



## Speaking Back

**Abstract** In this chapter, we consider how the public or certain publics were able to ‘speak back’ to public health, to challenge its practices and ideologies. We focus on three types of speaking back. The first involved resistance. This could be active, as in the rejection of public health initiatives, or more passive, such as hesitancy or reluctance to engage. The second form of speaking back consisted of complaints made to public health authorities. These included complaints about being surveyed and complaints made to local public health officials. The third form of speaking back involved reinterpretation or appropriation of public health recommendations and communications by sections of the public. We argue that the public, or at least parts of it, in specific contexts, had agency.

**Keywords** Resistance · Complaint · Surveys · Health education · Vaccination · Lay epidemiology · Coronary heart disease

The public in post-war Britain was not an inert object. Members of the public, as individuals and as groups, could ‘speak back’ to public health authorities. In this chapter we examine the various forms that speaking back could take, and the scenarios in which this took place. We focus on three principal types of speaking back. The first involved resistance, whereby members of the public deliberately opposed or reacted against public health

policies and practices. Such resistance could be active, as, for example, in anti-vaccination campaigns. Other kinds of public resistance could be more passive, encompassing reluctance or hesitancy to engage with public health initiatives. The second form of speaking back can be found in complaints made by the public to public health authorities. These included complaints about being surveyed and complaints made to local public health officials. The third type of speaking back involved reinterpretation or appropriation of public health recommendations and communications by sections of the public. Some members of the public were able to turn public health messages on their head, and present different interpretations or readings of these. By focusing on three areas we are excluding some other forms of speaking back. These include instances where the public made specific demands for public health initiatives like vaccination or screening (Millward 2017a; Lowy 2011). Such demands aligned with the goals of public health policy and practitioners, even if they were not realised at the time. In this chapter, we are interested in how the public offered a challenge to the practice of public health and its outlook.

All of these different types of speaking back indicate that the public, or at least certain parts of it, and in specific contexts, had agency. In this chapter we examine the settings and scenarios where the public was able to speak back. This encompasses public responses to public health practices like vaccination and the survey, as well as the different ways in which the public engaged with health education. We also pay attention to who was doing the speaking back. Often, the publics most able to speak back to public health were those in the most privileged social position. Middle-class white men, for example, were more likely to complain about being included in public health surveys than other social groups. Yet, speaking back can be found among more marginalised groups too. Women, and particularly mothers, were heavily involved in resistance towards vaccination. Working-class responses to health education messages about Coronary Heart Disease (CHD) displayed a reluctance to take these entirely at face value. Young people were able to actively reinterpret anti-drug campaign materials. Public health practitioners and policymakers, then, encountered a public that was far from inert.

## 1 RESISTANCE

Public resistance, or the refusal to accept or comply with public health practices and policies could be characterised as either ‘active’ or ‘passive’. Active

resistance involved the visible rejection of initiatives such as vaccination or refusing to participate in public health surveys. Yet, the public also engaged in more passive ways of resisting public health authorities. This included being slow to take up programmes like vaccination or being reluctant to talk to surveyors. The distinction between ‘active’ and ‘passive’ resistance was often blurred, but such a categorisation draws attention to some of the recognisable and less obvious ways the public opposed different public health initiatives.

### *1.1 Active Resistance*

Active resistance towards immunisation was nothing new in the field of public health. Objections to these procedures in Britain go back to the introduction of inoculation in the eighteenth century (Eriksen 2016). Once variolation and, later, vaccination were brought into local and national public health programmes during the nineteenth century, older concerns about scientific, economic, cultural or religious validity persisted. Objections became openly framed around the political consideration of the rights of the individual versus the need to protect the collective (Colgrove 2006). This became increasingly fraught after the introduction of compulsory vaccination in 1840. The Anti-vaccination League and protests associated with the movement led to the end of compulsory vaccination by the close of the nineteenth century (Durbach 2005).

This legacy made successive twentieth-century British governments hesitant to impose immunisation upon the population. For example, during the Second World War the diphtheria immunisation programme was based on advertising, education and persuasion. It was successful in combating the disease, despite lobbying from anti-vaccination and anti-vivisection groups. These organisations claimed that diphtheria immunisation did not work, was unsafe, should not be imposed on parents, was a waste of taxpayer’s money, and relied upon manufacturing techniques that were cruel to horses (Correspondence and ephemera). Parents nonetheless presented their children for the procedure in large numbers. Partly this was because they feared the effects of the disease, a well-known hazard in the 1940s. Also, as the programme progressed, it became clear both through official statistics and lived experience that diphtheria was becoming less common, immunised children were less likely to get the disease, and, if they did, they were much more likely to survive it. The response from parents, coupled with the legacy of nineteenth-century anti-vaccination sentiment, meant

that in 1948 the Vaccination Acts were repealed and future immunisation schemes were based on central government funding, education and persuasion rather than compulsion. By the time pertussis (whooping cough) and poliomyelitis vaccinations were added to the national vaccination schedule in the 1950s, anti-vaccination organisations had little reach.

While blanket anti-vaccinationism may not have concerned the Ministry of Health and its successors in the post-war period, campaigns against specific vaccines during moments of crisis did emerge. In the 1970s, reports that the pertussis vaccine might cause brain damage led to a significant decrease in uptake (Baker 2003). As parents made a conscious choice to avoid the vaccine, the campaign led by the Association of Parents of Vaccine Damaged Children successfully lobbied for social security payments to children where it could be shown that a vaccine probably led to serious disability. While the initial catalyst for the campaign had been reports of brain damage, it gained traction in the specific political climate of the 1970s. Parental trust in the medical profession had been dented by the thalidomide scandal. Moreover, debates over social security and collectivised risk for vaccine damage were magnified by the ongoing financial crisis and examinations of the viability of a comprehensive welfare state (Millward 2017b). The measles-mumps-rubella vaccine (MMR) crisis at the turn of the millennium was similarly a product of its time. Reports that MMR might cause autism—and that the government or medical profession might have made fatal mistakes—were believable following the scandals around bovine spongiform encephalopathy (BSE, or ‘mad cow disease’), contaminated blood, Alder Hey hospital and Bristol heart operations (Hargreaves et al. 2003). With both pertussis and MMR, new approaches to communicating with the public helped the government promote the mounting evidence that the vaccines were safe and that the science underpinning the vaccine-sceptic claims was flawed. But uptake took many years to recover, leading to outbreaks of the diseases that were significantly larger than if vaccination rates had remained at pre-crisis levels (Dobson 2008; Baker 2003).

A new feature of anti-vaccinationism from the 1990s onwards was the ability to form and mobilise internet communities, which were able to disseminate their literature to a much wider audience than was previously possible. This created a new challenge for public health authorities. The long-standing regime of education and persuasion did not produce linear progress in achieving universal acceptance of vaccination, as the pertussis and MMR crises showed. Still, active opposition to (or, at least, refusal of) vaccines remained relatively uncommon. Over 91% of children under

the age of two received the MMR vaccine in 2016–2017 (NHS 2017). Improvements in surveillance and follow up made a significant impact on increasing vaccination uptake since the 1980s, but practical developments alone cannot explain widespread public acceptance of vaccination. According to Jacob Heller, most of the population believes a particular narrative about vaccination: vaccines work, they are safe and advanced nations provide them as a sign of their modernity (Heller 2008). Individual vaccines at specific times, however, can produce opposition to which governments are forced to react. Vaccination, then, was both a site of active resistance and acceptance on the part of the public.

Active resistance to public health policies and practices was not confined to anti-vaccinationism. One of the most effective ways to ‘speak back’ to public health was to not speak at all. The refusal to participate in public health surveys registered the non-respondent’s dissatisfaction with the process, but also held the potential to jeopardise the study by making it unrepresentative; threatening the generalisability and validity of the results (Robinson et al. 2007). For this reason, studies run since the emergence of representative sampling worked hard to minimise refusals: developing persuasive information sheets; crafting carefully inoffensive questions; sometimes providing incentives; and concentrating on improving interviewer rapport; among other strategies (Dohrenwend and Dohrenwend 1969; Mitchell et al. 2007). The silent nature of this form of resistance also makes it difficult to trace and understand. The Government Social Survey (GSS) department was proud to note in 1949 that ‘only about two people in every 100 refuse to cooperate ... and 95 per cent of the people spoken to express their willingness to cooperate in future enquiries’, but held little information on that two per cent, who they were and what motivated their resistance to the survey (Complaints Received from Members of the Public Interviewed by S.S. Investigators, 1949).

In his study of mental health in Harlow across 1959 and 1960, researcher Sidney Chave made an effort to collect information on why people refused to participate. In his diaries we can see some of the reasons given by non-respondents to the survey interviewers and recorded by Chave third-hand. Early in the survey, one interviewer was refused twice on the same day by ‘a man who said he and his family were all healthy and did not care about anyone else’ and a ‘GPO [General Post Office] shift worker who said he was not interested’ (Sidney Chave, Research Diary—The Health Survey, 6 May 1959). These refusals seemed to indicate a misunderstanding of the purpose of the survey, or apathy, rather than overt disapproval. They were read this

way by Chave, who ‘drafted a persuasive letter’ to be given to ‘potential refusers’ the next day (Sidney Chave, Research Diary—The Health Survey, 7 May 1959). Despite this, small numbers of people continued to refuse. In the same month, Chave recorded the following account of three refusals in one household:

Large household: ... 8 children. Very dirty. Wife interviewed ... Husband big lout, foul-mouthed, kept interrupting, full of complaints about [Harlow] ... Got nothing else to do but go to bed/have children. Would not be interviewed, then made an appointment for Sunday – but when interviewer arrived kept her talking – full of complaints but would not be interviewed. Refused to let her see his teenage children. (Sidney Chave, Research Diary—The Health Survey, 22 May 1959)

This account of resistance to the process of being surveyed says less about why this man refused on behalf of himself and his children, and more about how Chave and his interviewing team viewed non-respondents. While the previous refusals were framed in terms of ‘apathy’, this refusal to participate was seen as part of a series of inappropriate behaviours; from keeping a dirty house and having too many children, to wasting the interviewer’s time by inviting her back only to refuse her on a second occasion. Despite the work put in to persuading people to cooperate, participation was treated as the norm, and an aspect of good citizenship. The expansion of the welfare state in the immediate post-war period brought with it a number of rights to access public services, including healthcare, but these were balanced with social responsibilities (Marshall 1992). Taking part in a survey could be construed as one of the duties of social citizenship. Indeed, refusal to participate was seen as not just a problem for the study, but a potential signifier of wider issues. Regarding this particular set of refusals, Chave noted that his interviewer had been ‘told by neighbours this family [was] a cause of much local disturbance’ (Sidney Chave, Research Diary—The Health Survey, 22 May 1959).

Such interpretations of refusal, and the people who refused, reflected the nature of social research at the time. Sociologist Mike Savage argues that in Britain a ‘gentlemanly social science’ concerned with ‘mapping populations and separating out groups according to their moral worth and respectability’ prevailed well into the 1950s (Savage 2010, 19, 12). Savage finds evidence of this ‘moralising and medicalising tradition’ in the field notes for Elizabeth Bott’s influential 1957 study *Family and Social Network*,

in which the respondents' 'psychological emotions and social states were extensively discussed' by the research team (Savage 2010, 96). We can see both tendencies, 'moralising' and 'medicalising', in Chave's Harlow study. By the end of the study Chave, influenced by Ann Cartwright's 1959 article on 'non-cooperators' in Oxhey, began to see non-compliance with his survey as a potential symptom of the mental health issues he was investigating (Cartwright 1959; Sidney Chave, Research Diary—Collecting the GP Records, 4 January 1960). Chave delved into the medical records of those who refused, and found in their histories a slightly greater 'prevalence of nervous symptoms' than in the average population (Taylor and Chave 1964, 197–98). In the 1950s, those who refused to participate had the potential to be seen as deviant or unwell.

However, across the post-war period, refusals could also be viewed as an alternative form of engagement. Rather than pointing towards a recalcitrant, apathetic or deviant public they contribute to our understanding of where people's boundaries lay in relation to participation. The National Survey of Health and Development, a birth cohort study which began in 1946, and is still surveying its members today, has monitored its loss to follow-up over the decades. In 1992, the then study director, Michael Wadsworth, noted that 'between ages 15 and 36 years permanent refusals of contact rose, most steeply than between 31 and 36 years'. Wadsworth suggested that the rise in refusals at 36 years could be attributable to the 'introduction of measurements of blood pressure and respiratory function, and the first adult measures of height and weight' in the study. For some study members, this was asking too much. On the other hand, the 'greatest source of loss at 43–44 years was temporary refusal ... when personal or family problems made it impossible for the study member to be interviewed or measured on this occasion', suggesting that some refusals were merely a deferral of participation (Wadsworth et al. 1992, 301, 303). Similarly, the most recent round of the National Survey of Sexual Attitudes and Lifestyles (Natsal) allowed participants to 'choose not to answer' any questions they were uncomfortable with. Surprisingly, the surveyors found that less than three per cent refused to answer 'the most sensitive questions' about sex but that twenty per cent refused to reveal their income (Soazig 2014). What people have refused to answer and when has been more frequently recorded by surveyors than why. Perhaps more telling is the way that researchers have responded to refusals. As studies moved away from the 'gentlemanly social science' model and began to view participants as individuals with rights and boundaries, it became possible to view refusal

not just as active resistance, but as an alternative form of engagement to be managed accordingly (Marsh 1985, 215).

### 1.2 *Passive Resistance*

More passive forms of resistance, such as being reluctant, apathetic or slow to engage with public health policies and practices, were also exhibited by the public at various times and in a range of different ways. Vaccination, for example, was not just met with active defiance, but more passive resistance too. As discussed earlier, the British government moved away from compulsory vaccination over the course of the twentieth century. The prioritisation of education and persuasion necessarily put the emphasis on individual choice to either vaccinate or not. In the post-war period, significant energy was spent on investigating why certain parents ‘chose’ not to vaccinate their children and what could be done about it. A common explanation was ‘apathy’. A sharp decline in uptake of diphtheria immunisation in 1950 was blamed on apathetic mothers. Public health authorities believed that a generation that had benefited from the successes of the anti-diphtheria programme now no-longer feared the disease and so were not making ‘sufficient’ effort to present their children for the procedure (A message from the Chief Medical Officer, December 1950). The lack of direct opposition to immunisation, as shown, for example, in the high number of permission slips returned for vaccinations in schools, indicated that parents were not against vaccination per se (Diphtheria Prophylaxis: Publicity Campaign for Immunisation). Yet, they did not present in sufficient enough numbers to satisfy the Ministry of Health, hampering efforts to continue to see year-on-year decreases in morbidity and mortality.

This hinterland between out-right opposition and compliance was shown in other vaccination schemes. Uptake of smallpox vaccination had been in decline since the effective end of compulsion in the 1890s (Rafferty et al. 2018). Advertising efforts led to some recovery in the 1950s, but routine infant vaccination rates remained stubbornly low. However, when local areas were at direct risk of an epidemic of smallpox, long queues snaked around the streets near the Medical Officer of Health’s (MOH) clinic demanding emergency vaccination (Douglas and Edgar 1962). Similarly, the Minister of Health was disgruntled when the death of footballer Jeff Hall from polio in 1959 saw a sharp increase in young adults presenting for polio vaccination, creating localised shortages. The Minister argued that if the population had complied with requests to register beforehand rather



than being ‘apathetic’ about the threat from these diseases, the surges in demand would not have put so much pressure on supplies (HC Deb, 27 April 1959).

Although surges in demand were seen as problematic, the Ministry spent little time analysing why parents made (in its eyes) the ‘right’ decision with vaccination. However, it showed awareness of structural factors that may have prevented parents from being compliant. Officials understood, for instance, that parents were more likely to present their children for vaccination when it was convenient. Diphtheria immunisation rates were much higher among school pupils—where vaccination required no further action on the part of the parent other than returning a permission slip—than among pre-schoolers where parents would have to present their children to a local clinic. Middle-class parents were also more likely to vaccinate, partly due to education but also because they had more capacity to take the time and effort to present their children. Over successive years, the Ministry introduced a number of initiatives to make vaccination easier for parents to access. This included the development of combined vaccines to reduce the number of clinic trips, moving vaccination away from the MOH’s clinic to the GP’s surgery, providing sophisticated automated reminder systems, compiling detailed statistics about uptake, undertaking regular surveys to monitor parental attitudes, and improving educational technologies to convince parents that the inconvenience of vaccination was far outweighed by its benefits to the individual and society (Silcock and Ratcliffe 1996; Begg et al. 1989; Yarwood et al. 2005).

Recent crises across the world have led to reappraisals of how vaccination programmes work and why publics make certain choices. To some, these crises are ‘inevitable’. As vaccines become ‘victims of their own success’, parents see stories of adverse events and come to question their utility. Subsequent outbreaks of the disease (combined with education efforts) reassert the vaccine’s reputation, leading eventually to the disease’s eradication (Chen and Hibbs 1998). Others have focused on decision making, both in the ‘positive’ and ‘negative’ sense. Work on ‘vaccine confidence’ looks at a range of factors for why parents make vaccination decisions. It posits that few people are adamant that they will always or never vaccinate, and that most are somewhere in between on a vaccine-by-vaccine basis (Larson et al. 2015). These explanations acknowledge the heterogeneity of public opinion and belief. They derive explicitly from the supposed ‘lessons from history’ of crises such as pertussis and MMR in the UK in the 1970s and 2000s (Berridge et al. 2011). But such explanations are also histor-

ically contingent responses to the politics of global public health in the twenty-first century. World Health Organization vaccination targets, for example, demand that 95% of children receive MMR before the age of 5. Thus, states and public health organisations are under pressure to secure near-universal compliance with vaccination policy. New metrics for confidence and compliance are therefore a key technology for identifying and combatting vaccine ‘hesitancy’ (Larson et al. 2014). This removes some of the accusatory undertones of the ‘apathy’ framing from earlier periods, emphasising choice rather than a lack of adequate care. At the same time, public health officials’ focus on reducing risk and ensuring compliance with medical guidelines mean that people that make the ‘wrong’ choices are still seen as deviant.

A slightly different form of passive resistance to public health can be identified in relation to the public health survey. Members of the public sometimes participated in public health surveys reluctantly. Tracing reluctance in the historical record is particularly difficult as it was rarely identified by surveyors at the time. For example, in May 1951, a woman from Croydon wrote to the GSS to express her dissatisfaction with being surveyed by the Wartime Survey of Sickness. She wrote that although she was ‘very busy and pressed for time’, she had participated in the survey because the interviewer had been ‘very insistent’. However, she had resisted the survey in the only way left available to her, by lying: ‘I am now glad to say that all [answers] were not true (I felt irritated and puzzled at the call)’. From this account, one might expect the interviewer to have realised that something was wrong. Yet when questioned, the interviewer was apologetic but replied that she did ‘not recall having had any difficulty at this address’ (Complaints Received from Members of the Public Interviewed by S.S. Investigators, 8 May 1951). This was not an isolated incident. In July 1951, an ex-army officer wrote to the GSS to say that he too had felt pressured into answering despite his reluctance: the interviewer’s ‘methods bore a slight resemblance to high-pressure salesmanship, a detective showing his search warrant, and a bailiff trying to gain admittance to a house’. Once again, the interviewer in question was unaware that there had been a problem: ‘These people seemed to be so friendly at the time of the interview’. The interviewer also expressed confusion as to why ‘people who do not wish to be interviewed ... do not “refuse” when ... the opportunity has been given freely and pleasantly to do so’ (Complaints Received from Members of the Public Interviewed by S.S. Investigators, 14 July 1951).

Some did refuse, but others evidently felt unable to and sought to resist the survey in more subtle ways.

As Natsal's qualitative research into their survey methods has shown, lying to surveyors is an unusual form of resistance. Once people agree to take part in the research, as Clifton Soazig notes, there often 'seems no point in giving inaccurate answers' (Soazig 2014). Rather than lying outright however, giving evasive answers was another form of subtle resistance available to survey participants. The final question of a 1944 GSS inquiry into venereal disease (VD) asked participants, 'what else do you think should be done to stamp out VD apart from publicity?' Only fifty-six per cent of respondents made suggestions, with thirty-nine per cent recording a 'don't know/no ideas' response and five per cent making 'no answer' at all. GSS researchers found that 'analyses by education, income, sex, marital status and age' showed 'that certain groups of people have more constructive suggestions to make than others'. Sixty-seven per cent of men made suggestions compared with forty-eight per cent of women, and seventy-three per cent on a 'higher income' did compared with fifty-four per cent on a 'lower income' (Wilson and Barker 1944, 53–54). For the most part, this may have been reflective of knowledge and education levels, and of confidence in one's views. But it is worth noting that this inquiry was carried out in factories and asked workers to 'sacrifice' their time even when they were 'working on piece-rates' (Box and Thomas 1944). Rather than being ignorant or apathetic, some people, male or female, might have answered 'don't know' to get back to work more quickly. It is possible they were conscious of their lost wages, embarrassed to be asked about VD at work, or unwilling to reveal the extent of their knowledge of sensitive subjects to an interviewer (Fisher 2008, 6, 67). In this light, claims of ignorance could have been utilised as a less confrontational form of resistance more accessible and familiar to some than outright refusal or complaint, and could be read as evidence of survey reluctance. Resistance to public health policies and practices like surveys, could, therefore, take a number of forms and move along a continuum from 'active' to 'passive'.

## 2 COMPLAINTS

One of the most obvious, although problematic, ways the public could speak back to public health was by complaining. Although rare, complaints offer useful insights into public perceptions and attitudes that can be otherwise difficult to grasp. The philosopher Julian Baggini argues that com-

plaining is more than moaning, that ‘there is value in reflecting on what our complaints say about ourselves’ (Baggini 2008, 3, 128). Reflections are possible because complaints require ‘going public’. John Clarke suggests that whereas a grievance can remain private, the process of submitting a complaint to the relevant authority and investigation procedure makes it inherently public and leaves a record. Complaints represent a ‘hinterland’ of ‘anxieties, doubts and frustrations’; the public articulation of private grumblings shared by many people (Clarke 2014, 261). They tell us not only what some objected to, but what other members of the public acquiesced to and the conditions they tolerated. There is also value in noting which people were able to make complaints. While the very act of complaining results in the creation of a public record and can be read as an expression of a public feeling, albeit a formally constructed and unusually vocal one, complaints are often individual and can reveal how different members of the public and sections of society were able to engage with public health (Clarke 2014, 262). Examination of complaints made to public health authorities reveals shared points of tension in the relationships between members of the public and public health and can shed light on other more subtle forms of ‘speaking back’ such as reluctance, apathy and hesitance.

### 2.1 *Complaints and the Survey*

For Tom Crook, modern public health involved multiple agents: experts and administrators matched an active and accountable public, all of whom were both ‘objects and subjects of power’ (Crook 2016, 16–17). The survey offers an excellent arena within which to observe how certain sections of the public were more able than others to ‘speak back’ to public health. This points to hierarchies of expertise and the relationships between different publics and public health. In sampling the whole adult population of England and Wales, the GSS’s 1943–1952 Survey of Sickness engaged a broad public in public health research. Some of those surveyed had not previously experienced the scrutiny of the state in their homes and had perhaps not recognised themselves as being a ‘public’ of public health before. The Ministry of Health still deemed it largely ‘inappropriate’ to focus on men up until the end of the 1950s (Berridge 2007, 188). Men who had experienced medical surveillance in the army could balk at attempts to survey them at home and in peace time (Newlands 2014, 27). Sections of the public were able to wield more power than others, but what the Survey of Sickness complaints show us is that the role of the public in public health

was not just varied, but up for negotiation. Men and the middle classes, newly aware of their role as the subjects of public health research, were able and willing to construct complaints, and in doing so affected change on the survey process. As Clarke argues, when institutional practices are transgressive of public–private boundaries, institutions expend a lot of effort to mitigate the transgression by ‘establishing the notion of consent—and the maintenance of legitimacy in the face of dissent’ (Clarke 2014, 263). This was evident in the response of the GSS to some criticisms.

As mentioned in Chapter 3, a frequent topic of complaint was from men concerned with being asked to give information about their salary. One man expressed shock at being asked questions of a ‘very personal nature ... my age ... my employment ... my SALARY’ (Complaints Received from Members of the Public Interviewed by S.S. Investigators, 3 May 1951). Another could not understand why such information was needed: ‘please let me know what connection ... there is between my daughter’s health and my occupation and Income?’ (Complaints Received from Members of the Public Interviewed by S.S. Investigators, 9 May 1951). But even those who understood the necessity of putting health in a social context, or trusted that there was a reason, expressed annoyance with having to reveal their income in person and on the doorstep. To combat this the GSS issued each interviewer with a card printed with income categories so that the survey subject could ‘indicate... his income’ non-verbally (Survey of Sickness: Instructions to Interviewers). The GSS met what Clarke terms the ‘modest demands of respect, dignity and recognition’ articulated by its new, male, vocal public. These demands were ‘highly individual and personal’, yet, when shared, evoked ‘norms of social and organisational conduct’ and questioned the practices of the survey (Clarke 2014, 268).

The complaints received—largely around issues of privacy, liberty, waste of time or government money, and the conduct of interviewers—were often reflected in wider public discourse, especially in the popular press (*Daily Mail*, 2 August 1940, 8 November 1941; *Daily Express*, 27 July 1944, 3; 17 November 1949; *Sunday Express*, 11 June 1950; *The Times*, 30 June 1944, 5 February 1946, 10 December 1948). For example, some people writing to the GSS used the popular press shorthand ‘snooper’ to complain about interviewers (Complaints Received from Members of the Public Interviewed by S.S. Investigators, Fieldworker Report, 19 July 1950; Beers 2006). Other sections of the public who were not represented in the complaints may have held similar grievances. In the case of the Survey of Sickness, very few complaints were from working-class women. As

explained above, these women may have resisted the survey in their own ways; through using ‘don’t know’ as a quick answer, or deliberately misleading survey staff, but the survey’s perception of them as ignorant of matters outside the home and their families often obscured such forms of resistance. As a result, they had little influence on the survey process (“Anatomy of the ‘Don’t Knows’,” December 1947).

The complaints made against the Survey of Sickness reveal a complex set of relationships between different sections of the public and the British state; ones of power and prejudice. As Sara Ahmed notes, a complaint that identifies and challenges ‘abuses of power teaches us about power’ (Ahmed, n.d.). Complaints about privacy and liberty suggested that for some people there was a definite limit to what information the state should ask from citizens and how it should collect that information. On a case by case basis people struck a careful balance ‘between rights and benefits’, relinquishing privacy only when they considered the exchange fair (Vincent 2016, 101). Complaints about wasted resources indicated that members of the public felt they had a stake in how public money was spent, and that the survey was not a good use of it. These complaints could overlap, as one woman articulated: ‘it is an absolute intrusion and an indignity—as well as a waste of Government money’ (Health Index Survey: General Correspondence, 29 July 1948). People also valued their own time and contested public health authorities’ claims to it, as one man wrote: ‘my house was invaded without notice and I only realised when it was finished that I had been participating in yet another waste of public money and private time’ (Complaints Received from Members of the Public Interviewed by S.S. Investigators, 21 July 1950). Last, complaints about interviewers suggested that the authority of the state was contingent on people recognising it and that this was influenced by existing prejudices and power structures.

While some of these complaints were context specific, such as those drawing on people’s experiences in the Second World War—‘I cling rather obstinately to the idea ... of freedom for which I fought during the recent war’—others have occurred in surveys since (Complaints Received from Members of the Public Interviewed by S.S. Investigators, 9 December 1947). Yet, just as GSS director Louis Moss wrote in 1951: ‘I do not accept complaints as inevitable for any kind of work. Our experience over the years has shown that we can, by appropriate care, reduce complaints to insignificant proportions’, researchers working on public health surveys increasingly accepted the need to make the process as tolerable as possible for participants (Complaints Received from Members of the Public Inter-

viewed by S.S. Investigators, 29 November 1951). As public health evolved in the post-war period, influenced by the ideology of social medicine, everyone became a participant in public health. But just as the role of public health was up for negotiation, so too was the role of the public, especially for those with the leverage to negotiate.

## 2.2 *Complaints to Medical Officers of Health*

The survey was not the only avenue open to those wishing to complain about aspects of public health policy and practice. Local public health officials encountered the public at various junctures and such interactions offered opportunities for complaint, both formal and informal. The MOH was the official in charge of public health at the local level from the nineteenth century until the scrapping of the post following the reorganisation of health services in 1973. The ability to complain about ‘nuisances’ to the MOH was not unique to the post-war period, but after the establishment of the NHS in 1948, the MOH retained responsibility for various aspects of environmental health about which the public could complain (Crook 2016). Indeed, the lack of formal complaints procedures within the NHS until the 1980s meant that those wishing to complain about certain aspects of public health were perhaps better served than those wanting to complain about treatment in hospital or general practice (Mold 2015, 69–93). Residents dissatisfied with the condition of food purchased from local shops and other outlets could complain to the MOH, who would then investigate. Such complaints, their pursuit and eventual outcome, featured heavily in the annual reports produced by the MOH. In his report of 1955, for instance, the MOH for Surbiton recorded complaints from members of the public about mould found in sausages, meat pies and Eccles cakes, as well as a wasp in a rusk (MOH for Surbiton, Annual Report 1955, 43–44). If such complaints were found to be valid, MOH could take various courses of action, including writing warning letters to food producers, or even bringing legal proceedings, potentially resulting in a fine or possible closure of the premises. The public could also complain to the MOH about other nuisances, such as noise. In 1962, the MOH for Woolwich noted that ‘Noise continues to give some residents cause for complaint, and the Public Health Inspectors made 50 inspections connected with noise complaints during the year under review’. Of particular concern were chimes from ice-cream vendors’ vans during the summer months (MOH for Woolwich, Annual Report 1962, 22). Various other noise complaints ranging from

crowding cockerels, to noisy ‘jive clubs’, hammering at all night garages, and factories blowing off steam late at night were dealt with by informal action. Banal as these complaints may seem, they indicated a willingness on the part of both the public and public health officials to take seriously the concerns of the local population and a desire to improve conditions for all.

Other, more informal, opportunities for complaint also arose, and could hint at wider concerns held by members of the public. One such scenario was during the public exhibitions run by MOH. These exhibitions were intended to educate the public about various aspects of public health, including topics such as food hygiene, smokeless fuels and the dangers of tobacco (Mold 2018). The exhibitions offered a rare chance for direct interaction between members of the public and the staff of the public health department. At an exhibition arranged by the MOH for Stepney in 1950 visitors were able to ask questions and complain to officials staffing the show. The MOH asserted that such complaints were frequently ‘irrelevant and turned on housing and personal economic difficulties’ (MOH for Stepney, Annual Report 1950, 64). While other MOH went out of their way to solicit the views of the public, they too did not always get the responses they desired. In 1959, the MOH for Camberwell conducted a survey to find out what the public thought of the borough’s ‘health propaganda’. Although some pertinent concerns were raised, the MOH grumbled that comments made by the public ‘often reflected the particular grievances of the respondents, such as complaints about litter on waste land, and inadequate housing’ (MOH for Camberwell, Annual Report 1959, 13–14). The public could use such fora as places to raise issues that concerned them, even if MOH thought these to be irrelevant or outside their brief. Indeed, the active use of such means by the public to complain raises the possibility that the public were able to use public health mechanisms to do more than simply respond, but rather to actively reinvent these for their own ends.

### 3 REINTERPRETATION AND APPROPRIATION

Some public health measures were open to reinterpretation or even appropriation by the public. This involved more than passive or active rejection or acceptance, but a concerted effort to change the meaning or purpose of such policies and practices. This could include reading public health campaign material in the opposite way to that which was intended, or even inverting the meaning of this and deliberately reworking such material to produce a different message. In this way, the public (or certain parts



of it) was able to create its own meanings and ascribe these to public health concepts and initiatives.

### 3.1 *Letters to Whitehall*

Public health surveys were designed to think of and deal with the public as a collective, but participants could turn this on its head, and use the survey to explore aspects of their own health. The Whitehall study was a longitudinal health survey of male civil servants carried out between 1967 and 1970. The study screened over 18,000 men aged between 45 and 60 years primarily for cardiovascular and respiratory conditions, with follow up dietary and exercise studies performed on samples of the cohort. The follow-up studies necessitated further communication between study participants and researcher Geoffrey Rose, whether he was sending them dietary questionnaires to complete or instructing them on how to use the pedometer sent to them in the post. Although the majority of participants completed their postal questionnaires without incident, a number used the opportunity to ask questions and engage with the study in ways which reinterpreted its purpose or appropriated it for their own ends.

Although the instructions accompanying the dietary survey questionnaire made it clear to the participants that they need only include a note if ‘the amount or type of food you ate on any of these days was unusual for you’, many wrote back to explain how they were in some way ‘unusual’ themselves, warning Rose that they may not be representative (Correspondence regarding dietary habits postal survey). As one man wrote, ‘we have most irregular eating habits and what is “fairly typical” to me is probably otherwise to others ... I feel that I do not well fit into an average category but if there are not too many of a similar nature in your sample it should not unbalance it’ (Correspondence regarding dietary habits postal survey, 3 June 1969). While some men seemed worried that they might prejudice the survey results, skewing Rose’s understanding of ‘the diet of the group as a whole’, others took the opportunity to either assert a sense of individual subjectivity or ask for reassurance or advice. Foucault argued that in research the interview acts as a ‘device for producing confessional accounts’, allowing ‘subjects to self-produce their subjectivity’ (Savage 2010, 165). With this in mind, it could be argued that for some participants in the Whitehall study, the questionnaire proved too narrow a form for self-expression. These men wrote to Rose to share more details about their lives. One man advised Rose that his questionnaire was ‘cer-

tainly not designed to help vegetarians', before launching into a description of a diet largely consisting of dried fruit, salad, vegetables and eggs (Correspondence regarding dietary habits postal survey). Another tried to explain his somewhat erratic eating habits: 'since I have been widowed I eat when I want to and at no special time. I trust this will help' (Correspondence regarding dietary habits postal survey, 15 July 1970). In both these accounts we can see what Sarah Igo calls the 'subtle conversion of individual experiences into social scientific data' (Igo 2009, 282). These men were keen to share their stories and did so with an understanding that this added information was 'useful to science', whether or not Rose ultimately took note of it (Savage 2010, 165).

For others, engagement in scientific research could be an opportunity to seek 'expert assurances' about their relative 'normality' (Igo 2009, 279). As one man wrote, 'my friends and colleagues seem to find my eating habits erratic and amusing. If they are medically unusual I would welcome your views' (Correspondence regarding dietary habits postal survey, 21 January 1969). Others' anxieties were prompted by the study itself: 'Naturally I am ... slightly perturbed at the inference that my survey medical check revealed some peculiarity that evoked further interest' (Correspondence regarding dietary habits postal survey). Another respondent was at pains to check that he was receiving the necessary medical advice: 'I assume that I do not come within the category "certain medical conditions" which might be associated with "special eating habits" ... If the contrary is the case I hope that either my medical practitioner or myself will be advised accordingly' (Correspondence regarding dietary habits postal survey). Rose replied to this man and the others who sent similar enquiries, explaining that they had not been selected for any specific reason, but that their contributions would put the study in a 'better position to help those individuals who are not fit' (Correspondence regarding dietary habits postal survey). As well as pleas for reassurance, in these interactions we can see the transactional element to participation in the study. These men understood that through their full participation they would gain early notice of any health problems they might have and were keen to make sure this was met. Others took it further, asking directly for advice: 'If any recommendations issue as a result of your survey I should be most grateful if I might be told what they are. I try reasonably hard to reduce my weight but achieve poor results, yet I feel that I do not over eat' (Correspondence regarding dietary habits postal survey, 26 January 1969). While indicative of an understanding of participation as a two-way exchange, this letter anticipating the results of

the study reminds us that the individuals who took part were also members of the public who could stand to benefit from the knowledge produced. As Igo wrote in her work on American public opinion surveys, ‘surveys are a peculiar sort of social investigation in which the public is simultaneously object, participant, and audience’ (Igo 2009, 4). The men who took part in the Whitehall study and its subsidiary surveys participated as asked, but they were not passive subjects. They each brought their own motivations and agendas to the study, and through speaking back in various ways embodied one of the tensions inherent to public health research, that of ‘being an individual and being a statistic’ (Igo 2009, 282).

### 3.2 *Health Education*

The relationship of the individual to the tools of public health authorities and their capacity to turn these to their own advantage is powerfully illustrated by health education. Mass media public health campaigns were first contemplated in the mid-1960s, but only really began to take shape in the 1970s. Such campaigns were open to active reinterpretation or appropriation by those that saw them. An excellent example is offered by the 1985–1986 ‘Heroin Screws You Up’ campaign. Prior to 1980s, there was very little health education messaging specifically on drugs. In large part, this was because health educators and drug experts believed that drug education would be counter-productive, indeed it might actually encourage young people to use drugs (Manning 2013). However, a significant rise in the number of heroin users during the early 1980s, and an ensuing moral panic about drug use, prompted the government to launch an anti-heroin campaign. The campaign, designed by the advertising agency Yellowhammer for the Central Office of Information (COI), consisted of a series of images reproduced on posters, in newspapers and in magazines as well as two brief TV commercials. All of the images featured young people, supposedly heroin users, in various states of distress. All were pale, with dark circles under their eyes, often with dirty-looking hair, and of a generally dishevelled appearance. The text surrounding the images listed some of the likely consequences of heroin use including addiction, sickness and loss of control. An evaluation of the campaign carried out for the COI found that it had a high degree of penetration: nearly all of the respondents recalled having seen either the TV advertisements, the posters or press images. Moreover, the research suggested that there had been significant change before and after the campaign in relation to awareness about the health risks

associated with heroin use. Respondents also reported being less likely to take heroin if offered it by a friend after the campaign (Research Bureau International 1986).

Yet, the Heroin Screws You Up campaign came in for widespread criticism from those working in the drugs field, the wider media and even an internal Department of Health and Social Security review. Some critics saw the tone of the campaign as making use of fear tactics to scare young people into not using drugs, something which could increase the stigmatisation around drugs and drug users. There were also concerns that such images would not be credible to those young people more familiar with drugs (Rhodes 1990). Worse still, from a prevention standpoint, scare tactics might actually have encouraged young people to use drugs as an act of rebellion (Falk-Whynes 1991). Other critics pointed out that the campaign was too broadly targeted, unlikely to achieve behaviour or attitude change and that attitudes towards drugs were influenced by a range of other media, and embedded within broader cultural and social structures and values (Hansen 1985; Woodcock 1986; Power 1989). Indeed, the public response to the campaign seemed to indicate that it did more than miss the mark. Some youths deliberately appropriated the campaign and its imagery. There were numerous reports that young people took the poster or the magazine and newspaper advertisements and put them up on their bedroom walls. In 1989, Barry Sheerman (Labour MP for Huddersfield East) told the House of Commons that 'The rather effete young man in the heroin posters became a pin-up for some young girls'. Health Minister David Mellor responded that this was an allegation that had never been proven (HC Deb, 8 December 1989) (Fig. 4.1).

It is hard to say for certain whether the Heroin Screws You Up posters really became teenage pin-ups, but the imagery the campaign used was open to wider cultural appropriation or even reappropriation. This is an example of what media studies theorists describe as the 'polysemic' nature of 'texts': that these are open to multiple interpretations and readings, some of which may be in direct opposition to that which the creators intended (Miller et al. 1998, 210–11). This went beyond the immediate context of the campaign. In the mid-1990s, a 'look' became popular within the fashion world known as 'heroin chic'. Models displaying heroin chic had emaciated features with pale skin, dark circles underneath the eyes, and were often androgynous (Arnold 1999; Harold 1999; Hickman 2002). Visually, this look was similar to that portrayed in the Heroin Screws You Up campaign. Of course, the campaign did not lead directly to the creation of heroin

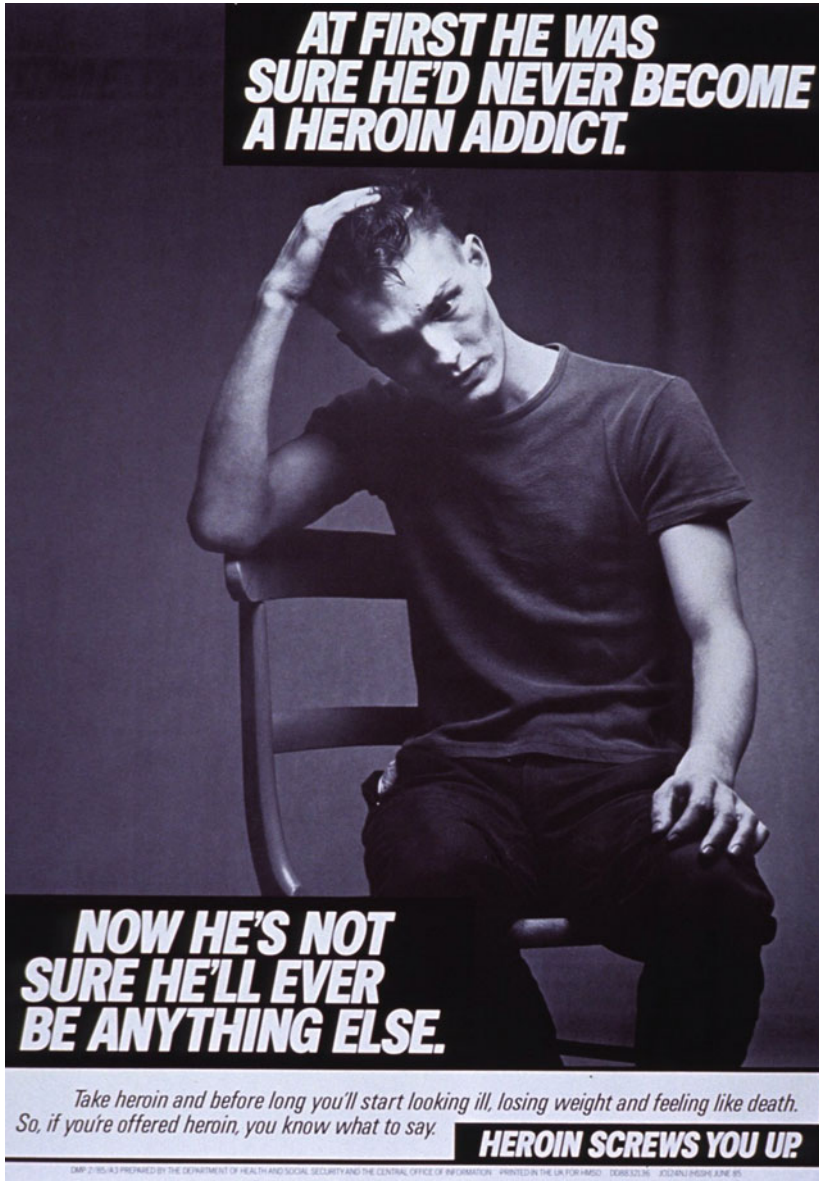


Fig. 4.1 Poster from the Heroin Screws You Up Campaign, 1985 (From the Department of Health and Social Security, Central Office of Information, shared under the Open Government licence. <http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/>)

chic. There were a whole host of other elements to this, but the similarity between the visuals, at least on the surface, speaks to the way in which imagery created for one purpose in one context is not owned by any one group or fit for one purpose. Just as the Heroin Screws You Up campaign drew on stereotypical images of drug users to try and sell an anti-drug message, the fashion industry could use similar visual tactics to sell clothes and a particular body image. The multiple readings and mobilisation of images was hardly unique to the 1980s, or to public health campaigns, but the enmeshing of motifs with commercial products illustrates the extent to which public health and its public had become embedded within the consumer society.

### 3.3 *Lay Epidemiology*

The influence of social and cultural context on the public's interpretation and reinterpretation of health education messaging was also at work in the development of the notion of 'lay epidemiology'. In evaluating 'Heartbeat Wales', a health promotion campaign aimed at informing the Welsh public about risk factors for cardiovascular disease, a group of epidemiologists and anthropologists coined a term to describe how the public interpreted those risks for themselves: 'lay epidemiology'. Their research participants, interviewed shortly after the miner's strikes of the early 1980s, constructed their beliefs about disease causation from a complex interaction between 'official' medical and public health sources, the mass media, and the lived experiences of friends, families and colleagues:

[I]ndividuals interpret health risks through the routine observation and discussion of cases of illness and death in personal networks and in the public arena, as well as from formal and informal evidence arising from other sources, such as television and magazines. (Frankel et al. 1991)

Unlike in the previous decade, when the public had been largely absent or otherwise conceptualised as obliging receptacles for health education, in the 1980s that public also spoke back; or, at least, appeared to. The views, attitudes and beliefs of the public were a central concern of energetic and generously funded government campaigns such as 1987's 'Look After Your Heart' (LAYH), and the public responses to them.

Indeed, the LAYH campaign was to a certain extent predicated on the idea that many of the public were 'cynics' about the health education that they received. The newer era of market research driven health pro-

motion campaigns ensured that ideas were audience tested and evaluated afterwards. LAYH was no different; the advertising agency Abbott Mead Vickers had run focus groups prior to creating television advertisements, while the Health Education Authority had commissioned Communication Research to conduct a survey on ‘attitudes to heart disease’ which found that ‘people’s general awareness of the causes and prevention of coronary heart disease is good’ but ‘that knowledge is not translated into action by nearly half of a representative sample of 1000 English adults’ (Health Education Authority 1987a). LAYH’s publicity materials were nothing if not gently self-deprecative; the explanatory text below a cartoon featuring the popular *Daily Mirror* character Andy Capp confided that:

Being human, there is always a temptation to sit back and do nothing at all, and carry on the way you always have. Perhaps that’s what Andy Capp would do. And perhaps the cheeky blighter would get away with and live to be 100. But there’s a difference between Andy Capp and you. He is pen and ink. You are flesh and blood. (Health Education Authority 1987b, 11)

But if health education campaigns were attempting to incorporate the views and health beliefs of the public into their campaigns, it was those that sought to critique these campaigns that were most adept at harnessing voices of the public. Some public health professionals began using these dissenting views to more critically evaluate how public health communicated its messages. In a witness seminar on public health in the 1980s and 1990s, health services researcher Nick Black recollected that:

there was a very exciting period in the early 1980s when public health was much more political ... One *samizdat* publication, by Wendy Farrant and Jill Russell ... couldn’t be published, because it was an observational study by two sociologists of policy making in the Health Education Council on coronary heart disease prevention, where the policies were not informed by the evidence at all, actually completely counter to the evidence. They showed this with a lovely piece of qualitative research ... it got circulated among the younger, more radical public health folk. (Berridge et al. 2006, 40–41)

Black’s use of the word ‘*samizdat*’ [emphasis in the original] is instructive, pointing to both the apparently dissident nature of Farrant and Russell’s work, and the views of the ‘radical public health folk’ on state-sponsored health education, allusive to the still-extant Soviet bloc. *The Politics of Health Information*, published in 1986 but possibly widely circulated



before that, was deeply critical of current approaches (Health Education Authority 1990). While critical of HEC (and by extension its successor body, the Health Education Authority)'s attempts to “sell” a “clear and simple” individualistic health education message’ and its alleged selective use of epidemiological evidence, Farrant and Russell’s most thrusting attack was that which was informed by their interviews with 21 informants (Farrant and Russell 1987, 39). Direct quotations were employed as ammunition to argue that the HEC’s efforts were ineffectual and misguided. From these, we can see evidence of both a sceptical public, but also the manner in which this evidence was mobilised to make political points. Like those interviewed in Wales, respondents cited anecdotal and personal experiences that contradicted official narratives—‘[t]here are people in their nineties who smoked all their lives, and are overweight, and as fit as a fiddle’—while also pointing to structural and socio-economic influences of people’s lifestyles:

[HEC] should also talk about the reasons why people eat bad diets and smoke – like the government’s interest in perpetuating bad health by their interest in tax from tobacco sales. (Farrant and Russell 1987, 49, 54)

The dissident voices of the public were also broadcast by the media. In 1987, ‘This Week’s’ TV documentary on heart disease and prevention programmes, *Lessons for the Living*, went into the pubs and social clubs of Sheffield to seek people’s views on the city’s attempts to address heart disease. Asking a young man whether he would be willing to change his lifestyle for a longer life, the presenter Jonathan Dimbleby received the reply, ‘I go when I go, don’t I?’ The man’s fatalism and indifference to the efforts of Sheffield’s health education workers was used as a brickbat by the programme to denigrate current efforts. *Lessons for the Living* closed with the warning that ‘unless more is done, Britain will continue to hold the worst record in the world’ on combatting heart disease (‘Lessons for the Living’ 1987).

Despite attempts to integrate lay epidemiology into both the practice and critique of health promotion folk knowledge about heart disease remained resistant to official advice. Partly this was out of confusion about what constituted healthy living; as one middle-aged man on *Lessons for the Living* asked: ‘Milk’s no good for you, bread’s no good for you, beer’s no good for you, smoking’s no good for you; what is good for us?’ It was also born out of a feeling that life was brutish and short enough already; one widow told Farrant and Russell that ‘[m]y husband was on a 2000 caloric



diet [before he died of heart disease] ... salad—it takes all the pleasure out of living ... better to live a shorter life’ (Farrant and Russell 1987, 51). But perhaps the strongest explanation for this resistance was that of lived experience and the existence of a folk figure who illustrated a ‘rich field of British cultural life, that of chance’ which contradicted official epidemiological narratives (Davison et al. 1991, 14–15). This figure was:

[a]n aged and healthy friend, acquaintance or relative – an “Uncle Norman” – who has smoked heavily for years, eats a diet rich in cream cakes and chips and/or drinks ‘like a fish’ is a real or imagined part of many social networks ... A single Uncle Norman, it seems, may be worth an entire volume of medical statistics and several million pounds of official advertising. (Davison 1989, 46–47)

The public understanding of, and response to, public health campaigns was complex, nuanced and sometimes in direct opposition to the intended message. Health education campaigns and the images they produced did not exist in vacuum. Rather, these were part of a complex cycle of appropriation, reappropriation, interpretation and reinterpretation by the public.

#### 4 CONCLUSION

Individuals were clearly capable of using the tools of public health, whether this be health education campaigns or the survey, to their own ends. This did not necessarily mean, however, that the long-running bargain between state and citizen over public health had tipped in favour of the individual. Many members of the public were aware that public health was concerned with collective health, and that this may involve some small element of personal sacrifice, whether that was the time spent talking to a surveyor or presenting one’s child for vaccination. Yet, certain publics in certain contexts could resist such collective responsibilities in order to prioritise individual rights or personal preferences. As noted in Chapter 2, the broad narrative of health citizenship in the post-war period would suggest that over time the public became more concerned with individual rights and less interested in fulfilling collective duties. Our examples upset such a linear chronology. We found individuals refusing to participate in public health practices for their own reasons in the 1950s, just as most members of the public continued to accept a number of collective health responsibilities, such as vaccination. It is hard, perhaps impossible, to say if there was more

‘speaking back’ by the turn of the millennium than there had been in the middle of the century. As we discuss in Chapter 5, much of this revolves around the changing meaning of publicness and the forms which it took. Indeed, there is a need to move beyond seeing the public response to public health only in terms of rights and responsibilities. The public, we suggest, was capable of ascribing its own meaning or meanings to public health policies, practices and materials. The very nature of ‘public’, was, therefore, open to active reinterpretation.

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