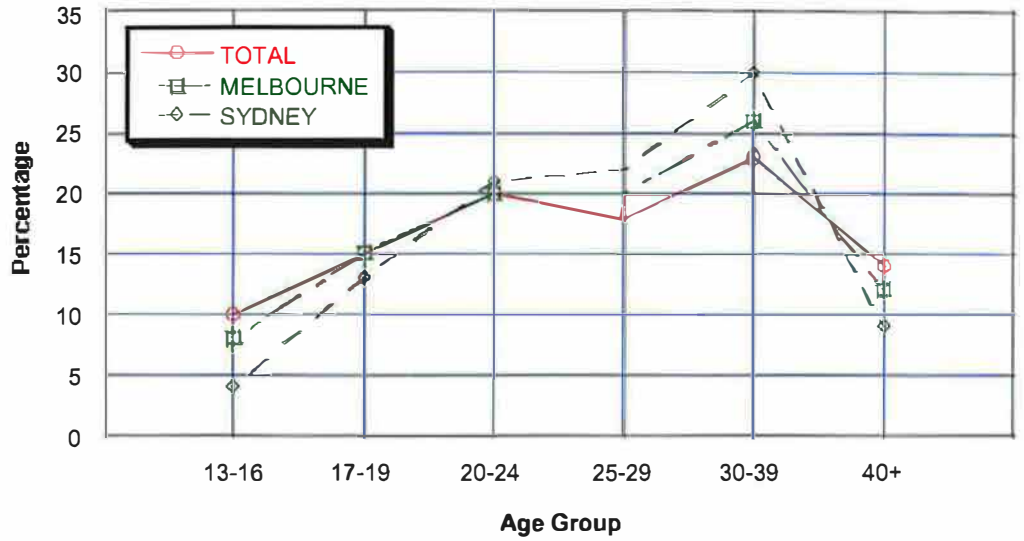
The principal measure used to decide whether the sub-samples are different is the chi square value. It should be noted that the underlying assumption of a chi square test is that the samples are randomly selected. This assumption is not strictly met here, since intercepts were made on an availability basis. Thus the test statistic is a guide rather than a strict measure. Chi square, however, is a stable and robust measure which generally is not sensitive to most violations of this type, with exception of clustering effects, and there is no reason to suppose that these are operating here in any important way.

Turning then to the data, we begin with a brief overview of the respondents.

First, with regard to sex, the overall breakdown was very close to two fifths female (41%) to three fifths male (59%) with little difference between Melbourne and Sydney. This breakdown held across the various types of location in Sydney with only small variations other than the Safe Injecting facility (a very small sub sample) where it split 17%:83% (i.e. 1:6 out of 7 respondents).

The age range of respondents was quite large—13 to 76 with a mean of 27.8. The overall distribution, in age groups, is shown in Fig 2:

Fig 2: Age Groups in the Sample

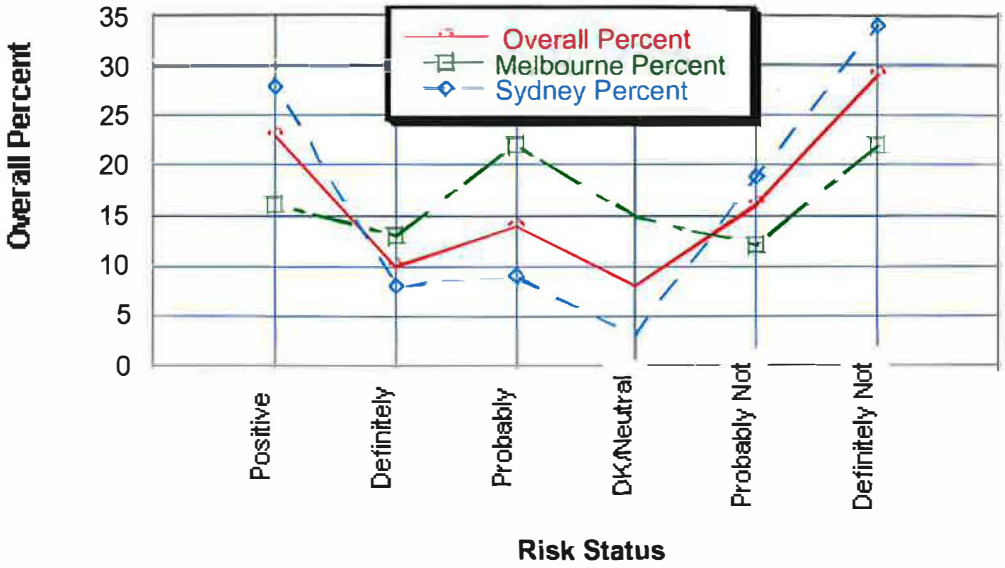


As the Figure makes plain, the largest group is in the 30-39 category and there is no great difference between Melbourne and Sydney.

Third in the demographic features is the question of marital status. In both Melbourne and Sydney around a half of all respondents were single and about one fifth were in a steady relationship (more in Sydney, 24% than Melbourne, 14%). More Melburnians were in de facto relationships (18%) than Sydneysiders (11%) with small minorities in other statuses.

Looking at perceived risk, about one quarter of all respondents were already Hep C positive, with varied levels of perceived risk beyond that. As Fig 3 (next page) shows, the largest groups are those with low perceived risk, which indicates that they are especially important to reach, since this risk assessment is likely to be unrealistic.

Fig. 3 Perceived risk of infection with HepC



Turning next to the material focused on the diseases the CA posters, the first question in the questionnaire was what respondents knew about HepC.

In response, did respondents think of HepC as a disease?

Overall, 77% of respondents identified HepC as a disease, but this varied from 91% in Melbourne to 67% in Sydney.

It seems very likely that this difference, like most of those that follow, is not so much geographical as based on sample differences.

In the Sydney data (Table 1) it is clear that there is a marked difference (chi square = 0.6) between those who were interviewed in health centres, needle exchanges and the Safe Injecting Facility and the others. Since the Melbourne sample is closer in character to those interviewed in the needle exchanges, what seems to be the case here is that the groups which include more IDUs are better informed, irrespective of geography.

Table 1: Percents of row totals for type of location by whether HepC is a disease

	Yes	No	Totals
Health Centre	71	29	100
Needle Exchange	84	16	100
Safe Injecting Facility	86	14	100
Tattoo Parlour	60	40	100
Youth Accommodation	52	48	100
Totals	67	33	100

It is also interesting and important that the youth accommodation group seems much less well informed—a finding of policy relevance.

The second issue is whether the respondents mentioned that HepC affected the liver. A similar pattern emerges as with the previous variable. Overall, 66% of respondents identified HepC as a disease, but this varied from 82% in Melbourne to 55% in Sydney and once more this seems to be sample rather than geographically based.

Looking closely at Sydney (Table 2) we see that once again the first three categories are much more likely to mention this (chi square is less than .01) with the youth accommodation group poorly informed by comparison with others.

Table 2: Percents of row totals for type of location by whether HepC affects the liver

	Yes	No	Totals
Health Centre	78	22	100
Needle Exchange	76	24	100
Safe Injecting Facility	86	14	100
Tattoo Parlour	40	60	100
Youth Accommodation	24	76	100
Totals	55	45	100

Similar patterns emerge for the question of whether HepC is infectious. The results are that overall 54% mentioned this, 70% in Melbourne and 45% in Sydney, with the Sydney respondents (see Table 3), once more varying along the same lines (chi square less than .01) and with the youth group least well informed.

Table 3: Percents of row totals for type of location by whether HepC is contagious

	Yes	No	Totals
Health Centre	46	54	100
Needle Exchange	74	26	100
Safe Injecting Facility	100	0	100
Tattoo Parlour	40	60	100
Youth Accommodation	19	81	100
Totals	45	55	100

Once more, similar patterns emerge for the question of whether HepC is blood borne. The results are that overall 70% mentioned this, 78% in Melbourne and 64% in Sydney, with the Sydney respondents (see Table 4), once more varying along the same lines (chi square less than .01) and with the youth group least well informed.

Table 4: Percents of row totals for type of location by whether HepC blood borne

	Yes	No	Totals
Health Centre	81	19	100
Needle Exchange	92	8	100
Safe Injecting Facility	100	0	100
Tattoo Parlour	60	40	100
Youth Accommodation	31	69	100
Totals	64	36	100

Interestingly, however, when we examine the question of IV transmission this shows no overall geographical difference. The results are that overall 73% mentioned this, 75% in Melbourne and 71% in Sydney. However, within the Sydney respondents (see Table 5), there is once more variation along the same lines (chi square less than .01) and with the youth group least well informed.

Table 5: Percents of row totals for type of location by whether HepC blood borne

	Yes	No	Totals
Health Centre	89	11	100
Needle Exchange	84	16	100
Safe Injecting Facility	100	0	100
Tattoo Parlour	20	80	100
Youth Accommodation	55	45	100
Totals	72	28	100

This suggests that the low level of consciousness of this issue among people in the tattoo parlours and youth accommodation is 'off set' by the extremely high rate among the other three groups, so that the overall average comes close to that of Melbourne. This may even imply that, among the IDUs in Sydney, awareness of this issue is even higher than in Melbourne.

Looking at the overall pattern of results in these first five tables, we can see that there is a reasonable level of information about HepC in the at risk groups, but with the youth accommodation group least well informed and, perhaps, least interested.

This indicates that the AIVL campaign is appropriately targeted and able to offer important information to at-risk groups.

The next block of questions concerned sources of information—specifically "where do you get information about HepC?" Five sources were identified—CA, health and IDU services, GP or other medical sources, friends and mass media. Overall results are shown in Table 6. This gives the percentages mentioning each source for the overall and for the two centres and then below the percentages mentioning each source for the various Sydney venues.

Table 6: Percents of row totals mentioning each source, all locations

	CA	H'lth	GP	Friends	Media	
OVERALL	29	63	48	39	38	
MELBOURNE	45	80	63	60	33	
SYDNEY	18	54	39	26	41	
Health Centre	12	71	52	27	57	
Needle Exchange	33	84	58	27	56	
Safe Injecting Facility	14	86	57	14	17	
Tattoo Parlour	60	0	40	25	60	
Youth Accommodation		10	23	17	28	20

In broad terms, the patterns in this table mimics those for Tables 1-5—that is, the geographical differences generally seem to be paralleled by differences within the Sydney sample, such that Melbourne responses look rather like those from the Sydney sub samples in the needle exchanges, the Safe Injecting facility and (in general) the health facilities.

However, this is not all the story. In particular, these patterns stand out:

- CA is mentioned by an average of one in three respondents (a high level for spontaneous mentions); more in Melbourne than Sydney in spite of group type and more among IDU related groups
- Health/IDU services are mentioned by an average of two in three respondents; more in Melbourne than Sydney and more among IDU related groups
- GP and medical sources are mentioned by an average of two fifths of respondents; more in Melbourne than Sydney spite of group type and more among IDU related groups
- Friends are mentioned by an average of two fifths of respondents; *far more* in Melbourne than Sydney spite of group type with no great difference among group types (the sample in the Safe Injecting Facility is too small for the lower rate to be significant)
- Mass media sources are mentioned by an average of two fifths of respondents; fewer in Melbourne than Sydney spite of group type and fewest among the youth accommodation sub sample.

These findings indicate that a range of sources are important for these respondents. Interestingly, the youth accommodation sub sample is not only the least well informed, it also names the lowest rate of sources, further emphasising the importance of informing this at-risk group. On the other hand, IDU related samples have a wide range of sources of information. The fact that CA is mentioned spontaneously by a substantial proportion of respondents despite being a specialised 'niche' provider offers support for the implementation campaign and for the relevance and effectiveness of the CA narrowcasting methodology.

Turning specifically to the CA posters, Table 7 summarises the data concerning the recall of the posters. The questions asked here were "First, when you were in the toilet area just now—or any other time you have used the toilets here—did you notice any poster displaying HepC messages?" and this was, if necessary, followed up with a prompt in which a modified version of the displayed poster was shown and the question "How about posters that looked this? Do you recall seeing any of these?"

Table 7: Percent recall of the poster, prompted and prompted, all locations

	Unprompted	Prompted	No recall	
OVERALL	53	29	18	
MELBOURNE	49	32	19	
SYDNEY	56	26	18	
Health Centre	57	18	25	
Needle Exchange	64	28	8	
Safe Injecting Facility	29	29	42	
Tattoo Parlour	100	0	0	
Youth Accommodation		50	22	22

This shows that the overall recall rate was well above 80% and that only one sub-sample—the very small group from the Safe Injecting facility—fell below 75%. This is a very positive result, and shows a clear pattern of success in getting the message to the target audiences.

Table 8 shows results for all respondents on the issue of whether they noticed a take away card with the poster.

Table 8: Percent who noticed the take-away card, all locations

	No	Yes	
OVERALL	42	58	
MELBOURNE	42	58	
SYDNEY	42	58	
Health Centre	40	60	
Needle Exchange	52	48	
Safe Injecting Facility	29	71	
Tattoo Parlour	80	20	
Youth Accommodation		34	66

About three fifths had noticed a card, a proportion which did not vary between Melbourne and Sydney and which showed no significant variation within the Sydney sub samples.

Respondents were also asked if they took a card. About one quarter said they had done so in both Melbourne and Sydney, and no trend emerged across locations that showed variation on this.

Most tests with take away cards show that low proportions are accessed—often because people will not take a card in a public location such as a toilet is others are present or if they are in a hurry. A rate of 25% is thus a fairly successful outcome for the strategy and shows success in getting the message to the target audiences.

How well did respondents recall the message? Interviewers were asked to grade responses from those recalled posters on a 4 point scale—very accurately (1) , quite accurately, some correct details, little or no accurate recall (4) . This was a complex task as a wide variety of posters were included in the full design, spread between the varied locations. Nonetheless, this subjective measures does give a useful 'rule of thumb' indication.

Table 9 shows the results of the gradings, arranged by various locations.

As may be seen, the general recall rate is good, with over half of all respondents in both geographical locations having good recall, a finding that shows no statistically significant variation within venues, although it may be that there is a trend for better recall in NSPs and Health Centres (which would fit with the higher recall rate in Melbourne).

Table 9: Percent who were graded at four levels of recall, all locations

	1	2	3	4
OVERALL	22	36	19	23
MELBOURNE	24	44	20	13
SYDNEY	20	32	19	29
Health Centre	39	33	11	17
Needle Exchange	25	35	20	20
Safe Injecting Facility	0	33	17	50
Tattoo Parlour	20	60	20	0
Youth Accommodation		20	32	19

29

If a respondent could recall the poster, how much of the material did s/he read? This was assessed using a four-point, self rated scale of all (1), most, a little or none (4). Results are shown in Table 10.

Table 10: Percent who read all a part of or none of the poster, all locations

	All	2	3	None
OVERALL	76	8	4	12
MELBOURNE	81	9	2	8
SYDNEY	73	7	5	15
Health Centre	53	16	26	5
Needle Exchange	24	24	33	19
Safe Injecting Facility	14	29	0	57
Tattoo Parlour	40	20	40	0
Youth Accommodation	26	10	32	32

The rate claiming to have read all or most of the poster is high (well over 80%) with a somewhat higher rate in Melbourne than Sydney. Within Sydney, there are no significant differences in the proportion of the poster that respondents had read. Roughly half had read all or most of the poster and the other half, little or none. The only noticeable trend is that the youth accommodation group had made the least effort to read it.

It may be important to note that the group that made the least effort to read the posters (youth) is also far less well informed than the first three groups. These three make more effort to read the posters, know more about the messages and are better informed. The likelihood is that (a) they are more open to information and (b) therefore the messages on the posters are getting through to them.

Of course, reading the poster is only part of the battle—did the respondents comprehend what they read? The answer here is very clear and very positive—across the board a high proportion of respondents claimed to have understood all of what they read (76%

said they understood it all and another 8% said they understood most of it). There were no substantial variations on this pattern.

The large majority also thought the poster appropriate—84% overall saying that it was definitely appropriate and another 7% having few reservations. These data are shown in Table 11 (next page), which arrays the answer from Definitely (1) to Definitely Not (5).

Table 11 shows that while support is extremely strong that the poster is appropriate in Sydney, the single marked exception is the safe injecting facility group. Perhaps this strong link to IDUs explains the slightly lower (but very high) rate of support in Melbourne, but this remains speculative.

Table 11: Percent thought the poster was or was not appropriate, all locations

	Def	2	3	4	Def
Not					
OVERALL	84	7	4	3	2
MELBOURNE	74	15	6	2	2
SYDNEY	89	3	2	3	2
Health Centre	100	0	0	0	0
Needle Exchange	90	5	0	5	0
Safe Injecting Facility	43	14	0	29	14
Tattoo Parlour	100	0	0	0	0.
Youth Accommodation	88	3	6	0	3

Turning now to the question of poster content, 95% of respondents claimed to have heard of HepC before they saw the poster, the only group that showed any exception being the youth accommodation group where 10% had not and another 5% were not sure.

On the other hand, not everyone had thought of the disease as infectious before they saw the poster. About a quarter had not realised or had not been sure (there was no Melbourne/Sydney difference on this) and only in the Safe Injecting facility group was there 100% recognition of contagion.

These results also indicate a marked success for the CA strategy—while it alerted very few to the disease as such, because everyone had heard of it, there are substantial numbers who have learned from the posters about the dangers of contagion.

Perhaps not surprisingly, therefore, we find that a large majority of respondents found material in the posters to be useful. Specifically, an average of about one third of all respondents found the material 'very useful' (slightly more in Sydney than Melbourne) and another half found it 'quite useful'. This pattern held across most locations, the exception being the injecting facility, where over 40% said it was 'not very useful' (perhaps because in this group they were already well aware of risks) and the youth accommodation group, where 15% said it was 'not very useful' and another 24% said it was of no use at all.

In short, the youth group is the least well informed and also pays least attention to the posters—it also is far more likely to rate the information of no use than any other group. This raises the policy issue related to this group very clearly.

A practical measure of utility than can be ascertained in an interview context is whether the material is useful enough to share with a friend. Just over half (53%) of the respondents said the poster provided them with material that they would consider sharing. This showed no geographical variation, but within Sydney there were large apparent variations by location, as can be seen in Table 12 (although because the sub-samples are small the chi square on this in only about 0.1).

Table 12: Percent who said that they would share material with a friend, all locations

	No	DK	Yes
OVERALL	32	14	54
MELBOURNE	32	17	51
SYDNEY	33	13	55
Health Centre	5	10	85
Needle Exchange	45	15	40
Safe Injecting Facility	57	14	29
Tattoo Parlour	40	0	60
Youth Accommodation	35	15	50

Finally, the data samples are too small, and two of the demographic variables either too large in range (age) or too skewed (marital status) to attempt much in the way of contingency analysis using these as independent variables.

The variable of sex, however, is reasonably evenly distributed, and hence some analyses using sex as an independent variable were undertaken. Nothing of substantive significance emerged from the analysis—in short, the impact was broadly the same irrespective of sex of respondent.

Conclusion

Data reported here indicate that the CA development and implementation of the *AIVL National Hepatitis C Education and Prevention Program* via a narrowcasting strategy has been successful. Important target groups have been reached and useful information conveyed to them in a manner that they have found appropriate and acceptable.

This finding holds across two major metropolitan centres and, within the large Sydney sample where analysis of sub-samples is possible, across different types of venue and target group. This is an important and rewarding outcome which shows a very useful application of the CA method to support an essential health initiative.

While there are some variations in the response of sub groups to the material, only one stands out as problematic—those in youth accommodation. It seems fairly clear that this high risk group is both the least well informed and at the same time the least interested in information. This has important policy implications for controlling the spread of BBVs like HepC.

Nonetheless, even with this most difficult of groups to reach, the CA strategy has succeeded in increasing knowledge and awareness.

Perhaps the major implication of the finding with regard to the youth group is that it may need specially targeted messages for that group. That is, it may be that while the *method* of getting messages to this group via CA narrowcasting is effective, they have special needs with regard to the *content* of those messages.
