

MASTER RESEARCH PROJECT

THEATRE OF THE MIND: PODCASTING  
AND PUBLIC HEALTH COMMUNICATION – A PILOT PROJECT

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## Abstract

### **Theatre of the Mind: Podcasting And Public Health Communication – A Pilot Project**

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This project explores how podcasting could be developed as a strategy for narrative self-representation as a means of exploring the broader socio-cultural context of specific health issues such as HIV/AIDS or methamphetamine addiction. The aim of the project is to understand how podcasting can be used to aid health agencies in determining the social context of behaviors that in turn can inform strategic communication programs.

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## **Theatre of the Mind: Podcasting And Public Health Communication – A Pilot Project**

### **Introduction**

The genesis of this Master Research Project (MRP) started in April of 2003, when I was hospitalized for a feeling of dizziness that came over me suddenly one sunny afternoon on a lunch break from work. The dizziness – a chronic sensation best described as the feeling one gets stepping off a merry-go-round - lasted several weeks and one Sunday morning when I couldn't get out of the shower on my own, I decided it was time to go to the hospital. Two neurologists at the Saint John Regional Hospital in New Brunswick spent five days examining me, launching what would become a two and a half year journey to diagnose this mysterious condition.

After much speculation and testing, including a CAT scan and two MRI scans, a less than definitive diagnosis was reached by one of the neurologists who suggested that my dizziness might be caused by a small clot of hemorrhaging corpuscles known as an arteriovenous malformation (AVM), a rather serious condition. The second neurologist didn't agree. I was then recommended to a world- renowned ENT specialist in Montreal, who tentatively diagnosed my condition as a possible transitory vestibular dysfunction. Translation: it is possible that the dizziness is a result of an inner ear dysfunction that comes and goes.

Over the next two years, my condition did indeed come and go as the ENT specialist predicted. I spent most of my time either stumbling around feeling nauseous when I was dizzy, or trying to figure out and avoid what might trigger another episode when not. The answer finally came two and a half years later during another emergency room visit, this time at Toronto Western Hospital where an intern neurologist quickly diagnosed my problem. I was diagnosed with benign postural vertigo (BPV), a condition that affects the semi-circular canals in the ear.<sup>1</sup>

The intern set up yet another series of tests appointments and recommended that I go on-line and check out the information available on BPV. I was very thankful and relieved since I was now armed with a diagnosis as well as a source of information for the condition that had disrupted my rather healthy life. Once home and settled at my computer, I did a Google search and was introduced to the world of BPV – an abundance of information on causes, treatments, and support. The day before I had sat in emergency, tired, disempowered, and embarrassed with my condition that up until this point defied diagnosis and treatment. For the first time since this started, I felt I was in control of this condition.

That night I sat in front of my computer, and read the archived entries on a BPV chat support site humorously called *The Dizzy Lounge Message Boards*,

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<sup>1</sup> The semicircular canals are three, fluid-filled tubes in the inner ear that act as a gyroscope and help keep your balance. When your head moves around, the liquid inside the semicircular canals sloshes around and moves the tiny hairs that line each canal. These hairs translate the movement of the liquid into nerve messages that are sent to your brain. Your brain can then tell your body how to stay balanced. With BPV, small particles of calcium carbonate migrate, settle, and disrupt the normal functioning of the semi-circular canal.

personal stories from people who have experienced what I was going through, what I had thought was happening only to me, and what I started to feel would never be fixed. I felt relieved that I wasn't alone. Although others suffer more and others suffer less, we all experience a common ailment and, through the Internet, share in the opportunity to exchange stories, compare treatments, as well as offer advice and support. The Web provided me with a portal to a vast amount of both formal medical explanations and informal, anecdotal personal narratives that would both contribute to my general sense of well-being. It was at this point that I started to recognize the important links between health communication, personal narrative, and new technologies.

The MRP project developed quickly in the summer of 2005 during an internship I had set up with the AIDS Committee of Toronto (ACT) as part of my MA requirements in Communication and Culture at Ryerson University. ACT was developing a large survey study called "Knowing Me, Knowing You" headed by Dr. Barry Adam from the Department of Sociology and Anthropology at the University of Windsor. The goal of the project is to investigate how communities of gay and bisexual men interpret messages in three recent HIV prevention campaigns, and how the campaign messages influence their decision-making about sex.<sup>2</sup> I saw this internship as an

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<sup>2</sup> During my field placement with ACT, I was part of a research team made up from staff members at ACT, and funded through the Ontario HIV Treatment Network (OHTN). Comprised of members of the academic community as well as health care professionals, the "Knowing Me Knowing You" (KMKY) research project is also supported by an advisory committee. The research team consisted of: Andrew Taylor, Project Coordinator; Haran Vijayanathan, Gay Men's Community Education Coordinator; Jason Asselin, Gay Men's Outreach Coordinator; Nick Boyce, Gay Men's Harm Reduction Coordinator; Winston Husbands, Director of Research and Program

opportunity to understand how public health campaigns are put together and how issues and messages are chosen, designed, delivered, and evaluated. I was also curious about how people identify, reject, and modify the same public health campaigns and information.

During the first few weeks of the internship, I read a number of research reports produced in part by ACT including *Renewing HIV Prevention for Gay and Bisexual Men* (Adam, 2003) where I was introduced to research that explored the sexual practices of men who have sex with men (MSM). In this study, a primary concern that emerges is the need to rethink current prevention strategies offered by AIDS service organizations (ASO). Two recommendations from the report had particular resonance. The recommendations state:

1. [e]ffective HIV prevention requires engaging the uneven communication processes of gay and bisexual men by creating public spaces and involving gay press, websites, and other media in which to develop public understandings around sexual interaction. In this sense, HIV prevention entails community development to be effective.
2. [w]hile social marketing approaches have the advantage of reaching a wide range of people, they are limited by being able to telegraph little more than “sound bites” messages. What also needs to be done is to engage a community dialogue through open forums, group discussions, web chats, even one-on-one counseling over time. (2003)

ACT is a community-based organization that provides support, HIV prevention, and education services for people living with and at risk for HIV/AIDS. An important aspect of the organization is to deliver safe sex, prevention, and harm reduction information to a range of communities that

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Development, and myself. My title was Assistant Research Coordinator and I worked with Andrew Taylor under the direction of Winston Husbands.

includes women, gay and bisexual men, and youth. The number of vectors in this already rich landscape includes language, culture, race, and class. This diversity exposes important questions regarding the theoretical and methodological models that are used in public health promotion. It suggests the need for a critical approach of health prevention strategies and how health knowledge and information is established, authenticated, organized, and distributed.<sup>3</sup>

I became committed to the idea of creating public spaces and community dialogue as envisioned by Adam, recognizing the potential of new and emerging information technology in relation to health information through my own experience. Originally, this project started as a digital video documentary and was to be based on a series of interviews about the nature of sexual risk taking. However, during the editing of a sample interview, I discovered that it was the audio track, the person's voice, and the story being told that captured my attention more than the video images. Given the rapid growth in the digital communications industry (including computer software, personal listening devices, and online resources for producing or downloading music and information), I decided to try working with podcasts, a small digital

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<sup>3</sup> For an interesting example, see: *Prevention Revived: Evaluating the Assumptions Campaign* (2005). The Assumptions campaign was adapted from a successful San Francisco AIDS Foundation campaign by AIDS Vancouver as a national prevention initiative. The original campaign was based on research from the Centre for AIDS Prevention Studies at the University of California San Francisco. The research indicates that gay men who engage in unprotected sex often do so assuming they "know" the sero-status of their partner. The campaign is bold in that it depicts a series of interior monologues designed to destabilize the assumptions, constructed meanings, and assumed knowledge that gay men currently inhabit in negotiating safer sex practices.

sound file with a prerecorded message. Podcasts are unique as a communication tool because they are inexpensive to produce, free and easy to download, and can be listened to at leisure through the privacy of a portable digital audio device or on a computer. I proposed to develop a series of podcasts to explore the possibilities of fostering “community dialogue” with this new medium.

Another influence that strongly shaped this project is the work of my supervisor, Prof. Jean Mason at Ryerson University, and her study “The Discourse of Disease: ‘Patient Writes’ at the ‘University of Tuberculosis’” (in press). Mason examines, among other things, the archived written works of former tuberculosis patients at the famed Trudeau Sanatorium in Saranac Lake, New York. In particular, I was struck by the tension that Mason draws between the scientific and medical discourses that describe and treat tuberculosis – the traditional “discourse of disease” - and the patient narratives that provide an intimate understanding of the social context of tuberculosis. Through the voices of my participants – all committed health activists – I hope ultimately to contribute to what Dr. Mason refers to as the development of a new model of health communication that “fully integrates the patient’s voice”.

The final and most persistent force behind this project has been my personal involvement over the last two and half decades with all the remarkable men and women who are living and have lived with HIV/AIDS. Ultimately, the events, theories, and observations that make up this project explore the conditions that have entered *my* experiences with HIV. In the spirit of Bourdieu’s “epistemological break” in which established knowledge and

research methods are rejected in order to explore the social construction of the object of study (Sterne, 2003), we are faced with an *episteme* (or narrative) I have “constructed” that traces my attempts at understanding illness and the stories that accompany it within the broader context of communication and public health.

For the record, I am currently HIV negative and over the years have maintained an ongoing role as an activist and caregiver for friends who lived with and those who are living with HIV and AIDS. I will be referring throughout this paper to HIV/AIDS as an example of the exigencies of communication and public health.

### **Justification of Logic**

Consistently throughout the AIDS epidemic there have been multiple construction of meanings and experiences of HIV that coexist at any given time. For example, Nina Glick Schiller (1992) has pointed out that disease threatens the “daily habits and practices” that maintain social order and that, by constructing cultural “others”, disease has often been used as a means to validate and re-establish social order (p.239). Susan Sontag (1989) has written about the myths and metaphors that surround experiences of illness that, in her words, constitute a set of traps that “have real consequences” such as fear and shame (p.102). Sontag hopes to invoke an understanding of cancer or AIDS as just a disease, “without meaning” (p.102). Kenneth Keniston (1989) observes that to mis-define AIDS is to risk shaping ineffectual policies. For example, strict moral definitions may produce limited responses that result in moral

judgments and moral reform movements while biomedical definitions risk overlooking the importance of social and cultural behaviors. Both approaches limit the potential for creating effective prevention strategies (p.xix). Others have critically examined the impact of media fear campaigns that stigmatized high-risk groups such as gay men and sex workers (Varas-Diaz & Toro-Alfonso, 2003; Karnik 2001).

Currently, the epidemic is in a new phase characterized by a general perception that HIV is a less serious and diminishing issue despite the fact that HIV infection rates are increasing among gay men between the ages of 18 and 25 (*Report on HIV/AIDS in Ontario*, 2002; Trussler & Marchand, 2005). This increase has also been attributed to a number of influences including barebacking, safe sex fatigue, and drug use. In an attempt to understand these behaviors within a broader context, I point to a tension between, on the one hand, “the envelope of restrictions and taboos” perpetuated through safe-sex prevention strategies, and on the other, the ontological drive for “self-expression” of the body (Turner, 1996, p.43). The latter has been highlighted by a number of academics and activists who have revisited pre-AIDS gay male sexual history as a means to understanding the complex intersection involving gay men’s sexual practices, HIV, risk, and the body.

Crossley’s (2004) work in particular explores the idea that some gay men view unsafe sex practices as part of a “resistance habitus” against the rigid safe sex strategies of the last two decades that limit sexual behaviors and expression (p. 236). Crossley experiments with the idea that this rebellious

behavior against dominant social values has precedence within a larger social and historical context (p.242). In a similar vein, Patrick Moore (2004) reclaims the North American gay male sex culture of the 1970's, referring to it as "a great social experiment", and argues that, presently, "we have lost the conception of sexuality as an art form created by gay men in the 1970's" (p.4). Moore views this time as a groundbreaking, creative, and essential period in relation to understanding current gay male sexual culture (p.4).

Rofes' (1998)<sup>4</sup> work is controversial in that it explores what has been referred to as "recovering the pleasure principle" (Clum, 1993 cited in Crossley, 2004, p. 234) from what he might call the "sexual wasteland" of the last two decades (Rofes, 1998 cited in Crossley, 2004, p. 235). As Rofes argues, gay men "value the enactment of our desires and will not always give them up in a grand gesture of sacrifice to the epidemic" (Rofes, 1998 cited in Crossley, 2004, p. 236; see also Jones, 1993). Instead of seeing the rise in risky sexual behavior and drug use as a disaster for prevention strategists, he prefers to view the newly perceived "freedom to perform such meaningful sexual acts" as evidence of emerging new gay male sex cultures (Crossley, 2004, p.235). Indeed, barebacking in some circles is being viewed as an act of self-expression, enlightenment and empowerment (Crossley, 2004; Tulloch & Lupton, 1997; Moore, 2004).

These studies suggest to me that there is a unique paradigm emerging around unsafe sexual practices – a new discourse that addresses identity, risk,

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<sup>4</sup> Rofes, E (1998). *Dry Bones Breathe: Gay men creating post-AIDS identities and cultures*. New York: Harrington Park.

HIV, and the body as a site of expression. However, as Crossley demonstrates, these are highly contentious and complex issues that complicate the dominant behavior change models of the last two decades (p. 226). Indeed, serious ethical and legal issues arise when someone knowingly infects someone with HIV or is willingly infected. Yet, there seems for some to be a strong bond with an identity that contrasts with the restrictions and taboos associated with safe sex practice. It is incumbent upon public health communication specialists to seriously consider and understand the complex psychological, interpersonal and psychosocial issues that are a result of the AIDS epidemic and manifest in various sexual behaviors (Crossley, 2004).

Information technology has contributed significantly to re-establishing the 'great sexual experiment' suggested by Moore in that it has brought people with shared sexual interests together. As early as 1994, marginalized groups have been using computer technology to foster community networks. Aside from the numerous dating and chat sites for gay men, I was interested in how users share information regarding safer sex issues like barebacking. This research looks at how such groups use the Internet to talk about health issues and share information.

The "Handball Site" (<<http://207.236.16.220/handball/index.htm>>) is an internet site where users have created a forum for sharing information regarding an extreme sexual practice called fist fucking (FF), posting everything from sex ads to responses to various streams of conversations. One of the on-going features of the site is the informal sharing of safer sex practice and health

information associated with FF. Often, questions arise concerning issues like fisting and HIV and STD transmission, safe cleaning practices, drug use, and the very serious risks of torn bowels or intestines (See Appendix 1). One can argue that the health information shared on the handball site is born out of the necessity for relevant information that is not available through more mainstream channels.

In fact, a summary glance of safer sex information available through community health organizations dealing with HIV/AIDS reveals that specific references to activities like FF are unavailable. For example, on a recent routine HIV test at the Hassle Free Clinic in Toronto, I discovered that the clinic screens only for unsafe oral and penis inserted anal sex and needle sharing. When I asked about FF, the nurse responded that FF is relatively low risk compared to anal sex without a condom and is not included in the screening interview.

The problem with this type of epidemiological hierarchy is that it circumscribes opportunities for discussing a patient's understanding of the full spectrum of their individual sexual behaviors by assuming that the abovementioned hierarchy of risk is shared and sufficient. Safer sex rhetoric is thus over-simplified and the *permutations* of people's sexual behaviors are obscured. It creates a climate that assumes that HIV is, among other things, a diminishing issue and is reinforced by the images of young, healthy, handsome, affluent, mostly white males characterized in representation such as anti-retroviral pharmaceutical ads in popular North American gay publications

(Fejes, 2002, p. 207). The point is that the lack of diverse and meaningful discourses and images reinforces potentially health-damaging, high-risk sexual practices, which play into larger behaviors of resistance, transgression, and shame.

Implicit in this medico-pharmacological drama is the notion of the body as a central player in the very process of consumption (Turner, 1996); HIV infected men identified as a niche market or what Fred Fejes (2002) refers to as “economic subjects” (p. 197). Fejes draws our attention to drug company ads that are premised around what Sarah Schulman refers to as the creation of a “fake homosexuality” and the rupture that occurs between lived experiences and the narrow representations depicted therein (p.207). These narrow representations become what is referred to as concentrated “symbols of a normative goal” for a particular culture and therefore warrant considerable power (Fejes, 2002, p.204). The principle driving force behind hegemonic discourse is its ability to reinforce existing beliefs by spreading ideas, which eventually become accepted as common knowledge (Karnik, 2003, p. 341).

Illustrating Bourdieu’s systemic *habitus* (Stern, 2003, p. 370), media tropes like the feel-good lifestyle pharmaceutical ads exclude (among other things) significant information regarding safe sex practices, the consequences of unsafe-sex practices, as well as the very real and serious physical, psychological, and social burdens that contracting AIDS actually inflicts.

## Podcasting

In response to these issues, Adam's (2003) report on the need for innovative and engaging communication strategies, Mason's work on illness and narrative, an emerging discourse involving controversial sex practices among a certain population of gay men, the role of the media, as well as my personal experiences, I have developed a series of podcasts as a prototype for documenting lived experiences and (albeit mediated) self-representation of knowledge. My goal is to claim social space and create a platform on which the social context of HIV/AIDS and related issues can be enlivened. At a time in the cultural history of HIV/AIDS in which voices are required, this is important new symbolic capital.

Podcasts are an increasingly accessible media with the ability to target specific groups of people by what is referred to as narrowcasting information. Like radio, podcasts have the potential to produce shared experiences, creating the *possibility* for dialogue within a wider community. As Jack Herrington (2005) states in *Podcasting Hacks*,

Audio is a uniquely intimate medium. You are talking directly to each person and they are experiencing your podcast on an individual level . . . Audio . . . is an active medium. As you hear a story you create an image in your head of what the speaker is talking about. This is called the theatre of the mind (p. 5).

In *The Bias of Communication*, Harold Innis was perhaps the first to understand this process and takes to task what he refers to as the

“mechanization of knowledge” (p. 190). Innis’s bias is towards recapturing something of lived experiences via oral tradition, the decay of which Innis believes has been the result of the “quantitative pressure of modern knowledge” (Ibid). According to Innis,

[t]he oral discussion inherently involves personal contact and a consideration for the feeling of others, and it is in sharp contrast with the cruelty of mechanized communication and the tendencies, which we have come to note in the modern world (p.191).

Unfortunately for my purposes, Innis’ criticism of mechanized communication includes newspapers, television, *and* radio. However, my intention is to use technology as a means to recapture “something of the spirit” of the oral tradition and through this intriguing new technology, “try to understand something of the importance of life or of the living tradition” that Innis seemed convinced has vanished (p. 190). Furthermore, I, like McLuhan (1964), believe that media technology extends our ability to communicate, share experiences, information, and messages.

Radio serves as an obvious example of the cultural relevancy of audio mediums. Bertolt Brecht foresaw the possibilities of radio fostering a range of new human relations (as cited in Dartnell, 2006, p. 92). Brecht believed that,

[t]he radio would be the finest possible communication apparatus in public life ... if it knew how to receive as well as transmit, how to let listeners speak as well as hear, how to bring him [sic] into a relationship instead of isolating him [sic] (Ibid ).

In Canada the history of radio was to a large extent predicated on relationship building or rather nation building, an essential antidote to the vast stretches of isolation of the Dominion. Paradoxically, it was also developed along regional and cultural lines such as Maritime radio and Aboriginal broadcasting, to name but a few. Generally speaking, radio has proven very resilient despite the proselytizers of television and video. In fact, many of us still have a daily if not regular relationship with radio<sup>5</sup> characterized by a highly segmented audiences and “drive-time” listeners (Hilmes & Loviglio, 2002).<sup>6</sup> As the authors have stated, despite the marginal position on the media landscape,

radio continues to be an important cultural form  
... raising questions about the relationship  
between the margins and centre of national  
discourse, and continuing to emphasize the  
primacy of voice as a central and often  
controversial feature of identity (p. xii).

Of course, radio has changed dramatically from the independently owned operations of the 1920's to what today is recognized as commercially driven corporate networks (Hilmes & Loviglio, 2002, p.3). More important, listeners today have a much broader selection of platforms to choose from, for example, satellite and web radio, the unreleased digital and high-definition radio, as well as portable and personal listening devices such as Mp3 players.

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<sup>5</sup> Currently, I am obsessed with Radio Canada *Espace Musique*.

<sup>6</sup> According to 2005 Statistics Canada figures, Canadians listened to the radio an average of 19.5 hours per week in 2004.

<[www.statcan.ca/Daily/English/050708/d050708b.htm](http://www.statcan.ca/Daily/English/050708/d050708b.htm)>

The advantage of podcasts is that they are characteristic of new web and digital technologies in a number of key ways. First, podcast technology and software are relatively accessible while production is fairly easy. As podcast guru Bart Farkas states, “with little more than a computer, a microphone, and some freeware, anyone can produce a podcast” (Farkas, 2006, p.2). Assuming that the hardware is accessible, free software like *Audacity*, a very powerful recording and editing software that is fairly easy to use, can be downloaded directly on to a computer (<[audacity.sourceforge.net/download/](http://audacity.sourceforge.net/download/)>). *Garageband* is another popular, easy to use recording and editing software that is part of Apple’s OS X operating system.

Second, podcasts for the most part are user-driven in that specific content is searched out, downloaded, stored on a personal computer or audio device, and listened to at leisure. However, this is not without problems. One of the current limits of podcasting is the lack of resources available for tracking user habits. Content providers are only able to track when listeners download a file and are unable to determine how much of the podcast is consumed let alone the impact of the content. However, a recent software company has developed an application called SONR that is able to track more user habit details including listening duration and includes more user features such as play lists that link users to content providers (<<http://blogs.zdnet.com/web2explorer/index.php?p=114>>). The limitation with SONR is that podcast users must listen to audio files through the SONR application. Although currently limiting, this suggests that it is only a matter of

time before sophisticated tracking software and personalized programming features will be *de rigueur* for audio file software.

A recent article on the BBC News website heralds 2005 as “the year of the digital citizen” (Twist, 2006). The author claims that 2005 was the year people “started to challenge those who traditionally provide us with content, be it news, music, or movies” (Ibid). New technologies such as video cell phones are becoming more than just devices to communicate with or consume mainstream media and have proven to be “powerful tools for political expression and reportage” through the potential for what the author refers to as “citizen reporting” (Ibid). In the past year, eyewitness accounts of the July 7<sup>th</sup> 2005 London bombings and the devastation after the 2005 hurricane in New Orleans are examples of this phenomenon.

Likewise, 2005 saw the first feature length film shot entirely on cell phones by South African director Aryan Kaganof<sup>7</sup>. The film, called *SMS Sugar Man*, was filmed on eight phone cameras over 11 days with three main characters. Alongside traditional cinema screenings – the film has since been transferred to 35mm format - the film will be played over cell phones in 30 three-minute episodes over the course of a month. I mention these to draw attention to how emerging technology has created new possibilities for what is referred to as “edge-in knowledge” (as opposed to bottom-up or top-down communication models) produced by what has been coined “the former audience” (Twist, 2006). In essence, we are facing significant developments in

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<sup>7</sup> From [www.digitalproductionbuzz.com/Archives/LiveThatWeek.php?date=2006-02-23](http://www.digitalproductionbuzz.com/Archives/LiveThatWeek.php?date=2006-02-23)

the production and distribution of new values, ideas, and interests, privatized information produced by non-corporate/state actors who have access to global communication abilities (Dartnell, 2006).

### **Communication and Public Health: Media**

This section calls attention to how media, culture, and behavior are often linked in the understanding of education, and public health prevention campaigns. The central paradigm examined is two-fold: what role does the media have, if any, in influencing behavioral change through public health media campaigns; and, is behavioral change a more complex process in which media provides only one facet of a larger socio-cultural dynamic?

Understanding public health issues is a complex process that converges at the intersections of allopathic notions of biomedical ethics, epidemiology and pathology, alongside an array of disparate social and cultural forces. The media has played an increasingly significant role as a provider of information for communities that are coping with health issues such as HIV/AIDS, and at the same time shapes the ways people live with and respond to HIV/AIDS.

In *The Making Of a Germ Panic* (2000), Tomes illustrates how the relationship between public health and the media grew in tandem as both revolutionary discoveries in bacteriology and the emergence of new forms of mass media such as newspapers flourished. Tomes argues that the emerging germ theories in science and medicine were the very foundations of aggressive health crusades that fueled incredible changes in everyday life (p. 192).

Everything from food and water safety, interior decorating, personal grooming and fashion were radically affected. The china toilet, screened windows, the refrigerator and vacuum cleaner, shorter hemlines and shorter men's facial hair styles are all direct results from the war on germs at the turn of the century (Tomes, 2000, p. 192).

The emergence of new forms of mass media and advertising played a significant role in the battle of the germs. As printing costs declined and daily newspapers grew in abundance, editors, publishers, and journalists were anxious to fill the pages with relevant stories. To fit the bill, marketable topics in scientific discoveries about the cause and prevention of infectious diseases emerged alongside new consumer products and a burgeoning advertising industry (Tomes, 2000, p.193).

In essence, Tomes demonstrates how a broad range of factors including the media, governments, health specialists, and scientists determines a culture's attentiveness to a perceived health risk. Tomes refers to this phenomena as "germ panic" (p. 192), defined as a series of moral imperatives that emerge from intense concerns about the origins and spread of disease and, as a theoretical model, can be applied to everything from Avian bird-flu to drug addiction. Indeed, Tomes' article and book provide an excellent study of the role that media has played in determining and framing public health issues.

An interesting feature of what Tomes calls "panic eras" is how industrialization and globalization play a key role (p. 195). For example, early 20<sup>th</sup> century mass immigration and travel were at record capacity in the same

sense as current international travel and immigration. Detainment camps like Ellis Island in New York and Partridge Island in Saint John, New Brunswick, the “Patient Zero” phenomenon of HIV/AIDS and SARS, the spread of Avian bird flu and Mad Cow disease can be considered collateral fallout of shifting populations, interdependence, and security risks associated with global governance. To paraphrase the German filmmaker Rosa Von Pranheim, a virus knows no borders<sup>8</sup>.

How issues are framed in the media is a major part of the battle in dealing with public health issues. A common evaluation model of media refers to “episodic” and “thematic” frames, two distinct approaches used by mass media to deliver news that has significant influence in determining how people respond to issues (Hoffman-Goetz, Friedman, & Clarke, 2005, p.147). On the one hand, episodic frames explain news and events through an individual’s anecdotal story or case studies that often depoliticize and isolate issues outside of any meaningful context. On the other hand, thematic frames focus on explaining situations through a sociopolitical lens that aims at exploring the issues that surround the event (Ibid).

A classic example characteristic of framing is the “us” versus “them” battle with the fast food industry and accusations of liability for the growing obesity epidemic in the U.S. Lawrence (2004) asks whether current public

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<sup>8</sup> Praunheim, Rosa von (Director). (1985). *A Virus Knows No Morals*. Rosa von Praunheim was born in 1942 as Holger Mischwitzky in Riga, Latvia. He chose his artist name Rosa to remind people of the pink triangle (“rosa Winkel”) that homosexuals were forced to wear in the Nazi concentration camps. He has made more than 50 films, many of which deal with his favorite subjects: homosexuality, older women, New York City. From [www.rosavonpraunheim.de/](http://www.rosavonpraunheim.de/)

opinion and framing of obesity is shifting from an “individualized” framing, where the cause is often determined to be a result of personal behavior and/or lifestyle, toward a “systemic” frame that broadens the focus to include larger social forces (p.57). Defining a problem in individualized terms limits government responsibility in finding a public health solution whereas a broader systemic frame paves the way for legislative intervention (Ibid).

This debate is reflected in official policy documents like the Health Canada document “Achieving Health for All: A Framework for Health Promotion” (2001). This document outlines dozens of objectives that act as a vision statement towards the future of health care:

We are aware that there are certain dilemmas inherent in health promotion. For example, we cannot invite people to assume responsibility for their health and then turn around and fault them for illnesses and disabilities that are the outcome of wider social and economic circumstances. Such a "blaming the victim" attitude is based on the unrealistic notion that the individual has ultimate and complete control over life and death (2002).

Framing the risk level of a public health issue is another feature in how the media responds to public health concerns. There are four familiar framing models used by public health communication specialists regarding public health risks that ultimately influence public policy. They are: whether the health risk is portrayed as “acquired deliberately or involuntarily”; whether it is portrayed as universal (putting us all at risk) or particular (putting *them* at risk); whether it arises from within the individual or from the environment; and, whether a risk is knowingly created (Lawrence, 2004, p.59). These frameworks are often played

out through news items on topics such as the safe injection site for injection drug users (IDU's) in downtown Vancouver<sup>9</sup>. Issues such as obesity, smoking cessation, and HIV are currently among the front line issues being played out in the battle to determine the extent and limits of personal behavior and responsibilities, environmental causation, and state sponsored public health authorities (Tomes, 2000; Lawrence, 2004). Indeed, harm reduction strategies are often controversial in that they also “breach boundaries, life-worlds, and sensibilities” (Abu-Lughod, 2005, p.45).

Another significant dynamic that works to influence the process of communication and public health is the relationship and differing perspectives between science and media. Whereas Tomes spoke of the lucrative nature of scientific discovery for newspapers, others have pointed toward how research scientists and journalists depend on each other in shaping public understanding of science and medicine (Nelkin, 1996; Karnik, 2001). However, Nelkin suggests that despite this dependence, the worlds of medicine and media often collide as a result of three fundamental differences in perspectives, including: differences in definitions of what is newsworthy within science; differences in

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<sup>9</sup> “Vancouver's heroin users get safe-injection site” (2003, September 15<sup>th</sup>). See: [http://www.cbc.ca/stories/2003/09/15/safe\\_injection030915](http://www.cbc.ca/stories/2003/09/15/safe_injection030915)

In the opening paragraph the article claims that the safe injection site “is expected to stop the spread of HIV and Hepatitis C from intravenous drug use and reduce the number of heroin deaths”. This ignores the notion of multiple risk factors, in essence framing the story – the safe injection site - as a salve against sharing needles. Within the context of the four risk framing models, the health risk is clearly of a “particular” nature.

communication styles; and, differing visions of what role media should play in reporting science (Nelkin, 1996, p.4).

Some have responded to growing concerns about the role of media in the reporting and framing of HIV/AIDS issues with proactive solutions. In South Africa, the STD Directorate, Department of Health, commissioned a report based on research presented during the 13<sup>th</sup> International AIDS Conference in Durban outlining major concerns regarding the ineffective response by the media to the epidemic. A number of important issues emerge including:

- AIDS journalism often falls short because it fails to integrate the following three elements –1) the perspectives of people living with HIV/AIDS; 2) the larger cultural, economic, and political context which shapes the epidemic; and 3) the science of HIV.
- ...journalists have tended to shy away from taking a proactive response to HIV advocacy, under the guise that they must remain ‘unaffected’ and stand-aloof commentators on the issue’.
- To contribute effectively to AIDS prevention and care, the media have to change their role into an advocacy role and promote the dignity and rights of people with AIDS and other marginalized groups.
- ...information about this problem in the media is centralized to the big cities, is limited, and very often lacks objectivity or seriousness. (Shepperson, 2000).

This report provides examples of innovative solutions towards the abovementioned shortcomings that involve the active participation of both media producers and health service organizations. Two notable projects are *Mediaworkers Project of the Beyond Awareness Campaign* and *Health-E*, developed in South Africa in 1999. Both projects produce accurate, current, and diverse information including articles, analysis, and photographs for journalists

and are available as online resources. Similarly, the Harare based Southern African AIDS Information Dissemination Service (SafAIDS) provides media kits and has developed a set of regionally relevant guidelines for investigating and reporting HIV/AIDS issues (Shepperson, 2000, p.5).

### **Social Context: Communication Across Cultures**

One of the contributions of the sociology of medicine and science has been to examine the variety of ways that disease can be constructed by social factors (Karnik 2001, Latour 1986; Tomes, 2000). Karnik (2001) examines the nature of dominant and hegemonic discourses of science and media and how this contributed to the creation of a particular narrative of HIV/AIDS in India during the 1980's. The author traces how Western categories of risk were reproduced and exported globally, arguing that understanding the power structures and infrastructural elements that enable the globalization of categories requires recognition of the formal elements of medical practice as well as the popular cultures through which scientific meanings travel (p.323).

In *Laboratory Life: the Social Construction of Scientific Facts* (1986), Latour provides an ethnographic study of the neuroendocrinology research laboratory at the famed Salk Institute. Latour throws light on our sacred belief in scientific method by demonstrating fundamental weaknesses that often produce inconclusive data, and are often attributed to faulty apparatus or experimental methods (1986). With this in mind, Latour claims that a large part of scientific training involves learning how to make subjective decisions about

what data to keep and what data to throw out, a process that to a large extent contradicts scientific orthodoxy (p. 18).

Both authors draw attention to how research, knowledge, and credibility are constructed through the often-mundane routines found in everyday environments of laboratories, clinics, organizational environments, and newspaper editorial offices. In the realm of sanctioned and institutionalized knowledge, which Foucault (1980) calls “contrivances of power” (p.31), Karnik and Latour seek to understand the ways that knowledge and credibility are constructed and influenced. In fact, as discussed below, credibility is a major issue for both on-line health information providers and users.

Kreuter and McClure (2004) have taken this critical approach to research a step further by examining the influence of culture on health communication effectiveness. In particular, the authors examine McGuire's communication/persuasion model, a commonly used framework reminiscent of Lasswell's classic communication model<sup>10</sup> dependent on five variables, including: source, message, channel, receiver, and destination. Indeed, health communication efforts are, at minimum, premised on variations of selecting credible sources, choosing message strategies, and determining optimal delivery channels (p.442).

Kreuter & McClure address three of McGuire's variables - source, message, and channel – which are re-framed around two important questions: how does this particular variable influence communication effectiveness; and

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<sup>10</sup> Lasswell's (1948) classic outline of the study of communication states: "Who ... says what ... in which channel ... to whom ... with what effect".

how does culture influence the variable? (Ibid) The authors provide us with a useful analytic tool to uncover how notions of expertise, trustworthiness and credibility, and structural and background similarities of peer educators are perceived and interpreted by audiences and how this works toward influencing and shaping perceptions of health messages (Kreuter & McClure, 2004).

Kar and Alcalay (2001) focus attention on the complexity of issues that arise when dealing with public health within diverse ethnic and cultural communities and what they refer to as the “multiplicity of social realities” such as culturally rooted beliefs, values, social networks, language, leadership structures, and customs (p.xvi). Effective health communication must first recognize the “felt needs” of diverse communities regarding specific health issues (such as heart disease or diabetes), and establish a “bond of relation” across the various communities, relevant stakeholders as well as health care professionals (Kar & Alcalay, 2001, p.339). For researchers, this more often than not means abandoning hypothetical questions intrinsic to evidence based research practice in favor of research that strives for more creative ways to respond with meaningful information and services to the multiplicity of experiences within communities (Latour, 1986; Lupton, 1995; Kar & Alcalay, 2001).

Alice McIntyre’s (2000) use of action research methodology is an excellent illustration of an innovative approach to research. Her work with urban youth focuses on facilitating members of the community involved in her project to articulate how violence is produced, reproduced, and experienced on

a daily basis. By positioning participants as “agents of inquiry and “experts of their own lives”, participants are able to initiate proactive strategies for promoting and sustaining non-violence in their school and community. McIntyre claims that, “the participants’ stories challenge us to redefine the parameters of how we think about and make meaning . . .” (p.125).

McIntyre notes that much of the research on violence and violence prevention is often accepted without a critique of the assumptions regarding research questions, methodology, and data analysis. As McIntyre states,

the students I teach embrace research that has a history of being ahistorical and acultural (or uncultural) and that often fails to take into account the interconnections and relationships that exist between the individual and her or his embeddedness in social contexts (Ibid).

Understanding interconnections and relationships is an important development in public health communication theory. For example, Brown, Maycock, and Burns (2005) explore the "symbolic interactions", that is, the ways in which gay men use, interact, and construct meaning with others in social environments such as on-line chat rooms (p.64). The authors are interested in how gay men create on-line spaces, the cultural *habitus* that develop and how these may change, and the opportunity that this may provide for health promotion initiatives. (Ibid).

Indeed, the research clearly determines that gay men are using the Internet for a variety of reasons including role-playing, discussions about sex, social and health information, seeking sex partners, and consequently have created a complex culture of communication. As the authors state,

the men would converse or reflect within themselves, pull out stimuli or cues selectively from the environment (such as the online chat and posted profiles), assess their significance and compatibility, interpret the situation, judge the actions and responses of others and self, and ascribe meaning. Interaction also took place within the individual men as they assessed their own feelings, attractions, moods, and sense risk (p.70).

What the authors bring to the table is the notion that although online communities create a unique opportunity for health promotion, it is important to consider the particular culture and the range of meanings and reasons for gay male use of the Internet. New technologies have clearly created new spaces where people congregate and interact. Although some social behaviors may carry over from face-to-face social interaction, it is important that we understand what Clifford Geertz (1973) referred to as the “webs of significance” that we have spun, reminding us that when examining any culture the “analysis of it must be an interpretive one in search of meaning” (p.5).

### **Communication Models**

Public health communication is predicated on numerous theories, principles, models of human behavior, and assumptions. By their very nature public health campaigns are embedded with values that both influence and help justify the goals and objectives of any health promotion campaign: the promotion of good health for all (Guttman, 2000; Lupton, 1995). Although the point is difficult to dispute, it is important to consider that public health

communication is not value-free but heavily influenced and shaped within its social context.

In this sense, public health is construed along the lines of power and knowledge and, as Foucault suggested, facilitates the reproduction of power relations that shape our bodies and identities and is based on ethical and moral practices of the self (Foucault, 1973). As it relates to public health discourse, Lupton (1995) states that the “knowledges [sic], discourses, and practices of public health serve both to constitute and regulate such phenomena as ‘normality’, ‘risk, and ‘health’” (p.4).

Currently, the social construction of health on the one hand, relies on the individual as a rational, unified self (Lupton, 1995; Crossley, 2004), and on the other, promotes the body as a vehicle of pleasure that must be preserved to “combat deterioration and decay” (Featherstone, 1991, p.170). A Foucauldian analysis frames this phenomenon as the conditions of power on the body through regulation, governmentality, and supervision acting as a form of control (1973). Turner (1992) claims the regulated body as pivotal in conducting social analysis and one might argue is itself adept and susceptible to function as a “regulatory system” (p.43). It is what Althusser (1971) would call the “expansion of the conditions of production” (p.127), the “*mise en scène* of interpellation” where as subjects we are reflected in the very structure of all ideology (p.177). Thus, I would argue that the body is simultaneously construed and experienced as an observable site, a *tabula rasa*, and a private affair.

Superimposed onto our constructed subjectivities and regulated bodies are public health communication models such as Social Cognitive Theories and Risk Communication. As more or less over-arching theories, the name of the game has been to understand the undercurrents of behavior and the choices people make when it comes to health behavior and to develop health education programs and campaigns that incorporate this knowledge (Crossley, 2004; Hornik, 2002; Singhal & Rogers, 2003).

Risk communication in general can be characterized by two distinct approaches in which the first is designed to assess, measure, and treat risk as an objective phenomenon. Under this model, risks are defined and determined by experts whose primary goals are to develop risk probabilities and develop management programs (Parrott, 2004; Alaszewski, 2005). An example of this approach in practice is a cognitively based prevention program known as AIDS risk reduction models (ARRM). ARRM's are designed to assess associations among AIDS risk behaviors and attitudes in an effort to predict for example, future condom use based on past behaviors. The goal in this case is to use the predictions to develop strategies that ultimately affect behavior change (Connor, Stein, & Longshore, 2005).

In one study, ARRM's are predicated on research that determined a link between risk taking behavior and risk seeking personality types (Connor, Stein, & Longshore, 2005, p.380). Research supports the hypothesis that high-risk seeking leads to increased risk for contracting HIV and that attitudes toward behavioral change differ between low- and high-risk seekers (Ibid). As well,

links have been determined between high-risk seekers and risky sexual behavior including higher rates of unprotected sexual intercourse and multiple sex partners (Ibid).

Although this type of research can be useful in detecting patterns and themes of behavior in order to establish intervention strategies, there is a problem when research depends on the very notion of developing personality 'types'. One concern is the construction of a definition of risk seeking that is conceptualized as irrational or deviant (Tulloch & Lupton, 1997) and characterized by problem behaviors. Although it is necessary to define the field in which you are working, it is difficult not to think of these terms as subjectively defined and embedded with bias and values.

The second approach to risk communication regards risk as a socially constructed, subjective phenomenon that is often characteristic of non-expert, individual understandings and behaviors toward risk. The primary goal of this approach is to understand the ways in which risk information is communicated and assumptions about social action and human behavior. Risk campaigns are often designed with the belief that individuals are "rational actors" who will simply respond to health risk information in positive and active ways (Alaszewski, 2005). However, the Rational Actor Model of risk communication is insufficient because risk information models constructed by experts most often rely on measurable and predictable components that aim to determine and

manage harmful events within populations despite how these events may actually be affecting individuals (Alaszewski, 2005, p.103).<sup>11</sup>

A major critique of this approach is based on research into how people access, search for, and use risk information. Obviously, new technology provides many individuals with convenient access to health information yet the Internet is by no means the only channel that people are exposed to or use. (Singhal & Rogers, 2003, Northouse & Northouse, 1992). Other issues include trustworthiness and credibility of information as well as the need to consider how people actively interpret risk information. One interesting concern that has been raised is the need to understand how target groups often do not share a homogeneous definition of a particular danger and the risks associated with it. Yet another issue is how some individuals actively seek out health information while others actively avoid information regarding specific health issues (Alaszewski, 2005; Seale, 2005).

The concept of risk is a social construct that often adheres to contradictory terms of definition. For example, risk is often construed as behavior that has only negative effects and actions. On the other hand, risk can also be considered a positive force in that certain risk behaviors are brave or

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<sup>11</sup> A recent BBC World News report on Avian bird-flu was an interesting example of this process. The journalist was interviewing a World Health Organization specialist repeatedly asking him the likelihood of a global pandemic. The WHO specialist kept repeating that it was important to keep the issue in perspective and to understand that there is no serious threat since Avian bird-flu rarely jumps species and that although any death is tragic, as of February 13, 2006, the World Health Organization (WHO) had confirmed 169 cases of H5N1 in humans in Indonesia, Vietnam, Thailand, Cambodia, China, Turkey and Iraq, leading to 91 deaths. As one health expert stated, "if I was a bird, I would be worried".

cool. As mentioned earlier, risk can be viewed as a sense of empowerment (Moore 2004, Crossley 2004, Rofes 1998), while for others risk is embedded in a particular culture such as athletics and high profile business (Tulloch & Lupton, 1997). Singhal and Rogers (2003) make the important observation that notions of love are often constructed in ways that require risk-taking in ways that can also contribute to unsafe sexual practices (p.213). Connor, Stein, and Longshore (2005) identify high-risk behavior as “impulsivity”, “disinhibition”, and engagement in “problem behaviors” but fail to identify the context in which these behaviors may be generated (p.380). As Tulloch and Lupton (1997) have rightly pointed out, there are important class and gendered responses to risk (p.6), taking into consideration that a neo-liberal lens often obscures the fact that some people have greater access to choice and greater authority over the ways in which risks are identified and managed. Finally, defining and identifying high-risk types challenges us to consider whether these types practice high-risk behavior in all situations.

Like Risk Communication Models, Social Cognitive Theory (SCT) defines human behavior as a process that takes place within a multitude of factors including social environments, behavior and feedback as well as a knowledge base obtained through experience. Personal agency and control over one’s life within a series of broad socio-structural networks is central to this theory as is the belief, suggesting that individuals are both products and producers of social systems (Bandura, 2002). In this sense, reality and behavior are understood as constructed, adaptable, and predictable and that by

understanding this process of identity construction, behavior can be observed, understood, predicted, and changed (Bandura, 2002; Connor, 2005; see also Baranowski, Perry, & Parcel in Glanz, Lewis, & Rimer, 1997).

As Singhal and Rogers (2003) have pointed out, there are several mistaken assumptions associated with SCT worth noting: first, behavior change strategies assume that individuals are in control of their context. It is imperative that we understand that, on the contrary and in the case of HIV prevention that: first, access to condoms, HIV testing, and clean needles are not universal; second, behavior change models often assume that all persons and relationships are equal; third, behavior change strategies often assume individuals make decisions of their own free will; and, fourth, the assumption that individuals make preventative health decisions rationally (p.212). With this in mind, how do we affect behavior change when, for example, desire, pleasure, and intimacy overrides the sense of risk?

The Health Belief Model is an attempt to address some of the weaknesses of Social Cognitive Models. Developed in the 1950's, it was designed to explain why and how people engage in certain health related behaviors (Northouse & Northouse. 1992). Rather than focusing primarily on the "transactional variables" of communication - the recognition that there are complex processes in place that affect and determine the information we communicate and how we communicate it<sup>12</sup> - this model is unique in that it

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<sup>12</sup> A brief and interesting example is Leary's model that stresses the "interactional" aspects of interpersonal communication. Leary developed his model as a result of his experience as a therapist. He noticed that his behavior was different with each client concluding that patients actually influenced the way he behaved towards them. Leary

focuses on individual perceptions of susceptibility to a disease, the perceptions of benefits and barriers to preventative behavior as well as the social-psychological variables that influence behavior and decision making (Rosenstock, 1974 cited in Northouse & Northouse, 1992, p.13).

A variety of transactional variables are often considered, including the influence of mass media and peer/family advice. However, the emphasis is on how individuals internalize, interact, and ultimately use information to construct health behavior decisions. As way of illustrating this, an acquaintance recently told me a story about an encounter between himself and a new sex partner. The two met on-line and decided to get together for sex. This is how my friend told the story:

We got together for the first time and he wanted to fuck me. He was younger than me – I think 21 or 22. I told him that was cool and that I was HIV positive – so if he wanted to use a condom, I was completely cool with that. He said that he didn't like using condoms and that he preferred to fuck raw. I told him again, I said, 'look dude, I'm HIV positive – are you sure you don't want to use a condom?'

The guy looked at me and told me that his sister died of AIDS and that it didn't scare him. He said that fucking raw made him feel connected to his sister (anonymous, personal communication, 2006).

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determined that individuals train others to respond to them in ways that are significant to them. For example, under Leary's model, a dominant person conditions others to behave submissively towards them. This draws attention to the transactional complexities of relationships as well as issues regarding power (Northouse & Northouse, 1992, p.10).

In conclusion, there is no shortage of public health communication models and theories. However, health promotion,<sup>13</sup> on the one hand, ultimately ignores the experiences of the individual in favor of a rationalist paradigm committed to identifying factors that will produce certain results under specific conditions. As Lupton succinctly states,

[the] dominant concern has been *instrumental*, [emphasis mine] directed at providing a model of explanation for the effects of a planned intervention, with the objective of more effectively influencing individuals or groups (p. 55).

On the other hand, most health communication models are premised on the so-called Knowledge-Attitude-Behavior (KAB) standard that assumes a linear trajectory reminiscent of early communication models<sup>14</sup>. The assumption is that, first, individuals are rational and, second, they will respond appropriately to transmitted knowledge that will in turn change attitudes and behavior (Bandura, 2002; Lupton, 1995). Furthermore, it seems that the continued development of evidence-based models as a method for constructing knowledge has limits. Although there is merit in fulfilling Baconian scientific methodologies, this practice of generating knowledge based on probabilities seems ultimately flawed in that constructing models based on positivist

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<sup>13</sup> The term "health promotion" is a relatively new concept, first introduced into the public health lexicon in a 1974 report by the Canadian Minister of National Health and Welfare, Marc Lalonde. Lalonde's report was significant in that it advocated preventative strategies that emphasized both the socio-cultural conditions as well as individual lifestyles as determinant factors in establishing and maintaining optimum health conditions. The recommendations in the report were adopted in 1976 by the Department of Health and Social Security in Britain in and in 1979 by the Surgeon General in the United States. (Lupton, 1995, p.50).

<sup>14</sup> The Shannon-Weaver model states: a message begins at an information source, which is relayed through a transmitter, then sent to the receiver.

approaches to determine behavior change are often predisposed to faulty assumptions regarding social equality, social and cultural context, and rationality (Lupton, 1995).

On the other hand, most health communication models are premised on the so-called Knowledge-Attitude-Behavior (KAB) model that assumes a linear trajectory: transmission of any communication model. The assumption is that, first, individuals must be aware of the health problem and its consequences; second, they must believe that the behavior is important to their health; and third, they must believe that the behavior is within their control. This model is based on the assumption that individuals will act rationally and that they will choose the healthiest option. However, this model is flawed in that connecting models based on positive health knowledge has limits. Although there is a link between health knowledge and behavior, this link is not always direct. Health communication models based on positive health knowledge often fail to account for the complex social and cultural context in which individuals live. For example, individuals may have the knowledge that smoking is harmful, but they may not be able to quit because of social pressures or addiction. Similarly, individuals may know that eating healthy is important, but they may not have access to healthy food options. Therefore, health communication models based on positive health knowledge are often flawed because they do not take into account the social and cultural context in which individuals live.

<sup>11</sup> The term "health promotion" is a relatively new concept first introduced into the public health lexicon in a 1974 report by the Canadian Minister of National Health and Welfare, Marc Lalonde. Lalonde's report was significant in that it advocated preventive strategies that emphasized both the socio-cultural conditions as well as individual lifestyles as determinant factors in establishing and maintaining optimum health conditions. The recommendations in the report were adopted in 1976 by the Department of Health and Social Security in Britain and in 1978 by the Surgeon General in the United States (Lupton 1995, p. 50).

<sup>12</sup> The Shannon-Weaver model states a message is sent by a transmitter, then sent to the receiver which is relayed through a transmitter, then sent to the receiver. (Lupton, 1995, p. 50)

## **Making the Podcasts**

As stated earlier, I became interested in investigating how podcasting could be used to aid health agencies in designing strategic communication programs and, in particular, creating a space to explore the possibilities of this new medium in fostering “community dialogue”. I approached John Maxwell, Director of Communications and Community Education with ACT, in November, 2005 with the idea of creating a series of podcasts that could be available for download on the ACT website. John was very enthusiastic, mentioning that based on preliminary result of the 2005 *Knowing Me, Knowing You* survey, ACT was strategizing around developing new on-line prevention and harm reduction strategies that would include podcasting. We set up a meeting with two ACT staff members, Haran Vijayanathan, Gay Men's Community Education Coordinator; and Nick Boyce, Gay Men's Harm Reduction Coordinator, to develop episode content.

The first production meeting was held on January 5<sup>th</sup>, 2006 to introduce the project, to explain the various format options, and to brainstorm around content. Everyone was really excited with the project. John Maxwell mentioned that ACT was interested in developing innovative communication strategies in light of new technology and the ways in which people are gathering information. I mentioned that alongside providing a unique communication channel, podcasting would allow ACT a unique opportunity to archive the responses of both the organization as well as the community to the various

health issues. The group was very excited about the possibilities of this and discussed future possibilities such as a monthly podcast news bulletin, and a variety of segmented podcasts targeted at youth communities and non-English speaking communities.

The next step for this project was to secure approval from the ethics review board at Ryerson University. I was required to establish a consent form for the participants (see Appendix 2) that proved to be a challenge in its own right. The basic stumbling block was with the social science language used in my proposal. For example, in my ethics proposal, I talk about “interviewing participants” which was construed by the ethics review board as a standard data gathering protocol when, in fact, it was meant in the journalistic sense. Furthermore, the committee could not conceive of why the interviews would be broadcast, the concern being for the public disclosure of the “informant” identities.

Eventually, the committee researched the nature of podcasts, and were finally convinced that the interview process was with well-known community activists and experts who would not be concerned with revealing their identity. Furthermore, I convinced them that the “data” gathered was based on my investigation into how podcasting can be used to aid health agencies in designing strategic communication programs, rather than the content of the podcasts. The project was approved and as it turns out the podcast pilot project is the first of its kind at Ryerson University.

## **Episode 1: Since Tina Moved Out: Life After Crystal Meth**

The idea for the first podcast project came from an ACT sponsored public forum on crystal meth called *Since Tina Moved Out: Life After Crystal Meth* part of *SEXploration*, an annual, week-long community event that explores issues concerning gay, bisexual and trans men. Held at Buddies In Bad Times Theatre, a central, popular mixed-use venue in Toronto, the forum consisted of a panel of three ex-crystal meth users as well as Shaun Proulx, a familiar Toronto journalist who acted as moderator. Also participating was Nick Boyce, Gay Men's Outreach Worker with ACT, who provided background on the very unique chemical characteristics of methamphetamine. About 60 people attended the event and an open microphone question and answer period provided an opportunity to ask questions.

The forum was designed to stimulate discussion, arouse debate and awaken passions around a number of issues that gay and bisexual men currently face. According to Haran Vijayanathan, ACT's Gay Men's Community Education Coordinator and *SEXploration* co-organizer, "creating safe and fun spaces for men to talk about these issues and learn at the same time, [is] crucial when it comes to the prevention of HIV/AIDS" ([www.actontario.org/](http://www.actontario.org/)). The panelists were remarkably frank, honest, candid, and even funny about their addictions, and shared invaluable insight into using and escaping crystal meth. I immediately thought that this would make a remarkable podcast.

I approached John Maxwell, Director of Communications and Community Education with ACT and proposed that we reassemble the forum

participants as a round table discussion in a recording studio at Ryerson University. I worked with Nick Boyce, providing him with an electronic copy of the project proposal and the consent forms, which he emailed to the forum panelists by means of an introduction. The major problem was coordinating personal schedules with the studio at Ryerson. In the end, Duncan MacLaughlan and Shaun Proulx were the only forum participants available to participate.

I must thank Richard Grunberg in Radio and Television Arts at Ryerson University for his invaluable support with this project. I approached Richard with the podcast project inquiring into the possibility of using recording facilities in the Rogers Communication Centre. Richard quickly set up a meeting with Lori Beckstead and Don Elder to discuss the project and what I would need and soon agreed on using the SPIRITlive Studio at Ryerson University.<sup>15</sup> I was then put in contact with Heather Kirby, Staff Advisor with SPIRITlive who generously offered her time as recording technician. Both podcasts were recorded in the SPIRITlive studio at Ryerson University.

The first podcast was recorded on February, 7<sup>th</sup> 2006. Present were Nick Boyce from ACT, Shaun Proulx, Duncan MacLaughlan, and myself. Shaun and Duncan were already prepared based on the ACT forum and other events that they have spoken at. Shaun Proulx is a Toronto-based writer and is frequently sought by mainstream media for opinions and comments on GLBT issues such as same-sex marriage, HIV/AIDS, and crystal meth. He is the editor and

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<sup>15</sup> SPIRITlive was launched on December 22, 1996, and is run by the School of Radio and Television Arts (RTA) at Ryerson University. The goal of SPIRITlive is to give RTA students an opportunity to put their knowledge, skills, and creativity into action in a modern broadcast environment.

publisher of GayGuideToronto.com, where he is known for his provocative and entertaining interviews. Shaun contributes frequently to the Globe and Mail and he is a feature contributor and columnist with Xtra! and Outlooks.

One of the main concerns for Duncan was how the topic of the podcast was going to be framed in the introduction. Specifically, Duncan was not comfortable with being a poster boy for gay men who use crystal meth. I suggested that what I believed was important in this exercise was his personal narrative about his experiences and how others could possibly see their lives reflected in his story. In this sense, Episode 1 adheres to a Peer Education Model that relies on the credibility of lived experiences as a means of delivering health information and support. One of the features of Peer Education is the need to understand the nature of interpersonal networks and how these networks can affect individual decisions and behavior. Furthermore, peer-educators are often identified and selected as opinion leaders because of their experiences with an issue (Singhal & Rogers, 2003).

One of the most important themes that emerges in the podcast with Shaun and Duncan is the complex socio-psychological intertwining of sex and drugs. It is not within my expertise or within the scope of this project to untangle the nuances. However, I was struck by Duncan's use of language and his willing to talk about the sexual and emotional intimacy that was such a significant part of his experience with crystal meth. What is interesting is how this sense of intimacy is extended through the drug experiences and into what Duncan refers to as the "core desire" to get and stay clean. Duncan's primary

experience is not one of depravity but rather of an intense physical and emotional desire. It clearly speaks to Turner's self-expression of the body, Crossley's "resistance *habitus*", and Rofes' recovering of the pleasure principle mentioned earlier. These are complex personal yet at the same time socio-cultural issues that require a deeper understanding than that offered by current health prevention models.

## **Episode 2: Women, HIV, and AIDS**

The idea for the second podcast came from a Toronto Star article on Women and HIV (Friday, December 9<sup>th</sup>, 2005). The focus of the article is on some of the problems that HIV+ women face, and in particular, the isolation that is often considered a hidden side effect. Currently, women represent a growing proportion of positive HIV test reports in Toronto, Ontario, and Canada. According to the most recent reports, women have accounted for about 25% of all HIV diagnoses in Canada over the past three years (2001, 2002, and 2003), 27.8% of all positive HIV test reports in Ontario for 2002, and 25% of positive HIV test reports in Toronto for 2002.<sup>16</sup>

One of the women interviewed in the Toronto Star article is Louise Binder. Louise Binder is an HIV+ female lawyer who was diagnosed with HIV

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<sup>16</sup> Women accounted for 38.6% of all positive HIV test reports among Canadians aged 15 – 29 in 2002. Heterosexual contact accounted for 58.3% of positive HIV test reports among women in 2002. In Ontario, heterosexual contact accounted for 79.5% of HIV diagnoses among women in 2002. Injection drug use (IDU) is another significant risk factor. IDU accounted for 37.2% of positive HIV test reports among women in 2002. As well, women from countries with high rates of HIV infection (so-called 'HIV-endemic' countries) accounted for 45% of all positive HIV test reports among women in Toronto in 2002. Women make up an increasing proportion of Canadians living with AIDS, from 6.1% before 1994 to 16.5% in 2002 (Report on HIV/AIDS in Ontario, Robert S. Remis, MD, University of Toronto, November 2003).

in 1993. Due to her disease she was forced to retire from work in 1994. Since then, she has been a volunteer board member and co-chair of the Toronto People with AIDS Foundation, and is currently Vice-Chair of the provincial women's AIDS organization, Voices of Positive Women.

After the introduction of highly active antiviral therapy (HAART) in 1996, Louise's health improved and she took on further volunteer activities. In 1997, she helped to found and, since its inception, has chaired the Canadian Treatment Action Council, which does systemic advocacy for access to HIV treatments. She is also co-chair of the federal Ministerial Council on HIV/AIDS; member of the Community Advisory Committee of the Canadian HIV Trials Network; member of the HIV/AIDS Ethics Committee of the University of Toronto; one of the founding members of the recently formed Blueprint for Action on Women and HIV/AIDS, and Chair of the Canadian Advisory Committee for the HIV+ Children's Hospital Project led by the Canadian Society for International Health.

Louise has been involved in many of the important advocacy struggles facing the HIV+ community over the last twelve years including the battle to save and increase federal funding for HIV/AIDS; the battle to get timely access to safe and effective drugs at the federal and provincial government levels; and, the battle to ensure earlier access by the pharmaceutical industry to drugs in development.

Louise has received a number of awards and honors for her efforts including the City of Toronto Constance E. Hamilton Award, the Order of

Ontario, an Honorary Doctorate of Laws from her alma mater Queen's University Law School, the Queen's Jubilee Medal, as well as awards from the communities she serves, including the Ontario AIDS Network Award and the Canadian AIDS Society Leadership Award.

Needless to say, I thought Louise would be an excellent person to interview regarding women and HIV. I sent Louise a copy of my project proposal via email and requested an interview for the pilot project. Louise called the next day, agreed to participate in the project, and arranged a time to meet and discuss the interview. Meanwhile, I met with Kristy Buck, Wellness Program Coordinator with ACT to tell her about the interview with Louise Binder. During my internship at ACT, Kristy mentioned that her research for her MA in Social Work involved women and HIV/AIDS.

Kristy Buck obtained a BAH in Psychology at Queen's University, Kingston, and a Masters of Social Work from the University of Toronto. During her graduate work, she had a placement at the Positive Care Clinic at St. Michael's Hospital where she developed a keen interest in HIV, and HIV+ women in particular. Kristy focused her studies on developing an evidence-based psychosocial model for working with women living with HIV and exploring existential issues related to the meaning of life for positive women. Kristy was interested in continuing to work in the field of HIV, and has been working at the AIDS Committee of Toronto since as a counselor, a case manager, and, currently the Wellness Program Coordinator.

Kristy's work at ACT has included a collaborative research project with the CLEAR Unit at McMaster University on case management. She has also facilitated the positive women's youth group, co-facilitated ACT's first youth retreat, helped to plan the annual women's retreat in collaboration with Voices of Positive Women and Casey House, co-facilitated ACT's first Media Training Program for PHAs. Kristy currently co-facilitates ACT's monthly Women's Coffee Night.

I asked Kristy if she would be interested in interviewing Louise for the podcast since I believed she had an excellent understanding of the issues. Kristy was very excited about the idea and immediately agreed to participate. I set up a production meeting with Louise and Kristy on March 6<sup>th</sup>, 2006, at ACT, when we planned what direction the interview would take.

The initial question was to determine who the intended audience would be. We decided that the target would obviously be women, but with a particular slant towards women who suspect they might be infected with HIV or have recently been diagnosed with HIV. We reasoned that this would allow for the conversation to include a wide range of topics including issues around testing, stigma and discrimination, equity and power relations, disclosure, as well as developments in treatment and prevention strategies. Kristy agreed to insure that we had the most current and reliable statistics available for the interview, which we decided would be held Thursday March 26<sup>th</sup> 2006, at the SPIRITlive studio at Ryerson University.

One of the important concerns that emerged in the Women, HIV, and AIDS podcast are the issues related to HIV testing for women. Louise describes her own experience with her doctor who was reluctant to test her for HIV because as a heterosexual woman she was considered at the time to be in a very low risk category. Once again, this illustrates the problems associated with an established epidemiological hierarchy where assumptions are made regarding the *permutations* of people's sexual behaviors as well as who is really at risk. In this case, her second husband who kept his own sero-positive status a secret from her infected Louise with HIV. Despite persistent and lingering infections and other health problems, it was primarily through her tenacity that her doctor finally tested Louise for HIV.

This conversation is significant because it draws attention to the importance of understanding the impact of our behaviors in relation to the disparate identities and communities, the interpersonal networks, and what Louise refers to as the "intersection of cultures and identities" that we inhabit. It draws attention to attitudes and the surprisingly persistent stereotypes of who is "at risk" to HIV infection. It draws attention to the serious socio-economic power imbalances that have direct consequences on women's bodies and lives. And finally, it draws our attention to the limits of concepts *and* language for providing a framework through which these issues can be addressed.

## **Discussion**

The impetus for this project came from my own experience with a medical condition and my discovery of an on-line community of individuals with the same condition. The *Dizzy Lounge* chat community allowed me to explore the stories of strangers who mirrored many of the symptoms and anxieties I was and still do experience. This relationship piqued my interest to explore other ways that people shared health related information on-line. In particular, I was curious as to how marginalized groups in the gay community were establishing networks that fostered dialogue on issues that were relevant, meaningful, and helpful towards their specific community.

I was lucky to be involved in a research project with ACT that allowed me to understand how large scale public health campaigns are constructed and evaluated. Research by Barry Adam suggested the need to create space for people to share and make available their stories as a means of addressing the uneven communication processes used in HIV prevention strategies. It is under these conditions that I have used podcasting to claim social space and create important new symbolic capital at a time in the cultural history of HIV/AIDS that requires voices. The graceful and eloquent voices and stories of Shaun Proulx, Duncan MacLaughlan, Kristy Buck, and Louise Binder exemplify the value of this approach.

In terms of evaluating the effectiveness of the pilot project, it is not within the scope of this study. However, as mentioned, there are serious

limitations with regard to tracking user habits of podcasts, yet, it appears this will quickly change as specific tracking software is developed. For now, an evaluation of the pilot podcast project for ACT will require more conventional methods such as user feedback requests, anecdotal evidence, as well as peer reviews. In the past, ACT has also participated in larger studies like *Knowing Me, Knowing You*, aimed at determining the effectiveness of a series of recent large scale AIDS awareness campaigns, suggesting that the pilot podcast series could be included in future research.

This, however, raises the question as to what aspect of the podcast project would be evaluated? The problem faced in designing a meaningful evaluation for this project is that it was not based on a public health communication model as such and, therefore, a model of intended effects was never established. I was interested in exploring how podcasting could be developed as a strategy for narrative self-representation (a term used in emerging health communication theory known as the “biographical research” (Zinn, 2005) as a means for exploring the broader socio-cultural context of, for example, HIV/AIDS or crystal meth. As stated in my ethics proposal, the aim of the project was not the content of the podcasts *but how podcasting can be used* to aid health agencies in determining the social context of social forces that in turn can inform strategic communication programs.

With this in mind, ACT is eager to explore a number of possibilities including a monthly podcast newsletter as well as podcasts targeted to youth audiences and non-English speaking communities. Future public forums (like

the original *Since Tina Moved Out: Life After Crystal Meth at SEXploration* organized by ACT in November, 2005) will undoubtedly be wired for sound and, therefore, will only require hooking up a laptop to the existing soundboard to record the sound on free software like Audacity.

The last thing on the table has been a discussion around the possibility of developing a partnership between SPIRITlive and ACT. The advantage is mutual in that, in exchange for studio time, the podcasts could also be broadcast on SPIRITlive radio as well as be available for download on the radio website. On the one hand, this would provide much needed content for SPIRITlive and, on the other hand, the ACT podcast would reach a wider audience. This type of partnership between community organizations and educational institutions could be a significant contribution to creating community dialogue and greater public understandings of public health issues.

**Appendix 1: Sample of posted messages and message streams on  
<[www.handball.com](http://www.handball.com)>**

(a)

I happily fucked, sucked and fisted my way through the sex clubs and alleyways of San Francisco in the late '70s and early 80's - it was thrilling, erotic, and oodles of fun. I survived it without getting HIV, but I caught the clap many, many times, crabs every now and then, Hep B, colds and Scarlet Fever twice - group sex is a very efficient way to spread ANY disease that's around, whether it's an official STD or not.

I think the message of those articles is that unprotected fisting is more likely to serve as a transmission activity for diseases than protected fisting. Well, that's no news, is it? Anyone with a grain of sense knows that HIV is not the only disease in the world, and that exchanging body fluids is more likely to spread microbes than not exchanging body fluids.

So - knowing about the diseases that are around and then modifying your behavior a bit so that you don't help transmit them is pro-fun, not anti-fun. I've had a lot more great sex than old friends who were caught by the unprotected sex route of disease transmission long ago and are now dead. They taught me that dead people do not have as many opportunities for good sex as live people, a costly lesson that I do not take lightly.

Taking modest steps to stay alive and healthy will lead to much more pleasure in the long run - if you leave responsibility for disease transmission to Fate, Fate will happily wreck your sex life.

(b)

I thought I would tell my story about being Hep C positive and fisting just to help put things in perspective. I have had 3 long term partners who remained negative to everything whilst I am Hepatitis C positive. My current partner tops me beyond the elbow - so obviously, lots of bare skin contact. Whilst we do not over worry we use sensible precautions such as checking for obvious breaks in the skin - hands are more likely to have a skin break than the arm. If my partner has a cut on his hand then he will use a glove for that hand - no big deal - a change is as good as a holiday as they say - I quite like detecting the difference between a gloved hand and non-gloved and gave up, a long time ago, trying to debate which felt better - after all, it is a matter of commonsense for the sake of my partner. We practice ordinary sensible hygiene - that is, my partner washes his hands and arms before play (since we do not want to compromise my health any further with any unnecessary infections).

We try not to let my Hepatitis C status dominate our lives but sensibly keep an awareness of it. My gay doctor is very supportive of our fisting practices and is happy with our extreme level of play. The main thing is to avoid blood-to-blood contact - assume that the bottom has some infected blood - even if not showing pink - which puts a lot of the burden on the top to assess his own risks. To date, over 25 years, there has been no problem for my respective partners who have remained negative.

By the way, living long term with Hepatitis C is hard so it is best not to contract it. If you would like more information on what it is like after 30 years then let me know. Also, I am currently on peg interferon 2a plus ribavirin treatment at the moment and that is extremely tough and I am just too weak to play. By the time I douche I am too tired, heart racing, to play - the side effects are horrendous. The financial impact is huge (my government, Australia) will not pay for my treatment because they paid for an earlier treatment that failed and they make value judgments because most people become infected through injecting drug use - I cannot work very much although I still have to support my staff. My partner has to do everything at home. I could not imagine doing this treatment without a great partner. I am responding to treatment and my liver is much better now (the liver can restore itself!) and I am optimistic for the future. At worst, I will have some good years ahead - ad [sic] because my liver is having such a nice holiday from the virus whilst I am on treatment. At best, I will be cured by this treatment.

## 2.

A "flush" with three table spoons of Metamucil 24 to 36 hours before a big scheduled play date followed with plenty of water and then a very low fiber diet will tend to carry everything out. Taking an anti-diarrhea drug helps the colon to dry things out, which is what you want. Lomotil prescription for an irritable bowel disorder helps also as it reduces peristalsis in the lower intestine and improves your comfort levels when your colon is empty or full of gas. Avoid fatty foods as that produces gas that tends to interfere with the flow of things.

Finally, consider that change in bowel habits, including change in how easily you clean out, can be an indicator of several things, including cancer or pre-cancerous conditions, low-grade infection, diverticulitis or chronic condition of inflamed diverticulae or pockets of detached surface of colon that can be irritated by seeds and nuts such as cashews or seed husks such as popcorn. Only a gastroenterologist using diagnostic techniques and tests can determine if a sudden change in things is due to a condition that must be treated. By all means have a colonoscopy done if you are over 40 or so and if your family has a history of colon cancer, get one done earlier in life.

There are rather harsh medications you can use such as colonoscopy prep kits to really flush out your system fast, but they contain high sodium and really do a

number on your system. They work, but just be warned that using them can alter your system's responses over time.

3.

I agree with Andrew fully. This thread does not come up often. But perhaps it needs to come up more. We need to have more information about our shared experiences. There are too many lives being damaged and the more we share the more aware we become.

Ten minutes ago I was messaged by a Top on Recon in his late 50s "would love to play with your hole for hours and hours chems help". By the time I explain to him that I was damaged last year, and we need to negotiate the parameters of what we are going to do, and when, and where, I suspect he isn't going to want to play with my hole anymore.

That's too bad. But I will still go through the motions of explaining to him what's what and insisting that I am not about to get wired for a Mr Right Now that I have never met and expose myself to whatever Mr Right Now happens to be up for.

Everything flows from personal responsibility.

4.

(a)

hello everyone,

having a FFing accident and having to go to the emergency room has me scared. I am not sure that is an accident I want to happen. Does that scare anyone else? Anyone have any thoughts on the matter?

(b)

Well, I was rushed off to emergency and would have died had they not operated immediately.

I lived. Thankfully. But I've had three major admissions and a colostomy and an ileostomy, and (sadly) I no longer look like Brad Pitt.

(c)

Fear will do its very worst. Knowledge and awareness are your best tools.

There are no accidents. There are only careless mistakes. However I never injured anyone or myself for that matter in some of the "over" intoxicated conditions I have given myself permission to play in. I am happy today to stand on more stable ground.

Never the less as a top I never asked for or accepted or did poppers, ethyl chloride or special "K" If your top does ask and he is insistent, leave immediately.

In my 35 years experience I think a lot of what has been said in recent threads concerning drugs, hooking up, selfishness and accidents, is very true. Having chosen to not participate in that thread I do want to take a moment to thank all those who have for speaking up and sharing their experiences.

## Appendix 2: Interview Consent Form

### ACT Podcast Pilot Project

#### Interview Consent

I am a MA student in Communication and Culture at Ryerson University and I am conducting a research project, under the supervision of Dr. Jean Mason, investigating how podcasting can be used to aid health agencies in designing strategic communication programs that will have significant effects on individual and community knowledge, attitudes, and behaviors.

The purpose of the project is to develop a three-part podcast pilot series for the AIDS Committee of Toronto (ACT). The aim of the pilot project is to explore how new technology can be used to deliver relevant information to specific communities.

Podcasts are a relatively new form of digital communication. A podcast is strictly an audio file that is downloaded from a website and listened to via your personal computer or mp3 player. Podcasts are an increasingly accessible media with the ability to share information. In this sense, podcasts, like radio, have the potential to produce a shared experience, creating the *possibility* for dialogue within the wider community.

Interviews for the podcast will be recorded and subject to editing into a half hour show. Podcasts will be available as a downloadable MP3 file on the ACT website and will also be hosted by rabble.ca. The podcast will not be produced for commercial purposes. No pictures or videos will be taken during this process. Participation will require engaging in a digitally recorded, moderated discussion approximately 2 hours in length.

You have been asked to participate in this project because of your experience and expertise with issues regarding HIV/AIDS. **Your names may be mentioned during the podcast. If you want your identity to remain anonymous, please check the box at the bottom of this letter.** Participation is voluntary and participants should know that they have the right to withdraw at any time during the podcast or to not answer specific questions or engage in a particular discussion, with no negative consequences or effects on any relationships at Ryerson University or at ACT.

If you have questions about the project please contact:

Martin Chochinov,  
416 364-0599,  
[mchochin@ryerson.ca](mailto:mchochin@ryerson.ca)

or

Ryerson University Research Ethics Board.  
Research Ethics Board  
c/o Office of the Associate Vice President, Academic  
Ryerson University  
350 Victoria Street  
Toronto, ON M5B 2K3  
416-979-5042

By your signature below, you agree to participate in the study and consent without further consideration or compensation to the use (full or in part) of all interviews recorded of your voice and/or written extraction, in whole or in part, of such recordings for the purposes of podcast broadcasting.

You will be given a copy of this form.

Participant signature \_\_\_\_\_ Date \_\_\_\_\_

Project Director \_\_\_\_\_ Date \_\_\_\_\_

I would prefer that my identity remain anonymous.

Please print your name clearly \_\_\_\_\_

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