The effectiveness of education and health promotion in preventing the transmission of hepatitis C has been limited. The social research literature provides useful insights for reinvigorating existing health education messages and designing new ones. This review draws on social research literature to question health education strategies to prevent hepatitis C transmission.

Approximately 264,000 Australians are estimated to have been exposed to the hepatitis C virus. The main risk factor for the transmission of hepatitis C is injecting drug use. An estimated 9,700 people contracted the virus in 2005, and 88.6% of those were exposed through injecting (Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis, 2006).

The Australian public health response to the transmission of blood-borne viruses (BBVs) among people who inject drugs was initiated in response to the HIV epidemic. It relied on health education messages and the supply of clean injecting equipment, in particular clean needles and syringes for each injection (Crofts et al., 1999). The use of clean needles and syringes for each injection is necessary but not sufficient to prevent transmission of hepatitis C. Hepatitis C can be transmitted by microscopic amounts of blood, invisible to the naked eye, remaining on any of the full range of equipment used in drug injecting, as well as on hands and environmental surfaces (Hagan et al., 2001).

A broader health promotion message, blood awareness, was developed to address the problem of transmission of hepatitis C. The change from a focus on sterile equipment to a focus on blood awareness recognised the numerous possible sites of blood contamination during the injecting process. But even with this change in focus, only limited success in the prevention of hepatitis C has been achieved.

In this scenario, health education messages need to be expertly constructed to meet the needs of the diverse target group of people who inject drugs. The social research literature provides some insight to inform the task of reinvigorating existing messages and designing new ones. It provides critical insights into the perceptions and experiences of the group towards which hepatitis C prevention education is targeted, and uses social theories to raise questions about the assumptions made by educational programs.

The authors of the articles summarised in this brief raise particular issues about the content of hepatitis C prevention messages, and also raise a number of key points. These include that:

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Although researchers can contribute much to the process of developing and critiquing health education messages, it is not for researchers to dictate the content nor means of delivery of hepatitis C prevention education. One of the key strengths of the Australian approach to hepatitis C prevention is ‘partnership’. People and organisations working most closely with people who inject drugs need to work through the issues raised. In particular, the experience of drug user organisations in testing and refining the insights drawn from research is an invaluable part of developing optimum prevention messages.

All of the papers reviewed here are from qualitative, interview-based studies of people at risk of or living with hepatitis C. Each of them raises issues relating to hepatitis C prevention that can and should be taken into account when designing health promotion messages. For example, do the messages place the individual injector as primarily responsible for avoiding hepatitis C (and hence blameworthy if hepatitis C is acquired)? Can messages of distributed responsibility be included which acknowledge the difficulties individuals may experience in taking steps towards safer injecting practice? Do messages use absolute language that fosters a sense of embedded routine? Can messages avoid suggesting that there is a ‘right’ way to inject safely, instead highlighting the unique aspects of each injecting scenario so that the injector can make a refined judgment about what is safest in each particular situation? These are some of the questions we should be asking ourselves when designing educational messages aimed at preventing the transmission of hepatitis C. (See page 4 for more.)

A full review of the qualitative social research on this subject will be published in the journal Addiction later in 2008.

Citation

References


In a UK study of injecting drug users, some participants said that they never shared injecting equipment. Further questioning revealed that this was not strictly true. They did share under certain circumstances.

Whether or not injecting equipment is shared is one of the key tools used in surveillance studies in Australia to monitor hepatitis C risk associated with injecting drug use. Participants in surveillance studies are generally asked how often they share (or re-use someone else’s) needles and syringes and other pieces of equipment such as spoons, tourniquets, swabs and water. This paper focuses on the practice of ‘sharing’ equipment among injectors in the UK.

In their study Rhodes et al. found that participants who said, ‘I never share’, did share under a range of circumstances. ‘I never share’ could mean that they shared equipment in a controlled manner, i.e. made calculated decisions about when and with whom to share equipment to reduce the associated risks. For example, participants might share the equipment of someone they believed not to have hepatitis C rather than re-use equipment from unknown sources.

The authors suggested that ‘I never share’ could be a symbolic statement that reflected the harm reduction advice seen or received by the participant. It could also deflect the shame of admitting to having taken the risk of re-using equipment so as to maintain an identity of a relatively risk-free and responsible injector.

With so many variations of meaning, ‘I never share’ suggests that the real frequency of re-use or sharing of injecting equipment is higher than indicated in quantitative measures. Although 20% or less of participants in Australian surveillance typically report sharing needles and syringes, information about the risks of sharing equipment (including information on the complexities of practice) should remain a feature of hepatitis C prevention messages.

This paper also highlighted generational differences in understandings and cultures of risk. Older participants tended to understand risk in terms of the hepatitis C prevention messages that followed the major campaign against HIV in the mid-1980s. In contrast, younger participants saw the notion of blood awareness as ‘common sense’ and having preceded their interest, knowledge of or use of injecting drugs. According to Rhodes et al., it is important to reinvigorate harm reduction messages to encourage young people to view the risk of contracting hepatitis C, specifically, as to be avoided.

Drug use is a shared, rather than individual, activity

Carruthers interviewed injecting drug users based in Perth, Western Australia. Part of her analyses of these data focused on the embedded nature and importance of sharing of all aspects of the drug-use process. She identified that sharing was integral to many participants’ purchase, preparation and administration of drugs, and in the aftermath of drug use.

Given that health education messages are usually targeted at the individual, understanding the shared nature of injecting drug use is important. The author described messages that advise people who inject drugs to administer drugs separately as unrealistic and failing to recognise the social nature and importance of sharing of the event.


How drug users perceive the risk of hepatitis C

Davis and Rhodes interviewed injecting drug users in the UK about their perceptions and avoidance of the risks of acquiring hepatitis C. They report a significant level of uncertainty among drug users around the health impact of hepatitis C and ways to prevent its transmission. Participants were looking at hepatitis C through an HIV lens, judging it as less serious than HIV, and this view could be reinforced by doctors at diagnosis who might seek to provide reassurance that ‘at least it’s not HIV’.

Participants also seemed to believe that many or most people who injected drugs would inevitably become infected with hepatitis C. Since hepatitis C was regarded as an ubiquitous risk, a sturdy disease (not easy to extinguish outside the body) and widely prevalent among people who injected drugs, avoiding the risk of hepatitis C was seen to be very difficult.


The importance of blood awareness during injecting

Davis and Rhodes’ interviews with UK drug users produced further findings. Participants thought of bleeding during injecting as minimal and manageable. The notion of there being unseen blood in the injecting environment hence provoked anxiety. In a social sense, the containment of blood was strongly associated with altruistic relationships with other injectors and as integral to the identity of a competent and virtuous injector.

This suggests that health education messages about blood management should build on the altruistic social relationships between injectors. However, participants were aware that cleanliness was an imperfect method of managing infection risk. Health messages that encourage cleanliness therefore need to be used carefully so as not to appear naive or unrealistic to their target audience.


Examining individual responsibility for safe injecting

Fraser analysed material from interviews with current and former injectors and reviewed hepatitis C health promotion material to examine the level of individual responsibility for hepatitis C prevention incorporated into these materials. They typically place the responsibility for safe injecting practice on the individual person who injects. However, the interview material shows both the complex nature of relationships between injectors and the complex array of competing demands (and responsibilities) they must manage when injecting drugs. Making the individual largely responsible for safe injecting drug use (and hence avoidance of the

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acquisition of hepatitis C) also makes the individual vulnerable to blame if injecting practice is unsafe and hepatitis C is acquired. Similarly, the illegal status of injecting, and the lack of availability of appropriate services for people who inject drugs, have an impact on an individual’s ability to take up safer injecting messages.

Fraser argues that hepatitis C prevention messages should avoid focusing on the individual as personally responsible and make clear that organisations, governments and societies are also responsible for creating conditions in which individuals can make decisions and take action for safer injecting.


6 Discouraging ‘mindlessness’ while injecting

This paper examines interview transcripts of former and current injecting drug users, using the concept of ‘mindlessness’ (or ‘automatic pilot’) as a lens through which to interpret injecting practice. Treloar suggests that the use of such theory can provide other ways to understand injecting practice and develop hepatitis C prevention messages.

Participants were very aware of blood-awareness messages but susceptible to becoming desensitised to blood during the injecting process. They became sufficiently skilful that they no longer paid attention to the small activities that made up the process of injecting. Blood became ‘invisible’ and participants ‘switched off’ to its presence.

The theory of automatic pilot can inform the design of health education messages to discourage the mindless performance of injecting. Language should be used that highlights that safer injecting depends on context; avoid language that gives the message, ‘This is the safe way to do it’. Health education materials should promote ‘certain basics’ of injecting, making clear that some situations are more risky than others. This may prompt individuals to actively assess each particular situation and decide on the safest course of action in that context.


7 Delivering relevant blood-awareness messages

Treloar et al. premised their study on previous research that demonstrated that some people who inject drugs were ‘bored’ with blood-awareness messages. This paper explored ways of embedding blood-awareness messages in discussions or education around other issues that would allow health workers to engage people who may otherwise ‘tune out’ to standard messages.

The authors’ study of clients of the Sydney Medically Supervised Injecting Centre showed that participants i) were confused and lacked correct information about specific aspects of injecting practice; ii) believed they were already taking action to protect themselves; and iii) were not necessarily fully aware of the details of their injecting practice because they relied on ritual and routine in injecting. They were not sufficiently aware that they could be at risk of hepatitis C, and needed additional information or assistance to develop safer injecting practice.

Health workers could provide this by discussing other issues of relevance, such as care of their veins, or hygiene, to engage them and open up opportunities to begin broader discussion of safer injecting practice, such as blood awareness. For example, discussing the role of post-injection swabbing as part of vein care would allow discussion of how blood is moved by the swab to other sites which may then be contaminated.


See also: