MERGING THE CULTURES OF HEALTH PROFESSIONALS, PROGRAMME AND DRAMA PRODUCTION IN THE DEVELOPMENT OF A HEALTH COMMUNICATION STRATEGY: AN ETHNOGRAPHIC ACCOUNT OF A CASE-STUDY CONDUCTED IN BBC LOCAL RADIO.

Thesis submitted for the degree of
Doctor of Philosophy
at the University of Leicester

by

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January 2000

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THESIS ABSTRACT

Merging the cultures of health professionals, programme and drama producers in the development of a health communication strategy: An ethnographic account of a case-study conducted in BBC local radio.

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The initial part of this thesis is an exploration of the effectiveness of health education campaigns that utilise the mass media. Research evidence is drawn from the traditions of media effects, audience reception and health campaign development which has qualified the author's understanding of what mass media could achieve in the health domain.

In Britain, the frustrations resulting from the limited success of mass media campaigns in health education have in recent years led some health educators away from conventional approaches to using the mass media to promote their health messages and towards more imaginative strategies. This thesis utilises one innovative project as a case study which has drawn on the knowledge from earlier failures and successes with mass media, and sought to incorporate best practice in an integrated media based health communication strategy.

The development of a health alliance between four district health authorities in the West Midlands, and a BBC Local Radio station is the basis for the case study on which this research is based. This alliance led to the development of a media-based health communication strategy that incorporates models of media advocacy, education entertainment and social action broadcasting.

This thesis is based on the implementation of the case study. Focusing on the implementation of the strategy enabled an exploration of the relationship interface of the three partners, drama production, programme production and health professionals; with each group exhibiting differing norms and values in terms of their perception of health and mode of operation.

The empirical part of the thesis consists of an ethnographic account and analysis of the relationship interfaces with the three parties involved in the implementation of the health communication strategy, health, drama and programme production staff. The thesis concludes with a discussion of the research findings in the context of their relevance, for health promotion specialists, broadcasters and communication researchers, in seeking to affect the portrayal of health.

ACKNOWLEDGEMENTS

That I have completed this thesis is due to the help and support of a wide range of people to whom I am extremely grateful. Firstly to my supervisor, Roger Dickinson, who not only helped me make sense of the alien world I inhabited for five years, but was also for still being there to support me through the numerous redrafts of this thesis.

To Michelle Guiness, Clare Catford, Eric Dixon, and Neil Pringle who presented and brought the features to life with considerable professionalism. To Donald Steele, Jim Lee and Andy Conroy for their support and expertise as producers. To the wide range of health professionals, too many to mention by name, who gave considerable time and support to the implementation of the Listen to Your Heart Project. To Jane Marshall for her professionalism and commitment to getting things right, to Keith Miles for his patience in baring the brunts of queries and suggestions. And not least to the Hillcrest Cast who were tremendously committed to the concept, and gave considerable time to features and outside broadcasts linked to the project.

To Stuart who with good humour has kept me to task and who has appeared to experience life as a single parent for the past eighteen months. To my parents for their continued support and who have had to wait a considerable time for their photograph. To my sister Mary who has helped me keep things in perspective, for her IT support and numerous proof reads. To my children, Harry and Georgia, who have taught me the true depth of unconditional love.

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INTRODUCTION

Recognition of the limitations of the mass media in public health campaigns seeking to bring about behaviour change in individuals and in whole populations has prompted critical reflection on the relationship between health and behaviour. Health educators have been led to revise their strategies for the effective use of the mass media in achieving public health goals, drawing on insights from advertising and marketing principles on the one hand, and models of community empowerment on the other. Social marketing, media advocacy and social action broadcasting are among the popular approaches that currently seek to address some of the shortcomings of previous mass media health education campaigns (Webb and Yeomans, 1981; Groombridge, 1986; Wallack, 1990b).

In contrast with some of the earlier mass media campaigns in which message and strategy development were centralised with little input from those whom the message was intended to reach, these new approaches have in common a recognition of the importance of public health strategies which are tailored to the needs and circumstances of more localised or targeted populations. The strong consumer orientation of social marketing implies a focus on the needs of the target audience: media advocacy stresses the involvement of the public in the policy-generating process; and entertainment-education draws on the entertainment media as sources for 'role model' stories. More critically, the various approaches recognise the importance of collaboration between broadcasters and health professionals and in the mobilising of local organisations as vital forces in the promotion of health (Atkin and Arkin, 1990; Meyer, 1990; McCron and Budd, 1981).

Several studies and research on national and local educational initiatives have informed my understanding of what mass media can achieve in the health domain. They demonstrate that at least as much attention must be paid to the 'non-media' aspects - or what are often referred to as support services, back-up or follow-up activities (Cartwright, 1949, Groombridge, 1972, McAlister, 1976; Puska et al., 1985; McCron and Budd, 1981; Farquhar et al., 1984; Farquhar et al., 1985; Singhal and Rogers, 1989). The Stanford Three Community Study in the USA (Maccoby and Solomon, 1981) indicated that by selective use of mass media and appropriate follow-up action in developing networks and initiating various levels of support, significant factors in health-related lifestyle can be changed and that the change could be maintained. The

North Karelia Project of mass media and personal education in Finland also demonstrated the feasibility of combining a mass media campaign with building a support system in the community to help people implement and maintain lifestyle changes.

Another development has been the utilisation of the entertainment media, as a strategy for attracting a large audience and incorporating health issues. Reviewing the general lessons from the use of entertainment-education strategies in developing countries, Singhal and Rogers (1981) identify two key principles: the necessity of the subtle repeated messages, and the provision of supplementary messages as part of an integrated communication campaign. I quote from previous work by Singhal in which he draws attention to the importance of partnership in an integrated media/health education strategy. He comments:

> **"Entertainment-education communication strategies are most successful when public health officials, broadcast media officials, development planners [...] and other involved parties work collaboratively. Such a collaboration creates consensus between participating organisations and facilitates co-ordination of the public service infrastructure."**
> **(quoted in Rogers and Singhal 1990 p181)**

In Britain, the frustrations resulting from the limited success of mass media campaigns in health education have in recent years led some health educators away from conventional approaches to using the mass media to promote their health messages and towards more imaginative strategies. This thesis utilises one innovative project as a case study which has drawn on the knowledge from earlier failures and successes with mass media, and sought to incorporate best practice in an integrated media based health communication strategy.

The development of a health alliance between four district health authorities in the West Midlands, a BBC Local Radio station and the Health Education Authority is the basis for the case study on which this research is based. The areas of empirical investigation for this thesis focus on the relationship interface between health professionals, programme production staff and drama specialists in the implementation of the case study. The method used to gather this data was ethnography which aims to give life and meaning to the research findings through the realisation of how the impacts in the case study were achieved, what the influences were and what barriers existed in the development, production and broadcast of the media-based health communication strategy.

Chapter One

In this chapter I review the strategies that have been devised since the 1940's to achieve public health goals using the mass media. The chapter plots the changes from viewing the media as the sole intervention to that of a component within a broad campaign strategy. It explores the use of advertising and marketing principles, and the development of campaign strategies that incorporate models of community empowerment and community involvement.

Towards the end of this chapter I draw on components from the previous research outlined which were used in the project under study to develop a creative, media based health communication strategy. This strategy sought to blend the approaches of social action broadcasting, entertainment-education and media advocacy, together with the co-ordination and collaboration of public services and the re-orientation of the media's portrayal of health. Coupled with this was the recommendation that health specialists and broadcasters work in collaboration.

Chapter Two

In this chapter I look at the nature of the two organisations that funded the development and implementation of the health communication strategy that is utilised as a case study in this thesis: the BBC and the Health Education Authority. In doing this I explore commonalities and how differing organisational aims merge to form an interest in funding the strategy's development.

Towards the end of the chapter I merge the areas of commonality between the two organisations in the context of an area of broadcasting known as 'social action' broadcasting or (in the USA) 'pro-social' broadcasting. Here I provide an account of examples of social action broadcasting at a network and local level in the UK. In doing this key themes emerge in the attempt to link broadcast features to non media support services (Rogers and Singhal, 1990). As this necessitates bringing disparate organisations together to work co-operatively and collaboratively, timing logistics and differing professional norms and values emerge in the relationships between health professionals and broadcasters. The relationships between the various participants in the implementation of a health communication strategy based on the social action broadcasting approach is the focus of this thesis.

Chapter Three

In this chapter I present the three areas of empirical investigation for the thesis, the research questions, a research justification for these questions and an outline of the relevant methods. I then describe the methods chosen to respond to the questions posed.

The areas focus on the relationship interface with the three parties in the development and implementation of the health communication strategy; health professionals, programme production staff and drama professionals:

- **Programme Production Staff**

Can the cultures of broadcasting and health merge, through the presence of a health promotion professional within the broadcasting environment, and influence the orientation of health in the feature broadcast output without detrimentally compromising the two distinctly different sets of professional values?

- **Drama Production Staff**

Is it possible to incorporate a radio drama into a media based health communication strategy without detrimentally compromising the two distinctly different sets of professional values?

- **Health Professionals**

Can a media based health communication strategy be established that enables and secures the active involvement of health professionals in the development of health programming?

The research strategy utlised ethnography, and more conventional quantitative tools to illuminate the social phenomena in question, the outcomes and context.

Chapter Four

In this chapter I will provide a description of the development of a partnership between a local BBC Radio station and four District Health Authorities which centres on the secondment of a health promotion specialist to the radio station for the duration of one year. This relationship was to stretch popular notions of collaboration between health and broadcast specialists and pave the way for a creative and challenging alliance.

What emerges from this account are two of the areas of empirical investigation for this thesis, that of the relationship interface with programme production staff and with local health professionals. In an attempt to influence the orientation of the radio station's health content,

the institutional differences between broadcasting and health, and the organisational challenge of mobilising local health professional resources becomes evident. Professional tensions and dilemmas are encountered as the health promotion specialist moves into the broadcasting environment.

Chapter Five

In this chapter I outline the developments between BBC CWR and the local health authorities as they sought to build on the experiences of the health secondment and challenge popular notions of collaboration between broadcasters and health specialists in the development of a creative media-based health communication strategy that combined the learning from entertainment-education, media advocacy, and social action broadcasting. It is the implementation of this strategy; 'Listen to Your Heart', that forms the research basis for this thesis in the form of a case study.

As the health communication strategy sought to incorporate radio drama, this marks the added dimension of a further relationship interface to consider as the differences increase in professional conventions, norms and values. The result was a strategy that stretched the imagination, patience, adaptability and flexibility of three distinctly different cultures, health, broadcasting and drama. The environment proved to be less accommodating as the health promotion specialist enters the world of radio drama.

Chapter Six

In this chapter I present my research findings from the ethnographic data collected during my role of implementing the project. I outline the process for interaction at the three distinctly different professional interfaces; programme production, health professionals and drama production. In presenting the ethnographic data I focus on the roles I undertook at these interfaces; initiator, mediator and enabler. I then explore the specifics of the interface with the health professionals, providing examples for analysis, combined with data triangulation with questionnaire evidence collected for the project evaluation.

Chapter Seven

In this chapter I will explore the nature of the interface with the programme production staff outlining a series of examples gathered from the ethnographic data. I then provide an analysis

of the empirical data triangulating it with interview data collected during the evaluation of the 'Listen to Your Heart' project.

Chapter Eight

In this chapter I outline the findings from the ethnographic data collected on the relationship interface with the Drama Production Team at both a formal and informal level. I then provide an analysis of key professional and organisational differences between the two professionals groups. I then triangulate these findings again utilising interview data from the project evaluation study.

Chapter Nine

In this chapter I draw conclusions from the empirical investigation into the relationship interface with the three professional groups; health, programme production and drama. As I revisit the research objectives I identify and discuss theoretical and practical outcomes from this investigation and their relevance for health promotion practitioners, broadcasters and communication researchers.

CHAPTER ONE

MASS COMMUNICATION RESEARCH AND HEALTH

Introduction

Studies of the effects of the mass media, whether 'popular' or scientific have generated heated debate, widespread anxiety, theoretical discourses and Royal Commissions sufficient to fill large hefty volumes. As this history of mass media effects is well documented, the aim of this chapter is not to repeat this historical account but to draw on some of the key authors to plot the evolution of theory related to the development of strategies to inform and improve public health. This is the evidence that supports the premise of the health communication strategy that is the object of focus in this thesis.

In this chapter I will explore a range of attempts to utilise the media in the promotion of health and lifestyle change that have been adopted during the last 40 years. Here the central aim from a public health perspective has been to attempt to harness the reach and allure of the mass media. Social scientists and health educationalists, during the late 20th century, have sought to realise the full potential of the media, exploring exactly what the media can and cannot do.

I will start with a brief exploration of the early views which focused on the belief that the media exerted a direct effect on the audience and was therefore central and often singular in many campaign structures, through to the later belief that the effect was less specific and difficult to control. The chapter then moves on to look at intervention models that seek to incorporate learning theory and behaviour change theory into campaign development. The chapter then focuses on models of intervention that recognise the importance of public health strategies which are tailored to the needs and circumstances of more localised or targeted populations, and combine 'non-media' based back up services; seeing the media as being of value, if part of a broader more comprehensive strategy.

Towards the end of this chapter I draw on components from the previous research outlined to develop a case for a creative, media based, health communication strategy. This strategy seeks to blend the approaches of social action broadcasting, entertainment-education and media

advocacy, together with the co-ordination and collaboration of public services and the re-orientation of the media's portrayal of health.

1.1 MEDIA EFFECTS

> **"...the entire study of mass communication is based on the premise that the media have significant effects, yet there is little agreement on the nature and extent of these assumed effects." (McQuail, 1994 p327)**

The direct effects model of mass media influence has a long history, which predates systematic empirical research in this area. It was this view which guided much of the early thinking by students of mass communication, informed as they were by late nineteenth and early twentieth century theories in sociology and psychology which implied a view of individuals in society being unable to defend themselves against messages communicated by the mass media.

This persuasive view of the role of mass communication in our lives implies that they are capable of influencing us, persuading us and generally affecting our opinions, knowledge, attitudes and behaviour. This common assumption retained from the early days of First World War propaganda, is that of the media having effects on the hearts, minds and social behaviour of the population at large and especially upon those who by virtue of being young, working class and disadvantaged, are presumed to be especially open to influence by the media. It implied a vision of society characterised by individuals separated from family traditions and their community. Due to this sense of isolation, it was believed that individuals were at the mercy of messages or recommendations for action proposed by the newly emerging mass media.

Despite a lack of evidence either way the model of having 'direct effects' on the audience became enshrined as the key issue and dominant way of thinking about the role of the messages themselves, or of the intentions of those producing the messages. It has proved an exceedingly difficult task to produce a shift from this focus, especially among lay people, even when it proved difficult to obtain evidence to support it (Brown 1970, Dembo and McCron 1976).

Most of the early measures of 'effects' were limited to the short term, and predominantly refer to changes of attitude or predisposition to act, rather than to actual changes of behaviour. As is known the link between attitude change and behaviour change is subject to considerable argument (Becker 1974, Fishbein and Ajzen 1975); change in attitude does not necessarily imply an accompanying change in subsequent behaviour. In the absence of such a proven link it is necessary to be quite specific about the objective of any persuasive communication; information gain, attitude change, change in beliefs or behaviour change. Dembo and McCron (1976), argued that it was untenable to sustain the view of the direct effects model given the weight of evidence to suggest the contrary; even when modified to incorporate the intervening characteristic variables of the audience.

The history of the study of mass media influence on audiences has been characterised by a gradual move way from this model. Gradually researchers were forced to acknowledge that a wide range of intervening factors had to be taken into account when seeking to explain media effects. It was seen then as inappropriate to perceive the audience as a homogeneous mass, and one which operated in a uniform manner. The recognition came that the audience had to be considered as a series of differentiated subgroups. Similarly research began to take into account characteristics of the message itself, and also of the communicator. Klapper (1966) in his classic summary of more than a decade's empirical research states

> **"The old quest of specific effects stemming from the communication has given way to the observation of existing conditions or changes, followed by an inquiry into the factors, including mass communication, which produced those conditions and changes, and the roles which these factors played relative to each other. In short, attempts to assess a stimulus which was presumed to work alone have given way to an assessment of the role of that stimulus in a totally observed phenomenon."**
> **(p137)**

The work of Katz marked a significant turning point for the early notions of powerful media effects, and paved the way for a 'limited effects' paradigm. This was then synthesised by Klapper. The emphasis turned from 'direct influence' models to an emphasis on media messages as just one amongst many types of social factors contributing to the formation of beliefs, attitudes and behaviour.

Katz and Lazarsfeld's publication 'Personal Influence'(1955) significantly altered Lasswell's (1948) classic question for mass communication research, 'who says what to whom with what content on what channel and with what effect?' It achieved this by demonstrating that the previous 'direct' flow of mass media influence was fundamentally mediated by pre-existing patterns of interpersonal communication in local communities. The innovative concept of the two-step flow challenged the popularity of the direct effects model, the separate study of mass and interpersonal communications, and the image of the viewer and listener as part of a mindless, homogeneous mass. As a result, 'Personal Influence' generated a research tradition which extended the theory in many new directions. It was also significant in that it established a mould for media research which many were to follow.[1]

Evidence for the 'limited effects' paradigm was continually growing. Society is not equally affected by verbal and visual messages, nor unselective in their attention to the range of media output, or lacking any framework of reference other than offered by the broadcaster. Far from being sitting ducks waiting to be shot at by the mass media, a notion put forward by Bauer (1971, although dating from 1964) was that audiences obstinately refuse to oblige the mass communicator. It was recognised that in real life it was unlikely that people would be influenced by mass communication at all.

A more realistic conception of the 'audience' was more fully taken up by the 'uses and gratifications' model. The audience comes to be seen as made up of social groups; men, women, differentiated by social class, religious beliefs and cultures, rather than as a uniform mass. Processes of communication between and within these groups are seen as actively selecting from media output, as interpreting images and messages and as constructing the meaning of programmes in ways that help them to gratify their needs: the media therefore does not use people, people use the media (Schramm, Lyle and Parker, 1961).

A number of studies in the 1940s had already focused on the variety of potential gratifications derived from media use (Herzog 1942; Suchman 1942; Berelson 1949; Wolf and Fiske 1949). Each of the investigations provided a list of functions served either by the content or the

[1] The theory of the 'two-step flow' was not without its critics (Gitlin 1978). It was suggested that the theory advocated minimal effects only because it studied short-term over long-term effects and behavioural over ideological effects. The problem, Gitlin argued, was that Katz and Lazarsfeld only considered effects that could be measured quantitatively and thus neglected the long-term consequences of the media. He also argued that witnessing 'no change' was not recognised as a measurable media effect.

medium used, to get information or advice on daily living, to provide a framework for the day, or to be more socially mobile in the case of listening to classical music etc. Commonalities in these early studies were related to their methodological approach which was primarily qualitative whereby open ended statements were elicited from respondents. As they did not explore the links between the identified gratifications and the psychological origins of the related needs this prevented a more detailed and cumulative picture from being produced in order to inform theoretical developments.

Katz, Blumler, Gurevitch (1974) outline a series of studies which promote a more systematic approach to conducting research on uses and gratifications of media use. All of the investigations sought to assess the media consumption in audience related terms rather than in aesthetic or technical terms.

A later view of uses and gratifications is grounded in five assumptions (Katz, Blumler, Gurevitch 1974, Rubin, 1994), that:

a) communication behaviour, including media selection and use, is goal directed;
b) people take the initiative in selecting and using communication vehicles to satisfy felt needs or desires;
c) a host of social and psychological factors mediate people's communication behaviour;
d) media compete with other forms of communication for selection, attention, and use to gratify our needs or wants;
e) people are typically more influential than the media in the relationship.

The uses and gratifications approach has been criticised for its functionalist conception focusing on the role of the media in satisfying audience needs. The reason is that the process is understood in purely individualistic terms rather than in relation to the social context of both the production and consumption of the media content[2].

[2] Elliott (1974) in his criticism of the approach states: "..it is necessary to analyse ownership, control, and production process to see which groups and interests are directly represented and which are used as a source in the production of the output."(p261-2) In the same paper he also states: "A final problem with the uses and gratification approach is that it would deny the media this creative role in contributing to social change'. (p265)

In the 1970's developments in the theory of the uses and gratification model have sought to link psychological and social antecedents, media motivation, behaviour, attitudes and outcomes. Restructuring of media orientations and the activity of audiences have produced renewed interest in linking gratifications sought and effects. Blumler (1979) summarised three primary media uses: cognitive, diversion and personal identity. The proposed three hypotheses about media effects are based on these gratifications. Firstly, cognitive motivation will facilitate information gain, secondly, diversion or escape motivation will facilitate audience perceptions of the accuracy of social portrayals in entertainment media. Finally, personal identity motivation will promote reinforcement of effects.

Attention has been paid to these hypotheses, (Rubin 1983, Atkin and Heald 1976). Windahl (1981) argues that a synthesis would help to overcome the criticisms and limitations of the uses and effects traditions. Such a synthesis he states would recognise that media perceptions and expectations guide people's behaviour, that besides needs, motivation is derived from interests and external constraints, and that there are functional alternatives to media consumption. Finally he professes that media content plays an important role in media effects.

Academic audience research is continuing to develop, and has continued to develop along a different trajectory for the last 20-25 years. Having recognised the impact of media effects in this area, criticisms have focused on the individualistic nature of its approach. Research in this area has since sought to incorporate different traditions in an attempt to reintroduce the notions of class and culture. Jensen and Rosengren (1990) discuss the merging of media effects, uses and gratifications; literacy criticism; cultural analysis and reception analysis. Rather than outlining a total union of the various traditions they suggest that discussion between them could lead to a 'dynamic state of coexistence', recognising the benefit in mutual learning. Similarly, Dalhgren (1998) in his critique of a range of contributors to the academic field of audience research, observes that the diversity of approaches undertaken within the parameters of Cultural Studies do not 'speak as a unified chorus', although they share a number of hypotheses.

Further exploration of this area of mass communication research is outside the scope of this thesis. Having explored the underpinning factors influencing media effects relevant to the application of this thesis, I will now move on from this tradition to view media effects within the context of developing public health communication campaigns. Here I will explore how

attempts were made to exert maximum effect by incorporating broader strategies of which the mass media was a functional part.

1.2 CAMPAIGNS AND HEALTH

After the early belief in the power of the media to persuade any audience faded, communication researchers were generally pessimistic about the probable success of such public communication campaigns. This pessimism was reflected in two historically significant articles, "Some Reasons Why Information Campaigns Fail" (Hyman and Sheatsley 1947) and "The Obstinate Audience"(Bauer 1964). The belief in the minimal effects of the media rested not only on evidence of several famous unsuccessful campaigns such as the Cincinnati campaign to win support for the United Nations (Star and Hughes 1950) but also, as previously outlined on the conceptions that media influenced individuals primarily via a 'two-step flow' through opinion leaders (Lazarsfeld, Berelson and Gaudet 1948).

The journal article "Some Reasons Why Information Campaigns Can Succeed" (Mendelsohn, 1973), is indicative of the change of mind in the early 1970's, amongst communication researchers interested in the role of the media in promoting behaviour change. Gradually, over the years, theoretical developments and evaluations of effective campaigns had shown that the chances of success are increased through research. Effective strategies were seen to incorporate: assessing needs, identifying programme failures, identifying relevant audiences, evaluating messages and effects continuously; systematic planning i.e. developing message strategies and taking into consideration external social factors; and the use of a complementary mix of appropriately mediated interpersonal channels. With change in mind and the development of a wider body of literature came the need to consolidate the developing understanding and expertise about campaigns

This thesis centres on the implementation of a health communication strategy which is influenced by the research findings on health campaign development. In order to reach the research basis for the strategy it is important to reflect on the nature of campaign structure. Much of the rich theoretical base that underpins the literature on campaigns can be described as theory 'for' the development of campaigns, rather than 'of' campaigns (Salmon 1989). As has been identified, researchers have utilised the theories of psychology and sociology in order to improve the effectiveness in achieving campaign objectives. A process-based strategy has also developed which involves the planning of campaigns in terms of objectives, messages,

contexts, and audiences. What this has led to is the development of a conceptual framework for understanding what a campaign should accomplish. This incorporates clarifying the roles of the campaign's stakeholders, adapting approaches to audience differences, co-ordinating and sequencing campaign activities, monitoring the campaign's potential weak points, improving the campaign based on trials, and seeking to transfer successful campaigns to different settings. Whilst there is general agreement in the process, this does not naturally ensure success, as many other influential factors can come into play.

Developments in campaign research have led Rogers and Storey (1987) to note the following generalisations (adapted and extended by Rice and Atkin, 1989):

I. While campaigns are typically viewed as merely applied communication research, the most effective campaigns carefully review and apply relevant theories; further more, campaign results can be used to extend and improve theories about media effects and social change.

II. Mass media can be used to improve awareness and knowledge, to stimulate interpersonal communication, and to recruit others to join in, but commercial media may also help to create or reinforce the initial problems.

III. Formative evaluation of specific campaign objectives and media messages is crucial to developing effective campaigns; it is also necessary to identify and understand the needs and media habits of the relevant audiences.

IV. Campaign objectives must, in some way, appeal to the values and cost-benefits of individuals rather than abstract collective benefits.

V. Long-term prevention objectives seem more difficult to achieve than more immediate campaign benefits; so campaigns aimed at prevention need to link future benefits to present benefits or currently held values.

VI. Characteristics of the message source i.e. viability as a social role model or credibility, influence a campaign's effectiveness; however, this influence may be in the opposite direction than intended or may conflict with other message components.

VII. The campaign message must reach a sufficiently large proportion of the desired audience, but the message must be a product of individuals' needs and must contribute to their own goals.

VIII. Campaigns must make their messages available through a variety of communication channels that are accessible and appropriate for the target

audience, but the message must also communicate specific information, understandings, and behaviours that are actually accessible, feasible and culturally acceptable.

IX. Behaviour change is more likely generated and maintained through interpersonal support, especially through pre-existing social networks, but for many campaigns this approach may not be cost effective.

X. Campaign objectives and criteria for success should be reasonable; not only is it difficult to pass through all the individual's information processing stages and to overcome constraints on resources, beliefs, and behaviour, but many public communication campaigns have typically set higher standards for success than the most successful commercial campaigns.

The tension and possible contradictions among some of these guidelines are indicative of the range of traditions and deeply held beliefs about public communication campaign theory, design and effects held by various specialists in the field. Within these traditions different perspectives are also represented. I will now explore a range of campaign applications that exemplify and challenge these traditions and recommendations. The purpose here is to identify specific approaches upon which to build an effective media based health communication strategy. First to be explored is the notion of social marketing.

The merging of the traditions of marketing and strategic communication i.e. information dissemination and public relations, received recognition in the late 70's and early 80's. It was seen as an attempt by researchers to overcome the artificial fragmentation of communication processes and focus on the more integrative uses and examination of communication (Pingree, Wiesmann and Hawkins, 1988), instead of exclusively focusing on certain modes of information dissemination.

According to Kolter and Mindak (1978), whilst the two disciplines of marketing and strategic communication have emerged from different origins, they have grown increasingly similar. Whereas marketing originated from the principle of 'selling' and later turned to information dissemination, strategic communication strategies originated with the purpose of mass information dissemination and have only more recently incorporated elements of the four 'levers' of marketing (product, price, promotion and place). The differences between the two disciplines become obscure when campaign issues are considered. This is because public

health campaigns designed to eradicate harmful behaviours and conditions e.g. smoking, and multimedia efforts by political groups seeking to influence the social agenda can be labelled information campaigns or social marketing with equal validity (Salmon, 1989).

Campaign planners in the late 1970's became increasingly concerned with the psychological needs of individuals who were seeking to change their behaviour, and the need for interpersonal support networks to sustain change. Due to this, social marketing techniques were incorporated into campaigns which in previous years may solely have consisted of mass mediated messages. Similarly, social marketers working on issues such as abortion and nuclear power, have used creative public relation tactics in order to illicit public support for the issue.

One criticism of social marketing is in its application for public health campaigns. Some researchers have criticised early campaigns aimed at promoting health in that they have emphasised the advertising aspect of the campaign (Atkin, 1981, Budd and McCron, 1981; McCron and Budd, 1981, Wallack, 1981, Solomon, 1984; Tones, 1990). The reasons advanced for ineffectiveness are a misunderstanding of the social marketing concept and a failure to commit resources to undertake formative research. For increased effectiveness, it is recommended that due attention be committed to the preparation, production, dissemination and evaluation stages in the campaign process.

Formative evaluation techniques provide campaign planners and those who design the messages with valuable information for decisions along each step of the design process from identifying target audiences to refining implementation strategies. Whilst this process is a mainstay in the commercial campaign sector, health educators have not generally used such systematic approaches at the pre-production stage, as mass media campaigns have tended to be implemented in the absence of a sound research base (Atkin and Freimuth, 1989).

> **"...messages tend to be produced in a haphazard fashion based on creative inspiration of copywriters |...| Only minimum background information about the audience is utilized in devising message appeals and presentation styles, in selecting source spokespersons and channels, and in identifying specialized sub-groups to be reached."**
> **(p132)**

This is seen by Atkin and Freimuth to be due to lack of technical expertise of those running campaigns, insufficient funding and a failure on behalf of funders to recognise the value of background information in the compilation of mass media campaigns.

> **"Until this important form of evaluation is given higher priority by managerial and creative personnel, non-commercial campaigning will continue to be handicapped and only sporadically influential"**
> **(p150)**

Formative research has however played an instrumental role in the success of a number of health campaigns using the social marketing approach. This is due to the campaigns or other interventions being developed from a solid base of communication and social-psychological theories, using marketing techniques to supplement the development of messages and programme implementation, and incorporating the mobilisation of local and interpersonal networks as a crucial element in the behaviour change process. This approach has received high visibility through its application to community heart disease prevention programmes in the USA (Maccoby and Solomon, 1981; Farquhar, Maccoby, and Solomon, 1984), and Finland (Puska, 1981; Puska, McAlister and Maccoby, et al.1985).

The Stanford Heart Disease Prevention Project is one of the best-known health promotion campaigns conducted in America. The Three Community Study began in 1971 and sought to utilise mass media and interpersonal communication methods to change attitudes and lifestyle behaviours. The prime aim was to reduce the risk of cardiovascular diseases. This study, and the subsequent Five Community Programme, have acted as prototypes for the rapidly proliferating programmes of comprehensive, long-term, planned social change. As they operated across multiple levels of the community ranging from individuals to organisations, these studies have been followed with considerable research interest. They are worth noting here because the formation of the health communication strategy which is the object of focus in this thesis was informed by these principles.

In brief the campaign consisted of a planned campaign dissemination of print and broadcast materials which incorporated television, radio, newspapers, cookbooks and information packs. An initial baseline survey was conducted two months prior to the media campaign which ran for nine months in 1973. The media campaign stopped during the second survey, and then continued for nine more months in 1974 at a reduced level. The study ended with a third

survey a year later which focused on the maintenance of effects produced in the two preceding years. The study was conducted in three towns one which received only the media elements of the campaign, one which also received face to face instruction and a control.

The researchers sought to integrate theory into the structure of the design, implementation, and evaluation of the programme. The eclectic approach to theory development drew on the early campaign effects work: individual behaviour change approaches, diffusion of innovations through interpersonal networks, individuals' hierarchies of learning and individuals' attitude change. For practical application and long term planning these perspectives were integrated into a framework that was later formulated as the Communication-Behaviour Change model (Farquhar, Maccoby and Solomon, 1984).

The development of the Communication Behaviour Change model was influenced by Cartwright (1949). He identified three psychological processes in behaviour change in campaigns: cognitive structures (knowledge), affective structures (motivation) and action structures (behaviour). Cartwright pointed out that action structures were frequently missing from mass media campaigns. He concluded that face-to-face communication could improve the likelihood of obtaining changes in behaviour. Bandura's (1969) social learning theory also influenced the model in that it reinforced the fact that behavioural skills are often prerequisites of establishing healthy habits. Skills, he professed, could be acquired through social modelling and guided practice, which would increase self efficacy, provide incentives for health behaviour, and give feedback on behaviour.

With regard to the results of the Three Community Study the media-plus intervention did have stronger results than the media-only intervention. This was consistent with the Cartwright formulation to the extent that there was considerable success when mass media were supplemented by intensive instruction. When the results were examined for each of the targeted health behaviours, it was evident that certain kinds of behaviour associated with risk reduction could be learned through attention to the mass media alone when that change depends primarily on acquiring new knowledge e.g. improved eating habits. However, other risk factors such as smoking required considerable skill development, self motivation and feedback; media alone were not enough in this instance.

The second well-known community based programme is the North Karelia Project that was conducted in Finland. One of the principle features of the project was that it was firmly grounded in the community. It was in fact initiated as a result of, amongst other lobbyists, a community led petition to the Finnish government to deal with the problem of premature death from coronary heart disease (Puska, Tuomilehto and Salonen, 1979).

The research strategy was designed to influence adults to stop smoking (Puska, McAlister and Maccoby, et al.1985). McAlister emphasised two important aspects of the campaign. The first notion was that communications aimed at influencing complex and persistent behaviours must perform three functions: informing audiences about those behaviours and their consequences, persuading audiences to stop or avoid those behaviours, and thirdly training audiences in skills necessary to translate their intention into action. The second notion was the importance of interpersonal support. The project sought to incorporate these approaches and was also guided by social learning theory, incorporating the key concepts of modelling and social reinforcement. The results demonstrated a modest but valid campaign impact, which was seen by the researchers to justify the use of social learning theory. They did however recognise that maintaining cessation from smoking once the person had given up, was a difficult problem.

One of the principles demonstrated here is the relevance of the incorporation of support services plus face to face contact in the development of health promoting skills. This principle sought to inform the development of the health communication strategy for this thesis. The tenet of integrating support services into media related health campaigns has also influenced the thinking behind certain broadcasting formats. In the next chapter a broadcast format that has become known as 'social action broadcasting' is explored in terms of its significance for incorporation in a comprehensive health communication strategy.

1.3 RECENT DEVELOPMENTS IN USING THE MEDIA FOR PROMOTING HEALTH

1.3.1 CAMPAIGNING FOR HEALTH

Although it has been demonstrated that success can be achieved from applying principles of social marketing, attempts to engineer change in society can be met with opposition. At the centre of this conflict is the fundamental tension between social control and individual

freedom. Social marketing campaigns, by definition, employ methods of social control e.g. laws and policies etc. to achieve campaign objectives, although these objectives are said to be in the best interests of the individuals or organisations being changed.

> **"....social marketing efforts necessarily compromise certain values and interests, often individual freedoms, in order to promote values and interests deemed more socially, economically or morally compelling by the organisation sponsoring the change.. "**
> **(Salmon 1989 p 20)**

The central thesis put forward by Salmon was that the objectives of social marketing campaigns which are usually framed by public service organisations as being 'in the public interest' e.g. smoking in public places, must be examined in terms of their latent social functions and dysfunctions. He proposed that the underlying assumptions of the campaigners need to be examined as well as the values they are either implicitly and explicitly seeking to promote. It is not satisfactory to assume that all social engineering strategies are actually in the public's 'best interests'. This view is more fully expanded by Rakow (1989) who calls for social scientists to stand objectively from researchers and practitioners in search of campaign effectiveness and explore information from a sociological perspective rather than a psychological one; the aim here is to explore the notion of institutional power over individuals.

One further criticism of the use of social marketing for public information campaigns is the inherent focus on blaming the individual for what is perceived to be their inappropriate behaviour. More often than not the initial reaction of the organisation who funds the campaign and defines the problem, is to engineer ways of changing behaviours of individuals affected by the problem, rather than addressing the root cause of the problem. This is in fact a derivation of the notion of 'blaming the victim' (Dervin, 1980; Lang, 1987; Levin, 1987). With regard to public health campaigns the social marketing approach is therefore often criticised as being manipulative and ethically questionable. It is also seen to reduce serious health issues to individual risk factors at the expense of ignoring the social and economic determinants of health (Budd and McCron, 1981; McCron and Budd, 1981; Wallack, 1990a).

> **"This focus on individual responsibility for achieving good health and avoiding poor health conveniently distracts attention from environmental and economic factors requiring social action to solve."**
> **(Levin, 1987 p 60)**

This conventional approach to preventive health education suggests that if individuals wish to live longer and healthier then their main priority is for them to alter their lifestyle; what they eat, drink, the level of physical activity and whether they smoke or not. This individual lifestyle argument however, has several serious flaws. The first is that there are doubts that when significant changes are made there is a subsequent change in health status, especially for chronic diseases (Lorig and Laurin, 1985). Furthermore, as was identified by McAlister above, when change is achieved it is difficult to maintain. Thirdly, and probably most significantly, the major determinants of health thought to reside within the individual in lifestyle theory are in fact known to be external factors (Townsend and Davidson, 1980; Budd and McCron, 1981; McCron and Budd, 1981; Whitehead, 1988).

Both 'The Black Report'(Townsend and Davidson, 1980) and 'The Health Divide' (Whitehead, 1988) show that lifestyle factors, while explaining some of the health differences observed, cannot adequately explain them all. Attention is drawn to all the causes of death showing a marked class gradient which does not appear to be linked to smoking, alcohol abuse or any other known risk factors. While some of the links between deprivation and ill-health are still very poorly understood, lifestyle is clearly far from offering the route to the whole answer. Even where lifestyle is implicated it cannot be assumed that the choice of lifestyle resides solely with the individual.

The third assumption with the lifestyle theory is that all people have an equality of opportunity to make significant health choices in their lives. For substantial segments of the population particularly those in greatest need, they have limited social and economic resources to facilitate the change process. There is broad consensus in the public health field that the health status of individuals is largely dependent on external factors over which they can exercise little or no control. One of the major yet resistant predictors of morbidity and mortality is income; people in lower socio-economic groups have higher rates of most diseases.

In the Whitehall Study (Marmot et al, 1984) the difference in mortality from coronary heart disease between grades of the Civil Service was reduced by less than a third when known risk factors were controlled. Evidence from in-depth studies (Keithley et al, 1984) also suggests that some people have more freedom than others by virtue of their individual situation and circumstances to choose a healthy lifestyle, others being restrained from adopting a healthier

life, even when they would wish to do so, by income, housing, work and other social constraints. Such evidence has led both researchers and other interested parties to criticise certain health campaigns for putting the emphasis on individual responsibility while neglecting the government's responsibility to develop policies to support the increase in health status. For example, on the 1987 Health Education Authority's 'Look After Your Heart' campaign, Dr Tim Lang of the London Food Commission was quoted as saying:

> **"... instead of exhorting people to eat better, smoke less and exercise more, Ministers should make it easier for them to improve their health - that means tackling poverty by improving welfare benefits, improving the quality of food and making the industry tell people what it puts in their food."**
> **(Guardian, 22 April 1987)**

The politics of health education is a salient theme to this thesis. This is because the theory associated with the ethics and content of health education interventions runs parallel to the theoretical developments in campaign effectiveness in terms of process. In the late 70's and 80's, research into the theoretical developments in health education and health information was gathering pace (Tones, 1979; Tuckett, 1979; Naidoo, 1986; Rodmell and Watt, 1986). This has led to criticism of funding organisations and scepticism of their intentions as to whether failure to apply principles of effectiveness were based on ignorance or choice. As has been identified above and as will be explored in the next chapter, the actions of the national health education organisations in England have been subject to criticism for their attention to media-focused health campaigns. Such criticisms have been from health education practitioners, journalists and academic researchers alike.

It has been shown already, that short-term small scale, media only campaigns will have little impact on peoples health behaviours that have been ingrained over a lifetime and which are strongly reinforced by their lifestyle, reference groups and family structure. It has been argued (Levin, 1987) that the most powerful determinant of health is socio-economic status and that by eliminating poverty and illiteracy, the greatest amount of health enhancement could be accomplished:

> **"A small rise in the educational or economic level for the individual or population has a far greater effect on health than all the so-called health resources combined."**
> **(p59)**

Public health problems are complex and difficult to define, and certainly difficult to solve. For campaigning organisations, they pose serious problems as they can not be easily broken down into smaller manageable parts (Wallack, 1989). As I will show later this result can be seen as the partial response of governments and health campaigning organisations, failing to accept indices of ill health.

For health organisations introducing broader socio-political issues such as poverty, racism and unemployment to public health campaigns creates considerable complexity. Rather than the message being simple and clear-cut, it would be quite complicated and fail to point individuals in the direction of change. For health campaigners having limited resources and control over the actions of those organisations that deliver social and health services, the conditions that have a serious impact on the life experiences of our communities are not seen as viable subjects for national campaigns.

> **"The apparent promise of the mass-media to contribute to significant improvements in health status by marketing health information is in fact illusory. Information is necessary but not sufficient to alter the determinants of health. Regulatory strategies that contribute to a generally more healthy society are also necessary. Public policies that address the basic inequalities in society that detract from health status are also part of a comprehensive health promotion approach. "**
> **(Wallack, 1989 p 361)**

Health educators have recognised this problem and have chosen to address issues relating to health inequalities by building them into their campaigns.

As has been argued throughout this chapter, the direct persuasive power of the mass media does have limitations but that is not to say that it has no impact on society. On the contrary, the media are capable of exerting influence, but in highly complex indirect ways; by structuring information, by constructing particular frameworks of interpretation, and as I will now explore, generally shaping the perspectives available through which the audience can see the world. In this exploration I move away from the notion of researchers and public health specialists using the media, to the actual organisation of the media, their influences, limitations and operation, and how these impact on their ability to promote positive health.

1.3.2 SETTING THE AGENDA FOR HEALTH

The concept of agenda setting came from studying voting behaviour within the context of mass communication research. Its metaphorical name was derived from the notion that the mass media have the ability to transfer the importance of items on their news agenda to the public agenda. In 1963, Cohen put forward the specific idea of agenda setting in his book 'The Press and Foreign Policy'. He provided the basis for the concept when he explained that the press

> **"...may not be successful much of the time in telling people what to think, but it is stunningly successful much of the time in telling people what to think *about.* And it follows from this that the world looks different to different people, depending not only on their personal interests but also on the map that is drawn for them by the writers, editors, and publishers of the papers they read."**
> **(Cohen 1963 p 13, emphasis in the original)**

Each day print and broadcast journalists deal with the news in several important ways. Firstly they decide which news to cover and which to ignore, secondly how the item is assessed in terms of importance which is usually expressed in duration and timing of broadcast or, length and size of headline, and placement of article. Clearly there is not enough space in the newspapers or broadcast time available to cover all issues, so these decisions are constantly being made by journalists.

The agenda setting theory is based on the idea that there is a direct causal relationship between the content of the media coverage and subsequent public perceptions of what the important issues of the day are. Researchers can establish this relationship by both examining the content of the media and through interviewing members of the audience explore the extent of congruity between media and audiences in the way in which they prioritise the issues. The salience of an issue in the agenda setting model is important since the model proposes that an issue of high media salience will be also perceived by the audience to be very important, whereas issues of lower media salience will not be highly rated by audiences, and ones of very low salience may never even be registered by audiences.

The concept of the agenda setting role of the news media was put to the empirical test during the 1968 American presidential election by McCombs and Shaw (1972), and their findings echoed Cohen's theory, that one of the mechanisms through which the media create

consensus, is not as a direct influence on attitude formation, but on what it is important to be thinking about. Since the McCombs and Shaw study there has been a great deal of research on the agenda setting process that I can only briefly refer to here. A review conducted by Rogers and Dearing (1988) established a positive correlation between the amount of mass media coverage and the level of priority in the public perception of importance. In addition, the public agenda seems to follow and not lead the media agenda (Iyengar and Kinder, 1987). As research on the agenda setting theory has grown observers have also noted that the process is more complicated. Neuman (1990) found that public influence has to be seen in the context of their own lives and experiences. Agenda setting is therefore a theory of limited media effects. This was emphasised by Brosius and Kepplinger (1990) when they replicated the design of the original McCombs and Shaw study. Strong agenda setting effects were found for five issues but for other issues the media trailed the public interest or there was no correlation at all.

Gandy (1982) moves the research analysis away from media definitions of importance, to those who have power and privileged access to the media. More recently, therefore, the question asked is who sets the news agenda? The assumption is often that it is set by external influences out of the control of journalists. Another facet is that the news agenda is partially set by the traditions, practices and values of the journalistic profession. The question of what is considered newsworthy is in itself a massive area of enquiry (Cohen and Young, 1973; Golding and Elliot, 1979). The main substance of the argument is that news is not a reflection of reality. It is a selective presentation of material reflecting journalistic assessments of what is relevant and of interest to the public they serve.

The mass media's ability to set the public agenda, amplify and lend legitimacy to the voices and views of the national political debate, means that they are potentially significant contributors in social change. However, as a communication strategy for promoting positive public health the agenda setting notion is a double-edged sword. Although health specialists have been able to harness the concept to good effect as will be outlined later in the chapter, it is against considerable odds. The negative, and some believe insurmountable, barrier is that the agenda for health appears to be already set, and ingrained in the routine operations and practices of journalists, resisting with vigour any attempts by those hoping to reshape it.

Karpf (1988) following her review of medical and health coverage on radio and TV in the UK and the USA, puts forward the view that despite greater diversity in the reporting of medical and health issues, the medical definitions and perceptions still prevail.

> **"... by excluding or marginalising other perspectives, namely a more political analysis of the origins of illness, the media play a central part in narrowing the public debate about health, illness and medicine."**
> **(p2)**

This stance is supported by a number of authors. The Unit for the Study of Health Policy (Best et al, 1977) monitored press and television coverage of health in 1976. Their content analysis sought to explore the evidence of the role of the media in shaping the climate for discussion on health. They found that the reporting of high technology was generally favoured over preventive measures. Garland's (1984) systematic content analysis of BBC TV medical programming during a three month period similarly provides evidence that

> **"Television medical programmes were shown to concentrate on hospital-based, technological and expert-dependent issues at the expense of primary care and community health."**
> **(p316)**

She further argues

> **"...whether its (BBC) television programmes about medicine adequately reflect the current realities and complexities of health and medical science."**
> **(Garland 1984, p319)**

Kristiansen and Harding, (1984) in their content analysis of seven British newspapers searched for evidence of 'mobilising information'; information which could support the audience in developing positive health behaviour. Their findings were that the attention given to various topics resembled the order described by Best et al (1977), that of disease, prevention, medical advances and the NHS. They found that the coverage of health was modest with little attention to detail. Signorielli (1990) in her review of the images and impact of health on television concludes that the images portrayed "...are often in serious conflict with realistic guidelines for health and medicine" (p111). Finally she calls for further research into the impact on the audience of the images and messages portrayed by the media on health; whether in fact their behaviour and understanding of health is influenced.

The basic conflict between the 'gate-keepers' (journalists, editors, producers) and the health sector is the judgement of what is newsworthy. This is due to a fairly fundamental difference in the organisational objectives of the two professions. Health professionals want accurate coverage of what is often complex and uncertain science, with the detail of risk factors highlighted, not commentary on individuals with health problems. The news media however, frequently ignore the broad societal issues that are of significance to health professionals in favour of what they perceive to be more interesting, personalised stories.

Atkin and Arkin, (1990) outline the differing objectives of broadcasters and public health specialists. In considering these, they go some way to identify why the promotion of positive health poses such problems and conflicts for both broadcasters covering health and health specialists utilising the media (Fig 1 taken from Atkin and Arkin, 1990 p16).

Conflicting priorities of mass media versus public health institutions

Mass media objectives	*Public health objectives*
To entertain, persuade or inform	**To educate**
To make a profit	**To improve public health**
To reflect society	**To change society**
To address personal concerns	**To address societal concerns**
To cover short-term events	**To conduct long-term campaigns**
To deliver salient pieces of material	**To create understanding of complex information**

Figure 1

A number of complexities and conflicts in the process of communicating positive health arise due to these differences between the two fields. This therefore, makes any attempt at joint working a considerable challenge. One particular difficulty arises from the fact that there is a diverse array of health topics requiring media attention and the media offer too little time to adequately cover what are often complicated health issues. The medium itself operates to

individual constraints. Television is a visual medium. It produces stories via pictures. Similarly radio relies on good audio to attract and maintain the interest of the audience. Both radio and television stories are short, which means that they may not include the complexities that can be explored in print. Furthermore, the media operate within a competitive environment often with considerable time constraints. This goes some way to explain the patterns of operation and the and traditions of journalists.

> **"News is conveyed through a manufacturing process. Constraints require information to be processed in a predictable, even ritualized, fashion so that it is gathered, evaluated, processed, and delivered on a continuous cycle. News people are forced to make quick judgements from imperfect information and deliver their product at a set time ready or not."**
> **(Meyer 1990, p52)**

Looking briefly at the orientation of journalists further illuminates the dilemma they face in meeting the demands of public health. Meyer (1990) in his summary of the journalistic perception of their professional judgement in shaping the news, outlines two guiding principles, that of balance and objectivity. These concepts will be seen to be central to the collaboration with drama professionals later in the thesis. In short, balance is manifest in the perceived necessity to routinely present two sides of an issue e.g. anti smoking, pro smoking. This notion of balance is seen to ensure journalistic objectivity, and can be readily demonstrated. However this news routine imposes a dichotomy when there may be more sides to the story (Tuchman, 1978). This procedure certainly poses a potentially damaging factor for preventive health education. The news media's policy of impartiality results in stories concerning for example the promotion of fluoridation or vaccination almost invariably being accompanied by statements arguing the opposite point of view. McCron and Budd, (1981) state that in other words

> **"...by careful selection of what he wants to hear, an individual can quite easily avoid any challenging health education information or at least obtain evidence to 'combat' it."**
> **(p136)**

In order to successfully utilise the agenda setting function of the media for purposeful health education requires an alteration of the status quo, a blending of cultures and the development of partnerships. McCron and Budd, (1981) profess that the producers of those perspectives on health are themselves a legitimate target of health education.

> **"It may be that ultimately, more could be gained through persuading media professionals to think more carefully about the ways in which they present health issues."**
> **(p136)**

It seems apparent that educational efforts are needed at both ends. Health care professionals need to be better communicators (Atkin and Arkin, 1990; Stuyck, 1990), and journalists need to understand the subtleties of health and illness (McCron and Budd, 1981). The power for coverage lies ultimately with the mass media industry and whilst there are calls for changes in operational practices of journalists, in order to achieve the desired outcomes the onus is frequently on the health specialist to adapt to the orientation of the journalist.

According to Stuyck (1990) the public health movement needs the media and cannot afford to totally alienate them, stating that public health needs the media more so than the media needs the field of public health. What he suggests is that this imbalance calls for greater effort and adaptation on the part of those in public health. This view point is echoed by Atkin and Arkin (1990) who reinforce the point that the mass media are not obliged to educate their consumers on matters of health.

> **"It is incumbent on the public health community, as one of many interest groups seeking co-operation of the media, to understand the motivations of media gatekeepers, to convince them of the importance of covering health issues, and to initiate collaborative ventures."**
> **(p40)**

The notion of collaboration between broadcasters and health educators will be elaborated on later in the thesis. One of the conflicting priorities between health promoters and health reporters can be seen very clearly in their attitude to repetition (Atkin and Arkin 1990 p 23).

> **"Repeated presentation of information is a key to effective health education, but it is the antithesis of news and to a lesser extent soft-feature material. The news media believe that rerunning the same basic themes will produce boredom and lose audiences."**

What they recommend in overcoming this problem is for educators to put new spins on stories to achieve the repetition of messages, identifying new and fresh angles and perspectives to convey core themes but still attain and maintain media interest. What is suggested here is that the health specialist learn the basic skills of the journalist; what factors determine the amount of time and coverage given to a topic, what factors make a story newsworthy etc.

It appears that the mass media present a paradox. On the one hand they seem to be a substantial part of the problem in that they act as a barrier reinforcing a narrow perspective on health. Yet on the other hand the mass media represent a considerable opportunity. Even with these limitations there are those who believe that the media still represent a promising avenue for promoting public health goals, if the necessary skills and expertise are used to good effect.

The principles utilised from this exploration centres around strengthening the positive health agenda. The challenge of the health communication strategy for this thesis is the development of an active partnership between health specialists and broadcasters. A further challenge is stimulating coverage of less contemporary health subjects; media advocacy as an approach, it has been argued, may go some way to unlock the potential of the media as a health promotion tool.

1.3.3 MEDIA ADVOCACY

Media advocacy seeks to change the rules for working with the media. This relatively new concept aims to alter the narrow and simplistic way in which the media traditionally frames health issues to that of the more challenging and complex exploration of the role of national public policy. It does not attempt to change individual behaviour but focuses attention on changing the way the problem is understood as a public health issue (Atkin and Arkin 1990). An example is the approach to the issue of nutrition, rather than focusing on an individual's poor eating behaviour, a media advocacy approach would frame the coverage to highlight the role of national public health policy in shaping manufacturing policies on saturated fat levels or the regulation on clear nutritional labelling. An active example of this is the Food Commission in response to the government's coronary heart disease campaign (previously quoted p 22).

Research is very important in becoming a reliable and credible media advocate, but this is not sufficient in itself. The advocate must not only know the key studies, significant data and contested issues regarding the particular topic, but also the characteristics of the various media outlets and skills in accessing and using them effectively. One key difference between traditional health campaigns and media advocacy is that advocates do not wait for the media to cover health issues, they attempt to create news. In doing this they use research results to build on breaking news stories by providing local statistics or local reactions relevant to the

story, or by comparing the risks of using the target product (e.g. cigarettes) to other health risks currently in the news (e.g. genetically modified foods). In order to attract media attention, media advocacy practitioners need to utilise considerable skills. Not only do they have to possess sound research skills in the development of creative and accurate epidemiological evidence, but they also have to possess a strong journalistic sense.

The tobacco industry through their pro-smoking lobbying group FORREST has in recent years developed mastery of the concept in its ability to craft its image as being an advocate of civil rights and protector of free speech, while portraying the public health lobby as health fascists and zealots; such is the advantageous position of the media advocate in being able to help shape the nature of the discussion. Anti-tobacco advocates, on the other hand, are seeking to re-frame the battle as one between, on the one hand, the tobacco industry's desire for profit against, on the other, the public's need for good health.

Success in utilising this approach in public health has been attributed to a number of projects in the USA (Wallack, Dorfman, Jernigan, Themba, 1993), Australia and the UK (Chapman and Lupton, 1994). Evidence with this approach at this stage is in the form of analysing case studies. The American case-studies illustrate a range of aspects of media advocacy, incorporating a small group of teenagers in New Mexico who used the media to remove alcohol billboards near to its school to an AIDS alliance that used media to promote national legislation. One of the two detailed case-studies outlined in Chapman and Lupton (1994), centres on the battle between health workers who attempted to have all privately owned swimming pools fenced to prevent children drowning, and owners who saw this as health workers over reacting.

As a strategy for improving health, media advocacy certainly challenges orthodox and traditional approaches, with some positive effects on media content. However, as Wallack (1990b) points out, this strategy has several limitations: firstly it is not clearly defined or tested and secondly it requires more subtle and complex skills than other health campaign approaches, and it may be seen as too time consuming by funders to cultivate such relationships with journalists. One other point is that as media advocacy focuses on social and structural influences on health, it may be more difficult to attract and hold media attention. Finally, it is almost guaranteed that media advocates will experience confrontations with powerful vested interests, both political and corporate.

> **"The media advocate needs to understand the media culture, including what is news, and how it can be framed to gain media interest and citizen support [...] the necessary time for research and cultivating media gatekeepers may be beyond the bounds of those working in public agencies [...] media advocacy approaches will tend to be controversial because they directly confront powerful vested interests."**
> **(Wallack, 1990b p162)**

In view of these limitations, media advocacy is unlikely to become a mainstay in the campaign approaches of public service organisations, but it will remain a significant approach for lobbying charities e.g. The Food Commission and Action on Smoking and Health. The principle of utilising media advocacy approaches in the framing of the health debate was incorporated in to the health communication strategy that is utilised as a case study in this thesis.

1.3.4 HEALTH ENTERTAINMENT

In the final section in this chapter I explore another approach to promoting positive health, that of using the medium of entertainment, and like the other approaches in this chapter there are a range of inherent advantages and disadvantages in its application. These provisos draw on the tenets from earlier on in the chapter, that of the framing of the health agenda, and the necessary collaboration between the health sector and media professionals, both areas of which inform the development of the health communication strategy which is analysed as a case study in this thesis.

In some ways, the entertainment media appear to be the perfect vehicle for the promotion of public health. They are at the centre of mainstream cultural activity, reaching extremely large portions of the British public with a constant stream of programming. Television in particular, with its broad reach and ability to provide repeated exposures, presents great potential. It does however also present a threat.

No matter how extensive public service mass media health campaigns are they are only likely to account for a small amount of the public's exposure to health information. Audiences are subject to an abundance of health-related information through various media formats; soap operas, feature articles, chat shows etc. As previously stated this information serves as a backdrop against which public health messages are seen or heard, thought about, understood,

and possibly, acted on by individuals (McLaughlin, 1975; Best, Dennis and Draper, 1977; Budd and McCron, 1981; McCron and Budd, 1981; Garland, 1984; Kristiansen and Harding, 1984; Turrow and Coe, 1985; Karpf, 1988; Wallack, 1989; Signorielli, 1990). In view of the extensive provision of health-related messages in the media generally, public health campaigns are placed in a hostile media environment.

Although the impact of this backdrop of health coverage on individual health beliefs and actions is unknown, the normative impact or incidental effects of mass media are an important consideration for public health. This concern is based on the assumption that although this constant flow of information is unlikely to affect the behaviour of readers, listeners or viewers, it may well 'norm send' or suggest to people that particular unhealthy or healthy practices are common and acceptable (Lowery 1980; Hansen 1986; Tones 1996).

Health specialists would wish to see the entertainment media deal with the portrayal of health issues with greater responsibility but understandably this is met with opposition. Firstly their priority is to entertain and attract large audiences, secondly if they are prepared to consider making changes they are only ever likely to be in the form of minor adaptations. They do not see themselves as a surrogate health service. The power of the media therefore takes on a different emphasis, not only are we talking about the power of effect, we also need to incorporate the power of the journalists, producers and editors; the 'media gatekeepers'. If a sympathetic ear is to be found, generalisations to other issues or programmes are not to be found, in short the support of individual producers or directors does not have any lasting effect on broadcasting policy. The power always resides with the individual broadcasters.

Montgomery (1989) in her study of the relationship between advocacy groups and prime-time network television outlines attempts by health-related agencies in the USA to work in collaboration with Hollywood writers and producers. The aim of the various groups was to incorporate specific health issues into entertainment programming. The common style was to approach the industry in a co-operative rather than confrontational manner, offering suggestions, providing background material etc. Breed and Defoe (1982) and Defoe and Breed (1989) also report significant success in the area of alcohol education.

In general although several groups had formed alliances with influential producers they were only on occasion invited to contribute to script development. Those issues that were

successful were not controversial, they were seen to lend themselves to dramatic outcomes or be easily incorporated into the programmes' background. The health specialist in entering the creative world of drama and programming was doing so on the broadcast specialist's terms. They had to maintain cordial relationships and have limited expectations of their effect. This imbalance in power is a theme that will reoccur throughout this thesis when collaborative attempts are embarked upon between broadcasters and health specialists. The central area of empirical investigation in this thesis is the exploration of the relationship between broadcasters, drama professionals and health professionals, when implementing a health communication strategy. Consequently the balance in power in the relationship is a salient issue as differing professional norms and values are explored in both the development of health programming and in the production of a radio soap opera.

Montgomery, (1990) in her study of prime time television claims that entertainment television can play a role in promoting health through providing role models (also Wallack 1990b).

> **"Through repeated messages in both the foreground and background of programmes, entertainment TV can depict certain healthy behaviours as normative and by doing this may be able to play a role in prevention. If TV characters routinely decline alcoholic beverages, viewers may be inclined to accept such behaviour as the appropriate thing to do in their own lives."**
> **(p 126)**

One way in which attempts have been made to provide positive role models is through the popular genre of the soap opera. The fascination with drama and the desire to harness its potential for reaching a mass audience is not a new phenomenon. Katzman (1972) in an exploration of television soap operas, alluded to the potential impact of the genre:

> **"The almost-realism of the characters and themes, the repetition due to slow pace, and the extremely large number of hours spent viewing soap opera indicate that these shows have a great deal of potential power. They can establish or reinforce value systems. They can suggest how people should act in certain situations. They can legitimize behavior and remove taboos about discussing sensitive topics..."**
> **(p212)**

There are occasional examples where co-operative consultation has produced desirable changes in the portrayal of health issues. Shaw (1986), describes a positive drugs focus in the young person's programme *Grange Hill.* When Zammo one of the popular characters became

involved in drugs, it hit the headlines. After a year of the issue being incorporated into the storyline the series joined forces with the BBC's Newsround (a young people's news programme) for a Drugwatch special which received a positive response from health professionals and the public. A final spin off was the release of an American inspired anti-drug song "Just say no". From the BBC's perspective this initiative was considered "a complete success" (Shaw 1986, p211); evidence being in the form of the high levels of telephone calls, letters and queries from parents and young people asking for advice.

Shaw sees great potential in collaborative projects between health professionals and drama specialists in the production of soap operas

> **"If the health material is handled sensitively, which implies that the health professional has established good relations with the radio and television producers based on mutual trust and understanding of the issues, then the soap opera can act as a most useful *additional* vehicle for health promotion."**
> **(p212, emphasis in the original)**

The absence of further detail of the collaboration precludes any discussion regarding the exact nature of the 'mutual trust and understanding of the issues' and where the power lay in terms of control over editorial content. It is however important to emphasise that this initiative's claimed success owes much to the concerns and interests of individual producers (Tones, 1996), rather than any policy decision taken for future young people's programmes at the BBC.

The promotion of health using the medium of the radio soap operas has attracted some interest in recent years. In the early 1980s, the Scottish Health Education Group in conjunction with BBC Radio Scotland produced a 15min daily drama *Kilbrek*, the aim being to disseminate health information to the attracted audience.

> **" During the course of the action various health issues were brought up and discussed in some detail."**
> **(Report of Activities April 1981 - 1983 p 20 Scottish Health Education Group)**[3]

[3] Despite mention in the report that *Kilbrek* was evaluated by the BBC Scottish Education Department and the Scottish Health Education Group, neither organisation has records going back this far due to reorganisation; neither has anything been published on the drama.

In 1988 BBC Radio Merseyside's *The Merseysiders* went on air part funded by the local health authority[4], education department and voluntary organisations, its aim to put over information on social issues amid tales of a working-class family. The storylines included references to: AIDS, abortion, prostitution and loan-sharks. The soap opera which was broadcast for 10mins twice a week for 20 months was followed regularly by an audience of half a million (Silk, 1990).

Unfortunately neither soaps were evaluated or written up in any way preventing any discussion with regard to their impact, the learning derived from the development, or the process of incorporating the messages into the drama format. But whilst superficially the health soap opera appears an innovative and creative vehicle for health promotion, it can not be seen by health educators as a panacea for public health.

The use of an entertaining style of presentation for health promotion has received some examination in recent years in Third World countries (Rogers and Singhal, 1990), incorporating the format of a prodevelopment (prosocial) soap opera into an entertainment-education campaign strategy. Pro-development soap operas in Third World nations represent a unique combination of entertainment and educational television. The entertainment-education strategy amounts to intentionally inserting educational content in entertainment messages, whether in radio, television, print or popular music. This strategy, therefore, combines two forms of mass media, entertainment and information campaigns and the main benefit is the attraction of a large audience (Singhal and Rogers, 1988).

Hum Log, one of the prodevelopment soap operas Singhal and Rogers describe, ran for 18 months in India and was aimed at promoting issues such as equality for women and the promotion of smaller families. The research on the series focused on applying social learning theory (Bandura, 1977) and para-social interaction (Horton and Wohl, 1956), and sought to answer questions with regard to reach, content, and impact. At the close of each episode a famous Hindi actor briefly summarised the main concepts, providing viewers with appropriate guidelines for action, in the form of a concentrated educational message.

[4] A meeting was held with a member of the Regional Health Authority who provided funding for the inclusion of a 'Fun Run' storyline. There was no involvement of the RHA in the development of the storyline. I was not able to trace reports on the project.

The research into the effectiveness of *Hum Log* was measured by a content analysis of the episodes, a random sample of letters from the audience and a questionnaire mailed to the letter writers. The results raise issues not only for the nature of the content, but also in relation to the partnership between the Indian government, the government funded broadcast network and the advertisers, and the necessary organisation needed to involve the audience.

Firstly, with regard to content, one of the major aims of *Hum Log* was to promote the theme of family planning, however pressures from the audience, sponsors and the government changed this after 13 episodes. Whilst other issues were covered there was a growth in storylines without an educational purpose resulting in diminished support from the government. Secondly the central aim of the soap opera was to impart prosocial models of behaviour intending viewers to relate to and imitate the actions of key characters. Positive and negative models were interwoven into the drama with the intention of negative characters being a source for debate. However, controlling which characters viewers related to was not possible, as some listeners chose an intended negative role model as a positive one, indicating that the modelling effects were mediated by the viewers' prior attitudes and experiences rather than the intentions of the organisers. Thirdly the tripartite planning arrangement for scriptwriting led to conflict due to the disparate values of each of the partners. In short the scriptwriters' aim was to entertain, the sponsors' to sell, and broadcasters' to get programmes on air on time. Fourthly, responding to viewers who contacted the network was seen to be a time consuming activity, requiring dedicated staff (Singhal and Rogers 1989). Many of these issues are revisited later in the thesis when the focus is on the interface between drama and health specialists in the production of a radio soap opera as part of a collaborative and integrated communication strategy.

Pro-development soap operas along with other educational/entertainment messages, do offer a promising potential as mass media campaign tools, provided that they are viewed as tools and not ends in themselves (Rogers and Singhal 1989, as cited in Rogers and Singhal, 1990). Drawing on a series of general lessons from the use of entertainment-education strategies in Third World countries, Singhal and Rogers, (1989) identify two key points to consider once the audience has been attracted; the necessity of subtle repeated messages and the need for the support of supplementary activities

> **"The entertainment-education communication cannot make the educational content too blatant or hard sell or else the audience will reject such messages."**
> **(Singhal and Rogers 1989, p348)**

> **"The effects of the (entertainment-education) strategy are increased when it is accompanied by supplementary messages to form an integrated communication campaign."**
> **(Rogers and Singhal 1989, as cited in Singhal and Rogers 1989 p180)**

As previously stated, no media format can claim to have a direct effect on its audience and any attempt to merely mask the message through an entertainment style will also inevitably fail. As with any effective campaign strategy, being realistic and clear about the likely effect of the campaign components is imperative. Some preliminary assessments can however, be made about how well entertainment television promotes public health. It seems fairly clear that entertainment programming can play an important agenda-setting role, making the public aware of certain health issues, though not, as outlined above, through the provision of overt and blatant messages.

In applying the principles outlined in this chapter, it would seem that the most appropriate role for a soap opera appears to be to set the agenda for health and maintain the focus on that agenda, in a creative and interesting way in order to attract and keep a loyal audience. It also appears important not to incorporate messages that are perceived to be obvious or blatant, requiring a sophisticated approach to incorporating the health agenda. In terms of norm sending the opportunity arises to explore the notion of role models for a variety of health related topics. The drama should however be part of an integrated campaign to obtain maximum effect. Finally it seems that it is also imperative that co-operation between broadcasters and public health specialists is achieved to ensure greater effectiveness, so that the effects of the media are utilised in setting 'healthy' not 'unhealthy' agendas. This is reiterated by Rogers and Singhal (1990) who state that the opportunity for increased effectiveness of health campaign strategies arises through collaboration and co-ordination of partnership organisations:

> **"Entertainment-education communications strategies are most successful when public health officials, broadcast media officials, development planners ... and other involved parties work collaboratively. Such a collaboration creates consensus between participating organisations and facilitates co-ordination of the public service infrastructure."**
> **(p 181)**

Focusing on issues pertinent to the incorporation of a radio soap opera into the health communication strategy the principles of maintaining a health promotion rather than health negating focus is explored in the interface between drama and health specialists. Viewing this notion of collaboration in practice is the nature of one of the central themes of this thesis.

Summary

In this chapter I have explored a wide range of research approaches which are utilised in the development of a health communication strategy that forms the case study for analysis in this thesis. I started by looking at the historical context of media effects moving to look at the notion of health campaigns and the variety of approaches used to promote public health. In doing this common barriers and opportunities have arisen looking at the health agenda, who sets it and how attempts can be made to shift the balance of power and content. All of these principles seek to inform the development of a project that is the focus of this thesis.

It is clear that no approach offers a panacea to the promotion of health, but the research covered here indicates the necessity of incorporating a range of styles and approaches into a comprehensive health communication strategy. Coupled with this is the recommendation that health specialists and broadcasters work in collaboration.

In the next chapter I look at the nature of the two organisations that funded the development and implementation of the health communication strategy that is utilised as a case study in this thesis. In doing this I explore commonalities and how differing organisational aims merge to form an interest in funding the project's development.

CHAPTER TWO

ORGANISATIONAL BACKGROUND

Introduction

In this chapter I will look at developments in the two key funding organisations of the case study: the BBC and the Health Education Authority, in relation to their interest in health communication campaigns. The aim here is not to provide an historical account of the two organisations, but identify the common areas of interest that has prepared the ground for the implementation and interest in the project that is the focus of this thesis.

Towards the end of the chapter I merge the areas of commonality between the two organisations. The Health Education Authority in looking to ensure that health campaigns have a local focus, and the BBC's commitment to public service broadcasting by dealing with local issues supported by back up services, can be seen to be complimentary to each other when looked at in the context of an area of broadcasting known as 'social action' broadcasting or (in the USA) 'pro-social' broadcasting.

Here I will provide a more detailed account of examples of social action broadcasting at a network and local level in the UK. In doing this key themes will emerge in the attempt to link broadcast features to non media support services (Rogers and Singhal 1990). As this necessitates bringing disparate organisations together to work co-operatively and collaboratively, timing logistics and differing professional norms and values emerge in the relationships between health professionals and broadcasters. The relationships between the various participants in the implementation of a health communication strategy based on the social action broadcasting approach is the focus of this thesis.

Both public service organisations (Health Education Authority and BBC) have undergone considerable change under the leadership of various Director Generals, but before I focus on the similarities of the two organisations, it is important to identify some significant differences. One major difference is that the BBC has had an agreed function to educate, inform and entertain, and whilst the organisation's implementation of this function has historically been open to interpretation, its stated aims have remained constant, supported by its Royal Charter. In contrast, the national health education organisations that have been

established, first as a limited company and then as a special health authority, have had no such clear and unchangeable remit. As a result, these organisations have been more susceptible to national government structural change.

A further difference is that the BBC exists as a national corporation with a national, regional and local network of radio and television broadcasting. In view of this, local broadcasting policy is influenced and often determined regionally and nationally. The two national organisations established for health education have had no jurisdiction over the delivery of local health education services, or any structure or network to enable them to comprehensively influence or support the provision of local services.

2.1 NATIONAL HEALTH EDUCATION ORGANISATIONS

A national organisation for health education has existed for many years in different guises, as mentioned earlier, firstly as a limited company and then as a special health authority. The common denominator with the two organisations has been their focus on national mass media campaigns. The ongoing area of contention with the national bodies and the local practitioners; and with staff within the organisations themselves, has centred around the efficacy of the advertising approach considered with regard to the research evidence on media effects. The relevance to this thesis stems from the internal and external lobby for the organisations to focus on locally-based activities at the expense of national advertising campaigns.

The account which follows is supplemented by data obtained through a series of interviews conducted with people who were involved in the Health Education Council during its period of change to form the Health Education Authority. Six interviews were conducted between June and September 1991. Each interview lasted around one hour and was tape-recorded and subsequently transcribed prior to analysis. The aim in conducting the interviews was to supplement the available literature by providing insider accounts of the effectiveness of the organisational changes at key stages that are relevant to this thesis: the influence of research on the media effectiveness in the development of public health campaigns. The interviewees consisted of Health Promotion Specialists who were employed by the Health Education Council or Health Education Authority and staff who were at the Health Education Council and were at the centre of the debate about the efficacy of the mass media campaigns.

2.1.1 THE HEALTH EDUCATION COUNCIL

In 1946 the National Health Service Act was passed, as a result Central and Scottish Health Service Councils were established to advise the Ministers on issues of health. In 1960 the Central Health Service Council set up the Cohen Committee to consider recommendations for the future of health education on a national basis under the chairmanship of Lord Cohen.

The Cohen Committee reported in 1963 and one of its recommendations was that:

> **"The Government should establish a strong Central Board in England and Wales which would promote a climate of opinion generally favourable to health education, develop "blanket" programmes of education on selected priority subjects, securing support from all possible sources, commercial and voluntary as well as medical, and assist local authorities and other agencies locally. It would foster the training of specialist Health Educators; promote the training in health education of doctors, nurses, teachers and dentists; and evaluate the results achieved by health education."**
> **(recommendation 19, quoted in Sutherland 1987 p 20-21)**

In 1968 the Health Education Council was established following the recommendations of the Cohen Committee. The Council which was to exist until 1987 had a broad remit to promote and educate the public on health education topics. It is this period that parallels the developments already outlined regarding media effects, as the necessity of reaching large numbers of people with health information prompted those involved to focus on using mass media campaigns, relying on their supposed powerful and direct effects.

The history of the Health Education Council, the changes in its leadership through various Director Generals, and the attempts made to alter the organisational focus on mass media advertising campaigns is described by Sutherland (1979, 1987). The latter publication is based on the personal experiences of the author who was the Director of Education and Training, at the Health Education Council (1970-1985), who challenged the disproportionate resource input on, and preoccupation with advertising. Sutherland describes attempts to influence the operation of the Health Education Council by bringing in research expertise to focus on the efficacy of mass media campaigns for health education.

Whilst I will not attempt to repeat this historical account I feel it is pertinent to summarise the attempts made to bring the national organisation for health education into line with the

academic findings on media effects. This is because it plots the various attempts to influence a national organisation in looking at more creative and effective initiatives to promote public health through the use of local networks and more localised activities.

The Health Education Council towards the late 1970s, under the Directorship of Alastair Mackie was beginning to review the trends behind the organisation's publicity policy in an attempt that the departments of advertising and education and training establish a degree of synergy. It was at this time that varying pieces of research were commissioned by the organisation, and links were made with academic institutions who focused on mass communication and health education, namely Leicester University's Centre for Mass Communication Research and Leeds Polytechnic.

It was at this time that the evidence of the limited effect of mass media campaigns was increasing (Mendelsohn, 1980; Tones, 1981; McCron and Budd, 1979; 1981; McCron, 1981). Some of this evidence was collected in research commissioned by the Health Education Council (McCron and Budd, 1979; Budd, and McCron, 1982; Gatherer, 1979). The shift recommended by researchers was supported by health education practitioners, who were calling for a more productive use of very limited resources held by the Health Education Council (Adams, 1991).[1]

The Health Education Council commissioned Gatherer et al, (1979) to conduct a review of health education campaigns. The research focus was on forty-nine evaluated studies carried out over 10 - 15 years. This provided the Health Education Council with a thorough and comprehensive assessment of the role of the mass media campaign. This research confirmed the view that there was no causal relationship between knowledge gain, attitude change and behavioural change. The overall assessment of mass media campaigns by Gatherer and his colleagues was that:

> **"There is a common assumption that the mass media has a powerful influence on our lives. However, these evaluation studies have shown that their effect is not very great, especially upon the individual."**
> **(Gatherer et al, 1979, p 9)**

[1] Adams, a health promotion specialist, was formerly Head of Community Development for the Health Education Council, and is now Chief Executive of Wakefield's Health Action Zone.

These findings were also supported by a growing theoretical basis for health education which was emerging (Tones, 1979). Health Education practitioners were drawing on academic expertise in their field of work as Diploma and Masters courses were being developed. Therefore not only was the process of communication being explored but there was a considerable change in approach to health education and the professional view on the determinants of ill health.

This approach was further supported by research conducted by McCron and Budd, (1982) for the Health Education Council. The research sought to emphasise the reality of the likely achievements from their mass media campaigns. Evidence of the limitations of the 'direct-effects' model led them to suggest an alternative strategy, of moving away from attempts to produce and measure behavioural change at an individual level:

> **"A combination of political action, alternative models of the communication process ... and more clearly defined but realistic goals for health education would seem to us to be an essential prerequisite for the future use of the mass media in health education."**
> **(McCron and Budd, 1982, p 228)**

The Health Education Council's response to these findings was to recommend opportunities for internal collaboration between the educationalists and the advertising department. Tones, (formerly Principal Lecturer in Health Education at Leeds Polytechnic, now Professor, recently at the School of Health and Community Care, Leeds Metropolitan University.) chaired a Health Education Council working party that looked at incorporating the research evidence into organisational practice. Tones recommended that the Health Education Council direct the majority of its resources to stimulating and supporting interpersonal education, through the NHS, schools and the community. These recommendations were accepted by the Council in June 1983 (as reported in Sutherland 1987 p 109).

The recommendations were welcomed by health education practitioners, who had been known to view the actions of the national organisation with scepticism, as it was not felt that its operation was based on existing evidence:

> **"At that time they (the Health Education Council) did have someone who knew something about health education and that was Keith Tones, he was the only one though and I do know that they (the Health Education Council) went through a lot of very interesting philosophical debates about the emphasis of their work. [...] and he (Tones) really did manage to persuade them (Health**

> **Education Council) that the mass media did have a role but it's role really was to set an agenda and to flag issues up, it couldn't do anything about behaviour change or change of attitude. It really needed to be complemented by a lot more intensive local activity in various forms: local media which was rarely even acknowledged at that point, education and training initiatives, community-based initiatives, working much more with local people. A lot of the stuff that was already going on throughout health education units [...] but was very little supported by the National body..."**
> **(Interview with Adams, 1991; Robbins)**

Unfortunately the emphasis on linked interpersonal education never came to fruition:

> **". . . although he (Tones) seemed to manage to capture that agreement on paper it never seemed to be followed through in the organisation. And I guess that's because different Directors came in at quite a rapid succession, brought their own different agendas and therefore weren't able to make that shift".**
> **(Interview with Adams, 1991; Robbins)**

The failure to achieve action was reflected by Sutherland (1987 p 113):

> **"The decision on the importance of interpersonal education, taken in June 1983, rapidly became a thing of the past and was never referred to again in any Council discussions..."**

In late 1982 the fourth Director General had been appointed to the Health Education Council, Dr David Player. The change at this time of the Director General was to reinforce the existing status-quo on the Council's use of advertising. Dr. David Player, formerly from the Scottish Health Education Group, had strong links with the Advertising Research Unit of Strathclyde University.[2] Counter to the aforementioned research (Gatherer, 1979; Tones, 1981; McCron and Budd, 1979;1981), Player believed that commercial models of advertising could achieve success if appropriately applied:

> **"In defence, it is possible to argue that the claimed ineffectiveness [of health publicity] in inducing change reflects the nature of the message promoted, or the style of presentation used, rather than the communication method per se."**
> **(Player and Leathar, 1981 p189)**

Player saw great value in the mass media and very visible approaches to health education:

> **"... there is the opportunity to 'set the agenda' for health, to build up the image of healthy activities as enjoyable and fun. The aim would be to affect social attitude so that they were more favourable to changes conducive to health."**
> **(Player, 1986 p 19)**

Leathar (1981) supported McCron's argument (1981) regarding the indirect effects of health education programmes using the mass media, believing that this was the approach adopted by Scotland for some time. The process operating in Scotland was to follow a sequential model of campaign objectives. Initially creating awareness and providing factual information, then once established, promoting emotional values to interact with and reinforce the work of their agendas is a classic marketing strategy in the promotion of complex concepts. Leathar and Player believed this underlay much of product advertising as well as health publicity, though they did highlight differences in implementation:

> **'In product advertising the stages of creating awareness, providing factual information and promoting imagery are often tightly compressed. In health publicity because of the salience of the subject and its negative, threatening nature, they are usually much less so and campaigns often progress very slowly indeed through various stages. It should thus be noted that dissimilarity of methods of implementing objectives does not imply dissimilarity of the objective themselves."**
> **(Leathar, 1981 p124-5)**

The answer to the ineffectiveness of mass media campaigns according to Leathar and Player lay in finely tuning the message to the needs of the target audience. They strongly believed that this approach was borne out by research conducted by the Advertising Research Unit e.g. the Great British Fun Run, The Health Race and the sponsoring of the World Cup promotion in 1982. Whilst references in research papers were made to contemporary research, they purported that success lay with the development process of the individual campaign.

2.1.2 THE HEALTH EDUCATION AUTHORITY

In 1987 the Health Education Council was disbanded to be replaced by the Health Education Authority, a Special Health Authority, established to give advice to the government on health education issues. Special Health Authorities are established by the government under the National Health Service Act 1977. Their general remit is to carry out duties of a national, supra-regional nature which it is believed cannot effectively be undertaken by any other health body. Examples of such authorities include the National Blood Authority, the Prescription

[2] The Scottish Health Education Group had funded the establishment of the Advertising Research Unit in1979.

Pricing Authority and three high security psychiatric hospitals, Rampton, Broadmoor and Ashworth. Whilst the Special Health Authorities work to varying terms of reference, the role for the Health Education Authority was to advise the Secretary for State for Health on health education and public campaigns; sponsoring research and publishing materials.

The new health education organisation was officially established to manage the Government's £20,000,000 AIDS Campaign. The level of media coverage on this episode of change was considerable due to the claims that the Government was seeking to contain and control the nature of the organisation's health campaigns. The detail of this argument is not relevant to this thesis. What is relevant is the Government's commitment to expending a high level of funds on the delivery of a mass media campaigns; flying against weighty evidence that such an approach would be ineffective. As a result the criticism frequently levelled at the Health Education Council for focusing on ineffective public health strategies was immediately transferred to the new Special Health Authority.

In 1987 The Central Office of Information executed a national leaflet drop and poster campaign together with other mass media publicity on the issue of HIV and AIDS. In ignorance of vast amounts of evidence as to the likely ineffectiveness of such a campaign, it existed in isolation of local knowledge and support. Instead it

> **"...preferred a strategy of calculated alarmism, disregarding most institutions with previous experience in the area and the entire literature of health education which so graphically describes the long history of total failures to effect major behavioral change through strategies based on intimidation."**
> **(Watney, 1987 p 64)**

The criticism was not new neither was the result as indicated by the Third Report of the House of Commons Social Service Committee, concerning problems associated with HIV and AIDS.

> **"We now find that it is those people least at risk from infection who are most concerned about AIDS and who are in greatest need of information."**
> **(Paragraph 54 p 36, quoted in Watney p 62)**

As could be predicted the high level of AIDS awareness was not matched by a parallel degree of accurate risk perception.

HIV and AIDS has not been the only Health Education Authority programme to come under external scrutiny. In 1987 a national coronary prevention programme was launched by the Health Education Authority in conjunction with the Department of Health; 'Look After Your Heart'. This campaign was established in England due to the high incidence of deaths from coronary heart disease. In their strategy "Beating heart disease in the 1990's: A strategy for 1990-1995" they outline the epidemiological evidence for this condition being given high priority. It is the single main cause of premature death, and in 1988 in England coronary heart disease accounted for 25,483 deaths among adults aged 15-64 years, it accounted for 32% of premature deaths among adult men and 15% among women (OPCS 1989).

The 'Look After Your Heart' campaign was to come under heavy criticism due to its initial preoccupation with mass media advertising at the expense of localised support (Jacobson, 1991; Adams, 1991). Dr Bobby Jacobson Director of Public Health at the City and Hackney Health Authority in London stated on the BBC Radio 4 programme 'Face the Facts' (7/2/91) that too much emphasis had been placed by the Health Education Authority on television advertising and too little on getting support through health professionals across the country:

> **"Unfortunately until relatively recently the balance has been much more towards short sharp mass media approaches, with not enough back-up for people working in regions and in health authorities."**

Lee Adams reiterated this point with regard to the Health Education Authorities campaigns:

> **"The two big areas for the Health Education Authority are the Look After Your Heart campaign and the AIDS programme, and clearly the AIDS programme do definitely have to do mass media work. But again I don't really think that is being balanced by the emphasis on local activity that it should be."**
> **(Interview with Adams, 1991; Robbins)**

The HEA's operational plan was believed to be written in a manner which obscured the fact that the budget balance was grossly in favour of mass media work (Adams 91):

> **"As now really the balance of the budget is all in favour of mass media work. Although its interesting the way that they're describing their Operational Plan, as this really hides that. Because they are seeming to describe it in a way that's interactive of all the activities in the HEA and puts them together, which I think really obscures the fact that still a great proportion of the budget goes on mass media work."**

(Interview with Adams, 1991; Robbins)

The Health Education Authority Annual Report 1990/1, (p 28) outlines their revenue expenditure (Figure 2). It is unclear what is meant by 'reaching people in their everyday lives', but note 3 indicates that £9,163k was spent on public communications rather than the stated £1,163k, reinforcing the comments made by Adams above. However, when I questioned Charles Gallichen (1991, Personal Interview; Robbins) who was the Head of Advertising at the time of interview, he disputed this. He professed to a substantial decrease in expenditure over the previous three years (Appendix I).

The Health Education Authority rationale for the high expenditure on mass media work for the 'Look After Your Heart' campaign was cited in their first five year strategy "Beating heart disease in the 1990's: A strategy for 1990-1995."

"..the initial direction of LAYH (Look after Your Heart) was shaped by three factors:

- **the need for the programme to become recognised and established quickly**
- **the many regional differences in identity, characteristics and approach**
- **the huge amount of time, effort and resources needed to develop and take forward a major and novel undertaking."**

(p 3)

A balance in emphasis towards local activities was believed to be achieved by the early 1990's according to the Look After Your Heart Programme Director, Paul Lincoln (1991, Personal Interview; Robbins). He claimed that within the programme's five year strategy a decrease in the allocation to advertising was evident in favour of supporting local initiatives. Reaching this position in the Look after Your Heart programmes strategy is pertinent to this thesis.

The Health Education Authority under their Look after Your Heart programme, was to fund four large Demonstration Projects in England each year of the strategy period 1990-1995,

"..with the aim of promoting innovation and generating ideas and practices which are worthy of being disseminated nationally."

(Beating Heart Disease In the 1990s: A Strategy for 1990-1995, p 10)

Our Health Concerns	**1990/1** (to the nearest £ thousand)
Smoking	**3,435**
Heart Disease	**4,816**
Nutrition and dental health	**312**
Cancer (note 1)	**386**
Alcohol	**1,505**
AIDS	**9,317**
Family and child health	**3,098**
REACHING PEOPLE IN THEIR EVERYDAY LIFE	**2,209**
PUBLIC HEALTH (note 2)	**1,403**
PUBLIC COMMUNICATION (note 3)	**1,163**
TOTAL REVENUE EXPENDITURE	**27,644**

Notes:

1. This figure represents money spent on the prevention of cancer in addition to approximately £10 million spent on such prevention but included in the expenditure figures for other health areas.

2. This figure excludes approximately £2 million spent on evaluation which is included in the health areas above.

3. This figure excludes approximately £8 million spent on public communications which is included in the health areas above."

Figure 2 HEA Annual Report 1990/1 p 2

The main criterion was that the projects were innovative, were operated and joint funded by a multi-agency alliance, that they were evaluated and focused on coronary heart disease.

The establishment of an alliance between the BBC and the health authorities of Warwickshire is the subject of Chapter Four. This alliance developed a creative health communication strategy using radio, and submitted it to the Health Education Authority for funding under its Demonstration Programme, and was successful. The detail of the criteria and the funding

process for the National Demonstration Projects is covered in Chapter Five. It is the dynamics of the relationships between the broadcasters and health professionals in the implementation of this communication strategy that are the focus of this thesis.

2.2 THE BBC

As formerly mentioned the BBC has as one of its guiding principles the aim to educate and inform its audience. Within this context the incorporation of social action broadcasting has taken many years to be established and has operated on a number of levels; it has however generally fitted within the corporation's educational philosophy. As indicated by a recent service review of local radio, its inclusion has many benefits:

> **"Campaigns of relevance to local communities make for good programming, powerful public relations and add another tier of value to our public purpose. They combine useful information and material that conveys the grain and texture of the community."**
> **(Chapman, 1997 p 10)**

Social action programming is not only considered within the context of local radio. National radios One and Two regularly feature campaigns geared towards their target audiences and specialist programmes with back-up services are intermittently produced for network television. It is important to emphasise that the broadcast interest in social action broadcasting extends further than the BBC, in that commercial broadcasters in both network television and local radio demonstrate an active interest in the concept, as it supports their public service commitment.

A common denominator for those who broadcast social action features is however the question of who provides the resources for the delivery of the non-broadcasting support services. Whether the project is being run within the BBC or commercial stations this has been an ongoing area of contention.

The area of social action programming has not been exposed to routine evaluation or research, as a result documentary evidence of the success or otherwise of such programming is limited. In view of this my intention in the next section is to explore the available evidence in order to explore the common organisational issues in the delivery of such programming.

2.3 SOCIAL ACTION BROADCASTING

As outlined in the previous chapter, the provision of non-media support services is a recognised pre-requisite for an effective and integrated campaign strategy (Cartwright, 1949; Groombridge, 1972; McAlister, 1976; Puska et al., 1985; McCron and Budd, 1981; Farquhar et al., 1984; Farquhar et al., 1985; Singhal and Rogers, 1989).

It is recognised that whilst many people may have the necessary information it is possible that they are unable to translate this into action. The reasons for this are many, they may encounter obstacles or may not possess the necessary skills. It is important therefore that professionals seeking to use the media to stimulate individual change need to take these factors into consideration.

One attempt to address these barriers is to provide non-media support services in the form of written materials or opportunities to speak to specialists by phone following a broadcast. These are seen as imperative if the intention is to capitalise on the audiences' demonstrated interest following a broadcast programme, feature or episode. This focus on non-media services seeks to overcome the limitations of the media in achieving education goals if part of a comprehensive campaign.

The illustrations that follow demonstrate a number of key issues relating to the implementation of social action broadcasting projects; these are the involvement of specialists in the development of the broadcast features, the necessary preparation time required to establish the network for the delivery of the back up services, and finally the need for all partners to work co-operatively in a strategic and effective way. Examples are then given of when these issues were not considered and either relationships suffered or audience satisfaction was not achieved. Finally a call is made for the necessary partners in the infrastructure for social action programming to work collaboratively. These issues are important as they formed the guiding principles in the development and implementation of the case study.

Since the middle of the 1970s there has been increasing interest in Britain, elsewhere in Europe and in the USA, in a form of broadcast programming which has become labelled 'social action' broadcasting in the UK or 'pro-social broadcasting' (in the USA). The adoption of this model moves away from the implicit belief in the power of the mass media to inform, persuade or otherwise influence their audiences. Instead it implies that there are limits to that

power and the more complex learning process must be left to more appropriate mechanisms. In Groombridge's exploration of the role of television in the democratic process he focuses on 'participatory programming' (1972) as a means to stimulate community action:

> **"Participatory programming is a democratically responsive social process, in which television programmes are a component in a multi-media mix, or in a multi-agency complex acting in consort to achieve social, community or political change and development."**
> **(p171)**

Since the purpose of participatory programming is to creatively stimulate social change there was in Groombridge's view clearly a need for more than the programmes themselves. Groombridge advocates the need for support from other media formats, materials and the involvement of non-broadcasting institutions and agencies. The format that he was proposing became known as 'social action broadcasting', and whilst his model was advocating collective political and societal changes other models have since developed which seek to achieve individual action on health and social care issues.

The most dramatic example given by Groombridge of a programme that stimulated social change was the drama *Cathy Come Home* broadcast by the BBC in 1966. This programme graphically depicted the continuance of poverty, in what was considered to be a prosperous society, the harassment of vulnerable people and the national housing crisis. The imagination and emotion of viewers was captured and the environment that was created stimulated the growth of Shelter's (the charity for the homeless) fund-raising and political agitation.

Another example focused on the development of sex education programmes for primary schools, which necessitated extensive pre-production consultation with teachers, parents, clergy etc. in order to ensure the accuracy of both the content and target group. The consultation process was not designed to seek advice on how to produce good television or how to attract the largest possible audience. The aim was to ensure that good television was relevant to the specific educational needs of an age-specific audience, who would be viewing in groups under the guidance of teachers. As a result, by the time Grampian Televisons' *Living and Growing* series went on the air the broadcasters knew what issues to deal with, what vocabulary to use, the sort of visual illustrations to use etc. This example illustrates the value in incorporating professionals in developing appropriate broadcast material. This community development type approach had a positive effect:

> **"...the programmes quickly broke down embarrassment, unleashed talk of a kind never possible before between the curious, nervous, eager children and their shy, inhibited, ill-equipped parents and teachers."**
> **(Groombridge, 1972 p 180)**

A further example in the early 1970s was where there was growing awareness that illiteracy and semi-literacy were a problem in the UK. Evidence accumulated from various sources (Highton, 1986) indicated that approximately two million adults in the UK had a reading age lower than that of the average nine-year-old child. Pressure from the British Association of Settlements (BAS), and the BBC's Further Education Officers stimulated a lengthy debate within the BBC which gave rise to a three year literacy project.

It was recognised that to make the project work a comprehensive national network of literacy classes was imperative. Without such a network the BBC would be unable to offer viewers a guarantee of help in their own locality. The danger then was raising expectations that failed to be met. The BBC's Further Education Advisory Council felt that:

> **"...it would be quite irresponsible for broadcasters to stimulate a demand for literacy help without ensuring the demand could be met."**
> **(Highton 1986, p17)**

As a result a Further Education Officer was appointed to undertake the necessary consultation with local education authorities and other organisations responsible for recruiting and training literacy tutors. This demonstrates the recognition that forward planning is required in order to establish the necessary support network.

Throughout the project's life over 300,000 adults received help, with the telephone referral service playing a crucial role. This clearly demonstrated the potential effect of broadcasting when part of a whole project. This example illustrates the success that can be achieved if all component parts work collaboratively to form an integrated strategy.

> **"For once, a system had been set up to suit its potential users rather than the users having to fit into the traditional structure of adult education night classes, and prospectuses in libraries, the last place to which many of these adults would go."**
> **(Highton 1986, p24)**

BBC's *On the Move* marked the start of a national resource to support broadcast programmes with a social action element. The Adult Literacy Support Service was set up to support the literacy project by operating the telephone referral service, researching and developing print materials and researching the effectiveness of the project. Although the initial intention was for the Service to exist for a year, it later changed its status into an independent charity, and its' name to Broadcasting Support Services (BSS). BSS exists today as a national support service receiving commissions from both the BBC and Independent, local and network radio and television.

Other early examples of the genre of social action broadcasting in Britain were Thames Television's *Help* and Granada Television's *Reports Action.* Each of these programmes was concerned with the recruitment of volunteers for a variety of community work projects and organisations. Although the precise formats varied, the basic structure was very similar. They broadcast short features about the nature of the work of various organisations, followed by an appeal for anyone in the audience who was interested in helping to contact either the organisation or a specially devised clearing house. It was then the task of the participating organisations to process the offers of help for a variety of community work projects and organisations. Many of the programmes were broadcast at peak times and succeeded in attracting and sustaining large audiences, and generating substantial responses; over 100,000 for one series of six *Reports Action* programmes, (McCron, 1981). Although initial response size is only one indicator of success, they were seen as sufficient to generate considerable interest in the potential of social action broadcasting.

Forging the necessary relationships and establishing the appropriate infrastructure (Rogers and Singhal, 1990) to fully extend the reach of mass communication campaign strategies is not a simple task. Attempts to establish partnerships between broadcasting and local health services, seeking to combine the cultures and the inherent skills in the campaign process, have achieved some positive results in the UK (McCron and Budd, 1981; Webb and Yeomans, 1981). This was not achieved without difficulties.

A joint partnership between BBC London Radio and Wandsworth Area Health Authority in 1981 resulted in the development of three local radio based health education projects. The initial project focused on setting up a multilingual telephone health counselling service aimed at London's Asian & Afro- Caribbean communities. The second project, being closely allied

to the first, involved setting up a health advice line aimed at the advice needs of the indigenous white population. Finally the third project explored the role that local radio could play in recruiting people to join support groups concerned with back pain. All three cases illustrate the problems and possibilities of collaboration between broadcasters and health professionals. The problems centre around two issues, division of labour and editorial control.

Social action broadcasting has operated largely outside of a research based framework, with the emphasis being on doing rather than necessarily thinking of the implications of the component parts. As a result the negotiation of appropriate roles for broadcasting and support services has yet to be fully clarified. Broadcaster's involvement in the back up structures of social action programming has been an area of contention and conflict, due mainly to them feeling that the administrative and publication tasks involved are outside the traditional broadcasting framework (Hargreaves, 1980), whilst maintaining the traditional hold over editorial content of the broadcasts themselves.

Involving those who will be providing the support services from an early stage is more likely to result in mutually agreed aims being arrived at for the project. This is reiterated by a number of health professionals who have engaged in collaborative ventures with broadcasters. Broadcasters are likely to benefit from the wide range of expertise both prior to and during transmission, and it could help them to gear the programming closer to the needs of the audience, (Highton, 1986). It is through this form of co-operation that each party is likely to have a better understanding of the unique contribution that media and non media inputs can make to the overall process. Budd and McCron, (1981) state that:

> **"For more effective co-operation, they need to have a better understanding of each other's problems and potential, and the professional constraints under which the other works."**
> **(p41)**

The division of labour was seen by Webb et al, (1981) to be a sensitive area between the broadcasters, who felt that their production resources were furthering the aims of support agencies, and back-up agencies who argued that their administration budgets were being used by broadcasters for their own public relations. In most cases the development of support services cannot be the main concern of the broadcaster whose skill it is to produce programmes, therefore the responsibility goes to an outside agency who is prepared to enter such a partnership. This partnership largely determines the success or not of any venture

entered into. Without the back up service the broadcast loses its educational potential, and without the broadcast the support service loses its access to the audience:

> **"If social action broadcasting is to make a positive contribution to tackling particular social issues, the broadcasters must come into closer relationships both with their audience, and with their collaborators. "**
> **(McCron, 1981 p123)**

When inadequate and poorly timed consideration is given to the infrastructure for back-up services the effectiveness of any campaign is severely compromised (Budd and McCron, 1982; Nariman, 1993). *Reports Action* attracted a very positive response but the support service namely Community Service Volunteers (CSV), was unable to sustain the interest. They experienced a 70% immediate drop-out-rate, with only half of these still involved nine months later (McCron, 1981). Possible reasons, as identified by McCron were: failure in the support mechanism to divert and sustain interest, and the possible incompatibility of the features to the reality of becoming involved as a volunteer. Broadcasters see their role as providing the programming and this is clearly where the emphasis lies, as a result support services are frequently an 'add on'. The result is that in general broadcasters underestimate the necessary cost and timescale required to develop a cohesive support system especially when operating nationally.

Attempts in recent years to counter the problem of adequate back up provision has resulted in broadcasters entering into partnerships with voluntary sector organisations specifically developed to provide such support, namely Community Service Volunteers (CSV) Media Programme, and Broadcasting Support Service (BSS). Since 1975, when they were first involved with social action programming in the shape of *Reports Action*, the trend for the CSV Media Programme, has been to work with more local media channels, mainly local BBC and Independent Local Radio stations. CSV seeks to forge links with local statutory and voluntary sectors in the running of 'theme weeks', such as unemployment, consumer and health issues. A popular format is for the issue to be researched, a ten minute script produced for broadcast throughout the day, experts to be interviewed on air by programme presenters and information packs to be prepared to back up the broadcasts and, often, phone-ins arranged. Another traditional format is the provision of daily bulletins giving information on subjects of community interest along with offers and appeals for help (Kendall, 1988).

The discord that remains unresolved lies in the editorial control of the broadcast material. As previously outlined this domain is one which is not readily relinquished, or often an issue for discussion. At a local level when outside agencies are involved in social action initiatives, their involvement is purely seen as providing back up services in the form of materials, staffing phone-lines and evaluating impact. Rarely is their expertise as professionals in developing health messages utilised. This un-relinquished power of the industry and the resistance to enter into equal partnerships is often an area of contention:

> **"Having an influence on programmes, or message content is an unrewarding battle for the health educator. In the area of content the media is highly protective and ultimately the decision maker [...] If health education has to lay ideas at the feet of a producer then should that outside agency be the financier and major carrier of the work load? It seems illogical to use scarce resources, be they money or time undertaking health education and broadcasting research, if the results are not going to be fed back into the programme content."**
> **(Webb and Yeomans, 1981 p 576)**

Issues for consideration lie, it would appear, in the balance between professional norms and values, those of editorial control and the timing and logistics of active collaboration. What is called for is research into health communication models that extend the traditional impact focus and for broadcasting be seen as an integral part of the implementation process. What remains to be demonstrated is the potential for developing and sustaining a multi-agency infrastructure capable of stimulating and supporting action in the community. Groombridge (1986) observes that:

> **"In addition to entertaining, informing and educating the audience, broadcasting, by using a range of alliances and partnerships, is now increasingly showing that it has the capacity for *involving* that audience."**
> **(p 12 emphasis in the original)**

Summary

In this chapter I have briefly looked at the BBC and the Health Education Authority: the two funding organisations for the communication strategy that forms the basis for this thesis. In looking at the two organisations, issues of commonality emerge. Although the aims differ the required outcomes seek to meet the priorities of both organisations.

Towards the end of the chapter I outline examples of a broadcast format commonly termed 'social action broadcasting'. In seeking to develop a broadcast format that incorporates a comprehensive consultation process, difficulties in active collaboration are explored. I then outline a number of examples which outline problems, and possibilities for organisational partnership. The issues raised here inform the development of a comprehensive, collaborative health communication strategy that is the focus of this thesis. Whilst issues of audience influence are pertinent to this study the main focus of this thesis is the production process of the project's implementation.

In the next chapter I outline my initial involvement in BBC Local Radio which prompted the development of the health communication strategy. Here the development of key relationships with broadcasters and health professionals are established which lay the foundations for the implementation of a creative campaign strategy utilising the format of social action broadcasting.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

Introduction

The focus of this thesis is the utilisation of radio in the educational process of health promotion. In chapters one and two I argued that previous research has shown that positive results could be achieved in the promotion of health using the media within a comprehensive strategy that incorporated the merging of the models of entertainment-education, media advocacy and social action broadcasting. I have suggested that this be accompanied by the re-orientation of health coverage and collaboration between health professionals and broadcasters.

What emerges from the first two chapters are a set of guiding principles to inform the development and implementation of a health communication strategy that would effectively utilise the media. The development and implementation of such a strategy is considered here in the form of a case-study, conducted in a BBC Local Radio station, whereby through collaboration with drama, health and broadcast professionals an attempt was made to re-orientate the way that health was covered by the media. In doing this three areas of empirical investigation unfold. The areas focus on the relationship interface with the three parties in the development and implementation of the health communication strategy; health professionals, programme production staff and drama professionals. These themes underpin the research strategy for this thesis.

This chapter now outlines the research questions posed for this thesis together with the proposed methods to be used.

3.1 THE RESEARCH QUESTIONS

The research questions of this thesis concentrate on the three relationship interfaces with the professionals involved in the implementation of the project that is described in this thesis in the form of a case study. The aim is to build on previous research and test the developed hypothesis that by blending the approaches of social action broadcasting, entertainment-

education and media advocacy strategies together with the co-ordination of and collaboration with public services, it is possible to increase the understanding of the conditions of health and alter the media focus on disease and illness.

As a result the three research questions are as follows:

Programme Production Staff

Can the cultures of broadcasting and health merge, through the presence of a health promotion professional within the broadcasting environment, and influence the orientation of health in the feature broadcast output without detrimentally compromising the two distinctly different sets of professional values?

Drama Production Staff

Is it possible to incorporate a radio drama into a media based health communication strategy without detrimentally compromising the two distinctly different sets of professional values?

Health Professionals

Can a media based health communication strategy be established that enables and secures the active involvement of health professionals in the development of health programming?

The theoretical underpinning of these questions will be outlined later in the chapter.

3.2 RESEARCH METHODOLOGY

Seeking to ascertain answers to such broad questions necessitated me drawing on a number of research fields and disciplines incorporating both qualitative and quantitative methods. What shall be argued here is that rather than eulogising either range of methods as sole providers of worthwhile systematic scientific evidence, a wide range of valid methods were identified and employed in order to capture the uniqueness of the research opportunity. The research strategy utilised ethnography and more conventional quantitative tools to illuminate the social phenomena in question, the outcomes and context.

Being based within a BBC radio station afforded me the opportunity to explore the potential for actively furthering the work done in the area of mass communication and health as

outlined in chapter one. This was both a tremendous driving force but it also posed a number of methodological problems.

The aim was to approach the line of enquiry from an action research perspective, continually reviewing and redefining the scope of the research. Whilst the initial intention was to position myself as a participant observer, with the emphasis being on the observer role, early indications were that this would not be possible. The reason for this was due to the scale of the participator role, it was too large to allow me the space to observe. As the instigator and developer of the work it was not possible to remain distant from the research activities, chiefly because it was my responsibility to implement the devised strategy. Being both a central participant and a researcher sometimes presented a barrier to the collection of data which was necessary in order to ensure a comprehensive representation of the operational context.

Firstly then to action research which has featured in the field of education for a number of years and has triggered a considerable amount of debate. In seeking to bridge the gap between educational research and practice, the 'teacher as researcher' model has been extensively discussed (Cope and Gray, 1979; Kincheloe, 1991; Calhoun, 1993). There has been a recent emergence in practitioner research (Anderson et al, 1994), and an evolving model is that of community based action research, that purports a collaborative approach, seeking to engage participants as equals rather than as subjects; this is considered at length by Stringer (1996).

There are many definitions of action research, Cohen and Manion describe it as

> **...essentially an on the spot procedure designed to deal with a concrete problem located in an immediate situation. This means that the step by step process is constantly monitored (ideally that is) over varying periods of time and by a variety of mechanisms (questionnaires, diaries, interviews and case studies, for example) so that the ensuing feedback may be translated into modifications, adjustments, directional changes, redefinitions, as necessary so as to bring about lasting benefit to the ongoing process itself rather than to some future occasion as is the purpose of more traditionally orientated research."**
> **(Cohen and Manion 1994 p192)**

Action research is based on the assumption that the mere recording of events and the formulation of explanations by an uninvolved researcher is insufficient if the aim is to

translate and apply research findings into professional practice. The approach taken centres around an ongoing reviewing process undertaken by those that are directly affected by the outcomes. One of a number of ways in which action research is envisaged is to "look, think, act". Kemmis and McTaggart (1988) (as cited in Stringer 1996 p16) present it in terms of a spiral of activity: plan, act, observe and reflect. The premise is that as participants work their way through each of the major stages they will work through the detail of their activities in a constant process of observation, reflection and action. This can be a complex process and does not necessarily move forward in a linear fashion. In some instances participants can find themselves working backwards through the process, missing stages or repeating processes.

Action research is not a method or technique, it is an approach which has proved particularly attractive to educators due to its practical, applied, problem solving nature. This approach is favoured by practitioners who have recognised a problem during the course of their work and see the value of investigating it and, if possible, of improving their practice. An important feature of this approach is that the task is not finished when the project is over. Participants continue to review, evaluate and improve practice in situ.

It is argued (Stringer 1996, and elsewhere) that action research sits alongside scientific method as an authentic approach to inquiry.

> **"The debate is far from concluded, though the weight of argument seems to suggest that what has traditionally been accepted as scientific research is but one of a number of legitimate approaches to academic and professional inquiry."**
> **(p145)**

As will be argued later, action research, together with other qualitative methods, should not be dismissed as illegitimate methods of inquiry because they do not follow the carefully prescribed procedures that normally denote 'scientific method'.

Action research within the context of this research was used to constantly review both the content and process of the implementation of the Listen To Your Heart project. Whilst there was an ongoing process of reflection there were key stages when this was more formally conducted, at the end of specific campaigns, every six and twelve months for the four years of the strategy's implementation. Reviews took different forms dependent on the section under

consideration, some focused on small sections of the strategy e.g. drama, others reflected on the project as a whole.

Ethnography which as I will now outline is another method of social research which enables the researcher to draw on a wide range of sources of information, observation, interview, and documentary evidence. Ethnographers participate either covertly or overtly, in people's everyday activities for an extended period of time, observing what happens, listening to what is said, asking questions; in short collecting whatever data is available to illuminate the issues that are being researched. As demonstrated by Wax (1971) in a detailed account of applied sociological fieldwork, this approach has a long history.

Ethnography can be seen in many respects as the most basic form of social research as it closely resembles the routine way in which everyday people make sense of their world. Some authors view this as its basic strength, while others see it as its fundamental weakness. On the grounds that the data ethnography produces is 'subjective' it is sometimes dismissed as inappropriate to social science, this is because it fails to provide a solid foundation for rigorous scientific analysis. Others argue that it is only through ethnography that the form and content of social processes can be understood (Parlett and Hamilton, 1976; Patton 1990; Cottle, 1998). The rationale here is that 'artificial' methods such as surveys, questionnaires and experiments are rejected as they are viewed to be incapable of capturing the meaning of everyday human activity:

> **'All social researchers feel the tension between conceptions of science modelled on the practices of natural science on the one hand, and ideas about the distinctiveness of the social world and the implications of this for how it should be studied on the other.'**
> **(Hammersley and Atkinson, 1990 p 2)**

Although the names given to the paradigms differ, as often does the content, many authors (Johnson, 1975; Schwartz and Jacobs, 1979; Hammersley and Atkinson, 1990; Cohen and Manion, 1994), present this tension as a choice between two paradigms, 'positivism' and 'naturalism', the former favouring quantitative methods, the latter extolling ethnography as the central research method.

Central to positivism is the concept of scientific method being modelled on the natural sciences. The concept generally purports that genuine knowledge is advanced by observation

and experiment (Cohen and Manion, 1994). The aim then is to produce a body of scientific knowledge that is open to and subjected to test. One particular characteristic is the attempt to eliminate the effects of the observer by producing a standardised set of tools and procedures.

With naturalism it is proposed that as far as possible the social world should be studied within the context of that world (Beck, 1979 quoted in Cohen and Manion 1994 p26):

> **"The purpose of social science is to understand social reality as different people see it and to demonstrate how their views shape the action which they take within that reality."**

It is also recommended that the social world under observation remain undisturbed by the researcher i.e. studied in its 'natural' state. Implicit within this connotation of 'natural', the use of false or 'artificial' settings such as those produced by formal interviews or experiments is prohibited. A key characteristic of this method is that the ethnographer be respectful and sensitive to the setting that is to be studied:

> **"Reality exists in the empirical world and not in the methods used to study that world; it is to be discovered in the examination of that world. Methods are mere instruments designed to identify and analyze the obdurate character of the empirical world, and as such their value exists only in their suitability in enabling this task to be done. In this fundamental sense the procedures employed in each part of the act of scientific inquiry should and must be assessed in terms of whether they respect the nature of the empirical world under study - whether what they signify or imply to be the nature of the empirical world is actually the case."**
> **(Blumer 1969:27-8 as quoted in Hammersley and Atkinson 1990)**

Naturalism, in drawing on a wide range of sociological and philosophical ideas argues that the social world cannot be understood in terms of causal relationships or the classification of social events. The premise is that the same stimuli can mean different things to different people, and possibly the same person, at different times. The crux of the debate concerning methods appears to be the concept of society: on the one side of the divide are those to whom society is no different from physical nature and therefore amenable to 'objective' analysis, while to those on the other side the fields of meaning which instil human characteristics, call for different methodological tools. My stance which is evident from the research strategy as outlined above is to endorse Schutz's distinction between the two fields:

> **"The world of nature, as explored by the natural scientist, does not 'mean' anything to molecules, atoms, and electrons. But the observational field of the social scientist - social reality - has a specific meaning and relevant structure for the human beings living, thinking within it [...] The thought objects constructed by the social scientist, in order to grasp this social reality, have to be founded upon the thought objects constructed by the common-sense thinking of men, living their daily lives within their social world"**
> **(1973 p 59)**

Intrinsic in this stance is an advocacy of qualitative methodology. While objective science, in its quest for an explanation of social structures and 'facts' uses quantitative, statistical techniques, interpretative enquiry with its emphasis on understanding culture, etc. suggests a qualitative methodology. With regard to this case-study I believe that a range of methods are appropriate but the method most apposite for the context of the research is a qualitative one. Whilst it is possible to present the broadcast output on health related issues without reference to the context of the strategy's operation I believe this would be a tremendous omission. What will give life and meaning to the research findings is the realisation of how this was achieved, the influences and barriers to the development, production and broadcast of health information. It is this area of professional socialisation and the unpacking of the broadcasters professional unconscious where further research is called for by Halloran (1998), who suggests that the research focus moves from the impact on the audience to the production process and the operations of programme producers.

Ethnography is utilised in this study in order to capture the developments in the process that enabled the achievement of the research outcomes. It is this approach that illuminates the complex forces, the organisational constraints and conventions experienced at each of the professional interfaces. Two related areas that are vital to our understanding of how the data was collected and what the problems were, are considered next. These relate to the research position taken whilst conducting the study and the methods used to collect the data.

Knowing where to position oneself during social investigations has always been a problem for social scientists. As outlined above there are those who encourage us to keep ourselves out of the enquiry, to take postures that are distant. On the other hand there are those who extol the virtue of total involvement, submersion in the activities of the environment to be studied. As Elliott (1972) states in his methodological appendix to his study of a television production team:

> **"It has been argued that distance is necessary to objectify the situation researched. But while distance may encourage a feeling of objectivity, it is anything but a guarantee that the researcher has completely understood the dynamics of the social experience."**
> **(p171-2)**

No matter where we choose to position ourselves during the investigation, at one of the extreme points on the continuum or somewhere in the middle, it is still a position. This will then inevitably influence what we look at, what we see, what we interpret and finally what we make sense of (Berg and Smith, 1988).

There have been several attempts to outline the various roles that ethnographers may adopt in research settings. Junker (1960) distinguishes between the 'complete participant' and the 'participant as observer', 'observer as participant' and 'complete observer'. In the 'complete participant' role the researcher's activities are completely concealed. Alternatively, complete participation may occur where the researcher is already a member of the group/setting that she or he wishes to study. In contrast to the 'complete participant' the 'complete observer' has no contact at all with those she or he is observing. Observation may take place through a one-way mirror or covert observation through a window. Both complete observation and complete participation paradoxically share many of the same disadvantages and advantages.

Some authors have suggested that 'complete participation' is the ideal to which researchers should aim and to some it may seem to be a very attractive and, in some instances, an easy position to adopt. Other than it possibly proving to be very taxing, if the researcher is operating incognito, it can also prove to be limiting in terms of access to data.

> **"The participant will, by definition, be implicated in existing social practices and expectations in a far more rigid manner than the known researcher. [...]It will prove hard for the field worker to arrange his or her actions in order to optimize data collection possibilities. Some potential fruitful lines of inquiry may be rendered practically impossible, in so far as the complete participant has to act in accordance with existing role expectations."**
> **(Hammersley and Atkinson 1990 p 94-95)**

Whilst my role of researcher was overt it did present some research difficulties and acted as a barrier to me completing the whole of the intended research strategy. Being an active participant prevented me from being able to elicit objective data from station and drama staff

with regard to their perception of the strategy development and achievements. As outlined above the chosen research position carries with it disadvantages as well as advantages; what can appear challenging can also be professionally disorientating (Cottle, 1998).

Whilst it was recognised that I was conducting research and needed to obtain copies of any communication or broadcast output relevant to my research objectives, my recognised role was as a member of the station's seconded staff. An important part of the research strategy was to ascertain the view of those involved in the initial development of the project and its operation namely, station management, staff in whose programmes the material was broadcast, and the drama production staff. It was also necessary to explore the view of the Regional Manager of Radio with regard to the status of such projects in the BBC.

As I was not viewed as an independent researcher it was not practical for me to conduct interviews with key personnel, this was due to the fact that I did not hold a neutral position. It was recognised that this was an appropriate area to be covered by the research; in many instances the Drama Production Team and Programme Production Teams wanted their say and they wanted it recorded, what staff were amenable to was for me to arrange for an outside agency to conduct the interviews. This data was used to compile a final report for the funders, the Health Education Authority, and it has also been published elsewhere (Dickinson 1995). I will triangulate between the ethnographic data and the data from the Listen to Your Heart Final Report in the presentation of results of the interface with the Drama Production Team and the Programme Production Staff.

The second issue connected to the position taken to conduct the research relates to the collection of relevant data. The methods used for recording the data were field notes, audio-taping, and documentary evidence. These were deemed most appropriate due to the medium researched. The production of good field notes, the indexing and filing of material, writing memoranda and making reflective notes are all demanding and time consuming activities. Long periods solely of observation for me were therefore quite unmanageable. The recurring theme within this chapter is that of the challenge posed by the adopted research position, due to my active role in the process. As a result a selective approach to observation and reflection was taken.

As identified, it was not feasible to collect purely observational data, but the chronology of events and activities, the detail of settings and persons involved were recorded in detail in order to provide a context for decisions and developments. In order to achieve this all meetings that were held in relation to the planning, development, implementation and evaluation of the study were tightly administrated through agendas and detailed minutes. All broadcast programmes were audio-taped and filed together with cues (introduction to the interview by the presenter) and back announcements (concluding statement that leads the presenter into announcing the next feature in the series, the information pack or the available counselling). All drama scripts were filed and the episodes audio-taped when broadcast. Where discussions were held between the drama producer and myself in relation to the covering of a storyline in an episode of the drama, notes were made on the script outlining the discussion and outcomes in terms of changes made. Copies of back up materials were also filed together with the details of those listeners who requested the services. Administratively this was a time-consuming, but necessarily detailed process.

Reflection took place in phases, notably in three related stages, firstly at the end of the broadcast of a campaign, secondly in the development of six monthly reports and thirdly every twelve months following the annual review meetings. The former was supported by campaign evaluation and script review meetings culminating in the filing of audio-taped and written materials, the latter two provided an opportunity to reflect more generally on the process and long term potential outcomes. This is the data that is utilised to supplement the ethnographic elements of this research strategy.

Grappling with the position held at the time of conducting the research was an ongoing dilemma, constantly interchanging between the role of practitioner and researcher; this was to remain throughout the development of the research. The later challenge became the ability to stand back from the submersion in the media culture and critically analyse the findings and make sense of them in the light of current sociological thinking. Schlesinger when reflecting on his direct observation in British broadcasting news-rooms advises:

> **"To arrive at a sociological analysis, however, one must go beyond immersion. One must become disengaged and reconstruct the data gathering in terms of a number of themes deriving from a sociological perspective."**
> **(Schlesinger 1987 p 11)**

In order to achieve this in the thesis attention has been given to both the writing style and structure of the thesis. Firstly, I have chosen to write in the first person in order to achieve a sharper distinction between the description of events and the later reflections and analysis. Secondly for clarity three themes remain throughout the thesis forming the basis for the research questions, the presentation of results and concluding comments.

Constant reflection in the light of the research questions has been undertaken in order to 'triangulate' the findings later in the concluding chapter. Denzin (1978) calls approaching data with multiple perspectives and hypotheses in mind 'theoretical triangulation'. Data source triangulation involves the comparison of data relating to the same phenomenon but deriving it from different phases of the field work or methods of collection. The value in structuring the research strategy in this way provides an opportunity to check inferences that can be drawn from one source with data collected from another (Cottle, 1998). In this way every attempt is made not to over extrapolate solely from the ethnographic data.

The remaining section of this chapter relates to the detail of the chosen research methods which form the research strategy. For clarity this is described under the three areas of empirical investigation, the professional interfaces with health specialists, programme production and drama staff.

3.3 THE RESEARCH DESIGN

I have taken an eclectic approach to the research design in order to capture the range of possible impacts in the implementation of the media-based health communication strategy. For effective operation of the project, communication was thought to be imperative between three distinct partners, the programme production teams, health professionals, and the drama production team. Each professional group was expected to exhibit differences in their professional codes of practice, orientation towards health and health promotion, modes of communication and finally, methods and timescales of operation. My co-ordinating function as the Project Officer operating at each interface placed me in a position to identify these differences for analysis. As outlined above, what I believe will give life and meaning to the research findings is the realisation of how these impacts were achieved, what the influences were and what barriers existed in the development, production and broadcast of the strategy.

The research strategy sought to capture the process of the interaction with the various stakeholders in the implementation of the project; the drama production team, programme production team, and health professionals. It explored whether working in collaboration calls for the three distinctly different professional groups to question their professional norms and principles, as they interact to implement their part of the health communication strategy. Understanding the professional interfaces between the three distinct groups underpinning how effectively they work in collaboration will enable more effective communication strategies to be devised, delivered and evaluated in the future. The principle method used to collect this data is ethnography. I will outline the roles I undertook in order to implement the Listen To Your Heart project. This will enable the exploration of the core functions that comprised the often invisible infrastructure supporting the project's operation.

Figure 3 outlines the various research methods and data sources utilised in this thesis. The thesis relies more heavily on the ethnographic and documentary evidence. However, in order to triangulate the research findings, three additional sources of data (Supplementary Material, Figure 3) are used, two were contained as sections in the project's unpublished Final Report (1993), one was a published article. One source that was not collected by me focused on the nature of the partnership between broadcasters and health specialists. This was conducted externally due to the nature of the sensitivity of my research position as outlined above. Data was obtained through a series of interviews conducted with people who were involved in the case study. Fifteen interviews were conducted between June and December 1992. Each interview lasted around one hour and was tape-recorded and subsequently transcribed prior to analysis. This source will be drawn on to cross-refer from the ethnographic data on the interfaces with the drama and programme production teams. The data has been published in an article which focused on the production of the drama (Dickinson, 1995). It did not look at the whole spectrum of relationships that operated within this research framework.

The second source explored the experiences of the health professionals involved in the case study. A self- completion postal questionnaire with both fixed -response categories and open-ended questions was distributed to 35 professionals from statutory and non statutory sectors (Appendix VI). These health professionals had been active participants in the initial planning, on-going design process and production of materials for a given health topic. Anonymity was assured and completed questionnaires were returned to an audit officer in one of the district health authorities who imput the data. I then undertook a frequency analysis of the data. This

source is published elsewhere (Sommerlad and Robbins, 1995) and will be used in this thesis to cross refer with the ethnographic data on the health professional interface.

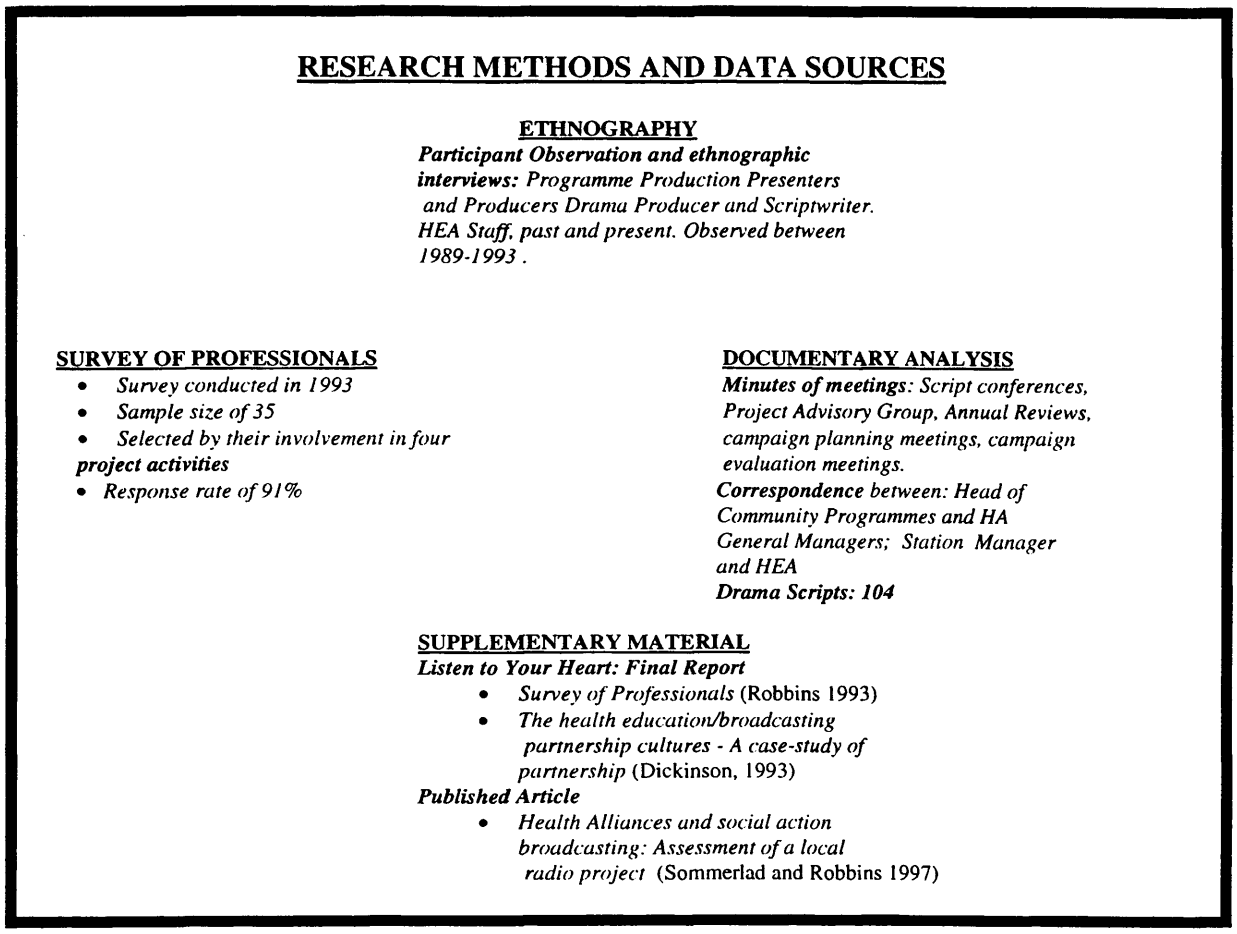


Figure 3 Research Methods and Data Sources

I will outline a number of examples in order to identify specific differences in professional norms and values. I will then provide an analysis which will view the ethnographic data in the light of other sources of data collected during my evaluation of the project. Triangulation in this instance is used for respondent validation, in order to check inferences drawn from the ethnographic data with other qualitative and quantitative sources. The aim is not to adopt an optimistic view that the culmination of the data sources will produce a definitive picture. The intention will be to identify and interpret commonalities and pursue differences and discrepancies (Hammersley and Atkinson, 1990; Cottle, 1998). The aim with this analytical approach will be to ensure greater confidence in the research findings.

I will now outline in detail the process and nature of the research evidence that will be utilised to respond to the three research questions.

Programme Production Staff

Can the cultures of broadcasting and health merge, through the presence of a health promotion professional within the broadcasting environment, and influence the orientation of health in the feature broadcast output without detrimentally compromising the two distinctly different sets of professional values?

Previous research as outlined, calls for collaboration between broadcasters and health professionals in the development of the broadcast health agenda. The strategy sought to respond to the criticism that the agenda set is one which blames the individual and ignores the social determinants of ill health (Dervin, 1980; Budd and McCron, 1981; McCron and Budd, 1981; Lang, 1987; Levin, 1987; Karpf, 1988; Wallack, 1990a), and one which perpetuates the medicalisation of health (Best et al, 1977; Kristiansen and Harding, 1984; Garland, 1984; Signorielli, 1990). The strategy also sought to reframe the local health agenda through collaboration between broadcasters and health professionals, aiming to bridge the differences in professional orientations (Atkin and Arkin, 1990; Meyer, 1990; McCron and Budd, 1981).

The sources of data to be collected to respond to this research question were field notes, audio taped feature programme series, back -up materials and documentary evidence The field notes captured the formal and informal opportunities for interaction with programme production staff, together with notes on salient issues and themes discussed. This enabled the process for operation of the project to be plotted and later analysed. Documentary evidence consisted of campaign and feature outlines, contributors, cues, questions and back announcements. Audio taped features encompassed cues, pre-recorded and live features together with studio discussions. This evidence enabled the volume and nature of the health coverage to be identified for later analysis. The findings were then triangulated with interview data from the project's Final Report.

Drama Production Staff

Is it possible to incorporate a radio drama into a media based health communication strategy without detrimentally compromising the two distinctly different sets of professional values?

Previous research as outlined has called for collaboration between drama production and health professionals in the incorporation of health information in the entertainment media (Montgomery, 1989; Breed and Defoe, 1982; Defoe and Breed, 1989). Whilst it was recognised that the entertainment media can play a positive role in the promotion of health

(Katzman, 1972; Shaw, 1986; Singhal and Rogers, 1988; Rogers and Singhal, 1990; Montgomery, 1990), the 'Listen to Your Heart' project also sought to redress the prevailing perception of the entertainment media 'norm sending' or suggesting to people that particular unhealthy or healthy practices are common and acceptable (Lowery, 1980; Hansen, 1986; Tones, 1996), through active and sustained collaboration.

The small amount of evidence available on the two British health promotion soaps *Kilbrek* and *The Merseysiders*, suggests that they were used as vehicles for direct health messages. Rogers and Singhal used the entertainment media in the Third World countries for the specific reason of carrying health messages. Rogers and Singhal (1989; Singhal and Rogers 1990) do however advise that the messages contained within the entertainment medium should avoid being too overt, in order to prevent alienating the audience. In the 'Listen to Your Heart' project, the drama existed to set the agenda for local health issues being broadcast on the radio station, therefore covering health issues within the context of life events; the forum for discussing the issues in depth lay in the feature coverage. (*A detailed description of the 'Listen to Your Heart' project aims and objectives is contained in Chapter Five.* This pivotal aim removed the pressure to provide overt messages, instead the drama could be subtle in its portrayal of health. The aim in this context was that good health promotion could equate with good drama.

The sources of data collected to respond to this question were field notes, drama scripts, audio recorded drama episodes and documents from meetings. Field notes focused on the relationship interfaces with the drama production team, and the formal and informal opportunities for interaction. This enabled the tracking of key issues where ongoing discussion was necessary. The drama scripts and audio recorded episodes enabled changes and patterns within the storylines to be identified for discussion. The documentation consisted of agendas, minutes and notes from script conferences, and Annual Review and planning meetings, this enabled the tracking of issues discussed, the nature of the discussion and the agreed outcomes.

The structure to present this data focus on the formal and informal interactions. In order to identify key issues for discussion, distinct examples are given. An analysis then ensues drawing out salient research issues pertinent to the differences in the professional norms and conventions of the health and drama professionals. These findings are then triangulated with interview data from the project's Final Report.

Health Professionals

Can a media based health communication strategy be established that enables and secures the active involvement of health professionals in the development of health programming?

Previous research as outlined called for the active involvement of health professionals in all aspects of collaborative ventures to promote health using the media, together with greater equality in the division of labour between health professionals and broadcasters (McCron and Budd, 1981; Webb and Yeomans, 1981; Groombridge, 1986; Rogers and Singhal, 1990).

The data sources used to respond to this question are field notes and documentary evidence. The field notes encompass the formal and informal interactions with health professionals, identifying key issues to pursue. The documentary evidence consists of notes from formal and informal consultation meetings, campaign planning and evaluation meetings. It also features agendas and minutes from the Project Advisory Group and the project's planning meetings and Annual Review.

In presenting this data the nature of the interfaces, both formal and informal are identified. I then provide salient examples of issues for further discussion and analysis. These findings are then triangulated with data from the project's Final Report that questions the perceptions of those professionals involved in the project's implementation.

Summary

At the beginning of this chapter I presented the three research questions for this thesis and the theory that underpins them. I then sought to outline the range of research methods pertinent to this thesis, together with an outline of the chosen methods for each of the key relationship interfaces; health drama and programme production.

In Chapter Four, I will outline the development of a partnership between a local BBC radio station and four district health authorities in the Midlands that sought to utilise the media within an effective and creative strategy for promoting health. The partnership was stimulated by the BBC who were in search of secondments from local public services to contribute to the broadcasting output of their Community Programmes Unit. The secondment of a health

promotion specialist to the BBC provided an opportunity to prepare the relationships for the collaborative development of a creative media-based health communication strategy that is the focus of Chapter Five.

CHAPTER FOUR

COMBINING THE CULTURES OF BROADCASTING AND HEALTH

Introduction

The focus of this thesis is the effective use of local radio in the promotion of health. In Chapter One I argued that through shared understanding of each other's roles, responsibilities and professional constraints, health professionals and broadcasters collaboratively could enhance the effectiveness of the media in the promotion of health and produce positive results.

In this chapter I will provide a description of the development of a partnership between a BBC Local Radio station and four District Health Authorities which centres on the secondment of a health promotion specialist to the radio station for the duration of one year. This relationship was to stretch popular notions of collaboration between health and broadcast specialists and pave the way for a creative and challenging alliance.

What will emerge from this account are two of the key research themes of this thesis, that of the relationship interface with programme production staff and with local health professionals. In an attempt to influence the orientation of the radio station's health content, the institutional differences between broadcasting and health, and the organisational challenge of mobilising local health professional resources becomes evident. Professional tensions and dilemmas are encountered as the health promotion specialist moves into the broadcasting environment.

4.1 BACKGROUND

During 1989, developments were underway for the establishment of the 36th BBC Local Radio station in England. To be based in Coventry, BBC CWR (Coventry and Warwickshire Radio) was to mark the near completion of the BBC's planned provision of 39 local radio stations. The underlying philosophy of the new local radio station was that it should be of local relevance to local listeners. To BBC CWR's newly-appointed Station Manager, this meant a station committed to social action broadcasting.

The recruitment drive for BBC CWR began in January 1989 in preparation for a station launch in January 1990. The management team was to consist of the Station Manager,

Programme Organiser, Engineer in Charge and the Administration/Finance/Personnel Officer. CWR was to break new ground nationally in its next appointment, Head of Community Programmes. This was to be an executive producer position and the person appointed was to head up a community programme unit that would support and develop the station's social action broadcasting output. The intention was to staff the unit through secondments to the station from local public services.

The secondment system, frequently used in broadcasting, is one which seeks to benefit all parties; the broadcaster in that the output can claim a degree of legitimacy in terms of accuracy of information for which they do not pay, the seconding organisation benefits from the kudos and commitment to the accuracy of the coverage of their professional issues, and finally, the individual for work experience and personal development. Secondments to both radio and television are common from Education and the Church; it is rare for other organisations to provide free staff in this way.

In July 1989, the promotion of the station's Community Unit and the recruitment of its staff began. The Station Manager and the Head of Community Programmes arranged and attended a range of informal meetings with heads of public service, i.e. Education, the Church, Careers, Employment Training, Community Service Volunteers (CSV) and more importantly for this research, Health.

In an attempt to secure a health secondment, the Station Manager together with the Head of Community Programmes visited the Chairmen and District General Managers of all four Health Authorities in BBC CWR's transmitter area; Rugby, North Warwickshire, Coventry and South Warwickshire separately.

During the second week of July 1989 a meeting was held between North Warwickshire Health Authority and the BBC. From the Health Authority were the Chairman and the District General Manager, and from the BBC were the Station Manager and the Head of Community Programmes. The purpose of the meeting was to explore the feasibility of seconding a health worker to the new local radio station, BBC CWR, that was due to go on air in January 1990. The BBC believed that a secondee would enable the development of close links with health authorities and be able to ensure that health issues were able to be reflected accurately. Subsequently the BBC met with the Chairman of the South Warwickshire Health Authority

who requested an outline of the possible features to be covered. 'The Outline for the Health Promotion Secondment' suggested that:

> **"A secondee would offer ideas and be responsible for the research, production and possibly presentation of programmes and features dealing with a wide range of health promotion issues (with printed back-up as and when necessary).**
> **The secondee, by tapping resources and contacts in the Coventry and Warwickshire Health Authorities, would also be responsible for programmes and features about people and organisations involved in the provision of health care.**
> **The secondee would receive BBC training in radio production (including full use of broadcast equipment) and develop skills that s/he could pass onto colleagues.**
> **S/he would be a media contact point for Health Authority personnel - especially in emergencies.**
> **It would enhance their personal development while they gain a greater understanding of the breadth of the health service."**
> **Jim Lee in Letter to Geoffrey Jackson, (Appendix II)**

A copy of the outline was sent to the Chairman of NWHA on 21st July 1989.

During the week of 24th July the District General Manager of North Warwickshire Health Authority contacted the authority's District Health Promotion Officer suggesting that a member from the department be released. On Friday 28th July a health promotion staff meeting was called to discuss the opportunity of one member of staff being seconded to BBC CWR. The secondment was to be for a year on a part-time basis, it would result in certain areas of work not being covered by the secondee, which therefore required the commitment of the whole department. All members of the department agreed to the proposal in principle. Two members of staff registered immediate interest in being seconded. All staff were requested to consider the issue and contact the District Health Promotion Officer if interested.

On Monday 31st July, I submitted a proposal to undertake the secondment outlining the rearrangement of my workload. The proposal was accepted and supported. On the same day I contacted the Station Manager and informed of the decision as to who was to be seconded, a meeting was scheduled for Thursday 10th August at BBC CWR. The letter outlining the secondment had not yet been received by the health promotion department. As a result I was not aware of the detail of the proposed role. My initial thought was that I would be required to run training courses for broadcasters on health issues.

On 2nd August the BBC wrote to the North Warwickshire District General Manager enclosing a copy of the 'Guidelines for Community Service Secondees with BBC CWR' (Appendix III). This document outlined the station's commitment to community service, the role of the secondees in extending the 'reach' of the service they represented, management accountability to the Head of Community Programmes, BBC philosophy, editorial policy, access to expenses and finally the aim not to put secondees in a compromising position whilst on placement.

On 3rd August the North Warwickshire District General Manager wrote to the other health authorities proposing a rotational attachment for one year each, with the possible exclusion of Rugby. This was mainly due to the low staffing levels of their Health Promotion Unit. He stated his intention to arrange the first placement due to the time-scale, outlining his request to North Warwickshire's District Health Promotion Officer to keep all four authorities informed as to the secondments development.

The meeting on 10th July to discuss the operation of the secondment was attended by the Station Manager, Programme Organiser, Head of Community Programmes and myself. The discussion focused on how radio could best promote health. The two professional outlooks had obvious differences: I outlined the barriers to behaviour change, whilst the broadcasters outlined their intention to provide the stimulus to the community to 'help themselves to better health'. As the Station Manager outlined his proposal to establish a firm commitment to social action broadcasting through his development of the Community Unit, it was agreed that there was value in using radio in health education. This, he believed, would have a direct positive effect on the health, social and educational prospects of Coventry and Warwickshire.

Monday 4th September was to mark the start of staff training in London and the start of BBC CWR, although it wasn't due to go on air until January 1990. It was the first day for all employees apart from the station management who had been together for approximately 12 months. I together with several other secondees from various public services; Education, Training/Careers, CSV, the Church, was invited to attend. The week based at the BBC Radio Training Unit, Grafton House in London acted as a team-building exercise. It consisted of an introduction to the station's philosophy, the news process, audience research, music policy and tours around relevant departments of the BBC in Broadcasting House, Bush House and Television Centre.

Back in Coventry, from September through to January was to be the concentrated time for radio orientation and staff training. Secondees involvement in the broadcast skills training was a clear indication of the station's intention that they be trained as broadcasters. My secondment was to start in November and due to other work commitments there was little time available to spend at the station until then. I did attend some training sessions, though not enough to effectively and competently piece together linked elements, i.e. packaging. A radio 'package' is a very popular and widely used structure for pre-recorded radio features. It is a combination of pre recorded interviews, sound effects and music to either cover a story or present an argument. I was able to attend the theoretical session on packaging during radio training which provided an opportunity to focus on method of the compiling them. Unfortunately, as the secondment had not formally started, I was unable to give the time to put the theory into practice, i.e. select topic, select and interview people, select music, edit and mix the final product, which initially can take two weeks to produce a 3 minute broadcastable package.

What was evident from both fellow secondees and CWR staff was that no-one knew what the role of the secondee could or would be. What was of more immediate concern to the senior management of BBC CWR was the training of new presenters and reporters as the pressure grew to develop a credible and professional base for the soon to be launched radio station.

In preparation for the secondment I met North Warwickshire's District Health Promotion Manager to discuss a variety of formats for covering health issues in an attempt to move away from the traditional medical coverage of the media, as previously discussed p26. As the radio station had a commitment to social action broadcasting it was felt that this new environment would be open to challenging and creative ideas for health coverage, especially with the in-house presence of a health promotion specialist.

The ideas discussed demonstrated a wide variety of approaches to health e.g. look after yourself, environmental, consumer and medical as suggested by Karpf (1988). They ranged from game shows to debates to panels to soap operas, though the financial implications and the skill/technical expertise required was unknown. Coincidentally, at CWR the Programme Organiser and the Head of Community Programmes were visiting Radio Merseyside to explore the feasibility of a social action soap opera. BBC Radio Merseyside had been broadcasting a weekly drama that aimed to explore local health, education and social issues,

funded by those local public services. The intention at CWR was to use a similar format linked to the Community Unit. The detail of its use at CWR was not thought out, at this stage the intention was to explore the issue of costings. As a result of this meeting it was realised that the funding required made it an impossibility for CWR to proceed, as the local public services were providing secondees it was felt inappropriate to ask them for further funding.

In preparation for the start of the secondment, I arranged for a delivery to CWR of Health Education Authority (HEA) leaflets. Although the detail of their use was unclear it was acknowledged that in support of health features, written information needed to be available as part of a back up service to programmes. I also set up a meeting with the Head of Community Programmes to discuss the possibility of applying to the Health Education Authority for a grant of £5,000. with the Head of Community Programmes; the Health Education Authority at this point within their 5 year strategy for their Look After Your Heart (LAYH) Programme, were offering grants up to a total of £5,000, for community based projects on Coronary Heart Disease Prevention. My aim was to explore the feasibility of securing such a grant in support of the production of materials to support health features and campaigns.

Prior to this meeting, the HEA released its criteria for the funding of long-term projects under its LAYH Programme; bids were to be considered up to a maximum of £150,000 over three years. In view of this the original meeting was cancelled and a meeting was scheduled for the 1st November for the Station Manager, District Health Promotion Officer, Head of Community Programmes and myself. The focus of the meeting was to discuss the feasibility of a joint proposal to the Health Education Authority from North Warwickshire Health Authority and the BBC to fund a social action soap opera. The detail of this initiative will be outlined more fully in Chapter Five.

4.2 THE SECONDMENT

My secondment to BBC CWR officially started on Monday 6th November and was to take the form of two weeks full-time at CWR followed by two weeks at North Warwickshire Health Promotion Service. Given the complexity of both jobs, this was felt the best way to manage the time available.

The aim was to establish a role and function both within the station and with the four local Health Authorities (North Warwickshire, South Warwickshire, Coventry and Rugby).

4.2.1 EXTERNAL COMMUNICATION

I realised from the onset that in order to provide a comprehensive and proactive link with all four Health Authorities and related health organisations their commitment and direct involvement was required. I also acknowledged that one secondee could not attempt this alone, if it was to be a joint Health Authority initiative, their active participation and ownership of the secondment as a creative and influential opportunity was required. As a result I sent letters to the District General Managers, Directors of Public Health, and Family Practitioners' Committees in Coventry and Warwickshire requesting individual meetings to discuss the secondment. The purpose of the meetings was to:

⇒ enlist their support,

⇒ establish a two-way process for communication,

⇒ offer a point of access to news and programmes,

⇒ request relevant documents - Annual Reports, Health Reports, Health Authority newsletters, community papers, summary of Health Authority meetings,

⇒ emphasise the need to be proactive regarding issues for coverage due to part-time coverage at CWR

⇒ provide a copy of the District's publicity policy

All agencies were supportive, seeing direct benefits in developing positive links with the media. Asking for the organisation's publicity policy was an attempt to ascertain their attitude to staff involvement in media related activities. The general finding was that organisations did not have one, but there was a recognition that always working through publicity departments may not be the most efficient strategy to adopt.

In order to promote the secondment externally articles about the secondment were included in both North Warwickshire and South Warwickshire Community Health Papers. For internal promotion an open evening was held at CWR for Health Authority senior staff at the end of November.

Letters were also sent to the four District Health Promotion Officers inviting them to a meeting at the end of November to discuss the focus for the secondment. Prior to the meeting a request was made to provide:

⇒ a who's who list of people in their district with a suggested list of people to contact

⇒ a brief summary of district projects

⇒ a copy of the district publicity policy

This information was required for a number of reasons; to enable both reactive and proactive broadcast coverage; to provide an initial contacts database; ideas for feature coverage; and the publicity policy would provide an awareness of the likely formalities and procedures necessary to secure interviewees in the different districts. As already noted, there was limited knowledge of the existence of such policies and procedures.

The group consisting of the four local District Health Promotion Officers was established in order to support the secondee and assist in identifying topical health issues. This group continued to meet on a bimonthly basis and the focus became that of the secondee feeding back on progress and developments made rather than receiving requests for coverage. All were supportive and enthusiastic about the secondment and whilst there was a willingness to be involved, advice as to how to proceed was not forthcoming. What became clear was as this initiative was new there was no protocol to follow. While it was possible to create a group of interested parties, advice on how to proceed was not available. This presented two potential dilemmas; a sense of professional isolation and the reality that an established 'Advisory Group' could not effectively advise. I will return to this issue later in Chapter Six.

I was committed to maintaining and supporting existing networks, as it was felt that increased involvement through shared learning would be likely to motivate and generate future involvement from individuals and organisations. It was also my intention to demystify the use of radio and being involved with a radio station: the belief being that familiarity with the surroundings would increase usage.

In an attempt to support the development of confidence in using radio, I decided that media training was imperative if the BBC were committed to forging a lasting partnership with the local health organisations; it was felt that training in how to handle the media would assist in mobilising local health professional resources. I together with the Head of Community Programmes devised and delivered a training programme. Health Promotion Units liaised with their authorities to compile a list of people requiring to be trained. Forty people were trained in the first year, ten from each authority.

The development of individuals' skill base was perceived by me to steer the course for future involvement of health professionals away from the traditional interview with consultant or doctor. The intention was to create a base of interested personnel who would be more prepared to link with the station once they had been provided with basic skills to enable and support their involvement.

One area that required my immediate attention, in order to move away from the traditional medical model of health coverage, was the request from the Station Manager to select a local 'radio doctor'. What I experienced was that the tradition of enlisting the support of such a doctor was strong from both the medical and broadcast fraternities. There was already a public health doctor who had a column in the local newspaper, and coupled with the request from station management, I was also contacted by a number of general practitioners offering their services in such a role.

The history of incorporating 'radio doctors' into the broadcast fraternity is long, as outlined by Karpf (1988) in her exploration of the reporting of health and medicine. As early as the mid 1940s it is demonstrated how the existence of such contributors ensured that the BBC was secure from medical criticism, and that the individual became an instant household name. My intention is not to outline this history (for the American experience also see Turow 1989), but in brief to state that the debate centres around a number of basic tenets. Media outlets incorporate them for convenience and reliability of access, for the provision of a sense of legitimacy and accuracy of medical information. In opposition, this role is disputed by the health information fraternity due to the involvement of doctors perpetuating the medicalising of health, also from the perspective that General Practitioners are by definition generalists and not specialist in all aspects of health and disease, therefore from the position of providing the most appropriate, accurate information, they may not be the best source of advice to the general audience.

Within the context of the secondment, my aim was to present a more creative and accurate coverage of health and therefore the identification of such a doctor was resisted. Instead I suggested an alternative strategy of establishing a team of 'friendly' general practitioners (GPs), who were willing to be accessible at short notice to news and programming, who were prepared to talk on a range of issues dependent on their specialist interest. This was to be achieved through collaboration with the Local Medical Committees, therefore ensuring

credibility for the station and legal protection for the GPs. I promoted this strategy on the basis that a team would ensure varied and broader access, rather than seeking an individual. This was supported by my involvement in the station, regarding access to other health specialists. This strategy was accepted by the station management.

Finally returning to external communication issues, I arranged a Heart Health day for staff at CWR run by North Warwickshire Health Promotion Service in December 1989. The benefits were envisaged to be twofold: staff from Health Promotion could be directly involved with all CWR staff, including presenters and producers, on a semi-informal basis; broadcasters could start to develop contacts.

4.2.2 INTERNAL COMMUNICATION AND THE DEVELOPMENT OF RELATIONSHIPS

As previously stated, detailed guidance was not given regarding the role of the secondees although providing accuracy and contacts were highlighted as important tasks. With a newly-appointed staff team from a variety of journalistic backgrounds priority was the development of proficiency in the broadcast medium and broadcasting technology. The result was that secondees were able, though often not through choice, to pursue the development of their own role. Basic training in recording and in editing was provided for the secondees on an individual basis during the first week of November. This was to be put to immediate use in support of the BBC Children in Need Appeal.

Grappling with the Technology - BBC Children In Need. Children in Need is a national charity initiated by the BBC to raise money for under-privileged children. Since its inception the format has been to focus fund-raising activities annually around one day in November with dedicated national television coverage during the evening. All BBC networks, local and national actively support the campaign with coverage on the day.

On 17th November the station was to break from its training schedule to go on air in support of Children in Need. Research was undertaken to ascertain the location of groups within Coventry and Warwickshire who had benefited from the charity's funds. A list was drawn up and the Station Management required presenters, producers and secondees at CWR to select a group, research as to how the money was used and produce a lively pre-recorded package ready for transmission on the 17th. I selected the 'Endeavour Group' from Southam in Warwickshire who had used the money to purchase clothing for outdoor pursuits.

The production of my first broadcasting package identified a number of key related issues:

- the process is similar to forming and shaping any educational message,
- the production process is an extremely time consuming process,
- the absence of a clear view of what the end result was to convey rendered the process even more time consuming in both the collection and editing of the material,
- available studio time is limited,
- once the package is broadcast its use has generally ended; a minority are repeated,
- speed in production is of the essence as a daily three hour radio programme can utilise a large number of 2.5min packages,
- feedback has to be sought and is subjective.

The latter point, the absence of feedback, increased the sense of professional isolation as the health promotion specialist was learning the trade of the broadcaster.

A key organisational and professional difference was the function of planning and what constitutes advanced warning of what was required. This theme will reoccur throughout the thesis, as what will be identified at the interface between broadcasters and health professionals is that they work to totally different time-frames. In preparation for the station going 'on air', I compiled a list of suggestions for covering health for discussion with the Head of Community Programmes. The list was devised in conjunction with the District Health Promotion Manager in North Warwickshire. Whilst this brought in a degree of planning for me it was developed out of context of what was feasible. This was because the role of the secondees was unclear, and I was ignorant of the cost and time implications of their production.

- Debates - ethical issues, euthanasia, smoking policies, mental handicap, inequalities in health, IVF, audience selected issues
- Social Action Soap - to reflect current health climate
- Men's Health Issues
- Healthy Workplace Series - follow developments in industry
- Question Time/Panel
- Right To Reply
- Go-For-It - game show format, focusing on the behaviour changes of the teams
- Access To Services

- Women's Health Shop
- Parents Anonymous
- A - Z of Positive Health
- A - Z of Alternative Therapies

All were seen by the Head of Community Programmes as 'good ideas'. It was suggested that something be prepared that could be used when the station went on air, short packages on the A - Zs were suggested. Direction on duration and compilation was not given. This together with a lack of confidence in the production process and the time required, resulted in me not embarking on this project. However, through consultation with local health promotion departments regarding local activities, I became aware of a locally operated minimum intervention alcohol project that was due to recruit participants in the New Year. The project was to recruit individuals who wished to focus on their drinking behaviour and once recruited would either be provided with ongoing telephone counselling or a self help pack. Following discussion with the project manager and the Head of Community Programmes separately, it was decided that this would be an ideal subject to cover in a package.

The intention was to use broadcast features to stimulate listeners to come forward and join the project. In discussion with the Head of Community Programmes it was clear that one feature would be insufficient to stimulate this; what was required, I suggested, was a week's series that would seek to explore the use of alcohol from a wide range of angles therefore seeking to make the issue relevant to as broad an audience as possible.

Constructing a series around the alcohol project used my existing skills, the challenge existed in 'managing' the interview with colleagues due to lack of confidence in the technology. The basic skills in researching, selecting, recording material and fitting that within a larger picture of a week's series, together with working with local specialists in the alcohol field, was to be an extremely useful experience. Not only did it set a precedent for the broad coverage of an issue but it also marked the start of local organisations being able to set the agenda and being directly involved in every aspect of the broadcasting process.

A new station with a commitment to social action broadcasting and local public service partnerships was a fertile ground for new suggestions and new ways of working. Inevitably when professionals move into a new environment they look for security in the use of their

existing skills, but it was felt that when this is combined with a willingness to adapt and an appropriate level of support the host organisation can only benefit.

4.2.3. DUMMY PROGRAMMES

Wednesday 6th December marked the start of dummy programmes. This was a dry run for each of the daily radio programmes building up to the full daily schedule. Without the added pressure of live broadcasting it enabled station management, presenters, reporters, engineers etc. to operate 'as live' and iron out any potential or actual problems. This process identified underlying assumptions about the secondees' role.

The secondees were to link primarily to the lunch-time News and Current Affairs programme which was to run from 11am - 1pm every weekday. The intention was to focus on local news and community issues, mainly through live interviews. The rehearsals took the form of morning planning meetings with secondees, presenter, producer and executive producer. Major issues were identified, usually from the press, potential local contacts were identified, they were given a timeslot and secondees then had to phone them and ask whether if the station were on air they would be interviewed that day.

This request identified underlying assumptions about the skills of the secondees, e.g. in my case the knowledge of contacts across four Health Authorities on any health issue, together with the ability to coerce people into being interviewed at short notice on an issue that was not necessarily viewed as crucial either by the secondee or the potential interviewee.

During this process the secondee met with the Head of Community Programmes, explaining that whilst there was recognition for the need for someone to chase contacts on a daily basis, this wasn't where the skills of the health promotion specialist lay. It was emphasised that skills did lie in researching and planning series which was more akin to their educational role. Subsequently, I was asked to research a week's series on the menopause for the dummy programmes broadcast internally in January 1990.

The change occurring in the role expectation of the secondment was not solely for health; shortly, requests were made of the education secondees to plan a series on bullying, etc. As previously stated the station was breaking new ground and as ideas were not fixed the management was open to new suggestions and alternative ways of working.

Both the lunch-time Producer and Executive Producer were experienced in social action broadcasting and therefore familiar with linking support services to broadcast output, this therefore was quickly introduced to the series format. The broadcast element of the menopause series consisted of:

- Introduction to the issue
- Sexual Activity
- Hormone Replacement Therapy (HRT)
- Osteoporosis
- The Male Menopause
- Daily off-air counselling and
- An information pack available from the station.

As the series was to be repeated when the station went 'live' this provided a unique opportunity for all contributors to actually practice (apart from the off air counsellors). This process raised a number of issues which were to contribute to the long-standing professional relationships between me as the health secondee, the programme producers and the health professionals. It became clear that success depended on these three parties having a degree of respect for and trust in each others expertise. The menopause series achieved a number of things for the health secondee, the health professionals and the broadcasters:

Secondee

- established the health secondee's role in working together with health professionals to research the content of the series and enabled the development of positive relationships,
- established the role of the health secondee in the writing of the cues, questions, back ground information for the presenter, and back announcement,
- established the close relationship between the secondee and the health professional in informing them of the cues, questions and back announcements in advance of the broadcast,
- made it clear that a key role for the health secondee was to provide support for contributors,
- gave an indication of the time required for the health secondee to provide the support,
- gave an indication of the time required to research and produce appropriate support materials,

- identified the need to take care in the selection of off air counsellors, so that the appropriate approach was taken and that people didn't hide behind the stern exterior of their professional status,
- showed that health professionals were prepared to make themselves available for initiatives such as this,
- established a precedent for professionals to be released from their workplaces to contribute to radio broadcasts,
- set the precedent for the acceptance among the broadcasters of less 'appealing' health issues like the menopause to be given lengthy air-time.

Health Professionals

- enabled new contributors to familiarise themselves with the process involved in live broadcast,
- identified that the health issue was sufficiently important to warrant planning,
- identified that their contribution as a professional was recognised,
- identified that support would be given in order to develop new skills,
- that involvement was possible in all aspects of the planning process.

Programme Producers

- established that involving a range of professionals rather than solely a consultant, could give a very broad approach to a subject,
- showed that the secondee could bring all elements: cue, back announcement, research, questions, interviewees, information packs, counsellors, together,
- showed that the secondee could stimulate disparate professionals to work collaboratively,
- showed that allocating 15 min. per day to one issue throughout a week was sustainable in broadcast and interest terms, rather than the traditional coverage of an issue being a one-off 3 min interview with a consultant,
- showed that bringing in an element of planning ensured that guests made themselves available and that this ensured that the most appropriate guest could be identified.

These factors in the relationship interface with the two professional groups is central to this thesis, and is progressively built on as the thesis develops.

4.2.4. 'GOING LIVE'

BBC CWR was launched on January 17th 1990. The Community Unit figured high in the day's broadcast with each secondee commissioned to find both news items and features, demonstrating the station's commitment to be 'really useful radio'. The station settled very quickly into the regular pattern of filling daily programmes with the coverage of local news and events.

At this stage in the chapter I move away from the detailed chronology of events and focus on the development of my role as health secondee, as described through the production and involvement in key programmes once the station was launched.

Individual packages were produced and interviews set up in addition to the series varying from professional awareness weeks to health days. I produced a package covering the launch of the Parents Against Tobacco Campaign, a national initiative aimed at developing active involvement of parents in preventing the sale of cigarettes to young children. This was followed by a live interview with a representative from the local Trading Standards Office and the local police reviewing the enforcement of the 1986 Protection of Children Act. Following the broadcast, the Programme Organiser received a full transcript of the coverage from the tobacco industry asking why they had not been consulted. They questioned the tone of the presenter's (my) questions and the format of the following discussion were all called into question, all of which was my work and responsibility. It also confirms the tenet put forward by Wallack (1990b) that by utilising media advocacy approaches it is almost guaranteed that the advocate will encounter confrontations with corporate vested interests.

I was fully supported by the station who informed the industry representative that the issue was focusing on the enforcement of the law and consequently the appropriate guests had been selected. A rider was added that should there be a requirement for the tobacco industry to be involved in the future they would, of course, be contacted.

The acceptance that the secondee could be the producer of related series and during live interviews, field questions directly to the ear piece of the presenter, did not remove the requirement for secondees to provide quick research and immediate guests. Neither did the coverage of positive health issues remove the request to focus on illness. The production of a series on mental illnesses highlights these factors. The following example highlights the

decisions I made that were calculated attempts to alter the medicalised/illness approach to health which comes naturally to broadcasters.

The lunch-time Producer identified 'mental health' as an issue for a series. A list of mental illnesses was outlined, one to be covered on each of the five days. It was requested that I select and prepare guests, write cues, questions and back announcements and compile an information pack. Rather than enter a debate regarding the nature of mental health and mental illness with the producer, I compromised by agreeing to identify the guests, withdrawing from further involvement in the series. My reason was that I was already committed to researching a pre-arranged series.

The commitment to refocusing the health coverage from that of illness was difficult to maintain as the pressure for 'traditional coverage' always remained. Entering into what would be perceived as a philosophical argument was not seen as an appropriate way forward, but success could be achieved with me coming up with ideas and outlines of series, which, as confidence increased, became the norm. What was evident was that series were not viable unless they were produced and researched by someone else, namely secondees, the programme producers could not dedicate the time to them. It also raised the issue that 'theme weeks' could only be run every two months due to the amount of preparation required. This logistical issue was to continue to affect 'Listen to Your Heart' project, as will be identified in Chapter Six.

Within three months of the radio station going on air it quickly became acceptable that the health agenda was set by the secondee in conjunction with local health organisations and that series would be provided for broadcast from theme through to scripting and on-air production. The control lay, in this instance, with the secondee who had gradually established considerable trust within the organisation.

The remainder of this section will outline how the level of skill in using and handling the technology sought to increase the professional trust of the station as the health professional became a broadcaster.

Alcohol Series

The week long series, broadcast during the week of 19th February, focused on a range of issues associated with alcohol; it was a mix of live interviews and pre-recorded packages. One aim through consultation with the local specialist was to raise the issue away from the national campaign Drinkwise that was annually held in June. This was an attempt to increase the issues exposure and avoid being predictable to the public. As confidence and knowledge of the operation of the BBC's broadcast network increased the series incorporated more challenging technology.

In order to raise the profile of local health issues and place them within the context of the national perspective national interviewees were secured and asked to be interviewed at Broadcasting House, London. This required the booking of a studio in London, booking a broadcasting 'line' from Broadcasting House, and arranging for the guest to arrive on time. The number of variables that were out of my and the station engineers direct control was immense e.g. line breaking up (interference affecting the sound quality), lost line (signal being lost) studio being double booked, guest being lost in Broadcasting House. For example during one broadcast the line for a contributor from the Portman Group outlining the voluntary agreement between the alcohol industry and the government was lost at the time of broadcast. As a result the industry perspective was lost as there was insufficient time to reschedule the interview during the week.

In the making of this series there was an attempt by me to provide coverage of the issue from each of the four health authorities. The relevance of this was that the health professionals from across the county and city were all involved and the station commitment to covering the whole transmission area was met.

'24 Hours At The Eliot'

The decision to record and broadcast a series on one of the local hospitals was made by the lunch-time producer and Station Manager. In an attempt to fully involve the secondees in station output, it was suggested that it be a joint project between the Producer and the Health Secondee. I suggested approaching the George Eliot Hospital in North Warwickshire which was the same health authority that I was seconded from.

The aim was to spend a day at a local hospital interviewing staff and patients in an attempt to cover the activities in a hospital from dawn till dusk. The production team (Producer and myself) met with the hospital management in preparation for the broadcast. This project was to further develop the trust developing between the health authority and BBC CWR.

Interviews conducted during the day were divided between the Producer and myself, there was no additional technical support. The Producer had experience of similar projects, but recording in such an open environment was a new experience for me, requiring greater confidence and accuracy in handling the technology e.g. recording levels, adjusting recording levels to take account of background noise, sound effects, accurately labelling and ordering tapes, and managing the interviews e.g. persuading people to be interviewed, asking appropriate questions, listening to their responses etc. Time was limited and therefore there was no time for repeats. The interviews were packaged into a six week series of 15 minute episodes with the editing and scripting done jointly.

All hospital staff that were involved in the broadcast were invited to an evening tour of the station, demonstrating the commitment on behalf of CWR staff to establish lasting relationships.

Aerobics On Air

The Station Manager requested that an aerobic class be broadcast live on BBC CWR, the reason being that it was popular and could directly involve the audience. The Station Manager was aware that my area of specialism was heart health and therefore requested that I co-present the class live with the mid-morning Presenter; a weekly 10 minute spot. It was to be scheduled into the entertainment based programme. The benefit as perceived by me was the development of live broadcasting skills, the negative side lay in the personal lack of training in aerobics. In response to the request, I compiled a ten week plan, consulted the Midlands Training Centre for the YMCA Exercise to Music Teachers who advised on the content, I then selected the music and sent out invitations to local aerobic groups (mainly for older people due to the target audience of station) inviting them to take part in the live broadcast from the station's reception area. An additional benefit of this session lay in the opportunity it offered to incorporate topical events such as National Physiotherapy Week by focusing on back strengthening exercises, etc. as the weeks progressed. It also marked the start of health being covered across the station output.

Diet Series

As part of the summer scheduling for the lunch-time programme, I proposed a 10 week series on weight reduction. This was accepted and was to take the form of a 10 minute head to head (live discussion between two people) with the presenter and myself (as my first degree was in nutrition I was seen as a legitimate expert). A phone-off was available after the feature for individual advice. This ran from May to July.

Running Series

External proposals for coverage were also received. In an attempt to promote the Heart of England Half Marathon, North Warwickshire Leisure Service contacted CWR proposing that the Health Secondee train and compete. This was agreed and the ensuing features were both to take listeners through a training programme and to promote the event in October 1990. Features covered the preparation required, i.e. fitness testing, purchasing of equipment, visit to physiotherapist, together with monthly progress interviews on the lunch-time programme. In support of the features, listeners could request training schedules, it also afforded the opportunity to promote local running groups and clubs. Coverage started in April and ended in October. On the day of the Half Marathon CWR broadcast their Sunday morning programme live from the event.

Healthy Eating Series

Following negotiation with the community dieticians from each of the districts, it was decided to establish a pattern of monthly cookery demonstrations by dieticians to keep the issue of healthy eating on the agenda. Agreement came as a result of much discussion due mainly to the fact that professionally, dieticians do not wish to be directly associated with food preparation as it is seen to undervalue their scientific training. It was clear that the station intended to have cookery demonstrations and therefore being able to influence the health content was seen to be of benefit professionally. This series ran from April to July and was broadcast live in the lunch-time programme.

The aim in providing these examples is to demonstrate the development of the health secondee's role within the first six months of the station being on air. The examples demonstrate the development of my broadcasting skills together with the establishment of positive relationships with programme production staff and local health professionals, both of

which were pivotal to the development of the 'Listen to Your Heart' project which is covered in the next chapter.

Summary

In this chapter I have outlined the development of a unique partnership between a local BBC Radio station and the local health professional community within the geographical area of Coventry and Warwickshire. This relationship which centres on the secondment of a health promotion specialist to the radio station, establishes the foundations for the collaborative development of a media based health communication strategy.

The development of the relationships between broadcasters and health professionals and the skill development of the health promotion specialist, as identified in the examples given, enabled the transition into the effective operation as a features broadcaster. The precedent that has been established within this period, sets the health secondee within the role of series producer, researcher and on-air specialist for heart health issues. As the station's commitment to a comprehensive coverage of a broad approach to health is established, the positive involvement of health professionals is also recognised as appropriate and beneficial. The cultures of broadcasting and health had merged and were bearing fruit.

In the next chapter I outline the developments between BBC CWR and the local health authorities as they seek to build on the experiences of the health secondment and challenge popular notions of collaboration between broadcasters and health specialists in the development of a creative media based health communication strategy. It is this strategy that forms the research basis for this thesis.

CHAPTER FIVE

DEVELOPMENT OF A MEDIA-BASED HEALTH COMMUNICATION STRATEGY: *THE CASE-STUDY*

Introduction

In this chapter I describe the development of the 'Listen to Your Heart' project. As the secondment sought to establish a local infrastructure for social action broadcasting for health, when the opportunity for external funding materialised, the partners were able to transfer their collective efforts into the development of the innovation itself. It is here that the developed strategy seeks to incorporate learning from past research regarding media and campaign effects. As the temporary focus for the partnership becomes that of accessing a Health Education Authority grant to further enhance the use of local radio as a medium to promote health, key relationship themes emerge which will be further developed and analysed later in the thesis.

5. I IN SEARCH OF FUNDING

The availability in the autumn of 1989 of grants from the Health Education Authority (HEA) to support innovative community based projects in the prevention of coronary heart disease provided an ideal opportunity to explore new possibilities in the partnership between CWR and the four District Health Authorities. It is important to emphasise that at this stage the secondment had not yet formally started, nor had the station been launched.

Look After Your Heart (LAYH) was a national coronary heart disease prevention programme for England joint funded by the HEA and the Department of Health. Launched in April 1987, the main focus was to increase public awareness of the major risk factors of coronary heart disease and in the long term reduce premature death and ill health caused by it.

The initial introduction and development of LAYH was not without criticism (Lang, 1987; Jacobson, 1991; Adams, 1991), due to the disproportionate amount of effort and resources

being devoted to mass media activity to the detriment of community activity. The HEA's rationale for this expenditure was cited in their first five year strategy "Beating Heart Disease In The 1990s: A Strategy For 1990-1995".

> **"...the initial direction of LAYH was shaped by three factors:**
> - **The need for the programme to become recognised and established quickly**
> - **The many regional differences in identity, characteristics and approach**
> - **The huge amount of time, effort and resources needed to develop and take forward a major and novel undertaking"**
>
> **(Beating Heart Disease In The 1990s: A Strategy For 1990 -1995, p3)**

In 1987 the LAYH Community Projects Scheme was established. Its aim was to provide funding for community-based coronary heart disease (CHD) prevention projects up to a ceiling of £5,000. By November 1989 some 200 local CHD initiatives had been funded.

At the beginning of November 1989, the HEA released details of their intention to extend the community projects scheme together with criteria for application. The scheme was to offer more substantial funding for larger and longer-term projects and was open to any organisation involved in or wishing to become involved in the prevention of CHD.

The LAYH long-term project criteria focused on innovative CHD prevention, co-sponsorship and collaboration, the requirement of clear management accountability, targeting and commitment to an integral evaluation strategy. The HEA's intention was to fund a minimum of four large demonstration projects each year over the strategy period:

> **"...with the aim of promoting innovation and generating ideas and practices which are worthy of being disseminated nationally."**
>
> **(Beating Heart Disease In The 1990s: A Strategy For 1990 -95, p10)**

The arrival at North Warwickshire Health Promotion Service in November of the criteria for the LAYH Community Project Scheme for long-term funding was to spark the imagination of potential developments between the health authorities and BBC CWR.

A meeting was held between the Station Manager, Head of Community Programmes, District Health Promotion Officer at North Warwickshire Health Authority and myself. The aim was to discuss the feasibility of putting forward a joint proposal from the BBC and North

Warwickshire Health Authority to the HEA to develop a social action broadcasting project on health that would encompass a radio drama, supplemented by health features and back-up services. Tasks were divided in order to meet the HEA's deadline of 30th November 1990 for project proposals. Although the overriding feeling was very positive towards the development of such a joint venture the motivation that led to that consensus varied amongst the three agencies involved.

For the health authority's health promotion services, the 'Listen to Your Heart' (LTYH) initiative provided an opportunity to challenge the stereotypical way in which health was covered by the media, to encourage broadcasters to move away from the medical model stance and to give them an opportunity to be more creative in their approach to the health of the community. The major task for the health promotion service was to place the proposed project within the context of current health promotion and mass communication research, jointly map out the budget and steer the proposal through a series of meetings with the HEA and Department of Health.

As a new BBC local radio station with a commitment to ensure that the broadcast output remained 'local' and of relevance to the community, this project would further demonstrate this concept both locally and nationally. The benefit of linking with the health authority lay around the issue of medical accuracy as is demonstrated in the document produced by the Station Manager (Appendix IV). The major role for the Station Manager was to identify costs for the drama production and explore the stance of the BBC on receiving external funding to execute such a project.

The Health Education Authority's role consisted of supporting both organisations through the developmental process of compiling the bid, especially in relation to the evaluation. Despite the initial belief of the secondee and District Health Promotion Officer, the HEA were not wanting to concentrate on outcome indicators such as morbidity and mortality; it was sufficient for such a project to focus on process and impact. This meant putting systems in place that would monitor the establishment of the project and to a limited degree, measure the impact of the project on the audience. The HEA were enthusiastic about the involvement of the BBC and the innovation of the partnership.

The bid met all the Health Education Authority criteria for selection in that it was *innovative,* in that no substantial work of this type had gone on before in health promotion. It was *collaborative,* as it involved four District Health Authorities, BBC CWR, and each would contribute to the costs in addition to the HEA. The proposal was *community orientated* in that CWR and the four District Health Authorities' Health Promotion Services were committed to community involvement and relevance and central to the support was the strengthening and development for community support. It was potentially *sustainable* in that the link with CWR via the Community Programmes Unit predated the proposal and was built into the structure and process of the radio station. The project was clearly a *demonstration model* and re-producable at a local level elsewhere in the UK as the local radio network was maintained and expanded.

The approach was innovative in that such a comprehensive approach using local radio had not been developed in the UK. Two years of radio drama on a weekly basis with comprehensive support was seen to have potential for maximising the role of the medium of local radio in contributing to health promotion. The partnership was unique and that in itself, led to some unique issues to be resolved, the details of which are explored throughout this thesis. The professional support of the BBC was seen as essential as was the need for professional actors. A Project Officer was also seen as essential to facilitate the production of all associated campaigns, features, public service announcements and the development of back-up literature.

BBC CWR had not actually gone on air, but early indications as to the likely audience for CWR were encouraging. A postal survey, conducted by the BBC's Broadcasting Research Department in January/February 1989 indicated that 79 % of respondents were either very or fairly interested in CWR. This figure compared favourably with a range of 63% - 78% in pre-launch surveys for other new BBC local stations.

5.2 LISTEN TO YOUR HEART PROJECT OBJECTIVES

The objectives of the Listen to Your Heart project that formed the proposal to the HEA were :

- To produce and broadcast a health-related 'soap opera',
- To produce a series of health promotion programmes of relevance to the needs of Coventry and Warwickshire with interactive follow-up,
- To provide a telephone line to enable individuals and groups to seek further health-related information,

- To produce and facilitate the provision of materials and resources to support health-related broadcasting,
- To facilitate in conjunction with the four local District Health Authorities' health promotion services community networks to extend activities stimulated by health-related programmes,
- To monitor, review and evaluate the achievement of these objectives.

Key criteria in developing the project objectives were to attract an audience's attention, sustain attention and stimulate action (Figure 4).

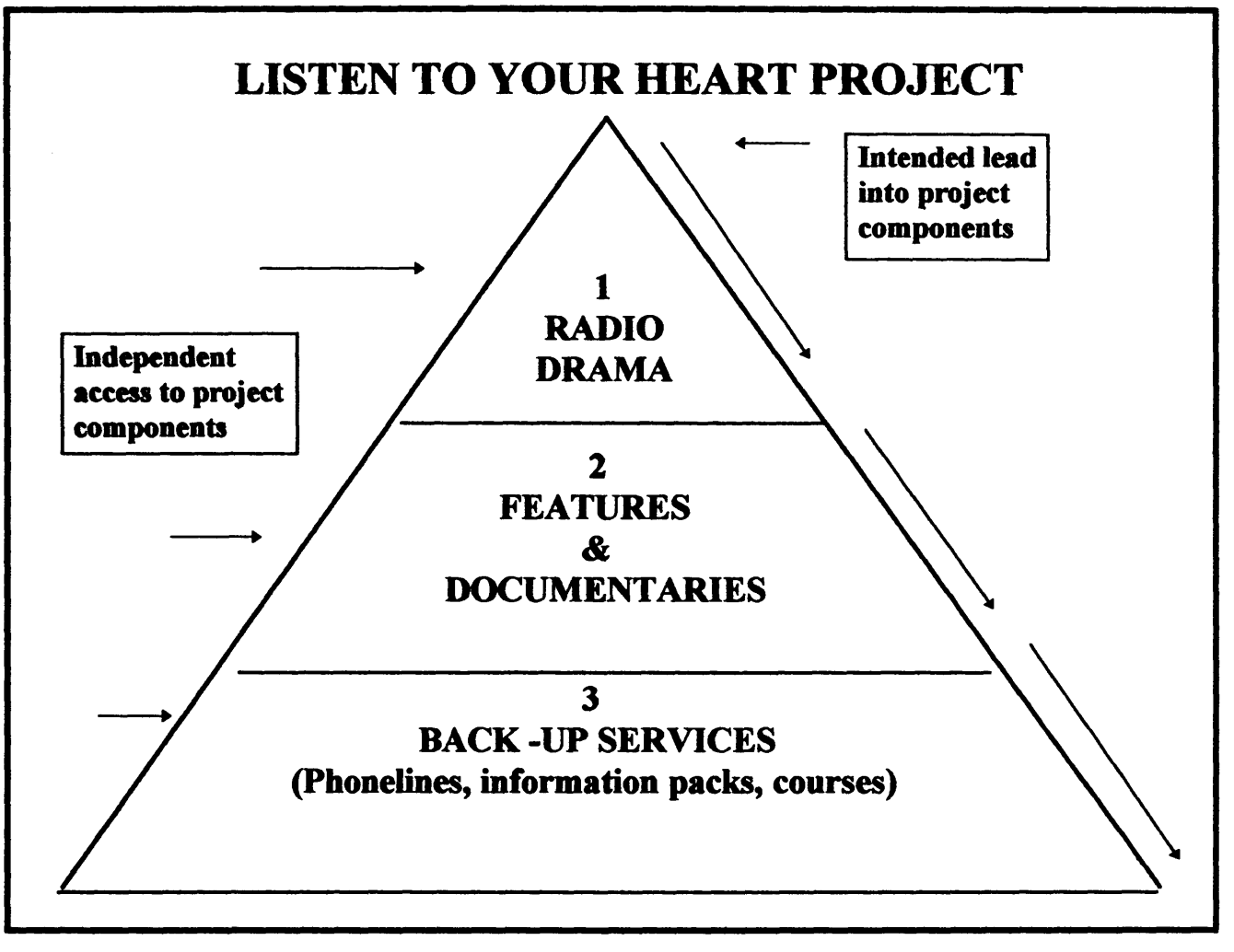


Figure 4 'Listen To Your Heart'- ***A Model For Social Action Broadcasting***

5.2.1. RADIO SOAP OPERA

The fundamental aim of the radio drama was to attract an audience. In attracting an audience a prime function of the drama had to be to entertain therefore maintaining the interest of the

audience. The drama was to be a 20 minute weekly (repeated on Sunday) radio drama set in a fictional area somewhere in Warwickshire.

The key objectives of the drama were to:

- trigger an interest in health
- lead the audience into the features and documentaries
- keep health on the audience's agenda.

Health issues were to be explored in the drama but not in the form of 'health messages'. Unlike previous initiatives, (Singhal and Rogers 1988 and others) as outlined in Chapter One, the intention with the drama in this strategy was not to insert educational messages into the drama itself, relying on the theory of direct effects. The aim was to explore health in the context of characters' lives in the form of life events, thus aiming to remove the potential accusation of the drama being health propaganda. The central focus of the drama was as a creative agenda setting agent.

5.2.2. FEATURES & DOCUMENTARIES

This element in the strategy was to mark the start of the main body of the educational process. Once the storyline for a health issue had been established in a number of episodes and hopefully stimulated an interest in the health subject, listeners were to be invited to stay tuned to find out more in later programmes. The aim, through a range of features, documentaries, series and debates was to:

- explore the issue from as many different angles as possible in an attempt to expand its relevance to the audience,
- stimulate debate,
- stimulate consideration for individual action,
- to inform the audience.

Dependent upon the issue to be covered, a suitable broadcast format would be selected for exploration. Factors involved in forming this selection lay in whether the issue was to stimulate discussion when a live debate would be selected or to trigger an individual response to courses or services, when a series would be used. The former would allow a wide range of views to be explored and confronted, intending to challenge and inform the views of the listener, the latter to approach all issues from a wide variety of angles and interests, aiming to attract the attention of the listener and stimulate a behavioural response through prolonged coverage.

5.2.3. BACK-UP SERVICES

In order to support and expand the educational process, back-up services were to be provided for each issue covered where appropriate; they were to take the form of :

◊ off-air phone-line counselling,

◊ information packs,

◊ community run courses.

The aim of this service was to :

- stimulate the development of county and city-wide materials,
- extend the educational opportunity of the broadcast through the provision of information packs,
- provide details of local services across the city and county,
- enable access to more individually targeted information through the provision of off air counselling,
- provide individual support following the coverage of sensitive issues,
- provide opportunity for skill based development,
- stimulate the provision of locally based courses.

The focus and format of the services provided were to be dependent upon the issue covered. If there was a possibility that anxieties would be aroused following coverage of sensitive issues or that more specific individual advice was necessary then phonelines were to be provided, operated by local professionals.

In an attempt to provide a more permanent record of the subject matter and therefore expanding the educational opportunity information packs were to be produced to support and supplement the issues explored in the broadcast and provide details of local services and activities. Where there were gaps in commercially produced materials the project would produce its own.

In addition to the verbal and written educational support provided by the packs and phonelines, where possible, listeners were to be directed to courses or classes across the city and county. Where gaps were identified the project would seek to stimulate local provision.

The aim of the Listen To Your Heart Project was for the radio drama to attract listeners and stimulate them to follow the process of listening to the features and sending for packs or attending courses if appropriate (Figure 4⟶). People could access the project components independently (Figure 4⟶). They could if they chose listen to the radio drama solely as entertainment; they could just tune into the features; or they could hear about the packs and courses through trails etc.

The intention of the project design was to redress the conventional approach to health promotion by the media both in terms of its content and its organisation (Figure 5).

COMPARISON BETWEEN CONVENTIONAL MEDIA COVERAGE AND THE LISTEN TO YOUR HEART PROJECT

	Conventional	*Listen To Your Heart*
Orientation	Medical	Health
Contacts	Medical Hierarchy	A Range of Practitioners
Agenda	News Led	Issue Led/ *Hillcrest*
Back-up Services	None	Phone-Offs/ Information Packs/Courses
Consultation and Involvement of Professionals	None	Integrated
Timing of Coverage	One Off/ Immediate/ Short	Planned/Explored Linked Features

Figure 5

The design focused on:

a) Setting the **agenda** for health

b) The **health orientation** of broadcast material

c) Developing **professional ownership** through consultation

d) Ensure multi-disciplinary approach to **health contacts**

e) The provision of **back-up services**

f) The forward planning and **timing of coverage**

As previously discussed, the way in which health is 'framed' by the media opens itself to criticism by both mass communication and health education specialists primarily due to its medical orientation and preoccupation with reacting to events as opposed to the exploration of issues. Throughout the project's operation a wide range of issues were to be explored in a positive attempt to direct attention from a healthcare, medical orientation towards issues of social importance and local relevance.

a) Agenda Setting

Rather than awaiting a news story or local incident to trigger media interest in an issue, the project's own regular vehicle for agenda setting, a radio drama would carry storylines that over the weeks would develop into topics of interest for the audience, thus the environment would be suitable to explore the issues raised in greater depth through features and back-up services without them appearing as isolated issues.

b) Ownership And Consultation

The need to establish effective partnerships with local organisations involved in health education was seen to be central to the Listen To Your Heart project's successful implementation. Its achievement lay in the belief that the development of successful co-operation could only be based on increased knowledge and understanding of each party's working practice together with active consultation at each stage of the strategy's implementation.

c) Contacts

Traditionally contributors for broadcast features are selected on the basis of their perceived authority, this selection is also strongly linked to professional hierarchies. Often the best person to provide a 'grass roots' account of what is happening, are the practitioners who are involved directly in the given activity. They are often missed by a failure of their organisation to put them forward, their lack of confidence in dealing with the media or the media's lack of interest due to their lack of seniority. The LTYH project sought to correct this tendency.

d) Back-Up Services

Back-up services in the form of phonelines, information packs and courses in the community were seen as an integral part of any issue featured.

e) Timing

To demonstrate and execute real commitment to local professional involvement and the incorporation of non-media aspects of the project as an integral package required a major shift in the traditional planning cycle for broadcasting. As we have already seen, planning and scheduling are problematic in broadcasting.

5.3 NEGOTIATIONS AND DILEMMAS

The negotiations around the development of the strategy once agreement in principle had been reached, centred around four key elements:

- Shared funding arrangements
- Editorial control
- Health orientation
- Management of the project

5.3.1 FUNDING ARRANGEMENTS

Originally funding was sought to run a twice weekly soap with an omnibus edition, together with a project officer for drama research and a negotiator of back-up features at an estimated cost of £85,000 per annum. The HEA were prepared to fund up to a maximum of £50,000 per annum, leaving an annual deficit of £35,000. In an attempt to secure the additional funding, the BBC sought to enlist the support of West Midlands Arts and Environmental Health Officers of Coventry and Warwickshire. No additional funds were forthcoming, and a decision was taken to slim down the drama production to 104 episodes over two years as opposed to the original intention of producing 312 over a three year period.

It was proposed that funding for the strategy, called "Listen To Your Heart", was to be shared between the Health Education Authority, BBC and District Health Authorities and was to involve the linking of existing resources to new resources from the Health Education Authority and also the BBC. The total estimated grant required from the Health Education Authority was £50,000 per annum over three years. Local District Health Authorities would provide a seconded health promotion worker (separate to the Project Officer) and the BBC would employ a producer for the drama and provide studio and associated support to the project. The grant required was to cover the Project Officer and administration support and employment of actors (Appendix V). It was felt appropriate to continue with the secondment of health

promotion specialists independent of the strategy. This would enable continued health coverage that was not project linked and provide coverage for reactive features. It would also ensure that the policy of involving health professionals was not linked to external project funding.

The funding of the strategy was thus agreed with the District Health Authorities and BBC re-orientating existing resources to link with the project and the BBC and the Health Education Authority providing new resources. Agreement from the Health Education Authority to fund the project for a minimum of two years provided significant leverage for the BBC to find new resources to fund a Producer for the drama. Additional costs not identified but covered by the BBC were to include studio time and studio support.

The three partners in the funding of the project were to contribute significant amounts of time and hence opportunity cost in negotiations, steering and reviewing the project on a regular basis. The three key financial stakeholders were to be making a significant and mutually supportive contribution to the project.

5.3.2 EDITORIAL CONTROL

Negotiations with the BBC in developing the strategy and the bid had been at a local and regional level. With the success of the proposal in attracting funding the unique nature of the proposal, unprecedented in at least one respect came to the fore.

The issue of editorial control, which had already been agreed locally, had to be resolved to the satisfaction of those individuals at a national level, with negotiations undertaken by the Station Manager. It was confirmed that in all respects, editorial control of all broadcasting on CWR relating to the project would remain with CWR and consequently with the BBC. This control would cover all matters relating to the drama serial; the selection, supervision and management of all personnel directly involved; the content of scripts and the production of all programme material. Where issues triggered in the drama were developed factually by other CWR programmes, again all editorial control remained with the BBC in terms of when and how that material was handled.

It was further acknowledged formally that the broadcasts associated with the project would feature a wide range of opinions and views some of which may not be the particular view of

the District Health Authorities or the Health Education Authority, although in striking a balance a range of views would be ensured. This concern was reflected from another perspective in the press at the time:

> **". . . we offer a word of advice: from time to time *The Archers* is accused - rightly or wrongly - of allowing the Ministry of Agriculture to interfere in the messages it conveys. The new series must be protected from similar depredations by the Department of Health - not that any such thing would ever cross the minds of anyone at Richmond House."**
> **(Health Service Journal, 17.5.1990)**

5.3.3 HEALTH ORIENTATION

The Look After Your Heart Programme as the name implies was specifically a programme 'to prevent heart disease and encourage healthier lifestyles'. The proposal for the Listen To Your Heart Project in Coventry and Warwickshire took a holistic view of health, the corollary of which implies that an over-emphasis on coronary heart disease risk factors would be inappropriate. In reflecting peoples' health concerns in the drama and associated activities focusing on such risk factors alone could not have been seen as the central focus. People do not experience health as risk factors but as a complex nexus of interrelated factors in specific contexts. Reflecting this in the drama was seen as of paramount importance to 'good drama' but more importantly 'good health promotion'. The Health Education Authority accepted the necessity for a holistic view of health in the context of social action broadcasting and in its agreement to fund the project for an initial two years stated full support for the position on health the strategy was to take.

Throughout the negotiations and developments the language used by the key stake holders was different for a variety of reasons. Differences in language were inevitable with different professional orientations. Regardless of the language, the understanding and concepts were common. In only one area was the use of language seen as crucial to the innovation and success for the project.

District Health Authorities referred to a 'health soap', BBC personnel referred to a 'medical soap'. The strategy was to be concerned with health, holistic health, not with medicine although there was acknowledgement that medicine contributes to health. The terms are not synonymous and the use of language was seen as crucial as the implied assumptions would indicate the orientation of the project. The orientation was to be towards health, as it is

experienced by people day-to-day. Emphasising health as a medical product was not the function of the project.

It has been argued earlier that the tradition of medical coverage as opposed to health coverage is well established and is difficult to counteract but as will be outlined, health without the traditional link to medicine and disease was seen as legitimate and valid in the context of social action broadcasting, though it continued to be an area of contention especially in relation to the drama, as the exploration of the relationship interface demonstrates.

The wide local and national press coverage of the project in the summer of 1990 emphasised the medical side. Parallels with Emergency Ward 10, Dr Kildare, St Elsewhere, Jimmy's, Hospital Watch, and a 'medical' Eastenders, were made. Even suggestions from the press as to a title for the drama - The Arteries, Coronary Street - were made. Some let their imaginations run further with outline plots and characters: Steph O'Scope, an Irish nurse, Wi Pin Yo, a doctor from China who has worked in the Black Country, Dr Dick Gladstone-Bag, a tweedy senior partner. Other headlines included:

"Introducing an Everyday Story of Medical Folk."	**(Coventry Evening Telegraph)**
"Health issues aired via medicated soap"	**(Birmingham Post, 8.5.90)**
"Move over Eddie Grundy"	**(Health Service Journal, 7.5.90)**
"Soap is just what the Doctor ordered"	**(Leamington Courier, 11.5.90)**
"New weekly dose of soap on the radio"	**(Wolverhampton Express & Star 8.5.90)**
"BBC radio soap opera to be well versed in health"	**(Guardian, 9.5.90)**
"Carbolic Soap"	**(Daily Mail, 10.5.90)**

The coverage focused on the drama and the supposed 'medical' nature of it did not reflect the synergism of the constituent parts which made up the strategy. The drama was medicalised in this coverage even before it began. A more erudite report by Nick Baker in the Guardian did, however, point out the limitation of the 'soap' as an educational medium:

> **"Soap opera is a continuum - slices of ersatz life cut regularly from a never ending loaf. As a form, it's part of the status quo, it can't change anything - attitudes or mass bullying habits. Archers' listeners tune in to hear whether Sid will find out about Kathy and Dave, not to learn about BSE."**
> **(Guardian, 9.5.90)**

5.5.4 MANAGEMENT AND ADMINISTRATION OF THE STRATEGY

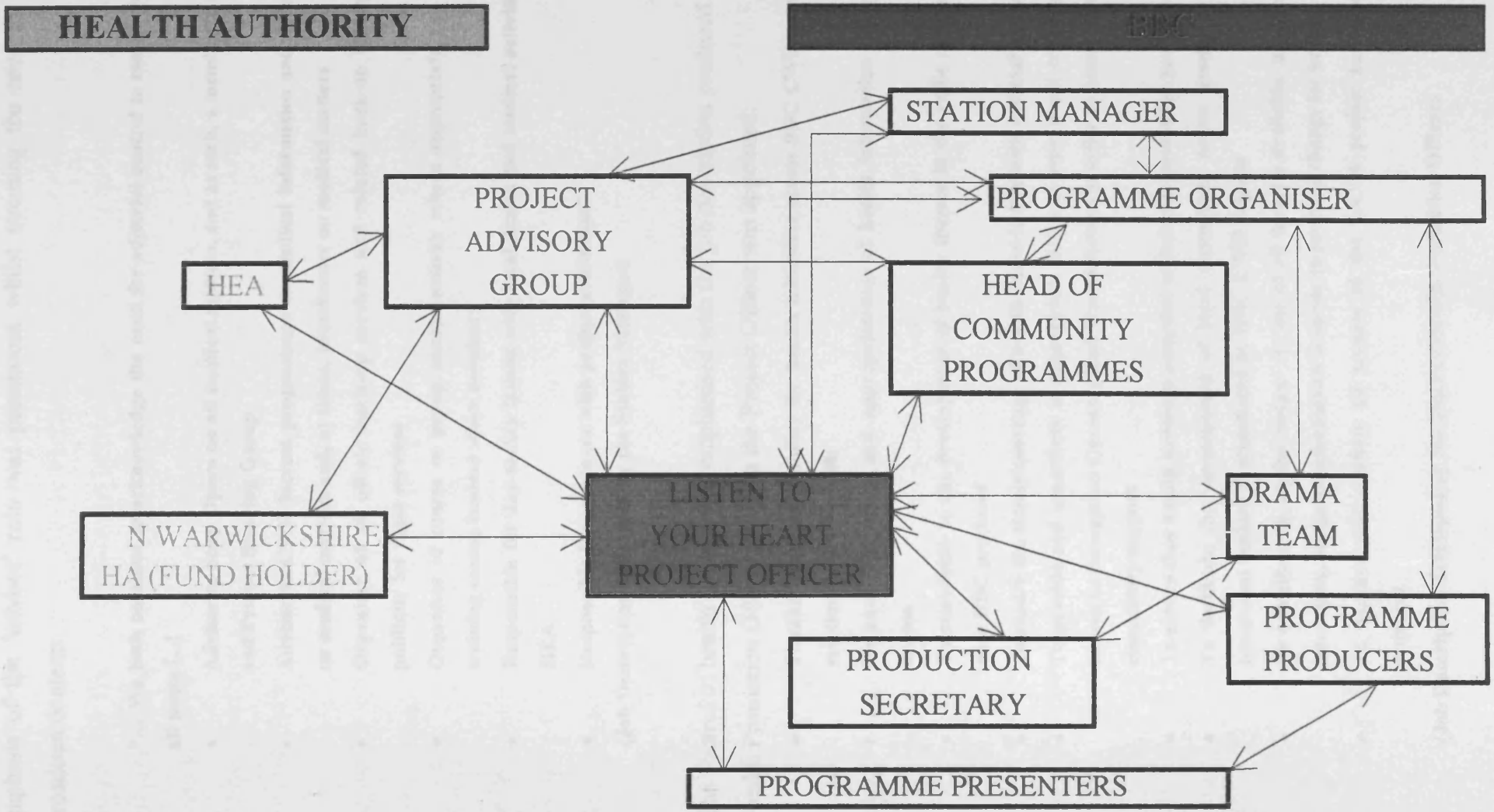
Partnership arrangements had to be structured to allow for a clear system of managerial accountability. The award of the Health Education Authority was made to North Warwickshire Health Authority and the nominated grant holder was the District Health Promotion Officer. Because of the limitations on the BBC in terms of receiving external funding and the necessity for professional support, the Project Officer was directly employed by North Warwickshire Health Authority but based at BBC CWR in Coventry.

The Health Education Authority grant was paid directly to North Warwickshire Health Authority to cover employment costs of the Project Officer and provide an 'educational grant' from North Warwickshire Health Authority to BBC CWR for educational programming and would be related directly to expenditure on the production of the radio drama. A Project Advisory Team was set up to provide support to the Project Officer in relation to the health coverage. The linked management and administrative structures can be seen in Figure 5.

The successful development of the project was the responsibility of the Project Officer. Professional management for the Project Officer was to be provided by the District Health Promotion Officer of North Warwickshire Health Authority, operational management by CWR. Key working arrangements and relationships were to be established between the Project Officer and the Drama Production Team and the Project Officer and the Programme Presenters. These relationships were to ensure an integrated approach to heath, linked to the drama, throughout the station's output.

A job description for the Project Officer based on the developed role of the secondee was negotiated with North Warwickshire Health Authority, who were to be the fundholders, BBC CWR would receive funds for the drama in terms of an educational grant. Due to the fact that only £50,000 pa was available, it was decided that the Project Officer be appointed for three years, to start in June 1990, responsible for developing the strategy for six months, the drama and associated features would run for two years from December 1990 - December 1992 and the Project Officer would be responsible for dissemination and evaluation during the last six months up to June 1993. Although the Project Officer was to be a health authority appointment, both the District Health Promotion Officer and Station Manager separately produced an outline of the tasks to be included in the job. Whilst in essence they dealt with similar issues the emphasis varied greatly; for the Station Manager, the

MANAGEMENT AND ADMINISTRATIVE STRUCTURES (Figure 6)



emphasis of the 'advisor' role was paramount whilst stressing the need for control over broadcast content:

> **"... We both continue to acknowledge the need for editorial control to remain with the BBC at all times [...]**
>
> - **Advisor to Soap Opera on all medical matters, and as such, a member of the script group and Project Steering Group**
> - **Advisor to CWR factual programmes on medical information and features, researcher on medical matters and, at times, broadcaster on medical matters**
> - **Organiser of all off-air back-up services and related back-up literature and off-air publicity for these services**
> - **Organiser of course or group session activity where appropriate and responsible for training course leaders when necessary**
> - **Responsible for day-to-day liaison with local health and medical activities and with the HEA**
> - **Responsible for assistance with project evaluation"**
>
> **(Job Description developed by the Station Manager)**

The control of health content was emphasised with the job description produced by the District Health Promotion Officer to which the Project Officer was appointed:

- **To take lead responsibility for health initiatives across BBC CWR output, especially in relation to heart health**
- **To ensure accuracy and appropriateness of health information transmitted by radio drama**
- **To contribute to the development of health themes in the radio drama, in conjunction with BBC producer**
- **To ensure the timely coverage of health issues in line with national and local initiatives**
- **To provide and contribute to appropriate skill and topic-based training for operational networks throughout Coventry and Warwickshire in order to ensure relevant and timely community support**
- **To ensure that health coverage complies with health promotion good practice**
- **To facilitate the development of local community action groups to support health promotion initiatives stimulated by BBC CWR outputs**
- **To contribute to station output via use of all formats available, pre-recorded packages, interviews, series documentaries in order to promote change for health**
- **To monitor and evaluate all aspects of the LAYH project and produce reports as required**

(Job Description developed by the District Health Promotion Officer)

The individual job descriptions were never formally discussed and I as the Project Officer, once appointed, was left to continue to develop as a producer of the health features associated with the project. The tension between the varying perceptions of my role and the BBC maintaining editorial control was never raised other than in relation to the content of the radio drama. This issue was never formally resolved. The failure at this stage to pursue resolving the discrepancy in role expectations was to result in the issue featuring heavily in the relationship interface with the drama production team.

Whilst the content of the LTYH project focused on a strategy for enhancing media influence and audience reception in promoting positive health, these themes are not the main focus of this thesis. Instead the concentration of the empirical investigation lies in the production process of the projects implementation.

Summary

This chapter gives an account of how broadcasters and health specialists collaborated to develop a media based health communication strategy. This relationship and merging of professional boundaries led to the development of a creative campaign strategy that combined the learning from entertainment-education, media advocacy, and social action broadcasting.

As the health communication strategy sought to incorporate radio drama, this marked the added dimension of a further relationship interface to consider as the differences increase in professional conventions, norms and values. The result was a strategy that sought to stretch the imagination, patience, adaptability and flexibility of three distinctly different cultures, health, broadcasting and drama.

In viewing the development of the collaboration between health professionals, broadcasters and drama production specialists the relationship interfaces form the three main themes of this thesis. In the next chapter I present my research findings from the ethnographic data collected during my role in implementing the health communication strategy that I have presented in this chapter as a case-study. Following the identification of key issues for discussion I present an analysis of the findings supported by triangulation with other supportive data.

CHAPTER SIX

RESULTS - INTERFACE WITH HEALTH PROFESSIONALS

Introduction

In the next three chapters I will present the findings from the research undertaken in response to the posed questions. Although the case study provided a range of approaches for enquiry, I will not focus on the nature of media influence in this thesis, instead I will concentrate on the production process of implementing the LTYH project.

As outlined in Chapter Three what I believe will give life and meaning to the research findings is the realisation of how these impacts were achieved, what the influences were and what barriers existed in the development, production and broadcast of the project. As Parlett and Hamilton, (1976) and Patton, (1990) emphasise when discussing evaluation methodology in general, processes are as important to understand as outcomes. In the context of this research, it is the media production process that I believe is as relevant, if not more so, to comprehend, than outcomes such as the impact on the audience; this stance is supported by Halloran, (1998). Understanding what happens when drama, broadcasting and health specialists collaborate will enable more effective communication strategies to be devised, delivered and evaluated.

The first section of this chapter seeks to outline the process of interaction with the various stakeholders in the implementation of the project; the drama production team, programme production teams, and health professionals. I explore how working in collaboration calls for three distinctly different professional groups to question and, at times, compromise their professional norms and principles, as they interact to implement their part of the health communication strategy.

The method used to collect this data was ethnography. Field notes, drama scripts, and documents from meetings were used as the main data sources. In order to provide a structure

for the presentation of this data I will outline the roles I undertook in order to carry out the research. In doing this, it will enable the exploration of the core functions that comprised the often invisible infrastructure supporting the project's operation. The main focus of this chapter and the two that follow will be the roles undertaken at each of the professional group interfaces: initiator, mediator, enabler.

For clarity I will focus on the interface with each professional group within a separate chapter, firstly health professionals, then programme production and finally drama production. Within each of these chapters I will outline a number of examples in order to identify specific differences in professional norms and values. I will then provide an analysis which will seek to triangulate the findings with other sources of data collected during my evaluation of the project. Triangulation in this instance is used for respondent validation, in order to check inferences drawn from the ethnographic data with other qualitative and quantitative sources. The aim is not to adopt a naively optimistic view (Hammersley and Atkinson, 1990) that the culmination of the sources will produce a whole and definitive picture. The intention is to recognise and interpret consistencies and pursue differences and discrepancies. The aim with this analytical approach is to ensure greater confidence in the findings.

All but one source used in this triangulation was collected by me. The one source that was not was a section contained in the project's unpublished Final Report, which focused on the nature of the partnership between broadcasters and health specialists. This was conducted externally due to the nature of the sensitivity of my research position as outlined in Chapter Three. The interviews quoted in Chapters Seven and Eight are taken from this section of the report. The data has been published in an article which focused on the production of the drama (Dickinson, 1995), but it did not look at the whole spectrum of relationships that operated within this research framework.

6.1 ROLES AND INTERACTION

Figure 7 represents the interfaces for the three partners in the implementation of the strategy. For effective operation of the project, communication was imperative between three distinct professional groups, namely the programme production teams, **(1)**, health professionals **(2)** and the drama production team **(3)**. Each professional group exhibited differences in their professional codes of practice, orientation towards health and health promotion, modes of communication and finally, methods and timescales of operation. My co-ordinating function as

the Project Officer operated at each interface **(4)**, **(5)** and **(6)** and sought to provide the balancing orientation, i.e. as a broadcaster when in negotiation with health professionals, as a broadcaster with a health orientation when negotiating with broadcasters and drama production team. The aim was to ensure effective lines of communication. The Project Advisory Group sought initially to operate at the interface between the station management and the health sector, as the project progressed it operated between all parties **(7)**, though this was only formalised towards the end of the implementation phase.

The three prime roles operating at each interface were that of:

a) Initiator

b) Mediator

c) Enabler

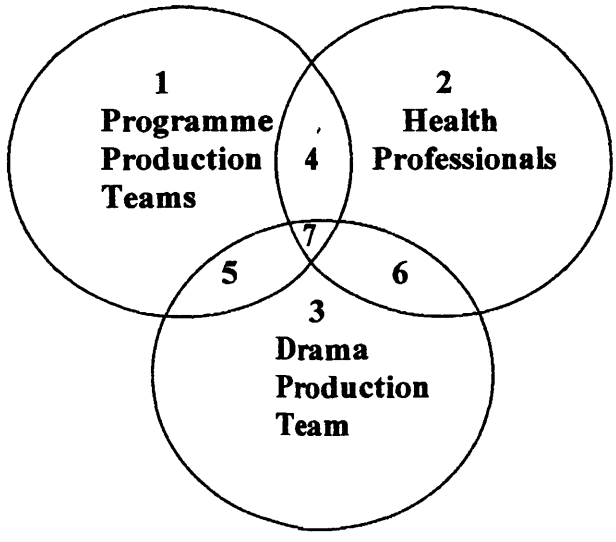


Figure 7 Organisational Interface Mediated by the Project Officer

a) ***Initiator Role***

Table 1 outlines how the Initiator role was undertaken at each of the professional group interfaces: health professionals, drama production and programme production. The prime focus of the project was for health professionals to take a lead in setting the local health agenda that was broadcast on the local BBC radio station. My role lay in supporting them in order to take the lead in identifying issues for coverage, and determining how issues were to be covered. The anticipated process was then for me to take a lead with the drama production team in determining the issues for coverage, and subsequently, initiate the feature coverage with

programme production teams. As will be detailed below this role was difficult to operationalise at the interface with both health professionals and the drama production team, but for different reasons.

b) ***Mediating Role***

There was a requirement when negotiating at the various interfaces for me to represent the orientation of the absent partner, i.e. provide a broadcasting focus when in negotiation with health professionals, to provide an understanding of the health issue when in discussion with the drama production team, and to provide a health focus whilst maintaining a broadcasting orientation when negotiating with programme production staff (Table 2).

The main function of the mediating role was to offer a level of justification for the recommendations and decisions of absent partners. This was a crucial role given the wide ranging orientation on health and communication of the three parties. The aim was for this role to facilitate a learning process for each of the parties regarding the other groups' orientation. As will be outlined below whilst this role was acknowledged by health professionals and programme production, it was a consistent challenge to provide justifications that were acceptable for the drama production team.

c) ***Enabler Role***

This role was imperative and central to the implementation of the project, as it was the function that ensured that the various components of the campaigns actually materialised: that health features were produced and broadcast, that the broadcast features were linked to the supporting storylines, that back-up services were in place; in summary that the overall sequencing and co-ordination of related components came to fruition. (Table 3).

As will be explored below this role was imperative to the achievement of the project goals at each of the professional group interfaces. Although the drama would have continued to be produced in the absence of the enabling function, without it the link with feature programmes, health professionals and therefore community activity would have been absent.

INITIATION TASKS

Health Professionals	Programme Production	Drama Production
Identifying the issue for coverage	Issue for coverage	Identifying issue for coverage in the storyline
Timing of issue	Duration of coverage	Timing of issue in storyline
Bringing together key agencies.	Timing of coverage	Orientation of issue
Planning timetable	Focus of features	
Focus of coverage	Format of features	
Priorities of coverage	Competition content	
Allocation of tasks		

Table 1

MEDIATING TASKS

Health Professionals	Programme Production	Drama Production
Target health information suitable for broadcast	To justify range of issues to be covered.	The importance of focus in health promotion terms.
Break down issue into manageable pieces.	To justify orientation.	Important triggers for programme activity.
Develop range of formats suitable to communicate health information.	To justify duration of focus.	
Selection of suitable contributors.	To justify order of issues to be covered.	
Duration of broadcast time available.		
Necessity of back-up service.		

Table 2

ENABLING TASKS

Health Professionals	**Programme Production**	**Drama Production**
Training and individual support of contributors. Editing and production of materials.	Selection and securing of guests. Booking and preparation of guests. Research and writing of background information for presenters. Briefing presenters. Outline of structure, cues and questions for live interviews. Production of live interviews and debates. Selection and interviewing of guests for pre-recorded packages and documentaries. Preparation and organisation of phone-line operators. Order and timing of activities on Outside Broadcasts (OB). Preparation for engineers prior to OB. Ensuring copy of broadcast feature is made. Writing of Press Releases. Securing prizes for competitions. Writing competition tasks. Distribution of prizes. Locating and securing sufficient copies of known booklets Production of booklets for information packs. Reproduction, compilation and distribution of information packs.	Provide script research Provide subject advisors Brief subject advisors. Review scripts.

Table 3

6.2 INTERFACE WITH HEALTH PROFESSIONALS

6.2.1 FORMAT FOR INTERFACE

The interface with the Health Professionals operated at a formal and informal level. At a formal level three forums existed, firstly a consultation process that operated prior to the implementation of the health communication strategy, secondly a campaign specific consultation process during its operation, and finally the Project Advisory Group which was established to support me and my role on an ongoing basis. Informal interaction existed during

the final stages of campaign development when negotiations were on an individual contributor level.

A strategic approach was taken to establish effective partnerships with the local health professionals. One of the prime organisational principles of the research was to develop professional ownership of the communication strategy. The aim was to ensure integration with agencies and activities operating within the local community and allow them to contribute to the development of the process. This required attaining individual, departmental, and senior management support, in each of the geographical areas, for their staff's involvement and the allocation of time.

Prior to broadcast, I held a series of formal consultation meetings at BBC CWR. The aim was to bring together local professionals and voluntary organisations (Table 4) to involve them in the development of the communication strategy. The meetings :

- informed them of the project's intentions,
- sought their advice on issues to cover in the drama and subsequent programming,
- offered the opportunity for further involvement,
- negotiated a strategy for professional involvement.

The meetings lasted for approximately two hours and followed a similar format of:

i. Introduction to the Station by Station Manager or Programme Organiser,
ii. Outline of project by Project Officer,
iii. Discussion on issues to be covered,
iv. Discussion on future links and involvement.

The response to the meetings was extremely positive and all sessions were well attended. Generally representatives attended from all sections of the county and city; where there were obvious gaps additional meetings were held. As a result of the consultation process there were four positive outcomes. Firstly, the co-operation of an enthusiastic group of professionals who were willing to support the project in terms of advice and support was attained (Appendix VII). With regard to the timing of their involvement, it was agreed that planning groups would be established two months prior to an issue being covered, and that these meetings would be task orientated. Ensuring that meetings were task orientated was to serve a number of functions. Firstly it established the principle that an individual's time was to be drawn on only

when a specific task related to them professionally was imminent, this reassured them that they didn't have to commit time to a series of ongoing meetings. Secondly, calling a meeting would signal the need to act as a result of their involvement in the planning process, the meeting would not simply be a general discussion on the issue in question. Thirdly, a comprehensive list of local issues for coverage was compiled (Appendix VII). Finally, members for the Project Advisory Group were identified.

PROFESSIONALS INVOLVED IN THE CONSULTATION PROCESS

Chief Leisure Officers, Sports Development Officers, Education Officers,
Sports Council Development Officers, Environmental Health Officers
Dieticians, Psychologists and Physiotherapists
Voluntary Organisations, Health Promotion Services
Smoking Cessation and Look After Yourself Tutors
Directors of Public Health, Health Authority Chief Executives, Family Health Services
Authority Representatives, Local Medical Committee Representatives,
Local Pharmacist Committee Representatives.

Table 4

The main outcomes of the formal consultation process was the strategic agreement to release professionals to actively support and be involved in the initiative, and secondly a task-orientated consultation process with local organisations was integrated into the planning cycle of the communication strategy.

The strategy for the implementation of the project was to organise the broadcast features around specific campaigns identified by health professionals. From the onset of an issue being mooted for coverage in the Script Conference, related organisations were invited by me to attend a campaign planning meeting. This multidisciplinary group of professionals from across the city and the county determined the focus and timing of the campaign. Although the original membership never remained static, that group contributed to decisions about every aspect of the campaign; the angle for drama storyline, script advisers, selection of guests or contributors for documentaries, sites for debates, and the nature and detail of the back-up services.

It had been agreed at the outset that campaign planning meetings would be task-orientated, therefore once meetings had been held and the direction of the campaign determined, the group did not meet again. Members of the original planning groups were encouraged to contribute at

varying levels dependent upon their experience and choice, with many being involved in developing materials, and organising staff in their locality for back-up services. If health professionals were to contribute on air, they were then provided with support by me prior to the interview and during production.

Following on from these meetings the number of professionals involved in the campaign increased dramatically as I then worked with groups and individuals to develop and produce the specific detail of the various campaign components. Due to any meeting being task orientated no group oversaw the development of a campaign; once the initial outline had been devised and contributors identified I then sought to implement the plan. Although some health professionals may have been involved in any one aspect of the strategy, it was not usual for them to be involved throughout the process. One professional group that did differ was community dieticians, as will be outlined in Example Two.

The final formal forum for interaction with health professionals was the Project Advisory Group. This group was established in August 1990 and originally consisted of me, the four District Health Promotion Officers and BBC CWR's Station Manager. This subsequently developed to incorporate the Health Education Authority, Black and Asian workers, representatives from Environmental Services and the two Local Medical Committees. It was anticipated that two members of the station's Advisory Council would join the group as listeners, though this never actually happened. The main focus of the group was to support and advise on the health coverage and for the group members to liaise with their respective organisations (Table 5).

The Purpose of The Advisory Group

To establish an on-going dialogue between the project and the agencies involved
To offer advice on the project's development
To provide local contacts
To provide feedback on drama and programming development as listeners
To promote the project in their areas of the community
To inform the project of local health needs and developments

Table 5

The main function of the Project Advisory Group had been clearly outlined by the original Station Manager at the first meeting:

> **"The Group is to provide for the factual aspects of the project, providing advice on topical matters, health/medical issues, providing relevant feedback and keeping in touch with public health needs and concerns"**
> **(20/8/90)**

Being a member of an advisory group for a broadcasting project was a new experience for all participants other than the Station Manager. Early support that the group were able to afford was for broadcast features to be thoroughly researched and produced. This added strength to my resistance to increase the amount of broadcast output in the strategy at the expense of what I perceived to be quality. This pressure had arisen early in the context of the Script Conference, where the initial assumption was that I would produce features on every health issue mentioned in the drama. The result was the recognition that campaigns would be broadcast every two months, to allow adequate time for professional involvement in the planning of features and the development of support services.

It was decided that the group would meet every two months. The regular format that developed was for me to provide a progress report on project activities to date and outline future initiatives; the element of advice and direction was lacking. It also became clear that members of the group were not listening to the features or the drama. Individuals who had heard snippets of the broadcast were making generalised statements that were not based on professional judgement but on personal impressions and opinion, as other members had rarely listened to the same episode or interview it was not possible to conduct an informed discussion. At the Project Advisory Group in May (7/5/91) I requested that the role of members be reviewed. I felt that it was imperative that participants' comments were considered and based on their familiarity with the content of the strategy components. It was agreed that I would provide audio tapes of the features and that each would be responsible for listening to the drama; the HEA representatives were to be sent regular copies of the drama when broadcast. The group was to become a professional listeners' panel. The Drama Producer was also to be invited to the meetings to respond to members' comments.

An unintended function of the Project Advisory Group was to make the radio station, as a partner in the alliance, externally accountable. As the funding organisation were represented on the group this enabled gentle pressure to be applied to ensure that the BBC fulfilled its original

commitment to engaging their London-based Broadcasting Research Department's Special Projects Unit to conduct an evaluation of the strategy's impact on the audience.

6.2.2 INITIATION ROLE (Table 1)

The initiation role operating at the interface with the health professionals was met with acceptance and enthusiasm. The consultation process had identified a comprehensive list of issues for coverage (Appendix VIII) and an agreed timescale for campaign planning; this provided the structure for the future involvement of health professionals. Whilst my role was to initiate the planning process and the bringing together of key agencies, it was through negotiation that the lead was taken for the orientation and timing of the campaigns by the health professionals themselves.

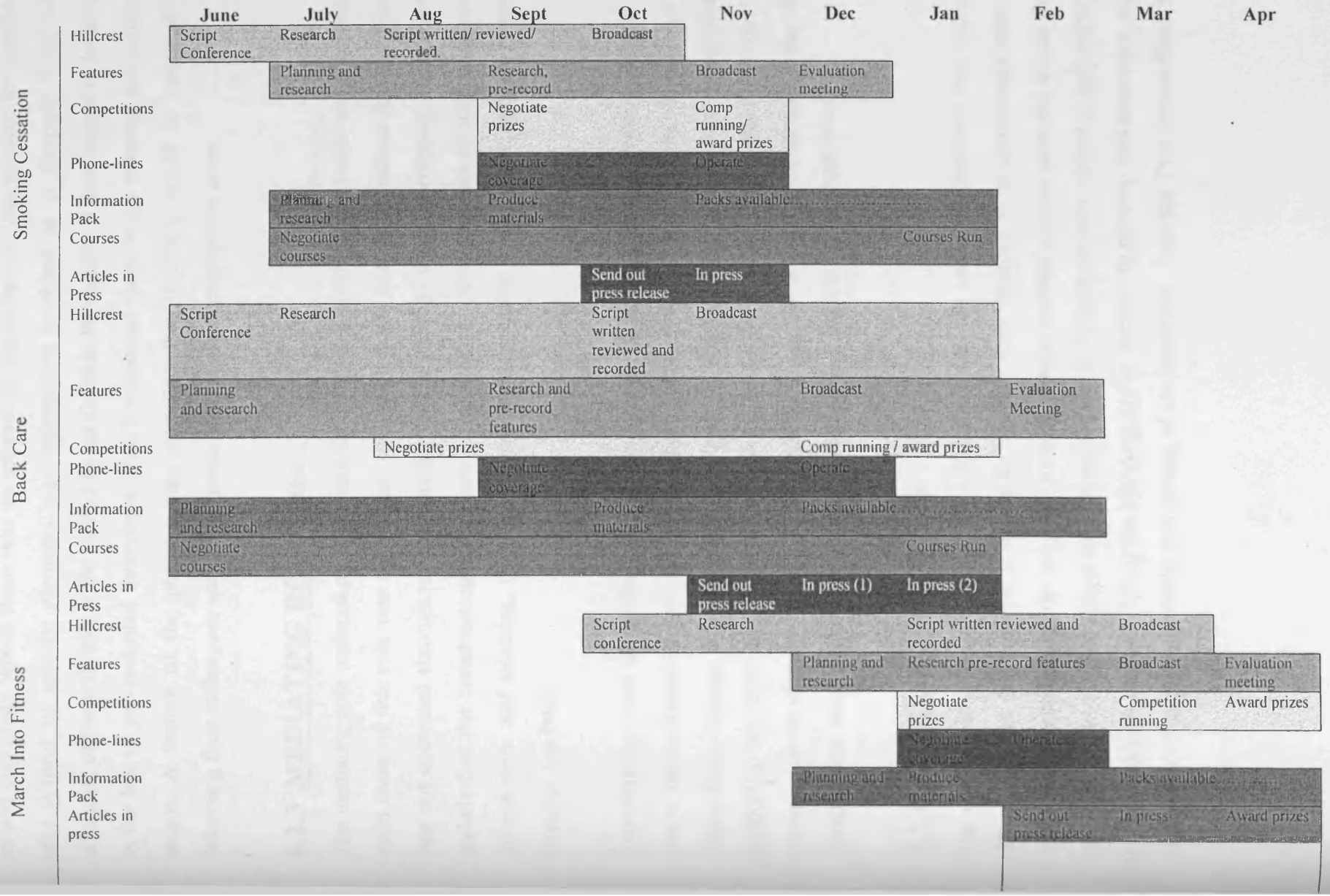
Identifying the issue for coverage was not a linear process from the health professionals to the Drama Production Team. Whilst the consultation process had identified a wide range of issues there was no formal health strategy to assist in prioritising them. The decision of what issue to cover in the drama was initiated through the Scriptwriting Conference.

The initiation for the orientation or focus of the campaign was the main role of the health professionals. Once the decision was made to cover a particular health issue in the drama the planning group advised on the necessary angle for coverage. This was often based on areas rarely challenged by the media, or current professional concerns that were thought to require public awareness. This was then fed through to the Drama Production Team through me and the person who was to be the subject script adviser.

The timing of the campaign was largely determined by the planning group. It was necessary for the timing to operate within parameters due to the complex planning schedule as demonstrated in Figure 8 (Timing of Strategy Activities) and Example Three. It was however, through negotiation that the decision was made to link with locally planned activities, as in Examples One and Two, and whether to follow national campaigns or raise the issue again at another time, therefore utilising the opportunity to place the issue on the public agenda again.

Once the main outline of the campaign had been decided an action plan was devised that outlined the necessary tasks. The plan contained the recommended contacts for interview, to

Timing of Strategy Activities **(Figure 8)**



staff for phone lines, materials to be developed etc. Members of the planning group were invited contribute where there was an interest or specialism. It was possible for members to take control of specific elements e.g. information booklets as in Example Two, or the arranging of the activities to be visited by an Outside Broadcast. If they wished to be involved in the live or pre-recorded interviews, then I supported them in the planning and production stages. A feature of the planning meetings was that members would be responsible for informing their colleagues and departments in their own geographical areas.

6.2.3 MEDIATING ROLE (Table 2)

The mediating role undertaken at the interface with the health professionals was accepted. The main focus of this role was to translate campaign goals into the broadcast format. This role was not contested throughout the duration of the strategy's implementation, reasons for this include that the broadcasting skills were not present in other members of the group, and the groups were self selecting, therefore notionally supportive of the concepts upon which the strategy was built.

One challenge with the mediating role was stimulating the provision of back-up services. This was a time-consuming area especially where there were to be community classes, and with phone line coverage it became labour intensive. Through negotiation it was recognised that supporting broadcast features with one-to-one contact was an imperative element of the health communication strategy. Sharing the workload among the relevant professionals in the various geographical areas made the task manageable. This is outlined in Example Two.

6.2.4 ENABLING ROLE (Table 7)

The enabling function operating at the interface with the health professionals was welcomed, this was due to the fact that it sought to develop their capacity to be increasingly more fully involved in implementing the project. On-going media training courses were run across the city and county, but also individual support was given to individuals who wished to gain experience in the broadcast medium. When the planning group decided to develop new resources, support was provided in the production and editing of the materials; Example Two demonstrates this.

6.3 EXAMPLES

6.3.1 *EXAMPLE ONE*

One of the central aims of the health communication strategy was for multidisciplinary groups of health professionals to develop ownership of the process and content of the campaigns. This example in outlining the 'March into Fitness' campaign identifies the extent of the health professional influence in determining the focus, content and duration of the campaign (see Appendix VIII for details of the campaign programme and the range of agencies involved).

When planning 'March Into Fitness', consideration was given to the following:

- the nature of the topic and the appropriate health education goals,
- timing and duration of the programme,
- health gain and appropriate media treatment of the topic.

This topic was approached as a behaviour change programme. As such, it was important that it be linked to external motivating factors, that it be long enough for new patterns of behaviour to be adopted and that it start from the likely circumstances and orientations towards exercise of most listeners.

One possibility considered was to time the programme for January, so that it could be linked to New Year's resolutions as a motivating factor. Apart from fitting this in with the sequencing of earlier campaigns, a major disadvantage here was the winter weather in January and the reluctance of people generally to be involved in evening or outdoor activity at this time of year. It was decided instead to run the programme in March, using the onset of summer and light nights as additional motivators. Additionally, International Women's Week was timed for the first week of March, offering the opportunity to tie the broadcast into the activities associated with another community initiative, each thereby being mutually reinforcing.

The planning group decided on two different foci for the month-long programme, targeted at listeners who do not usually take up exercise or take any measures for weight control. These were :

- **Uptake of exercise**
- **Putting weight gain into context**

◊ **Uptake of Exercise**

The health education approach adopted focused on accessibility, affordability and gentleness. An advantage of broadcast media for this topic was that it offered to listeners 'audio pictures' of a variety of different ways of becoming more active. Such an approach contrasted with the more prescriptive approach commonly adopted in fitness campaigns and other health education programmes such as promoting sport or assuring a level of regular activity. The topic was approached from a number of different angles:

I. Audio accounts of different exercise activities as experienced by a 'not-so-fit' reporter from the radio station,

II. Live interviews with national organisations responsible for exercise/ fitness activities, dealing with safety issues,

III. A 'news' issue: information on the start-up of National Vocational Qualifications for sports coaching,

IV. Live outside broadcast of March into Fitness Roadshow including fitness testing.

Community outreach activities supporting these radio broadcasts, included distribution of exercise sheets (used as the basis for the on-air aerobic class); involvement of local groups offering community-based aerobic classes and free access to aerobic classes in association with the live outside broadcast.

The above package of feature programmes was designed to provide:

- Information from a safety perspective so addressing the concerns which many people have about exercise,
- Motivation through providing ready access to information about available facilities and resources,
- Experiential accounts by a non-exerciser reporting on how it feels to do both familiar and unfamiliar forms of exercise.

◊ **Putting Weight Gain Into Context**

In the approach taken to this topic, the planning group eschewed the more traditional focus on weight control with its emphasis on weight loss, reduction of food, etc. in favour of broader coverage. The features dealt with the issue through a mixture of live interviews and pre-recorded packages:

I. A research focus - what does it mean to be obese?; for whom is weight a medical health issue?; interview with a Professor in Medical Research,

II. Body-image - the social psychological aspect; live interviews with women in a self-help group on eating disorders about the mismatch between body image and body shape,

III. Traditional aspects of weight control were placed in broader social, political and economic context, that demonstrated the barriers to taking action,

IV. Learning was taken into the supermarket by looking at labelling, cost, food choices and into the homes of listeners as they grappled with applying nutritional principles.

The topic was handled as an investigative documentary format over a month. In seeking to challenge the way that listeners saw the issue, it was recognised that the format needed to provide them with an unusually long period to question and possibly reorient their views and behaviours.

6.3.2 ***EXAMPLE TWO***

One of the prime aims of the strategy was for the professionals to gain support in taking the lead in campaign development. This example identifies the ongoing role the community dieticians had in developing the detail of the 'Food for the Heart' campaign.

The summary of the main activities comprising of the Food for the Heart campaign is outlined in Appendix X. It was decided by the campaign planning group of community dieticians to use the campaign to increase the coverage of activities that were planned for the Health Education Authorities' national campaign. The content was to steer away from the national focus and concentrate on the context of applying healthy eating principles.

One of the central themes of the campaign was the promotion of access to healthy affordable food that did not require complicated equipment or considerable skill to make. In order to demonstrate this I negotiated with the community dieticians for them to co-ordinate the development of a *Hillcrest* recipe book that met these criteria.

Recipes were invited from cast members, radio presenters and listeners and a competition was launched for the 'Star Recipe'. The recipes had to meet the above criteria and those that were selected were analysed by the community dieticians for fat, fibre, salt and sugar content. They

chose the winner and the listener was supported in giving a live cookery demonstration of the 'Star Recipe'.

The dieticians were also integral in the development of the feature coverage, choosing to work alongside me with the writing of the cues, questions and back announcements. They also chose which live interviews they would conduct and were supported by me during their production. Another feature of their involvement was the running of phonelines in English and in Asian languages and in the setting up of low-budget cookery courses. The necessary time commitment to the development of the campaign, particularly the materials was considerable. However, the workload was shared across the geographical boundaries and the materials did have a lasting benefit in that master copies were available to the professionals after the campaign for use in other settings.

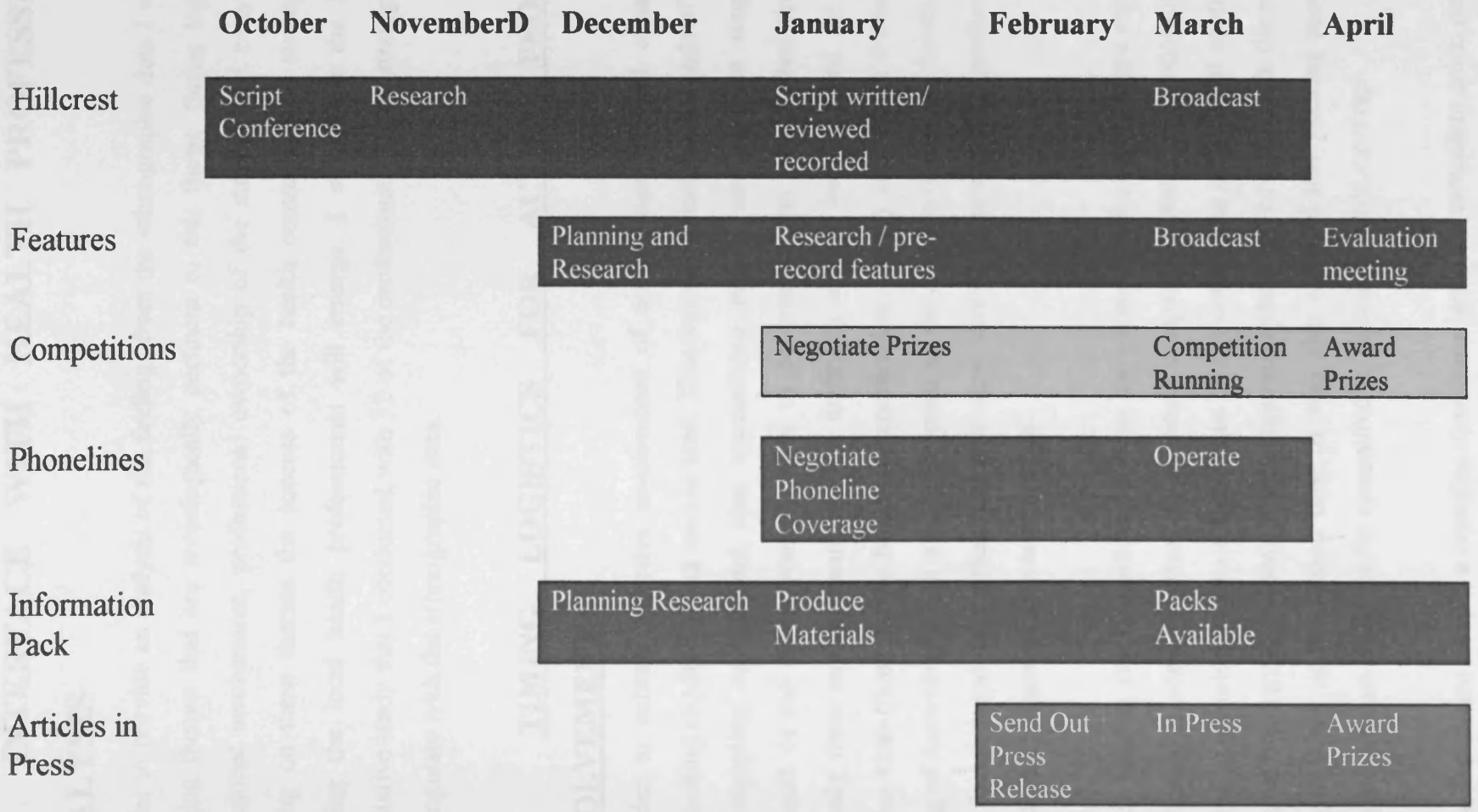
6.3.3 *EXAMPLE THREE*

This example demonstrates the complexity of the strategy that was necessary to incorporate the health professional commitment to the multifaceted components of the health communication strategy.

The planning process necessary to meet the negotiated lead-in time for the health professionals was complex. Whilst the campaign planning group had some say in the exact timing of campaigns, this flexibility did operate within parameters. The main constraint was the necessity to balance the planning timescales of all of the strategy components, the drama, features and back-up services. Figure 9 (March into Fitness: Timing of Activities) demonstrates the range of components involved in the campaigns and the diversity in the planning and timing imperatives. The complexity is further demonstrated when in Figure 8 (Timing of Strategy Activities) three campaigns are outlined simultaneously, emphasising the complicated nature of operating at the interface of the three professional groups; drama, health and programme production. In any one month I could be planning one campaign, recording for another, broadcasting a third and running evaluation meetings for a fourth.

March Into Fitness (Figure 9)

Timing of Activities



6.4 INTERFACE WITH HEALTH PROFESSIONALS - ANALYSIS

In order to provide an analysis of the findings from the ethnographic data I will draw out the emerging themes that are sociologically pertinent to this thesis: timing logistics for active professional involvement, professional ownership of the strategy and external leverage. In focusing on these themes the success of the health communication strategy in effectively engaging the local health professionals will emerge. I will utilise the findings from a quantitative study that I conducted with 32 of the professionals for the strategy's Final Report, to triangulate with the ethnographic data.

6.4.1 TIMING LOGISTICS FOR ACTIVE PROFESSIONAL INVOLVEMENT

In order to achieve effective involvement of outside agencies and ensure good quality broadcasting required a long lead-in time. This was set against the demands of operating within a broadcasting environment that necessitated regular and frequent output. The added dimension of the drama was the need to be creative and have limited timing constraints, especially from external sources. The ability to achieve both required the imposition of a complex time-frame on the health communication strategy (see Figure 9 March into Fitness: Timing of Activities) which sought to speed up the reaction time of the health professionals by being focused and task orientated and slow down the programme production process, by instilling an element of forward planning.

An individual in situ to mediate between the various professional groups enabled the various components to come together. As no single campaign operated in isolation of demands either from the preparation of future campaigns or the concluding activities of another (see Figure 8 Timing of Strategy Activities), it was imperative that each contributor in the strategy delivered the agreed task at the agreed time. It was also essential that planning meetings were task orientated, as time could not be committed to sustain multiple meetings.

The main outcome of such a complex time-frame was that campaigns could only run every two months. This resulted in there been considerably more drama episodes broadcast than features to support them; 19 hours of features were broadcast as opposed to 26 hours of drama (excluding repeats).

6.4.2 EXTERNAL LEVERAGE

Logistics prevented the Project Advisory Group from effectively fulfilling its original intended role of directing the development and implementation of the project. The innovation of the health communication strategy precluded the likelihood that relevant skills and experience were available locally. As members did not operate within a broadcasting environment their opportunities to monitor broadcast features were limited, this had an impact on their ability to contribute to meaningful discussions regarding the appropriateness of the broadcasts.

The multi-agency group became synonymous with external accountability, a feature unfamiliar to those working in the local radio environment. As a major focus became the evaluation of the strategy members were able to exert gentle pressure on the Station Manager (also a member of the group), to fulfil the BBC's commitment to the process. This involved him negotiating with the Head of Regional Broadcasting to arrange for the London-based research unit to conduct the audience research. It also ensured support for the co-operation of staff to be interviewed. The existence of this group provided a regular reminder to the station management of the need to be accountable for the receipt of funds awarded by a national body.

6.4.3 PROFESSIONAL OWNERSHIP

Problems can often occur with health and broadcasting ventures due to the lack of understanding by participating groups of how broadcasting works, both in terms of the technical operations involved and of the typical mode of working of broadcasting staff. This situation can be alleviated by taking positive steps towards demythologising the media production process. This process was engendered by the project in the following ways. Subject co-ordinating groups were able to contribute at whatever level they felt comfortable, selecting guests, providing research, or compiling information for the packs. There was not a requirement to be interviewed, but those who were, were provided with preparation and on-site production support. A strategic approach had also been taken to release staff so prolonged processes to authorise their involvement was not necessary.

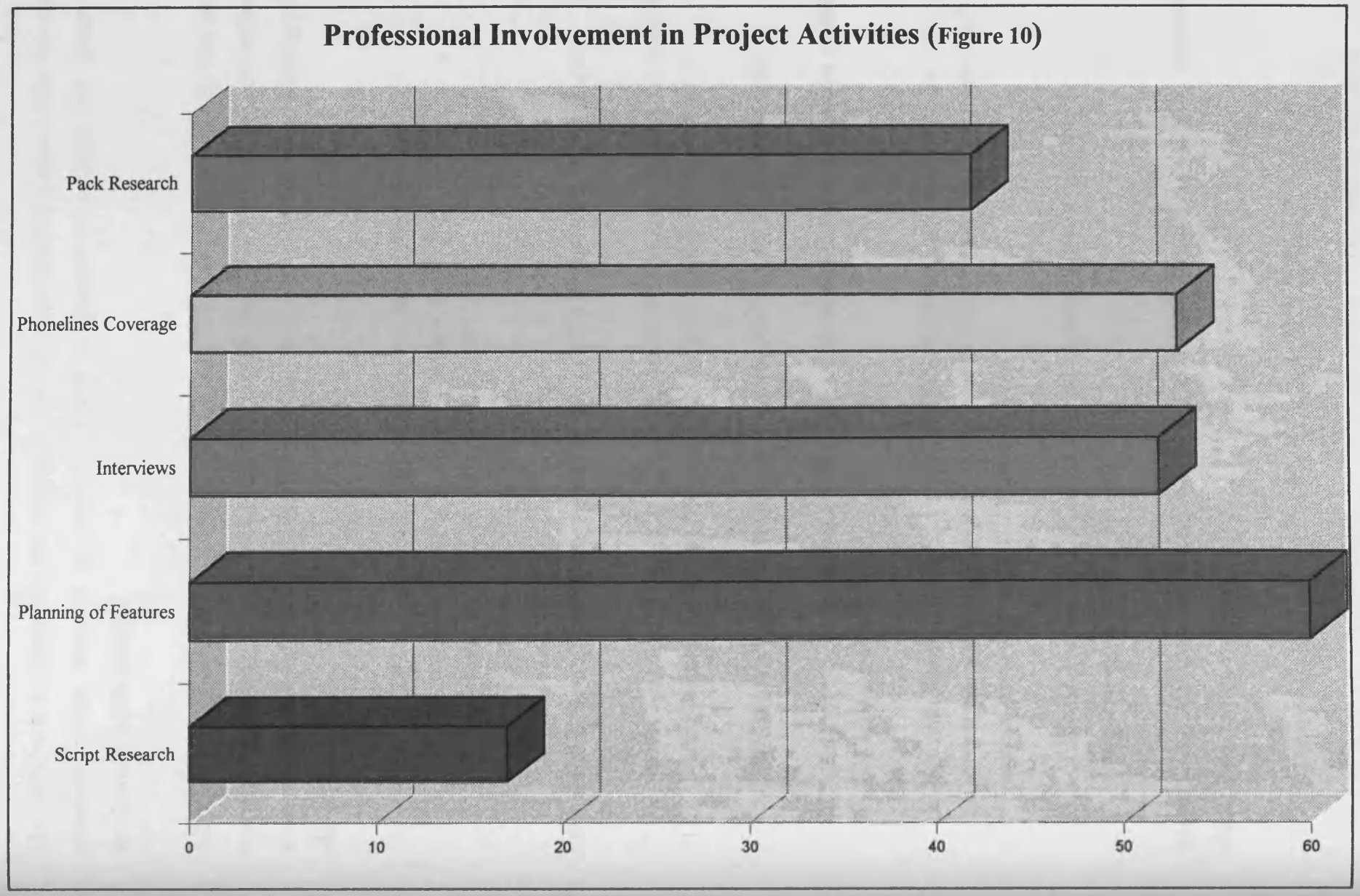
The health professionals did not encounter difficulties with programme production as these were mediated by someone else, they did not have to assert their different time-frame as this was planned into the process for them. They were invited to contribute within an environment that was seeking to meet their professional needs. This left them free to contribute in a secure environment, where they felt informed and to a degree, in control. The development of relevant

support also sought to ensure that they were more knowledgeable and experienced. This continued while there was a person in post with the commitment to communication and compromise, recognising the value of the merging of the professional modes of operation.

The collection of data on the 203 health professionals involved in the project was compiled using field notes, programme plans and annual reports as data sources. Figure 10 (Professional Involvement in Project Activities) denotes the nature of their involvement from the planning of features through to operating phonelines. My evaluation of the role of the Health Professionals in the communication strategy is covered in detail elsewhere (Sommerlad and Robbins, 1997), but will be summarised here.

A postal survey was seen as the most efficient way of gathering data from the many health professionals and workers in voluntary and statutory organisations who had been involved in the project. It was directed towards the people who had experienced a wide range of activities associated with the project rather than those who had been involved in only one aspect of it, for example just operating a phone-in line.

A self- completion postal questionnaire with both fixed -response categories and open-ended questions was distributed to the full complement of 35 professionals who had been active participants in the initial planning, on-going design process and production of materials of the various health topics covered by each storyline and linked features. The health professionals for the survey were identified on the basis of their involvement in a range of strategy activities. As previously identified, of the 203 professionals who took part in components of the strategy, there were relatively few who were involved in each of the processes that constituted a whole campaign on a given issue. For example those that were involved in the initial planning meeting may not have been further involved in the delivery of the campaign. Similarly, those who were involved either as a contributor, phone-line counsellor or in the development of materials, may not have been involved in or aware of the detailed planning process or of the other campaign components. On this basis only 35 professionals fulfilled the criteria and were selected. A response rate of 91% was achieved. For the purposes of this thesis it is important to draw on elements of this data to explore the experiences of those involved in the strategy and the impact this had on them professionally.


Professional Involvement in Project Activities (Figure 10)
Pack Research
Phonelines Coverage
Interviews
Planning of Features
Script Research
0
10
20
30
40
50
60

The purpose is to triangulate the findings to further explore the outcome of the two guiding principles of the strategy; to engender health professional ownership, and secure their involvement in the process.

With regard to the experience of health professionals, respondents were generally very positive in their responses to the open-ended question about their experience of the partnership. For some respondents, the consultation process which incorporated the campaign planning process was highly valued:

> **"It's nice to be consulted, listened to and fed back to, all of which happened"**
> **"To be involved from the beginning in the planning of the project"**
> **"The opportunity to contribute in the first instance"**
> **(Sommerlad and Robbins, 1997 p 61)**

Others valued the opportunity they had to influence the health content of broadcasts:

> **"It has encouraged a range of health professionals to be proactive in using the media to give health messages. It has made them more accessible to the public who have listened."**
>
> **"The opportunity to influence how things are done and what messages are broadcast"**
>
> **"Staff at BBC CWR listened carefully to the advice and information provided by professionals and acted upon it positively"**
>
> **"The fact that for a change, correct information was sought and given over the air. Far too often when it comes to health and fitness, radio and TV feature celebrities or non-professionals, often giving incorrect information or emphasis or values"**
>
> **"A keenness not to stereotype issues and problems and commitment to realism"**
> **(Sommerlad and Robbins, 1997 p61)**

Respondents also valued the opportunity to work with the media as a new approach for reaching out to the community:

> **"The opportunity to work within the radio broadcasting medium"**
>
> **"It enabled us as health professionals to become directly involved with the medium of broadcasting in creatively raising awareness"**

(Sommerlad and Robbins, 1997 p61)

Over a third of respondents had already made further use of broadcasting in their work or planned to do so in the near future, while all the rest would still consider doing so. None of the respondents considered social action broadcasting to have no relevance to their work.

With regard to the impact the strategy had on them as professionals, respondents identified many different benefits both tangible and intangible accrued from their involvement. The creation of networks and alliances between different agencies was widely acclaimed. Even within professional groups (i.e. community dieticians) it would seem that there are not many opportunities for joint working across districts, and the strategy provided a means for building these relationships.

The alliance between health professionals and media professionals was singled out as being important. For many respondents, the strategy served to demystify the media through facilitating their links with broadcasters, breaking down the technical barriers and establishing arenas where local professionals could make a genuine and valued input:

"The interagency approach to health issues."

"The development of a partnership between BBC CWR and professionals for future collaboration."

"Cross boundary working helped to increase networks. Demystified the working of local radio."
(Robbins 1992 p 66)

The acquisition of skills in using the media was another lasting gain reported by respondents. These included technical skills as well as developing a better understanding of how the media work and how to get health messages across through the medium of broadcasting. Respondents also felt that the strategy had increased their confidence in dealing with the media and improved their communication skills.

Several respondents commented on their raised awareness of the nature of effective community-based health promotion strategies. The initiative afforded an opportunity to experiment with the mass media as a strategy for reaching a large local audience at relatively

low cost. This was seen to be particularly important for health professionals who have limited contact with the community at large.

Summary

In this chapter I have outlined the process for interaction at the three distinctly different professional interfaces; programme production, health professionals and drama production. In presenting the ethnographic data I focused on the roles I undertook at these interfaces; initiator, mediator and enabler. I then explored the specifics of the interface with the Health Professionals, providing examples for analysis, combined with data triangulation with questionnaire evidence from the Listen to Your Heart Final Report.

In the next chapter I focus on the ethnographic evidence collected on the interface with Programme Production Staff.

CHAPTER SEVEN

RESULTS - INTERFACE WITH PROGRAMME PRODUCTION STAFF

Introduction

In the first part of this chapter I will explore the nature of the interface with the Programme Production Staff outlining a series of examples gathered from the ethnographic data. In the second section I will provide an analysis of the empirical data triangulating it with data collected during the evaluation of the Listen to Your Heart Project.

7.1 FORMAT FOR INTERFACE

The interface with the Programme Production Staff operated at a formal and informal level. Originally the interface was purely informal, requiring me to negotiate feature coverage with individual programme presenters and producers. This later altered to include a formal level of negotiation with the stations' Programme Organiser.

At the start of the implementation phase of the project, the Community Unit was in operation. Features triggered by the drama were initially channelled through the lunch-time news and current affairs programme, the same as if part of the unit. Booking features into the programme diary required discussion with the programme's Executive Producer (Head of Community Programmes) and the Producer. This was a familiar process to me as it was the strategy that had developed while operating as the Health Secondee.

Once the nature and format of the feature had been planned into the programme diary, it was for me to produce the series, documentary, or other inputs ready for the deadline. This necessitated me conducting every element of the process; research, preparation and interviewing of guests together with the writing of cues and questions for the Presenter.

In March of the first year of the project's implementation, the lunch-time presenter left and there was a major change in the station's Programme Production Staff, as other Presenters left

and new staff arrived under the auspices of the new Station Manager. For the next six months I continued the process of channelling the project's features through the lunch-time news and current affairs programme with the new Presenter; the Community Unit at this stage was diminishing in size due to the head of the unit moving to a presenting role.

At the Annual Review of the project (19/9/91) the Programme Organiser suggested that I meet with him each time new health campaigns were being planned prior to me meeting with Programme Production Staff. This was prompted by the Drama Producer who had suggested that I should receive additional support from the station. The aim from my perspective was to ensure broader coverage across the station output. For the period of time he was in post this became the formal interface with this professional group.

The format that developed for the meetings with the Programme Organiser was for me to outline the necessary emphasis of the feature component, the recommended format and duration. He would then suggest a programme, or range of programmes and agree to outline this to the relevant Programme Production Staff. I would then meet with the Presenters and Producers to outline the campaign in detail; the rest of the process continued as before.

There were considerable benefits from the introduction of this interface. Firstly it formalised the procedure of Programme Production Staff agreeing to carry campaigns, and in the absence now of the Community Unit it confirmed the stations' management commitment to the project. Secondly, it meant that the Programme Production Staff were already thinking about the campaign before I started discussing it with them as the Programme Organiser would have discussed the campaign with them after our meeting. Finally it challenged me to consider a wider range of programmes. With the March into Fitness campaign, it was the Programme Organiser who suggested that exercise be covered in the light entertainment Mid-Morning Programme and weight control in the news orientated Breakfast Programme. A considerable challenge was featuring the Back Pain campaign in the Mid-morning Programme. The support and time of the Presenter/Producers ensured that the campaign was more technically creative than I had the skills to produce independently. They were both technically experienced, and additionally supported the campaign through the production of trails and programme change-over discussions throughout the whole of the month long campaign.

For the final four months of the implementation phase of the strategy the Programme Organiser role was temporarily taken over by a Senior Producer. The same process was established, but as Example Three demonstrates, discussion in this setting was not a guarantee that the support would be maintained.

Initiating role (Table 1)

The initiating role undertaken by me with the Programme Production Staff at both a formal and informal level was accepted. The process of determining the duration and timing of the coverage, and the focus and format of the features was never contested.

Mediating role (Table 2)

The mediating role that I undertook with the Programme Production Staff was accepted and never challenged. The justification for the orientation, duration and order of features was given within the formal interface with the Programme Organiser. This role was not challenged either at this stage or with the Programme Production Staff.

Enabling role (Table 3)

The enabling role that I undertook with the Programme Production Staff was considerable. It was my main function within the station and it was accepted and expected that I would conduct each of the production processes for the health campaigns. My role was not to advise on the production process but to conduct it, how active they were in the production of the content in the latter stages was determined by the individual Presenters.

With regard to live studio interviews this encompassed the selection, securing and preparation of guests, the research and writing of background information for briefing presenters, writing an outline of the interview structure together with the cues, questions and back announcements and finally producing the interview when conducted. For live debates the previous tasks were required together with identifying the venue, negotiating with the necessary authorities (and parents in the case of the debates on Sex Education and Drug Education), briefing the contributors. It was also necessary to liaise with the sound engineers, conduct site visits and produce a written order of events for them. For pre-recorded packages and documentaries I was responsible for the selection and interviewing of guests and engineering the final compilation. Example Two demonstrates how the enabler role needs to

incorporate onsite attendance and example Three demonstrates how ineffective advising on the development of a campaign is as opposed to conducting it.

7.2 EXAMPLES

7.2.1 *EXAMPLE ONE*

Although this example differs from the others utilised in the presentation of results in this thesis this is the evidence that encapsulates the volume and range of features broadcast throughout the implementation phase of the project.

Throughout the 24 months of broadcasting, 32 health issues were featured in the broadcast output. These were scheduled across the whole of the station output: news, current affairs, entertainment and specialist evening programmes on education and young people. The volume and range of the campaigns are demonstrated by Appendix X (Summary of Campaign Activities).

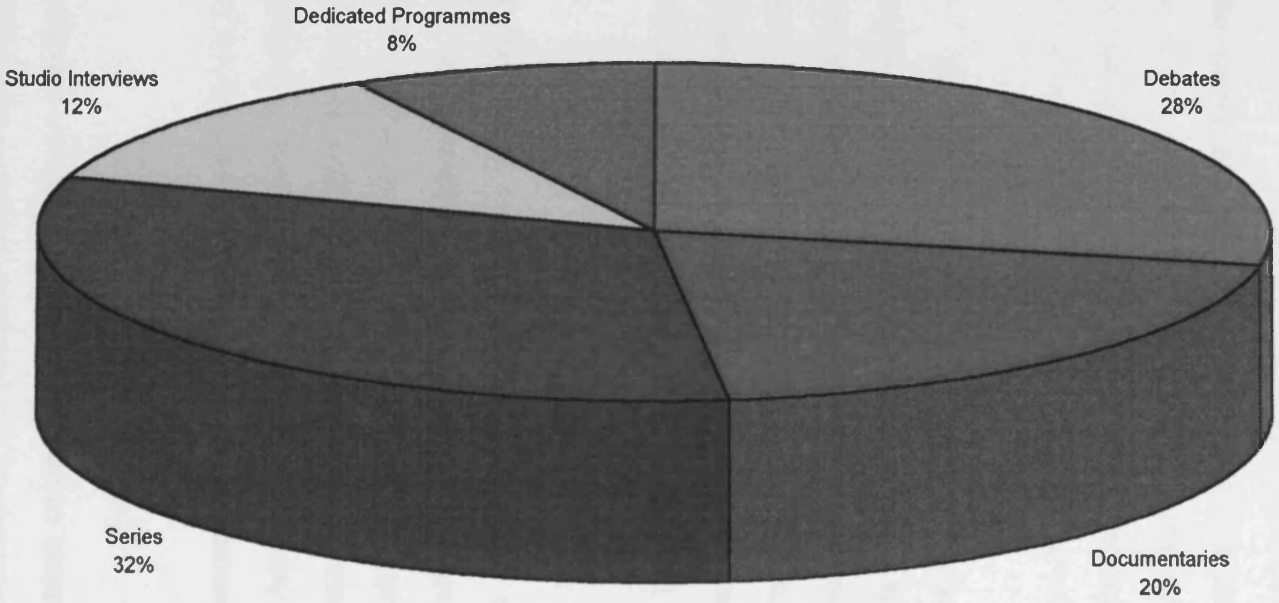
Whilst there was a wide range of formats used, the predominant ones were series (32%), debates (28%) and documentaries (20%), as demonstrated in Figure 11 (Feature Formats). The format that was used the least was dedicated programmes (8%), followed by studio interviews (12%). The total volume of 87 features constituted 19 hours of broadcast time.

7.2.2 *EXAMPLE TWO*

This example demonstrates how it was imperative to have someone on-site to ensure that the features were actually broadcast on time. Despite adhering to the programme booking protocols, the nature of the medium is that changes can be made at the very last minute.

On the morning of the Body Image feature, (March into Fitness campaign) the guest had been booked to be interviewed at 8.45am; cues and questions were on the ENS (Electronic News System) and were printed off for the Presenter. On the morning of the interview the usual producer was ill and the stand-in had altered the running order so the interview was to run at 9.00am. The interviewee had prior commitments, and had to leave the station at 9.00am. In order to ensure that at least ten of the planned fifteen minutes were available for the interview I had to re-negotiate with the News Editor. Despite the most comprehensive planning process,

Feature Formats (Figure 11)



radio is a changing and immediate medium, to ensure that the agreed time commitments given someone needed to be on-site at the time of broadcast.

7.2.3 *EXAMPLE THREE*

This example demonstrates the potential ineffectiveness of negotiating for another journalist to develop a features campaign, when they are not managerially accountable to ensure its delivery.

When racial harassment was to be covered within *Hillcrest*, I worked with the representatives from the Project Advisory Group and the local Race Relations Council to identify appropriate features and community activities. The aim within the features was to cover a range of issues incorporating health in the workplace; the Race Relations Council offered the use of their Health Bus to visit local organisations that requested this for their workers. Black and Asian health specialists were committed to assist in the development of broadcast features on request.

A newly trained Producer for the lunch-time programme also worked on the station's Afro-Caribbean evening programme. I suggested to the Acting Programme Organiser that this Producer be approached to develop this campaign for the project. Initial discussions indicated a positive commitment to the campaign, I therefore provided the Producer with the campaign outline and details of the contacts and their areas of specialism. I offered support in bringing the group together, but she felt that this was not necessary.

One month before the scheduled date for the campaign I enquired about progress. I was informed by the Producer that she did not have enough time to produce the campaign. When I raised this with the Acting Programme Organiser he said he would speak to her. The outcome was the production of a five minute package, with no professional involvement, community activity or back-up service.

7.3 INTERFACE WITH PROGRAMME PRODUCTION STAFF - ANALYSIS

In analysing the ethnographic data from the interface with Programme Production Staff the following themes become evident: staffing resources and the commitment to specialist

training ground and quality output. These themes focus on the culture within the radio station that supported the output of health features within the context of the health communication strategy, in a largely uncontested environment.

7.3.1 STAFFING RESOURCES AND A COMMITMENT TO HIGH SPEECH OUTPUT

BBC local radio stations are traditionally run on very limited resources, especially when compared to network radio or local television. The commitment to the delivery of 60% speech output poses a considerable challenge to Station Managers as the production of quality speech-based programmes is labour intensive. One way of achieving this is to rely on teams of volunteers, willing to work for little financial repayment, seeking instead to gain experience in the medium.

BBC CWR's response to the challenge of producing high quality speech output was the development of the Community Programme Unit, staffed largely by public service secondees. The station's commitment to the secondees was the provision of BBC training and broadcasting experience, the station in turn gained researchers in specialist areas.

The development of the project supported the production of speech output and drew on the availability of technical training for feature production. The production of a drama linked to series and features and community courses contributed to the fulfilment of the station's commitment to social action broadcasting, in a creative, innovative and comprehensive way. The aim of the strategy was not to advise on what the health related features should be, but commit resources to the development of that output. The outcome was that the speech output was considerably increased without drawing on the station's limited resources. While that commitment existed from external resources to fund the delivery of the broadcast output the support of the station was maintained.

7.3.2 FERTILE TRAINING GROUND

Local radio is recognised as a training ground for broadcasting. With the commitment to a high speech output and the traditional welcoming of volunteers, stations are unlikely to be staffed predominantly by trained broadcast journalists. The outcome is that the medium is an environment where onsite training is recognised as the norm for newcomers.

BBC CWR as a new station with a Station Manager who had a strong commitment to social action broadcasting was a fertile ground for experimentation. The innovation of a health communication strategy that incorporated a radio soap-opera was able to develop alongside the rest of the station output, drawing on the BBC training programme and building on experience gained in situ. As the project's existence was coterminous with the launch of the station it was also accepted as an integral part of the station.

7.3.3 QUALITY OUTPUT AND EDITORIAL CONTROL

Editorial control was never cited as an issue for the broadcast of the health features. Although a degree of autonomy existed for me in the development and production of the features, they were broadcast within an editorially controlled system. The system that existed was that of the traditional programme production hierarchy: Programme Presenter and Producer. Live interviews were also conducted by a Presenter as were live debates, and the opportunity existed for Programme Producers to listen to packaged features and documentaries prior to broadcast.

The duration of the implementation phase, the volume of features produced and the national awards won, sought to develop a high level of trust with the Programme Production Staff, station management and BBC senior management. An indication of this trust, based on the quality of the broadcast output, was the commitment of broadcast time to long features and series and the commitment of engineering resources to outside broadcasts. How the health features were viewed by the BBC's senior management is evident from the interviews conducted for the Final Report.

> **"Because (the Project Officer) has time you know if you're doing a project once a month as opposed to once every day then you can do stuff in much more depth you can actually plan things, you can get people organised, you can talk to the group of sixth-formers before the outside broadcast 'Here now look this is what's going to be asked in the broadcast and I want you to think about it' and so there's much more thought that goes into the process so it's a better broadcast. It's just more ... it's just better. So it's just one of those marvellous things that CWR can have is that there's more production effort goes into these items, it gives a better feel to the whole strand, you can't just do straight forward you know superficial interviews ... you can do a half hour outside broadcasts ... you can do packages which take forever to record but you get all the useful bits of an interview and the ideas are coming over and its well structured ...**
>
> **(Interview with Station Manager, Dickinson 1993 p 52)**

> **"... if you were to listen to any local station to its speech based output around midday, I mean you will find health features massively, it is, you know, a huge concern of people and of local radio so I think it's a fairly natural marriage and through actually having a stimulus and a fund of information actually on station it actually has meant that CWR has probably been able to do it more consistently, more thoroughly and probably more professionally than others who might otherwise have just been ringing up their local health education people who'd have come in, here yes, certainly its been able to be done more consistently ..."**
> **(Interview with Head of BBC Radio (Midlands), Dickinson 1993 p 52)**

Programme Production Staff also valued the quality of the broadcast features:

> **"Because we're a young radio station we ain't got a lot of listeners [...] But over the last year and a half we've actually had to create it, to find it ourselves, to go out and put it on the air in a disciplined form and that is what the *Hillcrest* spin-offs have actually done to us, we have got real people talking about real situations. Its high quality, fresh, original, well resourced stuff, that's why it's good for me yeah, lovely, bloody good material ..."**
> **(Interview with Senior CWR Producer, Dickinson 1993 p 53)**

Summary

In this chapter I have outlined the nature of the interface with Programme Production Staff. I provided examples from the ethnographic data that identified key evidence for analysis. I then sought to provide an analysis of that data supported by interview evidence drawn from the Listen to your Heart Final Report.

In the next Chapter I explore the nature of the interface with the Drama Production Team in the development of the radio drama *Hillcrest*.

CHAPTER EIGHT

RESULTS - INTERFACE WITH DRAMA PRODUCTION TEAM

Introduction

In this chapter I explore the relationship interface with the Drama Production Team in the production of the radio drama *Hillcrest*. Having explored the roles undertaken at this interface I outline a number of examples of empirical significance from the ethnographic data. In an attempt not to over extrapolate solely from this data, I triangulate the findings with interview evidence collected for the Listen To Your Heart Final Report.

8.1 RELATIONSHIP INTERFACE

8.1.1 FORMAT FOR INTERFACE

The interface with the drama production team operated at a formal and informal level. The formal setting for interaction was primarily the Script Conference which was scheduled every month for the first six months and then every two months. After I'd read through the scripts, I met with the Drama Producer if I felt it was necessary for changes to be made or a particular emphasis to be made.

Informally, in the early months I supported the Drama Producer in the auditioning of actors, and in the recording of the drama by being responsible for sound effects. I also joined the cast in the 'read through' prior to the recording of each of the episodes. This supportive role was entered into by me in order to understand, and be involved in this new and alien environment.

After the first year the opportunity for this informal involvement in the actual production of the drama was not possible to maintain, for a number of reasons. Firstly, due to the time demands of producing the educational features and series and, secondly, it proved untenable to provide both assistance in the production of the drama, and advice on the health content; both roles demanded differing and incompatible positions of authority in the same process. However, as I shared an office with the Drama Producer, discussions were frequently held with regard to the drama.

Initially, the formal meetings that were held to discuss the setting up of the drama were between me, the Station Manager, and a former Head of Regional Radio in the Midlands who took on the role of Programme Consultant. He had overseen the development of *The Archers* over a period of 25 years and was therefore able to advise the station on staffing, budget breakdown, and the technical and operational issues relating to recording drama.

Practical issues regarding the development of the drama were the main subject for discussion at these meetings but a lengthy debate was held at the first meeting regarding the setting for the drama. When the Programme Consultant suggested a Medical Centre, I raised concerns with regard to the overt nature of the 'medical' connection, emphasising that the focus needed to be on health not medicine. His justification was that there needed to be a central focus for the drama and one which enabled the involvement of a large number of characters. He emphasised that the drama would focus on the lives of those working at the centre and the surrounding area rather than necessarily deal with the conditions of the patients. We discussed other options such as a family but it was felt that this would not provide the scope to deal with a wide range of health issues, there was insufficient funds to cast for a village or a street, and neither a public house or a café seemed appropriate. In the end it was felt that a strong health connection in the form of the setting for the drama would be a positive choice so the Medical Centre became the proposed setting.

The Programme Consultant suggested a local writer who had written for *The Archers* and a locally based drama producer who had network experience. My request was that the producer had an awareness of social health issues. I was informed that she had produced a number of documentaries on women's health issues. I did not have any further role in the appointment of the producer or the writer, neither did any other health specialist.

The next formal meeting to be held included the Drama Producer and Writer; this group was to form the original membership of the Script Conference. The main focus of the initial meetings were the main characters. There was to be a broad mix of ages, social and cultural backgrounds. The second main theme was technical issues related to recording facilities. The production of a drama within the confines of a local radio station rather than purpose built network studios was the writers and producer's prime concern. Asserting a health position at this stage was a difficult task, as the detail of how to cover health issues was not an issue for them it was not raised for discussion in the initial meetings. The other members of the team were considerably experienced in radio drama and as I was inexperienced in this area I did not

possess the confidence to make health coverage an issue for early discussion. I did recognise that getting the drama up and running was of the utmost importance.

The Script Conference had two main roles, the first being to identify and develop the characters and shape the plot of *Hillcrest* over the proceeding months. The second function was to decide what health issues were to be covered and briefly what the emphasis should be. My key roles were that of 'adviser on medical matters' and script researcher. It took some time for me to develop an effective advisory role in this setting and for health to become a major focus of discussion. It was through the forum of the Script Conference that the difference in professional values with regard to the portrayal of health became evident and marked, with the drama specialists' view contrasting sharply with my own awareness of cultural and social health. The differences in perception of health became the subject of heated debate throughout the course of the project's operation. Although strategies were sought to dampen the effects and remove the inherent tension, none of the identified roles; *initiator*, *enabler* or *mediator* (Tables 1,2,3.) were readily accepted by the drama production team.

8.1.2 INITIATING ROLE (Table 1)

The health sector taking a lead or initiative in setting the drama health agenda was difficult to justify with the production team. The consultation process with local health professionals had produced such a comprehensive list of suggested subjects to cover, the absence of any recognised health strategy made the prioritising of any one subject over another a subjective task. As a result, I did not possess the confidence or evidence to hold an argument as to why an issue was more relevant than others suggested by the drama specialists. The funding of the project did however necessitate the coverage of heart-health topics at some stage.

The lead in identifying the health issues for coverage at the Script Conference was sometimes taken by the Writer and sometimes by me. The Writer identified the first two issues to be covered by the drama; an older character was to suffer a stroke and one of the young teenage characters was to become a single mother. When I raised the fact that one in four of the women who contacted the local Women's Health and Information Service did so due to panic attacks, this was added to the initial list for coverage.

Whilst the Script Conference was to remain the forum for decisions regarding the health coverage, the format for effecting the decision did alter over the period of the strategy's

implementation. The membership of the group also altered with the station's Programme Organiser joining to support the link between the features and the various programme production teams, and the Project Manager who was a local health promotion manager, to add weight to the health debates.

This alteration in group membership was initiated through a discussion between the Drama Producer and myself outside the context of the Scriptwriting Conference. The aim was to ensure greater commitment to the project from the station management and to add weight to the health input by demonstrating that my perspective was a professional one rather than a personal view. The Programme Organiser joined the group at the next Scriptwriting Conference (26/4/91) and I suggested at this meeting that the Project Manager be invited to join the group. It was agreed and he joined the Scriptwriting Conference in June (11/6/91) of the first year of implementation.

Once the production process of the drama was established, and a number of episodes had been recorded ready for broadcast, the Station Manager requested that I planned the health coverage for the forthcoming year. This was prior to the project being broadcast, but demonstrated the Station Managers commitment to ensure that the linked features were seen as an integral part of the process. This was to take on greater significance due to the Station Manager leaving in the December that the project was to be launched (1990).

Given the difficulties in prioritising the issues for coverage as outlined earlier, I sought to identify a combination of issues, some that required follow-up services e.g. back-pain and panic attacks, and smaller issues that could be supported by short features to fit in with local campaign agendas. Previous experience in the Community Unit had indicated that documentaries and series were only achievable every two months due to the production time that was required. Those that required that classes be established in the community were given the longest lead-in time. Large campaigns which focused on Back Care and Stress Management, were planned for the first and final anniversary of the project.

The aim was to coincide with some national campaigns and avoid others. Not linking with some national campaigns provided an opportunity for the issue to be raised again and given air-time outside the traditional annual campaign e.g. No-smoking Day, in March. This also meant that the Community Unit or the Action Desk could cover them.

The planning process allowed actors to be cast that would establish the necessary storylines. As the cast became established the necessity arose to fit the condition with the existing characters. As there were a limited number of episodes to be broadcast it was not possible to engage a new set of characters for each health issue. After the first year of implementation therefore, the process for agreeing the inclusion of the storylines altered. Through discussion, the Drama Producer and myself decided to meet prior to the Scriptwriting Conferences. Prior to the last three Script Conferences I produced a list of potential issues and suggested angles for coverage, we then discussed whose character they could fit with, and finally, she would discuss this with the Writer prior to the Script Conference.

Once the subject had been chosen I did possess the confidence to assert a particular stance on an issue, being able to emphasise, for example, that the main focus for the stroke story should be the carers and how they cope with identifying appropriate care and support for their relative. This orientation or 'framing' of an issue was an area that I felt was pertinent to my role, it was also an area that the network of health specialists could contribute to and assist in determining when dealing with their related topic. Influencing the 'framing' of the issue aimed to ensure that the storyline reflected the angle of feature coverage, which was led by negotiation with local health professionals. It is here that the strategy sought to challenge the traditional, and some would state, established, agenda of health coverage being that of perpetuating the medicalising of health and blaming the individual whilst ignoring the social determinants of ill health as previously discussed.

It was generally accepted by the drama team that I take the initiative in determining this orientation at the Script Conference. However this orientation was frequently altered during the process of writing the scripts. This area was one which resulted in considerable debate with the Drama Producer. The main reason was that any alteration to the orientation of the issue was only recognisable to me once I had been passed the scripts for checking. Changing a script that was written was then met with resistance by the Drama Producer, especially when the issue was not one of 'medical accuracy', but of agreed approach (Example One).

The inclusion of a health storyline had several timing imperatives. Firstly the story had to be sufficiently developed in the drama, and recognisable as a health subject for it to act as a trigger for the feature coverage. Secondly the relevant episode had to contain a key discussion or element of the health storyline on the day or week of the coverage, to enable a back-announcement to lead the listener from the drama into the features or series, thus connecting

two key elements of the communication strategy. It was seen as essential to me that when feature coverage was planned such links were effective. A main reason was that as there were considerably more episodes broadcast that were free from linked health coverage, those that did provide the link had to be distinctive.

Despite the timing being agreed at the Script Conference, the two components of the communication strategy were not always synchronised. Frequently when the scripts were checked by me the link was seen to be absent, or insufficient to be recognisable as a trigger. This was difficult to rectify once the script had been written; it was impossible if the character that carried the storyline was not cast for the episodes. Two instances where this dilemma arose are contained in Examples One and Five. Example Four outlines an occasion where the drama provided a trigger for a health campaign that was subsequently cancelled prior to broadcast.

8.1.3 ENABLING ROLE (Table 2)

My 'enabling' function within the process of developing the drama, centred around providing script research and reviewing the scripts once they had been written. The initial aim, from the drama perspective, was to ensure medical accuracy. As the health content rarely addressed anything of a technical nature, medical accuracy in its purest sense was never an issue for discussion.

The format and process for providing health information for the Writer evolved over the two years. As the aim was to cover the issue in the context of people's lives, my aim was to provide support that guided the Writer in developing the storyline rather than dictate it: this achieved varying degrees of success. The format initially used was either providing a range of consumer booklets on the issue, if they were available, and, or discussing the subject with a local health professional (subject advisor), making notes and forwarding them to the Writer. The reasons for this were twofold. Firstly it supported the health specialist who did not feel 'exposed' in the process of providing the information. Secondly it enabled me together with the health professional to shape and angle the information.

After six months in the Script Conference (11/6/92) the Drama Producer asked for a firmer health brief. I suggested that the health issues should be raised in the Script Conference where the ways they would be covered could be discussed, in which episode, and identify what

support the Writer needed. It became clear that the existing system was not an effective format for the Writer. The written text did not inspire the creative process of writing drama, so he requested to speak directly to the health professionals. In support of this strategy I then spoke to the person I had identified as the subject advisor prior to the Writer contacting them. Whilst this was preferable to the Writer it limited my ability to direct in anyway the information that the Writer used. In some instances whilst the angle of the storyline was agreed in the Script Conference the Writer changed this having spoken to the subject advisor, who in the process of discussing the agreed subject, spoke in general about other issues; this is demonstrated in Example Five.

Due to the nature of the health coverage in the drama, medical accuracy was rarely an issue. However my role in reviewing the scripts identified a number of professional variances between the drama professionals and the health promotion perspective put forward by me. As outlined above this materialised in the form of the health orientation. Next I will expand on how the focus of my checking became that of ensuring not only that the drama was health promoting but also, more importantly, that it was not health- negating in its approach.

8.1.4 MEDIATING ROLE (Table 3)

Maintaining a health promoting focus in the drama was a constant and difficult challenge for me, as it was an area that was often resisted and frequently strongly contested by the drama production team. It was an area where the different professional values, relating to a given position on what constituted a health issue, was very marked. The main dilemma here was that the debate did not refer to agreed health topics but the underlying messages of the general storylines that constituted the backdrop of the drama. This was further exacerbated in that it was only evident once the scripts had been written or, as in Examples Two and Three, when several had been written.

When I reviewed the scripts and commented on the general background stories that comprised the non health coverage or underlying themes, changes were resisted. Firstly there was a fundamental difference in the professional perception of what could constitute a health negating storyline, and secondly altering it would necessitate the scripts being sent back to the Writer to re-write. This was seen as problematic by the Drama Producer due to the tight timescale of securing actors and recording each episode, together with the limited budget

available to fund rewrites; although as will be outlined in Example Three this did happen on one occasion.

When this issue was discussed at the Script Conference, the absence of 'research evidence' to justify a particular angle, or justification that the suggested stance was 'medically accurate' resulted in heated debate. In such circumstances it was difficult to make progress and maintain a health promoting stance against what I believed to be unwise decisions with regard to perpetuating rather than challenging stereotypes. The common argument from the drama perspective was that 'people acted in this way' and therefore it was a legitimate stance to take. As it was not an issue of accuracy or scientific fact, acknowledging whether a character's comment was sexist was perceived as a matter of perception and opinion, and from the drama professionals' perspective it was important not to have a cast of politically correct characters. Whilst from the health perspective the intention was not to have a cast of characters that were exhibited as paragons of virtue, the aim was to control the potential negative effect of the entertainment media 'norm sending' or suggesting to the audience that unhealthy practices are common and acceptable. This is an area that the health communication strategy sought to redress unless challenged by feature coverage. Seeking to achieve this despite the opportunities for active and sustained collaboration was professionally challenging for both parties.

Mediating between programme production and the drama production team was not without tension. The aim was to ensure that there was sufficient relevant content in the storyline to provide an effective trigger for the programme activity. Despite the fact that the issues were agreed in advance at the Script Conference there was often limited coverage in the drama to sustain links for the duration of month long campaigns. The areas that appeared to pose difficulty for the team centred around heart health issues e.g. healthy eating and taking up exercise. The reason cited at the time was that the subjects 'didn't make for good drama'. Example One elaborates on this.

8.2 EXAMPLES

8.2.1 *EXAMPLE ONE*

In order to support factual series that ran for a month, ongoing subtle storylines were required to provide regular leads into the programmes. As outlined in Chapter Three, the pivotal aim of *Hillcrest* was to cover health in the context of people's lives, not to communicate overt

messages. The aim was for the drama to carry a storyline for a long period of time where regular reference is made to the subject but in a subtle and unobtrusive way. This would then provide ongoing opportunities to trigger related feature programmes.

Issues in the drama that were not successful, in my opinion, in producing effective triggers to the feature coverage, were those linked to heart health. With two specific campaigns, healthy eating and exercise, the actual result was intermittent references that were either undetectable or blatant health messages; they also frequently missed the planned dates.

It was agreed at one Script Conference (17/1/91) that a character would suffer two heart attacks. He was to have his first heart attack in May and the storyline would continue until the second attack later in the summer. The first time he would struggle to make the necessary lifestyle changes, but the second time he would make more progress, especially with what he ate. The aim was to link the storyline to a month's coverage on healthy eating in September. Following the second attack the storyline and features would focus on healthy eating, smoking and general post attack rehabilitation.

The character suffered his first heart attack in Episode 24 (Scene 6, 23/5/91), and an initial reference was made to healthy eating in Episode 31, (Scene 4 11/7/91). At the beginning of June when I reviewed the scripts for transmission in August I was concerned that the character that was to have the second heart attack was not written into the episodes. It was imperative that he was in the next two episodes in order to provide the linked storyline in time for September. I raised my concerns with the Drama Producer who informed me that the actor was not available for recording until Episode 40. He was then available for Episode 41 and 43. The result was that the drama would not trigger the features or run concurrent with the month-long series.

When the character was cast for Episode 40 (12/9/91) his second heart attack was written into the scripts. Episode 41 (19/9/91) did contain references to healthy eating and individual behaviour change but it was too soon after his heart attack for them to be plausible. Those references that were contained in the episode came across as overt messages.

(TRAY PUT DOWN. CROCKERY RATTLE)

Beth **.....There you are, Ted. How does that look?**

Ted **Fantastic!**

Beth **Healthy eating. That's the secret.**

.....

Ted **I can't rely on you for everything.**

Beth **But that's what I'm here for, Ted.**

Ted **No, it isn't. you've got a full-time job and a house to look after. I must start to take responsibility for myself. Lying in that hospital bed made me think good and hard.**

Beth **About what?**

Ted **The future. And whether or not I'm going to have one.**

Beth **Of course you are!**

Ted **Only if I mend my ways, Beth. It's no good letting you impose the changes from outside. They've got to come from within.**

Beth **You're so right.**

Ted **No more junk food, no more cheroots, no more stress and strain.**

Beth **I want to give you a great big hug.**

(Episode 41, Scene 6, Transmitted 19/9/91)

From a health promotion perspective I saw blatant messages as being counter to the aim of the drama, listeners were not expected to suddenly be jolted into listening about health. People experience health in the context of their lives, if an issue in the drama was seen to be relevant to individual listeners then the opportunity arose through factual programmes to explore it further, if not then they should be able to listen to the drama less aware of any specific coverage. With this in mind I sought to detect blatant messages within the context of the whole episode, if a scene's central focus obviously appeared to be promoting a particular message then I raised this with the Drama Producer. A further central tenet in the context of heart health issues is not to appear to blame the individual for their inappropriate behaviour .

As the character for the heart attack coverage was unavailable for Episode 42 (25/9/91) a scene was written in between his wife and friend. However as this did not fit with the rest of the scenes in the episode it was very obtrusive.

Eric **Ted got the message this time.**

Beth **Change your life - or lose it.**

Eric **That's blunt enough, Beth.**

Beth **It's the truth and he's come to terms with it. For the first time in our marriage, he's taken a real interest in cooking.**

Eric **That can't be bad.**

Beth **He keeps finding all these diet recipes. Things that're safe to eat and make you**

feel you've had a proper meal.

(Episode 42, Scene 6, Transmitted 25/9/91)

In Episode 43 which was transmitted on the 3rd of October, the week after the campaign ended, Scene 4 featured the key character and his wife discussing healthy eating. The reason given by the Drama Producer, (Script Conference 21/8/91), for missing the coverage, was that it came too soon after the character's heart attack to be realistic. As advance notice of seven months was given, my feeling was that the heart attack did not come early enough in the series for it to be a credible trigger.

At the Script Conference in October (1/10/91) the March Into Fitness Campaign was decided upon. It was to coincide with International Women's Day and have two major components, that of increasing the uptake of exercise and controlling weight. As the drama had already covered healthy eating it was decided that it would focus on characters taking up exercise throughout the month of March. I stressed that it was necessary for the drama to emphasise the positive aspects of women exercising, e.g. the growth in self-esteem, development of social contact, etc.

The two issues of concern with this storyline was firstly that there was insufficient coverage for the duration of the campaign and secondly the scripts did not contain the agreed orientation. On reviewing the scripts I felt that they stereotypically emphasised women's 'desire' to please men by exercising to alter body shape, etc. This was another example of the two very different professional orientations towards health. Whilst this stance was seen as a valid reason for some women choosing to exercise by the Drama Production Team, it was not seen as the orientation to be perpetuated from a health promotion perspective. The aim of *Hillcrest* in this instance was to depict female characters exercising and making casual reference to some of a range of positive outcomes. Whilst slight amendments were made, the Drama Producer's scope for change was limited given the characters that were cast for the episode.

On the first week of the month-long coverage two scenes made reference to exercise (Episode 65 5/3/92). Scene 1 centred around a young couple who saw swimming as an activity to do together and them planning to do a charity tandem ride together. The second reference was made in Scene 4 between two young women leaving an aerobics class discussing weight loss and exercise in the context of attracting men. In Episode 66 Scene 2 (12/3/92) a short eight

line reference was made to weight loss between a new mother and her friend. The following week a 10 line reference was made to an older character taking up indoor bowls as a distraction from the recent death of a pet (Episode 67 Scene 1 19/3/92). Exercise does not become a plausible ongoing storyline for the audience to recognise until Episode 71 (16/4/92), when the two characters mentioned earlier prepare for their charity tandem ride. This focus on exercise started two weeks after the months feature coverage ended.

When the role of the drama in this campaign was considered at the Script Conference (6/5/92) the Drama Producer stated that exercise was not seen as an 'exciting topic' to cover in any depth in the drama.

8.2.2 *EXAMPLE TWO*

The prime purpose of the drama was to keep health issues on the audience agenda. This example outlines the dilemma faced by me in seeking to ensure that the general ethos of the drama did not negate the health storylines permeating through it.

Alcohol abuse was chosen as a major issue to cover in *Hillcrest.* The character was to be male and the audience would hear how his use of alcohol affected his relationship and employment. The storyline ran from Episode 21(Transmission 2/5/91) until the end of the drama series. As the storyline weaved in and out of the episodes it was met with regular feature coverage, challenging, explaining, and expanding the issues covered in the drama. The pervasive ethos of how alcohol was used by the other characters in the drama, however, was not part of the planned process, neither was it challenged by factual programmes.

Preventing the development of underlying themes of health-damaging behaviour became an issue for me early in the drama's history. When reviewing the scripts I was concerned that there appeared to be a build up of scenes over the months that appeared to actively condone the use of alcohol. This started in Episode 10 when one of the doctors was explaining that his fiancé may not be making the party:

Chris **I'd hate to spoil the party.**

Richard **No question of that. There'll be joy unconfined at the Pope house tonight even if nobody turns up. I'll get plastered and listen to my Gilbert and Sullivan records.**

(Episode 10 Scene 1 transmitted 7/2/91)

In Episode 20 a theme was beginning to develop as two doctors meet after work:

Richard	**...One thing about Hillcrest. It meets the first requisite of any surgery.**
Mike	**Walking distance from a good pub.**
Richard	**Exactly. There are times when we all need a stiff drink. It can be very curative.**
	.....
Mike	**I'm glad I let you entice me in here for once. I feel much more relaxed now.**
Man	**Your change sir.....**
Richard	**Good man....Yes, we all need to unwind from time to time. (DRINKS) Ah! You can't beat the taste of real ale.**
Mike	**Has it got you in a receptive mood?**
Richard	**Very receptive.**
Mike	**Then this might be the time to raise the vexed question of night calls.**

(Episode 20 Scene 1 Transmitted 25/4/91)

By Episode 39 a definite pattern began to emerge. The scene is between a doctor and the local teacher, they meet in the local supermarket:

Mike:	**... has Richard Pope (GP) been prescribing a course of Chablis?**
Carolyn:	**Wish he would. My kind of medicine.**
Mike:	**And mine. Highly recommended for all complaints. *Especially after a long and tiring day at work.***
Carolyn	***I've certainly had that today.***
Mike	**You're a teacher I believe...**
Carolyn	**A very rusty one, I'm afraid. It was my first day back after a very long lay-off and I was completely out of my depth. Frightening!**
Mike	**No wonder you want a restorative *bottle of vino***
Carolyn	**Oh, its not for me, Dr Steadman. The wine is for...a friend.**
Mike	**Mine is for a friend as well - me...**
Carolyn	**.....Think I'll take your *sound medical* advice. Chablis. It will be the perfect gift....**

(Episode 39 Scene 6 Transmitted 5/9/91 italics indicates edits from the script)

When I raised my concerns with the Drama Producer her response was that it was common knowledge that GPs have alcohol problems; from her professional perspective this was a legitimate reason for the scene's inclusion, merely portraying life 'as it is'. From the health perspective as the storyline did not address or challenge the issue of alcohol use in the medical profession, it merely perpetuated a stereotype and added to an early theme in the drama of condoning the use of alcohol. As a result of the discussion minor changes, as indicated, were made to the script.

For me the problem was not superficial and it required more than changing a number of words. I felt that there were too many characters who were linked to drinking alcohol either as a form of stress relief, or to signal a social occasion. This conversation was based on me conducting a snapshot content analysis of the first 30 scripts, scanning them for references to alcohol and settings where alcohol was usually consumed.

When reviewing the scripts for this period it became evident that two female characters rarely met without the setting being a bar or them drinking at home. Of the twelve scenes they were in, three involved them drinking, and a further two scenes joined them at the end of a meal in a restaurant. An older married couple were experiencing difficulties with their business. Of the seven scenes in which they were heard discussing their troubles, they were drinking on three occasions and planning to go for a drink on the fourth. The message seemed to be that alcohol can be used as a coping mechanism. Finally, of the twenty characters included in the thirty episodes only six had not been involved in scenes involving alcohol and only one character had declined to have a drink when in such a setting.

Considerable research has been undertaken in this area (Breed and Defoe 1982; Defoe and Breed 1989) whereby attempts have been made to collaborate with drama professionals in reviewing their policy. Hansen (1986) systematically reviewed four national TV channels. His review demonstrated that verbal or visual references were made to alcohol at the rate of 1.7 per hour in two thirds of prime time programmes. More importantly consumption of alcohol was portrayed at a much higher level than in reality, and predominantly associated with positive outcomes like socialising, dining, etc., rarely was reference made to problems associated with alcohol use. Of specific relevance to this thesis these findings were echoed by Lowery (1980), who explored the coverage of alcohol in soap operas.

When I raised this as an issue for discussion at the Script Conference and Annual Review (21/8/91), the Drama Producer's response was characters' drinking was used as a way of 'writing into' (starting) a scene. It was agreed to avoid this for future episodes, by using other social settings. As the drama had now moved away from the characters employed in the Medical Centre the doctors rarely featured anymore.

It was not the specific scenes that were of concern from a health perspective but the potential cumulative effect. The effect that the drama was seeking to achieve in the planned coverage was also unlikely to be achieved because the incidental and unplanned negative storylines therefore were likely to act as a barrier to the incidental learning. One strategy for this would have been to produce a feature that challenged the angle in the drama. However, time did not allow for this and neither did it seem appropriate to accept this style of writing, when the aim of the drama was to be a trigger for positive health. I felt that it was important to challenge the cause and not treat the symptoms.

8.2.3 ***EXAMPLE THREE***

From the health perspective, by failing to address the Writers inadvertent style of incorporating negative underlying themes, the drama was adding to the overall barrier to positive health messages contained in everyday entertainment media (Lowery 1980; Hansen 1986, Tones 1996). In this instance the drama was joining forces with the ethos it was seeking to challenge. In this example I challenge the theme of sexism and sexual innuendo that permeated through one of the key characters' profile. Again as with Example Two the theme was neither planned nor could it be countered by factual programmes.

The first time the issue was mentioned it was by the new Station Manager the first time he joined the Script Conference (17/1/91). He stated that he had received a comment from someone on the station that the drama was sexist; no specific example was given. This was strongly denied by the Drama Producer who stated that *Hillcrest* dealt with real life and this included characters who were sexist. The issues of sexism, sexual innuendo and double entendre were to become the subject of constant debate between me and the Drama Producer over the ensuing months, when the scripts were being reviewed prior to recording.

Episode 11 Scene 2 aimed to trigger the issue of sports injury in the feature programmes. It did however contain the start of the characters' development in terms of sexual innuendo:

Dave	**Oh, I'm not shy, Dr Hilliard. <u>You</u> were the one I was worried about.**
Joanna	**Me?**
Dave	**Yeah, you know. Complete stranger limps in here an takes his pants off. Could be alarming that.**
Joanna	**I promise not to scream. Now if you could just bring yourself to.....**
Dave	**(STARTING TO ENJOY IT) Right away. Your word is my command. Down they come....Hey listen. Funny thing about that game of squash.**
Joanna	**What?**
Dave	**Well, until I did my leg in, I was really enjoying it. Even with all the blood, sweat and tears. (FADING) I had the feeling that I could get good at it.**

(Scene 2 Transmitted 7/3/91)

From reading the script, sexual innuendo appeared to provide a stronger trigger to lead into a feature debate than did the sports injury line; it was more prominent due to the greater number of references and, as the next scene indicates remained so for the rest of the episode. When the character returns to the surgery for the same injury the theme continues:

Dave	**Evening, Dr Hilliard. Looks like I'm the only patient left.**
Joanna	**I always save the best until last. Go into my room, please.**
Dave	**Who could refuse an offer like that?.....**

(Scene 3 Transmitted 7/3/91)

In Episode 15 Scene 1 (transmitted 21/3/91) the character injures the muscle again while at work; the Hillcrest Practice Manager is a customer at the time. His reference to the scene with the doctor was edited out (words edited in italics):

Dave	**...Aouw!**
Hilary	**What have you done?**
Dave	**Stretched too far. I think I've pulled that muscle again.**
Hilary	**Oh dear!**
Dave	**That really hurt. When you get back to Hillcrest, you'd better book me in to see that Dr Hilliard of yours (FADING). *She's going to get fed up with watching me take of my pants off...***

Later when the character sees a male GP with regard to the same complaint (Episode 15 Scene 5 transmitted 21/3/91) the theme is perpetuated:

Richard	**Thank you Mr Connolly. Pull your trousers up again now.**
Dave	**Seen all you need , Dr Pope?**
Richard	**Oh, yes. You can have too much of a good thing.**
Dave	**I often get complements.....Well what's the verdict?**
	.....
Dave	**.....You see, it (leg injury) doesn't just cause problems at work.**
	It interferes with my private life as well.
Richard	**I beg your pardon?**
Dave	**You invite her round for a candlelit dinner, fill her up with vino,**
	raise her expectations and then.....
Richard	**Denial is good for the soul.**
Dave	**This isn't denial, it's torture! ...**

When I reviewed the scripts and requested changes, the Drama Producer where possible, altered lines and phrases. This was usually achieved following considerable debate; only on one occasion, was a prolonged justification from me not necessary.

When Episode 41 was read through it was seen to be peppered with sexual innuendo and double entendre; two scenes contained an ongoing sexual banter between two male characters. Neither of the scenes could be sufficiently altered to become acceptable to either me or the Drama Producer. They were returned to the Writer to be rewritten. The scenes that remained I believed to be less than satisfactory. In Scene 5 the senior partner from the Medical Centre discusses the new locum and the local teacher with the video shop owner.

Richard	**Dr Fairburn is an excellent GP**
Dave	**But what is she like as a <u>woman</u>?**
Richard	**Very personable.**
Dave	**Is that all you can say? Give me some proper specifications here.**
Richard	**Gillian Fairburn was streets ahead of the three men who applied.**
Dave	**Okay, okay she is a medical marvel but how old is she? How tall?**
	What colour eyes? What sort of figure? Married or single?
Richard	**Married.**
Dave	**That's disappointing.**
Richard	**She's a very attractive lady in her late thirties.**
Dave	**Now you're talking, Dr Pope!**
Richard	**Medium height. Blue eyes.**

Dave **This gets better and better.**

Richard **A matronly figure but nonetheless appealing for that.**

.....

Richard **.....Carolyn is such an interesting woman. Alert, committed, throbbing with vitality.....**

Dave **Right on every account.**

Richard **So much to offer the right man.**

Dave **I know, doctor. Believe me.....**

(Episode 41 Scene 5 Transmitted 19/9/91)

Later in Scene 6 one of the characters visits his boss who has just come out of hospital following a heart attack.

Neil **.....What are these, Ted?**

Ted **Some videos that Dave Connolly sent round to cheer me up.**

Neil **Green Card, Zandalee, Goodfellas.....Blimey, look at this one!**

Ted **Shove it away before Beth comes.**

Neil **Love Hotel...hot Swedish import.**

Ted **It's got English subtitles.**

Neil **Who needs those? (BANG ON DOOR).....**

Beth **(CALLS OFF MIC.) Neil could you open this door for me, please?**

.....

Ted **Gimme that video. I'll stick it under the pillow.....**

.....

Beth **... What's this under the pillow?**

Ted **Dunno**

Beth **Love Hotel**

Ted **How on earth did that get there?**

Beth **It's a blue movie.**

Ted **The tooth fairy must have left it.**

Beth **Yes, and I know his name! Dave Connolly. This is the last thing you need in your condition. Wait till I see that man! I'll marmalise him!**

At the Script Conference Annual Review (21/8/91), I tabled sexual innuendoes for discussion with the group. This was supported by the Programme Organiser who recognised the need to look at the 'subtleties' of the issue. The Writer's response was that 'these views do persist in some groups, often with those who should know better'. My concern was that if this viewpoint remained unchallenged either at the time by other characters or after by factual programmes the drama would be seen to reinforce the view as being acceptable. As with Example Two the

challenge remained not only to ensure that a positive health input was achieved but that a negative one was minimised.

8.2.4 *EXAMPLE FOUR*

This is an example of the drama providing a very specific trigger to a health campaign that was later cancelled. This resulted in a dilemma as the information was not passed on to the Drama Production Team or me until the episode had been written and recorded.

Throughout the duration of the project the aim was to use the drama in a variety of ways to provide triggers into factual programmes. In general the drama, in seeking to cover health in the context of peoples lives, steered clear of providing specific health messages or links to actual events. It was however suggested at the Script Conference (11/6/92) by the Project Manager, a Health Promotion Manager, that a storyline be built into one of the episodes in October. The request was that it centred around the character who had previously had a stroke. The suggestion was that it coincided with 'Pressure Watch Week', which was to be run by Coventry Health Authority and Leisure Services. The aim of the campaign was to promote exercise as a means of reducing stress, and it was to be a city-wide high profile campaign, with a Health Fair being run in the newly-built shopping centre.

After considerable debate at the Script Conference, it was agreed to write the campaign into the drama, providing a direct link to the Health Fair running in West Orchards. The scripts for Episode 44 were sent to the station on the 13th August and recorded on the 27th August ready for transmission on the 10th of October. When I contacted the Project Manager in September to plan the coverage I was informed that there was a change of plan. They had decided on a low profile, non media campaign and there would be no Health Authority presence at the shopping centre at all.

The difficulty caused was considerable. The reference to the Pressure Watch stand was interwoven into the scene, building up to a direct reference in the middle.

Huw *.....I thought I'd seen that old Morris minor flashing past.*

Beth *Yes - Arthur is a bit of a demon behind the wheel isn't he...he's just taken her off to have a go at the pressure watch stand at West Orchards.*

Huw *The what?*

Beth *You know you can go and have your blood pressure checked for free. It's quite fun actually....exercise bikes and instant read out machines.....you should go and have a look.*

Huw ***There's nothing wrong with me. I'm young and fit.***

Beth ***You'd be surprised how many things can affect your blood pressure, stress, cholesterol, salt....drink!***

Huw ***OK,OK.. point taken. Anyway I didn't come here to talk about my blood pressure*****.....this appeal of yours - its a great idea.**

.....

(Episode 44 Scene 4 transmitted 10//10/91 italics indicate words edited from the scene)

It was not possible to transmit the scene as it was. As the reference to blood pressure took up one third of the scene editing it out was very difficult. Although Pressure Watch was the main substance of the scene it did lay the ground for two other storylines that were to be picked up on later in the episode, for this reason it was not possible to edit out the whole scene. The cost of bringing in the actors again to re-record a rewritten scene ruled out this option. In the end, editing out the section of the scene as cited above resulted in a substandard scene that had little substance, lacked cohesion, continuity and sense, which reflected badly on both the Writer and the Drama Producer.

8.2.5 *EXAMPLE FIVE*

The coverage of the issue of back pain provides two examples of research relevance. Firstly how the agreed health orientation can change during the process of writing the scripts and be consequently out of the control of the 'health adviser'. Secondly, in the pursuit of subtle health coverage, how essential a long lead-in time is, in order to establish the characters prior to introducing the health storyline. The absence of such character development can lead to people being recognised solely for their health condition which makes for less realistic drama. It also fails to meet the objective of dealing with health issues in the context of people's lives.

The first time that I raised the fact that we were to cover back pain in December 1991 was at the Script Conference a year before (1/11/90). I raised it at the next two conferences (26/4/91, 11/6/91) when latterly the context of the character was agreed. There was to be a young family whose father had a long-term recurrent back problem. He would be in a manual occupation and would be laid off work due to intermittent absences. At the Script Conference in August (21/ 91) I suggested that a history of the character was needed by November for the drama to be an effective trigger for the feature coverage.

Local physiotherapists informed me that the key issue with back pain was having the cause properly diagnosed straight away and treated. I therefore suggested the following scenario at

the Script Conference (21/8/91): that the character was prescribed an anti-inflammatory drug and told to rest. As this was ineffective he returned to the doctor who then referred him to a physiotherapist with a three week waiting list. I provided the Writer with a physiotherapist to contact who had been instrumental in determining the nature of the suggested storyline. The Project Manager also suggested that the character turn to alternative therapies e.g. chiropractic and osteopathy. It was agreed to set this up in Episodes 47 and 48.

The first time the character was cast was Episode 47 (transmitted 31/10/91). The opening conversation in Scene 2 launched the character, who was a plasterer, and the condition without warning:

Huw **'Morning Ian.....**
Ian **Oh, Hello, Huw.**
Huw **How's it all going?**
Ian **Be glad when I've finished this wall, I know that. My back is killing me.**

The next time the character was cast the Episode 49 (14/11/91) the storyline was again evident early in the first scene.

Huw **.....how's this back of yours?**
Ian **Don't ask!**
Huw **Still playing you up?**
Ian **Yeah. Torture sometimes.**
Huw **Complain to the doctor.**
Ian **I will. Going back to Hillcrest this evening**
(Episode 49 Scene 1Transmitted 14/11/91)

Scene 4 and 5 continued with the character been taken to the Health Centre and then being seen by the doctor. Episode 50 (transmitted 21/11/91) opened in Scene 1 in the characters home:

Linda **More tea, love?**
Ian **No thanks. I must be off.**
Linda **You're not going to work, are you?**
Ian **I've got to, Linda.**
Linda **In that state?**
Ian **I'm a bit stiff that's all. You know my back's always worse first thing in the morning.**

Later Scene 3 opened with:

Dave **Didn't know you were a swimmer, Ian.**
Ian **I'm not.**
Dave **So what brings you to the pool?**
Ian **My back, Dave Giving me hell.**

Later in Scene 7 the story continues with the character's back seizing in the car and him having to be helped out by his wife. Nothing is heard of the character until Episode 59 Scene 1 (Transmission 23/1/92) when his wife is pressurising him to do domestic tasks:

Linda **.....Ian you were supposed to mend that fence last weekend.**
Ian **My back was playing up.**
Linda **And whose fault is that?**
Ian **You saw me. I could hardly move.**
Linda **Then go to the doctor.**
Ian **I've been, Several times.**
Linda **Only when the pain is unbearable. And what happens? Dr Steadman sets up an appointment for you at the hospital an you don't bother to go.**
Ian **I felt much better, that's why.**

In Scene 7 the character recounts how he was reprimanded by his GP for not turning up for his appointment with the physiotherapist. It isn't until Episode 62 Scene 6 (13/2/92) that he decides to make an appointment with an osteopath. Finally he isn't cast again until Episode 73 Scene 1 (transmitted 30/4/92) when for the first time the storyline is not linked directly to the physical problem of his back; it is however linked to the consequence of his intermittent absences in that he is to be made unemployed. Unfortunately he had no positive, non health storyline to dampen the effect of the two other afflictions.

When I reviewed the first set of scripts I raised the lack of subtlety with the Drama Producer. The response was that the team were pressured to include the storyline with little advanced warning. Secondly when I raised the issue of the alteration of the health orientation I was informed that this was the emphasis placed by the physiotherapist I had provided as an adviser; it was therefore seen as valid.

8.3 INTERFACE WITH THE DRAMA PRODUCTION TEAM - ANALYSIS

In order to provide an analysis of the findings from the ethnographic data I will draw out the emerging themes that are sociologically pertinent to this thesis: health orientation, professional justification and roles, organisational logistics, demands and constraints and, alliance management. In focusing on these themes the different professional principles and values of drama and health promotion specialists will become evident. I will seek to triangulate these findings with the interviews conducted for the project's Final Report.

8.3.1 HEALTH ORIENTATION AND THE NOTION OF BALANCE AND ACCURACY

The most predominant, and significant, theme that emerges from the ethnographic data, in relation to the development of the drama, is that of the differing professional perceptions of health and the promotion of health. This difference challenged the mainstay of both professions' principles of operation. Failure to totally resolve this dichotomy resulted in the professional parties working in parallel rather than in partnership.

The dramatic process is based on a vision of life which is constructed through a range of characters exhibiting various perceptions of their world. From a broadcasting production perspective there is also the professional notion of 'balance', being non judgmental in their portrayal of the world, 'being realistic', 'showing life as it is'. Supporting this position is the professional belief that no angle or stance is taken, they are merely reflecting the actions and habits of real people. The resistance to take a position on a given health issue, or pursue a specific line of argument is clearly demonstrated by the Drama Producer when interviewed for the Final Report:

> **"You've got all these different characters and they've all got different perspectives and you show it, not as it is but as it could very likely be. And it's up to the audience to pick out of that what they will, but you don't take a stand. So I'm never pushing a health authority or a BBC line or any anything else line. But there are characters in the drama who will take all sorts of view and sometimes I know which one I would like to, but it's not my job to push a stance."**
>
> **(Interview with Drama Producer, Dickinson 1993 p 48)**

Seeking not to compromise the BBC's traditionally neutral stance, this view was also supported by the stations' Programme Organiser when questioned:

> **"What you're trying to do is provide information for the listener so the listener can then make a judgement about it. You're not trying to preach; what you're trying to do is just provide all the information so they can make a decision ..."**
>
> **(Interview with Programme Organiser, Dickinson 1993 p 49)**

Health from this perspective is experienced by individuals within the context of how their character has been profiled by the Writer and Drama Producer. It is however, only one influence on the character and plot development. How these characters react throughout the drama is then based on how the Writer and Drama producer believe they would react; being true to character. This is typified when the Writer describes at the Script Conference how one particular character's storyline will develop over future episodes:

> **'after his 'warning heart attack' Ted goes back to work in the kiosk. Later he will go on to have another, more serious, heart attack and he has to totally reorder his life as a result. This will mean he will have to take a partner in the garage, this could bring tension as the new man could be a very driving character who wants to push forward while Ted doesn't welcome change. It is also possible that the new man may become a love interest for Vicky.**
>
> **(Scriptwriting Conference Minutes 26/4/92)**

Health, from a health promotion perspective, permeates an individual's life and is determined as much by the individual's social, cultural and political environment as it is by their genetic and physical makeup. Drama from this angle enables scenarios to be constructed that explore and challenge common beliefs about how positive health can be achieved and maintained. The health promotion perspective is one that purports there is an overall imbalance in the projection of positive health coverage in the media in favour of negative health messages. The aim is therefore to tip that balance in favour of promoting positive health messages.

It was recognised by the Drama Producer that the drama was viewed from different professional start points:

> **'... in the script conferences.....because you have two health people there the obvious things is to start from saying 'well, we'd like to tackle this, we'd like to tackle that' rather than with *The Archers* you would say 'what good story can we concoct for Joe Grundy this morning?' So in away you're turning the process on its head and then once you've done that you have to drawback slightly and say 'well hang-on is it likely to happen to this character and how can we present it in such a way?'**
>
> **(Interview with Drama Producer, Dickinson 1993 p 48)**

The non health storylines were initially seen to be the free domain of the Writer, interweaving various aspects of the characters' lives to ensure that the health portrayals were seen as part of the characters' experience. They did however become the focus of attention due to the nature of the underlying themes that were developing. Whilst there was a genuine commitment to seek advice from me on the nature of the health topics to be covered, there was a reluctance to alter the status quo on what they perceived to be balanced perspectives when covering non health storylines.

The prospect of concentrating energy on ensuring that the drama was not a negative driving force seemed never to be a consideration. The drama and related features were established in order to increase the volume and quality of the health debate on the radio station. The irony was that this creative trigger had a natural tendency towards reinforcing not challenging the stereotypical focus on health as dominated by the media. This possibility was not foreseen. Whilst the Script Conference focused on the planned health coverage, as much energy was spent by me seeking to alter the non planned health focus that was not recognised by the drama specialists as 'health'. As outlined in Example Two while a positive storyline was developing looking at the effect alcohol has on relationships and employment the backdrop created by the other characters was one which condoned the use and overuse of the substance. Similarly, where the negative theme permeated one particular character, as in Example Three, the other characters colluded with rather than challenged his behaviour. From the health perspective it was seen as an insufficient argument to state that it was 'just the way this character was developed'.

This issue identifies traditional and professional conventions within health promotion principles and practice, that of 'attempting to counter prejudice and discrimination'; contained within the 'Principles of Practice and Code of Professional Conduct for Health Education and Health Promotion Specialists: 1997.' I saw it as my professional role to challenge the incorporation of potentially health negating information that could professionally be

perceived to dis-empower, rather than empower the audience. As a result not only was the feature coverage battling with the health focus of the station but it was having to wage war against its joint component in the communication strategy. This war was not jointly recognised, as the members of the Drama Production Team, from their perspective, were merely doing their jobs; following traditional, professional conventions. This difference in approach to characterisation was later recognised by the Drama Producer.

> **"Sometimes we've had disagreements when (the Project Officer) wanted us not to have any sexists. In one script (the Project Officer) said 'This is a sexist line' and that was her interpretation. I'm more likely to say 'That's how life is that's how that character would behave', so I suppose there's a different approach to something like that..... And I think the other things is, I suppose very often health people might see one character as being represented as this and not saying 'This is how people will react in certain circumstances' whereas drama people are more likely to say 'No, this is how this character is now written into the storyline in these circumstances."**
>
> **(Interview with Drama Producer, Dickinson 1993 p 49)**

A fear from a dramatic sense was that the removal of strong character traits would result in the drama being seen as bland and uninteresting. This would therefore mean that it was failing in its key objectives to engage and entertain. Drama specialists and broadcasters alike will resist any attempts to render their professional output boring to its listeners and risk losing them; effectively, they would not be doing their job. This belief is expressed by the Drama Producer:

> **"I think 'Thirtysomething' made a mistake of having lots of politically correct characters and after a while it became rather clichéd and dull and things. You have to be a bit careful about how you do it."**
>
> **(Interview with Drama Producer, Dickinson 1993 p 49)**

The professional differences in the concept of health pervaded all aspects of the drama, from plot, through characterisation, to health and non health storylines. At no point during the initial stages was a discussion held between myself and drama specialists to identify a common understanding. As a result no clear identification was made as to what the scripts would be checked for. Advising on 'medical matters' were contained within the job

description as outlined by the Station Manger, and 'accuracy and appropriateness of health information' were contained in the job description to which I was appointed, but at no point in the development stages of the project was the nature of health and health promotion discussed.

> **"Advisor to Soap Opera on all medical matters, and such, a member of the Script group and Project Steering Team"**
> **(from Job Description drawn up by Station Manager)**
>
> **"To take lead responsibility for health initiatives across BBC CWR output especially in relation to heart health."**
> **"To ensure accuracy and appropriateness of health information transmitted by radio drama"**
> **"To contribute to the development of health themes in the radio drama, in conjunction with the BBC producer"**
> **(from Job Description drawn up by the District Health Promotion Officer)**

Consequently the reviewing of the scripts became an ongoing source of tension. I reviewed them in the light of what was perceived to be good health promotion practice and these attempts to steer the drama in this way was met with opposition and resistance by the Drama Production Team.

The professional orientation of the Drama Production Team centred around producing a high quality product and building and maintaining an audience. To them this depended on the credibility and appeal of the characters, it also relied on the audience's ability to identify and empathise with them. There was a recognition from the health specialists that the drama had to be established and attract an audience prior to them tackling health issues. However the damage was done in the early stages as the characters profiles were set by the Writer, in the absence of any clear and explicit statement regarding the required orientation from myself, the Project Manager or the HEA. The absence of any discussion relating to health promoting rather than health negating characterisation, resulted in the Writer establishing the cast based on traditional dramatic conventions.

One area where there was professional consensus from the outset was that the drama would not contain clear unambiguous health messages. This was met with relief from the drama and broadcasting professionals as this was what they felt would be the main source of conflict in the partnership. Implementing this agreement was not as simple as it seemed. It did cause tension as Example One indicates, but due to me seeking to soften fairly blatant messages that were written into the scripts; my aim was to prevent the audience rejecting the drama (Singhal

and Rogers, 1989). It was not the actual words and phrases used, that necessarily resulted in obvious messages, it was how they were placed within the context of the scene or ongoing storyline. When the lines are seen as out of context with the rest of the script they stand out and therefore fail to meet either the health or dramatic aims. Stereotypically, listeners and broadcasters may have thought that this was the intention of the health specialists, rather than the style of the Writer.

8.3.2 PROFESSIONAL JUSTIFICATION AND ROLES

The notion of editorial control was a central issue at the developmental stage of bidding for external funding. The drama from the onset was manifested as the BBC's focus for editorial control. At the initial meeting with the Station Manager, Programme Consultant and myself, it was stated:

> **"Editorial Control in all programme matters to remain fully with CWR"**
> **(16/3/90)**

The initial response to agreeing to receive external funding to implement the communication strategy was to appoint a network drama producer. This was to be funded from regional funds rather than the external health money. The managerial concern centred around the BBC remaining independent from any desire from the health sector to strongly influence how the BBC portrayed the local health services.

> **"..It was confirmed that health issues would be raised, whether or not they were politically sensitive or controversial. These could then be discussed later in a balanced and unbiased fashion."**
> **(Station Manager, First Project Advisory Group Minutes 20/8/90)**

The appointment of the Drama Producer was based on assumptions that the health sector would seek to deliver health messages as suggested by the Health Education Authority, or seek to resist criticism of local services. This was further emphasised by letter to the Health Education Authority:

> **"Thank you for your letter confirming the understanding that editorial control with regard to the Listen To Your Heart project and the related drama serial will remain with the BBC.....As the drama serial will not be propagandist in its approach but will seek to arouse the interest in health topics through use of a strong fictional story in a health centre setting, I do not anticipate that the drama will offer 'health messages'. It will be the follow-up material in other programmes which will provide listeners with information, education, guidance and encouragement."**

(Station Manager, 23/10/90)

This fear was unfounded as the health sector never intended to use the drama as a channel for overt persuasive health messages. The evidence was clear that attempts to change the public's health via crude persuasive messages, however cleverly crafted, was unlikely to succeed.

Senior Management concern for editorial independence remained throughout the drama's existence. For this reason episodes of *Hillcrest* and documentaries produced by me were called for by the Head of Regional Broadcasting (16/9/91). BBC independence was also the main focus of the research conducted by the Special Projects Research Unit in London. One of the prime areas for probing was the public perception of the BBC receiving external funds to run such projects.

"Awareness of and reactions to health authority involvement."
(Graham, 1992 Appendix p 3)

Their fears were in fact unfounded as the respondents were overall in favour of the connection.

"There was very low awareness of any health education authority involvement in Hillcrest.....When told about the health authority connection the majority of respondents were quite accepting of the fact. They believed the intentions of the sponsoring body were basically good...Only a very small number were concerned about the idea of editorial influence."
(Graham, 1992 p12)

With the actual production of the drama the issue of editorial control was not related to a health or a BBC stance. How it was manifest was through arguments based on the drama's credibility and independence. It was not a BBC or non BBC issue, it was a drama or non drama specialist debate.

The issues surrounding the BBC's notion of accountability is covered in detail by Madge (1989). He describes the BARRTA (Broadcasters and Accountability: Responsiveness and Responsibilities Towards Audiences) project which explored the systems of accountability, as defined by broadcasters themselves, in the BBC e.g. advisory boards, audience research, audience responses etc. The organisational politics of broadcasting is not an area that I have pursued in this thesis. However, whilst Madge focuses on the BBC's accountability to its

audience, the issues around what could be perceived by broadcasters to be external interference is relevant to the analysis of the interface with the Drama Production Team. In the context of this research I use the terms 'accountability' and 'professional justification' to typify the unusual position the Drama Production Team found themselves in, in terms of them being questioned by non drama specialists through their involvement in the project.

Scriptwriters and producers are traditionally appointed to produce a product of a certain length or duration, being accountable to the Commissioning Editor who contracted them. Script conferences exist as the most visible form of accountability for the nature and content of the drama. Such forums are seen as assisting in the creative process of character and plot formation, drawing on the imagination and expertise of the participants, with each party arguing their case. Script conferences operate within the range of forums for professional justification in that those that need to have an input into the process are invited to attend. Whilst they are not hierarchical in style, those participants that thrive are those more familiar and comfortable within that environment. Further accountability lies in the level of audience attracted and the opinion, on occasion, of drama or media critics; no other forum exists to either influence or comment on the content and approach taken by the production team. The *Hillcrest* Drama Production Team were not afforded this usual degree of autonomy.

Local radio stations are not commonly the site for the production of drama series. In the case of *Hillcrest* the Drama Producer as a BBC employee, although funded by regional money, was accountable through the stations line management system. She was in turn responsible for the Writer and the recruitment of actors. The most visible demonstration of this process of professional justification was through the Script Conference; though it was difficult in the first instance to maintain a station management presence at these meetings, the reason was higher priorities of the new Station Manager.

The inclusion of the drama in the health communication strategy resulted in the Drama Production Team encountering an unprecedented form of justification. The existence of a health advisor unfamiliar with the dramatic production process was to prove both an assistance and a barrier to the creative process. The obvious benefit to the Drama Production Team was access to a wide range of accommodating and supportive health professionals to assist in script research. The negative elements were twofold. Firstly that a non drama specialist reviewed the scripts for 'accuracy', and secondly, that the drama was drawn into the projects's accountability forum, the Project Advisory Group.

The Drama Production Team were not used to an 'adviser' who recommended subjects to cover, angles to take and had the ability to strongly question the health approach taken. They were more familiar with 'script researchers' who traditionally played very little part in any decision making processes. The supportive role of script researcher conventionally exists to compile information on a range of notional ideas, for the producer and writer to select from. In reality with this process, once the research has been conducted and presented to the team, more subject areas are rejected than are accepted. This was not the case with the *Hillcrest* Production Team. Implicit within the decision to cover a subject, was the expectation that it would be acted upon. From the health perspective there was an expectation that my role would be proactive in determining the shape of the drama, though this was not necessarily shared by the Drama Production Team.

The notion of an 'adviser to ensure accuracy' presents a different picture, in that it assumes that there is an element of agreement to be attained. It confers acceptability and in some instances, professional credibility. The health advisor/specialist (me), as opposed to a script researcher, in this context is less subservient and holds more power. If the drama scripts are viewed by the health adviser (me) and perceived to be 'inaccurate', or inappropriate, it puts the Drama Production Team in a difficult position if they choose to ignore the advice given. The health specialist (me) in this instance incorporates a different and often unwelcome, level of professional justification. Being a non drama specialist does however prevent the status of the health specialist from being equitable with that of the Writer or Producer. As is evidenced in this research, this area is one that produced considerable tension throughout the strategy's implementation. It was a conflict of traditional levels of professional accountability and principles of operation.

Whilst the Project Advisory Group had no managerial control over any aspect of the project, and was established to provide support and advice for me, it did later provide an opportunity for vocal members to query, question and criticise the approach taken by the Drama Production Team. The absence of a representative from the Drama Production to make a justification for the stance taken, resulted in the negative comments being ineffectively challenged. The situation was exacerbated by the Station Manager, who attended these meetings, failing to support the Team in their absence, thus instilling a sense of isolation and vulnerability.

The Drama Production Team's defensive move was to attend these meetings in the latter stages of the implementation phase, in order to justify decisions they had taken. This differed markedly from any traditional justification forum they were familiar with as none of the members were drama specialists, neither were they regular listeners. This was further exacerbated in that the comments related to the style of the drama rather than the health content. The views expressed were not therefore perceived to be informed in either process or content.

In short the Drama Production Team were isolated from the rest of the station and inadvertently drawn into unprecedented external justification, without clear guidance and support from the station management.

From my perspective, whilst mastery of programme production was achieved, drama production was a different concept and posed different challenges. The position held within the drama context was distinctly different from that of programme production, in that with the latter the role it was to produce programmes, the former it was to provide advice. The level of control and power differed tremendously with the two distinct functions. Neither were the skills attained in broadcast journalism applicable to the drama setting; there was a whole new arena of specialist vocabulary and a different notion of justification. While Programme Producers readily accepted my recommendation for appropriate angles for coverage, the Drama Production Team wanted evidence as to why my suggestion was more appropriate than their own. I was therefore working to two different agendas, health in programme production and health in drama production.

My role in the drama production process was professionally problematic in that it originally consisted of two distinctly different functions, that of Health Adviser and the production of spot sound effects. The latter role was taken on initially in an attempt to be involved in the whole production process. This proved to be problematic in that the two functions spanned a range of professional hierarchies, 'advisor' and 'technician'. As the challenge increased to ensure that from an advisory capacity the drama was not health negating, the role of creating the spot effects was relinquished, for two distinct reasons. Firstly, the function of supporting the health input in the drama became a constant and time consuming challenge, not only ensuring that agreed subjects were covered but preventing negative underlying themes from developing. Secondly, challenging the decisions of the Drama Production Team with regard to how health issues were being addressed, and then supporting the recording of the episodes by

producing spot effects became untenable. The opportunity to extend the production assistant's time to cover tasks such as spot effects and material production enabled me to withdraw from the technical role. This ensured that some distance could be maintained between me and the Drama Production Team. This also released time to concentrate on the health content of the drama.

The initial struggle from my perspective was possessing the confidence to make health the prime issue for consideration at an early stage. Not fully understanding the process and not knowing how to effect change within that context was a considerable professional challenge. There was a constant need to question the application of professional beliefs as they were considerably outnumbered by those imposed by the Drama Production Team. This 'disorientation' is a recognised dilemma of the participant observer (Cottle 1998), as the researcher is forced to reflect on personal and professional value positions, while being immersed in the working practices of those under investigation. From my perspective when the approach taken on health was rendered unimportant by the large majority of the workforce it required strength to hold on to the premise that it was imperative to the strategy's implementation. It requires considerable confidence in the process to stand against the traditional drama specialist, especially when they are greater in number. The absence of relevant training for me in drama production and health promotion for the Drama Production Team, resulted in objectives being achieved through trial and error on both professional sides. Retrospectively improving the health focus of the scripts was a difficult and unrewarding task for all involved. From the Writer's perspective it could be perceived to be controlling and as direct criticism. From the health perspective it was frustrating that what was agreed was not coming through the scripts; and the Drama Producer was professionally placed in the middle with a commitment for the drama to meet its health and dramatic aims.

Professionally, the Drama Producer's first loyalty was to the Writer. Whilst the Drama Producer had no role in selecting the Writer, the success of the drama lay with there being a close relationship between them. Although on occasion the Drama Producer sought to alter the direction of the drama based on discussion with me and sometimes altered the scripts, there was a limit to her ability to influence while the same Writer remained under contract.

Writers absorb information from everyday experiences, from the people they know and from conversations with others. What they write is determined by how they view and perceive their environment and those that interact within it. They also traditionally have a network of

specialists who they can call on for information and examples. It is a process whereby they take snippets from their environment and that of others and recreate it in a dramatic format. Health information in this context is collected in the same way as subject matter for any issue, as a result seeking to influence the style of the Writer is unlikely to be achieved through the provision of information however presented.

From the Writers viewpoint creating a range of characters based on recognised stereotypes adds colour and texture to the creative and dramatic product, it promotes discourse and debate, and acts to distinguish one character from another. It is also seen as legitimate to present a range of views and values as represented in society. Similarly bars and drinking are used as a dramatic short hand as it equates with stress relief, winding down and having a good time. There is unlikely to be an intention to promote the use of alcohol - it is simply a traditional social setting for discourse. Unless there was recognition by the Writer to alter this status quo and represent the positive elements of characters or challenge the negative elements as in sexism and racism then any attempts to alter this will be resisted and seen as intrusion.
As is applicable to any behaviour change whether it be personal or professional it is not an issue of getting the right information to the right person at the right time. Information will not change behaviour, as it is not possible to externally determine what the receivers of the information hear or take from it or how they interpret it. It is to do with the attitude and circumstances of the person, their significant others, and the culture of the professional. Seeking to influence professional practice must start with the recognition from the individual that there is a need to change.

Aiming to support a process that is not understood is unlikely to be effective. Similarly if the reasons why changes are being suggested are not understood then any subsequent change is also unlikely. In the case of the drama, I was not familiar with the drama production process, neither was the Drama Production Team familiar with health promotion principles and practice. The result was to constantly plan, act and reflect through the forum of the Script Conference and the reviewing of the scripts. This often became a painful process for all parties as time after time one or the other's professional conventions were becoming compromised to excess. The frustration was further exacerbated as this occurred within a pressured environment with very tight deadlines. This general area of misunderstanding created tension and frustration as each party sought to act and operate professionally, and compromise to work with each-other's professional protocols. It was essential to understand each-other's area of

specialism as the production of a health promoting drama required the merging of both professions' characteristics.

As the Drama Producer and I attempted to understand the operation and professional orientation of the other, appropriate training would have supported the process of understanding. For me whilst ongoing and developmental training was provided for broadcast programming it was not for the drama production process. With regard to the Drama Producer, a brief foundation course in Health Promotion would have helped her to understand the health promoting focus; such training could have been built on by the experience of implementing the project. Although no such training was suggested or offered it was later recognised by the Drama Producer as a desirable process. Contained within this is the acceptance that should training have been suggested at the beginning it may have been resisted:

> **".....in away it would have been quite sensible to have made me take some sort of induction course in health promotion right at the beginning I mean I might have been resistant to it at that stage, I don't know but there are things that have become obvious to me over the eighteen months ..."**
> **(Interview with Drama Producer, Dickinson 1993 p 44)**

As the relationships evolved and strategies for compromising were tried and tested, it became evident retrospectively what would have assisted in making the developmental process smoother and more efficient, more quickly.

8.3.3 ORGANISATIONAL LOGISTICS, DEMANDS AND CONSTRAINTS

One of the prime factors that shaped the drama was available finance. Within a very tight budget (£63,000[1] over 2 years) the overriding demand was to produce a credible, professional drama of 104 episodes. For the two year period the Writer was contracted for £10,000 (less than £100 per episode) to develop a range of characters, and advance a number of interweaving health and non-health storylines. This was to be achieved within a weekly 15 minute episode of seven scenes using only six actors per episode. For £14,000 (£134 per episode) the Drama Producer was contracted to produce the recording of the drama, administrate the budget of £39,000 together with locating and auditioning actors. The facilities and technical support afforded the Drama Producer was considerably less than would have been available for a network production. The station's Boardroom was used for rehearsals,

one of the station's two recording studios were used for the morning of the recording with one of the station's engineers driving the desk; untrained in drama recording. Whilst the actors were paid Equity rates, they were in many cases paid far less than the actors could have demanded elsewhere. In short the production of the drama was conducted on considerable goodwill by all parties.

Despite such constraints 104 episodes were produced on time, within budget, using 38 actors, covering 32 health issues. The financial demands necessitated that the Drama Producer and Writer worked in close partnership in order to avoid rewrites. It is clearly recognisable that demands on time for both professionals did not allow for time-consuming involvement with outside agencies. The overriding urgency was to develop a professional series using as many actors as possible in order to sustain a wide number of storylines within budget and on time with very limited technical resources. They were not contracted to be interactive with external agencies, they were commissioned purely for the production of a product.

There was a commitment from both the Drama Producer and Writer to meet the health and drama objectives. However, synchronising these two components of the communication strategy identified many logistical dilemmas. Both areas in themselves were multifaceted, requiring complex deadlines, involving a wide range of individuals.

With regard to the production of the health features, the commitment to start the planning process for each campaign two months prior to broadcast necessitated that there was firm agreement from the drama to meet agreed deadlines. As there were always a large number of campaigns at varying production stages the time available to meet any further commitment to the drama than through the Script Conference or reviewing the scripts was rare. Outside agencies, programme contributors, and programme presenters were the priority.

Similarly the Drama Producer's operation required the complex logistics of a number of outside influences with key stages of development; availability of actors, contracting actors, the writing of the scripts, the recording of the drama, and editing.

The Writer stated in the Scriptwriting Conference 26/4/92 that

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[1] *Figures at 1990 prices.*

> **"It was sometimes difficult to follow on from stories due to the small cast of Hillcrest (6 actors per episode) and actors not being available for weeks at a time"**

For the Writer there were a number of logistical issues for consideration. One was utilising the offer of script advisers. As they were available during the hours of 9-5 this rarely coincided with the time the Writer chose to write. The result was that he utilised his own contacts. He also emphasises the difficulties he encountered:

> **"The main problems are logistical and are to do with keeping your eye on the ball really because very often the only problems I've had have been when (the Health Advisor) and CWR are not aware of how fast the story is moving and have asked me to do something which I've done two weeks earlier in episodes or will come in too late not always aware of how far ahead we work and how swiftly we work and ... that decisions have to be made maybe three months ahead in order to set something up because you can't just invent something out of the blue you have to, certain stories have to be nurtured along very slowly and then brought to their fruition...."**
> **(Interview with Writer, Dickinson 1993 p 46)**

This view was also endorsed by the Drama Producer:

> **"At any one time I'm working on a large number of episodes at once I suppose, with one that's going out this week; recording two that are going out in five week's time; editing the ones going out in seven weeks; the two going out in nine weeks are just about being written and casted; and the ones going out in twelve weeks that we are talking about at the script conference, and it's quite hard for someone not totally focused in on it to keep track on what's going on from time to time."**
> **(Interview with Drama Producer, Dickinson 1993 p 51)**

While Examples One and Five indicate that dates and episodes for the coverage of certain health issues were agreed, the inherent demands of both the production of the drama and the production of the features prevented the other people's agenda from being at the forefront of their minds. Consequently when errors occurred drastic action was usually required, as the result was likely to impinge on a number of issues, some which were not possible to change. This was demonstrated by the change in priority of the local health authority in Example Four. The Project Manager's main aim was the delivering of the campaign, forgetting the commitment of the Drama Production Team to make a direct reference to the campaign in the drama, and omitting to inform the project team of the change in focus. The pressure to incorporate issues to meet agreed deadlines when the necessary actors were unavailable,

resulted in the absence of subtlety in some of the storylines rendering them didactic in nature, as in Examples One and Five.

The opportunities for monitoring the process existed at the Script Conference which was held every two months, and when the scripts were submitted, which was every two weeks. Outside these times, both parties operated independently to produce their commissioned products, time was not available to shadow the actions of the other party. Despite considerable adaptation being achieved by both professional groups towards the end of the implementation period, the logistics often remained a barrier to complete success; all components of the strategy working in synchronicity to positive health promotion principles.

8.3.4 ALLIANCE MANAGEMENT

In the initial stages of the project's inception the Station Manager, who had a strong commitment to social action broadcasting, managed the process of bringing the parties of health and drama together. He mediated between the BBC at a regional and national level in order to gain acceptance for the project's operation due to the BBC receiving external funding. His tenacity in drawing on other departments in the BBC was used to good effect in finding solutions to problems, whether they were related to funding, or locally available expertise. At each stage he kept all parities involved and informed. This mediating function diminished when he left the station one month prior to the launch of the project. The priority of the new Station Manager was to increase audience share and attract a younger audience. This change was in BBC Local Radio policy at that time.

The change in role for John Birt from Deputy to Director General of the BBC in 1992 resulted in an increased pace in his mission to renew the licence fee, which was under renewal as part of the revision of the BBC's Royal Charter in 1996. This mission incorporated the review of BBC services that were perceived by the BBC to be vulnerable to external criticism from the government who sought to ensure that the BBC's coverage was distinctive and not currently replicated by the commercial sector. Changes in Local Radio instigated at this time by Ronald Neale, Director of Regional Broadcasting was a small part of the wider service review.

BBC Local Radio had to demonstrate its distinctiveness from its commercial competitors who also demonstrated a public service role in terms of delivering social action campaigns. Necessary changes incorporated targeting a younger audience (35+), hour-long 'solid speech shoulders' (periods of speech only output) during the Breakfast, Lunch-time and Drive-time programmes (morning, lunch-time and late afternoon), and reversing the speech/music ratio to 40% speech and 60% music. Implementing these changes was to become the priority of all Station Mangers[2].

The arrival of a new Station Manager in December 1990, when the project was launched, had a marked effect on the station's social action output. Resources were moved to mainstream programme production in an attempt to increase audience share. This resulted in the dissolution of the Head of Community Programmes post and consequently, as no effort was put into securing secondees, the Community Unit. There were also major changes in the programme presenters during the final year of the strategy's implementation as the move was to involve younger (and consequently less experienced) programme production staff. Overall leadership from the station management for the strategy's operation was absent for its duration. As the station sought to increase its listeners the focus became that of making programmes more upbeat and less like Radio 4. The challenge for the Station Manager was achieving this within a limited budget, yet retaining the high speech content; the drama was not his priority.

The involvement from station management was to be inconsistent and damaging in many aspects. The ability to evaluate external criticism prior to forwarding it to the Drama Production Team was not evident. As a result the team were neither protected or supported by its management structure, leaving them vulnerable to external criticism. As the station reviewed its focus, no guidance was given to the Drama Production Team on how to work towards common objectives, they appeared to remain isolated from the rest of the station output.

The Station Manager's absence from the initial Script Conferences was of concern to the Drama Producer. It was seen as essential that the managers of the station's output, either the Station Manager or Programme Organiser, were party to decisions that were being made at

[2] This data from my field notes was supported and supplemented by a recent telephone interview with Donald Steel, Chief Press and Publicity Officer for the BBC in London: 1/11/99.

Script Conferences. This was echoed by both the Drama Producer and the Writer when interviewed for the Final Report:

> **"... somebody else on the station should be aware of what we were intending to do for the next ten months ... I'm very happy for them to bounce ideas in but I really feel that if I'm going to be producing this for the next few months I don't want someone to come after the script's written and say 'I really wish you weren't doing this'."**
>
> **(Interview with Drama Producer, Dickinson 1993 p 53)**

> **"...I do think it's his (Station Manager) job to be involved in the creative process and I mean even as a listening brief he would have been welcome, instead of delegating it to somebody else who was then replaced by a third person who was not involved with the programme at the start. I mean we're talking about a very small scale programme here even though it covers two years and therefore one should be able to have a small well-knit group of people from start to finish, then you get continuity, the value of having the same producer is to get continuity, the value of having the same writer is to get continuity, its simply good or consistently bad that's a matter of opinion but at least it follows a line, you set your baseline and you never go below that as it were and it would be helpful to us if we'd had the input from the top of the same consistent level..."**
>
> **(Interview with Writer, Dickinson 1993 p 53)**

Partnerships with public services was not a priority for the new Station Manager. The absence of a mediator at a regional and national level resulted in the health sector being kept at arms length at a key stage in the strategy's evaluation. Although there was health input into the question design for the audience research, conducted by the BBC's Special Projects Research Unit, access to the presentation of results for non BBC employees was denied.

The management structure within the station was exacerbated by the overall lack of managerial guidance and support for the project during the implementation phase. Although groups were established to advise on particular aspects of the communication strategy; Script Conference, Project Advisory Group, no one person had total responsibility or was accountable for the project's success. The absence of a manager with a vision for social action broadcasting using drama was marked. As a result any differences between the Drama

Production Team and the health sector were exacerbated. What was lacking was a central mediation point, a manager with an objective, informed perspective and clear vision.

The Project Advisory Group possessed no authority or managerial power. The two main partners in the group, the Health Education Authority and the Project Manager, did exert influence but neither had direct responsibility or complete understanding of the whole operation. The Project Manager, a local health promotion manager, had responsibility for the total budget received from the Health Education Authority. He was later involved in the Script Conference but had no jurisdiction over any broadcast element of the project. Similarly the Health Education Authority who chaired the Project Advisory Group had no control other than to authorise payment of budget, and advise on monitoring requirements.

Whether the management would have differed had the original Station Manager remained in post is open to speculation. Clearly the management tenacity required from the onset in order to maintain a professional balance with such a diverse range of stakeholders was absent from his departure. The skills inherent within the person was not the sole factor, as the replacement of a Station Manager with a distinctly different focus was more a policy shift than professional choice. In the space of two years the BBC's commitment to establishing a strong network of local radio stations at the expense of the larger regional stations, was beginning to change. In the case of BBC CWR, fighting for an audience share where there was a well established and historically strong commercial competitor in the area was financially difficult to sustain.

Summary

In this chapter I have outlined the findings from the ethnographic data collected on the relationship interface with the Drama Production Team at both a formal and informal level. I then provided an analysis of key professional and organisational differences between the two professionals groups. I then triangulated these findings utilising interview data from the Listen To Your Heart Final Report.

In the next chapter I draw conclusions from the empirical investigation into the relationship interface with the three professional groups, health, programme production and drama. As I revisit the research objectives I will identify and discuss theoretical and practical outcomes from this investigation and their relevance for health promotion practitioners, broadcasters and communication researchers.

CHAPTER NINE

CONCLUSION

Introduction

In this chapter I revisit the path taken in this thesis and then review the research findings from the ethnographic data in the light of the research objectives and their likely significance for health promotion specialists, broadcasters and communication researchers.

In Chapter One I explored a wide range of research approaches which were utilised in the development of a health communication strategy that formed the case study for this thesis. I also identified a range of relationship issues encountered when the professions of broadcasting and health specialists interacted. I started by looking at the historical context of media effects (Katz and Lazarsfeld, 1955; Klapper, 1966; Katz, Blumler, Gurevitch, 1974; Dembo and McCron, 1976; Windahl ,1981; Jensen and Rosengren, 1990; Dalhgren, 1998) moving to look at the notion of campaigns (Hyman and Sheatsley, 1947; Star and Hughes, 1950; Mendelsohn, 1973; Salmon, 1989; Rice and Atkin, 1989) and the variety of approaches used to promote public health (Atkin, 1981; Budd and McCron, 1981; McCron and Budd, 1981; Wallack, 1981; Solomon, 1984; Tones, 1990). In doing this common barriers and opportunities arose, in relation to the theoretical application to health education and the relationship interfaces of broadcasters and health specialists (Atkin and Arkin, 1990; Meyer 1990; McCron and Budd, 1981). I looked at research exploring the health agenda (Best et al, 1977; Dervin, 1980; Budd and McCron, 1981; McCron and Budd, 1981; Kristiansen and Harding, 1984; Garland, 1984; Lang, 1987; Levin, 1987; Karpf, 1988; Wallack, 1990a; Signorielli, 1990), who sets it and how attempts were made to alter the content and shift the balance of power in its production. All of these principles sought to inform the development of the health communication strategy that exists as a case study for this thesis. The research indicated that there was a necessity to incorporate a range of styles and approaches into a comprehensive health communication strategy, together with the recommendation that health specialists and broadcasters should work in collaboration (McCron and Budd, 1981; Webb and Yeomans, 1981; Groombridge, 1986; Rogers and Singhal, 1990).

In Chapter Two I explored salient commonalities in the two organisations that funded the development and implementation of the health communication strategy; the BBC and the Health Education Authority. The issues of note here relate to the BBC's involvement in a form of broadcasting known as 'social action', and national health education bodies grappling with the reality of media effects in their delivery of public education campaigns. I briefly explored the historical battle between internal and external influences of the national health education bodies, both the former Health Education Council and the Health Education Authority regarding their funding commitment to mass media campaigns. I then provided a more detailed account of examples of social action broadcasting at a network and local level in the UK. This merges the two funding organisations within a complementary context that draws on the BBC's commitment to public service broadcasting by dealing with local issues supported by back up services, and the Health Education Authority in looking to ensure that health campaigns have a local focus. As 'social action broadcasting' necessitates bringing disparate organisations together to work co-operatively and collaboratively, timing, logistics and differing professional norms and values emerge in the relationships between the health professionals and broadcasters. Whilst the approach taken is of relevance to the development of the health communication strategy, it is the relationship interface that is the central focus of the empirical investigation of this thesis.

What emerges from the first two chapters are a set of guiding principles to inform the development and implementation of a health communication strategy that would effectively utilise the media. The development and implementation of such a strategy is considered in this thesis in the form of a case-study, conducted in a BBC Local Radio Station, whereby through collaboration with drama, health and broadcast professionals an attempt was made to re-orientate the way that health was covered by the media. In doing this three areas of empirical investigation unfold that form the basis for this thesis. The areas focus on the relationship interface with the three parties in the development and implementation of the strategy; health professionals, programme production staff and drama professionals. These themes underpin the research strategy for this thesis. In Chapter Three I pose the research questions for this thesis together with the proposed methods to be used.

Programme Production Staff

Can the cultures of broadcasting and health merge, through the presence of a health promotion professional within the broadcasting environment, and influence the orientation of

health in the feature broadcast output without detrimentally compromising the two distinctly different sets of professional values?

Drama Production Staff

Is it possible to incorporate a radio drama into a media based health communication strategy without detrimentally compromising the two distinctly different sets of professional values?

Health Professionals

Can a media based health communication strategy be established that enables and secures the active involvement of health professionals in the development of health programming?

Seeking to ascertain answers to such broad questions necessitated me drawing on a number of research fields and disciplines incorporating both qualitative and quantitative methods. What I argue is that rather than eulogising either range of methods as sole providers of worthwhile systematic scientific evidence, I identify a range of valid methods incorporating ethnography to capture the uniqueness of the research opportunity and to illuminate the social phenomena in question (Parlett and Hamilton, 1976; Patton 1990; Cottle, 1998). Finally I outlined the chosen methods for each of the key relationship interfaces; health, drama and programme production.

In Chapter Four I described the development of the partnership between BBC CWR and the four District Health Authorities in Coventry and Warwickshire which centres on the secondment of a health promotion specialist to the radio station for the duration of one year. This relationship stretched popular notions of collaboration between health and broadcast specialists and paved the way for a creative and challenging alliance. Whilst professional tensions and dilemmas are encountered as the health promotion specialist moves into the broadcasting environment what emerges from this account are two of the key areas of empirical investigation of this thesis, that of the relationship interface with programme production staff and with local health professionals. In an attempt to influence the orientation of the radio's health content, the institutional differences between broadcasting and health, and the organisational challenge of mobilising local health professional resources becomes evident.

In Chapter Five I described the development of a media based health communication strategy that was entitled 'Listen to Your Heart'. This was the strategy that combined the learning from entertainment-education, media advocacy, and social action broadcasting, and is utilised as a case-study in the thesis for research and analysis. What is of empirical significance is that the incorporation of radio drama in the strategy marked the added dimension of a further relationship interface to consider as the differences increased in professional conventions, norms and values. As I explain, the result was a strategy that stretched the imagination, patience, adaptability and flexibility of three distinctly different cultures, health, broadcasting and drama. These relationship interfaces form the three main areas of empirical investigation for this thesis.

Chapter Six marks the start of the presentation of my research findings from the ethnographic data collected during my role of implementing the health communication strategy. As this is the first of three chapters that present and analyse the ethnographic data, I started the chapter by outlining the process of interaction with the various stakeholders in the implementation of the communication strategy; the drama production team, programme production teams, and health professionals. In presenting the ethnographic data I focused on the roles I undertook at these interfaces; initiator, mediator and enabler. I explored how working in collaboration calls for three distinctly different professional groups to question and, at times, compromise their professional norms and principles, as they interact to implement their part of the health communication strategy. I then explored the specifics of the interface with the Health Professionals, providing examples for analysis, combined with data triangulation with questionnaire evidence from the Listen to Your Heart Final Report. The issues of empirical significance that emerge from this data are the timing logistics for actively involving health professionals; the external leverage gained by involving outside agencies in the planning and implementation of the strategy although based in a radio station and finally the professional ownership of the strategy by those involved in it. These are the issues that I will return to later in this chapter, when I explore them in relation to the research questions asked.

In Chapter Seven I explored the nature of the interface with the Programme Production Staff outlining a series of examples gathered from the ethnographic data. I then analysed the empirical data triangulating it with interview data collected during the evaluation of the Listen to Your Heart Project. The issues of empirical significance that I will address later in this chapter are the station's commitment to a high percentage speech output set against their

allocated staff resources; local radio's traditional reputation for being a training ground for broadcasting and finally the notion of editorial control and that of quality broadcast output.

In Chapter Eight I explored the nature of the interface with the Drama Production Team in the development of the radio drama *Hillcrest.* I looked at the roles undertaken at this interface and outlined a number of examples of empirical significance from the ethnographic data which I triangulate with interview evidence collected for the Listen To Your Heart Final Report. The issues of empirical significance are greater in number than the other two interfaces and centre on: the health orientation of the drama production team and the notion of balance and accuracy; the professional justification offered and the traditional roles undertaken; the demands and constraints imposed in undertaking the roles together with the organisational logistics of delivering the drama product and finally the management structure of the alliance.

As outlined earlier the focus of this final chapter is to consider these issues of relevance in the context of the research methods chosen, and the research questions posed, in Chapter Three. Firstly to the chosen methodological approaches which comprised of action research and ethnography.

Throughout the implementation of the Listen to Your Heart project I utlised an action research approach which provided an opportunity to reflect on the relationship interfaces of the three professional groups. Within this context it enabled me to reflect on the effectiveness of both the formal and informal opportunities for interaction with all three groups. The benefit of the approach was demonstrated through the necessary changes to the structure and nature of the Scriptwriting Conferences for *Hillcrest,* the development of the consultation process for health professionals and finally for securing the support of programme presenters and producers to incorporate the health campaigns in their programme schedules.

Adopting this approach enabled the reflection on the effectiveness of the interaction between the three professional groups to be viewed positively, providing opportunities for participants to recommend changes and adaptations. The absence of such a flexible approach may have resulted in adherence to structures and process that were viewed by participants to be less than effective. Finally, documenting the stimulus for change, the decisions made and the factors influencing these changes also provided valuable ethnographic data for later reflection and analysis on the relationship interfaces of the three professional parties.

The central issue with regard to the methods used in this thesis is the effectiveness of the ethnographic approach used in meeting the research objectives. In reviewing this one key theme emerges, the issue of transparency of data analysis. Given the integral role I held in the development of the process, the collection and analysis of the data, this methodological problem was unavoidable. What I will now outline is the approach I took to minimise the potentially negative impact my role as participant had on the presentation of results and the final analysis of the data.

As outlined in Chapter Three the position undertaken when operating as a participant observer, whether occupying a complete observer or complete participant role, will determine the nature of what is observed, translated and made sense of (Berg and Smith, 1988). The position I adopted was that of an overt complete participant; where I was viewed and participated as member of the radio station's seconded staff, and all participants involved in the project were aware of my role as researcher. Whilst this resulted in the ability to collect substantial data to illuminate the complex forces and the organisational constraints operating at each of the professional interfaces, a dilemma exists with the presentation and analysis of the findings.

Following the implementation of the case-study, both physical and psychological distance was sought from the broadcasting environment. This was necessary to enable some detachment from the data collection process. This also facilitated a more objective view of the data collected; this I wrote and rewrote until I achieved a degree of 'progressive focusing' (Hammersley and Atkinson, 1990), whereby through this revision process key issues and themes emerged providing a framework for analysis.

The research design provided a loose structure for the collection of the data, informed as it was by previous research in the three areas; health coverage in programme and drama production, and the involvement of health professionals. It also provided a backstop when I was seeking to analyse the ethnographic data and detect emerging themes. The design did not constrain the collection of, or findings from, the ethnographic data, it sought to support the illumination of recurrent themes which informed the structure for the analysis of each of the relationship interfaces.

The process I followed to formulate a structure for the presentation of the data was to utilise my field notes and the documentary evidence to outline the opportunities for interaction with the three professional groups. I then used this data further to identify key themes and examples for illumination e.g. campaign plans were utilised to demonstrate the range and volume of professional involvement in campaigns.

What I will now outline is the approach I undertook to maximise the transparency of analysis and minimise the methodological blind-spots caused by the participant role undertaken. In doing this I will reflect on the nature of triangulation in relation to internal validity. As previously mentioned, inherent within the ethnographic approach is the difficulty of ensuring reliability and achieving internal validity, the former due to the reliance on the involvement of the researcher, in this case totally, and secondly due to the researcher analysing the data. One way that I sought to minimise this negative effect of my position as full participant was through the use of additional data sources to achieve a degree of triangulation.

Triangulation can be carried out in a variety of ways, via time, method, setting, researchers, organisation etc. In utilising the additional data sources available to me I sought to triangulate via time, method and researcher. Three additional data sources were utilised as outlined in Chapter Three (Figure 3, p72), one was a published article and two were contained as sections in the project's unpublished Final Report (1993). One source that was not collected by me focused on the nature of the partnership between broadcasters and health specialists. As previously stated this was conducted externally due to the nature of the sensitivity of my research position as overt complete participant.

The analysis of the relationship interface with health professionals was informed by documentary evidence collected prior to implementation to inform the nature of the consultation process, documentary evidence collected during implementation to outline the nature and volume of involvement, ethnographic data collected over the two years to inform all areas of the interface and finally a self completion postal questionnaire in the final year of implementation to illuminate their perception of their involvement. In this instance triangulation was possible over time and method.

For the interface with programme production, the analysis was informed by ethnographic data collected over the two years to inform all aspects of the interface, documentary evidence collected during implementation to inform the formal and informal interface with programme

producers and presenters, together with the volume and detail of the health coverage. This was further supplemented by interview data collected by an external researcher conducted during the final year of implementation, which provided an account of programme producers and station management experience of the project. In this instance triangulation was achieved over time, method and researcher.

Finally, for the interface with the drama production team, the analysis was informed by documentary evidence collected prior to implementation to inform the development of the formal and informal interface, documentary evidence throughout implementation to inform the changes in the interface, and ethnographic data collected prior to and during implementation to inform the nature of discussions and decisions made. This data was again supplemented by interview data collected by an external researcher conducted during the final year of implementation, which provided an account of the drama production teams experience of the project. Triangulation in this instance was possible over time, method and researcher.

It is not possible to provide concrete evidence that the data triangulation process that I incorporated guarantees anything other than low internal validity. I do believe, however, that the diversity of data sources used to allow triangulation enabled some check on the validity of the data analysis, but the true degree of internal validity is unknown. Further evidence would need to be ascertained using a method other than ethnography.

With regard to the research questions posed it is important now to draw on the salient issues and explore how they respond to the research objectives. For clarity I will now consider each question in turn. Firstly then to the question regarding the presence of a health promotion specialist within the broadcasting environment with the aim of influencing the orientation of health in the feature broadcast output.

The evidence collected at the interface with the Programme Production Staff indicates that the merging of the cultures of broadcasting and health promotion within a local radio environment can have positive outcomes, in terms of equity of partnership and quality of the broadcast product. Through the merging of the two professionals' skills, broadcast features can be produced that provide a positive orientation on health without detrimentally compromising the editorial values of the station.

The research evidence presented in Chapter Three to underpin this question outlined conflict between the two professional orientations, which was perceived to prevent positive health coverage. What was called for was collaboration between the two parties in order to achieve a positive outcome. At BBC CWR, the notion of health secondments to a radio station with an innovative approach to social action broadcasting, presented an opportunity to explore the notion of collaboration and put into place the structures recommended by the previous research; this structure also informed the development of the Listen To Your Heart project

As outlined in Chapter Seven there was little conflict experienced at the interface with programme production staff. The reasons identified incorporated the fact that the secondees were invited to join the station by the station management with the intention of training them as broadcasters, that they had a function to broadcast features rather than advise the production teams, and finally the secondees in effect increased the staffing levels.

The significance of these findings for health promotion specialists is the potential use of a BBC local radio station as a partner in the promotion of health, through the development of secondments to the station. This research demonstrates that this environment has the potential for such collaboration. Of further significance is the recognition that an educationally focused health promotion specialist can with supportive training develop relevant skills to operate effectively in using local radio as a vehicle for public education.

The significance for communication researchers is that the cultures of broadcasting and health promotion can combine at a local level in BBC Radio without detrimentally compromising the two professions' values. That it is possible to develop an equitable relationship within the broadcasting environment where the skills of the health promotion specialist are fully utilised and assisted in their development. Of further significance is the potential for influencing the health orientation of the feature broadcast without detrimentally affecting the two distinctly different professional orientations, while a person is in post to operationalise and sustain that focus.

The significance of this research data for broadcasters in local BBC Radio is the indication that the involvement of a health promotion specialist in programme production can produce good quality broadcast material without detrimentally compromising broadcasting standards and editorial control. The material also indicates the involvement of such a specialist can

support the production of quality speech output and also support their public service commitment, through the development of social action programming.

Evidence however is not available from this research on the scale of impact or significance of the influence on the health orientation of the broadcast material. Further research would need to be undertaken to identify this by conducting, say, a content analysis of the broadcast output of BBC CWR during the implementation phase of the strategy and another local BBC radio station in the region with a similar demographic breakdown. Similarly the significance for the audience of the approaches taken in the development of the health communication strategy remains unsubstantiated, and would be difficult to identify given the nature of how the strategy was operationalised. All health series and features associated with the strategy were surreptitiously blended into general programming which ran across the station's output, in order that health received the same programme status as news and current affairs.

One issue for consideration regarding the possible replication of such a strategy in another local radio environment is a unique element in the relationship. As the local radio station was new, the notion of the health communication strategy developed alongside the rest of the station output prior to going on air, drawing on the BBC training programme and building on experience gained in situ. As the strategy's existence was coterminous with the launch of the station it was also accepted as an integral part of the station.

The second area of empirical investigation is the relationship interface with the Drama Production Team, and whether it is possible to incorporate a radio drama into a media based health communication strategy without detrimentally affecting the values of the two professional groups. The evidence collected at the interface with the Drama Production Team indicates that the merging of the cultures of drama and health promotion highlights a range of professional differences in terms of orientation and operation, which was suggested in the previous research as outlined in Chapter One.

Whilst strategies were put in place to limit the cultural differences it was not possible to eliminate them. The main reason was that my role was to advise on the health content, not to produce or write the drama. In such a capacity my scope for influence was limited; it was not possible for me to adopt the culture of the drama, as was the case with programme production. As a result the conflict in professional values remained.

In seeking to implement the project professional compromises were made by both parties. The areas of contention focused on three key areas, the understanding of and orientation towards health issues, the notion of independence from external influences and the issue of organisational logistics.

One central area of significance that the data highlighted is equally relevant for health promotion specialists, communication researchers and broadcasters. The professional differences in the concept of health pervaded all aspects of the drama, from plot, through characterisation, to health and non health storylines. For the key problematic area to be removed, requires that time is taken for the partners to fully clarify their position regarding their understanding of health and how this is to be operationalised in the drama, from the outset. This needs to be supported by detailed discussion on what success and failure to achieve these objectives would look like and how they would be monitored and evaluated, and how necessary changes could be made during the period of implementation. Once this has been clarified then appointment of the drama producer and writer need to be undertaken jointly, based on their ability to deliver a product that meets the agreed requirements. If the aim of the drama is to meet both health and dramatic objectives then the funders cannot leave the ability to deliver the objectives to chance or to one partner.

A further area of significance identified by the data for both practitioners and researchers is the need for an overall management structure that oversees the variation in the organisational logistics of the various strategy components. This function would need to be conducted by someone free from direct delivery of the components, whose purpose was to promote synergy in the strategy's delivery, enabling others to concentrate on the actual delivery the outputs.

One additional area of significance from the data for health promotion specialists is the need to recognise that when the role of the health promoter is in an advisory capacity, in relation to contributing to script conferences, seeking to affect the professional practices of others, the opportunity for influence remains small.

What remains undetected by this research is the impact and significance of the drama as a trigger for listeners to further explore the health issues in the broadcast features. Collecting such evidence would necessitate both the radio station and the project being more established

from the perspective of the audience than was the case for this research phase. This evidence would be of significance if the intention was to replicate the strategy given that the incorporation of the drama in the strategy was costly, both in terms of finance and time taken to ensure the product fulfilled its' health promoting objectives. Similarly it remains unsubstantiated whether the predominant health focus of the drama was positive or negative. Identifying such evidence would necessitate a full content analysis of the 104 episodes, which was beyond the scope of this research.

The final area of empirical investigation undertaken by this thesis was the relationship interface with Health Professionals and whether it is possible to establish a media based strategy that enables and secures their involvement in the development of health programming. The research evidence presented in Chapter Three to explore this question identified conflict between health professionals and programme production teams. This centred around the inability of the health professionals to influence the broadcast output, demonstrating an inequity in the partnership and the division of labour, as they were frequently perceived solely to be the providers of back up services.

The existence of the health secondee with a remit to broadcast, and a commitment to incorporating health professional involvement in the output, provided an opportunity to put in place a structure to ensure their involvement, thus removing the potential for conflict as experienced in previous initiatives as outlined earlier. This was further developed within the context of the Listen to Your Heart project with the enabling, initiating and mediating role of the project officer. This resulted in the establishment of a complex time frame to enable their involvement in the campaigns, and as is demonstrated in Chapter Six, little conflict was experienced. The main reason why the potential clash of cultures was prevented was because I belonged to both cultures.

The evidence collected at the interface with health professionals indicates that with a health promotion specialist based within the radio station it is possible to develop a strategy that enables and supports their active involvement, in a way that recognises and values their expertise.

One area of significance from the data for communication researchers is the feasibility of negotiating health professional involvement through the development of a long lead in time to

enable their engagement. Of equal significance is the range of activities that they were invited, and felt empowered to, engage in; linked to this is the value those involved placed on their contribution.

Of significance for health promotion specialists and radio broadcasters is the net benefit of negotiating a long lead time for broadcast series and campaigns. The evidence suggests that the long lead-in time to secure active professional involvement, ensured comprehensive coverage and produced what was widely considered to be quality broadcasting. Thus good health promotion can result in good quality broadcasting.

Of research significance for communication researchers is the notion of external leverage obtained through the involvement of outside agencies. The evidence suggests that the existence of external accountability for the receipt of grant assistance, enabled the exertion of gentle pressure on partners when needed. Of equal importance is the need for the external body to possess the necessary skills and understanding to effectively reflect and support developments within the implementation of the strategy.

Finally what is of significance from the data for communication researchers is the main result of the health and broadcasting partnership through the secondment of the health promotion specialist. In the skill transference as the health promotion specialist combines the health professional knowledge and understanding with technical broadcasting skills, the health professional becomes a broadcaster. The research findings indicate a shift in the balance of power in the health promotion specialist's ability to influence the nature of the broadcast output and those involved in its planning.

A set model for utilising the media is unlikely to be found and this thesis does not attempt to provide it. What is required is to try new approaches that meet the needs of the local community based on available research evidence of effectiveness. If the target audience listen to the radio then this may be an appropriate vehicle to explore, as part of a comprehensive communication strategy. Panaceas are not to be found and neither are there generic breeds of broadcasters and health promotion specialists, as both professions draw from a wide range of disciplines. The professional contexts within which both operate are also subject to change and review.

The current climate for the commissioning and delivering of local health services, including health promotion initiatives is to operate within a multi-agency, or inter-sectoral context. The stimulus for this is the Department of Health document Government's White Paper *The New NHS: Modern and Dependable* (1998), which provides a new structure for the multi-agency commissioning of health services. This philosophy is further developed in the Department of Health's public health document *Saving Lives: Our Healthier Nation* (1999). The significance of these documents to this thesis is the emphasis on inter-sectoral collaboration, the merging of different professionals working towards common goals. This focus was central to both the development and implementation of the Listen to Your Heart project. It has also formed the basis for the empirical investigation into the relationship interface with the three professional partners.

What is of significance for future collaborative projects based on the findings from this thesis, is the necessity of a central player to provide the main co-ordinating effort. My role was central to the collaborative operation in that I interacted with each of the sectors, media, drama and health, acting as mediator and enabler (as outlined in Chapter Six). The success of such initiatives hinges on the ability of a dedicated person to be able to operate at each of the professional interfaces.

The re-organisation of most health promotion services nationally has resulted in the establishment of units which cover large geographical areas such as counties, with staff having wide geographical responsibility for certain health issues. Under such an organisational structure it would be feasible to identify an area of specialism to be that of co-ordinating media based health campaigns in conjunction with the local radio station. However under *The New NHS: Modern and Dependable* the funding of health services is to be very locally determined through Primary Care Groups. Whether they will see value in financially supporting countywide health communication strategies is however yet unknown.
Similarly the national body for health education the Health Education Authority, is currently undergoing a further organisational revision. Although the detail of its remit are unknown at the time of writing it is understood that it is to be re-established as a Health Development Agency, working closely with the NHS Executive, which is responsible for national and regional research and the development of health services.

From the broadcasting perspective the context that such recommendations for collaboration must be viewed are in relation to the BBC's establishment of Social Action Producers in each of its local radio stations. One aim is for them to link with national campaigns incorporating local and network television and radio, under the auspices of the recently appointed Editor of Social Action, which was a national appointment. The effect this will have on the involvement of local health professionals is uncertain.

In conclusion this thesis has sought to explore the research evidence for the development of a media based health communication strategy, for the promotion of public health. This strategy has been utilised as a case study for this thesis. In focusing on the implementation of the project three areas of empirical investigation were identified. When exploring the relationship interface of the three parties involved in the implementation of the strategy, questions regarding the implications of their involvement arise in relation to their professional norms and values. As a result of the investigation the evidence suggests that benefits can be gained in the partnership between broadcasters and health professionals, particularly if a health promotion specialist is in situ.

Appendix I

HEA Advertising Budgets 1988-92
(includes Media, Production and VAT)
13-2-91

	1988/89 (£000s)	1989/90 (£000s)	1990/91 (£000s)	1991/92 (£000s)
AIDS	4,000	6,200	4,400	4,100
LAYH	2,400	1,550	1,058	995
MMR	600	440	------	------
Immunisation	------	320*	1,500	900
Teenage Smoking	------	1,250	960	775
Passive Smoking	250	------	------	------
Skin Cancer	------	200	------	------
Dental	100	100	------	------
TOTAL	**7,350**	**10,060**	**7,918**	**6,770**

Appendix II

Health Promotion Secondment at BBC CWR

A Draft Outline

A secondee would offer ideas and be responsible for the research, production and possibly presentation of programme and features dealing with a wide range of health promotion issues (with printed backup material as and when necessary), including:

HIV/AIDS and sexually transmitted diseases,

Gynaecological problems

Sex Education

Screening for Breast Cancer; Cervical Cancer; Testicular Cancer etc.

Healthier approach to alcohol

Drugs and solvent abuse

Stopping smoking

Diet and nutrition

Incontinence

Menopause/ PMT

Parenthood

Stress and relaxation

Dental health

Alternative medicine

Hygiene

Food hygiene

Exercise

Sickle Cell Anaemia

Women's health

Child health

Immunisation

Healthy heart

Epilepsy

Tranquillisers

Diabetes

Safety in the home .....etc.

The secondee, by tapping resources and contacts in the Coventry and Warwickshire Health Authorities would also be responsible for programmes and features about people and organisations involved in the provision of health care, including:

Ambulance service

Blood transfusion service

Hospital volunteers/ League of Friends

District nursing teams/ health visitors/midwives etc.

Community Health Councils

Family Practitioner Committees

Pharmacies

GP services

Health centres/ community care

Speech therapy

Physiotherapy

Well-women clinics

There would also be scope for programmes or features detailing the day to day running of hospitals, and reflecting the wide social and cultural mix of staff and patients. Certain 'request' type programmes (including Outside Broadcasts) would provide a means for patients to pass on messages to friends and family 'on the outside'. The Hospital Radio Service would be offered the opportunity to participate.

Some Benefits

The secondee would receive BBC training in radio production (including full use of broadcast equipment) and develop skills that s/he would be able to pass on to colleagues.

S/he would be a media contact point for Health Authority personnel - especially in emergencies e.g. major meningitis outbreak or urgent appeals for blood donors.

It would enhance their personal development while they gain a greater understanding of the breadth of the Health Service.

Increased and sustained awareness of Health Promotion Services with 'knock on' benefit to the Health Authorities.

JL July 1989

Appendix III

Guidelines for Community Service Secondees with BBC CWR

Secondments to CWR from various public Service sectors are part of the station's commitment to community services in Coventry and Warwickshire. The sectors most appropriate are those whose functions involve and require a substantial level of direct communication with the public - to educate, explain, support, help, advise, encourage or entertain. We envisage that secondees will, for the duration of their association with CWR, bring background knowledge, skills, etc. from their particular public service sector and will consequently be able to assist CWR's Community Programmes Unit to identify and address needs and opportunities. In that way, the secondees will be able, through a direct involvement in programme-making, to extend the 'reach' of the service they represent further into the community. We anticipate, too, that secondees will return to their branch of public service with genuine benefits from their experience in local radio - enhanced knowledge of media activity, a basic awareness of radio skills, and, in some cases, a new perspective on communicating with the public. It may also be that there will be benefits through a number of the secondees from differing backgrounds working together on appropriate radio projects.

At all times during their association with CWR, secondees will remain the employee of the service from which they have been seconded, and it is accepted that they will continue to be bound by their employer's terms and conditions.

Unless otherwise agreed in advance, secondees will, during their involvement with CWR, be attached to the station's Community Unit, working under the direction and supervision of the Head of Community Programmes, who will agree training needs and direct programme projects. While every effort will be made to provide secondees with opportunities to develop public service broadcast material fully relevant to their skills and background knowledge, editorial control for all material broadcast or in any way associated with CWR remains with the station's Manager in his capacity as the Editor in Chief of local output. Secondees' broadcast material must also conform with the essential requirement of all CWR's programming in that it is balanced, fair, objective and free from personal political bias. Copyright of broadcast work remains with the BBC, but wherever possible, and particularly where material is likely to have a lasting application, secondees will be encouraged to take

recordings back to their public service sector at the end of their secondment - as in the case of a teacher returning to Education with recordings likely to be of use in the classroom.

Throughout their involvement with CWR, secondees will be expected to comply with all station requirements and disciplines concerning the operation of equipment, safety and security.

Out of pocket expenses incurred by secondees in the production of radio material will normally be reimbursed by CWR, but wherever possible these should be agreed in advance.

We strongly recommend that in all their dealings with the public during secondment, secondees make their position fully clear, i.e. that they are currently working with BBC CWR on secondment from their particular branch of public service.

While secondees are encouraged and largely expected to involve themselves in as wide a range of CWR activity as possible, it is station policy not to compromise a secondee in any way and to avoid situations which might involve a secondee in compromising his/her employer.

JL July 1989

Appendix IV

Health Soap Opera Project (Confidential)

In conjunction with North Warwickshire Health Authority, and with the possible backing of the Health Education Authority, BBC CWR is exploring the possibility of mounting a major health education initiative which would be based around a radio soap opera.

Ideally written by local actors and performed by local actors, the soap opera would in itself a piece of fictional radio drama. It would, however, serve as a catalyst to a wide variety of initiatives promoting health education and better health. The prime concern would be the promotion of heart health and the prevention of coronary heart disease.

some of the initiatives would take the form of features and campaigns in other CWR programmes. There would also be off-air activities such as a counselling service, and associated literature. It is possible, too, that if a local theatre group were involved the radio scripts could be adapted for stage performances in schools and church halls extending the promotion of health education still further into the community.

At the centre of the project's concern with health issues would be the objectives of the 'Look After Your Heart' campaign as reflected in the lifestyle health needs of the people of Coventry and Warwickshire. There would, however, be ample scope for addressing other health issues in terms of both personal and environmental health. There would be scope , certainly, for the soap opera to touch on topical matters such as an outbreak of illness or food poisoning, preventive measures, AIDS and so on.

The soap opera would be fictional. As with any piece of drama it would require strong storylines consistently capable of engaging and holding audience attention. Its characters would require full credibility, and it would, to be fully effective, require professional writers and actors working to an experienced editor/producer.

It would probably be abased around the everyday comings and goings at a health centre. At present it is envisaged that it would take the form of two 15-minute episodes broadcast each week, with a 30- minute omnibus edition at weekends.

It would probably be abased around the everyday comings and goings at a health centre. At present it is envisaged that it would take the form of two 15-minute episodes broadcast each week, with a 30- minute omnibus edition at weekends.

And while fully addressing the artistic concerns outlined above, the soap opera, together with associated initiatives, would be the means of enhancing public interest in health matters, of extending health knowledge, of making the public more aware of the health 'choices' available to them, and, above all, of promoting better health.

Clearly, while it will be important to achieve a fully convincing, quality product so far as the soap opera is concerned, it would be of equally high priority to maintain impeccable authority and accuracy on all health matters.

To help achieve the former, Jock Gallagher, a senior figure in BBC Radio production for the past 20 years, will act as a consultant during the first year of the project. BBC facilities, probably at CWR, will be used for the production activity.

Ensuring complete accuracy throughout the project will be the responsibility of a Project Officer, provided from the funds available to the project. The Project Officer will arrange full medical consultancy for the soap opera writers/actors and will liaise with CWR in the organisation of back-up programme activity, possibly a weekly family lifestyle programme, awards for health initiatives, and an off-air Heartline service, giving advice and information. The Project Officer would also organise support literature and publicity.

The project would run for three years from mid 1990. At current prices, it is calculated that the soap opera would cost £50,000 pa, this sum covering scriptwriting, actors, and production. Cost of the full-time Project Officer, technical and clerical support, and resources for associated off-air activities is calculated at a further £30,000 pa. Project evaluation would cost a further £5,000 pa. The total annual cost at current rates therefore would be £85,000. If successful, an approach to the 'Look After Your Heart' campaign would generate £50,000 pa. for three years, leaving a further £35,000 pa. to be raised from other local sources. A decision on the approach to LAYH is expected by early February.

MM December 1989.

Appendix V

'LISTEN TO YOUR HEART' PROJECT ANNUAL COSTS AND SOURCE OF FUNDING

(At 1990 Prices)

Source Of Funding

	Health Education Authority	District Health Authority	BBC
Project Officer	£18,300		
Administration/ Project Secretary	£7,300		
Equipment and Running Costs		£1,000	£4,000
Materials		£1,000	
Writer	£5,000		
Producer			£7,000
Seconded Health Promotion Officer		£15,000	
Actors	£19,400		
TOTAL = £78,000	**£50,000**	**£17,000**	**£11,000**

Appendix VI

LTYH QUESTIONNAIRE : CONSULTATION WITH HEALTH PROFESSIONALS

Please provide the following information:

Title of your post/position

.....

Name of your organisation

.....

District (if relevant)

.....

1. **What kind of involvement have you had with the LTYH project? Tick as appropriate.**
   ---- Participation in initial consultation meeting,
   ---- Planning in relation to a particular health topic,
   ---- Specific contribution e.g. script research, selection of contributors, interviews,
   ---- Participation in media training day.

2. **If you have been involved in the planning of a particular health topic, please indicate which health topic(s) this was and then tick whichever activities apply to that topic.**
   Health Topic (1) ----------
   ---- attend planning meeting,
   ---- select off-air support materials for information packs,
   ---- prepare/write off-air support materials for information packs,
   ---- identify people to be interviewed,
   ---- provide background information for interviews,
   ---- contribute on-air (e.g. interviews),
   ---- provide research for scripts, either written or oral,
   ---- arrange back-up events (e.g. community classes),
   ---- organise staffing for phone-ins,
   ---- other (please specify) .....
   Health Topic (2) ----------
   ---- attend planning meeting,
   ---- select off-air support materials for information packs,
   ---- prepare/write off-air support materials for information packs,
   ---- identify people to be interviewed,
   ---- provide background information for interviews,
   ---- contribute on-air (e.g. interviews),
   ---- provide research for scripts, either written or oral,
   ---- arrange back-up events (e.g. community classes),
   ---- organise staffing for phone-ins,
   ---- other (please specify) .....

3. **How much time would you say you have spent overall in planning/preparation/delivery of the above health topic(s)?**

Topic 1	**Topic 2**
---- 0 -2 hrs	---- 0 - 2 hrs
---- 3 - 5 hrs	---- 3 - 5 hrs
---- 6 - 10 hrs	---- 6 - 10 hrs
---- more than 10 hours	---- more than 10 hours

4. **Which of the following best describes how your main work relates to your involvement in the LTYH project? Tick <u>one</u> as appropriate.**

   ---- involvement with the LTYH project is an integral part of my job,

   ---- involvement with the LTYH project is complimentary to my general work responsibilities,

   ---- involvement with the LTYH project is incidental to my work role.

5. **Is involvement with the LTYH project formally written into your job remit? Tick as appropriate.**

   ---- Yes ---- No

6. **Has your involvement with this project been helpful to you in any of the following ways? Tick whichever apply.**

   ---- established new contacts with other professionals,

   ---- developed a better understanding of the potential of the media for my work,

   ---- gained useful experience of working with the media,

   ---- developed my skills in producing health information on complex issues, in a form suitable for broadcast,

   ---- extended my knowledge of a particular health topic.

7. **Have there been any other benefits to you, in your professional role, as a result of your involvement in this project? Tick as appropriate.**

   ---- Yes ---- No

   If yes, please indicate what these have been.

   ---

8. **From your experience in this project, would you say that it is a worthwhile means of reaching the public with health information? Tick as appropriate.**

   ---- Yes ---- No ---- Unsure

9. **Do you consider your involvement in the LTYH project to be an effective use of your time? Tick as appropriate.**

---- Yes ---- No ---- Unsure

10. What have you most valued about the approach taken in the project to involving professionals in the planning and delivery of health broadcasting?

---

11. Do you have any suggestions about how professionals could make an effective contribution to this project?

---

12. Has your involvement in this project influenced your view of the potential role of broadcasting in your work? Tick as appropriate.

---- I have already made further use of broadcasting in my work,

---- I plan to do so in the near future,

---- I would consider doing so,

---- I do not see any scope for using broadcasting in my work,

---- I am not happy about the idea of using broadcasting in my work.

13. Have you made use of the off-air materials developed as part of this project, in other ways?

---- Yes ---- No

If yes, please indicate how you have used them.

---

14. Are there any other comments you would like to make about your experience of being involved in the LTYH project?

Thank you for co-operation.

Please return this questionnaire to : Ms Jill Canning, Medical Audit Assistant. BY 26TH JUNE 1992

Appendix VII

AGENCIES REPRESENTED AT FORMAL CONSULTATION MEETINGS

Leisure Services: North Warwickshire Borough Council, Nuneaton and Bedworth Borough Council Coventry City Council, Stratford District Council, Warwick District Council

Education Department: Warwickshire, Coventry

Sports Council: West Midlands

Henley College, Coventry

Psychology Service: South Warwickshire Health Authority, North Warwickshire Health Authority

Dietetic Service: North Warwickshire Health Authority, South Warwickshire Health Authority Rugby Health Authority, Coventry Health Authority

Physiotherapy Service: North Warwickshire Health Authority, South Warwickshire Health Authority Rugby Health Authority, Coventry Health Authority

Community Health Council: North Warwickshire, South Warwickshire, Coventry

Women's Health Network

Standing Conference of Women's Organisations

Alcohol Advisory Service

CRUISE: North Warwickshire

St. Barnabus Centre, Coventry

Sports Advisory Centre

Health Promotion Service: North Warwickshire Health Authority, South Warwickshire Health Authority, Rugby Health Authority, Coventry Health Authority

Smoking Cessation Tutors: North Warwickshire, South Warwickshire, Coventry

Look After Yourself Tutors: North Warwickshire, South Warwickshire, Coventry

Family Health Services Association: Warwickshire, Coventry

Local Medical Committee: Warwickshire, Coventry

British Medical Association: North Warwickshire

Local Pharmaceutical Committee: Coventry

Public Health Department: Coventry

General Management Team: North Warwickshire Health Authority

Environmental Services: Nuneaton and Bedworth Borough Council, Coventry City Council, Stratford District Council, Warwick District Council

Appendix VIII

ISSUES RAISED DURING CONSULTATION MEETINGS FOR INCLUSION IN COMMUNICATION STRATEGY

Exercise and Leisure

- Target Groups: young people, women, pre and post natal exercise, older people
- screening and motivation
- formal/informal exercise, activity levels and intensity
- access to facilities, information, personnel and environment
- regular activity vs one off
- stress and relaxation
- health in the workplace
- fitness testing
- weight reduction and smoking cessation
- sporting events
- school and PE - leisure education, active lifestyles
- clubs available
- access and available transport facilities
- the benefits of exercise

Dietetians

- diet during pregnancy, preconception, breast/bottle feeding and weaning
- diet, teenagers moving away from home
- middle age, consequences of health screening, coronary heart disease, alcohol, obesity
- preparation for retirement, issues that concern diet, osteoporosis, arthritis, hypothermia, diabetes
- cooking for one, food costs
- vitamin supplements, food allergies
- weight reduction

Voluntary Services

- Sport as therapy for health - social contact, to aid weight reduction and fitness, to prevent ill-health and aggression
- Death - taboo subject, CRUISE to provide social contact and counselling service, drop in centre and groups, attitude to death in work situations, emotional and social issues, grandparents moving in
- Other loss - miscarriage, prenatal death, childlessness and abortion
- Elderly- fear of falling and not being detected, sheltered accommodation
- Alcohol - sensible drinking rather than severe abuse, prevention rather than cure, misdiagnosis by GP, role of alcohol in business entertainment

- Parents - stress, depression, single parents, stress and unemployment, long distance commuting.

Health Promotion

- care in the community
- communication of GPs
- screening
- recognition of family groupings other than nuclear
- retirement
- life events
- rural deprivation
- employment and health

Environmental Health

- Food control and food safety: new responsibilities and duties (Food Safety Act 1990), sampling of foodstuffs for bacteriological and chemical analysis, food poisoning, problems with home catering, food hygiene training, unfit food, closure of premises
- Health and safety: safety in the workplace, accidents at work, satisfactory work conditions/environment, control of substances hazardous to health, smoking and alcohol policies, training courses run by local authorities
- Housing: Bed-sits and houses in multiple occupation, unsatisfactory housing conditions- dampness, leaking roofs, lack of modern amenities, improvement grants, landlord/tenant relationships, caravans- residential, touring
- Environmental protection: enhanced pollution control, industrial emissions, litter, contaminated land - methane gas problems
- Public health in general: health education - health and safety, home safety, water supplies - chemical and bacteriological quality of drinking water, recreational waters - blue/green algae, Weal's disease

Appendix IX

MARCH INTO FITNESS CONTENT OF CAMPAIGN

In outlining the components of this campaign the breadth and duration of content will be evident.

1. DURATION

One calendar month

2. HILLCREST STORYLINE

Several characters made reference to either exercise or weight reduction, though none were involved in any real detail. A young single mother embarked on an exercise programme in an attempt to get out of the house and lose weight. A young couple went swimming. Reference was made to one partner of an older couple teaching the other to play indoor bowls' in an attempt to distract her from a recent animal loss.

3. AGENCIES INVOLVED

- Sports Development Officers from District and City Councils
- Health Promotion Officers (Heart Health)
- National Coaching Foundation
- London Central YMCA Training and Development Unit
- West Midlands Sports Council
- Community Dieticians
- Women's Health And Information Service

4. FEATURE FORMATS

A wide range of formats were used throughout the month from pre-recorded packages through to live exercise programmes and outside broadcasts. In order to instil a degree of continuity, the series was divided into two main constituents and hosted by two main presenters. The exploration of weight control was undertaken in the Breakfast programme whilst the uptake of exercise was covered in the Mid-Morning entertainment programme. This did not, however, preclude other programmes from covering features throughout the month.

A. BROADCAST OUTLINE - WEIGHT CONTROL

I. Breakfast Programme

Week 1

Tuesday - The Real Problem Of Weight Control live interview with Professor Garrow (who devised the Body Mass Index Chart).

Thursday - Body Image - package of women's views on society's pressure to conform to a particular body shape followed by live interview with local health promotion consultant.

Week 2

Tuesday - Eating Disorders - package of women's experiences of eating disorders followed by live interview with the leader of a local group (Women's' Health and Information Services).

Thursday - Pressures Against Change In Dietary Behaviour - live interview with local community dietician.

Week 3

Tuesday - Food Choices And Meal Patterns - live interview with Project Officer.

Thursday - Fads And Diets - live interview with local community dieticians.

Week 4

Tuesday - Low Fat Low Calorie Products - pre-recorded package with Project Officer and student dietician at supermarket.

Thursday - Weight Maintenance - live interview with Project Officer.

II. Lunch-time Programme

Week 1 Weight Watchers - pre-recorded packages plotting the developments of
& a young mother who went to weight watchers.
Week 3

B) BROADCAST OUTLINE - <u>THE UP TAKE OF EXERCISE FOR THE NON-EXERCISER</u>

I. Mid-Morning Programme

Week I

Monday - Safety In Exercises - live interview with Director of Training and Development, London Central YMCA.

Tuesday - Exercise For The Non-Exerciser - Live interview with reporter. Allocated exercise tasks to complete and feedback into the programme throughout the month.

Thursday - Circular Walks - pre-recorded package of reporter plus local leisure service staff exploring local walks. Followed by live interview with both parties.

Week 2

Tuesday - Aquacise - pre-recorded package of reporter participating in the class. Followed by live interview with reporter and teacher.

Thursday - NCVQ - live interview with Senior Officer, National Coaching Foundation, exploring the benefit to the consumer of this planned development.

Week 3

Tuesday - Trim Trails - pre-recorded package of reporter plus local centre manager exploring outdoor trim trails. Plus live interview with both parties

Thursday - Cycling - pre-recorded package of reporter plus cycling club member. Followed by live interview with both parties to include discussion regarding favoured activity.

Week 4

Aerobics Live On Air - conducted by Project Officer and Presenter with daily guest clubs

Monday	Warm-Up and Pulse Raiser Component
Tuesday	Stretch Component
Wednesday	Aerobic Component
Thursday	Strength Component
Friday	Whole Component and Stretch

II. Afternoon Programme

Week 4

March Into Fitness Road Show - outside broadcast dedicated programme in North Warwickshire in conjunction with Leisure Services, Health Promotion and Environmental Services. To encompass:

- Air-obics - outdoor class
- Body MOT
- Bear-obics - outdoor class for children + bear
- Aquacise - in the pool
- Gentle Extend - exercise class for older people
- Free aerobic or swim session was awarded to each person going through the Body MOT

5. COMPETITIONS

a) Breakfast Programme

In order to promote the availability of restaurants offering healthy choices, prizes of dinner/lunch for two were offered each week in restaurants who had been given the 'Heart Beat Award', i.e. William IV - Coventry; Baddesley Clinton (National Trust) - Knowle; Pilot Inn - Coventry; Falcon Inn - Priors Marston. Prizes were donated free of charge. In order to win, listeners had to ring in and answer several nutrition-based questions.

b) Mid-Morning Programme

In order to assist those who prefer to exercise at home, YMCA Exercise Videos were given as prizes by the YMCA. Ten each of Fat Burner, Y Plan, Exercise In Pregnancy. Throughout the month listeners had to ring in and answer several exercise-based questions.

c) Coventry Health Link

A joint competition between BBC CWR and Coventry Health Link. A question relating to components of fitness was asked, Readers were invited to write into CWR with their answers. BBC Enterprises donated a Rosemary Conley Video.

6. PHONELINES

Phonelines were available following each feature on weight control throughout the month. These ran for two hours and were staffed by local community dieticians and the Project Officer.

- Phone calls received: Nutrition 27, Exercise 21

7. INFORMATION PACKS

The pack consisted of the following:

- **Exercise**

How Do I Choose A Good Class	-	Sports Council
Safe Exercise	-	Sports Council
Women's' Week 8th - 14th March	-	Nuneaton and Bedworth DC
Women's' Activity Week	-	Coventry City Council
Circular Walks	-	Nuneaton and Bedworth DC
Exercise Why Bother	-	Health Education Authority
Eric and Anne's Exercise Plan*	-	To accompany the aerobics on air

- **Weight Control**

Lose A Few Pounds - How To Choose A Slimming Club*	Local Dieticians
Lose A Few *Pounds* - The Eating Habit*	"
Hillcrest Cookery Book*	"
Enjoy Healthy Eating	HEA
Healthy Eating Fact Sheet	"
Weight Loss and Control Fact Sheet	"

**Leaflets produced specifically for this campaign*

- **Distribution**

CWR Listeners	89
Phone-off Requests	27
Letter Requests	5
Aerobics Plan	21
North East Warwickshire Community Health Paper "Health Matters"	54
Coventry H.A. Community Health Paper "Coventry Health Link"	80

8. ARTICLES IN PRESS

Articles promoting the campaign and advertising the information pack were included in North-East Warwickshire Health Authority's community health paper 'Health Matters' and Coventry Health Authority's community health paper 'Coventry Health Link'. Articles covering the Roadshow in North Warwickshire were in 'The Tribune'.

SUMMARY OF CAMPAIGN ACTIVITIES Appendix X

DATE	ISSUE	HILLCREST STORYLINE	FEATURE FORMAT	AGENCIES INVOLVED	INFO PACK	PHONE LINE	COMMUNITY ACTIVITY	ARTICLES IN PRESS
December 90	**Teenage Pregnancy**	Young single teenager becomes pregnant. Difficulties occur as she decides what to do and who to tell.	30min Documentary "Why?" Exploring the effect pregnancy has on young women's lives. Live 1hr. outside broadcast (OB) Debate - "How appropriate is sex education in schools"	Coventry Education Home Tutoring Service, Local School Teachers, Sex Education Specialists, George Eliot Hospital, Health Information Skill Store.	Leaflet giving information on parent advice lines, young peoples advice line, young peoples family planning sessions, details of parenting courses**	Yes	None	None
January 91	**Care of Older People**	An older woman becomes more dependent upon her family, due to a stroke. The storyline focuses on the issues faced by carers.	Week long series consisting of packages exploring care in the community, and peoples reactions and expectations of old age. 1 hour live debate "Who cares about older people?"	CWR Community Programme Unit, Age Concern, Pensioners Action Group, Coventry Social Services and North Warwickshire Health Authority.	None	Yes	None	None
March 91	**Sports Injury**	Male character incurs injury during one-off squash game	Live discussion "Who cares about Sports Injuries?"	Sports Physiotherapist, David Moorcroft and Henley College.	Leaflet giving details of local sports physiotherapy clinics.**	None	None	None

DATE	ISSUE	HILLCREST STORYLINE	FEATURE FORMAT	AGENCIES INVOLVED	INFO PACK	PHONE LINE	COMMUNITY ACTIVITY	ARTICLES IN PRESS
April 91	**Panic Attacks**	Strong successful woman starts experiencing strange panic sensations. Focuses on how these develop and how she deals with them.	1 hour documentary "When fear takes over."	Psychology Services, Relate, Phobic Action and SHARE.	Leaflets of local support groups, self help groups, statutory services, private councillors and available books**	Yes	Stress Management courses.	Yes
May / June 91	**Maternal Health**	Explores young mother's adaptation to pregnancy, access to welfare benefits, housing, pressure of finance, appropriation of health care.	Series of 15 min packages and 15 min discussion on health in pregnancy, finance and pregnancy, choices in labour and changes the birth brings.	Community Programme Unit, Women's Health and Information Centre, George Eliot Hospital, La Leche League and the National Childbirth Trust.	None	None	None	None
June 91	**Alcohol**	Young man encountering problems with his relationship due to excessive drinking.	Week's series throughout station output exploring Young People and Alcohol. Debate "Aren't Teachers wasting valuable resources Teaching Young People about Safe Drinking Unless Adults Change Their Drinking Habits?" Drink Driving and Domestic Violence.	Community Programme Unit, BBC CWR Action Desk, Alcohol Advisory Service, Health Promotion and Road Safety.	Selection of Leaflets on specific groups and alcohol. Audio cassette produced in Asian languages.	Yes	Jingle competition conducted in schools. Drinkwise activities.	Yes

DATE	ISSUE	HILLCREST STORYLINE	FEATURE FORMAT	AGENCIES INVOLVED	INFO PACK	PHONE LINE	COMMUNITY ACTIVITY	ARTICLES IN PRESS
June 91	**Headlice**	Medical Centre receptionist encounters fraught mother who's child has headlice.	Live feature of young school children singing the "Headlice Song"	Community Programme Unit, Health Promotion, Warwickshire Education Department.	Leaflet providing facts about headlice and action to be taken**	None	Launch of Headlice Strategy, North and South Warwickshire.	None
September 91	**Heart Health 1. Coronary Pulmonary Resuscitation (CPR)**	Middle aged man encounters second heart attack. Story line follows his rehabilitation and focuses on behaviour change.	Live interview with police on CPR. Series on attending First Aid Course.	St John's Ambulance Warwickshire Police	Details of CPR and First Aid courses.	Yes	First Aid Courses.	
	2. Rehabilitation		Live interview with Angina sufferer followed by discussion	Health Promotion County Education Department	Details of local classes	No		No
	3. Food for the Heart		Month's live and recorded features and debates putting healthy eating into the context of people's lives, ie poverty, access, role of government, etc. Live demonstration OB Competitions and Quizzes.	Dietitians Environmental Services	Low Budget cookery book	Yes (English and Asian)	Food for the Heart Activities Budget Cookery classes	Yes

DATE	ISSUE	HILLCREST STORYLINE	FEATURE FORMAT	AGENCIES INVOLVED	INFO PACK	PHONE LINE	COMMUNITY ACTIVITY	ARTICLES IN PRESS
November 91	**4. Smoking Cessation**		Week's series of live and pre-recorded interviews exploring methods of giving up smoking. Plus the impact of the EEC regulations.	Community programmes Unit Quitline Health Promotion	Booklet on alternative therapies to giving up smoking**	Yes	Smoking Cessation Courses	Yes
December 91	**Back Care**	Middle aged man experiences back pain, as a result he loses his job. Storyline follows his progress from GP to therapist.	Week's series of live and pre-recorded packages and OBs focusing on aspects of back care, exercise and furniture.	Physiotherapists, National Back Pain Assoc, Henley College, Chiropractors, Osteopaths, Reflextherapists	Details of local back care classes. Booklet on back care. Leaflets on activities and back care.	Yes	Back care classes Chiropractic sessions.	Yes
	Domestic Violence	A violent scene erupts as the stress of a declining business affects the husband who blames his wife.	Live interview discussing stress, Christmas and violence.	Community Programmes Unit, Alcohol Advisory Service, Walsgrave Hospital.	None	Yes	None	None

DATE	ISSUE	HILLCREST STORYLINE	FEATURE FORMAT	AGENCIES INVOLVED	INFO PACK	PHONE LINE	COMMUNITY ACTIVITY	ARTICLES IN PRESS
January 92	**Housing and Health**	Young single mother in search of appropriate accommodation.	15 min report on hidden homeless. Live interview.	Social Services, Community Programmes Unit, District and City Council Housing Departments.	Details of local voluntary and statutory services available to assist in securing accommodation**	Yes	None	None
February 92	**HIV**	Heterosexual couple face dilemma of whether to have HIV Test following contact from GU Clinic regarding the woman's previous partner.	15 min live discussion 'To Test or Not to Test'	HIV Advisors, Health Promotion Officers, Terence Higgins Trust, Association of British Insurers.	Details of local counselling services; national services; the HIV test; use of condoms; **	Yes	Local roadshows Theatre Performances, Music Events	Yes
February 92	**Domestic Violence**	Following a succession of violent outbursts, the man is given an ultimatum to get help or leave.	30 min documentary 'Anger, Power, Regrets, Excuses. Why Men Abuse' followed by 20 min live discussion.	Community Programmes Unit, Home Office, PAX, MOVE, Clinical Psychology.	Details of local help lines and services for women; national help lines and organisations for men**	Yes	None	None

DATE	ISSUE	HILLCREST STORYLINE	FEATURE FORMAT	AGENCIES INVOLVED	INFO PACK	PHONE LINE	COMMUNITY ACTIVITY	ARTICLES IN PRESS
March 92	**Health Related Fitness**	Young Single mother decides to take up aerobics to loose weight and make social contacts. Young couple go swimming.	Months series of live and packaged interviews on exercise and weight reduction, daily broadcast exercise class plus outside broadcast of health fair.	Leisure Services Health Promotion Sports Council National Coaching Foundation, YMCA Local exercise Groups, Local Sports Association.	Details of local exercise services, Ways to Reduce Weight**	Yes	Women's Activity Week: Cross district exercise initiatives for women.	Yes
May 92	**Menopause**	Woman experiences difficulty in finding relevant advice on HRT to cope with her mood swings etc.	15 minute montage 'It's too damn hot' followed by 10 minute interview.	Women's Health and Information Service, CWR Community Unit.	Details of local counselling services, self help groups, booklet 'Living with the Menopause'	Yes	None	None
June 92	**General Health**		Hillcrest versus Archers Quiz.	Leisure Services, Health Promotion, Alcohol Advisory Service.	Copies of all packs available	No	Royal Show Health Roadshow.	Yes
June 92	**Health in Old Age**	The marriage of an older couple and the affect that has on the rest of the family.	Dedicated two hour programme 'A Celebration of Old Age'	Help the Aged, Age Concern, Health Promotion.	None	No	None	No
September 92	**Domestic Violence**	The violence continues. The decision for her to leave is finally made when raped by her partner.	Live 1 hour debate 'But she could have left'	Campaign Against Domestic Violence, Workers for Change Committee. CWR Community Unit Police Service, Home Office.	Details of local services available to support women in violent relationships. Information on legal services. **	Yes	Campaign meeting and local march.	Yes

DATE	ISSUE	HILLCREST STORYLINE	FEATURE FORMAT	AGENCIES INVOLVED	INFO PACK	PHONE LINE	COMMUNITY ACTIVITY	ARTICLES IN PRESS
September 92	**Racial Harassment**	Young Asian Man is subjected to racial harassment at work, this is compounded by his father's refusal to accept his relationship with a white woman.	Vox Pop and live interview.	Community Relations Council, Hindu temple, Health Promotion.	No	No	No	No
Sept / October 92	**Drug Education**	Two brothers use solvents during the summer holidays. Problems occur when one uses it to escape from the arguments at home.	Live debate 'Young People and Drugs' in local school. Packages Coventry Drugs Services, Drug Education in Schools.	Education Department, Community Drugs Team, Health Promotion, Radio 1 FM.	Details of local services for young people and parents. Information on drugs for young people and parents. Teaching pack: to accompany the videoed drama.	Yes	Hillcrest drama tour of schools, supported by workshops. Conference for young people on drugs.	Yes
November 92	**Stress**	Young woman takes on full employment against the wishes of her partner, guilt is increased as she sees little of her children. This is compounded by a disorganised manager.	Months series consisting of live interviews and packages explaining various aspects of stress and our responses.	Psychology departments, Manchester University, Health Promotion.	Details of local relaxation and stress management courses. Booklet on 'Stress Management and Assertiveness'**	Yes	None	Yes
**	Booklets, leaflets, activities or courses specially produced for the project.							

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