

Article

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'Because even the placement of a comma might be important': Expertise, filtered embodiment and social capital in online sexual health promotion

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Abstract

The Terence Higgins Trust (THT) is a leading UK HIV and sexual health organization, and community outreach and support remain a key tenet of the charity's philosophy. Outreach work includes campaign drives in bars, clubs and saunas, peer-led workshops, support groups, condom distribution in community venues and one-to-one intervention programmes to help raise HIV/AIDS awareness. But what happens to community activism and outreach when the community one seeks to engage moves online? In this article, we report on a study capturing the experiences of workers engaged in THT's digital outreach service, *Netreach*. Using ethnographic and other qualitative methods, we identify the shifting nature of health promotion outreach work and the

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changes in expert–client relationship that occur when community outreach takes place on digital platforms. We identify how issues of (dis)embodiment, expertise and cultural capital play a role in determining the success – or failure – of online outreach work.

Keywords

Digital culture, e-health, embodiment, gay men, Netreach, outreach, sexual health

Introduction

The World Health Organization defines health promotion as ‘the process of enabling people to increase control over, and to improve, their health’ (WHO, n.p.), thus shifting responsibility and expertise to the individual. This process involves a ‘wide range of social and environmental interventions’ (WHO, n.d.) that engages specific communities as well as the wider public. More specifically, the UK’s Department of Health defines sexual health promotion as ‘not just about preventing disease or infection but also means promoting good sexual health in a wider context, including relationships, sexuality and sexual rights’. (DoH, 2014, n.p.). The Society for Sexual Health Advisors (SSHA, 2004) state that such work responds to evidence that ‘people at high risk of sexually transmitted infections (STIs) often make poor use of genitourinary medicine (GUM) services’ (2004: 200).

Community sexual health outreach work (herein known as ‘community outreach’) that targets men who have sex with men (MSM) has traditionally involved a wide range of activities. Distributing condoms and lubricant in gay bars and clubs and making patrons aware of relevant information or local services is perhaps the most visible form of outreach on the contemporary gay scene. Other forms of outreach include talking to men at cruising grounds about their concerns, offering safer sex material, guiding them towards HIV/STI testing facilities or offering such services on-site. These diverse forms of outreach all share one thing in common, and they take place in the spaces that MSM use to meet one another for sex, for socializing or for other activities. This form of site-specific intervention is integral to the definition of community outreach, which calls for the establishment of ‘contact with at risk individuals or groups *on their own territory*’ (SSHA, 2004: 251, emphasis added). In this case, peer expertise is situated within the embodied experience of users and socially contextualized to the space.

The last 15 years have witnessed a dramatic shift in the ways in which men meet one another for sexual and social contact. The *location* of gay male communities and the sites in which men meet for casual sex have radically changed (see Grov et al., 2013; Liao et al., 2006; Rosenfeld and Thomas, 2012). The works of McLelland, (2000), Campbell (2004), Davis et al. (2006), Dean (2009), Mowlabocus (2010) and Race (2010) serve to underscore the central role that digital and social media now play in the sexual and social lives of gay, bisexual and MSM men across the globe. It is within this landscape that e-health and mobile health initiatives have been lauded as the saviour of public health. In a time when the British Government is investing heavily in online service provision,¹ it is not uncommon to hear digital technologies being touted as ‘seamlessly help[ing] healthcare services transform, save money and improve patient experiences’ (Digital Life Sciences, 2013: n.p.).

Terrence Higgins Trust (THT) has been reflecting these changes in its own community outreach practice. *Netreach* is a pioneering community outreach initiative, targeting gay, bisexual and MSM

men living in the United Kingdom, utilizing the same digital platforms that they use to negotiate sexual contacts and to build and maintain social ties with other gay, bisexual and MSM men. *Netreach* is an evolving initiative and has existed in some form since 2007. In 2013 (during which researchers collected data for this article), *Netreach* workers were operating across 11 different digital and social media platforms. With the exception of one platform, all of the intervention sites were commercial services designed specifically for MSM use.

Our analysis of the THT *Netreach* service suggests that digital platforms offer an unparalleled opportunity to engage with cohorts of MSM who are sourcing sex regularly via online platforms and who may be engaging in high-risk practices. Our research, alongside the work of others cited in this article, suggests that digitally enabled community outreach provides an ideal environment for full disclosure on the part of the client and speedy referral to relevant services (including, but not limited to, local HIV testing, STI screening, condoms distribution points, counselling and support services) on the part of the health promotion worker. From this perspective, and given the fact that the projected national cost of HIV treatment for 2013 was £750 million (AidsMap, 2011: n.p.), a digital outreach service such as *Netreach* provides an attractive alternative to costly, ongoing clinical interventions.

In this article, we are chiefly concerned with how digital sexual health outreach is responding to the changes through their practices of engagement, building trust with the community and creating dialogue on digital spaces. We explore this below. Finally, this article will conclude by responding to what these online community outreach practices mean for notions of expertise.

Filtered embodiment in digital outreach

There's that lack of physical space between you [that] certainly allows you to explore greater issues and provide more thorough, robust advice. (Oscar, focus group 2)

The theme of (dis)embodiment has pervaded discussions of digital culture since the first MUDs and MOOs² were developed. The narrowness of bandwidth afforded by early dial-up connections led commentators to surmise that the Internet offered a space of disembodied freedom, where gender, race and class ceased to be organizing principles for identification – or discrimination (e.g. see Haraway, 2000; Macrae, 1997; Rheingold, 1993; Stone, 1998; Turkle, 1998 [1995]). In truth, such optimism always relied on analyses of specific expressions and platforms that actively distanced the user from their embodied selves. As early as 2002, Kendall highlighted the racial, gendered and sexual 'defaults' inscribed upon digital spaces, whilst Campbell (2004) identified the role that the body played in gay male cyberspaces. Commentators such as Tsang (1996), McGlotten (2013) and Kojima (2014) have illustrated the ways in which gay men's online culture is, by default, White, involving the same forms of discrimination, stigma and stereotyping as that found in the offline spaces of gay male culture. Meanwhile, the popular 'Douchebags of *Grindr*' *Tumblr* (www.douchebagsofgrindr.com) has served to underscore the multifarious ways in which embodiment is both central to the gay male digital experience and fraught with anxiety, tension and prejudice.

Such discussions and practices notwithstanding, digital platforms do complicate understandings of embodiment, and the relationship between the physical body and its online manifestation is, to say the least, elastic. It is perhaps more accurate to think of digital embodiment not as a binary opposition to physical embodied experience but as part of a mediating process, in which a set of 'filters' are mobilized in the production and reception of the body online. Thus, whilst health workers regularly commented on their presence online during the research (via images, text and

interactions with others), these filters of digital mediation were widely recognized as creating a distance between health worker and client. These filters include the screens that mediate communication between the worker and the client, the design and architecture of the platform itself and the tools of communication available for use in that space. Taken together, the filters serve to create a distance between the client and the worker, and this distance was often characterized as a form of mediated embodiment.

This filtered presence has positive effects, and one of the key benefits is the increased level of disclosure that clients engage in during one-to-one interactions with health workers online. Echoing Rosser et al.'s (2011) findings, the ethnographic research identified a far deeper level of disclosure during online interactions compared with offline interventions. In particular, instances of unprotected sex, 'infidelity', 'chem-sex' and sexual abuse were more regularly disclosed by clients online. When interviewed about such disclosures, workers stated that it was rare for these to be made during initial interventions offline.

I find it interesting online, one of the main things I find interesting is the gush ... that you go from pleasant conversation that's vaguely about something sexual health and then 'gush' somebody will gush out this quite in-depth, interactive needy sort of personal deeply confidential stuff, that doesn't necessarily happen offline apart from cruising sites. (Focus group 1)

It's stuff like PEP, its stuff like 'this is a scenario, this is a situation, this happened a day and a half ago, what should I do?' 'I'm feeling kinda down, I've just been diagnosed'. These are the conversations we can have online that we can't have offline in a public populated setting. (Focus group 3)

The benefits of such immediate and honest disclosure are not difficult to identify, and detailed disclosure allows outreach workers to provide information, advice and support that is closely aligned with the situations and predicaments the client finds themselves in. As one worker remarked during a focus group, 'people ask more in-depth questions online and they're more at a stage where they're ready to have a more in-depth conversation' (Focus group 2). In this context, filtered embodiment allows for interactions in which MSM feel comfortable talking about their past sexual experiences and current anxieties. The distance created by such filtering supports self-disclosure and allows services user to discuss intimate and potentially stigmatizing issues more easily.

At the same time, however, this position also poses challenges to health workers, who regularly highlighted the role that non-verbal communication plays during conventional outreach work:

I feel I have to go into a lot more explanation online and say 'you know, all sexual activity involves a level of risk, it's about assessing that level of risk', erm, and giving them all of that extra, cos you can't convey 'yes there is risk but it's a very small risk', it doesn't have the same ... it's not the same 'but it's a small risk'. (Focus group 1)

During the above conversation, the outreach worker used facial expressions, hand gestures and tone of voice to articulate the way he mitigated the potentially disconcerting response he was mandated to give when discussing the risk of HIV infection via oral sex.³

Within the ethnographic research, the challenge of working without the aid of visual and non-verbal cues came to the fore most often when outreach workers were called upon to discuss a client's sexual practices in relation to potential health risks. In such situations, outreach workers have to ensure that accurate information and advice are provided within a framework that avoids undermining client self-confidence. Given research (Crossley, 2000; Evans and Stoddart, 1994) that identifies the role self-confidence and self-esteem plays in maintaining safer sexual practices

among MSM, such framing is vital. Within conventional outreach work, embodied cues and gestures support such framing and the inability to draw upon similar resources online was regularly discussed in the research interviews:

People get so frustrated when they get text messages because you don't know what the emotion is behind the text messaging. And when you're online you have to be so creative and so artistic with your words and sort of to get through that emotion and that empathy. (Focus group 3)

With talking [offline], there is a fluidity to it and more flexibility when you're verbally talking to someone. When you're online, before I send anything I make sure I double-read it. I go over it again because [even the placement of] a comma might be important. (Focus group 3)

In lieu of the fluidity and flexibility of verbal communication, *Netreach* workers relied on written skills to convey both information *and* empathy. This involved a substantial amount of labour and *Netreach* workers were regularly observed drafting, editing, checking and (re)framing their responses to client questions, before posting them online. Additionally, workers were observed developing responses that sought to open up, rather than close down conversations (see below). As one worker explained, 'you're always looking for that bigger intervention'.

It appears then that the filtered embodiment required of digital outreach work supports a greater degree of self-disclosure among target populations, whilst simultaneously posing a challenge for workers when responding to this increased level of self-disclosure. Such filtering also shifted worker perceptions of their own expertise and skill, where a lack of emplacement reduced the repertoire of communication tools available during interventions. This inevitably impacted on the ways in which client and worker interacted around the information sought and given.

Mediated expertise

Beyond the lack of non-verbal cues and resources, the mediated experience of digital outreach also appears to alter the relationship between workers, their clients and the information sought and given. To begin with, the increased level of disclosure means that health workers feel they require more in-depth knowledge of sexual health information during *NetReach*:

The only thing I would say for online is that I think you actually probably need, because of the length and the breadth and the depth of all these interventions online, I think you have to possibly need even more knowledge and more skills. (Focus group 3)

Beyond this concern, however, the research also identifies a shift in the ways in which clients approach workers and communicate with them during interventions. Several research participants noted this during the ethnographic research. Whereas physical interactions most commonly took the form of a conversation, online, workers felt that clients approached them as if they were a search engine or an information portal, rather than a peer educator. Of most concern (for the workers) was the belief that, online, clients seemed to want 'simple' answers to their questions more often and could become agitated or frustrated when such an answer could not be given. The following quotations articulate some of the challenges workers face in this regard:

Quite often in this world [the digital environments used for *Netreach*] people want black and white answers. There's no such thing as a black and white answer when it comes to risk. And people have to understand that. And that's when people get irate, particularly if they're waiting⁴ as well. (Focus group 3)

And that's what some people want as well. They don't want to read through all the bumf, they just want to know 'ok is this gonna kill me? Should I get tested?' (Focus group 1)

I find it easier to articulate the grey areas offline [. . .] Because quite often that one question they have, I have got whole list of questions to ask back. So 'I had unprotected sex last night, what is the chances that I've got HIV?' Now, for [me to answer] that, there's a million different things you need to ask somebody. But they want a few characters in a message and then 'send'. (Focus group 3)

I think often the people who ask the same questions are, they've been googling it and they've wound themselves up into a google frenzy and then they've come to us as the people who are going to calm them down and tell them that, you know (Focus group 1)

These responses point to several interrelated issues that came to the fore during the research, regarding the relationship between clients, outreach workers and information. Firstly, the responses identify the increased pressure that workers perceive in needing to provide simple 'yes or no' answers to client questions when engaging in outreach work via digital platforms (something that, in practice, they actively resist doing).

Secondly, the responses highlight the information searching practices that clients appear to undertake prior to approaching the *Netreach* service. As one participant in a user focus group declared:

My online bible is always Google. I Google everything, so it is always whatever comes in the first page, ideally, whatever comes. (MSM Older focus group 3)

At the same time, however, the accuracy, relevance and motivations behind the provision of online resources was a concern to many participants of the user focus groups. Previous research into sourcing sexual health information online (Gray et al., 2005; Macmaster et al. 2003; Pedrana et al., 2013; Singh & Walsh, 2012;) has identified similar concerns and trying to find information online can be anxiety inducing:

- Googling your symptoms [. . .] it's the worst thing you could possibly [do].
- Why is it the worst thing?
- Because it nearly always comes back 'you've got cancer'. (Laughter)

(MSM focus group – pilot)

Echoing this sentiment, the third point to draw from the worker responses is that users face challenges when trying to access and interpret information they have sourced online (see also Cline and Haynes, 2001; Hesse et al., 2005; Lewis, 2006). The earlier reference to clients being in a 'google frenzy' is particularly relevant here. In such instances, outreach workers have to reduce anxiety whilst also explaining that the answer to their question is more complex than 'yes' or 'no'.

Invariably, the design of commercial platforms also impacts upon the interactions between the client and the outreach worker. Mobile applications such as *Grindr* and *Scruff* were considered by workers to be ideal contexts for *Netreach* work, but the architecture of the services (often built around a simple instant messenger format) and the style of communication engendered on the platform (short-form text messaging and image sharing) created challenges for the outreach team, who struggled to generate and maintain in-depth interventions on these mobile platforms.

In spite of platform limitations and client requests, *Netreach* workers strive to develop nuanced and ‘inviting’ responses to initial questions and requests for information. The point of this was summed up by one worker as follows:

You’re always aiming for that bigger intervention I suppose. So I think sometimes it’s keeping that conversation going. It’s asking those questions and while you’re having that conversation some of that other stuff gets teased out, you know ‘I’ve never been for an STI screen’ or ‘I don’t need to go’ you know and you can branch off from it. So I think that’s part of it, you know, trying to get something out of it. (Focus group 2)

Alongside the fact that there is quite often more than one correct answer to a client’s question then, ‘keeping the conversation going’ means that the specific circumstances and contexts in which an enquiry is being made can come to the fore and shape the outcome of the intervention. To frame this differently, sometimes, the client is seeking the ‘right answer’ to the ‘wrong question’, and only through an extended conversation can the outreach worker determine what the best course of action might be. At the same time, the client is often asking his question(s) on a platform that promotes short messaging styles and is not designed for extended discussions.

Finally, as the following quotation demonstrates, the client–worker–information relationship can take a negative turn online. Service users may well evaluate or challenge a worker’s response based on their own Internet research:

So for example if somebody asked a question about undetectable viral loads and transmission [. . .] and you can’t give a black or white answer so kind of, a website might say ‘this is the percentage, this is the statistic, this is the likelihood’ and then if you look at another website, it will say something similar but not exactly the same [. . .] So it’s kind of then phrasing that right so you don’t give any misleading or inaccurate information, which if you’re on a forum somebody might verbally deck you with and then you know that’s your reputation on that forum looking a bit rubbish. (Focus group 2)

Of course, outreach workers face these kinds of challenges in physical settings. However, *Netreach* workers feel that the visibility and ramifications of such confrontations increase in online settings, whilst their ability to deal with such challenges decreases. In part, this is due to the space in which the worker is operating in:

Like, when you’re in a bar, if you say something wrong, well not wrong, but like you say something that the punters don’t agree with or, so if you do that, you go home and you’re ‘Damnit! I screwed that up’. But online it is always there [interviewer: how is screwing up different online?]. Well, ‘cause in a forum, people are still there. They’re still the same people. It’s different people in the club, or they’ve forgotten. But online people don’t forget. They remember you and what you got wrong. (Oscar, ethnographic interview)

The public record of one’s ‘screw up’ was considered to be a major concern for *Netreach* workers. Whilst some professed to enjoying the anonymity that mediated outreach offered them, and many spoke of the ability to source information from a range of sources when working online, the impact of making an error, or being challenged (and perhaps not handling that challenge well), was of particular concern. Issues of embodiment and of a filtered co-presence come to the fore once more in such instances, serving to destabilize the expert’s sense of authority – and the capacity to handle challenges to that authority.

The role of social and cultural capital in community outreach

What does happen if you ‘screw up’ on *Netreach*? What are the consequences? How does a worker deal with being challenged online? The following ethnographic ‘vignette’ serves to highlight both the challenges and the opportunities available when undertaking community outreach work in digital contexts. (Figure 1)

Social capital can be defined as ‘the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition’ (Bourdieu, 1986: 249). Ellison et al. (2007: 1145), who have written extensively on the subject of social capital in social networking site (social networking working) contexts, suggest that the term ‘broadly refers to the resources accumulated through the relationships among people’. Of particular relevance here is the fact that social capital ‘provides each of its members with the backing of the collectively-owned capital, a “credential” which entitles them to credit, in the various senses of the word’ and that this set of relationships ‘are more or less really enacted and so maintained and reinforced, in exchanges’ (Bourdieu, 1986: 249). As Ellison et al. note, ‘[g]reater social capital increases commitment to a community and *the ability to mobilize collective actions*, among other benefits’ (2007: 1145, emphasis added). Synthesizing the variety of definitions of social capital, Portes declares that social capital should be seen as ‘the ability to secure benefits through membership in networks and other social structures’ (1998: 6).

The role of social capital within public health contexts has been widely discussed (see Hawe and Shiell, 2000; Lomas, 1998; Wakefield and Poland, 2005). In most cases, the focus has been on the development of social capital by service users (offline). However, in the vignette on the opposite page, it was Fabian, the outreach worker, who drew upon his accrued social capital in order to ‘rescue’ the planned intervention and transform it into something useful. He utilized his long-established ties with this community to draw upon a set of resources (discursive forms familiar within the community) to align himself with the membership. He positioned himself carefully in relation to other members, praising significant examples of creative and witty posts.

Fabian’s success in managing this intervention can be measured by the overwhelmingly positive response that he received from the same community during a future intervention. In this sense, the social capital that Fabian had generated for himself (as the THT *Netreach* worker) on the site, allowed him to ‘mobilize collective actions’ that supported the sexual health of the community.

Social capital was considered to be integral to *Netreach* and often workers framed the acquisition of social capital to issues of ‘platform literacy’.

I think people [[workers]] should be using it [[an intervention site]] for its means, even if they’re not using to pick up and have sex because of their relationship arrangements or their personal preference, they should be using it to engage with people, and they should for at least a week if not two. Have a profile, be given a photo if they’ve not got one, and actually use it to chat and send photos and understand how it works. (Focus group 1)

This need to understand and become literate in the social dimension of MSM platforms was regularly discussed by workers, though it wasn’t felt to be easy to achieve:

Like say if you sat there on *Grindr* and you just looked at the profiles, you’d have a very, you could be forgiven for thinking that . . . if you talked to someone who’d never used *Grindr* before and said ‘you know, have a look on *Grindr* and see what’s going on’ and they had a work profile and they were just looking around – that sort of thing – you wouldn’t necessarily know how much sex takes place or how sexualised a lot of the conversations are. (Focus group 2)



Success Through Failure: Maintaining Social Capital Online.

Fabian was working on a gay men's community site and posted new health promotion campaign poster (see figure one) to the site's discussion forum. A discussion thread rapidly developed, criticising the poster in arch and witty ways, a discursive style that is common in this community. Fabian was distraught. His well-meaning post was being ripped to shreds and, with it, his standing in the community.

What to do?

Having worked extensively on the site in question, Fabian knew that if he attempted to 'educate' the users by explaining the importance of the campaign, he would be laughed off of the site. At the same time, ignoring the burgeoning discussion would similarly

lose him credibility. As Fabian watched the discussion unfold it became evident that users were appropriating the poster as a 'communal object': something around which they could bond. The poster became an object through which to 'do' community building. It acted as a resource for establishing, building and demonstrating (sub) cultural capital, but it also served to strengthen ties within the social network. In doing so, the community bestowed a degree of cultural capital on Fabian, for bringing this object into the community and strengthened his ties to the network, increasing his social capital. The campaign poster thus allowed Fabian to strengthen relationships amongst this community.

Of course, Fabian had to tread a careful line in order to achieve this (previously unforeseen) objective. He could not, himself, attack the campaign: to do so would have crossed professional boundaries and contradicted this prominent health initiative. At the same time, if he defended the campaign poster he would have faced ridicule. Instead, Fabian carefully distanced himself from the campaign without encouraging criticism. He did so by adopting a self-deprecating and mildly selfmocking tone in his forum responses. He then 'joined in the banter' and made witty references to other users and their contributions, providing positive feedback on their 'critiques' while avoiding the subject of the critique. The result? Fabian not only recovered from a potentially damaging incident, he managed to translate a 'generic' health promotion advertisement into a resource for building a relationship with the users of this community, on their terms. When it came to running a more localized campaign (postal HIV testing kits) within this community, the cultural and social capital that Fabian had garnered paid dividends and the response from the community was positive.

Figure 1. Public health England's 'It starts with me' campaign poster.

The ethnographic research provided further evidence of this challenge. During one observation period, a volunteer who had never used sites such as *Gaydar* or services such as *Grindr*, joined the outreach team. Whilst their knowledge of health promotion messaging was excellent, their lack of ‘platform literacy’ made it near impossible for them to undertake *Netreach* work without further training. Having never accessed MSM dating and sex sites before, the volunteer struggled to navigate their way through conversations, to understand what was being said and how to immerse themselves within that community. As Fabian commented, when reflecting on the intervention ‘faux pas’ documented above:

... striking that language, understanding that culture and saying the right things. Trying to be funny in the right way and likeable and knowledgeable and part of that community. And keeping in mind that you’re building an online image of yourself that will dictate interventions you have over time. That is what you need, it’s really important. (Fabian, focus group interview)

Conclusion: Rearticulating understandings of expertise in digital community outreach

being seen as a ‘peer’ is important on the barebacking sites. Being seen to be empathetic and understanding is really important. (Ethnographic interview)

Digital expertise according to Bassett et al (2013: 20) is different from digital literacy. It produces new questions and ways of thinking about digital tools. Whilst digital literacy is simply awareness and having the access to digital resources which can be applied towards communication and construction of new knowledge, expertise ‘requires investment and work to reach a specific level of ability to operate in relation to a defined field’ (Bassett et al, 2013: 22). Community outreach relies upon embodied and emplaced expertise being deployed in spaces where potential users of a service congregate for sexual and social purposes. However, the reception and appraisal of such expertise relies upon the development of social capital in various environments including the digital by the community outreach worker and, by extension, the organization that they represent. The research that this article draws from provides for an exploration of how understandings of outreach expertise shift when peer outreach work moves into digital contexts.

On the one hand, digital outreach provides a different form of co-presence, a ‘filtered embodiment’, which allows service users to feel more comfortable in discussing intimate and non-normative behaviours with a health worker. This allows for an efficient and targeted deployment of expertise within the field, providing health workers with an opportunity to shape interventions that more accurately match the needs of the client. However, the challenges posed by the same sense of ‘filtered’ embodiment means that outreach workers require additional training in developing, maintaining and broadening out client interventions.

Digital outreach serves to destabilize notions of outreach expertise, opening the health worker up to more intense scrutiny and requires far more of outreach workers in terms of both knowledge and social capital in order to work effectively and maintain an appropriate – and valid – role within a given online space. Bassett has suggested that computing design has ‘long followed a path designed to lead to increasing ‘invisibility’ in its use’ (2013: 212) and that with it digital expertise (operating the visible software/machinery) has somewhat problematically become seen as something ‘anyone can do’ (2013: 212). This research not only challenges notions of outreach expertise but also underlines the more hidden elements of digital expertise required by outreach workers in

this environment. The opportunities that digital platforms have afforded for challenging or otherwise augmenting the authority of health experts has been well documented (see Ahmad et al., 2006; Broom, 2005; Hardey, 1999; McMullan, 2006). This article contributes to the existing body of knowledge by identifying how peer experts, employed in community outreach programmes must increasingly negotiate ‘information-rich’ environments, where users are far from passive observers and can in fact respond with their own information-sourcing activities, positioning themselves as (at best) complimenting and extending the service offered by the expert and (at worst) challenging the wisdom, expertise and experience of the worker. Such a ‘precarious’ environment of engagement requires new digital literacy skills and expertise (social, technological and cultural) of health workers in order that they maintain a ‘performance’ of expertise and authority without alienating potential users or disrupting the environment in which they are working.

Notes

1. Perhaps the best example of this investment is the Government Digital Service initiative which seeks to ‘be the unequivocal owner of high quality user experience between people and government by being the architect and the engine room of government digital service provision’ (GDS, n.p.).
2. MUDs (multi-user domains) and MOOs (multi-object-oriented spaces) were text-based gaming and virtual life environments that predated the arrival of spaces such as *Second Life* and *World of Warcraft*.
3. It is unsurprising that this HIV transmission question was used as an example here as it is one of the most common questions that workers get asked during outreach (whether online or offline). The question might be common, but the answer provides a useful illustration of the challenges that disembodied work poses for outreach workers. There *is* a theoretical risk of being infected with HIV via oral sex. However, there have *never* been any reliably reported cases of infection from oral sex. So there *is* a risk, but there isn’t *really* a risk . . . but there *is* a risk . . . but not *really* . . . it’s complicated. The risk is minimal but very difficult for outreach workers quantify.
4. The reference to ‘waiting’ here articulates the context in which this statement was made, namely, a conversation around managing several online conversations simultaneously. In such cases, a client might have to wait several minutes for an answer.

References

- Ahmad F, Hudak PL, Bercovitz K, et al (2006) Are physicians ready for patients with Internet-based health information? *Journal of Medical Internet Research* 8(3): e22.
- Aidsmap (2011) Annual UK HIV treatment and care costs could reach £750 million [online]. Available at: <http://www.aidsmap.com/Annual-UK-HIV-treatment-and-care-costs-could-reach-750-million-by-2013/page/1618137/> (accessed 5 August 2014).
- Bassett C (2013) Feminism, ‘expertise and the computational turn’. In: Thornham H and Weissmann E (eds) *Renewing Feminisms: Radical Narratives, Fantasies and Futures in Media Studies*. New York: I.B.Tauris, p. 213.
- Bassett C, Fotopoulou A, and Howland K (2013) Expertise: a scoping study. Available at: <http://www.communitiesandculture.org/files/2013/04/Sussex-scoping-report.pdf> (accessed 20 June 2014).
- Broom A (2005) Medical specialists’ accounts of the impact of the Internet on the doctor/patient relationship. *Health* 9(3): 319–338.
- Bourdieu P (1986) The forms of capital. In: Richardson J (ed) *Handbook of Theory and Research for the Sociology of Education*. New York: Greenwood, pp. 241–258.
- Campbell JE (2004) *Getting It On Online: Cyberspace, Gay Male Sexuality and Embodied Identity*. London: Harrington Park Press.

- Cline RJW and Haynes KM (2001) Consumer health information seeking on the Internet: the state of the art. *Health Education Research* 16(6): 671–692.
- Crossley M (2000) *Rethinking Health Psychology*. Buckingham: Open University Press.
- Davis M, Hart G, Bolding G, et al. (2006) Sex and the internet: Gay men, risk reduction and serostatus. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care* 8(2): 161–174.
- Dean T (2009) *Unlimited Intimacy: Reflections on The Subculture of Barebacking*. Chicago: University of Chicago Press.
- Department of Health (DoH) (2014) Guidance for commissioners of HIV, sexual and reproductive health services' [online]. Available at: <https://www.gov.uk/commissioning-regional-and-local-sexual-health-services> (accessed 4 August 2014).
- Digital Life Sciences (2013) Exciting new business to lead digital healthcare transformation [online]. Available at: <http://www.digitallifesciences.co.uk/exciting-new-business-to-lead-digital-healthcare-transformation/> (accessed 5 August 2014).
- Ellison N, Steinfield C, and Lampe C (2007) The benefits of facebook 'friends': social capital and college students' use of online social network sites. *Computer-Mediated Communication* 12(4): 1143–1168.
- Evans R and Stoddart G (1994) Producing health, consuming healthcare. In: Evans R, Barer M, and Marmor T (eds) *Why are Some People Healthy and Others Not?* New York: Walter de Gruyter.
- Government Digital Service (GDS) (2014) About the government digital service. Available at: <https://gds.blog.gov.uk/about/> (accessed 5 August 2014).
- Gray NJ, Klein JD, Noyce PR, et al. (2005) Health information-seeking behaviour in adolescence: the place of the Internet. *Social Science & Medicine* 60(7): 1467–1478.
- Grov C, Agyemang L, Ventuneac A, et al. (2013) Navigating condom use and HIV status disclosure with partners met online: a qualitative pilot study with gay and bisexual men from craigslist.org. *AIDS Education and Prevention* 25(1): 72–85.
- Haraway D (2000) A cyborg manifesto: science, technology and socialist-feminism in the late twentieth century. In: Bell D and Kennedy BM (eds) *The Cybercultures Reader*. London: Routledge, pp. 291–324.
- Hardey M (1999) Doctor in the house: the Internet as a source of lay health knowledge and the challenge to expertise. *Sociology of Health & Illness* 21(6): 820–835.
- Hawe P and Shiell A (2000) Social capital and health promotion: a review. *Social Science & Medicine* 51(6): 871–885.
- Hesse GW, Nelson DE, Kreps GL, et al. (2005) The impact of the Internet and its implications for health care providers: findings from the first health information national trends survey. *Archives of Internal Medicine* 165: 2618–2624.
- Kendall L (2002) *Hanging Out In The Virtual Pub: Masculinities and Relationships Online*. London: University of California Press.
- Kojima D (2014) Migrant intimacies: mobilities-in-difference and basue tactics in queer asian diasporas. *Anthropologica* 56(1): 33–44.
- Lewis T (2006) Seeking health information on the Internet: lifestyle choice or bad attack of cyberchondria? *Media, Culture & Society* 28(4): 521–539.
- Liau A, Millet G, and Marks G (2006) Meta-analytic examination of online sex-seeking and sexual risk behavior among men who have sex with men. *Sexually Transmitted Diseases* 33(9): 576–584.
- Lomas J (1998) Social capital and health: implications for public health and epidemiology'. *Journal of Social Science & Medicine* 47(9): 1181–1188.
- Macmaster S, Aquino R, and Vail K (2003) Providing HIV education and outreach via internet chat rooms to men who have sex with men. *Journal of Human Behavior in the Social Environment* 8(2–3): 145–151.
- Macrae S (1997) Flesh made word: sex text and the virtual body. In: Porter D (ed) *Internet Culture*. London: Routledge, pp. 73–86.

- McGlotten S (2013) *Virtual Intimacies: Media, Affect, and Queer Sociality*. New York: SUNY Press.
- McLelland M (2000) *Male Homosexuality in Modern Japan: Cultural Myths and Social Realities*. Surrey: Curzon Press.
- McMullan M (2006) Patients using the Internet to obtain health information: how this affects the patient–health professional relationship. *Patient education and counseling* 63(1): 24–28.
- Mowlabocus S (2010) *Gaydar Culture: Gay Men, Technology and Embodiement in the Digital Age*. London: Ashgate.
- Pedrana A, Hellard M, Gold J, et al. (2013) Queer as F**k: reaching and engaging gay men in sexual health promotion through social networking sites. *Journal of Medical Internet Research* 15(2): e25.
- Portes A (1998) Social capital: its origins and applications in modern sociology. *Annual Review of Sociology* 24: 1–24.
- Race K (2010) Click here for HIV status: shifting templates of sexual negotiation. *Emotion, Space and Society* 3(1): 7–14.
- Rheingold H (1993) *Virtual Community: Finding Connection in a Computerized World*. London: Minerva Press.
- Rosenfeld MJ and Thomas RJ (2012) Searching for a mate: the rise of the internet as a social intermediary. *American Sociological Review* 77(4): 523–547.
- Rosser BR, Wilkerson JM, Smolenski DJ, et al. (2011) The future of internet-based HIV prevention: a report on key findings from the men’s internet (MINTS-I, II) sex studies. *AIDS and Behavior* 15(1): 91–100.
- Singh G and Walsh CS (2012) Prevention is a solution: building the HIVe. *Digital Culture & Education* 4(1): 5–17.
- SSHA (2004) The manual for sexual health advisors [online]. Available at: http://www.ssha.info/wp-content/uploads/ha_manual_2004_complete.pdf (accessed 4 August 2014).
- Stone AR (1998) *The War of Desire and Technology at the Close of the Mechanical Age*. Cambridge, Mass: MIT Press.
- Tsang DC (1996). Notes on queer’n’asian virtual sex. In: Morton D (ed) *The Material Queer: LesBiGay Cultural Studies Reader*. Colorado: Westview Press, pp. 310–316.
- Turkle S 1998 [1995] *Life On The Screen: Identity in the Age of the Internet*. Cambridge, Mass: Simon and Schuster.
- Wakefield S and Poland B (2005) ‘Family, friend or foe? critical reflections on the relevance and role of social capital in health promotion and community development. *Social Science & Medicine* 60(12): 2819–2832.
- World Health Organisation (WHO) (n.d.) Health topics: health promotion [online]. Available at: http://www.who.int/topics/health_promotion/en/ (accessed 4 August 2014).
- Ybarra ML and Bull SS (2007) Current trends in Internet- and cellphone-based HIV prevention and intervention programmes. *Current HIV/AIDS Reports* 4: 201–207.

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Justin Harbottle is a programme officer for HIV Prevention England at the Terrence Higgins Trust. He leads on sexual health and HIV prevention services for men who have sex with men and has previously introduced new types of online outreach and used social media platforms to expand the charities health promotion work.

Previous research has focused on the use of pornography, depicting unprotected anal intercourse by MSM, and he is currently undertaking a research project with the European Centre of Disease Prevention and Control to gain a better understanding of the use of smartphone applications on MSM's sexual health across Europe.

Ben Tooke is a senior community engagement officer at Terrence Higgins Trust South. He coordinates the Informed Passions project that addresses the high prevalence on HIV among men who have sex with men (MSM) in Brighton and Hove, with a particular focus on online health promotion and chem-sex. He works with a number of local groups, including people living with HIV and Trans* communities. He also works in partnership with the NHS on delivering their specialist MSM sexual health clinic.

Craig Haslop is a lecturer of media and public relations in Brunel University. His research focuses on qualitative research method and audience studies with a particular interest in queer media representations and consumption, cult television and science fiction television. Prior to joining Brunel, he was an associate tutor at the University of Sussex in media and cultural studies.

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