Making it Real: Sexual Health Communication for Young People Living with Disadvantage

Deborah Keys, Doreen Rosenthal, Henrietta Williams, Shelley Mallett, Lynne Jordan and Dot Henning

THE UNIVERSITY OF MELBOURNE
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Foreword

Access during adolescence to reliable and accurate sexual health information is a vital component in the development of a healthy sexual adult life. In spite of considerable health promotion in this field, notification rates of sexually transmitted infections (STIs) have significantly increased in Victoria in the last 5 years (Victorian Infectious Diseases Bulletin, 2006). These rising rates are occurring in the context of decreasing age of sexual debut and an increasingly sexualised mass media. Moreover, there is evidence that some groups, particularly the socially disadvantaged and marginalised, are especially vulnerable or at risk.

The rising rates and poor levels of testing suggest that the plethora of information available is inaccessible, poorly targeted, not utilised, or rejected by adolescents. We do not currently know what works for young people. The research reported here recognises that young people are not a homogeneous group and acknowledges that their cultural, family and social contexts influence access to and use of health information. In determining how best to reach this population with information about STIs we sought answers from young people to a number of questions. How might technology be used in a creative and effective way to communicate information? What creative ideas do young people have for new information formats? How do young people evaluate the quality of information from various sources? How do they weigh up messages from different sources (e.g., media vs. parental messages) about what constitutes acceptable sexual health practices? What are the particular messages in their own sub-culture? Are these similar to, or different from, the youth culture more generally?

This research, underpinned by key partnerships with youth services, provides an evidence base to inform the development of a systematic, coordinated response targeting young people through gathering evidence on how young people access, interpret and implement sexual health messages, and the evaluation of a range of current interventions. Findings will enable those delivering public health messages to develop new modes of communication, bridge the gaps between accessed, trusted and implemented sources of information, target specific sub-populations of young people as needed, and improve the likelihood of positive sexual health messages being implemented.

Executive summary

The *Making it Real* research aimed to identify best strategies in STI communication for marginalised young people and to provide an evidence base for the development of appropriately targeted STI communication strategies for these young people.

The project sought:

- To identify the factors that facilitate or impede access to STI information and aspects of messages that engage or 'turn off' young people;
- To understand how young people seek information and evaluate the trustworthiness and relevance of sources;
- To identify the types of messages that young people believe will facilitate or impede their implementation of positive STI prevention practices; and
- To document young people's ideas for innovative and effective communication strategies.

Participants were aged between 16 and 25 years and were drawn from socially disadvantaged groups known to have an elevated risk of poor sexual health. Secondary school students were also included as a comparison 'mainstream' group. Young people were recruited through selected agencies. A total of 11 focus groups were held with 112 young people, including homeless young people, young mothers, Aboriginal young people, same sex attracted, transgender and intersex young people (SSATI), incarcerated youth, Horn of Africa young men and Somali young women, regional youth and secondary school students. Focus groups consisted of group discussions and evaluations of a range of sample sexual health promotion pamphlets.

The findings demonstrated important commonalities between the groups.

Health seeking behaviours:

- With the exception of SSATI youth, young people are reluctant sexual health information seekers.
- Information seeking is more likely to occur after risky sexual experiences or the appearance of symptoms, rather than as a preventative strategy.
- Lack of interest, stigma and denial of risk discourage and hinder information seeking.
- Any financial cost is a deterrent to health seeking behaviour.
- Young people in regional towns note a shortage of sexual health services and information for young people which discourages health information seeking.

Message:

- Young people differentiated between awareness raising messages and detailed health information. They stated that communication strategies needed to reflect these different purposes. They acknowledged clear differences in broad based big picture sexual health information and more specific sexual health information that may be communicated to them on a one to one basis.
- There is a strong need to reduce the stigma associated with STIs.
- Short, simple messages are preferred in unsolicited information.

- Many young people are unaware that males can catch Chlamydia and think awareness of this fact needs to be increased.
- Most young people rated a broad range of information about STIs (symptoms, treatment, etc.) as very or quite important for young people.
- There were few differences between young men and women in the relative importance they allocated to types of information young people need.
- Many young people think scare tactics are necessary to reach some individuals but a small majority think scare tactics increase stigma and can scare people into inaction.

Medium:

- Targeting a captive audience is key to an effective strategy, therefore using 'opportunistic advertising' is considered the most effective approach for raising awareness.
- The preferred communication strategies for raising awareness and providing short sharp messages about Chlamydia are television advertisements and posters.
- The preferred sources of detailed health information are people not technology: – help lines, school sex education and doctors.
- Young people continue to value and trust the expertise of health workers and doctors and think it is appropriate for them to raise STIs as an issue for discussion.
- Young people trust information that is endorsed by government or doctors.
- It is important to work with the community to reach Aboriginal youth.
- New technologies are not popular as sources of information.
- The internet was identified as a medium for awareness raising/delivering short sharp messages but not favoured as a site for obtaining detailed sexual health information, other than by SSATI young people.
- Using text messaging via mobile phones was rejected as an acceptable method, other than by those in the SSATI group.
- Pamphlets are only of interest to those who have an STI diagnosis or are concerned they may have contracted an STI.

Style:

- Over-dramatised' advertisements are not credible.
- Young people (except Aboriginal youth) prefer peers or actors who can convincingly portray people 'like us', rather than celebrities, in mass media campaigns.
- Television advertisements that present realistic and emotionally engaging scenarios are highly favoured.
- Preference for the use of humour or a serious approach is an individual predilection.
- Young people prefer messages to be conveyed by images, with minimal text.
- Simple language that does not attempt to be 'too cool' is preferred.
- Aboriginal and African youth were attracted to material that contained images, symbols or language associated with their cultural backgrounds.

Conclusion:

The key finding was one of similarities in attitudes and preferences for STI strategies among the sub-populations we studied. Similarities were strongest in regard to preferences for medium and style of communication. There were some differences and these were primarily between males and females and between the educationally advantaged and disadvantaged rather than between particular sub-populations.

There were gender differences across groups in relation to attitudes to STIs and differences between young men and women in relation to individual health concerns. Young women were less likely to stigmatise STIs and were more concerned about their fertility.

SSATI young people and secondary school students shared many views and these tended to differ somewhat from the other groups, especially the less educated males in the homeless, Aboriginal and incarcerated groups. This was most pronounced in relation to the stigmatisation of STIs and those who may have contracted an STI, with the most educationally disadvantaged males engaging in high levels of stigmatisation.

These findings suggest that young people do not need a large-scale media campaign that targets specific sub-populations. While socially disadvantaged young people do not favour or access all of the media embraced by young people in the general population, they access enough of the same media to benefit from a general mass media campaign to raise awareness of STIs. Rather than targeting sub-populations, general campaigns need to be inclusive of all young people. They must aim to increase awareness that both males and females can contract STIs, particularly Chlamydia, and de-stigmatise STIs.

Small-scale campaigns, developed with input from relevant young people, would benefit Aboriginal youth, young people from the Horn of Africa and those significantly economically/educationally disadvantaged.

Mass media campaigns must be complemented by interventions providing detailed information and health services. While reluctant to seek out STI information, young people think it is important to have access to comprehensive STI information when necessary.

Recommendations

Recommendations regarding principles of sexually transmitted infection information provision to young people precede specific recommendations based on awareness raising and comprehensive information campaigns.

Over-arching recommendations

1. Communication strategies should comprise:

- a broad mass media awareness raising campaign; and
- a range of strategies to disseminate more detailed health information.

2. Large-scale culturally and ethnically inclusive health promotion campaigns should be prioritised given the considerable similarities between marginalised groups of young people.

> *'White, Asian, whatever — I think we'd all relate. We're all human beings, we all catch it.' (Young man)*

Small-scale targeted campaigns, developed with input from relevant young people, would benefit Aboriginal youth, young people from the Horn of Africa and those who are significantly economically/educationally disadvantaged.

One suggested action: Fund an Aboriginal community group working with youth to adapt campaign materials for Aboriginal youth.

3. Health education campaigns need to address as a priority the belief that young women are the prime carriers of STIs, and the predominant myth that Chlamydia is a 'women's disease'.

One suggested action: Include some male targeted advertisements, for example, set in football clubs. A possible slogan could be 'Chlamydia: Guys get it too'.

> *'My problem with the whole Chlamydia thing was I thought only women could get it.'*
> *'Dirty women give it to you.' (Young men)*

4. Communication strategies for detailed STI information should utilise trusted sources of sexual health information, such as health professionals, rather than less trusted, and possibly trustworthy, media such as the internet.

5.Services where young people can obtain free sexual health information, testing and treatment should be identified and widely publicised.

> *'If it's not free most of us drop kicks don't want to know about it.' (Young man)*

One suggested action: Include Action Centre Freecall number on advertising.

6. New STI campaigns should be developed with the assistance of young people, including young people from marginalised groups.

One suggested action: Engage young people in slogan competitions.

7. Educationally disadvantaged adolescents, particularly males, should be targeted with messages that decrease the stigma of STIs and address issues of respect, blame and scapegoating.

Awareness raising campaign

8. Develop a widespread awareness campaign to reach all young people through television and cinema advertising, posters, billboards, banner style advertisements on social networking websites, shopping dockets and other 'opportunistic' advertising locations. This campaign should deliver simple information about STIs, including Chlamydia.

> *'It should be plain and simple. This is reality. Here's what can happen, here's what you can do about it, here's the people you can call for help.' (Young woman)*

One suggested action: Put simple health messages on Met tickets.

9. The awareness raising campaign should utilise a range of styles to engage diverse young people. Messages should be short and simple. Images should be used and text kept to a minimum. Materials should be bright and engaging and employ catchy slogans.

10. Awareness raising materials should include humorous and serious elements, as different approaches were effective with different individuals.

> *'Well I reckon one of the most powerful ads I've ever actually seen is probably that ice ad that's been featured on TV….it shows the kids there's some Ice users who get their skin feeling like there's bugs under the skin. … Yeah … [you need] something powerful like that.' (Young woman)*

11. Advertisements should present a realistic portrayal of STIs that young people can relate to and not over-dramatise the health effects or social consequences. This would include the juxtaposition of dramatic negative health consequences with positive outcomes.

> *'I reckon they should show two versions of it — the good version and then the bad version — like taking two paths.' (Young man)*

Comprehensive STI information

12. Comprehensive STI information should be presented in a more serious style than awareness raising material and be endorsed by government and/or medical authorities to indicate that it is from a valid, trustworthy source.

One suggested action: Consideration should be given to providing a means of identifying information from such sources (comparable to the Heart Foundation tick).

13. Young people want to access people rather than technology when seeking more detailed information. The awareness raising campaign should direct young people to sources such as doctors and other health workers, help lines or other trusted sources of information.

14. Help lines should be answered by a person not a recorded message, should be free and should have the information to refer young callers to appropriate health services. Help lines should advise people of free services where available and any potential costs related to testing or treatment should be communicated in advance.

> *'You ring up and get someone who really gives a shit.' (Young man)*

15. Consideration should be given to providing more comprehensive school-based sexual health education in late primary school (years five and six) and throughout secondary school.

16. Doctors and other health professionals should be encouraged to be proactive in discussing STIs with young people when consulting about related health issues. Up skilling of health providers and patient access need to be addressed.

> *'When young people are going to the doctors and getting the pill [doctors] should go through the pamphlet with them on Chlamydia and other STIs.'*
> *'I love that idea because that's smart. That is very smart.' (Young women)*

Example of suggested action: Provide additional resources to develop and strengthen the role of school nurses as providers of STI education within a sexual health framework.

17. Pamphlets and downloaded information sheets are appropriate media for young people seeking or requiring comprehensive STI information and should be integrated into health service consultations rather than merely left for young people to collect.

> *'You look at it and you're like "Oh, I'm not going to bother reading it, it's too many words".' (Young man)*

Background

Access during adolescence to reliable and accurate sexual health information is vital to the health and wellbeing of young people. This information should include knowledge about contraception, blood borne viruses, sexually transmissible infections (STI), how to access services and how to negotiate safe sexual behaviour. Although STI rates are only one measure of sexual health, in the context of increasing notification rates, they provide a relevant and convenient surrogate of at-risk sexual behaviour on which improvements in the sexual health of a society can be scrutinised. Given the decreasing age of sexual debut (Rissel et al. 2003) and an increasingly sexualised mass media (Moore and Rosenthal 2006) it is likely that STI rates will continue to rise.

Certain groups of young people, particularly the socially disadvantaged and marginalised, are especially vulnerable to poor sexual health (Smith, Phillips et al. 1988; Warr and Hillier 1997; Blake, Ledsky et al. 2001; Couch, Dowsett et al. 2004; Williams and Davidson 2004; Temple-Smith and Gifford 2005; Moore and Rosenthal 2006; Victorian Department of Human Services 2006; ABS 2007; Henning, Ryan et al. 2007). One particularly vulnerable group is young homeless people, particularly those involved with the juvenile justice system and those engaging in substance abuse. These young people have poor knowledge about STIs, including Chlamydia, use condoms inconsistently and commonly have limited, interrupted or no access to school sex education (Mallett 2005; Henning, Ryan et al. 2007). Unsurprisingly, they also experience high rates of infection. Information about the sexual practices and sexual health of indigenous youth is hampered by incomplete epidemiological STI notifications data. It is established that this group have poor access to services which is a contributing factor to STI transmission (Stark 2007). Other groups at high risk of poor sexual health outcomes as a result of isolation and difficulties accessing information or health services include young people living in rural and regional Victoria, young women at risk of unwanted pregnancy and young people from culturally and linguistically diverse backgrounds, especially recent immigrants (Warr and Hillier 1997; Song 2005). Lastly, SSATI youth have been shown to be at increased risk of STIs (Blake et al. 2001; Hillier et al. 2005). While there are clearly differing levels of vulnerability, the rising rates and poor levels of testing overall suggest that the plethora of sexual health related information available is inaccessible, poorly targeted, not utilised or rejected by many adolescents.

We currently do not know what sexual health promotion works for these diverse populations of young people. The little research that has sought young people's views on sexual health communication has focused on sex education in schools (Trafford, in Family Planning Victoria 2005). However, it is clear that a more diverse and nuanced approach is needed. First, not all young people are in school; second, young people choose a variety of sources other than school-based programs in their information seeking; and last, school-based education largely provides a 'generalist' response targeting adolescents as if they were a homogeneous population, rather than recognising the heterogeneity among young people. Recognising diversity among this population requires new or enhanced strategies targeted at specific sub-populations and framed in terms of their particular sexual cultures. Different strategies are likely to be effective with different groups. For example, new technologies may be key avenues of information transfer for some sub-populations, but are likely to be less accessible to others.

Sexual health information is available through various sources including schools, family, peers and health professionals, in a variety of mediums such as television, radio, print media, internet, text messaging and eye-catching written information in the form of 'credit card' sized pamphlets. Despite this, there is very little evidence documenting young people's preferred sources (including new forms of technology), sites, content, and styles of sexual health information (Smith and Rosenthal 1995). Research findings do indicate a considerable gap between the sources used and those trusted (Smith and Rosenthal 1995; Hillier, Warr and Haste 1996). Young people trust the sexual health information provided by parents and health providers, however they frequently do not utilise these sources, preferring instead sources such as books, magazines and other media in which they report having little or no trust (Hillier et al. 1996). Resolving this anomaly is central to developing effective communication strategies about sexual health.

Successful effective policy has to be built on evidence that is based on young people's evaluations of existing and proposed interventions. It requires an understanding not only of preferred sources, but of the factors that influence uptake of positive sexual health messages. We know that the dominant 'risk-based' focus does not resonate with this

population. This research takes a broader approach, one that acknowledges the cultural, family and social context and considers the content, format, tone and medium of sexual health messages. We are particularly interested in young people's own views about 'best' and innovative sources in order to communicate effectively about STIs.

STI rates in Victoria

Notification rates of Chlamydia, gonorrhoea and syphilis have significantly increased in Victoria in the last 5 years (Victorian Department of Human Services 2006). Gonorrhoea and syphilis notifications are mainly amongst men who have sex with men (MSM). The number of Chlamydia notifications has increased by 200% in the last eight years from 3264 cases in 2000 to 11,220 cases in 2007 (Victorian Infectious Diseases Bulletin 2008). In 2007, as in previous years about 60% of notifications were for females and 40% for males (Victorian Department of Human Services 2007). Chlamydia notifications show a peak prevalence in women aged 20 to 25 years of age (Victorian Department of Human Services 2007). Rates in men are believed to be higher than suggested by notification rates as a result of the asymptomatic nature of Chlamydia infection and lower use of health care services by men (Chen and Donovan 2003; Chen and Donovan 2004). Even in women, only 7% of Victorians aged between 16 and 24 years of age were tested for Chlamydia in 2004 (Counahan, Hocking et al. 2003; Vajdic, Middleton et al. 2005).

Young people and STI vulnerability

In Australia the median age of first intercourse is 16. Chlamydia is most common in those aged under 25 years and although other STIs are less strongly associated with this age group, there are still significant numbers of syphilis and gonorrhoea occurring during the early years after sexual initiation (Rissel, Richters et al. 2003; Victorian Department of Human Services 2006; Victorian Department of Human Services 2007).

Whilst many of the obstacles to accessing sexual health information and services are common to all young people, the needs of those from certain groups demand additional consideration. The Federal and State Government, as well as the Chapter of Sexual Health Medicine of the Royal Australasian College of Physicians, have highlighted young people as a priority group in their STI strategies as well as ATSI, MSM, and IVD users (Australasian Chapter of Sexual Health Medicine 2004; Commonwealth of Australia 2005; Victorian Department of Human Services 2006). Young people are at risk as a result of sexual risk taking behaviour, their cognitive development and their difficulty in accessing health care services (Aral and Holmes 1999; Williams and Davidson 2004).

Making it Real identifies relevant communication strategies for Chlamydia, the most common STI among young people in Australia. However, project participants spoke of Chlamydia and STIs more generally in focus group conversation. The findings are not therefore confined to the issue of Chlamydia and are broadly applicable in relation to other STIs.

Background literature

While few studies of young people and sexual health have focused on the identification of relevant sexual health communication strategies, considerable work has been done on the risk-taking behaviours and vulnerabilities of young people. The studies that have been conducted with sub-populations of young people indicate that gender, sexuality, ethnic and cultural background and other forms of social disadvantage such as the experience of homelessness, influence young people's ability to maintain sexual health.

Many young people are multiply disadvantaged, sharing common circumstances that contribute to increased vulnerability to STI infections. These include low socio-economic background and disengagement from educational institutions. Substance use, another risk factor, is also higher amongst some disadvantaged sub-populations than in the general youth population. Difficulty accessing medical care is another factor common across groups but more pronounced in certain sub-populations.

The first section of the review presents a brief overview of the prevalence of STIs amongst the sub-populations targeted by the *Making it Real* research project. While evidence exists of contextual factors and sexual practices that place young people in these sub-populations at particular risk of STIs, incidence and prevalence data have not been collected for all groups. Where there are no prevalence data available, some information from studies of factors contributing to vulnerability has been included. Where Australian studies are not available, international studies have been included. The section on sub-populations is followed by a brief review of recent literature about communication of sexual health information to young people.

Sexual health of selected groups

Aboriginal youth

Information about the sexual practices and sexual health of Aboriginal youth is hampered by incomplete epidemiological STI notifications data. However, the rate of Chlamydia diagnosis among Aboriginal and Torres Strait Islanders is more than seven times that of non-Aboriginal Australians and is almost four times higher in the major cities (National Centre in HIV Epidemiology and Clinical Research 2007). For Aboriginal and Torres Strait Islander youth, Chlamydia diagnoses are almost as common in 15-19 year olds as in 20-29 year olds, while non-Aboriginal youth are more likely to be diagnosed in the older age group. It is also established that this group have poor access to services — a contributing factor to STI transmission (Australian Government 2005; Stark 2007). Aboriginal and Torres Strait Islander people are identified as a priority group in the National Sexually Transmissible Infections Strategy 2005-2008 and the Victorian Sexually Transmissible Infections Strategy 2006-2009 (Commonwealth of Australia 2005; Victorian Department of Human Services 2006).

Same sex attracted, transgender and intersex youth

Same sex attracted, transgender and intersex youth (SSATI) are at increased risk of STIs with rates of STI diagnoses among these young people up to five times higher than among the heterosexual school population (Blake et al. 2001; Hillier, Turner et al. 2005). Same sex attracted youth are likely to engage in sexual activity earlier than their heterosexual peers, putting themselves at greater risk of infection (Hillier, Turner et al. 2005). Gay and homosexually active people are an identified priority group in the National Sexually Transmissible Infections Strategy 2005-2008 (Commonwealth of Australia 2005; Hillier, Turner et al. 2005).

Incarcerated young people

Recent US studies have found a high prevalence of Chlamydia infections and recurrence of infections amongst incarcerated young people (Kelly, Bair et al. 2000; Robertson, Thomas et al. 2005; Joesoef, Kahn et al. 2006; Bretl, Vukovich et al. 2007). A 2003 study of the health of incarcerated youth in NSW reported Chlamydia rates of 6% amongst males and 7% amongst females (NSW Department of Juvenile Justice 2003). Given the rising rates of Chlamydia in the general youth population, current prevalence is likely to be considerably higher. Young prisoners tend to come from disadvantaged backgrounds and are dealing with multiple social issues along with poor health (Levy

2005). Aboriginal young people, a sub-population already at increased risk, are over-represented in this population in Australia with an incarceration rate of 44 per 1,000 compared with non-Indigenous Australians rate of 3 per 1,000 (Australian Bureau of Statistics 2007). Aboriginal and Torres Strait Islander youth represented 42% of the sample in the NSW study cited above. In Australia, the Victorian Sexually Transmissible Infections Strategy 2006-2009 identifies people in correctional settings as being at increased risk of STIs, although they are not designated as a priority population (Victorian Department of Human Services 2006).

Young people experiencing homelessness

Young people experiencing homelessness are particularly vulnerable; over-represented in this group are young people involved with the juvenile justice system and those engaging in substance abuse. Some young people in this population have poor knowledge about STIs, including Chlamydia, use condoms inconsistently, and have limited or no access to school sex education (Hillier, Matthews et al. 1997; Mallett 2005; Henning, Ryan et al. 2007). Their daily lives are not conducive to either safer sex practices or seeking health care. Unsurprisingly, such matters can be assigned low priority when experiencing homelessness (Hillier, Matthews et al. 1997). As a consequence, they also experience high rates of infection. For example, one US study reports a prevalence rate of 12% for young women experiencing homelessness (Noell, Alter et al. 2001). Out of a sample of 403 young people experiencing homelessness in Melbourne, 11.1% of the 39.5% who had been tested for an STI other than HIV or HCV reported positive test results (Rossiter, Mallett et al. 2003). A recent study by Kang reported that 5.7% of clients of a youth health centre that served homeless young people tested positive to Chlamydia (Kang, Rochford et al. 2006). At the Centre for Adolescent Health's Young People's Health Service in Melbourne, Chlamydia prevalence among males (16-24) was 10% and among females, 11.4% for the 6 month period from January to June 2007 (Centre for Epidemiology and Population Health Research Burnet Institute 2008).

Homeless young mothers

Young mothers are often from disadvantaged backgrounds with curtailed education, and commonly histories involving sexual risk-taking (Woodward, Fergusson et al. 2001). A systematic review of sexual risk among young pregnant and mothering teens in the US found that young women in these circumstances were more vulnerable to STIs than other women their age (Meade and Ickovics 2005). One study found that young mothers tend to use condoms inconsistently (Coley and Chase-Lansdale 1998). Meade and Ickovics conclude that pregnant and mothering teens would benefit from interventions that promote condom use to prevent STI infection in addition to hormonal contraception (Meade and Ickovics 2005). Circumstances that leave young women vulnerable to STIs can be exacerbated both by homelessness and by young motherhood. For example, the cost of medical appointments can lead to young mothers spending available money on their children's medical costs and neglecting their own health. The added vulnerability associated with homelessness can combine with these factors to increase the risk of undiagnosed and untreated STIs. Data on incidence or prevalence of STIs in this sub-population are not available.

Young people from the Horn of Africa

Young people from the Horn of Africa, who have recently arrived in Australia as refugees or have refugee-like backgrounds are likely to have missed out on sex education in schools and from parents. They are therefore likely to be less knowledgeable about STIs and their prevention and transmission, and at higher risk than the youth population overall of contracting an STI. Negotiating cultures of origin with Western youth cultures, without comprehensive sexual health education, makes this group particularly vulnerable (McNally and Dutertre 2006). Figures are not available for rates of STI infection among young people from the Horn of Africa.

Regional youth

Young people living in regional or rural locations are at increased risk of experiencing untreated STIs due to a dearth of medical services, a situation that puts their peers at risk of infection. There are few, if any, youth-friendly health services that young people can approach for prevention education or testing and treatment for STIs. Additionally, studies have shown that a shortage of accessible general practice clinics means that young people may feel too uncomfortable or too concerned about confidentiality, to seek information, testing or treatment about an STI when the only general practitioner available is their family doctor (Warr and Hillier 1997; Poljski, Atkin et al. 2004). A recent study found reasonably high rates of Chlamydia (3.9% overall and higher in those with more than one sexual partner in the last year) amongst sexually active non-metropolitan young men (Gold, Hocking et al. 2007). Higher rates

of births to women under 20 years have been recorded in rural and regional areas of Victoria than in metropolitan Melbourne, suggesting the possibility of more unplanned pregnancies, possibly related to less effective or regular condom use, amongst young women in these areas (Victorian Department of Human Services 2007).

Gender

Gender has long been recognised as a key factor in sexual health. Whilst even a brief discussion of how gender impacts upon sexual health is beyond the scope of this report, a few points must be noted.

Firstly, young women are at greater risk of STIs due to social and biological factors. Social factors operate at the level of society and the individual; young people construct themselves as sexual beings within the practical contexts and discourses of their societies. Despite changes in social and cultural mores young men and women still appear to construct their sexual worlds in different ways (Moore and Rosenthal 2006) and these differences greatly influence sexual health outcomes. For example, a recent Australian report noted that 20% of females (compared with 5% of males) have been coerced into unwanted sexual activity (Family Planning Victoria, Royal Women's Hospital et al. 2005).

Gender shapes male as well as female vulnerabilities. Studies regularly find that young women are more prepared to seek help from someone for health issues and more prepared to attend health services than young men (for example, Booth, Bernard et al. 2004). As Melendez and Tolman (2006, p.33) have noted 'gender is never constructed in a vacuum but is always informed by other individual and social factors', however commonalities, based on the very fact of being male or female in a society, remain and serve to affect levels of vulnerability to STIs across populations of young people (Melendez and Tolman 2006).

Sexual health communication

It is well understood that targeting individual behaviour (through increasing individual awareness of STIs and STI prevention and improving knowledge, attitudes and skills) is but one necessary component in any successful attempt to reduce STI prevalence among young people (Aggleton and Campbell 2000; Couch, Dowsett et al. 2004; Moore and Rosenthal 2006). It is, however, a crucial component. Most research about young people and sexual health communication has considered sex education within schools. As the brief for the Making it Real project was to identify relevant sexual health communication approaches for sub-populations of young people, many of whom are commonly outside the education system, this review excludes studies of school-based education programs. It provides a brief overview of five areas: used and preferred sources for sexual health information, media literacy, medium (with a focus on public information campaigns and new technologies), current sexual health messages, and style of current sexual health material.

Used and preferred information sources

Studies over the last decade that examine levels of use of information sources and trust in these sources have found that parents, teachers and health educators are the preferred and most trusted sources of information on STIs (Rosenthal and Smith 1995; Smith, Agius et al. 2002). Smith, Agius et al.'s most recent study of Australian secondary school students found school programs, pamphlets, media and teachers are the preferred sources of sexual health information (Smith, Agius et al. 2002). A more recent qualitative study in West Australia showed a wide range of preferred media for *provision* of sexual health information, including television, radio, posters, magazines and the internet. Health professionals or the internet were the preferred options for *obtaining* sexual health information (Wilkins and Mak 2007).

Media literacy

It is interesting to note that television and other media continue to be major sources of information for young people, despite research indicating they are often regarded as untrustworthy (Rosenthal and Smith 1995; Smith, Agius et al. 2002). Studies in Australia and overseas have repeatedly found that young people are dubious about the quality

of information available on the internet (Gray, Klein et al. 2002; Smith, Agius et al. 2002); the internet was found to be the least trusted source of information in one US survey (Kaiser Foundation 2001). The results of the Kaiser Foundation survey support the common finding that young people continue to use sources that evoke high levels of scepticism. No gender differences in levels of internet use or levels of trust in the information available on the internet were found among Australian secondary school students (Smith, Agius et al. 2002). In Australia, websites were more trusted and more likely to be used than chat rooms and discussion groups (Smith, Agius et al. 2002; Blanchard, Metcalf et al. 2007).

Studies of how the credibility of health information material is established, which generally include participants of all ages, report disheartening results. Consumers of health information often state that source credibility is used to evaluate the credibility of health information (Eysenbach and Kohler 2002; Bates, Romina et al. 2006). However, one recent US study found that on measures of trustworthiness, truthfulness, readability, and completeness of internet health information, differences in attribution to a source did not have a significant effect on consumers' evaluations of the quality of the information (Bates, Romina et al. 2006). Consumers have also reported considering professional design, scientific or official touch, language, and ease of use as criteria for establishing credibility (Eysenbach and Kohler 2002; Sillence, Briggs et al. 2004), while internet sites that combine health information with overt commercialism are avoided (Morahan-Martin 2004). Sillence, following studies with older women seeking health information, proposes a staged model of trust with design appeal initially predicting possible rejection, and credibility of source and personalisation of material content (written by people like themselves) predicting trust (Sillence, Briggs et al. 2004). No studies investigating how young people evaluate the trustworthiness of health information websites were found.

Medium

Medium is a critical factor in health promotion. This section reports on some recent studies and reviews of the efficacy of public information health campaigns using mass media and the use of new technologies as tools for health promotion.

Mass media campaigns

Most basically, mass media campaigns can be described as strategies where the target is a mass audience and there is no direct interpersonal contact between the communicator and the audience (Tones cited in Nicholas 2002). Flay and Burton (1990, p.130) provide the following more comprehensive definition: 'an integrated series of communication activities, using multiple operations and channels, aimed at populations or large target audiences, usually of long duration, with a clear purpose' (cited in Shanahan, Elliot et al. 2000). The purposive use of media to convey health messages generally employs advertisements on television, radio, and/or billboards or print media with the aim of changing knowledge, attitudes or behaviour.

In a 10-year retrospective of research of mass media health campaigns in the US and internationally, Noar (2006, p.21) concluded that the literature is beginning to show that targeted, well-designed mass media campaigns on health issues can have 'small-to-moderate effects not only on health knowledge, beliefs and attitudes, but on behaviours as well, which can translate into major public health impact given the wide reach of mass media' (Noar 2006). While reviewers note the difficulty of rigorous campaign evaluation, evidence does exist to support growing optimism around the effectiveness of mass media health campaigns and it is possible to derive some common factors in successful campaigns (Noar 2006; Zimmerman, Palmgreen et al. 2007).

Noar reports that the major principles of effective campaigns are the conduct of formative research with the target audience, using theory as a conceptual foundation, the segmentation of audience into meaningful sub-groups, use of a message design approach that is targeted to and engaging to the sub-group, the strategic placement of messages within channels widely viewed by the target group, the conduct of process evaluations that monitor activities ensuring exposure to target audiences, and use of a sensitive outcome evaluation design (Noar 2006).

Other recent literature reviews of campaigns identify similar components; the following four aspects are regularly cited — formative research, the use of more than one form of media, a sustained campaign, and integration of a mass

media campaign with other on-the-ground supportive interventions (Shanahan, Elliot et al. 2000; Nicholas 2002; Delgado and Austin 2007; Zimmerman, Palmgreen et al. 2007).

Formative research involves the delineation of a well-defined target audience, research to understand the target group and pre-testing of the campaign materials (Dejong and Winsten 1990 cited in Shanahan, Elliot et al. 2000). In relation to targeting different youth populations, Noar reported that several campaigns that segmented youth into sub-populations were effective, leading him to conclude that segmentation and message targeting to different sub-populations appear to be successful strategies (Noar 2006). Shanahan, Elliot and Dahlgren's review (2000) supports his view and stresses the importance of having a full understanding of the proposed audience's attitudes and motivations in relation to the salient health area (Shanahan, Elliot et al. 2000).

Awareness raising campaigns that use more than one medium, particularly if they incorporate television advertisements, are more effective than those employing only one medium (Shanahan, Elliot et al. 2000). Nicholas observes that the optimum time frame for an effective campaign is unclear but says 'one-off, one shot' mass media campaigns are ineffective' (Miller and Ware 1989, pg. 6 cited in Nicholas 2002). Shanahan et al. conclude that campaigns dealing with young people and risk-taking behaviour should be ubiquitous and long-term (Shanahan, Elliot et al. 2000).

There is strong support for integrating mass media campaigns with more local interventions such as help lines, sexual health services, school-based programs or interpersonal communication strategies. Mass media campaigns appear to be particularly efficacious in awareness raising and agenda setting through their ability to attract community attention, while changes in behaviour are slower to occur (Shanahan, Elliot et al. 2000). Nicholas cites the successful Australian anti-smoking campaign that combined a mass media campaign to raise awareness with the interpersonal contact of a help line or health practitioner to assist with behaviour change (Nicholas 2002). In a well-designed study of a two city television advertising campaign about safer sex, targeting young adults, Zimmerman et al. found that although the campaign was effective in increasing condom-use beliefs and behaviours, the effects were short-lived. They concluded that a continuing campaign presence or the combination of the campaign with other interpersonal interventions may have helped sustain the effects (Zimmerman, Palmgreen et al. 2007).

A US mass media campaign that aimed to increase awareness of personal risk for Chlamydia infection, facilitate information dissemination through a help line and promote attendance for Chlamydia screening among young people was evaluated and found to be an effective strategy to deliver STI messages (Oh, Grimley et al. 2002). In line with the effective strategies listed earlier, this campaign used a range of channels to disseminate the information and was linked to an interpersonal response. Calls to the help line averaged 99 per week until the television advertisement ceased to air, when the number of average calls dropped to only 9 per week. Bulk mail outs of information also appeared to boost call numbers to the help line. In total, only 31 individuals reported for Chlamydia screening, 87% during the period of the television campaign. However, the campaign was clearly successful in raising awareness of the risk of Chlamydia. The study confirms that television is an appropriate medium for sexual health messages for young people; it also once again raises the question of the optimum length for a campaign.

Recent research commissioned by the National Youth Affairs Research Scheme (NYARS) has examined the effect of public information campaigns about youth risk-taking on improving knowledge and awareness and achieving behaviour change among youth (Shanahan, Elliot et al. 2000). In addition to the findings referred to above, this report comments specifically on engaging 'alienated' or 'specific problem' youth, reporting that key informants believe that such youth are more effectively reached through community level interventions. Shanahan, Elliot and Dahlgren also note the importance of recognising cultural diversity, even within minority populations such as Aboriginal youth.

New technologies

Young people in general are highly media literate and new information communication technologies (ICT), such as the internet and SMS text, have been recognised as having significant potential as health promotion tools for this population (Skinner, Biscope et al. 2003; Nicholas, Oliver et al. 2004; Macdowell and Mitchell 2006; Moore and Rosenthal 2006). ICTs are increasingly being used as vehicles for health promotion (Suggs 2006) but most research into young people's use of ICTs has drawn on a small sub-section of the youth population and extrapolated

to young people in general. In this way, differences according to age, ethnicity, socio-economic situation and life circumstances have been obscured (Wyn, Cuervo et al. 2005). One exception is a recent Australian project that explored marginalised young people's use of ICT technology (Blanchard, Metcalf et al. 2007). Participants in this study included young people from Culturally and Linguistically Diverse (CALD) backgrounds, Aboriginal youth, same-sex attracted youth and young people with a disability or learning difficulty. Findings from this research are included below.

Internet: Access

In Australia there is almost universal access to the internet, either at home or elsewhere, with 64% of Australian households connected (ABS 2007). Blanchard, Metcalfe and Burns' study reported that non-Aboriginal Australians, and those who are employed, well-educated and in the top two quintiles of household income are most likely to be connected (Blanchard, Metcalf et al. 2007). Young people who do not reside in such households may access the internet at other locations, such as school, libraries and community or welfare agencies. Higher than expected access rates to the internet were found in the Blanchard et al study, with 93 of the 96 participants having access. However the sample may be biased as those with internet access may have been more likely to volunteer to participate (Blanchard, Metcalf et al. 2007). In another Australian study, young people from the Horn of Africa reported easy access to the internet and high internet use (McNally and Dutertre 2006). Home, schools and libraries were the most common access points. Gray et al. found that access to school computers in the UK is highly competitive, increasing the digital divide for those without connected home computers (Gray, Klein et al. 2002). This is likely to be a situation common to Australian schools.

Blanchard, Metcalfe and Burns found social networking websites were popular amongst most groups of marginalised young people, however familiarity and choice of websites differed between groups. MySpace was the most popular social networking site overall but it was unfamiliar to those young women with juvenile justice involvement, while Bebo was favoured by Aboriginal youth (Blanchard, Metcalf et al. 2007).

Internet: Use as a health information source

For the internet to be a useful health information source for young people, more than simple physical access is required (Gray, Klein et al. 2002; Blanchard, Metcalf et al. 2007). Gray, Klein et al. (2002) list the following possible inhibiting factors: lack of capacity, speed and sophistication of hardware and software; content filtering software that blocks sexual content, which may block sexual health information; and possible difficulty managing the 'paradigm shift' from passive to active information seeking. One US survey reported that 46% of young people searching for sexual health information (15% of whom were seeking information about sexual health and contraception) were blocked from non-pornographic sites by filtering software (Kaiser Foundation 2001).

A recent literature review noted that the role of the internet in regard to health information search behaviours remains unclear but behaviours may differ both between different social groupings and in relation to different health issues (Renahy and Chauvin 2006). Some overseas studies (for example, Delgado and Austin 2007) found the internet had an important place in young people's health seeking behaviours. A nationwide US survey of over 1,000 young people found 75% of the participants had searched the internet for health information, and 44% of these were looking for information about sexual health, including STIs (Kaiser Foundation 2001). Rates of internet use for health information in Australia appear to be much lower. One study found that 66% of secondary students never used the internet as a source of health information and 28.9% only used it rarely for this purpose (Smith, Agius et al. 2002). A more recent Victorian study found that young people from the Horn of Africa relied on the internet (along with personal contacts) for health information, however they did not know of any websites providing sexual health information (McNally and Dutertre 2006). Same sex attracted young people also report that the internet is an important source of sexual health information (Hillier, Kurdas et al. 2001). Other research gives some indication of preferred information topics, for example, Gilbert found that among users of a sexual health information site the subject of STIs was one of the least popular topics (cited in Gray and Klein 2006).

The appropriateness of sexual health information available on the web for marginalised young people is also an area of concern. Lazaras and Mora (2000), who undertook a study of existing content on the World Wide Web, note that many sites are too text oriented which makes them inaccessible or unattractive to those with lower literacy skills.

They also report a dearth of culturally appropriate information created by underserved communities themselves (cited in Bernhardt 2000).

Additionally, we have scant information on what effect, if any, accessing internet health information has on young people's health knowledge, behaviours and healthcare (Renahy and Chauvin 2006). The information we do have is generally drawn from the mainstream youth population (Blanchard, Metcalf et al. 2007). For example, a recent review of studies carried out in the US reported some computer-based or internet interventions to be effective in increasing STI knowledge, condom usage, intention to practice safer sex and reducing the likelihood of being diagnosed with an STI (Delgado and Austin 2007). A key feature of these interventions was their interactive nature. In another US study, data were disaggregated by gender and showed differences in health information seeking and responses to that information. Not only were young women more likely to seek sexual health information from the internet but they were more likely to discuss what they read with others, and were more likely to visit a health provider because of what they had read (Kaiser Foundation 2001).

Mobile phones and text messages (SMS)

According to a recent Australian study, which surveyed 1000 16 to 28-year-olds, 94% own mobile phones (Spin Communications 2004). Mobile phone access differs according to socio-economic background with high income earners more likely than others to use mobile phones (Blanchard, Metcalf et al. 2007). It is unclear whether this socio-economic difference is as strong among young people. Disadvantaged young people are likely to have less access to the mobile phones they do own due to financial costs.

Text messaging, in the form of general messages sent to particular populations and responses to consumer queries, has been identified as a potentially effective tool for health promotion, due to its low cost, anonymity, accessibility and convenience. However, little rigorous evaluation of this information medium has taken place. Three recent studies have produced encouraging results. A randomised controlled trial in Melbourne found that receiving regular sexual health-related SMS and email messages can improve knowledge in young people and health seeking behaviour in young women (Lim, Hocking et al. August 2007).

A recent Western Australian campaign used SMS as one facet of a broader campaign that aimed to increase Chlamydia testing among 15 to 24-year-olds (Wilkins and Mak 2007). Wilkins and Mak report that the focus group responses to text messaging were paradoxical. Participants found SMS advertising to be annoying and an invasion of privacy but many thought it would be effective as it raised awareness and promoted discussion. During the course of the campaign, over 11,000 young people received two SMS messages alerting them to the issue of Chlamydia as an asymptomatic infection and encouraging testing. While lack of pre-campaign data precluded attribution of the changes in levels of knowledge of Chlamydia that took place during the campaign to the campaign strategies, it appears likely there was an association. The researchers concluded that SMS was well-tolerated if permission to receive SMS advertising was granted and SMS is an acceptable medium for the distribution of sexual health messages to young people (Wilkins and Mak 2007). In one further study, text messaging was found to be effective in increasing access to clinical services among young people at greatest risk of STIs (Dobkin, Kent et al. 2007).

Message

This section provides an overview of the STI-related messages that are most available in print for young people in Victoria. It is drawn from the written material supplied by project partners who are working in frontline service delivery with the sub-populations selected for this project. See Appendix 2 for details of pamphlets. The intention is not to provide a comprehensive overview, rather to focus on the most readily available material. A brief précis of key findings around message from the National Youth Affairs Research Scheme study of campaigns addressing youth risk-taking follows (Shanahan, Elliot et al. 2000).

The practice

Some material was developed specifically for young people; other commonly available material was developed for the general population. Some pamphlets were designed to target Aboriginal youth. Some material dealt with sexual health or STIs generally; other material was specific to Chlamydia.

The scan of common, written material available to young Victorians indicates that content falls into six main areas — STI definitions and modes of transmission, symptoms and consequences, prevention, testing and treatment, health service access, and the social context relating to good sexual health.

Most pamphlets available for young people in Melbourne begin with a definition of STIs in general and provide information about the most common STIs. Modes of transmission are made very clear and oral, anal and vaginal sex are generally all referred to and explained. Some longer pamphlets provide quite detailed information about how STIs are transmitted, for example the role of sex toys.

Pamphlets generally list signs and symptoms and explain that STIs are common and often asymptomatic. Short-term and long-term consequences are included but only two of the readily available pamphlets mention that Chlamydia could lead to male problems with fertility. That STIs, particularly Chlamydia, are common and that it is not possible to identify an infected individual by sight (as stressed in the *'You never know who you'll meet'* campaign) are key messages. Despite the fact that the message is generally that STIs can affect any sexually active person and the inclusion of descriptions of sexual activity that are non-gender specific, few pamphlets explicitly refer to SSATI young people or show images of same sex couples.

All evaluated pamphlets discuss prevention. Brief pamphlets encourage the use of condoms with lubricant and dams and give directions for correct condom usage. More comprehensive pamphlets discuss the meaning of the term 'safe sex' or 'safer sex' and describe a range of activities that fall under these headings. A few examples suggest being prepared by always carrying a condom.

Testing and treatment are covered in varying degrees of detail. Most basically, young people are advised to get tested, either regularly or if symptoms are present; only one brochure suggests regular testing for common STIs. Young people with symptoms are urged to seek treatment promptly. Around half of the pamphlets explain the need for partner treatment and only a couple suggest abstinence until testing and treatment are complete. Two give some details of what tests may be required. A key message is that most STIs are curable and easily treated. Some materials describe the likely treatment that will be prescribed.

All pamphlets include health service contact details. Youth specific pamphlets generally only contain phone numbers, although a few more recent publications include website addresses for family planning services or the Melbourne Sexual Health Centre. One booklet lists useful contact numbers, services and their addresses and websites under the headings 'Ring', 'Go', 'See'.

The longer pamphlets commonly include discussion of the social context of sexual activity, including social stigma around sexual activity and around STIs, interpersonal relationships and communication, and the right to autonomy and safety. Young people are encouraged to overcome any feelings of shame or embarrassment in relation to purchasing condoms or seeking health services. The need to communicate with partners, particularly about condom use but also more broadly is emphasised. The right to safe sex, to say no to sex and to resist pressure are covered in terms of self-care and respect for your body. A few pamphlets touch upon the issue of safety and trust in relation to STIs, making the point that safer sex should be practiced even with trusted partners. This message is commonly linked to the related point that many people who have an STI do not know they are infected. One brochure directly addresses the misconception that only people who are promiscuous contract STIs, stating 'By not wanting to take chances you are just being sensible. It shows you respect both yourself and your partner — and your partner should have the same respect for you.' (Marie Stopes International Australia, VACCHO and the Mildura Aboriginal Health Service)

Two pamphlets refer to the reasons young people may have for having sex, for example intimacy or fun, and include positive images of young couples (both same sex and male/female) embracing. Other material tends to take a practical tone that neither condones nor discourages sex between young people. None of the pamphlets employ scare tactics.

The literature

Studies tend to show that young people do not respond well to negative 'Don't do it' exhortations (Shanahan, Elliot et al. 2000). A key aspect in developing health messages for young people is the establishment of credibility. Rogers and Sopory (1992) and Tones (1996) suggest emphasising current rewards rather than possible future negative effects (cited in Shanahan, Elliot et al. 2000). Shanahan et al. conclude that although negative appeals are effective in awareness raising, positive messages may be more successful in changing attitudes or behaviours (Shanahan, Elliot et al. 2000).

They also provide a useful summary of the 'fear literature', concluding it is difficult to evoke fear in campaigns and when a campaign does evoke fear, audiences may try to avoid the anxiety (e.g. use denial) or make efforts to deal with the threat. Messages that do evoke greater fear or anxiety are likely to be persuasive but the fear tactics approach is least successful on those most at risk. Finally, scare tactics can be very effective but are sensitive to the situation and can easily backfire (Shanahan, Elliot et al. 2000). Given the risks associated with fear appeals, Shanahan et al. stress that such approaches need to be carefully executed and this requires inducing only moderate levels of fear and including mechanisms for reducing any fear through preventative measures or other productive action (Shanahan, Elliot et al. 2000).

Style

This section describes the range of styles of the written material readily available to the young people in the sub-populations selected for *Making it Real* and reports briefly on the findings regarding style by the National Youth Affairs Research Scheme report on campaigns addressing youth risk-taking (Shanahan, Elliot et al. 2000).

The practice

Written materials range from wallet-sized glossy cards through A4 photocopied fact sheets to 60 page A5 booklets. The DL envelope sized pamphlet is the most common format. Innovative formats include the *'It takes 2 to tango'* envelope (Sexual Health and Family Planning Australia, Bayer), the *'You never know who you'll meet'* Chlamydia campaign postcard (DHS, Victoria) and the long fold out *'Snake'* brochure on condom use (Marie Stopes International Australia, VACCHO, Mildura Aboriginal Health Service).

Some material, for example the *'KISSS'* brochure (ANCAHRD 1998), was created to appeal to young people. It employs a very busy, colourful format with a mix of photographs, illustrations, and text presented in a variety of layouts. Text is broken into small sections and presented in tables, speech bubbles and other innovative formats. A colourful, very dense chart provides relevant details of common STIs. The language is informal and contains colloquialisms used by young people without creating a 'trying to be cool' effect. *'What is Hep C'* is in a similar style to the *'KISSS'* pamphlet with the information presented in a brightly coloured, but much simpler design. There is scant text and cartoon style drawings illustrate each point. Another product designed to appeal to young people is Family Planning Victoria's wallet card *'What's not always talked about'* advertising the Action Centre, which features a manga style illustration and fluorescent colouring.

'674: A Pocket Guide to Keeping Well on the Streets' (Project i, University of Melbourne) targets young people who are homeless or at risk of homelessness and includes information about sexual health and STIs. It is the only pamphlet which features photographs as the only images, although the *'KISSS'* pamphlet does include some photographs. The photographs in *'674'* are in black and white and have a 'gritty' look aimed to attract young people on the street. This 60 page booklet has a lot of text, although the language used is simple and there are no dense blocks of text. Direct quotes from young people are used throughout. The *'KISSS'* brochure also presents text in the form of direct quotes.

Young people are also given booklets that were not specifically designed for them such as *'Sexually transmissible infections: Treatment is good/prevention is best'* (DHS, Victoria 2005). This booklet, in a 2-colour print, is plain and simple in design. Information is structured under 14 headings, each heading being a question about STIs. Half of the booklet is devoted to details of specific STIs, with one page allocated to each infection. The language is not youth orientated but is informal. The page layout retains plenty of white space which, together with the use of short headings in coloured font, makes the information easy to locate.

'Chlamydia' (FPV) is a DL envelope style pamphlet in a two colour print. The only text on the cover is the words 'Chlamydia' and 'Family Planning Victoria', and the image is of an abstracted human figure. Inside, information is presented in a straightforward, simple style under six coloured headings, each a question relating to Chlamydia. Chlamydia Fact Sheets are also downloadable from the Melbourne Sexual Health Centre and these are printed and given to young people in some services. The A4 format with material presented under clear headings, once again in the form of questions, is very plain and information is therefore easy to locate.

Several pamphlets are available that target Aboriginal Australians. These commonly have illustrations incorporating Aboriginal iconography, and some use language. The *'Snake'* pamphlet presents a section titled 'Spot the rubbish excuse' that presents arguments for not using condoms (which it then proceeds to refute) as direct quotes.

Only the *'KISSS'* and *'What is Hep C'* pamphlets employ humour and in both cases this is through the use of cartoon style characters.

The literature

In addition to undertaking a literature review, Shanahan et al. interviewed campaign managers with experience of youth mass media campaigns to identify effective ways to present information about risk-taking behaviour to young people. Campaign managers believed that youth are a particularly critical audience, requiring well-researched and pre-tested materials (Shanahan, Elliot et al. 2000). In stressing the importance of presentation and content, they state that 'the medium is the message' (Shanahan, Elliot et al. 2000, pg. 28).

A second point to come out of their study is the importance of selecting a clear and not overly complicated message that is easily understood by the target audience (Shanahan, Elliot et al. 2000). Makkai, Moore and McAllister (1991) found that the general public does not generally like to read detailed information, and this dislike is greater in young people (Shanahan, Elliot et al. 2000). Evaluations of *Streetwize* comics dealing with issues pertinent to young people, such as the *'What is Hep C'* brochure, and targeting marginalised young people have been extremely positive, finding them well received by their target audience. Young people preferred the comic style to pamphlets which contained more text and were regarded as boring (Mohr and Tressider 1989 cited in Shanahan, Elliot et al. 2000). A similar preference by marginalised youth for pictures over words, along with directness and brevity was noted by BB Professional Services in their evaluation of comics developed for a youth and alcohol project (Shanahan, Elliot et al. 2000).

While Shanahan et al. conclude that it is important to use images and language that young people can relate to, they caution against using obviously 'groovy', 'try hard' approaches that can come across as forced and turn young people off (Shanahan, Elliot et al. 2000). The involvement of young people in design, as well as the development of message, is the most effective way to avoid this and produce a product that will not be rejected before the message has been conveyed.

Aims of the research

The aim of the research is to provide an evidence base for the development of appropriately targeted, STI communication strategies for socially disadvantaged young people. This includes a critical analysis of the content, format, tone and medium of these strategies. The objectives of the research are to:

- Identify the structural and individual factors that facilitate or impede access to STI information;
- Identify aspects of sexual health messages that engage or 'turn off' young people;
- Understand the ways in which young people seek information and evaluate the trustworthiness and relevance of sources;
- Identify the messages that young people believe will facilitate or impede their implementation of positive sexual health practices; and
- Document young people's ideas for innovative and effective communication strategies.

Methodology

The participants

Sub-populations of socially disadvantaged young people who have an elevated risk of poor sexual health were identified through the literature and the research knowledge of the investigators. Factors associated with social disadvantage included poverty, education levels, gender, sexual orientation, young motherhood, cultural background, rural or regional location, Aboriginality, homelessness, and incarceration. A secondary school students group was also included in this project to reflect the breadth of the youth population.

Participants were aged between 16 and 25 years of age as the need for sexual health information is greatest amongst this group[1]. Because the median age for sexual initiation in Australia is 16 years of age, it was particularly important to include 16 to 18 year-olds — a group that is often excluded from sexual health research.

Our research found considerable diversity of young people even within the sub-populations we have delineated. Many young people identified with several of the groups. For example, participants in the young Aboriginal women's group we spoke with were all mothers; the youth living in a regional town were attending a project for 'at risk youth' and the participants of the mixed gender Aboriginal group lived in a regional town. Sex/gender cut across groups, as did ethnicity, and sexual identity or practice. Additionally, there were varying degrees of common experience between groups regarding circumstances and behaviours that impact upon sexual health and health seeking behaviours, such as homelessness and drug use. This cross-membership and degree of commonality in circumstances is advantageous because it both increases validity by boosting the numbers in the less well-attended groups (the two homeless groups and the Aboriginal youth group) and results in a sample that is multiply disadvantaged.

Participants were recruited through agencies selected with the assistance of the project partners. Agencies included community health centres, accommodation and support services and a youth justice centre. Some participants were drawn from the general client groups of the agencies while others were members of agency run groups, for example young mothers' support groups. Workers in the selected agencies informed young people about the proposed focus group and assisted with the organisation of the groups. The researchers informed potential participants that participation was voluntary and there would be no negative ramifications for non-attendance. However, in the case of one group comprised of young people engaged in a regional youth training program, the researcher was informed during the focus group that participants had been told that attendance was a requirement of their training course. Participants were informed of confidentiality and informed consent was obtained.

1 Two young Aboriginal mothers aged 26 years of age participated

Table 1: Composition of focus groups

Group	Male	Female	Unspecified	Total
Homeless youth	3	1	1	5
Homeless young mothers*		6		6
Aboriginal youth	3	2		5
Aboriginal young mothers		9		9
Same sex attracted transgender intersex youth (SSATI)	4	3	2	9
Secondary school students	5	3		8
Incarcerated youth	20			20
Horn of Africa young men	16			16
Somali young women		19		19
Regional youth	13	2		15
Total	**64**	**45**	**3**	**112**

* Focus group of 2 was supplemented by 4 telephone interviews

Eleven focus groups, representing 10 sub-groups, lasting approximately 1-1 ½ hours were held with a total 112 young people including 64 young men, 45 young women and three young people who did not wish to specify their sex. Groups ranged in size from 2 to 20 participants. Due to the level of difficulty young homeless mothers experienced in attending a group, the focus group with 2 participants was supplemented with four individual telephone interviews based upon the group interview schedule.

Male only groups were held with incarcerated youth and young men from the Horn of Africa. The incarcerated participants were divided into two groups for security purposes as those classified as high risk could not attend with other youth in the justice centre. Female only groups were held with young homeless mothers, Aboriginal mothers and young women from Somalia. Male and female groups were held with homeless young people, SSATI, secondary school students, Aboriginal youth and young people living in a regional city. While the gender balance was relatively equal in most of the mixed groups, the regional youth group was dominated by males with 13 males and only 2 females attending.

Procedure

Focus group methodology is particularly suitable for this topic, giving young people the opportunity to discuss, challenge, and debate 'best practice' among themselves (Skinner, Biscope et al. 2003). Previous sexual health related research undertaken by the researchers has demonstrated that young people find the group process engaging and less threatening (especially for young men) than individual face-to-face interviews.

Focus groups were held on site at the selected agencies. They were facilitated by the first author with assistance from workers and in the case of the homeless young mothers' and SSATI groups a young peer educator from the Council to Homeless Persons' PESP Program. Discussions were audio-recorded, with the permission of the participants, and transcribed.

Focus groups comprised three activities:

- Group discussion guided by an interview schedule;
- Completion of a scale assessing the importance of Chlamydia-related information; and
- Evaluation of a range of sample sexual health promotion pamphlets supplied by the researcher.

These were preceded by a brief explanation of Chlamydia prevalence, definition, symptomatology, sequalae, treatment and prevention provided by the researcher.

Group discussion

Semi-structured interview schedules were devised by the investigators with assistance from the research partners. One interview schedule was devised for use in all groups with additional probes added to elicit any particular issues for each sub-population. The schedules were then trialled with young people from the various sub-populations and some minor changes were made to make the schedules appropriate and relevant for each group. These changes generally involved changes in language, usually the simplification of questions. Aboriginal staff members of the University of Melbourne, including Onemda VicHealth Koori Health Unit, assisted with the development of the questions for the Aboriginal youth focus groups. The development of the focus group questions was an ongoing process. Emerging issues and suggestions elicited from focus groups were incorporated into the schedules employed in subsequent groups in order to check their salience for other sub-populations.

Participants were asked for suggestions of how to disseminate both short, sharp messages and more detailed information about Chlamydia. Young people's input into possible innovations in content, form and medium of sexual health promotion strategies was sought. We were particularly interested in young people's views about innovative ways to use technology and peers in health information service delivery. Some general questions about health information seeking were also asked (see Appendix 1 for interview schedule).

Importance of information scale

In response to the statement "We'd like you to tell us which kinds of information you think are most important for young people to know about sexually transmitted infections like Chlamydia", participants rated the importance of 13 Chlamydia-related items (see Table 2). Levels of importance were rated as 'very important', 'quite important' and 'not important'. Young people were also given the opportunity to respond 'don't know'.

Evaluation of pamphlets

Participants were presented with a range of pamphlets (see Appendix 2) and asked which ones they liked and disliked and the reasons for these responses. They were asked whether they thought other young people would want to pick them up and read them. Other questions related to content (both substance and comprehensiveness), tone, language, design and format.

Analysis

Digital recordings were transcribed and integrated with notes taken during or after the sessions. Patterns and themes in the data were identified using thematic analysis. Such analysis is an inductive process requiring repeated readings of the transcripts. The researcher's interpretation of the data was presented to the project partners for verification. The research team met on a regular basis to discuss findings and achieve consensus on interpretation. Descriptive statistics (%) were calculated for the importance of information ratings.

Ethics

Ethics approval was granted by the Department of Human Services Human Research Ethics Committee, the Royal Children Hospital Human Research Ethics Committee, the Office for Children Research Coordinating Committee and the University of Melbourne.

Findings: Cultures and discourses

Findings were in some cases particular to a group and in others common to a number of groups. Overall, despite the diversity of participants and their attitudes and opinions, four areas stood out as warranting particular attention: cultures of disadvantage, gender, stigma, and reluctant health seeking behaviour. The findings reported in the following sections need to be considered within the context of these themes and discourses as they form the background for young people's views and should inform any effective response.

Cultures of disadvantage

While groups were not formed according to any strict criteria of social or economic disadvantage, there appeared to be consistency in background levels of disadvantage within some groups. Two groups, the secondary school students and SSATI groups, stood out as having participants with higher levels of education. In most cases the responses of members of these groups also indicated more advantaged backgrounds, with significant family support described in the case of the secondary school students. As well-educated and advantaged (in the main) young people they were articulate and had often been involved in creative thinking about young people's health or political campaigning through school or youth-based advocacy campaigns. They were very aware of media and communication issues. Some demonstrated sophisticated levels of media literacy and awareness of marketing and health promotion.

Homeless (young mothers and others), incarcerated, Aboriginal mixed gender and regional groups were at the other end of the education and socio-economic continuum. Their connection to family and community was less discernible and was likely to be varied, given their circumstances — homelessness, incarceration and participation in a program for 'at risk youth'. The incarcerated, homeless and Aboriginal youth, lived in milieus where violence was normalised and common. These factors affect their level of vulnerability to poor sexual health outcomes and have implications for the nature of sexual health communication.

The young men from the Horn of Africa, the young women in the Somali group and the young Aboriginal mothers were less likely to identify disengagement with family than the disadvantaged groups listed above. The young Somali women were mostly still enrolled in school. The Horn of Africa group included newly arrived immigrants and some longer term residents, while the young women tended to have been in Australia longer. The young men from the Horn of Africa were engaged with an employment and training program which suggests less attachment to secondary education.

Early school leaving or disengagement from school was associated with literacy problems for some participants. Only three participants volunteered that they required assistance to read the focus group forms but several of the incarcerated young men and all of the Aboriginal young mothers ticked the 'very important' box for every type of information young people may need on the scale items. This may have indicated their considered opinions or may indicate lack of interest, or reluctance to read each question, possibly due to difficulty with literacy. This was the only written component of the focus group and therefore the only indication of possible literacy problems.

The findings from this research indicate that a low level of education, especially when combined with poverty and lack of social connectedness, places young people in a particularly vulnerable position in regard to sexual health. The young people with these multiple disadvantages (homeless young people, Aboriginal youth, incarcerated youth) indicated that they lived within cultures where rigid gender hierarchies dominated, cultures of violence were normalised and STIs and those who contracted them were highly stigmatised. These themes are explored further below.

Gender

'Don't fuck'n cheat on me bitch.' (Young man)

Gender emerged as a key differentiating factor. There were major differences in attitudes to STIs between young men, particularly those who were least educated and most disadvantaged, and women, that impact directly on sexual health. Young men and women also differed slightly in their views about which information about Chlamydia is most important for young people to have (see Table 2).

Both sexes were generally ignorant of the fact that males could contract Chlamydia, or that there could be negative effects on men's reproductive health. When discussion occurred around males contracting Chlamydia, incarcerated, homeless and Aboriginal young men were quick to refer to young women as 'dirty' disease carriers – the source of infection. Chlamydia was seen to be a 'girls' disease' with young women's possible lack of knowledge that they were infected not regarded as a mitigating factor in the attribution of blame. The young men saw it as women's responsibility not to contract Chlamydia, rather than their own to protect themselves through condom use. They suspected young women deliberately hid their STI status so they could remain sexually active.

The blaming of young women occurred in a culture of sexual opportunism where young women were both disparaged and regarded as objects for young men's sexual gratification. This was apparent in the focus groups with incarcerated, homeless and Aboriginal young people. There were hints of this attitude in the regional group although comments were more subdued, possibly due to the presence of workers in the room. Some young men spoke of trying to avoid using condoms. Amongst these groups, there were references to retributive violence towards sexual partners who may have had Chlamydia. Such attitudes or references were not expressed in the female only groups, the group from the Horn of Africa or the SSATI or secondary school student groups.

'And also a lot of men, they tend to ah, like basically just go if I don't mention it I might get away with not having safe sex. Like, they'll purposely not mention it and then, you know, do the whole sweep the woman off their feet and do whatever they possibly can to distract the woman and by the time it gets to that stage it's like "oh damn, we didn't really get a chance to pick up [the condoms]."' (Young man)

'That's why alcohol and drugs are good for sex. Get 'em drunk and off their face, mate, and it don't matter what frick'n place you're in or anything like that. Mate, you just get away with it [unsafe sex]. Smash, smash, smash, it's all over red rover.' (Young man)

Stigma

'If I got tested and had Chlamydia I'd shoot my head off.' (Young man)

Participants of both sexes from all groups exhibited behaviours that indicated, or noted the issue of, shame associated with STIs. In these ways they evoked the historical stigma of STIs. There was common acknowledgement of the role stigma played as a disincentive to health seeking behaviours around Chlamydia. However, despite all groups being aware of the stigma there were differences between them in their responses. Those from the least disadvantaged backgrounds (secondary school students and SSATI youth) were most likely to talk about the need to de-stigmatise Chlamydia, as were young homeless mothers and Somali women. Gender differences emerged in this area, along with differences associated with education levels, with young men from more disadvantaged backgrounds being more likely to participate in the ongoing stigmatisation of STIs and those who experience an infection.

'[If] it's got something about Chlamydia written on it, man, you're just like no way, get that away from me.' (Young man)

Young men who were homeless or Aboriginal expressed disgust when speaking of sexually transmitted infections such as Chlamydia. Gender differences cut across the groups. Young men combined the stigma of an STI with fear of women as disease carriers. There was also evidence of the double standard around sexually active young women. These elements resulted in general expressions of disgust about young women. Consequently, the stigma adhered both to Chlamydia itself and the young women they feared may carry it.

'Girls and guys drink. That's when they're most likely to just root around.' 'That's right. Root some "random" when they're drunk. So you let 'em know before they get drunk — use protection.' (Young men)

Fear of stigmatisation influenced health seeking behaviours. According to all groups, to even talk about Chlamydia or be seen to be interested in protecting oneself from Chlamydia was to be potentially labelled as someone with Chlamydia. As one young man said "if people think you have it you won't get girls".

'[Picking up a pamphlet about an STI]…It's like stamping it on your forehead.' (Young man)

Young people who lived within cultures of violence, such as those who had lived on the street, said they would respond violently to any sexual health promotion strategies that they believe could identify them with the taint of Chlamydia. For example, while those in the SSATI group suggested and supported the use of a nightclub pass out stamp that referred to Chlamydia and safe sex, young men who were homeless were adamantly opposed, with one stating "I'd burn that club down".

'She goes "I got Chlamydia". I said "Fuck'n dirty Chlamydia bitch — I'll kill you."' 'That's disgusting. I'll kill 'em, hey. I'll kill 'em straight out then.' (Young men)

Reluctant information seekers

'People in general …have a lot of apathy, anything that's going to involve them going out of their way, it's not going to happen. You've got to actually sit there and put it in front of their face.' (Young man)

Overall, participants presented themselves as passive and reluctant rather than active or keen health information seekers. This was the case across groups, although least pronounced among those in the SSATI group.

Females are generally thought to be the more active seekers of health information and services, but this gendered aspect was only weakly observable among young people in this study.

Some reasons for lack of active information seeking were common across groups, while some appeared to vary according to education levels and level of marginalisation. Although young people enthusiastically took part in the focus groups, a pervasive lack of interest in seeking sexual health information was frequently personally attested to and described as common among their peers by participants in all groups.

Poor literacy skills amongst the most marginalised young people (homeless young people, incarcerated youth, young Aboriginal men and women) certainly played a role in discouraging some young participants from accessing and reading information about STIs however, this was just one aspect of a broader lack of desire to seek information.

> *'I'm going to go look that's for somebody's older than me, he's got bigger brains. I'm not going to read that. I'm not going to understand it.' (Young man)*

Cognitive development level was reported to be a factor by some participants (particularly the homeless young men) and was observed to be an issue by the researcher. For example, several of the young men in juvenile justice misunderstood the 'importance' scale, thinking it was a test of their knowledge of Chlamydia despite the researcher attempting to clarify that it was asking participants to rate the importance of various types of information about Chlamydia for young people.

However it was not only those who experienced literacy or cognitive difficulties with the material who wanted brief simple messages. Homeless young people, Somali women, incarcerated youth, young men from the Horn of Africa, and young mothers all stated they preferred pictures over words, a preference that was also reflected in the evaluation of pamphlets by participants in other groups.

> *'A lot of people don't want to read a whole lotta stuff.' (Young man)*

Several participants expressed the view that young people just weren't interested in STIs; the subject was not engaging and they would rather not devote time to reading about it. Clearly, although some participants enjoyed talking about sex itself they did not find talking about sexual health at all 'sexy'. Rather, the topic was associated with a generally unpopular activity — education and a distasteful subject matter, disease. Reading about Chlamydia was regarded as both boring and unpleasant by most participants.

> *'Only time I had to look up one [a sexual health website] was for a school project and even then I didn't want to.' (Young man)*

The young Aboriginal mothers, who were mostly in their early twenties, stated that those in their teens felt invincible. Having more pressing concerns, such as dealing with family violence or gang issues, was also mentioned as a reason for not seeking health information by one participant in the homeless young persons' group.

The expressed lack of interest was not generally due to confidence that they were already well-versed about Chlamydia. Some said young people in general were quite ignorant about STIs, particularly Chlamydia. They also observed that young people tended not to take STIs seriously. Those in the secondary school students group were the exception. They felt well-informed about STIs (although several did not know males could contract Chlamydia) and this, along with the belief that their families would be available to assist them with information, led them to think that they probably wouldn't need to seek further information. Almost all participants were unaware of currently available sexual health websites, help lines and youth messaging services such as Sextxt.

Stigma also put young people off information seeking. Prevention was not identified as a motivation to seek sexual health information. Rather, participants generally thought that young people would only seek detailed sexual health information if they thought they had caught an STI, either because they had had sex with people they thought were high-risk or they had symptoms. One young Aboriginal man said he would only access detailed information in a 'life and death situation'.

'[Young people might want more STI information] because they been sleeping with some dodgy buggers. … like sleeping with someone who I thought was a real sort of scummy kind of scanky kind of person.'…. 'It's not necessarily that you can tell but it's just an assumption that's made in your subconscious, I know that it's fairly baseless but it's still the way, especially young people, are going to form their opinions of when they should or shouldn't get tested.' (Young men)

'It's not until you actually have something that you actually care. You learn about it at school but they think "Ew, that's disgusting. That'll never happen to me"'. (Young woman)

Findings: What young people want to know

In developing effective communication strategies we need to know what information young people consider is important to know about. Table 2 presents several noteworthy findings from our 'importance' ratings.

Table 2: Percentage of young men and women rating items as important

Type of information	*Females (n=45)*			*Males (n=61)*		
	Very / quite important	*Not important*	*Don't know / no response*	*Very / quite important*	*Not important*	*Don't know / no response*
1. What is Chlamydia	*93.3*	*0*	*6.7*	*96.7*	*0*	*3.3*
2. How common Chlamydia is	*88.9*	*4.4*	*6.7*	*88.5*	*3.3*	*8.2*
3. What happens to your body if Chlamydia is not treated	*93.3*	*0*	*6.7*	*88.5*	*3.3*	*8.2*
4. How you get Chlamydia	*95.6*	*0*	*4.4*	*83.6*	*9.8*	*6.6*
5. Signs and symptoms of Chlamydia	*91.1*	*0*	*8.9*	*86.9*	*4.9*	*8.2*
6. Where to get tested	*91.1*	*4.4*	*4.5*	*86.9*	*6.6*	*6.5*
7. What tests will be done	*86.7*	*2.2*	*11.1*	*72.1*	*13.1*	*14.8*
8. That it can be treated	*95.6*	*0*	*4.4*	*93.4*	*0*	*6.6*
9. What the treatment is	*88.9*	*4.4*	*6.7*	*86.9*	*4.9*	*8.2*
10. Where to get information about Chlamydia	*93.3*	*2.2*	*4.5*	*86.9*	*6.6*	*6.5*
11. How you can tell whether the information you find is correct	*84.4*	*11.1*	*4.5*	*73.8*	*13.1*	*13.1*
12. How to talk to your partner about preventing Chlamydia	*84.4*	*8.9*	*6.7*	*80.3*	*14.8*	*4.9*
13. How to avoid having unsafe sex	*93.4*	*4.4*	*2.2*	*86.9*	*8.2*	*4.9*

Most significantly, all 13 information items were rated as quite or very important by over four-fifths of the young men and women, with the exception of items 7 and 11 for males. Conversely, few items (items 11 and 12 for young women and items 4, 6, 7, 10-13 for young men) were rated as not important by more than 5% of our participants. Notably, young women were more likely than their male peers to consider the information items as important. Nevertheless, it is clear that there were few differences between young men and women in the relative importance they gave to types of information. The least concern for information (but still rated highly by most participants) was reported for items 7 (What tests will be done), 11 (How you can tell whether the information you find is correct) and 12 (How to talk to your partner about preventing Chlamydia).

Examination of the ratings by individuals in different focus groups showed very few differences between the sub-groups in their ratings of importance of information items. Although numbers of participants in some sub-groups were small, it is noteworthy that all items were rated as quite or very important by the great majority of members of each sub-group. The only difference worthy of comment was the finding that a small minority of incarcerated young men, and Horn of Africa young men and young women rated more of the 13 items as not important than did the other groups (9 out of 13, 11, and 8 respectively).

Findings: Communicating with young people about STIs

The medium: What works

Participants were asked for suggestions of how to disseminate both short, sharp messages and more detailed information about Chlamydia. While they commented on the form and content of both levels of information, they commonly said that young people could not be bothered reading about STIs and only wanted brief essential information or messages. However, when asked to rate the importance of types of information about Chlamydia they identified many messages as important (see Table 2). This apparent discrepancy may be accounted for in a couple of ways. First, young people can simultaneously rate lots of information about Chlamydia as important, yet want this information delivered in 'small bites' — one or two ideas per message. Secondly, young people thought that different levels of information were needed in different circumstances. Short, sharp, 'catchy' messages to raise general awareness about Chlamydia and provide key messages could be broadly disseminated, while the more comprehensive information for those who want to know more to can be made available through other channels. It was the view of most of the young people that only those who either had a diagnosis of an STI or suspected they had been infected would be interested in accessing detailed information.

Mass media campaigns, along with more comprehensive sexual health education in schools, proactive, non-judgmental doctors and free help lines were the most popular health promotion strategies overall.

Sources and Sites: Awareness raising campaign

The preferred media for short, sharp messages in all focus groups were television and posters. Print media, cinema and radio advertisements and the internet were also suggested as places for simple messages about STIs.

TV advertisements

> *'Something realistic because real life is scary anyway. …Young kids can tell between bullshit and not.'*
> *(Young man)*

Television was supported as an appropriate medium for short sharp sexual health messages by almost all young people.

The strongest message to come through from all groups was to make an advertisement that looks 'real' and 'tells it like it is'. Young people favoured advertisements that they perceived to be serious and realistic but did not over-dramatise or over-emphasise the dangers. The term 'realistic' encompassed notions of the accurate portrayal of life according to young people's experience and convincing acting.

> *'All the danger ads just desensitise you and you're just like yeah, whatever, whether it's about drugs or anything. You just like, yeah, you're not actually showing any kind of truth here, you're just showing an extreme case so what's the point of even watching.… It's just, you, you know it's written by bureaucrats who have never touched a drug in their life and you're just kind of like, well, brilliant, you know exactly what you're talking about dude.'*
> *(Young man)*

They also reported that they liked advertisements that allowed them to relate to the main characters. They emphasised the importance of including 'people like us' in advertisements. Popular suggestions for styles of advertisement included having someone speaking from personal experience of Chlamydia or an actor playing that role, or 'realistic' acted out scenarios. Only the Aboriginal women favoured using a celebrity to convey the message, although some of the SSATI group were open to the idea. They suggested Aboriginal spokespeople such as Anthony Mundine, Cathy Freeman or other Aboriginal sports players. A minority of homeless young people, including young mothers, Somali women, secondary school students and SSATI youth thought that using celebrities could work with some young people. However, most participants thought that celebrities who spoke on particular health issues lacked credibility; some said they had 'sold out'.

They're doing it more to promote themselves. (Young man)

'People would just think only celebrities get it. Get a normal person to do it.' 'Just an ordinary kid man.' (Young men)

Late evening was regarded as an appropriate time for STI TV advertisements as young people would often be watching TV alone then. There were mixed views as to whether embarrassment viewing STI advertisements with family members was an issue within most groups. Young Somali women said it was not an issue at all and regional youth said many young people had televisions in their rooms so the issue did not arise.

'Good' and 'bad' television advertisements

Members of all groups nominated similar advertisements as 'good' advertisements. There were mixed views about whether being memorable could be equated with being effective, with some people being of the opinion that annoying advertisements were effective because of their memorable nature and others that annoying advertisements 'turn you off' and are therefore ineffective. Some people identified particular advertisements or campaigns as 'good', others were unable to name the campaigns or campaign sources but discussed particular images or messages that they found memorable, appropriate or affecting. Anti-drug, anti-smoking and other cancer-related advertisements, anti-violence, sexual health, and road, internet and work safety advertisements were put forward as examples.

Anti-drug advertisements

The ice campaign was praised for the power of the images and the realistic depiction of the consequences of ice use. Although the scenes depicted were dramatic, some young people regarded them as realistic and related to them.

'There's one about ice…You sit there and watch it… You don't like change the channel. You're interested.' 'That was me at the hospital. I was flipping out.' (Young men)

The *Lost Dreams* campaign advertisement that contrasted childhood aspirations with the realities of substance abuse was considered moving and effective by some in the secondary school students group.

'Do you know what I thought was really good, that ad…I think it was for meth or something, like against drugs… It was like … a teenager or like a twenty one year old who was showing their life as what it's become. But there's like a voice over — a little kid talking about I want to be a fireman…' 'At the end they, like they zip the bag up.' 'Yeah. And they're talking about I want to be a fireman, "And I'm going to save my mum and dad and stuff". (Young men)

Anti-smoking advertisements

When asked about current health related advertisements, graphic anti-smoking advertisements were often the first to be raised for discussion. They were however often considered to be memorable but ineffective. Young men in the Aboriginal and homeless young persons' groups exhibited considerable bravado, stating these advertisements just made them feel like having a cigarette. A couple of the young homeless mothers said they were good because you remembered them. The young men in the Aboriginal group liked the humour of the Nicorette advertisement that included a cheer squad chanting *'No, Gary, no'*. They also liked Toohey's beer advertisement that featured a tongue leaving a mouth in search of a beer, for its humour and gross quality.

Cancer-related advertisements

Young people in the secondary school students group, the SSATI group and some young women from the regional group nominated advertisements that they found emotionally engaging. These advertisements aroused identification and empathy and often contrasted positive 'before' scenes with negative 'after' scenes.

> *'I like the cancer ad where there's like, you know, Jenny Smith, aged twenty two, like …you see her in a hospital and then it goes take two and you see her in the dance club and … it was like the movies are supporting Peter Mac when you buy a movie ticket. It was like well, I'm going to go see a movie and it's going to help someone, sweet.' 'Give cancer the flick, really good, really good catch phrase.' (Young women)*

Anti-violence advertisements

The *'Australia says no to violence'* campaign engendered mixed views within and across groups. The secondary school students group thought the approach (enacted scenarios and voice over) was appropriate but some found the acting unconvincing, an important perceived shortcoming given the weight young people in general attributed to making advertisements look realistic. One young man in the homeless group thought the advertisements were over-dramatic and did not think the messages of the campaign were feasible or appropriate in his social milieu.

The following quote illustrates the extent of differences of opinion within groups. It also provides an example of very different responses to the anti-violence campaign from two young men and a young woman. Additionally, it once again raises the question of whether catchy advertisements are annoying or effective or indeed both. Incidentally, this discussion between young people experiencing homelessness demonstrates that extremely socially disadvantaged young people (the two young men had very little education) are able to engage with, and form an important resource to, those working in health promotion.

> *'Well the domestic violence against women ad, like I totally agree with it, there's no way I wouldn't agree with it.' (Young man 1)*
>
> *'Yeah, see that's catchy.' (Young woman)*
>
> *'But the ad really annoys the crap out of me. It's just it's too over dramatic for me. And so if they did something like that for Chlamydia I'd just…' (Young man 1)*
>
> *'I actually like that ad.' (Young man 2)*
>
> *'It's stupid. It goes "does your friend hit his girlfriend?" And they go "oh there's nothing I can do. Yes you can". It's like no, you just keep out of it.' (Young man 1)*
>
> *'Yeah, but the point is like they're making you think about it.' (Young woman)*
>
> *'No they're not…' (Young man 1)*
>
> *'So, see it's already in your brain.' (Young woman)*
>
> *'They're making me pissed off, that's what they're doing.' (Young man 1)*

Road safety

> *'Even my six year old goes to my husband "If you drink and drive, you're a bloody idiot." That message has sunk into a kid.' (Young woman)*

The Transport Accident Commission's *'Drink/Drive/Bloody idiot'* campaign was nominated as very effective in raising awareness by young women in the Aboriginal mothers' group. The catchy slogan was seen to be the key to the success of this series of advertisements. When recommending 'scare tactics' as a strategy many young people suggested the TAC advertisements, along with the anti-smoking advertisements, as models.

> *'I love the TAC ad about that woman who had the accident which was very graphic, …I just thought wow. And then, quite recently another ad showing this woman and she's skinny, explaining how she — her voice is like slow and like is really — I mean, you want to get the remote and turn the channel but you can't, you just stare.' (Young woman)*

Safety on the internet and safety at work advertisements

Secondary school students nominated a Victorian Government Worksafe advertisement and an advertisement for online safety as engaging. Each of these advertisements have an element of suspense and according to these participants 'make you care' about the people in the scenarios.

> *'You know the one for paedophiles on the computers. Like that kind of like tricks your mind, like wow.' 'Oh, the two kids talking to each other and then they go back and there's the dude' 'Yeah, like that creeps you out.' 'Yeah, like, it's just like pretty good though.' 'So it doesn't have to be a slogan, just something that you don't understand and then it kind of clicks.' (Young man and woman)*

> *'You know that Work Safe ad when the kid's playing basketball and he's waiting for his dad to come home. You're really drawn in, you think "shit, is he going to come home?" …In that ad the length really works, because you're just drawn in.' (Young man)*

Sexual health

Two young mothers nominated drug advertisements, which featured treatments for thrush and Herpes as effective in raising awareness. They understood these to be health promotion messages.

Radio

> *'Everyone listens to the radio while they're driving.' (Young woman)*

Radio was thought to be an appropriate medium by incarcerated youth, regional youth, homeless young mothers, Aboriginal mothers, young Somali women and secondary school students, with some young Somali women expressing more enthusiasm about radio than the participants from the other groups. Conversely, the young men from the Horn of Africa did not think radio would be a particularly effective medium. A secondary student noted that a downside of employing radio as a health promotion medium was the fact that it was easier to tune out from the radio than television when advertisements came on, but suggested a style of presentation that may encourage attention.

'It's like rah, rah, rah, rah rah, do this, do that, buy this, that, that's a cool thing to do, go to that club, do this, do that, you're just kind of like okay, like I get it, and then I think, I agree with what you're saying that [if] they've got that one slow ad and you're like wow, … like it gives such a juxtaposition between the two that you're kind of like oh, okay, wow, that's intense because it's like, it's been surrounded by so much hype that you get this slow kind of really serious note and you're like, yeah, I don't want that, kind of thing' (Young woman)

The homeless young mothers thought that a lot of young people do listen to the radio however this focus group also favoured television as a medium. The most commonly suggested stations across groups were Nova, Fox, Mix 101.1 and Gold. Regional radio stations were suggested by the two regionally located groups – the Aboriginal youth and the regional group. The young Somali women suggested Somali youth radio programs. Overall, television was considered to be a better option than radio for the promotion of sexual health.

Posters

'You can kind of go unnoticed like when you're looking at a poster.' (Young woman)

After television, posters were the most popular medium (excluding face-to-face interaction). Posters with bold, sparse text, preferably catchy slogans, and engaging images were attractive to young people and afforded a level of privacy, as they allowed surreptitious perusal.

'I reckon just go with something funny.'
'That's why I said like that Captain Condom thing. Because I've had that in my head for over ten years man.' (Young men)

Ideas of what may constitute an engaging image varied greatly. Both regional and incarcerated youth supported the use of photographs of 'real people', while secondary school students and SSATI youth preferred less obvious images, or even images or text that aroused curiosity.

'The most outstanding way is a poster with really simple lines, like catchphrases, so you remember it, or they're really funny or really bright.' (Young woman)

Most participants suggested the inclusion of a Freecall help line number and/or website URL, with a few proposing a number to SMS, to access for more detailed information.

'People my age don't want to look at a poster with lots of information. They'll look at a poster that says 'Avoid Chlamydia: Use condoms' and they'll follow it up if they want to.' (Young woman)

See **Message placement and opportunistic advertising** section for a discussion of the best location for posters (following section).

Magazines and other print media

Health promotion advertisements, articles and comic strips were all suggested. There was general agreement that *Cleo* and *Cosmopolitan* (for older adolescent females), *Dolly* (for younger girls), magazines such as *Ralph*, *FHM* and *Zoo* (for young men) and *MX Express* (for all) were the most appropriate print media. The fact that *MX Express* was free was a noted plus. The SSATI group and both Aboriginal groups suggested advice columns such as Dolly Doctor and feature articles could be used as well as advertisements as vehicles for conveying STI advice.

Discreet wallet-sized cards were popular and these could be a useful medium for short, sharp messages and contact details of help lines, appropriate health centres and website addresses. In part, participants may have been influenced by the colourful, youth oriented design of the particular card they evaluated, but they also noted that the size allowed discretion which they valued.

> *'They're good for the wallet.'*
> *'But I don't know if I'd carry it in my wallet.'*
> *'It's easy to conceal that you're reading about Chlamydia though, like if you had something that small. People probably wouldn't pay too much attention to you if you're looking at some little card in your lap.' (Young women)*

Pamphlets were considered more appropriate for provision of detailed health information and are discussed in the following section.

Message placement and 'opportunistic advertising'

> *'Random weird places you wouldn't expect are best .' (Young man)*

> *'If it requires effort no one will do it.' (Young woman)*

The best location for posting messages about STIs was a subject of much discussion in the focus groups. In this section we discuss the location of printed matter other than pamphlets and print media and report on a range of unusual strategies suggested by young people. We have used the term 'opportunistic advertising' to capture the idea of unexpected, 'in your face' locations for sexual health messages. The unavoidable and the effortless nature of such health promotion strategies accords with young people's reluctance to actively seek out STI information.

Public transport, bus shelters and railway stations were the most popular locations for posters. All groups thought these locations effective as they were places where young people spent a lot of time and were often bored and 'likely to read anything'. Several young people also suggested large advertisements on the sides of buses. Locating posters with STI messages alongside posters for events or music, such as in the current Ice campaign, was a highly recommended approach.

> *'The most important thing with a poster is the less words the better. People are rushing by. Under railway bridges with band posters or at Flinders Street station — that would be absolute gold.' (Young woman)*

Both groups of Aboriginal young people suggested bottle shops could be appropriate locations, as buying alcohol was associated with a night out and the possibility of a sexual encounter. The SSATI youth said that STI posters tended to be placed in over-18 venues but there was a need for them in underage venues and schools.

'By the time they get old enough to get out where they can see them, it might be too late already.' (Young man)

Secondary school toilets were thought to be effective locations to reach young people. One participant from the incarcerated youth group thought phone boxes would be effective places as posters could advertise free help lines and people could ring these on the spot. Health services, youth and community services, schools, public toilets, hotels and clubs and shopping malls were also suggested, as were billboard posters. School sick bays were suggested by the young Aboriginal mothers group.

'You have to sit there and stare at something while you're in the train or at the bus stop.' (Young woman)

In addition to recommending posters placed in these 'unavoidable' locations, participants suggested a range of more unusual places where STI messages could be placed to reach young people. Most focus groups recommended condom packaging or condom point of sale as good places to alert people to Chlamydia. One young woman proposed the slogan *'Protect your fertility'* as suitable for display on condom packaging. Alternatively, *'Combat Chlamydia – Use a Condom'* could appropriately convey the message. Some groups (see Table 3) suggested additional unexpected places STI messages could be placed. The key point was that messages need to be 'in your face' but not interrupt what you are doing.

Table 3: Additional opportunistic awareness raising sites

Homeless young people	**Incarcerated youth**	**Aboriginal youth**	**SSATI**	**Secondary school students**	**Homeless young mothers**
Back of Met tickets	Stubby holders	Taxis	School diaries	Advertising in backgrounds of computer games	Phone games
Shopping dockets	Cards	Skywriting	Club pass out stamps		
Chocolate bars	Phone boxes	Stickers			
Coke		Chip packets			
Inside shoe boxes					
Beer coasters					
Phone games					

New technologies

'Put the message in my face but don't interrupt me.' (Young woman)

Mobile phone ownership was common, although likely to be constrained by financial difficulty, across most groups. The regional, Somali, SSATI, and secondary school students groups all indicated 'everyone has the internet'. Homeless young people said they had access but for some this was reduced access as it was via mobile phone. Young mothers were the only group to report difficulty accessing the internet, with the Aboriginal and Horn of Africa groups silent on the issue.

Only the secondary school students and SSATI groups identified the internet as the best or a good place to provide STI information. The use of mobile phones as a source of brief information about Chlamydia was roundly dismissed by almost all. The only exception was where sexual health information could be incorporated into a free phone game, an idea proposed by a young man experiencing homelessness and enthusiastically received by incarcerated youth. It was also suggested by one of the young women in the homeless young mothers group.

Communication technologies such as the internet and mobile phones were associated with entertainment and fun, and young people, other than the SSATI youth, did not generally want to use them for sexual health education in their leisure time.

'What about the internet?' (Facilitator)

'No, because the ones that are sitting on the internet you don't have to worry about because they're sitting at home playing with themselves because they're losers anyway….So you don't have to worry about them [catching Chlamydia].' (Young man)

'Do you or your friends use the internet much?' (Facilitator)

'Nah. I use the internet to look at cool stuff. …I use the internet to look for bikes and stuff, and cars.' (Young man)

Internet

Contrary to previous research with mainstream youth (Skinner, Biscope et al. 2003; Nicholas, Oliver et al. 2004; Macdowell and Mitchell 2006; Moore and Rosenthal 2006; Wilkins and Mak 2007), the internet was not favoured as a site for detailed STI information by most young people.

'Internet's shit — you've got pop-ups, you've got carry on — wouldn't advertise a dead dog on there because no-one would know about it… you become immune to it.' (Young man)

Based on their view that young people generally do not want to look for STI information but will read something if it is 'in their face' many participants saw the internet primarily as a site for short sharp messages about STIs but not detailed information. SSATI youth, and to a lesser degree secondary school students, were the exceptions. Several young people in each of those groups thought the internet could be used more broadly to promote sexual health. Secondary school students and regional youth stated they would only look at a sexual health website if very worried. Other groups thought neither they nor their peers would access such sites.

'I think even though web sites are a really good idea, like if I was going to have sex I wouldn't be thinking "I'm going to have sex, cool, I'll go to a web site and find out how it's all done"…' 'Research it.' 'Yeah…it's like, I would not do that…I'm not going to worry whether it says use a condom, make sure it's the right person, blah, blah, blah. You're just kind of like well, yeah, I know that stuff. Like, and I guess a lot of people don't know that stuff too but the people who don't know that stuff are not going to be the people that go to a website and find out.' (Young man and woman)

Social networking home pages were suggested places for brief messages. These included, in particular, Myspace (regional, Somali, SSATI, Horn of Africa, secondary school students and Aboriginal mothers) and Bebo (Aboriginal mothers) along with Hotmail or MSM instant messaging sites (Somali and Aboriginal mothers) and chat room sites (incarcerated youth). Bebo.com (www.Bebo.com), which has been previously identified as a popular site with Aboriginal Australians, has on its homepage a Be Well section that would provide an ideal location for information about Chlamydia and other STIs. Bebo has recently become the most popular social networking site in the United Kingdom (http://www.smartcompany.com.au/Free-Articles/Trends/20071115-Bebo-media-deal.html).

Porn sites were also highly recommended as places for STI-related health messages or a help line number. They were suggested by homeless young people, incarcerated youth, and Aboriginal and homeless young mothers.

Young people strongly advocated banner style or small health promotion advertisements over pop-ups which they either blocked or did not open due to concerns about viruses and download allocations. The following quote comes from a young secondary school student.

'We are the internet generation — you should use that in a campaign. Pop-ups, they drive me nuts! Every kid, when a pop-up comes up it's, "Oh, piss off!" They won't even look at it twice.' (Young woman)

The main message from the focus groups was the need for instant impact with the whole message accessible at a glance.

'It needs to be like a simple and strong message. It can't be something long because they're just going to glance at it.' (Young woman)

SMS

'There's no good time during the 24 hours each day to get a message about you should get tested for Chlamydia.' (Young man)

Text messaging has been identified as an acceptable and effective strategy for raising awareness of STIs amongst mainstream youth (Dobkin, Kent et al. 2007; Lim, Hocking et al. August 2007; Wilkins and Mak 2007), however, participants in all groups in this study said that sexual health text messages would be intrusive, annoying, and embarrassing to receive. They also said they could be disappointing, as they would be alerted to a message arriving only to find it was an educational message about STIs rather than a text from a friend. Only one young person from the SSATI group thought text messages would be an effective way to communicate sexual health information.

'You'd think a friend's messaging you to have lunch or something…[then]
…you'd just think "Okay, I'm over it". And delete it before you read it.' (Young woman)

Most participants thought that young people would not want to sign up for messages due to a general lack of interest in educating themselves about STIs. Secondary school students and SSATI youth generally thought that SMS had 'been done before' and was 'too bland', suggesting they found it 'gimmicky' rather than effective. One secondary school student also said he would not like to be on a sexual health message database.

Bluetooth marketing

'They have the panels where you have the infrared and Bluetooth sensors, you can put your mobile phone next to them, they deliver messages to your phone … those do target young people and you use your mobile phone media. So I mean, if you want to go down that way there are methods of doing it.' (Young man)

Wireless or Bluetooth marketing allows individuals to download digital information to a mobile phone from a 'touchpoint' such as an interactive panel or poster. Although panels currently exist in some cinema foyers and similar locations, only one young woman (from the secondary school students group) had used one. Most participants had not heard of this form of marketing.

However, as greater awareness of Bluetooth technology develops, this may prove to be a popular form of communication. Benefits include anonymity, ease of access and free access. Sexual health information could be included along with more popular forms of information or possibly games. Posters could arouse curiosity and encourage accessing the 'touchpoint'.

Sources and sites: Comprehensive sexual health information

People not technology

Mass media, in particular television, was seen as the best place to raise awareness of Chlamydia; personal contact was favoured over print media or new technologies for learning more. Although the internet was not favoured as a site for detailed STI information by most young people, some groups did suggest it could be offered as an option to those seeking more information. An appropriate website URL could be included along with a Freecall number on posters or other advertising.

Help lines

'If they really need help or they're worried about something, they would [call a help line]. It's really convenient you don't have to get out of your own comfort zone.
You can just call.' (Young woman)

Help lines with 'real people' answering were regarded as a good option for obtaining more detailed health information by the homeless, Aboriginal, incarcerated, secondary school students, regional and young mothers groups. However, most participants thought young people would only ring if *really* worried they had an STI.

Common views across all groups:

- Participants like convenience, anonymity, ability to get personalised response
- Help lines should be free, well advertised and have a catchy number
- Most preferred person to person rather than recorded information; a few (regional) wanted the option of recorded information (for increased confidentiality) or a sign up option for text updates
- There should be both male and female operators

> *'If you're speaking to a machine you just think okay, I can't exactly ask the question that I'm concerned about. The person doesn't want that. They need to know someone else is on the other side.' (Young woman)*

Doctors

Doctors were seen as trustworthy information sources. As such, they could feature in advertisements (actors acting out scenarios), legitimise internet sites and pamphlets through their endorsement, and could offer a site for displaying posters and pamphlets, in addition to providing detailed information about STIs. Concerns that young people may be turned off by the mention of authority figures, such as doctors, appear to be unfounded. The young people who participated in this study, while having some unease around judgemental attitudes from doctors, clearly stated that when they are in need of accurate detailed STI information it is reassuring to receive that information from doctors. While not mentioned by name, young people's comments suggested that other health workers are also considered trustworthy sources.

Both the young Aboriginal mothers and Somali women thought doctors should 'go through' the pamphlets on Chlamydia with young female patients when they presented for contraceptive advice. Somewhat surprisingly, the young men from the Horn of Africa stated they would rather go to a GP than an internet site, although there was a view that doctors should just offer the information and tests without enquiring about your sex life. There was some concern across groups that doctors can be judgmental and an acknowledgment that some degree of embarrassment attached to visiting a doctor to discuss STIs.

> *'They should just treat it like, you know, it's a responsible thing to do and not ask any questions. It's like "okay we just test everybody for everything".' (Young man)*

Schools

> *'In the class they should … actually make a certain amount of time each year for kids to actually go and get tested from each school. So [at] the local Health Care Centre say oh, you know, this is our two open days. [It takes] one person to say they're going to do it and then a whole group will do it.' (Young man)*

In all focus groups, school was nominated as a highly preferred location for both quick messages (posters, school diaries) and detailed information and education. It was the first suggestion made in the focus groups with homeless young people, regional youth, young mothers and young Somali women. Young people in the first three of these groups nominated school as the best site despite their often tenuous or truncated school attendance. Generally, sex education was seen to start too late and finish too early and to focus more on pregnancy prevention than STIs and sexual health. Incarcerated youth suggested a school-based campaign and homeless young people proposed free STI testing for all students, carried out in schools in liaison with health centres, similar to the immunisation program. Secondary school students, SSATI and homeless youth all

suggested that 'real people' coming to schools to talk about their experience with Chlamydia would be an effective strategy. Videos and podcasting, especially of peers with personal experience of an STI, could also be used.

Get a young person who's had it to go around to youth centres and schools and talk about it… You think about it more if you see a real person' (Young woman)

Other locations

Health centres and youth justice centres were identified by incarcerated youth as possible locations for classes on sexual health but, given young people's professed lack of desire to actively seek information, any classes depending on voluntary attendance seem unlikely to succeed. The group from the Horn of Africa suggested targeting young men at sports clubs. Young men in the homeless youth group proposed a youth sexual health conference, with school groups being bussed in. The convention could include lectures, discussion groups and information stands. Young mothers suggested guest speakers at mothers' groups and clinic visits for STI health checks accompanied by youth workers.

'It would be really good to get it [STI information] in young mothers' groups because some people just don't want to talk about it and then they realise it's very common and they'll listen and not be embarrassed because everyone else is there too.' (Young woman)

Pamphlets

Participants also discussed the value of pamphlets as a source of comprehensive sexual health information. Although these are not 'people-focussed' they are a commonly used means of communication about STIs.

'Not a lot of people take them. They don't take the time to read them.' (Young woman)

When shown pamphlets, participants had strong opinions about those aspects they liked and disliked but they also commonly stated they would not pick them up or read them outside the focus groups. Pamphlets were generally seen slightly more positively by young women, who liked their anonymity and convenience. Those who would pick up a pamphlet often said they would not read it cover to cover; even the most attractive pamphlets would be skimmed. They also noted that while comprehensive pamphlets were unappealing to young people, those who had been diagnosed with an STI may turn to them for information.

Several participants implied that they were given too many pamphlets and a few, particularly some in the secondary school students group, implied pamphlets told them nothing new.

'The amount of pamphlets we've been given — like hundreds, and you're just kind of like "Oh, okay, use a condom"— bin. Like "Oh, okay, ice — don't do it" — bin.' (Young woman)

Conversely, it was common for participants to suggest mass mail outs of pamphlets and home test kits for Chlamydia. Other suggested distribution strategies were through maternity hospitals, young mothers' groups, clubs and pubs, and fashion outlets. They thought material could be designed to target both young people directly and their parents.

A couple of participants from the secondary school students group recalled the Victorian Government's STI campaign for young adults, *'You never know who you'll meet'*, that featured groups of young people with names

that included 'Syphilis' and 'Chlamydia'. Some people understood the message immediately and thought it was an effective campaign; others were puzzled by the strategy, concerned about the stigmatisation of the individual named Chlamydia, and failed to get the message.

'I think I've seen on TV or in the movies some type of Chlamydia advertising.

Like they had the four people and like they're called like four different names and the last person's called Chlamydia. So that anyone could have it. I don't think it's a great ad. I think it's a bit like sort of, it's, everyone laughs at it whenever I've seen it. So…' (Young man)

'But you still remember it.' (Young woman)

'You do remember it, it's true, but it's a bit of a — I think that maybe not the best way to tackle it.' (Young man)

The message: What works

In discussing what might constitute effective messages about Chlamydia and health, young people considered motivation for prevention, testing and treatment of Chlamydia and corresponding strategies.

To scare or not to scare

With fear identified as a motivation and lack of interest or denial of risk identified as barriers to addressing sexual health, there was discussion about whether or not scare tactics should be used in advertising.

'Fear does motivate people. Well, it motivates me.' (Young man)

Groups were divided about whether scare tactics were an effective or desirable means of conveying the message. The most marginalised groups (incarcerated, homeless and Aboriginal — males and females) were the strongest advocates of scare tactics. It was common for participants, particularly in the other groups, to initially suggest scare tactics — such as showing 'gory genitals' or using slogans such as 'sex kills' but then modifying their views as the negative aspects of scare tactics were raised. Some who spoke of using scare tactics equated these with showing the situation realistically. Others made the point that scare tactics in health campaigns often over-dramatised the situation which turned young people off because the representations did not accord with personal experience. Interestingly, some who advocated scare tactics also acknowledged this point, indicating how fine a distinction exists between 'realistic' and 'over-dramatising' representations.

'Don't say everything is bad, bad, bad — explain how having tests is normal.' (Young woman)

Arguments for scare tactics:

'You do have to up the shocking level though because, especially our generation, are exposed to a shit load of ads every day and I think we're a little bit desensitised so if you do……want people to pay attention then…it's got to be different from the rest.' (Young man)

- Scary, gory things work
- They catch your attention
- Necessary for a desensitised youth population
- They plant a seed in your head
- It shows you the risks

Arguments against scare tactics:

> *'I really don't think you should touch the shock tactic at all. It's been milked way too much.' (Young man)*

- Increases stigma
- Chlamydia is not a 'bad' enough disease
- Girls will be too scared to have sex with us
- People will be too scared to seek treatment
- People will think it is untreatable

A balanced message:

> *'I don't know. Have a girl like on it having a miscarriage and the doctor sitting there telling her and then as that finishes turn around and say one pill can change all this. Stuff like that.' (Young man)*

In most groups, there were participants who were anti or pro scare tactics and those who felt a balanced message needed to go out. It was suggested that scare tactics could be used to initially grab the viewer's attention and then be counteracted with information about easy treatment or prevention.

> *'Don't scare the crap out of them but have kind of a "but if you do this, it'll have a happy ending" kind of thing.' (Young woman)*

Both regional youth and young mothers suggested showing young people they had a choice of paths — easy testing or treatment now or possible long-term negative health effects. The secondary school students said that a campaign needed to get a balance between the message that Chlamydia is serious and Chlamydia can be easily dealt with.

> *'Just something that says that it's very common and it's like just something to make the community aware of the problem. And it has an easy solution as well, and it's nothing to be ashamed of.' (Young woman)*

While stressing the existence of an easy cure was commonly suggested as a strategy to reduce the fear and, sometimes the stigma of Chlamydia, there were mixed views regarding whether this message may be counter productive. Young people in the homeless and Aboriginal groups mentioned that stressing an easy cure may make young people think protection was less important.

'I'll just pop a pill, it'll be all good in a couple of days. Sweet as.' (Young man)

A few young men said that as no one will use condoms anyway a campaign should focus on telling young people about testing and treatment. Young people were generally familiar with the message to use condoms and often spoke in ways that suggested they were tired of the message or in some cases thought it was unrealistic.

'Everyone's not going to wear a rubber.' (Young man)

Stressing prevalence

'Numbers are persuasive… [and] the numbers of how many people have got a disease play a large part in how people react to what they've caught.' (Young woman)

Some young people thought it was important to stress how common Chlamydia was as this would be likely to encourage screening, or possibly safer sex.

'The one in eight people have Herpes ad. You, you just sit there and one day you'll see one of the signs and you'll be like "what?" So you look around you, like counting all these people around you, like "hmm, I wonder which one?" …It makes me think, you know, I look around I find it funny and I'll go like okay, yeah, that's not a good thing 'cause you think when you go out all you're seeing is people that you're attracted to, you're not seeing they might have something that they don't know they have, especially Herpes and Chlamydia.' (Young man)

Stressing the consequences

Groups discussed the effectiveness of campaigns stressing long-term or short-term consequences of untreated Chlamydia. Publicising the risk of infertility was often suggested by groups. However, when asked how salient an issue fertility was amongst their peers, participants expressed mixed views and showed little engagement with the subject. Both young men and young women tended to think fertility was more of a concern for young women than young men. However, a few young men in the incarcerated, regional, homeless and Horn of Africa groups stated that their fertility mattered to them. Other than in the Horn of Africa group these comments were not followed up by others in the group, which may signify a lack of agreement or discomfort with the topic, or perhaps indicate little thought had been given to the subject, itself an informative finding. There was general agreement in the Horn of Africa group that fertility was important.

'Everyone cares man.' (Young man)

'But I think it's really, really important to do some of these brochures or ads about the long-term because you want people to know this and if they don't know what the long-term effects are then they might not even think as seriously about it.' (Young woman)

Stressing no cost

Stressing no cost was seen as an important strategy. Young people stated that in order to encourage young people to seek information or undergo testing and treatment, each step of these processes should incur no cost. Help lines, testing and treatment should be free, as should condoms.

> *'[A poster could say] …get tested every two months or something, you know. I don't know. Some shit. But make sure it's got free on it. If it's not free most of us drop kicks don't want to know about it.' (Young man)*

Targeting

> *'It doesn't matter what colour you are, you're still going to get Chlamydia.' (Young man)*

Participants commonly observed that young people were all different, and intimated that these differences were individual rather than group-based. For example, they frequently said that different young people respond to different types of messages, with some needing to be shocked into action. They also said that different young people prefer different media so a campaign would need to be adapted to accommodate these differences. When asked if they thought young people 'like them' or 'in their community' would benefit from a tailored campaign, groups discussed gender, ethnicity, Aboriginality and sexual orientation/identity as possible criteria upon which to delineate a targeted campaign.

> *'If it was something with a Koori design on it, I'd read it.' (Young woman)*

The Aboriginal, Somali, Horn of Africa youth and, to a lesser degree, Aboriginal mothers concluded that they did not need health promotion campaigns or materials that were different from those directed at Anglo-Australians. However, that position was expressed alongside the view that they were attracted to, and thought they would be more likely to pick up, pamphlets which displayed images or used some language that related to their cultural background. One of the young Aboriginal mothers stressed the importance of working through Aboriginal health workers and community.

> *'Yeah, yeah. I reckon if you're going to get into Koori community, especially with young Koori girls, you go through the Aboriginal [workers because] they don't listen to white people — it's terrible to look at it like that but that's the way it is…when you're young like that you're ignorant to what people say. But if it's someone from your community.' (Young woman)*

Homeless young people thought campaigns should target high risk groups, although they did not identify homelessness as a risk factor or themselves as particularly vulnerable. They thought sex workers were likely to be a high risk group.

Gender targeting was suggested by a few groups. Young Somali women thought sexual health campaigns usually targeted young women when they should be also targeting young men. Some young men also noted that males and females responded to different language or images. Several SSATI young people said that using young men and women (not necessarily SSATI) in advertising campaigns would allow all to relate and noted that detailed information should begin with 'the basics' so young men, who were less likely than young women to want to read about STIs

could then stop reading. The inclusion of young people of both sexes in health promotion material was commonly suggested.

'I chose this pamphlet because it has the male and the female so they're trying to reach both sexes and I think that's very effective because I feel as though that women are always put under the projector and they're always the ones that are being advised about safe sex or being aware of all the sexually transmitted diseases.' (Young woman)

'Your sexuality and like your background or nationality shouldn't matter too much because once you've heard the message you can apply it to yourself.' (Young woman)

Young Somali women thought including images of Muslim women may attract criticism but such an inclusion would be worthwhile in order to raise awareness. On the other hand, young men from the Horn of Africa believed young women wearing the hijab should not be depicted as they are expected to be chaste anyway. Young Somali women reported that their peers were not usually sexually active until after marriage. Young men from the Horn of Africa intimated that because it was against their religion to have sex before marriage their parents did not think they needed STI information.

Both groups with participants from African backgrounds reported that parents were not appropriate sources of sexual health information as young people were not supposed to be sexually active before marriage. Some thought parents, who they believed to be ignorant about STIs, needed access to information. However some young men were concerned that informing parents would result in increased admonitions not to have sex — a situation they were not keen to encourage. Both groups stressed that young people from their communities needed direct access to STI information.

Overall, the groups stressed the need for any campaign to be inclusive, to address people from a range of cultures and in particular to address both males and females.

'You should have ads with people from different cultures because maybe a black guy will compare himself to another black guy, and other guys will compare themselves to other guys on the ad, so you should have everyone in it.' (Young man)

The Style: What works

Design matters

'You don't want to push. You want to attract people and they'll come to you.' (Young woman)

Participants' evaluation of pamphlets elicited some general guidelines for design of any written material, including posters.

It would seem that quite different formats and styles are appropriate to the general awareness campaign and the provision of detailed information for interested parties. Awareness raising material needs to be bold, colourful and attention grabbing; it needs to captivate users with intriguing or startling images or messages.

'It keeps their attention because not only is it realistic but it's a gag and the fact that, you know, normally in society you're not allowed to see that kind of stuff. So if you really want to draw attention it's gotta be something that's considered taboo.' (Young man)

Catchy slogans and attractive images were frequently recommended. On a poster or billboard, any text needs to be of a font large enough to allow people to read the text from a distance.

'The most outstanding thing is a poster with really simple lines, like catchphrases, so you remember it, or something funny or really bright. People my age don't want to look at a poster with lots of information.' (Young woman)

More detailed information should be provided in pamphlets and presented in a more serious style and tone. In evaluating various pamphlets, some participants indicated that those they were attracted to were not necessarily as trustworthy as those they rejected. In fact they noted that colourfulness and a style geared towards youth in format, layout, images and wording could be an indication that the source was less trustworthy, as trusted sources such as governments tended to produce more 'bland' products. This finding presents a considerable challenge, as young people indicated that they would not want to read really 'boring' pamphlets. The use of images, such as comic strips or simple diagrams rather than dense tracts of text may assist in striking an appropriate balance. The preference for more illustration than text was strongly expressed in all groups and warrants particular attention.

'I think this one's very small, very compact, gets straight to the point, there's information where I think even if you need extra information you call the number at the back and its eye catching. It's like things you see when you go to open days at universities and they put it in the open day packages.' (Young woman)

The following quote illustrates differences in preferences regarding whether material should clearly announce its subject matter or alternatively arouse curiosity. Some young people thought having the name of an STI boldly stated on a front cover would discourage people from picking it up as it would be embarrassing and would invite stigmatism.

'Yeah, I think they should say [what it's about] straight up so it gets to the point, not boring.' 'Big and bold.' 'I like the idea of not saying what it is because people actually pick it up to find out. Like they're curious, they'll want to find out what it is about and when they pick it up and then they start reading and then they want to continue reading it, you know what I mean?' 'Rather than, yeah, if it says "Chlamydia" most people won't be interested in that particular topic.'

'I thought it would be the other way. If it's big and bold, colourful and bright, eye catching, then the person will pick it up and look at it, if they've got that problem or even if they've heard about it or want to know more about it.' (Young women)

Images not words

'Some of us idiots look at pictures and can get the whole thing from a picture.' (Young man)

Despite differences related to education levels and other aspects of cultural disadvantage, overall the participants across groups indicated that they prefer to receive STI information if not aurally then primarily through images rather than text.

For some participants this preference may stem from poor literacy skills; for others it was associated with the professed lack of interest. They just did not find the subject appealing or interesting enough to hold their attention more than briefly.

Comic book style forms or amusing illustrations were quite popular among homeless youth (young mothers and others) and Somali, Horn of Africa, Aboriginal and regional groups. However some young people across groups indicated a preference for photographs they could relate to and the SSATI and secondary school students liked clever graphics. The inclusion of quotes from personal experience was also seen as quite effective.

Who's talking (language and tone)

Language

'If young people are talking about it young people will listen.' (Young woman)

Young people indicated there was a fine line between using youth appropriate language and trying too hard to sound cool. Most suggested using simple 'normal' language not 'scientific' language. A few young men suggested using slang, including hip hop 'gangster talk' but most believed this would exclude or alienate those who did not relate to that subculture, particularly young women. Some noted that information was usually pitched at too sophisticated a level. The Aboriginal groups mentioned it was important to use language 'like we talk' including Aboriginal words.

'Give 'em full on information about it and get some drugged up hippie to do it. I'll do it. Sit there and write it in proper words, you know, that a young person will understand.' 'Either that or actually just write it properly. Because trying to write with slang when you actually speak with correct grammar you just, it just comes out and you're just like "Man, come on".' 'You know it's fake.' 'We're not stupid.' 'And on top of that it really does insult your intelligence.' (Young men)

Humour

'If you're serious — they'll take it seriously.' (Young man)

'People like me don't want to hear serious crap all the time, yeah. They start talking serious and I go to sleep.'… 'You can't make everything a joke.'… 'Young people don't take things seriously so what's the point in making it serious.' (Young men)

There was no agreement about whether humour would be effective. Aboriginal and SSATI young people favoured humour on the whole, while incarcerated youth and young men from the Horn of Africa were against it in health promotion regarding STIs. The other groups expressed mixed views suggesting the appeal, or otherwise, of a humorous approach was an individual matter. Humour was seen as attention-grabbing, memorable and appealing to young people. A joke on a taboo topic was seen as particularly attention-grabbing. The common argument against using humour was the fear that unless STIs were presented in a serious manner young people would not take them seriously. Some suggested combining humour, to attract interest, with the more serious message; as one regional youth said, 'A joke but serious all in one'. Humour may be more appropriate to the general awareness campaign than the second communication strategy of comprehensive information.

'Yeah, do a depressing picture.' (Young man)

'…it makes you aware that it's a possible thing. Like I said, it brings reality back into it.' (Young woman)

'Some people turn a blind eye to those things because they don't want to see it.' (Young man)

'Not a joke, because people think that you're not serious.' (Young woman)

'Yeah, a joke but in a serious sort of way, all in one.' (Young man)

Resisting the message

'If you focus on benefits of using protection people just turn away — people like bending the rules.' (Young man)

While not a major point of discussion in the focus groups, young people's penchant for resisting authority was mentioned in the incarcerated and homeless groups. Resistance to some health messages, such as the graphic images of lung cancer and the challenge to gender norms of the *'Australia Says No to Violence'* campaign was evident in the group discussions.

'Youth'll run if you try to bash down their front door.'... 'Or laugh at you.' (Young men)

Participants suggested that health promotion would need to take this dynamic into account, either using 'reverse psychology' or strategies that encourage engagement with health promotion messages in a non-directive way. This view also informed young people's suggestions to use peers who had personal experience of Chlamydia and young people's voices to disseminate the message.

'Personally with posters, I get drawn to the ones that are …basically daring you to read them. Like oh yeah, you're not allowed to read this, so then, so you read it.' (Young man)

Media literacy and health promotion

'If it's a government website then they'd know it's authentic. If it's just some other dot com web site then…' (Young woman)

Young people nominated government sources and those endorsed by doctors as the most trustworthy sites for obtaining information. As noted above, peers with direct experience were seen as credible sources of information while celebrities involved with advertising campaigns were seen as 'having sold out' by all except the Aboriginal mothers' group. Participants did qualify their support for peers as sources, endorsing peer educators and peers used in Government funded health promotion campaigns but being wary of materials that looked amateurish. This finding supports other studies that report professional design and an official touch affect views on trustworthiness.

Some young people demonstrated considerable awareness of marketing and mass media health campaigns. For example, a participant in the homeless young people's group advocated for a sustained campaign, saying only sustained campaigns were successful. Regional youth noted that television advertising campaigns need to change over time, and need to be rested for brief periods, in order not to become irritating or boring. They also noted, as did the SSATI and Somali groups, that different young people use different media, so any campaign would need to employ a variety of media. Similarly, they recognised that different approaches were effective with different individuals, necessitating the creation of a health promotion strategy that incorporates elements of humour, realism and even judicious use of scare tactics. Some young Somali women noted that just as anti-smoking campaigns may work better with non-smokers (dissuading them from starting to smoke) than smokers, certain approaches (for example, prevention messages) may be more effective with young women before they are sexually active, while a different approach may be applicable for those who are already sexually active.

The secondary school students had a sophisticated understanding of message dissemination and made the following suggestions for a large-scale Chlamydia or STI health promotion strategy.

- Create an awareness month
- Involve young people, through schools and more broadly and organise activities in Federation Square (for example, the Movember Campaign for men's health)
- Use peers and draw upon popular culture to engage young people as done by the Reach Foundation ('for example "cool people doing cool things" such as break dancing in the street to draw you in and make you want the information')
- Employ an innovative and comprehensive approach (for example, pink bottle tops on bottled water for breast cancer awareness)
- Devise identifiable symbols such as the anti-cancer daffodil or pink ribbon
- Run a slogan competition

Conclusion

Making it Real investigated relevant communication strategies for STI information for young people, taking into account that young people are not a homogeneous population. The research sought to ascertain whether targeted campaigns were necessary for particular sub-populations of socially disadvantaged youth. Our focus was on Chlamydia, but findings can be confidently extrapolated to other STIs. The key finding was one of similarities in attitudes and preferences among the sub-populations we studied, although there were also some differences. Similarities were strongest in regard to preferences for medium and style of communication. Differences in attitude to STIs that will need to be taken into account in the development of sexual health messages occurred along gender lines and in relation to education and/or disadvantage. This finding of the predominance of similarities differs from the conclusions of some recent reviews which advocate segmented and targeted campaigns to different youth sub-populations (Shanahan, Elliot et al. 2000; Noar 2006). The needs and preferences of the socially disadvantaged youth in this study did differ in some areas to those of mainstream youth, however, the differences were not great and substantial similarities existed among sub-populations. This supports our conclusion that socially disadvantaged youth can be reached through mass media campaigns targeting the general youth population.

While there was no evidence to support the necessity of mass media campaigns targeted to the different sub-populations, some small-scale campaigns would be appropriate for Aboriginal youth, young people from the Horn of Africa and those most significantly economically and/or educationally disadvantaged. In regard to dissemination of detailed STI information our finding is therefore more in accord with the previous literature (Shanahan, Elliot et al. 2000; Noar 2006).

It is also important to note that individual preferences cut across gender and education/disadvantage lines and sub-populations. Findings are elaborated below under the headings medium, message and style.

Medium

Two key messages relating to medium emerged. First, **utilise a medium that provides a 'captive audience' to disseminate simple messages** about Chlamydia and other STIs. With the exception of the SSATI young people, all groups expressed great reluctance to actively seek STI information. Many also stated that STI information needed to be 'in your face', or even unavoidable, requiring no effort on the part of the recipient. Consequently, participants suggested cinema and television advertisements and posters as the most effective means to alert young people to Chlamydia and other STIs.

The second important finding in relation to medium was that young people prefer to interact with **people rather than technology** when requiring more comprehensive information. Surprisingly, the internet was not regarded as an effective medium for the delivery of comprehensive information by our marginalised young people, with the exception of the SSATI young people. Our data indicate that most marginalised young people, other than SSATI, differ from mainstream young people in this regard; they also reject text messaging as a strategy for disseminating sexual health information or STI awareness raising. The finding that SSATI young people favour the internet as a source supports earlier research (Hillier, Kurdas et al. 2001). Studies with mainstream youth have generally reported greater engagement with the internet and openness to text messaging as sources of STI information (Wilkins and Mak 2007; Kaiser Foundation 2001), although Smith, Agius et al. (2002) report relatively low level of internet use as a source of health information.

Awareness raising posters and TV or cinema advertisements could direct young people to a help line (a popular source of detailed information) or even to internet sites which may be accessed by some groups. As reported elsewhere (Wilkins and Mak 2007), young people express little interest in picking up pamphlets; these are most likely to be useful when integrated into health professional consultations with concerned young people.

Overall our findings regarding medium are in accord with earlier studies that stress the importance of combining mass media awareness raising campaigns with on-the-ground interventions providing detailed information and health services (Shanahan, Elliot et al. 2000; Zimmerman, Palmgreen et al. 2007). While we did not address the optimum

length for a campaign, we would concur with Shanahan et al.'s conclusion that ubiquitous and long-term media campaigns are the most successful (Shanahan, Elliot et al. 2000).

Message

Young people across groups unequivocally stated that messages about STIs should be **simple and realistic**. Scare tactics will work with some young people but negative messages should be balanced by information about prevention and how to take action to productively manage any anxieties provoked. This finding is consistent with a major review of campaigns to young people (Shanahan, Elliot et al. 2000). Findings from the one question which quantified participants' responses are somewhat at odds with comments made during the open-ended focus group discussions. Nevertheless, data presented in Table 2 indicate that most young people consider that information on a variety of matters associated with Chlamydia is important, suggesting that health awareness and promotion messages could usefully cover an extensive range of topics.

The need for messages to **counteract the stigma associated with STIs** was made clear in all groups. While the most educated groups of young people stressed the importance of de-stigmatising STIs, young men in the most disadvantaged groups engaged in the stigmatisation of STIs and those who may have contracted them. This difference, along the lines of gender and level of education was the most marked difference in participants' views. It is crucial that any Chlamydia campaigns are inclusive, reaching both males and females and stressing that **Chlamydia is not just a 'girls' disease'**.

Style

Young people clearly stated that they prefer **images over text** in posters, pamphlets or any other written medium. This finding accords with those of previous studies (for example, Lazarus and Mora cited in Bernhardt 2000). Young people also like messages to be presented in a **'realistic' rather than an 'over-dramatised'** style, in everyday simple language as used by themselves and their peers. Employing young people in advertisements or as public speakers to convey the message is a favoured approach. While the style needs to be bright and interesting in order to be engaging it should not try too hard to be 'cool'. Detailed STI information may be deemed more trustworthy when presented in a more serious tone and plainer format.

Aboriginal young people and those from the Horn of Africa were attracted to information that incorporated images or text that were associated with their cultural background (a finding in line with McNally and Dutertre 2006), but expressed no other important differences to the other groups in regard to style preferences.

Limitations and strengths of the research

A strength and a weakness of focus group methodology is that different groups focus on different aspects of the issues under discussion, sometimes due to interest and intensity of engagement but at other times due to the order of issues raised by the facilitator or process matters such as interruptions or time constraints. While it is sometimes clear which issues are most salient with a group, lack of discussion of other issues does not necessarily reflect a lack of importance or relevance.

Research partnerships were a great strength of this research project, providing invaluable knowledge of particular youth sub-populations and guiding the project throughout. Research partners also facilitated access to sub-populations of young people that can be difficult to include in research, such as incarcerated youth.

Recruitment through health services and other agencies was very successful; young clients' levels of trust and rapport with individual recruiting workers encouraged participation in the project. While this strategy was advantageous for the research, it did entail some costs in regard to criteria for participation in two groups and the size of a further two groups. Our initial aim was to hold two groups with Aboriginal young people, one male only and one female only group. However, young women were recruited by workers and came along to the proposed male only focus group. Due to the small number of participants, the researcher elected to continue with a mixed sex group, rather than running a male only group. In the Aboriginal mothers' group, two participants indicated that they were outside our selected age criteria (they were aged 26 years) but were keen to participate. Recruitment of young people from the Horn of Africa was far more successful than anticipated by the recruiting workers. Consequently the groups were

over the optimum size for focus groups; there were 16 young men in one group and 19 young women in the other. Given that recruiting young people in these populations is difficult, the researcher made a decision to be flexible about criteria and group size in these cases.

Final words

Contrary to the belief that socially disadvantaged young people are most effectively reached through community level interventions (key informants in Shanahan, Elliot et al. 2000), our study indicates that such young people are open to mass media awareness raising campaigns if the medium, the message and the style are right. The effectiveness of the mass media campaign in changing behaviour, as well as knowledge, beliefs and attitudes, will depend on the provision of appropriate on-the-ground interventions to provide comprehensive STI information and health services to those that need them.

It is interesting and heartening to find that although young people are reluctant information seekers, they nevertheless think it is important to be alerted to the risk of Chlamydia and to have comprehensive information available on-call. This is the challenge. The most vulnerable young Victorians have told us of how best to inform them. Importantly, this study has shown that **there is little need to tailor awareness raising campaigns to specific marginalised groups of young people**. Indeed, with few exceptions, our marginalised participants had the same views about how to best communicate as did our secondary school students, so that broad-based population health promotion strategies can be employed. **However the needs of specific groups should be taken into account in developing strategies for providing detailed STI prevention information**.

We found it encouraging that young people were able to identify a range of favoured communication strategies that were common to all groups. Those responsible for developing STI prevention communication materials might well use input from young people such as those engaged in this research in the process.

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Appendices

Appendix 1. Making it Real focus group questions

Focus groups will begin with information about the research project and some brief information about Chlamydia. Focus groups will comprise free flowing discussions around the following questions. Questions may not follow this order. After consulting with young people from the sub-populations, questions will be slightly modified for each group. Ideas raised in early groups will be proposed to later groups for comment.

If we wanted to get young people's attention about Chlamydia what would be the best way of doing that?

Where do you think we should put that information?

Why do you think that would be a good place?

What's the best way to get the message across (prompts if necessary: pictures, words, humour)?

What sort of thing do you think other young people wouldn't like?

Do you think this is the same for young men and young women? (applies to all questions above)

What about if we wanted to give people more detailed information?

Where do you think we should put that information?

Why do you think that would be a good place?

What's the best way to get the message across (prompts if necessary: pictures, words, humour)?

What sort of thing do you think other young people wouldn't like?

Do you think this is the same for young men and young women? (applies to all questions above)

Activity 1.

We have made a list of the kind of information that is usually included in pamphlets, internet sites and other places. We'd like you to tell us which kinds of information you think are most important for young people to know about sexually transmitted infections, like Chlamydia. (Likert scale provided)

Activity 2.

We've brought some examples to show you and we'd like to hear your opinions.

Prompts if necessary:

Do you think there is not enough/too much information?

Does it include the most important things young people need or want to know?

Do you think the way it talks about STIs is relevant to/appropriate for young people?

What about the way it looks; do you think young people would want to pick it up and read it?

What about the way it's written?

What about the pictures?

We know that if Chlamydia isn't treated, it can have some pretty nasty consequences — how do we best tell young people about that?

Motivation and trust

How do you think young people decide whether the information they get is reliable?

What motivates young people to seek out sexual health information?

What sort of things would we need to think about if we wanted to provide sexual health information to young people with a similar background to you?

Appendix 2. Written materials presented to focus groups for evaluation

The following examples of sexual health material were provided for focus group discussion. A range of materials, including a pamphlet on Hepatitis C, were provided to facilitate discussions of style as well as content.

Sexually Transmissible Infections: Treatment is good/prevention is best (DHS, Victoria)

Chlamydia (Family Planning Victoria)

Chlamydia Fact Sheet (Melbourne Sexual Health Centre)

It takes 2 to Tango (Sexual Health and Family Planning Australia, Bayer)

Keep it Simple Guide to Safe Sex – KISSS (ARCSHS for ANCAHRD)

Sex: You decide! (Family Planning Victoria)

What is Hep C? (Hepatitis C Council of NSW)

674: A Pocket Guide to Keeping Well on the Streets (Project i: University of Melbourne, the Ian Potter Foundation)

What's not always talked about (Family Planning Victoria, DHS, Victoria)

Safe Doori (sex) for you and your partner (VACCHO)

Grab one of these and you won't get bitten *'Snake brochure'* (Marie Stopes International Australia, VACCHO, Mildura Aboriginal Health Service)

You never know who you'll meet postcard (DHS, Victoria)

'The message is to everybody. There's no black, white, pink, whatever.'

'You need to get the message to a broader range of people — private school kids or street kids or whatever not just focus on one audience.'

'Make the community aware that Chlamydia is very common and it has an easy solution. It's nothing to be ashamed of.'

'Make the message short and sharp.'

'The more writing — the less interested I'll be.'

'Constantly, there is too much information just being banged into us and it's just like "Whoa, whoa, whoa!"'

'You don't want to scare people — you want them to actually get up and do something about it.'

'It's very important to get rid of the stigma of STIs because that's the reason people can't talk about them.'

'A lot of sex education in schools is about pregnancy and that's it.'

'For young people you've got to actually put the information in front of their face.'

'You don't want to create a stigma about sex because as long as you're safe about it, it can be fine.'

'By having more information about STIs in the media it can actually get rid of some of the negative thoughts and prejudice about it.'

'Help lines are very helpful because they don't see who you are. You don't see them judging you.'

'They should get some young person to talk about it then I reckon the young people will understand it more.'