Using New Media Cultures to Provide Sexual Health Information for Young People
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“Facebook is part of everyday life now”

“I don’t think there’s any ultimate number one way. I think you’d have to have a combination of things”

“Not just facts because that’s boring”
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# Glossary of terms

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<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>App</strong></td>
<td>An abbreviation for application, an ‘app’ is typically downloaded to a phone, or used on a website. Apps can range from games to ways to read online newspapers.</td>
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<tr>
<td><strong>Blog</strong></td>
<td>A blog is a website updated by individuals or groups with writing, video, links, etc. It can be highly personal in the style of a journal, or it can be themed around a topic and provoking discussion. Blogs typically allow and invite comments from readers.</td>
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<tr>
<td><strong>Facebook</strong></td>
<td><em>Facebook</em> is a free social networking site that allows users to create a profile, on which they can post updates, share links to news stories, use applications, and interact with other peoples’ profiles, and those of organisations.</td>
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<tr>
<td><strong>Flickr</strong></td>
<td><em>Flickr</em> is a photo-sharing site. Users have a profile through which they can share their photos with friends, but <em>Flickr</em> also encourages communities based on themes or interests. Photos are ‘tagged’ so that searching for a photo of an object or a type of object becomes easier.</td>
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<tr>
<td><strong>ICTs</strong></td>
<td>Internet and Communication Technologies including multimedia and interactive aspects of online communication.</td>
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<tr>
<td><strong>Platforms</strong></td>
<td>Platforms are the architecture of an application. Internet platforms refer to software applications being built on the Internet, as opposed to on the desktop.</td>
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<td><strong>RSS feeds</strong></td>
<td>RSS Feeds (previously termed RDF Site Summary) are user-generated systems in which updates to selected blogs and websites are immediately forwarded to a user’s RSS reader, generating a log of all updates as they occur.</td>
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<tr>
<td><strong>Smart Phone</strong></td>
<td>A smart phone generally indicates a mobile phone with added capabilities, for example an iPhone or a Blackberry, which allows the user to download apps and access the Internet.</td>
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<tr>
<td><strong>Twitter</strong></td>
<td><em>Twitter</em> is a ‘micro-blogging’ service (that is not only used on <em>Twitter</em>’s website but through applications and mobile use) that allows a user to post a 140 character update. <em>Twitter</em> is also used to ‘follow’ other users, resulting in a constant stream of information and updates.</td>
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<tr>
<td><strong>Troll</strong></td>
<td>This term describes anonymous participants who deliberately post challenging, argumentative or inflammatory material in online environments, such as <em>YouTube</em> comment pages or <em>Facebook</em> sites. The term is used as both a noun and a verb ie ‘There’s a lot of trolling on that site’.</td>
</tr>
<tr>
<td><strong>User generated content</strong></td>
<td>Refers to instances of a user of an Internet site or service creating their own response, writing, video, photograph and so on. A wiki is user-generated, for example.</td>
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<tr>
<td><strong>Web 2.0</strong></td>
<td>Commonly refers to the second generation of the Web,</td>
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with an increased focus on interaction, sharing content, social networking, and a change in the behaviours of how people use the Internet. Users need no specific technical knowledge to interact and share.

<table>
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<tr>
<th><strong>Widget:</strong></th>
<th>A widget is a small application (or app) that can be downloaded or used while embedded on a website.</th>
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<tbody>
<tr>
<td>** Wikis:**</td>
<td>A wiki refers to a type of website that allows any user to edit or create pages. Wikipedia is an example of this, but wikis are also used in educational institutions and in communities.</td>
</tr>
<tr>
<td>** YouTube:**</td>
<td><em>YouTube</em> is a video sharing site which involves users uploading videos which range in content from professional or informational videos, to personal diary entries. Viewers can comment on videos and share them on web pages or social networking sites.</td>
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1. Executive summary

This project highlights the cautions and possibilities of using social media and social networking services (SNS) for the promotion of sexual health among young people. A primary caution is the need to tie social media and mobile technology sexual health campaigns into the broader sexual cultures of young people. Young people’s online and offline worlds are mutually constituted and should not be treated as different or opposing spaces, yet these spaces offer new ways to promote sexual health. Online and SNS sexual health campaigns cannot substitute for access to culturally appropriate ‘real world’ services, but can support these (and vice versa). SNS and social media are viewed by young people as personal and private, and therefore should not be infiltrated by health promoters without negotiating with users of these spaces.

We suggest that sexual health practitioners and agencies can embrace and use the participatory nature, peer-learning, immediacy, creativity and speed that social media and SNS enables, and that young people enjoy about this new media. Sexual health campaigns involving a one-way flow of information on policies, treatment, consequences and advice are less likely to connect with young people than approaches that involve input from, and dialogue with, social media users.

An extensive literature review is provided, looking at various literature and studies that address issues around social media, mobile technologies, young people, and sexual health. This literature is interdisciplinary, emergent, and thus still progressing in various fields such as cultural studies, health psychologies, youth studies, and STS (science, technology and society) studies. The literature review was used to inform subsequent fieldwork involving young people.

Fieldwork involved four initial focus groups with young people from Sydney (Parramatta) and regional NSW (Wagga Wagga), in groups aged 16-17 and 18-22. From discussion generated here, two follow up workshops were conducted. In these, returning participants were asked to map out social media campaigns for young people which addressed the issue of sexual health. These built upon
preview focus group discussions, and inform many of the recommendations herein. Key findings from this research are as follows.

- Young people have a digital life across a number of mediums, including television, Internet, and mobile phones.

- Young people carefully manage their digital profile. The dominant and preferred social media platforms are Facebook and YouTube, and other platforms were much less significant.

- There was little mention of Twitter in any group, and MySpace was seen to be outmoded (superseded by Facebook).

- Any digital medium and content should be simple, easy to use, and low-tech, as many of the young people’s phones do not support high-tech websites e.g. Adobe Flash software.

- Young people like humour as a communication method, though also appreciate information that is more serious.

- Some participants noted a gender inequality in sexual health campaigns in which young females are targeted more than males, and felt that this should be redressed.

- There is low uniformity of types of mobile phones and how they are used among participants. With mobile phones, text messaging is the preferred method of communication as it is more cost effective.

- There is low trust in online health information in general. However information that originates from official bodies such as the Government, universities, or health organisations is considered trustworthy.

- Facebook was considered the most common social media used among participants, and one that was accessed (though in different ways) via
computers and mobile phones. **YouTube** was also considered to be fairly ubiquitous, and somewhat indivisible from Facebook.

- A common concern revolved around the maintenance of **privacy and confidentiality**, particularly among under-18s, who regarded online and phone communications as potentially disruptive of privacy, and sites prone to **bullying**.

- All groups were concerned by the **stigma** attached to seeking information regarding sexual health, though humour was seen as a useful strategy for minimising risk in this respect. (Note: Participants rarely used the term stigma, but referred to a need for secrecy/privacy, as well as a fear of exposure when searching for health information online).

Participants suggested many creative and practical ideas for campaigns that engage with social media, but also gave warning about the difficulties of these spaces where users have multiple agendas, and where various patterns of information seeking are in place and should be considered in the development of such campaigns. From these findings, we make the following recommendations.

**Recommendations**

- Online or mobile resources for sexual health promotion should contain mix of humourous/parodic and serious/factual content. Scare campaigns are likely to add to existing stigma around sexual health issues.

  Options suggested by our research include:

  - A text messaging service / hotline (with sign up and opt out function) with a coordinated media campaign across using various forms of media to promote the opt-in service.
• A combination of strategies utilising Facebook: including Facebook ads, and Facebook page linked to a central website from a credible source such as government, university

• A stand-alone ‘.gov’ resource website with Q&A forum in the style of “Dolly Doctor”

• A series of dating and relationship scenarios/STI testing stories and tips that are fictionalised but ‘real’.

• A series of humorous or satirical YouTube clips, linked to ‘serious’ (.gov) information and advice.

• Online and mobile media campaigns linked to already established youth events, such as music and sport.

• Emphasis on privacy and confidentiality, particularly for under-18s. (Facebook ads were praised for providing confidentially in search histories).

Caveats:

• There is no need to get “too clever”, such as with apps and games as people will not use them due to the potential stigma associated with having the app or game on their phone. Further, many young people’s mobile phones still do not support such functions (that is, they do not have expensive smartphones)

• Any online or social media-based health promotion campaign must be well resourced, to allow for ongoing moderation of content, and evaluation.

• To this end, organisations utilising social media must provide adequate and ongoing training for staff, and implement a social media policy to ensure privacy and confidentiality is maintained for both staff and media users/consumers.
2. Objectives

The project objective was to provide

• an international literature review on young people (aged 16-22), innovation, social and mobile media, media cultures and the provision of sexual health information.

• a summary and analysis of new media cultures, innovation, health promotion and young people based on the research

• an evidence-based pilot strategy to engage young people in a social media and mobile phone sexual health information campaign

• a report with recommendations to inform NSW Health policy on the use of social and multimedia and mobile technologies to deliver sexual health messages to young people in NSW, and to receive feedback.
3. Background

Due to the rapid uptake of social media and mobile phones, the way in which information is created, shared and disseminated is changing dramatically. Media researchers emphasise online and mobile collaboration and sharing among users. What is most important to recognise is the fact that social media and mobile phones engender a strong participatory element.

Media cultures (that is, the environments in which media is used) contain elements of interpersonal communication (i.e. the ability to deliver individualised messages to one person at a time) and mass communication (i.e. the ability to deliver one message to many different people at one time) and to receive questions and feedback that can modify the communication and message to suit a diversity of contexts, situations and needs. Rather than a simple one-to-many model, communication patterns range from one-to-one, one-to-many, to a complex many-to-many-to-many model.

As media cultures change, young Australians are turning to these new media sources more frequently for health information. However, to date there is no clear and systematic evidence-based research on using social media and mobile phones to communicate sexual health information, encourage healthy sexual behaviour, address long-term public sexual health needs, and respond to urgent sexual health threats.

It is obvious that relentless connectivity to digital information and peers is changing the way in which sexual health information is created, shared, and disseminated, as well as the way in which sexual health information is sought, accessed, filtered and consumed. What is not clear, however, is how all of these changes impact young people’s information processing and what, if any, implications these changes may have on the creation of sexual health messaging and content development.

Research is needed to explore users’ motivations for accessing health information by way of social media and mobile phones. This would further
current understandings of how different, shifting, and adaptive media are not only accessed by young people, but how they are integrated into their everyday practices, including practices of health maintenance.

If health marketers are to effectively harness opportunities to deliver health messaging via social media and mobile phones, there needs to be a creation of evidence-based health content that is compatible with the available options and platforms. More content often means more informational clutter because other content providers will also be competing to deliver their messages via these channels. Moreover, this new media now affords friends, family, strangers and foes the ability to create, publish, and disseminate content. The more clutter, the greater the challenge for health marketers to make contact with their target audience.

It has become critical that health marketers become skilled as evidence-based (credibility and accuracy) brokers of information and attention getting strategies that may serve as gateways to young people. Not only do social media and mobile phones allow health marketers to deliver and create content via new media vehicles and cultures, it also allows young people to identify the mix of content that uniquely matches their own needs and interests. Content can be compiled from various sources, and then mixed, edited or ‘curated’ by media users to meet their specific needs.

Rather than seeing this as a barrier we see this complexity as an opportunity to help NSW Health keep health messages familiar and relevant. To fully capitalise on the advances and advantages of new media it is now necessary to move beyond simply re-purposing old information for distribution via digital channels. Through research, NSW Health can acquire and cultivate expertise in creating content that maximises the interactivity and the user input of social media and mobile phone options, as well as the interplay across complementary media.
4. Literature Review

The research for the literature review was undertaken by searching through internationally recognised research databases (Ingentaconnect, Taylor and Francis, Sage Online, the Australian Public Affairs Full Text, JSTOR, Proquest, Informaworld, Project Muse, Google Scholar, Medline, Communication and Media Complete, Web of Science). Searches included journals focused on public health, health communication, community health, education, sexual health, gender, sexuality, young people, media and communication, and cultural studies. The research team searched Australian government websites for details of current programs and media usage statistics, the team also searched professional research agency websites such as Nielsen Research. Research was conducted through major Australian university catalogues, and through concomitant research centres and institutes housed at these universities. Additional pre-press material was sourced at the pre-conference research meeting for the Sex::Tech Conference, hosted by Internet Sexuality Information Services (ISIS), Inc. in April 2011.

Several health providers have identified and mobilised social media and mobile technologies for personal health application in recent years (such as Google Health, Microsoft HealthVault, and Dossia) where, at the request of the patient, data is compiled from various sources and kept in a permanent database. Eysenbach (2008b) terms this ‘Medicine 2.0’: web-based services, apps and tools that are oriented towards care-givers, patients, researchers, healthcare professionals, and consumers to facilitate collaboration, openness, social networking and participation. Also emerging are creative uses of widgets and apps for the promotion of sexual health messages through peer-to-peer content sharing and interactivity (Levine 2009; Neergaard 2010). However, these remain at a pilot stage.

Social media and mobile technologies (such as mobile/cell phones/tablets) is a constantly evolving area for health promotion. It has been argued that social media and mobile technologies can help young people harness media for better health: from sticking to personal goals; following health initiatives; searching for
health information; sharing web links; researching healthy habits; disseminating resources, alerts and advice; and activating support groups (Eysenbach 2008a, 2008b; Levine 2009; Neergaard 2010).

Through social media and mobile technologies, health organisations can communicate instantly and directly with the public and the public with them. Key to the appeal of social media and mobile technologies is that they not only enable interpersonal communication and mass communication, but also allow ‘participatory communication’, that is, the ability to receive questions and feedback that can modify the message to suit a diversity of contexts, situations and needs. So rather than a simple one-to-many model, communication patterns can vary and allow a complex many-to-many-to-many model (Thackeray & Neiger 2009; Gold et al. 2010). Thus, social media and mobile technologies can enable health professionals to explore, listen and engage with the public over health issues, and not to simply disseminate health information (Gold et al. 2010).

Sheana Bull (2010) notes that technology-based health promotion programs (including health promotion via social media) can offer unique advantages that don’t exist in face-to-face or broadcast media campaigns. These include: increased reach (including the potential to reach disadvantaged, stigmatised or marginalised groups); standardised content; the ability to target specific groups according to ‘user profile’ (e.g. a Facebook based campaign could conceivably target only gay-identified males over 16 but under 20); interactivity (including gaming); privacy and autonomy (i.e. mobile phones offer personal, 24-hour access to information); portability; and potentially lower program costs (Bull 2010, pp. 4-9).

However, Bull also observes that there are issues regarding sampling and generalisability of health promotion research conducted online, given that “not all information discovered in online venues can be generalized to the real world” (Bull 2010, p. 12). For example, the online space may be a site where particular kinds of sex are discussed, but the descriptions of sexual activities may not be translated into embodied practice. Bull also warns of the potential for a
campaign launched in a specific social media platform to become obsolescent or irrelevant in a fast-moving technological environment (Bull 2010, pp. 12-16).

While individual decision-making is obviously a factor in health behaviours, Bull notes that mobile and online interactions take place within social networks, and that health promotion initiatives that encompass virtual communities and locations must take this into account (Bull 2010, p. 19). Technology-based sexual health promotion campaigns should be interconnected with other resources and information that engages with young people’s specific, localised sexual cultures (accounting for local understandings of stigma, pleasure, practices, ethics, and desires).

**Social Media**

Social media refers to websites or services that promote interaction and communication. It doesn’t refer directly to a type of technology or website, but the ways in which people communicate online, and the types of interaction facilitated by that technology. In social media, users and producers are involved in a dynamic communication process.

The term is commonly used to refer to social networking services (SNS) which enable users to create online profiles featuring information about themselves, and to create and share information with others (including videos, text, photographs, sound). Users are able to define a personal network and also demonstrate their relationship and connection to other people, communities and organisations. Social network services (SNS) have been defined as web-based services that allow individuals to (1) construct a public or semi-public profile within a bound system, (2) articulate a list of other users with whom they share a connection, and (3) view and traverse their list of connections and those made by others within the system. The nature and nomenclature of these connections may vary from site to site (boyd & Ellison 2007).
Examples of SNS include platforms such as Facebook, Linkedin, Twitter, and Bebo.

‘Social media’ is not restricted to SNS, but is a broad term that encompasses text messaging, interactive websites, message boards and forums, blogs, micro-blogging (Twitter), wikis, game-modding (fans modifying computer games), and video hosting sites (Livingstone & Brake 2010; Collin et al. 2010). YouTube (video), Vimeo (video), Flickr (photo-sharing), and Picasa (photo-sharing) are media sharing platforms and increasingly feature their own SNS services (boyd & Ellison 2008). This is an increasingly common result of the new media environment. Technologies and uses converge as companies pursue a competitive, innovative edge, and users request a broader array of participation, efficiencies and interactivity from the one service.

**Mobile Technologies & Social Media**

Most social networking services have applications (apps) specifically designed for the mobile technologies they are hosted on and accessed through. Mobile technologies are increasingly integral to young people’s use of social media.

By the end of 2010 there was an estimated 5.3 billion mobile phone users worldwide, including 940 million subscriptions to Internet services (ITU 2010). Globally, mobile phone use is exponentially higher than the use of fixed landlines (In 2010, 76.1 out of every 100 persons had a mobile, in comparison to 17.1 per 100 persons who used a fixed landline) (ITU 2010).

In Australia 97% of young people aged 16-29 years old have a mobile phone, and the majority of these phones provide Internet access (Nielsen 2010a). With increased use of mobile devices comes increased opportunities for social connectedness (Bittman et al. 2009). Mobiles have led to a ‘geo-mobile web’, where a massive trove of information is logged to RSS feeds, web pages with comments, and social media sites (Crawford & Goggin 2009). Young Australians spend an average of 22 hours per week online (Nielsen 2010a).
Lefebvre (2009) describes mobile technology as an always-on, multi-directional communication channel. This makes them quite different to traditional one-way communication channels such as television or radio, which rely on a broadcast model, in which a ‘target audience’ in a fixed location (such as a living room) receives a fixed, unchangeable, pre-produced message at a specific time (ie an 8pm television program). Mobiles link individuals, and can offer a signal or cue for action, a resource of instant access to information (including health), a tool for social support and the development of social capital, a production tool, a way to engage audiences, and a data collection and feedback device (pp. 493-494).

Mobile phone use includes accessing the Internet for information, entertainment, updating SNS status and profiles, viewing others SNS profiles, email, shooting and editing photographs and videos, uploading and downloading content such as music and games, writing and pasting blog content, commenting on news and participating in online forums and communities, micro-blogging (e.g. Twitter), text messaging, and making phone calls (Collin et al. 2010; Lenhart et al. 2010).

The increased functionality of ‘smart’ mobile phones and broadband mobile Internet allows young people to connect with peers and source information at the bus stop, in the classroom, or anywhere with reception. This mobile media means that this generation regularly experiments with media platforms, communication, as well as sourcing and creating content, information and identity via these means. They are ‘always connected’ and thus have a demand for immediacy (Collin et al. 2010). Yet Bull warns that the benefits “mobile phones offer on terms of ‘always on’ or ubiquitous computing may be diminished by an inability to deliver sophisticated or detailed content [via SMS]” (Bull 2010, p. 218). This does not mean mobiles should be ruled out as tools for health promotion, as even short, simple messages can successfully be used as adjuncts for more sophisticated clinical or community-based programs (Bull 2010, p. 230).
Young People & Social Media

Young people are both consumers and producers of media, or what Axel Bruns (2009) has argued to be ‘produsers’. This concept refers to ‘user-led, collaborative processes of content creation’ (p. 3). This environment empowers young people with ‘new means of creating and sustaining connections with others’ (Collin et al. 2010).

Young people are particularly drawn to platforms they can ‘create with’. As well as using SNS, many young people: create personal profiles online; blog; build wikis; rip, mix and burn music; download and upload digitally altered images and film; build and modify computer games and websites; email; chat via instant message; SMS; and engage in forum discussions.

The interactive and creative nature of social media and SNS allows young people to play with their identity online. This often involves questioning and finding out about sexuality, cultural differences, ethnicity, class, and gender (Notley & Tacchi 2005). Many young people consider online spaces as safer for experimenting with identity. The safety can be found in anonymity, and in managing online spaces that are only accessible to people they trust. Young people can also find support and advice in relation to aspects of identity that offline may be seen as ‘strange’, ‘abnormal’, ‘other’, or ‘not appropriate’ and be met with scorn, derision, bullying, or even violence (Notley & Tacchi 2005). For example, young people who are same sex attracted are able to meet peers, learn from each other and create a sense of belonging online, when offline this may be risky (Hillier & Harrison 2007). “Free from adult regulation” they can articulate and express “various parts of their identity to their friends” and receive support from peers (Collin et al. 2010).

Young people learn and experiment through social media. There has been a significant uptake of social media for ‘e-learning’ (learning through online mediums) (Brennan 2003; Notley & Tacchi 2005). Mazer et al. (2007) argue that through e-learning, which includes SNS use, teachers and students have improved cooperation, engagement, rapport and motivation. Mobile technologies, SNS and Internet access have led to an increase in informal
(outside institutional settings such as schools) and peer-based learning as young people share, express themselves, develop technical skills and media literacy, and discuss and create content (Ito et al. 2008; Jenkins 2007). The informal and peer-based learning tends to be self-directed, and as such tends to focus on what young people are curious about or feel they don’t understand (relevancy) and is available when they feel they need it (convenience).

Studies have indicated that learning information from peers can often be more effective than learning from adults (Spiranovic et al. 2008; Walsh & Ward 2010; Donaldson 2009; Carmody 2009). Young people view their friends, or peers a few years older, as a credible source of information from whom they would like to learn (Pitts et al. 2003).

Importantly, young people use social media, mobile technologies and SNS to strengthen their interpersonal relationships, despite assumptions that such use alienates them from ‘real’ social relationships (Valentine & Holloway 2002; Gross 2004; Valkenburg et al. 2006). There has been concern about how SNS communities and relationships are not ‘real’ as they supposedly mark a move away from schools, clubs, neighbourhoods, and families as the definers of what we consider to be community (Collin et al. 2010). But Collin et al. argue that SNS communities and relationships extend, rather than diminish, these traditional places of community. It is now understood that young people experience ‘online’ and ‘offline’ social worlds as ‘mutually constituted’ (Holloway & Valentine 2003). By way of social media, SNS and mobile phone use, young people connect with others, debate, set up or dissolve alliances, make useful connections and cut off those that cease to be useful. Through social media young people negotiate their relationships, including intimate ones (boyd 2007).

**Sexual Health Information & Social Media**

Young people are generally reluctant to seek sexual health information for a variety of reasons including stigma, lack of interest, lack of services, cost or denial of risk (Sorenson & Brown 2007; Pitts et al. 2003; McQuire & Barber 2010; Janssen & Davis 2009). When information is actively sought face-to-face by young people, it is usually post-facto – after already engaging in risky sexual
behaviour (Sorenson & Brown 2007; Pitts et al. 2003). Pitts et al. (2003) argue that young people see the Internet as a valuable medium for disseminating simple and short messages, but the Internet is not favoured as a site for obtaining detailed sexual health information, other than by same-sex attracted and sex/gender diverse young people. Voluntary or inadvertent assumptions of sexual risk, coupled with an inability or unwillingness on the part of some young people to access professionals face-to-face, help underscore the need for implementing awareness and referral programs through cost effective, engaging and wide-reaching media forms (Spironovic et al. 2008, p. 52).

Online and mobile media not only take sexual health resources or services directly to young people, they also offer young people an opportunity to provide immediate feedback on the resource or service. The use of interactive media can assist service providers who wish to adopt youth participation models, and engage young people in the design, implementation and evaluation of their services (Levine 2009; Livingstone & Brake 2010; UNESCO 2006; Lefebvre 2009; Fjeldsoe et al. 2009; Eysenbach 2008a).

In focus groups conducted with young people in 2008, Judy Gold et al. (2010) found that text messages are an acceptable means of health promotion, particularly if messages are positive, relevant, short, and cover a variety of topics. Participants were more likely to remember and share messages that were funny, rhymed and/or tied into particular annual events. To be accepted and forwarded to friends, SMS health messages needed to be signed off by a credible organisation, informal and familiar in language, easily understood, well timed (e.g. before the weekend), and indirect so that the message doesn’t feel like an accusation that one already has a sexual health issue (Gold et al. 2010). The authors particularly highlight how SMS offers a “confidential and non-confrontational means of communication” given that sexual behaviours can be “socially sensitive”.

User-Generated Content (UGC), whereby users participate on websites (for instance software applications, videos, commentary, images, etc.) provides an interesting forum for sexual health promotion. For example, contests in poster design, video creation, song-writing or story-telling have been used to educate
and promote sexual health. An Australian example is the ‘In Brief’ campaign, launched by the Internet Sexuality Information Services (ISIS) for STD awareness month in 2008, where youth aged 16-24 years were asked to design a pair of underwear that displayed a safe sex message. There were over 500 entries, 650,000 engagements with the website through voting, views and reviews, and entries were shown on almost 700 different websites (Levine 2009).

Internationally, examples of mobile technology and social media sexual health intervention include SexINFO, Hookup and Vive-it. SexINFO is an opt-in service developed in response to rising gonorrhoea rates among young people, where a participant texts the word ‘sexinfo’ to a designated phone number, and subsequently receives a menu with codes instructing them to text for answers to commonly asked questions, such as ‘what to do if ur condom broke’, ‘if s/he’s cheating on you’ or ‘if ur not sure u want to have sex’. The service has recently been combined with Hookup, a service that participants may subscribe to that sends small amounts of information every week, and offers referral services to free clinics in the United States. Vive-it is an SMS based virtual coach that gives day-to-day motivational instructions and advice on topics of the user’s choosing, including exercise, medication, safe sex, and general wellbeing.

Interacting with young people online about sexual health also presents legal risks. Albury et al. (2010) discuss the legal implications of youth ‘sexting’ (generally regarded as sending images of themselves naked/semi-naked via mobile phones). According to Federal law, images of young people under the age of 18 can be considered child pornography. This may be the case even when the producers are otherwise over the age of consent, and they are producing images of their own body. Albury et al. observe that youth here are seen as both ‘victims and perpetrators’ of assault (2010, p. 4). While there is a possibility that educational material would be exempt from the Federal laws, any agency considering a social media campaign involving user-generated material should be mindful of the potential legal issues involved in self-representation. At time of writing, the Australian Law Reform Commission is reviewing the Classification System, and the authors encourage health promotion agencies to make submissions that raise concerns around the lack of safeguards for health workers
and educators within the current system. In the interim, it is recommended that all forums are moderated, and that young people are cautioned against posting sexually explicit images or written descriptions (such as ‘sex diaries’) online, or distributing them via mobile SNS.

**Cautions and Possibilities**

While in this review we have advocated what social media and mobile technologies can enable in regards to sexual health promotion it should be noted that such channels are also capable of going wrong where erroneous health information is widely and quickly disseminated. While there is a growing desire amongst health professionals for using social media, SNS and mobile technology for health promotion, and despite the pervasiveness of these in young people’s lives, some young people may feel that it is inappropriate and potentially dangerous to develop connections with health professionals and organisations or discuss sexual health matters via this new media.

Further research is still needed to explore how young people measure and build trust and intimacy by way of social media and mobile technology and how to make sure this is present (Livingstone 2008). Young people’s digital social profiles and mobile technologies can be highly personal and intimate and any uninitiated contact via these may be considered intrusive. It is worth noting that this new media affords friends, family, strangers and foes, who have access to such profiles and the technology, the ability to access and disseminate personal sexual health content that the young person may not agree to.

Concern has been expressed about ‘cyber-bullying’ (Besley 2008) and the possibility of private information becoming public, as well as the possibility of young people being sexually preyed upon online (Collin et al. 2010). Young people are aware of public vs. private concerns and the vast majority carefully manage their social media and SNS activity by being strict about their privacy settings, keeping their peers informed if privacy settings change or whether their information has become public, and reporting to online community moderators instances of ‘cyber-bullying’ (Livingstone 2008; boyd & Ellison 2007).
It has been argued that access to mobile technologies and social media is limited for disadvantaged young people, due to such factors as cost and lack of infrastructure in remote areas. Some Indigenous young people, those from low socio-economic backgrounds and those living in remote areas do face challenges in terms of Internet access and literacy (The Smith Family 2008). However, Blanchard et al. (2008) and Jenkins (2009) argue that although the quality of access varies, the perception of limited use of social media and mobile technologies by marginalised young people is over-stated. In remote areas young people can access supportive agencies and peer groups not available in their local area (Collin et al. 2010; Coleman & Rowe 2005; Hillier & Harrison 2007; Blanchard 2008; Stephens-Reicher et al. 2010). A 2007 ACMA study found that "there were no particular socio-economic or demographic barriers" to 8-17 year-olds accessing the Internet or mobile phones (ACMA 2007, p. 4). Ninety percent of all 15-17 year olds surveyed had at least one mobile phone; however, the study also found that young people from families in country areas were less likely to own a phone with advanced features (ACMA 2007).

Marginalised young people do use social media, SNS and mobile technologies.

There are also unique ethical issues arising from mediated health promotion projects. While young people provide an abundance of information in social network profiles that could be relevant for health promotion (such as details of sexual behaviour, drug or alcohol use), they do not always consider this information to be ‘public’, and may not welcome unsolicited contact from researchers or health promotion workers (Bull 2010, p. 38). Where health promotion activities coincide with research, it is vital that researchers take measures to protect the confidentiality of participants (such as encryption of data gathered) (Bull 2010, p. 38). Bull also cautions health promotion staff working with young people online, observing that transparency is essential, so that young people (and their parents/guardians) can give informed consent where this is required. Special effort should be made to ensure this information has been understood, in the absence of non-verbal cues and body language (for example, by asking follow-up questions that do not assume prior understanding) (Bull 2010, pp. 41-42, Bull et al. 2011).
A fundamental caution we have identified is the need to tie any social media and mobile technology sexual health campaigns into the broader sexual cultures of young people. Sexual cultures “include the many ways that sexual knowledge is constructed, how sexual values and norms are struggled over, how sex is depicted, talked about and ‘done’” (Attwood & Smith 2011, 237). This includes experiences of courtship, ethics, practices, fears, dangers, hopes, intimacy, sexual tastes, cultural expectations, gender and sexual diversity, and experimentation. Sexual health does not rank highly on many young people’s interest scale when it comes to sexual knowledge (Pitts et al. 2003, Boyars et al. 2011). As such, a broad-based cultural approach is required rather than an approach that narrowly defines sexual health in terms of reproduction and sexually transmissible infections (STI)s, but excludes issues relating to intimacy, safety, gender and power, and other aspects that influence young people’s capacity to make ‘good choices’.

The classic ‘media effects’ model suggests that the media influences people directly and uniformly by ‘injecting’ them with appropriate messages designed to trigger a desired response (Silverstone 2005). This model suggests a direct flow of information from the sender to the receiver, whereby messages are injected into a passively receptive audience. It was a favoured theory in the 20th century when print and broadcast (television and radio) media dominated. However, there has been a sustained critique of the media effects model and the idea of passive audiences, which is made more questionable by the participatory nature of new media (Gauntlett 2005; Ang 2001).

The media effects model does not account for the multiple factors that impact on audience ‘reception’ of media messages, and cannot account for the networked and mobile nature of mobile technologies, SNS and social media. When health professionals try to control the point of arrival or a desired future destination they run the risk of over-coding young people’s interests, thus alienating them, and so losing vision of the dynamic possibilities of new media, and more importantly, opportunities to connect with young people’s sexual lives.

A cultural approach demands an appreciation of how media use is not limited to a one-to-many model but a complex multi-directional process that is an integral
part of young people’s lives, and not an addition to it. Social media and mobile technologies are not simply an instrument or tool to use but a foundation upon which learning and inter-personal relationships are negotiated. The different digital technologies should not be viewed in isolation, but rather as interrelated communication technologies that facilitate and integrate young people’s cultural communities and activities (Jenkins 2009, p. 7).

A flexible approach to sexual health promotion via social media would enable sexual health campaigns to accommodate more peer group learning. Peer-to-peer sexual communication via social media and mobile technologies is an effective way to demonstrate to young people that they are trusted and that their way of learning is valid, but all the while supporting this with a networked resource that they can use to verify opinion, gather credible information, share information, and challenge misinformation being passed on.

**Conclusions and Implications**

Social media, SNS and mobile technologies will change the way in which sexual health information is created, shared, and disseminated, as well as the way in which sexual health information is sought, accessed, and consumed by young people. However, other than the small study by Gold et al. (2010), to date there is no large, clear and systematic evidence-based evaluation of using social media and mobile technologies to communicate sexual health information, encourage healthy sexual behaviour, address long-term public sexual health needs, and respond to urgent sexual health threats. At the time of writing, there are evaluations underway, assessing SNS-based health promotion projects in Australia and the United States (Boyar et al. 2011, Gold et al. 2011). However, there is no definitive answer to the question: do social media and mobile technology driven sexual health promotion programs actually work?

There is a risk of a ‘media effects’ bias to current campaigns that do not appreciate the participatory culture, engagement, peer-learning, immediacy, and speed that new media can enable. The education arm of health initiatives may favour messages that can be locked down or ‘signed off’ at Departmental level (such as posters or brochures), leading to one-way information provision to
young people. Unfortunately, this mode of communication is now more likely to read as out-of-touch and viewed as talking at young people rather than having a conversation with them. While they are not a panacea, social media-based, SNS-based and mobile technology-based sexual health campaigns can allow young people to share their voices and connect with sexual health discussions and practices in creative ways, and in ways that are convenient and relevant for them.
5. Methods

In the fieldwork that followed on from the literature review, the research team followed David Buckingham and Sara Bragg’s (2004) study of sex, sexuality, popular media and young people’s lives in the United Kingdom. Buckingham and Bragg stress the value of using in-depth focus groups with young people, which generate discussion between peers (Gauntlett 2007). Buckingham and Bragg emphasise discussing with young people the different socio-economic forces such as family history, education, sexuality, class, ethnicity, and gender and how they intermingle in young people’s use of media and its relation to sex. A broad definition of popular media is used in this research project to ensure the inclusion, not only of traditional print and broadcast media, but also of social networking sites and mobile technologies (so that comparisons can take place).

Our fieldwork comprised six focus groups conducted in NSW from March to July 2011, in which young people (aged 16-22) discussed their use of social media and mobile phones, as well as possible ways in which sexual health promotion campaigns could engage with young people via these technologies. Focus groups involved young people from both urban and rural settings and took place in two phases. Preliminary focus groups involved more participants and a broad-ranging discussion of social media uses and habits. Follow-up focus groups involved fewer (returning) participants, and a more specific workshop in which health promotion campaigns were proposed by group members.

**Phase One**

In the preliminary round of focus groups (March 2011), two groups were each conducted in Western Sydney (Parramatta) and regional NSW (Wagga Wagga). An external recruiter was employed to arrange six participants for each focus group, ensuring that the following criteria were met. Participants:

- must be aged 16-22 years
- must be current users of social media
- must currently live or study in Western Sydney or Wagga Wagga
- should be available for a follow-up focus group (approx 2 months later)
In each location, two groups were split by age: one for ages 16-17, and the other for ages 18-22. Genders were mixed, and the recruiter was asked to source an even split of males and females. It was felt by researchers that gender diversity could generate more discussion around gender difference and sameness in social media use and potential sexual health strategies.

Due to some non-attendance, a total of 22 participants took part. Following is a break up of their gender and location.

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The focus group discussion followed a question schedule (see Appendix) to ensure that each focus group explored the same key issues, yet there was room for discussion to expand beyond a specific line of questioning. In the first part where participants were asked about their use of online social media and mobile phones, and the second part focussed on how a sexual health campaign using social media would best engage with young people.

The focus group discussion was recorded and transcribed, and key themes that emerged were documented for analysis and to inform the Phase Two focus groups.

Given the available resources and the pilot goals of the project, this sample size does not yield results that can be generalised to a broader population. However, it provides data and analysis useful for the development of NSW Health campaigns.
Phase Two

In the follow up focus groups (July), one group each was conducted in Western Sydney (Parramatta) and regional NSW (Wagga Wagga).

Six participants (aged 16-22) were invited by the recruiter (again, a mix of ages and genders) to return for a focus group that would build on previous discussions. Due to the unavailability of all participants from Phase One, the external recruiter was asked to formulate groups of mixed age (16-22). Due to further non-attendance, only eight participants took part in these focus groups. Following is a break up of ages and genders.

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In these focus groups, suggestions and concerns from previous focus groups were highlighted and reviewed. A one-page document was given to each participant, which listed all ideas that arose in the first round focus groups, with a brief blurb accompanying each. The ideas are as follows:

1. Ads on Facebook
2. Facebook group
3. Online forum (eg. Formspring)
4. Anonymous Q & A service
5. YouTube videos
6. Games for mobile phones
7. Novelty song
8. Facebook Events
9. Ads on YouTube
10. Video making competition
11. Posters with SMS inquiry number
12. Anonymous phone line
This acted as a memory prompt but also gave insight into ideas from other groups. After the facilitator gave a brief overview of these ideas, a quick rundown of social media platforms was also given. Participants were then asked, in pairs or solo (depending on group numbers), to plan a sexual health campaign for young people that engages with social media. Each team was given a stack of word cards so they could more easily map their campaigns. Words included a range of platforms (e.g. Facebook, YouTube, Twitter), demographics (e.g. girls, boys, 16-17 years, 16-25 years), campaign features (e.g. online forum, Facebook event, real-life stories), sites (e.g. clinics, university), people (e.g. nurses/clinicians, youth peer educators), and styles (e.g. funny, serious, scary, sexy). Blank cards were also distributed so that participants could add their own words.

Participants were asked to imagine that their campaign message was around the promotion of condoms and sexual health check-ups.

From the two focus groups, six campaigns were designed. Each team/participant was asked to describe their campaign to the rest of the group which was followed by a general workshopping about the design, process, and feasibility of each campaign. If not already discussed, the group facilitator asked the following questions (based on concerns raised in the first round of focus groups).

- How will people’s privacy be protected in this campaign?
- Why do you think this style (humour, seriousness, etc.) will appeal to young people?
- What gives this campaign credibility?
- What makes this campaign appropriate for young people (or this particular age group)?
- Is this campaign appropriate for people of different genders, sexualities and cultural backgrounds?

This generated further discussion amongst participants about various limitations and potentials of social media campaigns and how they might best engage with young people around sexual health issues.
6. Findings and Discussion

Summary of findings from focus groups

- Young people have a digital life across a number of mediums, including television, Internet, and mobile phones.
- Young people carefully manage their digital profile. The dominant and preferred social media platforms are Facebook and YouTube, and other platforms were much less significant.
- There was little mention of Twitter in any group, and MySpace was seen to be outmoded (superseded by Facebook).
- Any digital medium and content should be simple, easy to use, and low-tech, as many of the young people’s phones do not support high-tech websites e.g. Adobe Flash software.
- Young people like humour as a communication method, though also appreciate information that is more serious.
- Some participants noted a gender inequality in sexual health campaigns in which young females are targeted more than males, and felt that this should be redressed.
- There is low uniformity of types of mobile phones and how they are used among participants. With mobile phones, text messaging is the preferred method of communication as it is more cost effective.
- There is low trust in online health information, particularly if it is not coming from official bodies such as the Government, universities, or health organisations.
- Facebook was considered the most common social media used among participants, and one that was accessed (though in different ways) via computers and mobile phones. YouTube was also considered to be fairly ubiquitous, and somewhat indivisible from Facebook.
- A common concern revolved around the maintenance of privacy and confidentiality, particularly among under-18s, who regarded online and phone communications as potentially disruptive of privacy, and sites prone to bullying.
- All groups were concerned by the stigma attached to seeking information regarding sexual health, though humour was seen as a useful strategy for minimising risk in this respect. (Note: Participants rarely used the term
In all, participants suggested many ideas for potential campaigns that engage with social media, but also gave much warning about the difficulties of these spaces where users have multiple agendas, and where various patterns of information seeking are in place and should be considered in the development of health campaigns seeking to engage in social media.

**Privacy and confidentiality**

The issue of privacy was raised several times in focus groups, signalling that many participants do not expect privacy to be maintained in much communication that occurs online or via mobile phones. Some participants expressed that they would think twice about visiting sexual health websites, or using a search engine to find sexual health information, as evidence of this may be left in a computer’s search history. On this basis, a Facebook ad (which appears on the side bar), is thought to be a more useful way of getting to such information, as seen in this discussion from the rural 16-17 year group:

Male: ...you wouldn't thought you'd be found out if you just clicked on it through a Facebook thing. No one's going to go on a search engine and see that you've looked up herpes or Chlamydia, or something.

Female 1: Yeah.

Female 2: If I was going to look that up, that's what I'd be afraid of. So if you did it through Facebook you could be, like, oh, yeah, I just clicked on a link...

Here, ads on Facebook offer ‘plausible deniability’ of the young person’s intention to visit a sexual health website. That someone can just accidentally click an ad offers the security in not being found out as seeking this information, and therefore being implicated as potentially having an STI.
As privacy and confidentiality are not usually expected on Facebook or mobile phones, participants carefully manage their profiles and what they do and don’t access. They are very protective of such spaces.

“Regarding your health and somebody finds out or they tell someone it can spread like wildfire” (Rural, Male, 16-17)

When they are not so protective of these spaces (some younger participants spoke of sharing Facebook passwords with friends or parents), they are certainly careful about what personal information is shared in these spaces, and how it is shared. For this reason, peer dissemination of sexual health information via these platforms was thought to be most unlikely among participants.

“I only say stuff on there that I would say to everyone” (Rural, Female, 18-22)

**Gender**

Gender issues were raised in several focus groups, particularly among female participants who felt that they were more often targeted by sexual health messages which they considered unfair. One interviewee expressed annoyance at being made responsible, while boys were not.

“I just feel kind of angry that the females are getting bombarded like we have to take control of it and we have to control Chlamydia whereas the guys don’t have any information on it at all.” (Rural, Female, 18-22)

There was also some reflection on different styles of campaigns for young males and females, with some participants feeling that humour works better for males.

**Population and age diversity**

Most participants felt that any campaign should have broad appeal among young people from various ages, but that multi-faceted campaigns would ensure that many styles (e.g. humour as well as seriousness) and platforms will invite a
broader ranging engagement with young people, accommodating different ages, genders, and tastes.

In devising their sexual health campaigns many involved different strategies for different age groups, recognising that a 16 year old and 22 year old would likely be drawn to different media and messages. Yet there was much contradiction on how to approach different age groups.

“The scary and serious stuff is... aimed at like the school age because that’s when they need to get scared the most” (Rural, Male, 16-17)

“I have got scary for all age groups but for the younger group is funny and serious” (Rural, Female, 18-22)

In most discussion, the target group was implicitly heterosexual; no suggestions were made to target non-heterosexual groups differently. When asked about if campaigns need to target different cultural and sexual groups, most felt that this could be done in one campaign which had an array of materials and features.

“I think because Australia's so diverse, it would be hard to kind of reach, to do something for this demographic and that demographic.” (Urban, Female, 16-22)

Mobile phones

In the first round of focus groups, participants were asked to discuss their phones and what they use them for. Most showed their phone to the group while discussing it, and spoke about its various benefits and limitations. Not all participants had smart phones, and not all wanted them. Generally, the younger groups were more concerned about having phones with maximum capabilities. Some participants from the older groups spoke about the dangers (or experiences) of losing and breaking phones, and how they’ve now opted for cheaper and simpler phones that are less costly to replace and unlikely to be stolen.
Most people used **Facebook via their phone** (especially if the feature is built in) but only some used other Internet functions on their phone.

> “That’s how I do most of my Facebook [via mobile phone]” (Rural, Female, 18-22)

16-17 year olds in the rural area tended to have very basic features on their phones but desired high-tech phones. Some people indicated that their use of Facebook was differed when they used their phone as opposed to a computer. Due to slow speeds and limited capabilities, phone use of Facebook was more for browsing than socialising.

As well as issues with speed and cost, participants noted that some websites (such as Facebook) are more **suited to mobile phone** than others, and can be accessed with a wider variety of phones.

> “You can’t go to most websites” (Rural, Male, 18-22)

**Text is the preferred communication method via phones.** A text service is welcome but only if it can be **personal**, not just a fact sheet.

> “If it was just a mobile number and they had like a system where you could text them a question that you would be too embarrassed to go to the doctors to ask” (Rural, Female, 18-22)

It was noted that a phone number is easier to record than a website. The number can go straight into phone and is not descriptive like a website address.

Participants emphasized that any text messaging service must be a **sign up** system that has an **opt-out** feature

**Online**

Facebook was the most commonly discussed SNS. Most people no longer use MySpace (“it’s only for bands now”). Some people use Twitter but found it
uninteresting. There was frequent mention of YouTube. Other sites mentioned, but with low frequency, were Flickr, Formspring, Bebo, Tumblr, Skype, MSN, Wordpress, and Blogger.

Information seeking online is seemingly common outside of SNS platforms, with many participants mentioning the **Google search** as the most common access point to health information.

> “I just go straight to Google” (Urban, Male, 18-22)

Frequent mention of ‘Google searching’ indicates that health information seeking is typically done alone. It is also timely, with search engines providing immediate access to sought information. This may increase the unlikelihood of routine and scheduled sexual health consultations with clinicians, thereby highlighting a need for more reliable information to be available online, when required, and from trusted sources.

The Internet is not always trusted, and authorship of particular information is extremely important.

> “I don’t really get any of my health information off the Internet at all. I don’t know I just feel like I trust it less” (Rural, Male, 18-22)

Issues of trust and credibility are important considerations for young people in their online lives, as discussed later.

**Facebook**

All participants in the focus groups use Facebook regularly/daily, with only a few using it less often.

> “It's part of everyday life now” (Urban, Female, 18-22)
Facebook is a preferred platform because everyone is already there. Membership to Facebook is free, and some phones have Facebook built in, or freely available as part of a service provider plan. Facebook was discussed as an ideal medium.

“I think Facebook is the key to this rather than anything else. You just have it on Facebook then you can have your forum, you can have your notes, you can have your posts, you can have your video posts, your photos and it’s basically the centralised thing for all these different branches” (Urban, Male, 16-17)

Unprompted, each group came to discuss the benefits of Facebook ads as something likely to reach most people regardless of social and educational backgrounds. It was felt that it would be easy, quick, and discrete to click on an ad link, rather than seeking sexual health information via search engines or other means. Yet many participants also stated that they themselves were unlikely to visit ads placed on Facebook.

“I never click on the ads” (Urban, Male, 18-22)

Though some participants felt that if it was catchy and interesting enough they might click on such ads.

Many felt that Facebook ads would be preferred to Facebook apps, as the use of an app tends to appear on the user’s wall or newsfeed. This is of concern to participants who acknowledge the stigma around sexual health, and felt that joining, or even ‘liking’ such groups/pages could cause peers to think that they have an STI. Yet there was some discussion about the potential humour aspects of ‘liking’ STIs.

Despite frequent discussion about Facebook as not being a private space, and being fraught with potential for misreading (and therefore the unlikelihood of sharing sexual health information in this space), there was still discussion about the possible benefits of Facebook for a broader-than-Facebook sexual health campaign. As Facebook is considered ubiquitous, some participants felt that if information could be sourced there (securely and anonymously), this would be
useful to many young people.

“I think if you were a member of that on Facebook or something of a sexual information or there was a forum, you could be just on Facebook and you can just type in sexual information and up it comes, you go onto it, it has all these links, you just click one, it’s just there in front of you … lot easier than trying to find somewhere on Google, find a contact or email” (Urban, Male, 16-17)

Some people felt that a Facebook group would be useful, particularly one that was administered by a university or health body, as this would bring legitimacy. The potential for a Facebook event was discussed and it was felt that this could be tied into things such as a ‘Get tested day’, or ‘Sexual health week’. One group suggested the possibilities of mass Facebook status updates, yet some participants felt that these were becoming too common, so it would need to be something original and interesting in order to take off.

Other participants were less keen on the potential role of Facebook for sexual health campaigns, and some reflected on instances of interpersonal ‘drama’ or cyberbullying that they have witnessed or been involved in.

“I don’t really like the whole Facebook. There’s too many dramas on it.” (Rural, Female, 16-17)

The younger urban group recounted stories of cyberbullying, which included discussion of a Facebook group where high school students anonymously submit gossip about peers which is then be published anonymously. This discussion illustrates grave concerns about potential gossip and ‘drama’ (particularly for this age group), and how this concern moderates Facebook usage. Amidst these concerns, online identities are carefully managed and any potential for ‘drama’ or unfavourable speculation (such as personal affiliation with STIs) would be avoided. Therefore, a peer-to-peer online sexual health campaign is unlikely to work, particularly for younger groups.
**YouTube**

YouTube was also discussed as quite ubiquitous. It was stated that when online,

“if you’re on Facebook, you’re probably on YouTube as well” (Urban, Male, 18-22)

These sentiments were echoed in the younger urban group, where it was felt that Facebook and YouTube were seemingly indivisible.

“YouTube and Facebook are beginning to be more entwined because if you’re scrolling down your newsfeed you’ll see a few videos here and there that have been shared and that’s how I’ve gotten onto quite a few things.” (Urban, Male, 16-17)

It was also suggested that a **YouTube video** of young people asking questions and getting answers about sexual health could be useful, but that the video should be funny or satirical (despite ‘serious’ content). Given that YouTube clips that are shared on Facebook are ‘public’, humour was seen by participants as insurance that the forwarded message would not implicate the sender and receiver in anything beyond a shared appreciation of humour.

“Because people would be like, oh this is funny you should watch it and then they may post it on to people’s walls and stuff” (Rural, Female, 18-22)

This is consistent with the literature review which found that a shift is required from a simple one-to-many model, to communication patterns that range from one-to-one, one-to-many, to a complex many-to-many-to-many model.

One of the benefits of a YouTube clip is that it may potentially go viral through peer dissemination, which cannot happen with advertisements placed on Facebook, YouTube, or Google.
One of the participants’ campaign proposals included a series of YouTube tutorial videos, which could work in conjunction with a Q&A forum.

“YouTube does a lot of a tutorials and people look up how do you do this, how do you do that?” (Urban, Female, 18-22)

**YouTube ads** were suggested in the first round of focus groups, which was incorporated into some campaign proposals on the basis of finding a broader audience.

“Because millions of people look at YouTube. It would really get across really quickly” (Rural, Male, 16-17)

Further to this, it was said that part of the value of YouTube ads is that they can’t be skipped, as was mentioned elsewhere.

“As much as I hate ads before YouTube videos, I mean that way you have to watch it if you want to watch the video” (Urban, Male, 18-22)

For some, YouTube ads were considered more appropriate than YouTube videos of tutorials or stories about sexual health.

Female 1:  Like they're real life ad stories, yeah. So you wouldn't be YouTube-ing STIs. Like I don't think I would go on YouTube to look for something like that, so I think...
Female 2:  Most people would Google it.

However, the use of video was a common aspect of most campaigns that were developed, as participants in the final urban focus group noted.

Facilitator:  So why are videos good?
Female:  Because you don't have to read, you just watch it.
Male:  Yeah, you'd rather watch it than read it, yeah.
Facilitator:  Okay.
Female: Like some people might like to read but usually it's more like books and stuff rather than a whole paragraph about STIs, or this and that. But whereas if you're watching a video, it's kind of told to you, yeah.

**Online forums**

An online forum where sexual health related questions can be anonymously posted and answered by professionals (nurses/clinicians) was suggested in initial focus groups. It was said that this allowed more privacy than a GP visit (which some participants only do with their parents). It was suggested that this could take the form of Yahoo! Answers, Formspring, or Dolly Doctor. Many felt this would be more engaging than slabs of factual information, as it would involve questions and stories that readers could relate to.

Any forum or discussion platform would need to be **moderated** for trolling, according to the participants.

"Must be regulated otherwise it will be seen as a joke" (Urban, Male, 18-22)

Forums were proposed in two separate campaigns of the follow up (urban) focus groups. In discussing these, further concerns were expressed around privacy, the extent of moderation, and who gets to be involved in responding to questions – whether this would be professionals only, or other readers too.

Female: [asking another participant for clarification] So for the forums, so do you ask a question and is it posted, so anyone can see your question, or is it...?

Male: Yeah, anyone can see your question but not anyone can answer.

The other group proposed a forum project that fed into the production of Q&A style videos. In this, the most popular questions on the forum would be made
into videos featuring responses from professionals. This group extended authorship of forum comments to readers, but felt that these should be moderated prior to being published.

Female 1: I think maybe what you could do is anyone could comment, or ask a question but you wouldn't be printed straight away. Someone would read it and then it would be like okay and then they'd put it up.

Female 2: Yeah of course, yeah.

Many felt that a forum could offer a serious and trustworthy component to a broader campaign that could elsewhere feature funny videos, ads, or games.

**Website**

Though not really discussed in any specific way, all groups proposed a website that would be the central hub of their campaign. Many participants noted that ads, posters, games, and other strategies would all point to the central website where clear and detailed information would be found. Yet the website could also host many of these things, including audiovisual components.

“You've got one central website using sexy and funny videos because that's what sells and we're an audio visual generation” (Rural, Male, 18-22).

It was suggested that ads on Facebook or YouTube would be short, simple and ‘attention grabbing’, enticing readers to the central website.

“Youp, so basically all these other mediums, they're just there to get your attention and get you to go to the website” (Urban, Female, 16-22)

**Video competition**

One participant proposed a video competition in which young people would be invited to make a video. These would be disseminated online (via SNS), and a winner would be found via audience voting and professional judgement.
Yeah like they could do anything with the video that they want to. Like they could do animated video, real video and I guess they could take it any way they want. Like funny, serious, real life story, so it gives the people the option so you’d have a lot of different views in that. (Rural, Female, 16-17)

This participant outlined that such a campaign could avoid potential issues around privacy and would also ensure that many different styles of (user-generated) messages would feature in the campaign. Therefore, sexual health could be presented as both funny and serious. It would also provide opportunities for real-life stories, should filmmakers wish to take this route.

This campaign included a government logo to assure participants and their parents that it is a legitimate venture. Through voting, peer engagement (and education) could also feature, as well as interactions between young people and health professionals.

“I guess you could have like a poll. People vote for the video that they like the most. Then from there the professionals could decide on which one would be the most important. Then that could run as a campaign…” (Rural, Female, 16-17)

**Storytelling**

Storytelling was suggested as a good way to engage with young people, though some warned that stories presented to them should be real, not ‘made up’, and should reflect genuine experiences. There was some overlap here with discussing the benefits of online forums.

Female: If there was something that interested you, like a real life story. I would click on that. Not something just...

Male: Not just facts. Because that’s just boring.

Female: But if you can incorporate facts into a story, people would read it.
Male: Not a story that someone’s made up because people can tell the difference. One would be boring and one would be interesting.

Female: It can be anonymous but make it...

Male: Stories. I think something that would be good, like on forums you post questions to people and you can be anonymous.

(Urban, 16-17)

The power of storytelling was also evident in focus group discussions in which participants engaged in sharing stories/gossip relating to sexual health. This was particularly the case with one participant whose father was a health professional.

“Yeah, if I hear a good story from my Dad I might repeat it to my friends. Like there were these two guys who got Chlamydia from the same girl”

(Rural, Male, 16-17)

Such anecdotes were clearly enjoyed by other participants, as they would return to certain punch lines throughout the ensuing discussion.

One proposed campaign (Rural, Male, 16-17) featured YouTube ads involving real life stories about STIs, but in workshopping this, the difficulty in protecting privacy was made apparent.

Male: The only non-private thing would be the real life stories unless they used fake names.

Female 1: Blurred their faces.

Male: Do a little face.

Female 2: Or just actors or whatever you know.

Male: ‘This is a real life enactment.’

**Mobile Phone Games**

A mobile phone game as a delivery method for sexual health information was suggested though not popular. Yet, there was some animated discussion about
an existing game called “Mr Cond”, in which the aim is to catch sperm in a condom.

“I think, like, if it was in – like, if it was kind of a joke but at the same time it was serious …” (Rural, Female, 16-17)

One campaign proposal involved a game component suitable for phones and iPads, which was similarly humorous.

Like Angry Birds or something, Angry Herpes and it’s just trying to take over the world, something like that, something people can play. Like it will be an actual game but the name of it, or the concept of it will be something to do with using condoms, or running away from AIDS, or something like that. (Urban, Male, 18-22)

**Novelty Song**

In the younger rural focus group, it was suggested that a song could be made that was humorous or a parody. Accompanied with a humorous video, it was said that it would have potential to go viral.

Female 1: It could be, like, I just got Chlamydia. Oh, it's a song.
Female 2: It could be catchy. It could be, like, I just got Chlamydia, and then everyone starts writing it as their [Facebook] status, and everyone's, like, why is everyone writing these statuses, and then everyone becomes aware all of a sudden.
Female 3: Then someone's like, hey, what's Chlamydia? I'll go research it.

One member of this focus group continued to believe that a novelty song was a viable option for a sexual health campaign, on the basis that it meshed well with how younger people engage with YouTube.
“The YouTube novelty song - you know YouTube’s pretty much funny videos so people like 16 - like school people they don’t really go on for serious matters” (Rural, Male, 16-17).

**Humour**

As discussed throughout this report, humour is a significant and recurring feature of suggested campaigns and considered as a beneficial way to engage with young people around sexual health.

“It would probably make people more inclined to share if they made an ad that was funny but at the same time pulled off like a message about getting checked out or whatever.” (Rural, Male, 18-22)

Caution was offered about possible manipulation of the message if it is too serious. It was said that the tactic to avoid manipulation is for the campaign not to take itself too seriously.

“You just have to be wary of that and by taking things too seriously. I think that’s how you leave yourself open to be made fun of a lot of the time” (Rural, Male, 18-22)

Yet at times the use of humour was challenged in focus group discussions as it could potentially misguide the seriousness of STIs. Often there was talk of the need for a message to incorporate elements of humour and seriousness. The former was seen to be most useful in enticing young people to notice and engage with a sexual health campaign, whereas inclusion of a serious message about sexual health would be useful in learning about STIs and how to avoid them.

“Well I think you need to have a funny element because if it’s just serious it’s going to scare people off. So I think you need to draw people in using funny and then maybe have like a serious kind of punch line at the end or something”. (Rural, Female, 16-22)
In discussing her idea for a video competition campaign, one participant describes an approach incorporating funny and serious.

“So you’re not going to get people to do it if you’re dead serious and you’re not promoting it in a fun way. So it’s got to be promoted funnily but with a real issue behind it”. (Rural, Female, 16-17)

This blend of humour and seriousness was a common point of discussion in follow up focus groups.

“…it’s serious but the videos are, yeah, not so serious” (Urban, Male, 18-22)

“It’s sort of a serious ending to a funny thing” (Rural, Male, 16-17)

Humour was also seen as a useful way of combating stigma.

“If you could find other reasons that people should watch the videos without that direct link to the diseases that you are talking about because that’s a lot of where the stigma comes from.” (Rural, Male, 18-22)

Often examples were given of particular styles of humour, sometimes ridiculous, that might generate videos with greater potential for peer-to-peer sharing, a ‘viral’ response, or repeat viewings.

Female: Or you could make it into the funny video by having like you know someone like Russell Crowe or something like that, or Julia Gillard - pretend it’s relaying the story of someone about catching crabs or something.

Facilitator: Yep.

[Laughter]

Female 1: Because then people would laugh at that.

Male: Julia Gillard catching crabs!

(Rural, 16-22)
Scare campaigns

Mostly, scare campaigns were not thought to be a good measure in appealing to young people, and many thought that these would add to existing stigma around STIs and testing.

“People just need to stop feeling scared about it” (Urban, Female, 16-17).

Although some people in the later focus groups did incorporate scary messages into their campaigns, as well as funny messages.

“I have got scary for all age groups but for the younger group is funny and serious” (Rural, Female, 18-22)

Much discussion indicates that not only are scare tactics in sexual health campaigns ineffective, but they are also not useful. One participant points out that they miss the mark in terms of raising awareness.

“I think for something like sexual health, because a lot of their ads are geared towards you might have something or it’s more almost scare tactics. It’s not trying to say hey this is just what you should do.” (Rural, Male, 18-22)

Elsewhere it is mentioned that scare campaigns only work insofar as getting your attention, but are not something you tend to engage with by seeking more information.

“Like there’s those drinking campaigns, like they get your attention while you’re watching it but then it doesn't make you go to their website, or make you think about it any further type thing”. (Urban, Female, 18-22)

As the following statement points out, scare campaigns are seemingly less useful where a concern for STIs already exists.
People that have sex need to be checked, like I don't think there's anyone on this earth that doesn't worry about what could happen. (Urban, Female, 18-22)

If it’s the case that STI concern is already present amongst young people, than a scare campaign is not needed to create that concern. Rather, a campaign can pitch a message at existing concerns, and do so in a fun and friendly manner, as is suggested throughout focus group discussions.

The need for something more friendly was reflected upon in relation to the current Get Tested, Play Safe campaign that some participants were familiar with.

Male: ...with the campaign so negative, you wouldn’t really be like check it out, but if maybe there was a campaign that was more just friendly and...

Female: More awareness like breast cancer and prostate cancer and all that.

**Trust and Credibility**

In the first round of focus groups there was some discussion about the need to find trustworthy information that comes from a credible source, with a common understanding that there is much spam and dubious information online.

“I have looked for information on the net for health, but again you always have to take it with a grain of salt because you are not sure how reliable it is” (Rural, Male, 18-22)

Amidst this discussion, it was stated that a sexual health campaign must appear credible, and many thought that a government website and logo would offer this assurance. It was suggested that it is important to use a .gov or .edu tag for legitimacy
“Something with a government backing or some proper organisation backing is probably a bit more trustworthy” (Urban, Male, 18-22)

In discussing an idea for an online forum, it was said that it would need to be administrated by a reliable source

Facilitator: So what would a reliable...
Male: A government agency. The government is always reliable.
Female: Because otherwise people would just think it’s some person wanting to know everyone’s business.

In follow up focus groups however, not everyone agreed that a campaign should clearly mark itself as a government initiative. One participant justifies why he wouldn’t include a government logo on his campaign materials:

“We don't like official things. If someone's trying to push their info in my face, don't force me to do that kind of thing, so yeah. But at the same time, that website will be like a professional government body and maybe you have a logo somewhere in that website but very inconspicuous, yeah”.
(Urban, Male, 18-22)

In particular, young urban participants were less likely to want prominent government branding.

Male: It's credible. [The government] wouldn't really lie to you.
Female: Yeah it would be really credible but I just thought like I don't particularly like ads by the Government. Like you said, it wouldn't really appeal to me. I don't think it would appeal to a lot of 16 to 18 year olds, if they are talking about condoms and STI testing and stuff like that.

Here, and in the previous example, the aversion to government branding is perhaps more about taste (and awareness of a government advertising genre) than a need for credibility. At another point in this discussion, it is suggested that credibility can come from elsewhere, not just government authorship.
Female 1: It doesn’t have to have like the Government to be credible, like it could still be informative and right even if...

Female 2: Yeah I'm sure there's other organisations, yeah.

Facilitator: Okay, well how do you convey that something is informative and right?

Female 1: Just the style of writing, I think you could sort of tell. Like see, I would probably think something that would be on the forum, or even the video would be more credible than what I'd be finding out through the video game. Like it’s just the medium.

In the follow up rural focus group, there was more support for obvious government backing.

Facilitator: Do you think a government logo says something or does something to a campaign?

Female: I think it just kind of confirms it. You know it’s not some random person out there trying to suck you in. It’s the government and it’s real. It’s just certified.

Facilitator: So it’s more legitimate.

Male: Yeah it’s not just spam.

In contrast to the urban participant who didn’t want government logos, a rural participant highlights why this is important for her video-making campaign.

“I have got the government logo in there because maybe for people under 18 their parents might not be comfortable with them doing that. If you have got the government in there then they’d go for it”. (Rural, Female, 16-17)

In follow up focus groups, there was also talk of celebrity involvement, and how this can lend a certain credibility to campaigns. One participant suggested the likes of Delta Goodrem. When asked if she would appeal to all young people, she said “it wouldn’t just be Delta”, indicating a need for multiple celebrities/personalities, so as to maximise the campaign’s appeal and reach.
Other suggestions for increased credibility included the involvement of universities, or endorsement by the NSW Nursing Association.

6. Recommendations

Privacy and confidentiality
Any contact with the campaign and service should be anonymous. For example, the opt-in and sign up service should be anonymous and the Facebook page should not link back to people’s “walls” and “newsfeed”. Under 18s were particularly concerned by the potential for ‘drama’ on Facebook.

Specificity
All groups were emphatic that no one strategy or platform was appropriate for all audiences, but some young women argued that there should be an increased focus on targeting young heterosexual men. The interactive and creative nature of social media and SNS allows young people to play with their identity online. This often involves questioning and finding out about sexuality, cultural differences, ethnicity, class, gender, and the like. Young people experiment online with identity and consider it a safer place to do so.

Humour
Humour (particularly in the form of novelty songs, or parodies) can provide an entry point to more ‘serious’ or ‘scary’ content. Humorous content encourages “sharing” and may improve the possibility of the campaign going “viral”. The focus here could be on being “light-hearted” or “silly” as genuine humour is difficult to achieve.

“because no one wants to get a lecture whilst they are online and trying to be doing their social thing” (Rural, Male, 16-17)
Branding
A recognisable and youth orientated branding needs to take place, to brand the whole campaign so as to not be too intimidating and keep the campaign feeling “friendly”. Such government branding will also ensure the campaign is “trustworthy”.

Multi-platform and multi-modal strategy
There should be a combination of content and mediums. There was little consensus around potential strategies. This suggests the need for multiple approaches.

“I don’t think there’s any ultimate number one way. I think you’d have to have a combination of things” (City, Male, 16-17)

A cultural approach appreciates how ‘media’ is not a one-to-many model but a complex multi-directional process that is an integral part of young people’s lives, and not an addition to it. Social media and mobile technologies are not simply an instrument or tool to use but a foundation upon which learning and inter-personal relationships are negotiated. The different digital technologies should not be viewed in isolation, but rather as interrelated communication technologies that facilitate, and are crucial aspects of, the young people’s cultural communities and activities.

This multi-faceted approach enables educators and learners to reach across geographical contexts.

Any campaign should be engaging and interactive. A common preference was for campaigns to have a story focus that they can relate to, as if they were hearing the story from peers. They do not simply want facts and statistics.

“Not just facts. Because that’s just boring” (Urban, Male 16-17)

Any digital tool (website, app) should be simple to use.
“It should be set out easily. You shouldn’t have to go through too much stuff” (Urban, Female 18-22)

There was some enthusiasm in one rural group for text reminders, particularly during a “national test day”.

**Facebook ads**

The idea of using Facebook advertisements for a sexual health campaign arose in all initial focus groups. Most participants felt that these should be simple, funny, and attention grabbing.

“Maybe just like a funny little thing that teenagers say, just like a really funny phrase and then people click on that see what the hell is that about, yeah” (Urban, Female, 18-22)

Facebook ads were discussed not as a central campaign aspect, but as peripheral, and a good way to direct young people to a campaign website, and familiarise them with a campaign message or image. Facebook ads were seen as one of many potential outlets, and so the likelihood of most young people not clicking on the ad link is perhaps not a huge concern.

Clicking on the link would take the young person to the campaign website featuring more detailed sexual health information. For most participants, the website would preferably be government branded, and may host a range of other media such as YouTube videos, or an online forum for discussion.

**Website**

The website was commonly seen as the hub for any style of campaign, and a place where clear and detailed information can be found.

Non social media were not excluded from an array of possible campaign features, with some campaign proposals incorporating TV advertising, posters, a hotline and pamphlets. One group’s campaign proposed that pamphlets would be
developed for dissemination through schools and GP clinics, and that these too would direct young people to a campaign website (Urban, 16-22).

Female 1: I think they’d be really informative, I just don’t think many people our age would really go to a pamphlet.

Female 2: But even see for the pamphlets and stuff like that, you know when you get your school diary and stuff like that and you could just have it included in there.

Male: That could work, yeah.

Female 2: Yeah and when you go to uni, you get that introduction bag; you can just put them in there.

This discussion shows that some of the ‘old ways’ are still useful, and recognises that pamphlets and Facebook ads (and other single media items) do not work on their own, but different formats, in different spaces, will reach different people, depending upon their needs, circumstances, and interests.

**Online forum**

In many groups, an online forum was suggested, which had many possible incantations. It could be peer-focussed or responses might only come from professionals. It might require a login ID, or it might be freely available. It may be moderated by a health organisation, or self-moderated.

A Yahoo! Answers modelled forum with responses from professionals and peers (with professional responses highlighted in some way, such as rising to the top of the page), could be useful for generating conversation/engagement, as well as the provision of “credible” information. This would also generate immediate responses, which is an important aspect of Yahoo Answers!. It also allows for greater autonomy, and entrusts a level of self-moderation, as happens on Yahoo! Answers where people are quick to expose ‘trolls’.
**Video competition**

A video competition which leads into a campaign would be one way for user-generated content to be central to a sexual health campaign, and created videos would be disseminated amongst friends and peers for review and voting, thus broadening the reach of such sexual health messages.

“I guess you could have like a poll. People vote for the video that they like the most. Then from there the professionals could decide on which one would be the most important. Then that could run as a campaign”

Involving both professionals and peers would be more conducive to a dialogue between young people and health professionals, and ensure that the voice of such campaigns is more familiar and less institutional.

**Text message campaign**

A text message campaign could be tied to a youth event, such as a music or sport festival. By reaching out to young people where they socialise and in a style they can relate to, health promotion staff or marketers can make it easier for youth to seek help and support.

Young people can receive updates about ‘the event’ tagged with messages on how to get tested and not just to get tested, in addition to a hotline number they can save to their phone for future reference. This way they can save the number under any name they want (and avoid stigma if someone sees the contact list on their phone).

Messages also needed to have variety (not the same message over and over), be short and sharp and to the point, signed off by a credible organisation, use informal and familiar language, use easily understood statistics, be well timed (for example, before weekend), have a balance of new and reminding content, and indirect so that the message doesn’t feel like an accusation that one already has a sexual health issue
The number for the text Q&A text message hotline should be publicised across a wide range of media: posters, Internet, Twitter, Facebook and YouTube advertisements. The focus should be on getting people to remember the phone number first and foremost.

Publicity of the phone number to opt in and opt out of the text message campaign can be distributed on posters (toilets were noted by participants as where they remember such posters), on television, on a Facebook page and on YouTube advertisement. A phone number is easy to note and remember, and can be non-specific, unlike a website address. Young people’s digital social profiles and mobile technologies can be highly personal and intimate and any uninitiated contact via them may be viewed as intrusive.

Any text message should imply sexual health, rather than be explicit. This would avoid concerns by young people about being associated with the stigma of STIs. This can be accomplished by couching information within relationship and dating advice, as well as sexual ethics. A fundamental caution we have identified is the need to tie any social media and mobile technology sexual health campaigns into the broader sexual cultures of young people. For instance, experience of courtship, ethics, practices, fears, dangers, hopes, intimacy, sexual tastes, cultural expectations, gender and sexual diversity, and experimentation. Any media campaign should not isolate the sexual health message from young people’s sexual cultures.

It is cheap, people can use low-tech phones, it is easy to write a text and remember a phone number. The text service must be sign-up and have an opt-out function

**Online**

A Facebook page can function as the first point of online contact, as it is the most visited platform, but should link to a ‘credible’ .gov website, with search engine optimisation (so as to rank highly in Google searches).
This could include a *moderated* Q&A wiki whereby NSW staff could update the site and young people can help build their own stories and links and website, the text message service sign up and opt out function, and other resources (such as services where young people can get tested). Young people have their own ideas about what they’d like to learn about ethical and safe sexual relationships, and when they need to learn it.

Young people in focus groups emphasised the need for information ‘on demand’. A moderated Q&A session with anonymous participants could be run via a text and email service then be uploaded to Facebook and the stand-alone website when anonymity and confidentiality can be assured. In this way, people’s sexual health, contact with STIs or even information on STIs cannot be leaked. A catalogue of issues could be kept. A search option for ‘FAQs’ should be provided.

Video scenarios about sexual health couched within relationship and dating advice could be prepared. These clips should be inter-related. Young people could make their own movie by having various clips that they can drag and drop into a series.

Scenarios could be written for distribution via text message too. For example, a scenario could be written that includes reference to an upcoming music or sport event that is “hot” at the time so people can visualise “realistic” and up-to-date scenarios. Scenarios should also be tied to sexual curiosity (sexual ethics, dating and relationships) of young people and not only address sexual health.

The stigma of STIs rules out the use of a sexual health game and app *unless* such content is considered ‘cute’ or ‘funny’. However, many young people’s phones still do not support such content.

### 7. Conclusions

New media technologies and cultures are both emerging, and evolving, at pace. Our focus group findings reflected the diversity of young people’s approaches to these media, in that participants recommended the use of multiple (and
sometimes conflicting) strategies across multiple media platforms. Just as there is no ‘magic bullet’ in sexual health promotion, and there is no ‘magic’ online and mobile media campaign or strategy. However, mobile and online media in general, and SNS in particular, are spaces as real as any geographical location for the young people who use them. They are spaces in which young people form communities, and intimate relationships, where they seek information, and where they experience rejection, confusion and conflict in relation to their gender and their sexual attitudes, behaviors, identity. For this reason, they are spaces where services that provide sexual health education and outreach need to be if they are committed to not just talking at, but also listening to young people.

While online and social media may appear to be ‘low-cost’ in contrast to television, cinema and billboard campaigns, it is important for any organisation seeking to move into these spaces to be fully aware of the need for a) comprehensive policy guidelines and training for campaign staff, including training in online moderation; b) the need to continually monitor and update campaign content and c) the need to factor evaluation into any campaign strategy. The use of new media technologies in health promotion is new and evolving – there are no guaranteed strategies for success. Ongoing research and evaluation is crucial, in order to build a body of evidence-based practice.
8. Appendix

Focus Group Questions

Part One: Media Use

[Social media definition – read to group]

Social media refers to the use of technology to communicate, interact and share information online. It most commonly refers to social networking sites which enable users to create online profiles with information about themselves, as well as ways to interact and share information with others. Some examples of these sites include Facebook, MySpace and Bebo. Social media is not restricted to social networking sites, however. It can involve other networks such as message boards and forums, blogs, Twitter, wikis, podcasts, photo-sharing service Flickr or video-sharing services like YouTube.

[Questions asked]

1. What social media services do you use, and why? Which ones don’t you use, and why?

2. What kind of mobile phone do you have? Why did you choose that kind of phone?

3. How often do you use your phone? What do you use it for mostly?

4. How often do you use ‘social media’? What do you use it for mostly?

5. Do you use online social media differently to how you use your phone? What are the main differences?

6. Is there something you’d like to learn more about in terms of your phones or the social media that you use?
Part Two: Health

1. Do you think mobile phones and social media would be good for sharing health information? Why/why not? [trustworthy?]

2. How often do you talk to your friends about health? How is health information usually passed on within your friendships?

3. Have you ever used social media or your mobile phone to find health information? Have your friends?

Now, more specifically on sexual health:

4. Do you ever think about sexual health when you’re interacting with your friends?

5. What do you know about Sexually Transmitted Infections?

6. Have you ever shared what you know about sexual health? How?

7. How have you found about sexual health in the past? Do you recall any campaigns? Did they work for you and your friends?

8. Would you pass on sexual health information to friends? How would you do this?

9. If you were to pass on sexual health info through social media and mobile phones, what do you think this would this look like?

10. Do you think a sexual health campaign using social media and mobile phones would work?

11. Do you have friends who pass on sexual health information? What do you think of this? Why do you think they do this?

12. How do you think online social networking could help you and your friends find out about sexual health? What would that look like?

13. How do you think online social networking could add to or confuse what you and your friends know about sexual health?
9. References


