HEPATITIS C AWARENESS CAMPAIGN – THE WAY FORWARD 2008-2010

May 2008

Background

Hepatitis C is a blood-borne virus that is mainly spread by blood-to-blood contact. It causes chronic infection in most of those infected and in around 20% of cases it can lead over time to cirrhosis (scarring) of the liver and primary liver cancer. There is currently no vaccine available but infection can be treated with drugs, these have around a 55% average success rate.

It is estimated that about 200,000 people in England (0.4% of the population) are infected with hepatitis C – the majority without knowing it. There may be mild symptoms but in most cases there are none until the serious liver disease begins to develop about 20-30 years after being infected.

Communications activity to date

The FaCe It campaign started in 2004 with the first target being to raising awareness and knowledge levels amongst healthcare professionals. Between 2004 and 2007, the campaign was PR-driven and gradually extended its reach, first into raising public awareness and then among specific groups such as prisoners and South Asian communities.

In March 2007, an advertising campaign took place for the first time. The campaign invited self assessment / identification using a flow chart device illustrating most of the potential transmission routes. This campaign was repeated in the second half of 2007/08 but with the addition of a new radio advertisement, which addressed former drug users for the first time.

Public awareness research has been carried out in 2003, 2006 and 2008 and this continues to show improvement. For example, the number of people saying they know nothing about hepatitis C has almost halved over this period.

There has been a marked increase in hepatitis C testing and diagnosis e.g. a nearly 30% increase in laboratory diagnoses of hepatitis C in 2006 compared to 2003 (the year before the campaign began).

The recent advertising has considerably increased the web traffic and enquiries to the call centre, the March 2007 campaign producing over half of the annual response for 2006/07 for example.

However, while there have been some obvious successes there is some evidence that this has led to an increase in calls from the worried well. Also using general awareness type communications to target a small and self-selecting group is inefficient and potentially costly.

Communications strategy 2008/09 onwards

Our strategy is to prioritise audiences, with the highest priority being the harder to reach groups who cannot be targeted in other ways and/or by other campaigns. Developing a more tailored approach will lead to a more effective and cost efficient campaign.

We recommend continuing the campaign to encourage people in the main at-risk groups to be tested and running a prevention stage, eg through communications aimed at travellers. This follows the plans outlined in the 2007 campaign submission of 13/2/07.

There is a case for taking a new fresh look at the role stakeholders play. At the moment, the DH is working with a rather small group and are having difficulties expanding that. There is a need to commit further resources to attracting a wider group of active stakeholders both from the clinical and voluntary sectors.

Objectives

The current objective of the campaign is to:

- To raise awareness of hepatitis C and its prevention, diagnosis and treatment amongst healthcare professionals and the public in a responsible manner, while tackling the stigma attached to it.

We aim to do this by:

- Educating healthcare professionals on the causes, effects, prevention, diagnosis and treatment of hepatitis C
- Encouraging and supporting healthcare professionals proactively to identify at risk individuals who may be infected and refer those infected for specialist assessment and treatment.
- Encouraging healthcare professionals to provide information and advice about avoiding the risk of hepatitis C infection.
- Increasing public awareness and knowledge about the causes, effects, treatment and prevention of hepatitis C, without causing alarm.
- Encouraging people at risk of infection towards testing by directing them to primary care and other health services.

These objectives still stand for 2008 – 2010 but the strategy for achieving them will be to take a more targeted approach.

Prevention should continue to be a secondary objective, but with a higher profile, e.g. people travelling abroad. As well as the obvious outcomes, this offers an opportunity to raise general awareness levels without stigmatising (potential) sufferers.

We will develop a picture of what success will look like to enable campaign targets for increased testing and diagnosis to be set.

Audiences

In the third quarter of 2006/07, the Department of Health commissioned desk research with the aim of uncovering existing knowledge of Hepatitis C's prevalence and to confirm the at-risk groups. The first part of the study examined all the available knowledge on hepatitis C from the Department, other government bodies and non-government organisations such as charities. We did this by a combination of interviewing relevant people and bodies and the study of published reports/research. These confirmed that ex intravenous drug users (ex-IDUs) were the main category at risk. The second half of the study attempted to profile ex IDUs and looked at trends in needle behaviour/use.

The study confirmed the target audiences we needed to address but did not provide any further insight. It was recommended that we commission further research amongst ex IDUs.

On the basis of the desk research, the audiences should be ranked as follows:

Dependent and non-dependent ex intravenous drug users (IDUs)
All the information we have points to them being the biggest at risk group at around 60% of those estimate to have chronic infection but also the most difficult to communicate with, for example, our research sample include people aged between 23 and 71. We would consider this group as our main priority. We have specially commissioned research looking at this group; the methodology and some results are described below in the research section.

Minority ethnic communities originating from countries with high hepatitis C levels
Many countries are known to have considerably higher hepatitis C prevalence rates than the UK (e.g. Egypt). South Asians, who form a significant proportion of the UK population, are an increasingly recognised risk group for infection. Preliminary results from a study investigating the prevalence of hepatitis in people originating from these areas, suggest that people coming from Pakistan are at increased risk of HCV infection. The disproportionate number of HCV infections seen amongst individuals originating from the Indian sub-continent, detected during routine screening of blood donors, also provides evidence to support a higher HCV risk in these groups. Further results from this study will help inform future activities to raise awareness among South Asian communities, particularly Pakistanis. As this issue could be very contentious we intend to commission a specialist BME agency. At the moment the best intelligence we have points to a campaign directed at the Pakistan community.

Travellers abroad to countries with high prevalence of HIV hepatitis B and hepatitis C
An active prevention campaign particularly among the student/back packer communities. We recommend early discussions with the FCO's "Before you Go" campaign to identify cost-effective opportunities to get the message out. This will build on the work done on the leaflet on avoiding risks of hepatitis B, hepatitis C and HIV when travelling abroad. This needs to be done to prevent general blood borne virus transmission. Travel abroad is also relevant to South Asian communities who may be exposed to the risk of infection e.g. through injections with non-sterile equipment.

The rationale for this group is the same as above but in a preventative context. The two groups we need to look at are:

- South Asian communities in the UK who return to South Asia for visits etc
- Students/back backers/general travellers to higher risk countries

Current IDUs including offenders
We believe these audiences are relatively well informed and in touch with services that will give them information and refer to screening. However, we can add value by working closely with the Frank campaign, and work that may be done under the DH action plan on reducing drug-related, to inform and support the prevention element of that campaign, and through stakeholder channels that cover current and ex-prisoners.

GPs/other healthcare professionals
This group should continue to be targeted with information for their patients and to improve their own knowledge of hepatitis C. However, we may also need to understand, for example, why some GPs are not agreeing to patient requests for testing and the size of this problem. (Call advisers' comments from the current campaign call centre report). Research may be needed here. Some unpublished research has been carried out in Scotland which we attempting to get a copy of.

General public

There is a role to play in raising and maintaining awareness to prevent stigmatisation of the condition, which could be counterproductive to our strategy to encourage dabblers into screening. It could also pick up at-risk individuals not reached by targeted activity. This would be done by running a smaller secondary campaign along side that aimed at IDUs.

Recommended marketing mix

Advertising
PR
Helpline
Website
Stakeholder engagement

All the other marketing elements are liable to be used across the whole of the target audience but in a measured response according to their priority and suitability.

Research

Following the desk research we were confident that the audience is known and we can communicate with them. However, the ex IDUs required further investigation.

We used a creative-led approach to the research, which overcame the need to recruit large numbers of ex-IDUs (logistically very difficult). This entailed us putting the current creative and further mocked-up options into concept testing research via in-depth interviews. The ads produced for the research were intended for development only.

We especially sought confirmation, or otherwise, of the need for other transmission routes to be included to act as "cover" for non-dependent ex IDU and explored:

- what would encourage them to come forward for testing?
- the obstacles to prevent them getting testing - fear of insurance black listing, being ostracised by family and friends etc
- media consumption
- preferred route for info/help – helpline, website, SMS, GP, Govt, charity, etc
- branding options – NHS, DH, FaCe It, charity/non Govt.

The main findings from the research were as follows:

- Shock alone does not work and is a relative thing, especially for such a target audience. This is not to say shock does not have a place but it should be balanced with reassurance and facts
- The ads should not be too clever or complicated
- Images need to be relevant, realistic and not over sanitised
- It is not necessary to provide 'cover' for IDUs in terms of encouraging screening, although it is important that anyone 'at risk' is nevertheless reached
- In terms of branding, while opinions are divided, overall it is felt the adverts should be branded NHS or NHS / Face It

In order to inform the prevention strand of the campaign we took advantage of research being carried out on the new Travel Safe leaflet. We included questions about media consumption, attitudes to Hep C, what research they did before travelling and what precautions they already take. This will help us develop further work, apart from the leaflet, aimed at this audience.

Similarly, we added questions to the South Asian campaign research in order to inform the development of that work.

This work has identified a number of useful points such as the need to use the local name for hepatitis C when communicating with a South Asian audience and how to style content for the young traveller. Of the existing work for the South Asian campaign that was tested, the CD of music and interviews proved to be significantly the most popular while translated leaflets struggled.

Evaluation

While we can use the number of responses to the call centre and the web usage figure as a basic measure of campaign there is a need for more sophisticated measurement. The 2008 advertising campaign moved some way towards this with the use of unique phone numbers and web addresses in order to improve the monitoring of results and the efficiency of particular changes in realigning the target audience.

Routine statistics from the Health Protection Agency have some limitations as the supplying of the data is not compulsory and there is no consistent format for reporting. For example, only 23% of laboratories report on the possible transmission route. However, more complete data are gathered through Sentinel Surveillance in 23 laboratories in England.

Patient confidentiality prevents direct tracking of callers to the helpline to measure full conversion rates. We may therefore need to develop either a proxy measure or a way of estimating conversion rates with a fair degree of confidence. It may be possible to supply callers to the helpline a contact point that they could use to let us know if they have been tested without revealing their identity. We will also carefully monitor the quality of the call to see if the more targeted campaign has the desired consequences.

We may also need to consider a more regular tracking study to enable us to monitor awareness amongst the public/travelling public.