

Australian Research Centre in Sex, Health & Society

Faculty of Health Sciences, La Trobe University
1st Floor, 215 Franklin Street
Melbourne VIC 3000 Australia
Tel: +61 3 9285 5382 Fax: +61 3 9285 5220
Email arcshs@latrobe.edu.au
<http://www.latrobe.edu.au/arcshs/>

ELECTRONIC TECHNOLOGIES, HIV EDUCATION AND HEALTH PROMOTION TARGETING GAY MEN AND MEN WHO HAVE SEX WITH MEN

REPORT TO:

Dermot Ryan
Manager ANET & Indigenous Projects

Michael Hurley
Senior Research Fellow



Electronic technologies, HIV education and health promotion targeting gay men and men who have sex with men

Summary: Gay men and MSM use the net to meet each other, however there is no evidence of any strong link between using the net and increased prevalence of STIs or HIV. The reach and excitement offered by the internet to HIV health promotion need to take into account known saturation issues in HIV information and education. Simply reproducing familiar materials will reproduce the problem in two ways. It will duplicate already available treatments and prevention information when it could instead focus on making available information easier to find. In the case of prevention resources, cultural relevance has come to mean resources match the production values of commercial products, thus making them difficult to distinguish from any other resource. Evaluation of past print resources has already indicated that sections of the audience 'turn off' to HIV education in this context. The result is a spiralling pressure to incorporate ever higher levels of educational interactivity and 'engagement'. The biggest challenge is in using the net to promote varieties of social interaction that support and extend a range of self care practices. This may require a shift in favour of new forms of peer education on the net, locating expert driven notions of information inside a focus on how gay and MSM develop well informed practices of everyday life.

This paper was asked to address three matters:

1. research into gay and other men who use the internet to find male sexual partners;
2. current uses of the internet for HIV health promotion;
3. possible future uses of the internet for HIV education and health promotion.

The discussion begins by locating these 3 issues in relation to how sex and gayness are currently thought about and the huge opportunity cyberspace seems to offer health promotion.

The internet has played a major role in increasing the representation of gayness internationally. Part of this has been directly related to HIV. The net has multiplied possibilities for the expression of same sex desire through email, websites, chat rooms and list serves. It has contributed significantly to commodifying identity and same sex desire through the relaying, advertising, marketing and sale of imagery, text, sound, consumer products and new cyber spaces. Health issues are packaged into and dispersed through these processes as news, as commodities and as part of the modelling of individual subjectivities. As a result, the question seems to be, how can health promotion and its resources be made usefully and efficiently visible in this context?

Even after allowing for the increased social 'normalisation' of gayness, we still need to take into account what society asks of sex generally and the specifics of gay sex (Altman 2001). Sexuality is currently constructed as a key issue in psycho-social identity formation and the 'healthy' narration of the self. We ask of sex that it tell us 'our' truth. Sex and sexuality are also freighted by considerable social anxiety in ways quite distinct

from legality. For younger gay men, coming out and 'finding your feet' often occur in situations of quite contradictory social approval/disapproval and are closely linked with sexual and emotional novelty. Quite rightly, they reject perspectives which try and link this experience too closely with the threat of disease. Cyberspace seems to offer a more free floating place to explore the possibilities while allowing the user to be quite instrumental in relation to health information. For older and/or more experienced gay men, both HIV negative and positive, sex in the widest sense has been deeply affected by HIV.

When 'sex' and 'health' are narrated together the pressure on sex and sexuality is enormous. For gay men, anal sex often becomes a focus of this pressure. It's a pressure that eroticises. On the one hand, a romantic discourse of 'connection' emerges, sometimes accompanied by lack of experience and/or extreme sexual passivity, other times by a hungry devouring in which the aim seems to be simultaneously a form of unity with, and a dissolution of the self into, the other. However the search for ultimate dissolution is also often seen in the most experienced of sex players, in the search for the sublime. In both these versions anal sex is positioned as the gateway to heaven. Pleasure is constructed by puritanism. When HIV is caught up in this dynamic, notions of acceptable risk can shift considerably.

Many lived gay sex cultures refuse this pressure and explore ways of narrating sex differently. Pleasure and anal sex are creatively displaced in a refusal of puritan dialectics and in some subcultures rewritten (Dollimore 1991). Cyberspace is crisscrossed by all these possibilities being simultaneously available. For some, it offers utopia. Others move between the possibilities on and offline.

Much international HIV education, social research and politicised sex regulation positions itself quite confusingly in relation to these matters. 'Barebacking' fantasies are taken literally and the net is spoken about and blamed for allowing, if not causing, the fantasy. Little attention is paid to differences between unprotected and unsafe sex (Kippax *et al* 1997) and there is no sustained consideration of why anal sex cultures might be important (Parnell 1993). For some, they are implicitly seen as a problem for public health interventions to fix. And if those dirty gay men won't do it themselves we'll do it for them. Others adopt, within political limits, a more hands off funding approach and ask community-based educators to broker acceptable forms of education and health promotion.

Internet health promotion becomes a frontline test of HIV education. Ways of intervening in gay cyber cultures become defined by sex and disease. These become the sole or primary portals of intervention. International research into gay men's use of the internet indicates the following activities are common and/or relevant to this discussion:

- Health information seeking;
- Making friends
- Creation of safe spaces;
- Rehearsing possible social and sexual situations face to face;
- Romantic and/or sexual fantasising;
- Formation of social and sexual networks;
- Meeting sexual partners
- Entertainment and escapism;

- Advocacy.

Further, as a mode of delivery, internet based health promotion has to take into account the state of play in HIV education in Australia in much the same ways as other modes of delivery do. While rates of unprotected anal sex in casual contexts are increasing (NCHSR 2001), there is substantial research evidence that this involves highly informed, harm reduction strategies which maintain low rates of new HIV infections (Van de Ven *et al* 2002). Most new infections do not appear to be in men ignorant of general safe sex information. It is social and sexual contexts and personal meaning that are at least as relevant to the incidence of new infections (Bollen *et al* 1998), as well as uneven knowledges of how sexual risks are constituted (Race 2002).

HIV education for gay men in Australia occurs in an ongoing context of saturation levels of HIV information and continually changing ways of living gay that decentre HIV. Criteria of cultural relevance shift rapidly. This puts enormous pressure generally on modes of delivery of health promotion resources. HIV education is ironically also challenged by high levels of HIV health literacy and the emergence of risk reduction in casual sex as a major tendency in lived sex cultures. A highly informed, sexually sophisticated target group rapidly and mostly successfully adapts to new information by moving between different kinds of HIV prevention strategies in different contexts.

In this context, demand for net based health promotion is amplified as a 'new' method for delivering education. With that demand come associated economic, social and political costs, shifts in workplan priorities and challenges to make what is produced 'visible' and useful. The risk is that the product becomes the outcome rather than the educational processes it is meant to enable.

Australian HIV education practices have been characterised by 'cultural sensitivity', reflexivity and by being pro-sex. That is, they have been attune to the lived gay cultures of their target audiences while intervening in understandings of what constitutes 'safe' sexual practice. At its best HIV prevention has understood that its cultural relevance and appropriateness is determined by the provision of cultural information as much as by health promotion messages. The delivery of the first ('relevance') ensures greater credibility of, and efficiency in, the delivery of the second (health information). However, 'relevance' is not just a vehicle for the delivery of the message. It is part of the message.

This has increasingly posed problems for HIV education because the relevance has been packaged in print resources in such a way that it has become part of gay saturation. For example, relative sexual explicitness has made prevention materials look like any other sexualised 'product' that uses specific representational conventions: smooth, unmarked glowing skin (whether white, brown, yellow or black), nudity, muscular focus in sexual situations. In any shift of resources from print to electronic modes of delivery the challenge is to break with these forms of visual representation.

These representational conventions have been used in quite culturally specific ways to signify a knowing gayness. In the process much HIV health promotion has crossed over and/or moved between three genres: info-tainment, edu-tainment and medical information. Two important educational spaces have resulted, often with shared participants. The first the quasi-clinical, where treatments information mixes with treatments experience and cultures of care including safe sex (Hurley 2001; Willis *et al* 2001). The second is constructed at the intersection of gay media cultures, lifestyles and

HIV education (Hodge *et al* 2002). The use of generic representational conventions has been the case with both broad-based social marketing in gay media and more specifically targeted interventions aimed at users of sex venues or those who engage in specific sexual practices. The result is twofold. Firstly, both narrow and broadcast social marketing 'mirror' wider cultural practices and in that sense have relevance as well as a visibility problem; they require ever smarter techniques in product positioning if they are to be 'seen'. Secondly, the social marketing is largely divorced from social interaction. 'Reach' and distribution are understood primarily instrumentally, rather than as intervention issues in lived cultures.

Promoting social interaction is much harder than social marketing. Is it time to scale back on social marketing in favour of more social interaction? Do high levels of health literacy mean a refocussed peer-based strategy is irrelevant and that the focus should be on targeted information distribution?

1. Research into gay and other men who use the internet to find male sexual partners.

Best practice in health promotion is characterised by the encouragement of reflexivity. Reflexivity includes having perspectives on the relation between health and living, an active awareness of issues in information assessment, a conscious capacity to understand and interact with personal repertoires of life management, maintenance of social support systems, and more and less knowing engagement with practices of cultural representation. Reflexivity also includes the relaying of practices of self care amongst gay men and multiple strategies in health promotion.

Cyber excitement and social danger

Cyberspace is exciting. It's full of the promise of psychic pleasures. Along with the excitement of entry into cyberspace comes the power to use it (Livia 2002). For regular, as distinct from new, users, that power is currently vested partly in the routinisation of net use (email, chatrooms). What was glamorous has become routine, and in that sense habitual.

One difficulty is that the net is currently being constructed as a social space dominated by stalkers, pedophiles, bug chasers, pornographers, lying husbands and barebacking gay men. It's become a new site of moral panics and social danger just as television was when it first appeared and the novel was before that. Each invited the user to be self examining of what it means to be sexually hygienic. Except that 'hygiene' here is health driven rather than excitement driven. The invitation is to be a good sexual citizen.

The net intensifies these invitations by extending the sites on which they are made. These spaces are already full of health information, conversations about HIV, AIDS and STIs as well as sex, the ethics of gayness and desire: for sex, for intimacy, for social contact. These desires conflict and produce endless chatroom negotiations ("What is it with gay men, this is a chat room and no-one chats. All in private I suppose.")

They also involve legal and illegal activities, such as drug taking. All Commonwealth funded, net-based resources which address recreational drug use in lived cultures of gay men have to engage in increasingly challenging political calculations of how tensions between harm reduction and the control of supply and demand are to be negotiated in any given resource if it is to be approved (Fitzgerald and Sowards 2002).

Gay men, the net and sex

As high end users of new technologies in general and the net in particular, many gay men have clearly incorporated net use into various sexual and emotional strategies, including meeting face to face.

About 50% of the 450 HIV negative men in the Sydney-based Health in Men sample had met sex partners from the net in the previous twelve months (Mao et al 2002: 10). In 2000 about a third of the sample in the Asian Gay Men in Sydney survey had met sex partners through the internet and the report made a point of saying that 'contrary to some expectations, those whose primary language was not English were no less likely to use either personal advertisements or the internet' (Prestage et al 2000: 37). The 2002 Melbourne Gay Community Periodic Survey indicated occasional (35%) and frequent (12%) use of the net to find sex partners (Hull et al 2002). While no strict comparison is possible, in a 2001 Melbourne study of mostly non-gay men (Pitts et al 2002), 8% of the men reported using the net to acquire sexual partners. Another 4% had used the net to start a relationship and 6.6% reported cybersex. For them, net use was a medium for sexual interest and gratification especially amongst younger, more educated users. Pitts et al. concluded 'no significant relationship was found between reported sexually transmitted infections and internet use...most internet use would seem to offer a relatively safe way of achieving sexual gratification.'

Gay men, the net and risk

Use of the net to meet sexual partners has been linked in popular imagination to the sexual transmission of infection, especially syphilis. This link was created by media circulation in 2000 of a report in the *Journal of the American Medical Association*: 'Tracing a Syphilis outbreak through cyberspace' (Klausner et al 2000). Klausner et al identified seven [sic] new cases of syphilis amongst men who met through America on Line. Highly intrusive¹ contact tracing produced five more cases. These twelve cases and AOL's refusal to allow initial direct contact with chatroom users were relayed around the world. In an associated intervention, relevant doctors and clinics in San Francisco were notified, there were press ads and the chatroom was flooded with hate messages. Gay male internet use was linked irrevocably and internationally with high risk practice. No research has been done on the social and economic costs of this intervention, its impact on gay men in San Francisco or its effect on health promotion agendas internationally. What epidemiology identifies as a shift in notifications is not an automatic basis for new health promotion programs, as distinct from health alerts, nor does it define what any such programs might be.

In this scenario net use becomes a disease risk factor in ways directly paralleling and compounding the characterisation of the net as a social danger. There is of course no research indicating that the net or net use of itself causes increases in HIV and/or STI infection.

¹ 'For 2 weeks, ...staff entered the chat room site, electronically contacted hundreds of users and informed them of the syphilis cluster, and encouraged persons who may have met sexual partners in the chat room to seek medical evaluation. To notify partners of their possible exposure ... sent email messages to the screen names and requested a reply. The screen names of persons who replied or presented to [clinic] were compared with a list of screen names of reported partners.'

There is research that purports to link some net-using gay men and other men who have sex with men with higher risk practices when they meet offline for sex. Researchers at the Australian Research Centre in Sex, Health and Society (ARCSHS) reviewed 45 articles on this matter, mostly from the U.S.A and the U.K. Most samples were of gay men, often those attending clinics. Appropriate comparison groups were rarely used, creating sampling and other problems including counting male to male sex as in and of itself a risk factor. The difficulty is that many of the studies uncritically represent epidemiological risk indicators as social indicators of risk. This ignores the fact that what they are doing is mapping the lifestyles of gay men and men who have sex with men in relation to non-gay/msm and how they play out in net use. The net is then implicitly blamed for any disease vectors associated with differences in lifestyle. In that sense, much of the research confounds variables to associate internet use with 'unsafe' sex. ARCSHS researchers concluded that there is little evidence that the Internet is any more 'unsafe' as a site for arranging sexual encounters than other venues.

Other social research tells different, much more productively powerful stories about the role of the net in gay men's lives, particularly the lives of same sex attracted youth (Hillier *et al.* 2001). Use of the net to meet sexual partners is complemented by strategies including various forms of emotional risk management both online and in the management of personal safety when meeting people.

2. Current uses of the internet for HIV health promotion

Internet health promotion appears to be dominated primarily by the provision of information, by proliferating small-scale interventions into chat rooms and by social research.

HIV health information internationally includes a number of major websites (thebody.com; aidsmap.com), organisational web pages (afao.org.au;ashm.org.au), list serves (<http://www.cia.com.au/hol/ozpoz/>), electronic journals, conference reports and a vast array of resources and pages produced by individuals, community-based organisations, professional associations and activists.

The three major gaps in internet health promotion for gay men are very basic. There is no Australian portal/gateway that allows you to find relevant local sites without you first having a working idea of what you are looking for. Secondly, perhaps arguably, there is no easily found, accessible safe sex website that takes the user progressively and non-judgementally through the options. Thirdly, which holds for all HIV prevention resources, there are no resources that address self-reflexivity in 'updating' information, attitudes, practices. Given 'adaptation' is a key characteristic of lived sex cultures then a site that supports informed 'adaptation' practices would seem to be central. This might take the burden of representation off each new individual resource that it covers all bases.

Most existing sites are information based and information rich. Knowledge on these sites is positioned mostly as a pre-prepared authorised product delivered to an information seeker. Given high levels of health literacy amongst much of the affected population this is often sufficient. Sometimes there is more active online support for medical decision making in infotainment formats (www.aidsmap.com/wheel/starthere.htm). Generally the sites allow for active health information search strategies, survey participation and email contact, but rarely support active, net-based social interaction of the kind seen in gay chat lines, on bulletin and message boards, list serves or in, say web-based, moderated discussions associated with television programs or formal online education. Education

resources are often print resources transferred to the net in various hypertext formats with little exploitation of multimedia possibilities, active learning or the facilitation of peer-based activity on and offline. Phillip Keen has referred to possibilities of 'trailing chat-outreach methodologies' and the role of educators in relation to them (Keen 2002). The issue is perhaps cyber outreach if chat rooms are not to be full of educators.

While many AIDS organisations have online publications, specific multimedia resources produced for use online are much less common. Two examples are www.supershaqland.com and AFAO's Sex in Queer Places website which is currently offline. These are international state of the art internet health promotion resources. Both draw heavily on popular culture (animated graphics, game strategies), are lifestyle savvy and information rich. Interaction is constituted mechanically (button/mouse/arrow) and cognitively (what choice do you want to make). They are sophisticated media delivery of edu-tainment in several ways: they bypass some of the one size fits all problems of posters and leaflets; they understand that 'relevance' is not just a vehicle for the delivery of the message, but is part of the message to the extent it gives credibility and authority; they 'compete' on the net in terms of design literacy. However, there are also three major contradictions. Firstly, the sophistication is used to deliver an already largely available body of information. Secondly, the user is mostly positioned passively as an individualised button pusher. Thirdly, though the life matters are cleverly contextualised, the built in pedagogical relations are overly didactic. They are forced to privilege authorised and approved ways of doing sexual things to the detriment of self-determining reflexivity.

The net, health information seeking and medicalisation

Researchers estimate that 70-100,000 websites provide health information (Grandinetti 2000; Kalichman *et al* 2002). A credible literature review identified health information seeking amongst internet users as 'the most common and influential function of interactive health communication today' (Cline and Haynes 2001). The reasons include 'emphasis on self-care and prevention'. American research identified an 'overlapping demography of people living with AIDS and the population of persons disconnected from information technology' – 'the less educated, economically disadvantaged and socially marginalised' (Kalichman 2002a: 110). However, given epidemiological differences, this situation seems less likely in Australia. *HIV Futures 3* indicated the net was one of a matrix of information sources for people living with AIDS (Grierson *et al.* 2002:48-51; Hurley 2001). *Futures* also indicated a suitable caution amongst users about reliability. The credibility and accuracy of the information on web pages varies and many sites offer resources to evaluate information sources.ⁱ

Much health information seeking behaviour is linked to visits with doctors, diagnoses and treatments and is part of medical self-management. Self-management practices include participation in online support groups (Cline and Haynes 2001: 673). The Australian eHealth Study 2002 surveyed 3,900 consumers as well as GPs, specialists and pharmacists. 'Consumers' identified online medical sites as the second-most used source of information by net users after doctors. 70% of those with a recent medical diagnosis said they would use information from the net to ask their doctor questions and 20% said information gained online would affect their decision to see a doctor. Over 25% of medical practitioners said they refer patients to websites for additional information (A.C. Neilson 2002).

On this basis we might ask when is it useful, if at all, to provide separate resources to those already available and should these be short updates on 'new information only'? When are separate 'gay' tagged resources needed and are they needed in the same way as print resources were in the past given both the growing 'normalisation' of gay socially and the number of gay and HIV internet sites?

3. Possible future uses of the internet for HIV education and health promotion

Educational and health promotion best practice, together with social research, provide useful ways of structuring considerations of how the net might be used. A recent editorial in the *British Medical Journal* spoke of how:

'more and more of life's processes and difficulties birth, death, sexuality, ageing, unhappiness, tiredness, loneliness, perceived imperfections in our bodies are being medicalised. Medicine cannot solve these problems. It can sometimes help but often at a substantial cost. People become patients. Stigma proliferates. Large sums are spent. The treatments may be poisonous and disfiguring. Worst of all, people are diverted from what may be much better ways to adjust to their problems... If health is about adaptation, understanding, and acceptance...(Smith R. 2002).

Race (2001; 2002) has been developing a sustained argument about the relation between medical technologies of testing (HIV, viral load) as forms of scientific knowledge and the sexual practices of gay men. He points to links between individualised risk management and moralism and consistently draws attention to disparities in the distribution of these knowledges and their implications for risk. I have written elsewhere about the educational challenges associated with the speed, volume and technicality of media relaying of medical information, particularly in relation to people living with HIV. The characteristic mobility of electronically distributed treatments information is seductive, but sometimes that's all it is, pure movement, that is quite separate from communication understood as making sense either of the movement or the information. Information outpaces communication and education. Querying the impulse toward medicalisation doesn't mean ignoring the role of medical technologies. Rather, as Race suggests, it is an educational question about how to distribute scientific knowledges in ways useful to how people live their sexual lives.

This means biting the bullet on explicit discussions of sexual risk reduction in ways exemplified by sex in queer places. However this is currently overdetermined by politics and requires multi-strategic responses that may have to involve considerable rethinking of the kinds of resources produced, packaging and modes of distribution. Might AFAO, for example, more usefully outsource controversial resources? Are adaptive safe sex cultures best addressed through cyber-based resources? How is cyberspace best used to facilitate participants in unprotected sex informing each other about effective self-care?

What might an information-based site on these matters look like and how might its cultural legitimacy be established other than through notions of the image? Can the relations between text and sound be usefully reworked here in ways not involving the primacy of images?

Is HIV health promotion for gay men at a point where government sanctioned health promotion may have a limited role on the net? How can the issues be taken up as volunteer or peer driven activities away from net-based resource production and state funding and approval.

The educational challenge is to moderate the information, by taking control of it, stepping aside from speed at selected points and focussing on practices of social communication. Different educational and media practices can do this in different ways, but in each case the task is to make the information vector interactive on terms set as far as possible by the users, while taking into account medical accuracy. This might include distinguishing perhaps between different medical diagnoses (genital herpes, gonorrhoea, anal warts, HIV), the likelihood of success in a condom using strategy for STIs pre and post diagnosis and how people with these infections do and don't incorporate them into their sexual practices.

Commercial advertisers are very cautious with the net: 'though Australia has one of the highest levels of internet penetration [sic], the amount of time we spend online is near the lowest in the western world'. The daily average is 26 minutes (Liddell 2001). However, in 2000, 50%+ of gay readers of the *Sydney Star Observer* were using the net and spending on average over eleven hours a week doing so (Keen 2002). Net marketers also reject 'reach' as a useful measure. They have found small, committed audiences are far more profitable. Marketing practices specific 'subscription' targeting.

The analogue of subscription targeting in net education is potentially the email based discussion list. The description above of health information seeking, and medical decision making, suggests a possibly greater role for specific purpose, perhaps time limited discussion lists like a 2 week list for those recently diagnosed with an STI that is repeated as needed, or an email based question and answer service for men who avoid doctors, or a list for married, bisexual and non gay identified msm (Peterson 2001).

Assuming health information seeking is either accompanied by or complemented with self-entertaining uses of the net, it may be that links can literally be made through selective placement of 'links' on specific health information sites. Bull *et al* (2001) concluded in a large U.S study (n=4601) that 'men who have sex with men and persons with a history of testing for STD are consistently more likely to endorse STD/HIV prevention through chat rooms, E-mail and websites' than those without that history. As we know, endorsement is one thing and using them another, however this does suggest the possible need for different strategies for those with histories of testing and those without. There is also some evidence internationally that the net may be used more by less gay community attached men who have sex with men (Tikkanen *et al* 2000; Ross *et al* 2000) who are also less likely to test for HIV and more likely to engage with UAI. However there was no linking of the UAI as a sexual practice with contexts characterised by high HIV prevalence. Risk is in that sense constructed abstractly as though the same practices of unprotected anal sex have the same risk irrespective of context.

What can be said on the basis of the discussion so far?

1. The provision of net-based health information to a relatively health literate population does not necessarily require sophisticated health promotion programs that imbed the information inside wider contextualised resources. Information seekers will seek anyway.
2. Net-based health promotion faces the same challenge as that posed to print resources: cultural saturation in modes of delivery and HIV and health saturation.
3. Ways of incorporating social interaction need to be prioritised as part of health promotion strategies, whether net-based or not;

What else needs to be taken into account?

4. While STIs can increase HIV risk exposure and are a problem in and of themselves, health literate gay men know they can be treated and are rarely life threatening. This raises the need to seriously question linking them through common health promotion strategies. Antibiotics cure STIs. Treatments do not cure HIV.
5. What epidemiology identifies as a shift in notifications is not an automatic basis for new health promotion programs, though it might require health alerts.

CBOs may well have to balance, if not choose between, strategies that allow for rapid, very specific responses, all over the place, at any time, and the production of sophisticated resources that are expensive in design, labour and implementation. This puts a lot of weight on considering volunteer based activities that at least partially displace expert and content driven notions of education. Training of 'trainers' becomes central as a role for educators. It may also mean some educators being trained to surf at work in the ways they do at home, using a whole gamut of techniques to deliver questions, interventions, information, to assist in decision making, support the forming of social bonds, engage with substantive content. We need such programmatic perspectives, but we have to think about the contexts not just as social contexts of risk but as social spaces where the new technologies, bodies of information, political issues, emotions, lived experience and cultural re-evaluation occur and how educational processes of various kinds can be used.

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ⁱ http://www2.vuw.ac.nz/staff/alastair_smith/evaln/evaln.htm