To my mother, and to my father who did not live to see this work completed.
ABSTRACT

This thesis represents a study which began when the term health promotion first appeared in health authority policy documents but, at the same time it appeared to be a term little understood by those health care professionals deemed responsible for its implementation. Clarification of the concept of health promotion was pursued by the researcher using grounded theory methodology. Health visitors, health education officers/health promotion officers, and general practitioners participated in a series of group interviews and the data was analysed by cognitive mapping (Jones 1975), and constant comparative analysis (Glaser & Strauss 1967). Results from analysis of the qualitative data formed a theoretical framework which guided the second, quantitative stage, of the study.

A postal survey of a national sample of 1000 health visitors was undertaken. The response rate was 65% comprising 557 health visitors. Analysis of data was carried out using the SPSS statistical package. The results revealed that health visiting workloads and priorities remain fairly traditional although over 60% of respondents identified client and community led health education/health promotion work as one of their priorities. Examples of health promotion undertaken by health visitors revealed a wide range of activities but with emphasis placed clearly on parent/child issues. A majority of health visitors (63%) thought health promotion activities could be measured, but over 80% of respondents recognised the complexities of doing so. Although over half of the practising health visitors rated their mode of practice as both individualistic and community orientated in approach, over 50% of respondents identified a need for additional skills in group work, teaching, research and assertiveness.

A number of obstacles preventing health visitors from developing health promotion activities were identified. The position of health visiting in the context of current political ideology is examined.
ACKNOWLEDGEMENTS

It is impossible to acknowledge all the help and encouragement that I have received from so many people over a time which seems like an eternity. I have received enormous support from my supervisor, Dr Sara Arber, who managed to keep me motivated to complete the study and gave me invaluable advice whenever it was needed. To her my most grateful thanks.

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Finally, my thanks go to my family and friends who have had to put up with my anti-social behaviour for so long.
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<tr>
<td>B.S.</td>
<td>Batchelor of Science/Batchelor of Surgery</td>
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<tr>
<td>Cert Ed.</td>
<td>Certificate in Education</td>
</tr>
<tr>
<td>CQSW</td>
<td>Certificate Qualification in Social Work</td>
</tr>
<tr>
<td>DCM</td>
<td>Doctor of Comparative Medicine</td>
</tr>
<tr>
<td>DHA</td>
<td>District Health Authority</td>
</tr>
<tr>
<td>Dip ASS</td>
<td>Diploma in Applied Social Science</td>
</tr>
<tr>
<td>Dip HE</td>
<td>Diploma in Higher Education</td>
</tr>
<tr>
<td>DMU</td>
<td>Directly Managed Unit</td>
</tr>
<tr>
<td>DRCOG</td>
<td>Diploma of the Royal College of Obstetricians &amp; Gynaecologists</td>
</tr>
<tr>
<td>FE Teaching Cert</td>
<td>Further Education Teaching Certificate</td>
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<tr>
<td>FHSA</td>
<td>Family Health Services Authority</td>
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<tr>
<td>FWT</td>
<td>Fieldwork Teacher</td>
</tr>
<tr>
<td>FWT (Cert)</td>
<td>Fieldwork Teacher Certificate</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HEA</td>
<td>Health Education Authority</td>
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<tr>
<td>HEO</td>
<td>Health Education Officer</td>
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<tr>
<td>HPO</td>
<td>Health Promotion Officer</td>
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<tr>
<td>HV</td>
<td>Health Visitor</td>
</tr>
<tr>
<td>MB</td>
<td>Batchelor of Medicine</td>
</tr>
<tr>
<td>MRCP</td>
<td>Member of the Royal College of Physicians</td>
</tr>
<tr>
<td>NNEB</td>
<td>National Nurses Examination Board</td>
</tr>
<tr>
<td>PGCE</td>
<td>Postgraduate Certificate in Education</td>
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<tr>
<td>PGCEA</td>
<td>Postgraduate Certificate in Adult Education</td>
</tr>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>PHV</td>
<td>Practising Health Visitor</td>
</tr>
<tr>
<td>RGN</td>
<td>Registered General Nurse</td>
</tr>
<tr>
<td>RM</td>
<td>Registered Midwife</td>
</tr>
<tr>
<td>SCM</td>
<td>State Certified Midwife</td>
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PART ONE - INTRODUCTION

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PART ONE - INTRODUCTION

Towards the end of 1986 the researcher observed a sudden proliferation of the term health promotion. Overnight door labels mysteriously changed from Health Education Department to Health Promotion Department. 'Health Education Officers' went home from work one day only to find themselves 'Health Promotion Officers' the next day.

Health authority directives and policy statements seemed to mention health promotion in almost every second paragraph and a series of job advertisements for 'Health Promotion Officers' began to appear in the health service and professional press.

Whilst these changes may have occurred as a consequence of the World Health Organisation's first international conference on health promotion, held in Ottawa, (WHO 1986), many grass roots health professionals appeared unaware of the rationale, motive and purpose of these changes. Although there appeared to be a great deal of rhetoric on the topic of health promotion at this time (October 1986) the literature on the subject in the United Kingdom appeared very sparse. There were numerous articles on health education, health beliefs, health services, health ethics etc., but few publications focused on 'health promotion' except in the most general terms or, more usually, as a strategy for new policy developments.

Health promotion as a concept appeared more frequently reported and discussed in American literature although again the literature tended to focus on policies for health rather than the identification of any operational approaches to health promotion. What did emerge from both the UK and American literature was that often the terms health education and health promotion appeared to be used synonymously. Given the general confusion surrounding the concept of health promotion, both in the literature, and in the workplace, the researcher decided to explore the topic further. The researcher was
particularly influenced by the work of Conill and O'Neill (1984) who suggested that when a new rhetoric emerges one should attempt to understand which interest groups promote it, for what reason, for whose benefit, how and why it happens. It was also thought by the researcher to be theoretically important to explore how health promotion was perceived by health care professionals. This was in view of the potential knowledge base and operational skills, likely to be required by key health workers and how these might impact on the development, management, and power base of the health care professions.

The first stage of the research involved groups interviews with health visitors, health education/health promotion officers and general practitioners. On completion of the qualitative part of the study however the researcher realised that to involve all three professions in the research would probably be over ambitious. As the researcher had particular insight into the often maligned role of the health visitor (McCarthy 1992) it was decided to explore aspects of health promotion from a health visiting perspective. This work represents that exploration. A short guide to this thesis follows.

READERS GUIDE TO THIS THESIS

This thesis comprises six parts. The first part describes the development of health visiting as a profession with particular emphasis on the health visitors' role in relation to health education/health promotion. The emergence of health education as a profession is then examined, and the role of HEOs/HPOs is compared and contrasted with that of health visitors'. The final section of part one explores health promotion in the context of the National Health Service.

Part two describes a grounded theory approach used by the researcher for the purpose of achieving concept clarification of the term health promotion. Part three
comprises analysis of the qualitative data and presentation of a conceptual framework which guides the second, quantitative phase of the research.

Part four describes the methodological approach used by the researcher in undertaking a postal survey of a national sample of health visitors and part five analyses and discusses the data obtained from the postal survey. Part six, the final section of this thesis, explores current political ideology in relation to health promotion and then examines the position of health visitors in relation to health promotion.
CHAPTER 1

THE DEVELOPMENT OF HEALTH VISITING AS A PROFESSION
AND ITS RELATIONSHIP TO HEALTH EDUCATION/HEALTH PROMOTION

This chapter aims to explore both the development of health visiting as a profession, and its early involvement in the emergence of health education/health promotion. The researcher suggests that an understanding of the history of health visiting will help to explain the position of the profession today in relation to the development or lack of development of the role of the health visitor in health promotion.

Health visiting emerged during the latter years of the last century in the industrial cities of the UK. McCleary (1935) points out that the earliest organised system of health visiting was started by the ladies section of the Manchester & Salford Sanitary Reform Association, founded in 1862. The Association decided to employ "a respectable working woman to pay door to door visits and to teach and help". Seymer (1955) states that Florence Nightingale writing in 1891 to Mr. Verney, chairman of the North Buckinghamshire Technical Education Committee, made an emphatic statement in line with the Ladies' Reform Associations policy. "It seems hardly necessary to contrast sick nursing with this (ie. health visiting). The needs of home health bringing (sic) require different but not lower qualifications and are more varied. She (the health visitor) must create a new work and a new profession for women" (1891:18).

The recognition that "home health bringing" generated a diversity of needs requiring different qualifications illustrates the perspicacity of Miss Nightingale. Her persistence in beginning to professionalise health visitors was rewarded in 1892 when Buckinghamshire County Council employed three health visitors who had successfully undertaken a course of instruction arranged by the North Bucks Technical Education Committee. This course of instruction, although limited, was the first step towards
achieving special education for health visitors and the first step in the process of professionalisation.

In spite of the appalling living conditions that arose during the first half of the nineteenth century when Britain was becoming urbanised, it was not until after the Boer War, when the poor state of health of the recruits had given cause for concern, that health visitors were encouraged to focus their education and social skills on mothers and babies, so becoming part of a national policy to ensure the survival and fitness of the nation's infants. It is important to note that, even in the 1890s, education on skills were widely emphasised. The health visitor's role soon extended beyond maternal and child welfare. School nursing developed following the Education Act 1907 and this role was sometimes carried out by health visitors.

Following the Mental Deficiency Act (1913) health visitors were involved in giving special help to parents of 'ineducable' children. They started assisting the Medical Officer of Health with the control of infectious diseases and, during the First World War, they started to supervise crèches established to provide day care for children of munitions workers. "By the beginning of the First World War we have a worker with responsibilities for maternal and child welfare, school nursing, tuberculosis, visiting of mentally handicapped children and the control of infectious diseases" (Henderson 1977:4).

In spite of the early deliberations of Miss Nightingale, it is not surprising to find that at this date health visitors had a variety of training and qualifications. Many health visitors had been women sanitary inspectors, some even women doctors, but a nursing background did not become important until the 1920s. Dingwall (1977) makes the point that the nursing background was originally envisaged as playing a secondary role to a direct entry of students taking a two year diploma course, normally associated with an
institution of higher education, which included education on social sciences and domestic subjects. Dingwall claims that by adopting this nursing background, health visiting acquired a more narrow clinical framework at the expense of social and psychological perspectives.

It is interesting and perhaps significant today to note that whereas nursing had virtually no power, status or role outside medicine, according to Dingwall (1977:78), "health visiting had a large amount of self help about it". He further likens the collective attempts of the early health visitors to improve their status as a group to some aspects of early trade unionism and temperance movements. Thus in terms of attitudinal attributes on the one hand, we have hospital nurses working in a highly structured environment, for the most part subservient to the doctors and some administrators, whilst on the other hand we have the early health visitors working in a highly unstructured environment, for the most part striving as small but dynamic groups to acquire greater recognition of their skills and abilities. One must ask, however, did the nursing influence subdue the early health visitors enthusiasm to forge a profession of their own and does the main body of the nursing profession still threaten the existence of health visitors today?

The Nurses Act (1919) provided the first statutory regulation for nurse training and probably led to the revision of health visitor training in 1925 when the Royal Sanitary Institute (later Royal Society for the Promotion of Health) became the central examining body. Trained nurses were allowed to qualify as health visitors in six months, provided that they were also qualified midwives. (It is interesting to note that the Royal Sanitary Institution apparently had the vision as early as 1955 to change its name to the Royal Society for the Promotion of Health, although this title is now subsumed under the title Royal Society of Health).
The between-wars emphasis was on the prevention of death and the spread of infection amongst children. The health visitor was working largely with the families of semi-skilled and unskilled workers. During the Second World War food rationing had brought all social groups into child welfare centres to get priority allowances of milk and other nutrients and, following the war, there appeared to be a greater integration of social groups with health visitors involved in work with all mothers and children. Initially the role of the health visitor was viewed very positively but by the 1940s, doubts began to be expressed about the value of the health visitor’s work. A revised account of the duties of the health visitor was published by the Joint Consultative Councils of Institutions (Ministry of Health 1943) recognised as responsible for the organisation and training of health visitors, namely the Royal College of Nursing and Women Public Health Officers’ Association (now the Health Visitors’ Association).

The National Health Service Acts of 1946 and 1947 (Ministry of Health 1948) greatly affected health visiting. In England and Wales the service became the statutory responsibility of the counties and county boroughs to the exclusion of the district councils. The 1946 Act says (Section 24, Part III):

"It shall be the duty of every local authority to make provisions in their area for the visiting of persons in their homes by visitors to be called "health visitors" for the purpose of giving advice as to the care of young children, persons suffering from illness, and expectant or nursing mothers, and as to measures necessary to prevent the spread of infection".

In spite of this pronouncement, uncertainty prevailed and in 1953 the Minister of Health appointed a working party whose terms of reference were "to advise on the proper field of work, the recruitment and training of health visitors in the National Health Service and the School Health Service" (Ministry of Health 1956:V). The committee
reported three years later (Jameson Report 1956). The working party report defined the function of the health visitor as "health education and social advice" (1956:VI1) but with the emphasis firmly on health education. "Health visitors should continue to keep contact with families where there are children" the report said (1956:VI1), but should be prepared to extend their role to be a "general purpose family visitor" (1956:114).

The committee made no attempt to draw a model for the future, in fact they were rather cautious. Whilst supporting the idea that the health visitor's role should be mainly one of education, they said "the committee took it that the pattern of need was changing and therefore until a clear picture emerges, perhaps not for some years, it would be unwise to attempt to prescribe too rigidly the form of organisation required to meet family welfare needs, or the functions of family health and welfare workers" (Ministry of Health 1956:3).

In evidence to the committee, other occupations had questioned the generalist approach of health visitors and the working party was in no doubt that the field work and functions must be considered together, if the fieldwork was too wide and the function too diverse and demanding, then the future health visitor would be ineffective.

The working party recommended that registration as a nurse should continue to be the prerequisite for training as a health visitor, and because of the institutional nature of Part 1 of the Midwifery Certificate, it was recommended that intending health visitors should be either fully qualified midwives or have undergone a three-month course in midwifery relevant to health visiting.

Wilkie (1984) in her case study of the Council for the Education and Training of Health Visitors also questioned the justification of health visitors having a nursing background. Her view was that Medical Officers of Health had gradually assumed that
there would be advantages to health visitors having a nursing background. Wilkie's own view was that:

"To some extent the view was associated with the health visitor's employment within the maternity and child welfare departments directed by the medical officers and reflected the expectation that doctors would be assisted by nurses" (Wilkie 1984:15).

It is interesting to note that a considerable amount of evidence had been submitted to the Jameson Working Party in which there was clear opposition to nursing training for health visitors, and this evidence might well have been supported had the working party made an attempt to examine and define the work and skills involved, and the impact on clients of health visiting services.

Yet another opportunity was lost when a working party, set up to examine the staffing of local health and welfare authority departments, (the Younghusband Report 1959) did not remedy the need to clarify the health visitor's role, because its terms of reference were too restrictive.

The Jameson Committee had approved a Central Training Council for Health Visitors with the course extended to one year, and it was considered desirable that intending health visitors should have the General Certificate of Education at 'O' level in five subjects. The recommendations were realised when the Council for the Training of Health Visitors was set up, under the Health Visiting and Social Work Training Act 1962. The Council replaced the Royal Society for the Promotion of Health as the examining body for the Health Visitor's Certificate and became responsible for the education and training of health visitors, approval of existing and new courses, and recruitment.
In 1962, 28 health visitor training schools were in existence, varying in the quality and length of training they provided, and in the practical experience that the students received. The major task of the first council was "to devise a new Syllabus of training to match the needs of the service and to provide scope for the use of new teaching methods as well as a sound theoretical framework for practice which would allow adaptation in a rapidly changing environment" (CETHV Information Bulletin, May 1975).

The new syllabus of training was implemented in July 1965 and, with a few notable exceptions, it still forms the basis of health visitor courses today. The syllabus embraces five sections - Development of the Individual, Individual in the Group, Development of Social Policy, Social Aspects of Health and Disease, and Principles and Practice of Health Visiting. These changes to the syllabus were to have considerable impact on the profession not least in their contribution to attracting health visitor students and their lecturers into higher education. Wilensky (1964) noted that many occupations passed through a sequence of changes affecting the structure of that occupation. One such change identified by Wilensky (1964) was the establishment of a knowledge base, and in order to do this efforts were made by the occupation's early leaders to improve the education and training of its members.

Whilst in an educational and structural sense the setting up of the Council for the Education and Training of Health Visitors in 1962 was a major achievement in the professionalisation of health visiting, health visitors by then, had begun to express unease about the nature and future of their role. In a survey of the work of the staff of social welfare services in an English county, Jeffreys (1965) had identified low morale among a sizeable minority of the health visitors in her sample. Jeffreys suggested that uncertainty about the content of health visiting work, and the contribution it was making to the welfare of mothers and children, may well have been associated with the concern about
status, and problems in relationships with other professionals, which some of the health
visitors had disclosed during the survey.

Feeling that the lack of a clear definition of the health visitor's role had been a
barrier to recruitment, in 1967 the Council for the Education and Training of Health
Visitors published a pamphlet which defined the functions of the health visitor in the
United Kingdom. They identified the five main aspects of her work as being:

1. The prevention of mental, physical and emotional ill health and its consequences.
2. Early detection of ill health and the surveillance of high risk groups.
3. Recognition and identification of need and mobilisation of resources where
   necessary.
4. Health teaching.
5. Provision of care; this will include support during periods of stress and advice and
guidance in cases of illness, as well as in the care and management of children.

The health visitor is not however actively engaged in technical nursing procedures
(CETHV 1967).

Whilst the Council for the Training of Health Visitors was developing its
strategies and functions, a new orientation to management had developed in nursing via
the implementation of the Salmon Report (Ministry of Health 1966). The Report centred
on the premise that nursing was a profession in itself, complementary rather than
ancillary to the profession of medicine. In practice, however, the Salmon Committee
found that nursing occupied a subordinate position. Having identified that the nursing
profession was not represented officially, and held little status at governing body
meetings compared with medical and administrative staff, the committee recommended a
new management structure for nursing based on a managerial principle of line control.
The committee commented "It seems to us that the assertion of professional status of
nurses could best be achieved by assuring the right of the profession to be heard (Sapiential Authority) on all matters concerning nursing that are controlled by governing bodies" (Watkin 1975:319). The proposed management structure provided an elevation in status for most senior nurse administrators in hospital and most principal tutors of colleges of nursing.

In the autumn of 1968, before the recommendations of the Salmon Report had been fully implemented, a working party under the chairmanship of Mr. E.L. Mayston was appointed "to consider the extent to which the principles of the Salmon Report on Senior Nursing Staff structure of senior posts and changes in the definition of post may be required" (DHSS 1969:1).

The Mayston Committee came to the conclusion that there was a need for three levels of nursing management and recommended that all local authority nursing services (incorporating the health visitors) be reviewed and restructured. In a redefinition of the role of the health visitor, Appendix 8 states:

"A health visitor is a woman who visits persons in their homes for the purpose of giving advice as to the care of young children, persons suffering from illness, and expectant and nursing mothers and to the measures necessary to prevent the spread of infection, and who performs such other duties as may be assigned to her, and who has the qualifications prescribed for a health visitor" (DHSS 1969:21).

This redefinition of the health visitor's role, in conjunction with the progress made by the Council for the Training of Health Visitors, was seen to herald some promise of a future for health visiting. Unfortunately before the recommendations of the unpublished Mayston Report had been put into effect in local authorities, the Seebohm Report (Ministry of Health and Scottish Home and Health Department 1966) was published and
was seen by some to regenerate the degree of uncertainty attached to the health visiting profession. The Seebohm Committee drew a sharp distinction between the work of the health visitor and that of the social worker, with the result that many local authorities saw the position of health visitors as being placed firmly in primary health care teams.

In some respects, the resultant move to 'attach' health visitors to general practitioners may have been a major obstacle to the process of professionalisation, particularly in relation to acquiring autonomy, a characteristic seen as fundamental to the professional model (Freidson 1970:133). As early as 1965 Jefferys (1965) had identified health visitors as having some problems with interprofessional relationships, the Salmon Committee had agreed that nurses were found to be subordinate to the medical profession and furthermore, in practice, very little investigation or preparation was made to facilitate attachment of health visitors to general practitioners. Not surprisingly, members of the profession soon began to express doubts about the policy of attachment, the perceived abandonment of district based work, and the medicalisation of their work (Health Visitors' Association 1975:252). In a review of health visitors and health visiting, Hicks (1976:247) quoted, "For the future we can visualise the health visitor as a member of a primary care team and not as an independent advisor/clinician or as a 'practitioner in her own right' as the Council for the Education and Training of Health Visitors describe her".

Hicks' claim that the health visitor could not be seen as a practitioner in her own right was reluctantly, but duly acknowledged by the profession. After all, how could health visitors be considered practitioners in their own right when they were paid through the nursing budget of the NHS and were professionally and managerially accountable to nurse managers, many of whom may have had little or no experience of health visiting practice?
The profession, however, defended the description of the health visitor as an independent practitioner (i.e. able to set her/his own priorities and objectives) and this basic concept is still highlighted in health visiting course curricula today, although with the advent of purchasers and providers in our contemporary health service this independence of the health visitor will be sorely tested (see Chapter Two).

During the 1970s there were many other factors which influenced the development of health visiting and which increasingly focused the attention of health visitors on the subjects of health education and health promotion. The changing pattern of diseases which are partly attributable to changing human behaviour, e.g. drug addiction, solvent abuse, VD, coronary artery disease etc. have presented a great challenge to the health visitor’s educative role and possibly to his/her selection of priorities in health visiting. Public demand leading to legislation have also had an impact, for example in the area of child abuse rigorous methods of record keeping have been instituted (Children Act 1989). Health visitors have been described as supporters and advisors to parents and at the same time as assessors of child development and the possibility of child abuse, a conflict of professional roles that has been perceived as detrimental to health education (McCarthy 1992). Also, probably because the National Health Service Act 1946 had made it a statutory responsibility for local authorities to provide a health visiting service for expectant and nursing mothers and for giving advice as to the care of young children, some onlookers perceived that the health visiting role was too narrowly focused on children under five years, thus inhibiting involvement of health visitors in community development (Poulton 1977). Whilst other onlookers predicted that increasing numbers of elderly people and immigrant families would increase demands on health visitors’ time (Akester & MacPhail 1963), Clark (1973) and other researchers found that the work of health visitors was not focused solely on the
needs of children under five but covered the health needs of all family members including the sick and the elderly (Gilmore 1970; Clark 1981). Recognising the complex and difficult role of health visitors and probably sensing their own demise the CETHV (1977) identified and publicised the principles considered to reflect the nature and content of health visiting practice.

These were:

1. The search for health needs.
2. The stimulation of awareness of health needs.
3. The influence of policies affecting health.
4. The facilitation of health enhancing activities.

Analysis of these principles demonstrates without doubt that health visitors were indeed well ahead of the rest of the nursing and medical profession not only in proposing health education/health promotion activities and strategies affecting individual lifestyles and behaviours, but also in highlighting policy perspectives for health.

It seems highly regrettable to the researcher that these specific health visiting principles were neither examined in practice, nor made the subject of Department of Health funded research, particularly as the most recent government health publications purport to support health promotion activities (DOH 1989(a), DOH 1991). (see Chapter Two).

Gott and O'Brien (1990:167) in their study of the role of the nurse in health promotion comment that "Community nurses in general and health visitors in particular will probably be in a position to work across the greatest number of health promotion fronts". These words have fallen on stoney ground.

Within months of the CETHV's investigation of the principles and practice of health visiting, the Nurses, Midwives and Health Visitors Act (1978) came into being.
The Act subsumed (with other nursing statutory bodies) the existing CETHV into a
United Kingdom Central Council (UKCC) and four National Boards for Nurses,
Midwives and Health Visitors (HMSO 1979). By 1983 the Nurses, Midwives and Health
Visitors training rule 18(1) (Statutory Instrument No. 873), required candidates entering
training for admission to Parts 1 to 8 of the register (P2000 nurses) to "acquire the
competencies required to:

a) advise on the promotion of health and the prevention of illness.
b) recognise situations that may be detrimental to the health and well being of the
   individual."

It is interesting to note that whereas the CETHV principles document had
indicated social policy perspectives, the UKCC training rules indicated an individualistic
approach (see Chapter Two).

During the 1980s a major review of all pre-registration nursing education took
place (UKCC 1986). Whilst the Project 2000 competencies for student nurses
demonstrated a switch from an individual medical model style to a more collaborative
health focused approach, the report still acknowledged the lead given by the health
visitors to the profession in relation to health promotion activities (UKCC 1986:52).
Other important developments likely to have an impact on the future of health visiting
include the publication Targets for Health for All (WHO 1985) and the Ottawa Charter
for Health Promotion (WHO 1986).

Recognising the importance and relevance of these two publications, the Health
Visitors' Association responded by publishing Whither Health Visiting? (Goodwin 1988).
The report showed the importance of the health visiting service being focused on needs
and based on epidemiological principles. It also emphasised the urgent need for the
health visiting profession to move away from an individualistic interventionist approach,
to a more radical social action model of health education/health visiting practice as
described by Slavin and Chapman (1985).

Prior to, and since the publication of *Whither Health Visiting*, a number of
policies and publications have emerged from the Department of Health. These included
the White Papers (DHSS 1987, DOH 1989a, 1989b) which were closely followed by the
National Health Service and Community Care Act (1990).

According to Cowley (1991) all this recent legislation has ignored the role of the
health visitor and community nurses and given the lead for health promotion to general
practitioners. In the researcher's opinion the Government's decision to give the
responsibility for health promotion to GPs will undoubtedly impact on the role and status
of practice nurses. If health promotion in group practices is focused on disease
prevention via immunisation, health education and the provision of routine screening
tests, then practice nurses are ideally placed to provide such services at the GPs behest.
Also, at present, practice nurses command lower salaries than health visitors, district
nurses and community psychiatric nurses which makes them an attractive proposition for
GPs seeking to expand their health promotion services. Furthermore, the fact that many
practice nurses are employed by GPs and paid only for sessions worked, incurring no
employment 'on costs' such as national insurance and pension schemes creates a
dangerous precedent regarding the future terms and conditions of employment for all
community nurses.

It is suggested that it is not simply a matter of coincidence that the number of
practice nurses employed by GPs is steadily increasing. Ross (1992) found that the
number of practice nurses employed in England and Wales since 1986 had quadrupled
and, unpublished figures on the community nursing workforce (England only) confirm
this trend.
Table 1.1 Trends in Community Nursing Workforce (WTE) 1985 - 1990
(England only)

<table>
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</thead>
<tbody>
<tr>
<td>Health Visitors</td>
<td>10,680</td>
<td>10,800</td>
<td>10,730</td>
<td>10,680</td>
<td>10,050</td>
<td>10,480</td>
</tr>
<tr>
<td>District Nurses</td>
<td>9,930</td>
<td>9,990</td>
<td>9,500</td>
<td>9,390</td>
<td>10,160</td>
<td>10,380</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>2,502</td>
<td>2,983</td>
<td>3,479</td>
<td>4,632</td>
<td>7,695</td>
<td></td>
</tr>
</tbody>
</table>

Source: DOH 1992

The figures in Table 1.1 show that the number of practice nurses employed since 1986 has increased by over 300% compared with the district nurse workforce, which despite the trend towards community care (National Health Service and Community Care Act 1990), and increasing hospital throughput, has increased by only 5%. Significantly, the health visitor workforce has decreased by 2% over a five year period.

Most practice nurses have had minimal training (e.g. six weeks compared to one year health visitor/district nurse courses) for the complex role of health promotion, and what training they have had has tended to be based on a sickness/medical model. Furthermore, practice nurses have very little autonomy being both accountable and subservient to the doctors in charge of their practices. No matter how much practice nurses may protest at this analysis, the fact remains that at present services provided by practice nurses are determined by their patients' medical registration and current illness profile, rather than their personal, social/economic and/or occupational position.

At the time of writing this thesis, the UKCC has recently published a report on proposals for the future of Community Education and Practice (UKCC 1991). This report is currently out for consultation with the professions, and the new purchasers and providers in the health service. The results of these consultations are expected in the
imminent future. The report seems to suggest a diminution of the roles of health visitors and district nurses with the work of practice nurses increasing at their expense.

SUMMARY

In summary this short account of the development of health visiting has attempted to demonstrate the struggle of relatively small groups of health visitors (mainly women) to advance professionally. From the inception of the health visiting profession, health teaching, health education and health promotion have been central concepts in the many role descriptions of the health visitor which have emerged over time.

How effective health visitors are in this role has never been properly examined and this may be politically significant. Although, as a group, health visitors have come a long way towards correspondence with the professional model (Volmer and Mills 1966), as evidenced by their increasing knowledge base, level of education, and achievement of their own professional organisation etc., politically health visitors remain in a weak position. This perceived weakness is probably due to a number of factors. These include:-

a) the comprehensive but complex nature of the health visitor's role.
b) the position of health visitors in a 'sickness centred' NHS.
c) the roles played by other healthcare workers in health promotion and health education.
d) the politics of health promotion per se.

The next chapter of this thesis will examine some of these issues more closely.
CHAPTER TWO

HEALTH EDUCATION AND HEALTH PROMOTION IN THE
CONTEXT OF THE NATIONAL HEALTH SERVICE

PAGE NO.

The development of health education as a profession. 22.

Health education and health promotion in practice. 29.

The development of health promotion and the influence of
the World Health Organisation. 31.

Health promotion in a national 'sickness' service. 33.

Summary. 38.
CHAPTER 2
HEALTH EDUCATION AND HEALTH PROMOTION IN THE CONTEXT OF THE NATIONAL HEALTH SERVICE

Throughout the twentieth century all health care systems have tended to focus primarily on medical and illness care not health care. Such medicalisation of care highlights not only the prescriptive nature of the 'disease expert' but also a tendency by the 'disease expert' to view ill health as a problem of unhealthy lifestyle (normally attributed to individual inadequacy rather than as a result of social and/or economic processes). As we have already seen in Chapter One, one of the early responses to the perceived problem of ill health in working class people was the appointment of health visitors to teach mothers infant care and hygiene in the home. Interestingly, Tones (1991:6) suggests "perhaps this is one of the first examples of 19th century victim blaming". Dingwall (1977) however, makes a contrasting point by suggesting that the early health visitors facilitated a considerable amount of self help. Although Dingwall was referring to the development of the health visiting profession per se, it is quite likely that this self help culture would have permeated down to some extent, to the health visitors' clientele. This would be in direct contrast to the patient's deference to the physician in the doctor-patient relationship described by Freidson (1970:113).

In the post war period, as the medicalisation of care expanded, it soon became apparent that a number of health issues were not being properly addressed, and the subject of medicalisation received a great deal of attention from social scientists, social anthropologists, doctors and others (Wadsworth et al 1973; Hannay 1979; Zola 1973). The term medicalisation refers to the way in which the power of modern medicine has expanded in recent years, and now encompasses many problems that formerly were not
defined as medical (Gabe and Calnan 1989). Freidson (1970) suggests that this expansion of medicalisation is primarily a consequence of the medical profession exercising its power to control what constitutes health and illness in order to extend its professional dominance. Medicalisation can operate on at least three levels, Conceptually when a medical definition is used to explain a problem, institutionally when doctors legitimise a programme or problem in which an organisation specialises, and interactionally between doctor and patient when actual diagnosis and treatment of a problem occurs. The term 'medical imperialism' is used by Strong (1979) to capture the increasing and encroaching medicalisation of the social world. The recognition of this medicalisation of care resulted in a series of criticisms of the medical profession. McKeown (1979), for example, suggested that not only was medicine having difficulty in dealing with chronic degenerative diseases, but it was neglecting its caring role. Illich (1976) claimed that dependence on the medical profession diminished the ability of people to face reality in illness, and such dependence frequently undermined individual autonomy in the management of care.

Numerous authors have been critical of the medicalisation of childbirth, claiming that childbirth has moved not only from a social and biological event to a medical and pathological event, but also from female orientated midwifery to male dominated obstetrics (Finkelstein 1990; Oakley 1984; Savage 1986).

This type of criticism of the medical profession drew attention to the need for society to develop alternative approaches to health and illness and health education began to emerge in the late 1960s and early 1970s as one potential solution to the perceived shortcoming of medical care (Tones 1985).
THE DEVELOPMENT OF HEALTH PROMOTION AS A PROFESSION

According to Sutherland (1979), the Jameson Report (Ministry of Health 1956) was the first government report to state that health education was important, because it was closely linked to factors such as social advice and social action (paragraph 287). This was in sharp contrast to the medical focus taken for granted up until this time.

Sutherland (1979:14) asserts that, "From the date of this report onwards one can trace a collective movement which no longer relies on the enthusiasm of individuals". It is paradoxical that whilst a collective movement was being formed to promote health per se, health education as practised then, and to a great extent as it is practised now, still offered an individualistic solution to health problems. The reasons for this are explained later.

The Cohen Report on Health Education (1964:19) recommended 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. The board would 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 in the conduct of programmes locally. It would foster the training of Specialist Health Educators, promote training in health education for doctors, nurses, teachers and dentists, and evaluate the results achieved by health education".

Three interesting points are found in this recommendation. First, the recognition by the Committee that doctors themselves needed training in health education, secondly that intersectoral approaches to health education involving lay and professional expertise would be beneficial to the public, and thirdly that there should be evaluation of the results of health education. It is interesting, if not surprising, that it has taken nearly twenty
years for these recommendations to be appropriately addressed. As a result of this report a Health Education Council was set up in England in 1968. The Council was set up as a limited company and, as such, health education activities were subject to financial and managerial control, rather more in keeping with the 1990s culture. In Scotland the existing Council in Health Education remained and a new Health Education Unit within the Scottish Home and Health Department was established.

The Cohen Report (1964) and the Kirby Report on the Education and Training of Health Education Officers (1981) gave substantial support to the view that the role of health education officer (HEO) was a specialist occupation, and a Society of HEOs was founded in 1982. Thus historically, in occupational terms, by the mid 1970s there were two groups of non medical health professionals, namely health visitors and health education officers, with health education/health promotion as a central function of their roles.

Educationally, the first full time course for health education officers began at Leeds Polytechnic in 1972. The course was initially at diploma level. A second course followed in 1974 at South Bank Polytechnic. Postgraduate education for health education officers was also established at Leeds Polytechnic in 1972. In comparison, despite their early origins and their entry to higher education in 1962, the first and only postgraduate course for health visitors did not materialise until 1986 (at South Bank Polytechnic). Even then this postgraduate course had its critics, almost exclusively from within the nursing profession. The criticism was largely due to a perceived elitism in the health visitor course compared to other nursing courses. Regarding working practices, there are claims by both professions that there are differences in the way health visitors and health education officers perceive, interpret and act out their roles in health education/health promotion. These differences will be discussed later in this chapter,
however, first one needs to expand on the development of health education officers as an occupational group.

Whereas all health visitors had to be nurses and thus were socialised into their professional role of working for doctors as well as with doctors, health education officers were spatially distanced from the medical profession, some being based in local authorities, others specifically outposted away from hospital settings. Health education officers were recruited from a variety of occupational groups providing the potential for their gender mix to be more balanced than the 98% female composition of health visitors. A sample of HBO/HPOs (n = 518) in a study undertaken in October 1985 by Rawson and Grigg (1988:24) however, showed 73% of their sample to be female.

A breakdown of the backgrounds of health education officers may help explain the gender composition. In a study of the role and function of health education officers (Tones 1974), the previous occupational experience of the sample was surveyed. Nursing was found to be the background of 53% of the health education officers, teaching formed the background of 16%, whilst the remaining HBOs came from administration, dietetics, the public health inspectorate, and a combination of teaching and nursing. The occupational background of 12% of Tones's sample of health education officers was unknown. Given that over half of the sample came from a nursing background it is not surprising that the gender mix tended to be female biased.

In a more recent study, Rawson and Grigg (1988:25) assert that "whilst nursing and teaching still account for the majority of health education officers experience (67%), nursing only forms 28% of the contemporary picture, (that is a reduction by almost half)". The researchers do not comment on whether selection procedures have been responsible for the reduction in the number of nurses entering the profession, whether more applications are received from other occupational groups, or whether there has been
negative discrimination against nurses wishing to reach this position. There is also the question of whether the practice and approach of ex-nurse health education officers differ from that of non-nurse health education officers, and if so, in what ways do these differ?

With regard to the role and function of health education officers, Rawson and Grigg (1988) found that the greatest proportion of health education officers' time was spent in dealing with the health education methods and media (e.g., group teaching, campaigns etc.), although these were related to numerous processes surrounding health topics such as smoking, alcohol, nutrition and drugs etc., this is discussed later. The topics were elicited by Rawson and Grigg (1988) through analysis of work diaries completed by health education officers for their research on the 'Training and Development Needs of Health Education Officers' (SHER Project).

The researcher attempted to use various sources to compare the nature of practice between health education officers/health promotion officers and health visitors but this proved difficult for a number of reasons. First, the Rawson and Griggs (1988) study comprised a 1 in 5 sample of practising health education officers and secondly the respondents were sampled nationally. Although a number of health visiting studies (which also used work diaries) have been completed, (Marris 1971; Clark 1973; Henderson 1977) the content of the work rather than the nature and process of the work was examined making direct comparisons difficult. Also, as well as being very dated studies there is no certainty about the completeness, or reliability of these studies, as it is doubtful whether a full range of health visiting activities can be reflected in diary recordings of only 1 or 2 weeks duration. Clark (1973), used a designed visiting schedule for a one week period, and Marris (1971) and Henderson (1977) used diary recordings of only two weeks duration. To illustrate the probable gaps in these studies, had the health
visitors completed the diaries in summer, advice on hypothermia would not have been reflected in the results.

First, with reference to the reliability of such studies, Clark (1981:26) in her critique of health visiting research using diaries, makes the point that "unless such records are properly completed their reliability is doubtful, and their apparent precision spurious". Secondly, whereas the SHER study had sampled 1 in 5 of all practising health education officers, the study of health visitors completed by Marris (1971) was confined to the work of health visitors in London, the study by Henderson (1977) explored the work of health visitors in Hampshire, and the work of Clark resulted in a descriptive analysis of health visiting in Berkshire. One would therefore be making national versus local comparisons which may or may not be appropriate to this study. Thirdly, although a number of more recent studies involving health visitors or health visiting have been completed (Vetter, Jones and Victor 1986; Robinson J. 1982; Robinson K. 1987; Cowley 1991) these studies mainly focus on specific elements of health visitors' work such as health visiting the elderly (Vetter et al 1986) and conversational and content analysis of health visiting interactions (Robinson K. 1987). However, because of the highly specialised and unidimensional nature of health visiting practice examined by these authors, it was felt by the researcher that despite the time interval since the work of Clark (1973) and the limitations of being confined to Berkshire, it was still the most appropriate together with the 1988 SHER study for Health Education Officers, for use in comparing the two roles.

The comparison demonstrates clearly that, at the outset of this research, there appeared to be many similarities and very few differences in the content of the work of the two groups of professionals. This can be seen in Table 2.1 (overleaf).
<table>
<thead>
<tr>
<th>Health Education Officers/Health Promotion Officers</th>
<th>Health Visitors</th>
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</thead>
<tbody>
<tr>
<td><strong>% of Time</strong></td>
<td><strong>Topics</strong></td>
</tr>
<tr>
<td>1. Other Multiple</td>
<td>29</td>
</tr>
<tr>
<td>2. Health Education Methods</td>
<td>20</td>
</tr>
<tr>
<td>Alcohol</td>
<td>5</td>
</tr>
<tr>
<td>Drugs</td>
<td>6</td>
</tr>
<tr>
<td>4. None</td>
<td>7</td>
</tr>
<tr>
<td>10. Mother and Baby Care</td>
<td>2</td>
</tr>
<tr>
<td>13. Dental</td>
<td>1</td>
</tr>
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</table>

Source Rawson and Grigg SHER Project (1988)  
Source Clark (1973)

Analysis of Table 2.1. indicates a fourth difficulty in making comparisons between the two studies. Rawson and Grigg use time spent on a health education topic by health education officers as a measurement of work priorities (e.g. 1% of health education officers time is spent on accident prevention). Clark however uses proportion of households visited in which a given topic is discussed by health visitors, as a measure of work priorities (e.g. dietary issues for under one year olds was covered in 37% of households visited). With regard to similarities, key topics covered by both groups include nutrition/diet, general health/body maintenance, accident prevention/home safety,
family planning, mental health issues and mother and baby care. One should emphasise that although it may seem from these examples that most of the health visiting advice or discussion relates to under five year olds, this was not the case. The key finding of Clark's research was that the work health visitors did was much more varied than the 'underfives visitor' stereotype suggests. It is also important to explain that visiting under five's gives access to a variety of carers and social groups which very few other professionals (if any) can match. Clark's findings were reflected in the title of her research, namely 'A Family Visitor'. Health visitors in Clark's study appeared to cover many social issues such as housing and employment and psycho/social issues such as emotional and behaviour problems, marital disharmony and adjustment to illness.

The time difference between the studies may account for the health education officers' particular focus on smoking, alcohol and drugs which reflect addictive behaviours of the late 1980s. Another key topic covered by the health education officers was use of the National Health Services. This approach demonstrated their role in empowering the public in this case to access themselves to NHS Services. Perhaps most significant of all was time spent by health education officers on health education methods and media. This concerns the method and process used in health education, an issue apparently not seen as pertinent at the time of the health visiting studies, but an issue which is of vital importance to the process of self empowerment and the promotion of health (Anderson 1986) (A topic which is revisited later in this thesis).

Finally, in relation to topics covered by health education officers, the largest amount of their time appears to have been spent on the 'other multiple' category. Topics in this category are not specified but may include those initiated by clients themselves, and research exploring consumer initiated health topics would provide a highly relevant health promotion perspective. Remaining topics specific to the health visitors' work
embrace issues mainly related to primary prevention such as immunisation, housing, home safety etc. According to Caplan's (1961) explanation, such action is designed to prevent the occurrence of a problem and, in the researcher's view, primary prevention relates far more closely to the WHO's concept of health promotion. Other topics discussed by health visitors in this research e.g. screening, child development, and postnatal care are good examples of secondary prevention, i.e. the detection of illness or deviation from normal where intervention may cure or control.

HEALTH EDUCATION AND HEALTH PROMOTION IN PRACTICE

Although analysis of the two studies reveals more differences between the two groups of professionals in terms of their mode of working and the amount of contact with patients/clients, it is hardly surprising to find so many similarities existing between and within the health visiting and health education professions, given that both groups function within the context of the National Health Service. Rodmell (1983:3) asserts that "the medical profession had determined the ideological imperatives for health education". At the time of writing, Rodmell perceived health education officers as having to constantly seek affirmation and approval of their activities from medical practitioners. Likewise, the attachment of health visitors to general practitioners in the late 1960s resulted in a large element of medical control over the health visitors' work. This was evidenced by a group of health visitor field work teachers who identified 'GP referrals' as the second most important priority in their work (Chapman 1979). General practitioners themselves, working as generalists within a highly specialised profession, were seen to pursue the approach of individualism in their practice seeing health status as a matter over which the individual had control (Rodwell 1986). Naidoo (1986:18) in his critique of individualism, asserts that individualism denies that health is a social product, assumes
that free choice exists and furthermore is not effective within a person's own terms of reference. (See also below).

In practice, Tuckett et al (1985) in a study of 1,470 consultations found that general practitioners' efforts to increase their patients' knowledge of health issues by providing information and explanations were limited, unsystematic and opportunistic. Only one third of the patients observed were given comprehensive advice on a particular health issue and some patients with obvious problems were offered little or no advice at all. Similarly, a number of other studies have supported the view that interest expressed in health education and health promotion by general practitioners has not been reflected in practice (Armstrong 1988; Killoran 1993). These studies suggest that a more equal doctor/patient relationship is needed where patients are helped to make decisions for themselves.

In relation to the way patients communicate their health concerns to professional health workers, the work of Blaxter and Patterson (1982), Graham (1984) and Calnan (1986) demonstrate clearly that an understanding of lay perspectives of health care is crucial for general practitioners and others to deal effectively with patients, particularly when advising on health education issues. In a study exploring the perceptions of women from different social classes regarding health maintenance and prevention of illness, Calnan found health beliefs to be both complex and sophisticated, and products of social, economic and cultural environments. "Health education needs to be appropriate for the needs of groups living in different environments" (1986:176). Similarly with regard to free choice, Graham (1984:188) found that women had in fact very little choice. Their lives and actions for health depended much more on their routines and network of carers than on any professional advice available.
Thus health education during the late 1970s and early 1980s whether delivered by health visitors, health education officers or general practitioners tended to be very much information giving focusing largely on individuals and sometimes on specifically targeted groups such as smokers, alcoholics, disease sufferers and others perceived to exhibit deviant behaviour. Few evaluation studies were done on the effectiveness and efficiency of these health education activities but it was already clear to a number of critics that environmental and social processes needed to replace the individual focus of attention (Abbott and Sapsford 1988; Draper 1991).

THE DEVELOPMENT OF HEALTH PROMOTION AND THE INFLUENCE OF THE WORLD HEALTH ORGANISATION

According to Tones (1986:5) the World Health Organisation Conference on primary health care in Alma Ata (WHO 1978) defined the parameters and development of health promotion. Health education had traditionally focused on information giving, assuming that individuals were able to choose whether or not they accepted such information, or acted upon it. In contrast the WHO strategy of health for all by the year 2000 went beyond the individualistic model. New horizons became apparent, which included awareness of the necessity of generating policies which might directly and positively influence peoples' health, the development of legislation against anti-health practices, processes and activities, and the identification of targets for improving the quality of life. They are overall, not dissimilar to the principles of health visiting identified by a working group of health visitors and published by the Council for Education and Training of Health Visitors a year earlier. The CETHV (1977:9) identified four principles of health visiting processes and practice. These were:

1. The search for health needs.
2. The stimulation of awareness of health needs.

3. The influence on policies affecting health.

4. The facilitation of health enhancing activities.

These principles identified an urgent need to influence policies rather than focus on individual solutions to problems. The search for health needs highlighted the importance of epidemiological analysis to determine priorities in practice, and the remaining two principles indicated a major drive towards promotion of health rather than secondary or tertiary prevention of ill health. It is interesting that the publication of the CETHV report received few accolades except from within the health visiting profession itself. The WHO publication (1978) which in essence said little more than the CETHV document, received almost worldwide acclaim. Discounting the amount of publicity surrounding the WHO publication, it was perhaps because health visiting was poorly recognised within the nursing profession and was a small and virtually female occupational group, that its pronouncements were largely ignored.

Four years later a summary report of a working group on the concepts and principles of health promotion (WHO 1982:6) argued for a demedicalisation of health stating that "because of the traditional orientation of the medical profession towards disease prevention its contribution to health promotion is likely to be limited". The wider realisation that health promotion needed a multisectoral approach in which people, occupations, professions and committees could readily participate, probably stimulated all those working in health care to look critically at the theory and principles underpinning their own practices, and management of health issues. (An overview of theoretical approaches to health education and health promotion is given in Chapter Ten).

In the period 1985-90, the promise of a new era was heralded for those professional groups working in health education/health promotion (WHO 1986; 1987). It was new in
the sense that, with the demedicalisation of health, non medical health professionals might have a real opportunity to work more autonomously and collaboratively than before. In contrast to this, in the United Kingdom a new enterprise culture was introduced, resulting in government policies which have had a direct and indirect impact on the National Health Service and the way in which health education and health promotion is delivered (Department of Health 1989a, 1990, 1991).

The next part of this chapter will briefly examine the concept of health promotion in relation to the National Health Service per se.

HEALTH PROMOTION IN A NATIONAL SICKNESS SERVICE

In their analysis of British health policy, Harrison, Hunter and Pollit (1990) identify the problematic nature of management of the National Health Service. Examining a plethora of recent policy documents - Caring for People (DH, 1989a), Working for Patients (DH, 1989b), the authors illuminate the many different perspectives embedded in the reports, and, in consequence, question the precise aims of the NHS. "Are they essentially about care, about cure or, as seems more likely, about some combination of all these?" (1990:68).

Whilst identifying that the NHS has a contribution to make to the achievements of the WHO strategy, Health for All, the authors draw attention to the fact that both the Royal Commission on the NHS (1979) and the document Working for Patients (DH, 1989b) endorse the fact that the NHS has always been a 'treatment service' (1990:69) and herein lies the crux of the matter. The authors in their analysis make a number of telling statements about why health promotion in the NHS has not really progressed beyond rhetoric.

One of the key reasons for this is budgetary allocation and control, and as
Harrison, Hunter and Pollit (1990:71) state, "In the NHS acute sector interests have successfully resisted any challenge from competing sectors and have protected budgets from being allocated to different priorities despite some local successes in implementing the shift in priorities".

When the new market system was first introduced into the health service GP fundholders were encouraged to hold health promotion clinics. From July 1993 health promotion clinics will be replaced by health promotion programmes (Killoran 1993:26). Fundholding and non fundholding GPs may apply to their Family Health Services Authority (FHSA) for payment and the amount of payment will depend upon the levels of health promotion activity, including opportunistic work as well as a structured range of activities such as group discussion and teaching.

To date, much of the work being done by GPs and/or their practice nurses may be described as disease orientated with immunisations, annual health checks for those people over 65 years and routine screening tests representing secondary and tertiary illness prevention rather than the health promotion as envisaged by the World Health Organisation (WHO 1984). The fourfold increase in the number of practice nurses appointed by GPs during 1990-92, which is discussed in Chapter One, highlights the tight control over health promotion exercised by the medical profession; a trend which runs contrary to the WHO's recommendations for the demedicalisation of health. The latest publication on Government Policy relating to health care and health promotion - The Health of the Nation (DOH 1991) further reinforces this perspective in that priorities for health promotion continue to be defined within a disease framework. This is exemplified by the topics chosen for targeting which include coronary heart disease, diabetes, cancers, stroke, smoking and asthma. Dietary issues and prevention of accidents are also
included, but the secondary prevention of disease remains the main framework for the UK's health promotion policy within the NHS.

The identification of these disease or illness related topics, demonstrates a limited form of health promotion, largely ignoring the WHO (1984:unpublished) perspective that "health promotion is directed towards the determinants or causes of health and therefore requires close co-operation of sectors beyond health services". Although the UK Government does acknowledge the need for local communities, the voluntary sector, industry, commerce and trade unions, etc. to become involved in achieving these targets, there is little evidence to demonstrate an intersectoral approach at national policy level. The Departments of Trade and Industry, Environment, Agriculture and Fisheries, Housing, Education etc., all departments which have considerable influences on health, are currently battling with the Treasury to retain their own highly segregated and specifically targeted resources. This scenario supports the view expressed by Millo (1986:130) that "it is common in industrial nations to segregate the health sector from other policy areas". Rather than encourage multisectoral approaches to health like those, for example, used in Norway (in food and nutrition) the UK Government has chosen to allocate a post graduate education allowance for GPs and the earmarking of specific resources for postgraduate and continuing medical and dental education, (DOH 1991:112) thus ensuring the medicalisation of health. Not surprisingly the same report just happens to mention that the nursing profession has adopted "a strategy which encompasses planning, training and the use of nursing personnel in line with Health for All policies and the primary care approach" (DOH 1991:112). In contrast to the funding of medical education for health promotion, no mention of resources is made for the education of those nurses, midwives and health visitors who have not had the privilege of
undertaking a Project 2000 course which presumably is argued by Government to adequately prepare nurses for health promotion activities.

Outside clinical practice, apart from health visiting practice, health promotion is perceived by health care professionals to be operationalised through health education, the responsibility now of the Health Education Authority (for England), and District Health Education Units (rapidly being changed to Health Promotion Units) locally (see below).

The Health Education Authority (HEA) is a special health authority, special in that it is separate from Regions and Districts, but, it is answerable to a Board of Officers who are appointed by the Secretary of State for Health. Although the Board currently has representatives from education, sport and the Church, it continues to benefit from strong representatives from the medical profession. It is hardly surprising therefore that the Health Education Authority's 1992/93 Operational Plan (HEA:1992) identifies seven programmes for health promotion which almost duplicate the priorities outlined in the Health of the Nation (DH 1991). The programmes include:-

- HIV, AIDS and Sexual Health Education.
- Heart Disease Education.
- Cancer Education.
- Smoking Education.
- Nutrition and Dental Health Education.
- Alcohol Education.
- Family and Child Health Education.

Operationalisation of these programmes will depend on the 2575 health education/health promotion officers in post, situated in 260 units throughout England, Wales and Northern Ireland (Rawson and Grigg 1988). Health Education Units vary in size, the largest being cited in Glasgow and comprising twenty-five to thirty staff, other
medium size units comprise six to eight staff whilst smaller units hold two or three health education officers/health promotion officers. Given the prescription of priorities described above it is little wonder that the central place of medicine in health promotion is seen as problematic by some health education officers, academics and others. Authors from the Research Unit in Health and Behavioural Change, University of Edinburgh (RUHBC 1989:144) state that "although health education is an integral part of health promotion, the latter cannot be conceived narrowly within a disease prevention model". Even before the publication of Health of the Nation (DOH 1991) and the Health Education Authority's priorities for health, Marks (1988) was critical of the government's health promotion programme, stating that "By narrowing the focus of health promotion into the role of individuals and their GPs, and by narrowing the focus of general practice into preventive care, some complex debates are neatly evaded" (1988:17). An example of one such debate is the present Government's refusal to ban advertisements for cigarettes. Other subjects which merit more public debate and implementation of health promotional policies by government include the health of the homeless, harmful nitrate levels in drinking water, and high levels of dioxin which can cause cancer, genetic defects, and reduced sperm count. High levels of dioxin have reputedly been found in the production of chemicals used to produce adhesives, fungicides and film (Scott 1993:4). Examples of this kind of serve to illustrate the need for policy decisions at societal level rather than decisions focusing on individual health issues. In some cases government can be challenged for diminishing health promotion, for example in weakening Health and Safety legislation and in abolishing the low pay unit thus depriving individuals and families of an agreed minimum wage. The decision to abolish the low pay unit flies in the face of much research which clearly demonstrates the relationship between wealth and health (Blaxter 1990, Blackburn 1992).
In summary then, we have seen the World Health Organisation's advocacy of the empowerment of individuals, professionals, committees, communities and organisations to formulate and participate in health promotion activities. The WHO perspectives have also raised an awareness of the need to transform social structures, policies and conditions that contribute to ill health. In a discussion of the principles of health promotion, WHO (1984) identifies the need for political commitment to health promotion at all levels, local, regional and national. Despite these suggestions, we have seen in the UK a new market style management in which there is even tighter budgetary control involving contracting and competitive tendering. The responsibility for health promotion has been put clearly in the hands of general practitioners, perhaps the least well prepared group of professionals for that role. Killoran, for example in examining the current position of training in health promotion identified that 26% of GPs had no training in health promotion and that over half of practising GPs had requested training in practice organisation and management (1993:27). As to why GPs have been 'granted' such a prominent role in health promotion, the researcher suggests that one reason is that the medicalisation of health depoliticizes health thus diverting attention away from social issues such as those described above. Another possible explanation for GPs being given responsibility for health promotion is that it begins to shift the balance of power away from consultant providers to GPs and their FHSA purchasers/managers. We have also explored the emergence of health education/health promotion officers who, it was initially envisaged, would offer an alternative approach to the biomedical definitions, treatments and approaches to health, but this has not happened for the reasons discussed above.
Thus, whilst we have all the rhetoric about health promotion, the reality is that although health promotion is currently seen as an important force within the 'new public health' (Bunton and Macdonald 1992:1), there has been little or no change in the organisation of health promotion and there has been, to date, little or no visible shift in allocation of health resources and the management of health, except to GPs which means the medicalisation of health is strengthened.

Whereas this chapter has sought to contextualise the position of health promotion in relation to World Health Organisation and government policies, the following chapter seeks to explore the views of health care professionals from an empirical perspective. Chapter Three therefore outlines and discusses the initial research aims of this thesis.
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<td>The context of the workplace of the health professionals.</td>
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PART TWO - THE QUALITATIVE PHASE OF THE RESEARCH

CHAPTER 3

THE QUALITATIVE PHASE OF THE RESEARCH

PRELIMINARY AIM OF THE RESEARCH

The first chapter of this thesis began by describing the development of health visiting as a profession and its early role in health teaching and health education. Recognition by the profession itself, of the need to move from an individualistic approach to a community health and epidemiological perspective was noted. The second chapter identified health education officers as a 'significant other' group of non medical health professionals involved in health education and health promotion. The context in which these two groups of professionals practice, namely, the National Health Service, was examined.

Analysis of the context in which health visitors and health education officers work, and their relationships to the medical profession, goes some way to explain the problems associated with the perception and operationalisation of health promotion.

At the outset of the study, the researcher identified the conceptual confusion between health education and health promotion, identified not only by the professionals themselves, but also in the literature available at the time of the commencement of the study (1986).

The preliminary aim of the study therefore was to attempt to achieve clarification about how health promotion is defined and interpreted by health care professionals themselves. Further aims of the study would be derived from the findings of this qualitative part of the research.
TOWARDS A METHODOLOGY

It is generally agreed in the literature that a profession and/or a semi profession is driven and led by influences both within and outside the profession itself. Such influences might include, professional bureaucratisation, internal management, routinised practices, health authority policies and definitive reports (Wilensky 1969, Chapman 1979, Esland & Salaman 1980). It is perhaps less frequently acknowledged that individuals construct the meaning and significance of their lives by bringing their own values and complex framework of beliefs to characterise, categorise, explain and predict the events of their life and work (Fransella 1970; Kratz 1978:29).

In her study of the care given to stroke patients in the community, Kratz (1978) for example, discovered that district nurses tended to bring many of the values from their experience in acute nursing, to their care of the chronically sick in the community. Kratz also found that decisions made by district nurses on the type of care that they should give to patients emanated from the nurses’ own biographies, rather than being based on the actual health status of the patient. Recognising the significance of these findings, it was thought desirable by the researcher, to explore individual orientations and beliefs in relation to health promotion.

In order to probe the personal and professional beliefs that were held about the concept of health promotion, the researcher decided to use a grounded theory approach, not as an end in itself, but as a method of concept clarification. It was hoped that appropriate research questions would be elicited from the professional practitioners to enable the researcher to generate hypotheses and test them in the second part of the study.

Glaser and Strauss (1967) introduced the term 'grounded theory' to describe a methodology in which constructs or theories are generated from data, and remain grounded in the world in which they are located. Lofland and Lofland (1984:2) state that
this type of qualitative approach allows both the researcher and participants to start from where they are at that moment. This may have certain disadvantages, for example, the gender, age, and biographical data of the participants may influence both the researcher and the researched. However, as so few empirical studies have been carried out which examine the sphere of health promotion, the researcher believed that the information to be gained would outweigh any difficulties. Added to this is the point made earlier, that individuals bring their own interpretations to their lives and work, therefore this methodological approach was thought to be of particular significance in eliciting from health professionals their own perceptions and interpretations of health promotion.

A grounded theory approach is inductive and process orientated. Glaser and Strauss (1967) explain that their research approach aims to produce a systematic account of the relationship between key variables, often confined to a particular setting. The setting in this research would most likely be the interface between the public and the health professional. The researcher intended to use either indepth or group interviews and apply the method of constant comparative analysis to the emerging data. Carrying out the concurrent procedures of data collection and analysis in this systematic and sequential way enables potentially important aspects to be gathered by the research process (Corbin and Strauss 1990). Constant comparative analysis is undertaken in conjunction with a process of theoretical sampling which involves searching the data for comparison groups according to ideas, working hypotheses or propositions which evolve as the continuous analysis proceeds. These emergent categories provide what Glaser and Strauss (1967) describe as substantive theory. Formal theory arises when one seeks to explain a process that may arise in a range of settings.

Positivist researchers tend to be critical of this type of research, largely because of
questionable reliability and validity (Baker, Bevan, McDonnell and Wall 1987:293). These issues will be discussed as the research progresses (see Chapter Six).

DEPTH INTERVIEWS OR GROUP INTERVIEWS?

In order to achieve clarification of the concept of health promotion, the first objective was to interview a number of practising health visitors, HEO/HPOs and if possible, general practitioners. The justification for choosing these groups of professionals was that all are identified in the literature as having a role in health promotion (UKCC 1986; Hunter, Harrison and Pollitt 1990; Rodmell and Watt 1986). Although health promotion officers and health facilitators were newly conceived professionals at the time of the study in 1987, they had prompted new departments being set up, and new ways of operating had been identified, therefore it was thought that research on HPOs would identify new perspectives and allegiances.

A great deal of consideration was given to whether the interviews should be individual depth interviews, or whether group interviews would be more appropriate. On balance there seemed to be more advantages to be gained by the use of group interviews. The main advantages were considered to be those highlighted by Hedges (1985:71) and Walker (1985:8), namely that group interviews appear more useful when insight, understanding and clarification of concepts is required and when the generation of ideas (in this case for a research framework) is desirable. Other benefits in using group interviews were the opportunity for interaction amongst the professionals and an assumed saving of the researcher's time by exploring group views rather than those of individuals. The disadvantages of group interviews were considered but, as both individual and group interviews were reported to have disadvantages, it was thought that any discussion would be more appropriate on completion of the work.
SIZE OF THE GROUPS

The next objective was to determine what number represented a group. Hedges (1985:75) identifies six or seven as normally the optimum size. For the purpose of this research, it was decided by the researcher that a group would consist of not less than two individuals and not more than five. This decision was taken in the light of difficulties anticipated in transcribing tapes from essentially ‘unknown individuals’. It was thought that groups of 3 - 4 individuals would be ideal.

SAMPLING

For the first stage of the research it was recognised by the researcher that a convenience sample would be required but that the problems of representativeness would need to be addressed. Clyde Mitchell (1983) however, argues that influences and extrapolation from qualitative studies is in fact based on the validity of analysis rather than representativeness of the data. In exploring the rigour of non-positivist approaches to methodology, Silverman (1985) explains that Mitchell was more concerned with theoretical principle rather than statistical analysis. "Quantitative survey research takes great care to select a sample in a way to ensure no bias is present. The aim is to try to reflect accurately the characteristics of a parent population. Conversely, in a case study, the analyst selects cases only because he believes they exhibit some general theoretical principle" (Silverman 1985:113).

Although group interviews may not appear to directly equate with case studies, the researcher contends that the principle put forward by Clyde Mitchell can apply equally to group interviews, each group interview being a type of case study in its own right. Thus the identification of group interviews as a suitable research approach could be supported.
According to Hedges (1985:76) two groups are seen as an absolute minimum for a large scale project, so on the basis of this recommendation the researcher aimed initially to conduct interviews with two groups of health visitors, two groups of health education/health promotion officers and, if possible, two groups of general practitioners.

In order to at least partly address the problem of representativeness, it was decided to interview groups of individuals with a minimum of two years professional experience in their jobs as health visitors, health education/health promotion officers or general practitioners. It was acknowledged that the interviewees might be 'atypical' in terms of social class, educational background, professional training experience, age and other characteristics, but representative when using the criterion that general practitioners and health visitors had gone through a nationally recognised professional education and training.

In the case of health education officers (or their equivalent), although it was the trend that increasing numbers of health education officers were completing a Diploma in Health Education, this was not a mandatory course, and therefore it could not be assumed that all health education officers would have experienced similar education and training. For this reason it was considered that a minimum of two years work experience would introduce a degree of comparability across all three groups of professionals.

PREPARATION FOR GROUP INTERVIEWS

Health Visitors

A group of thirty two health visitors attending an inservice educational course at a London Polytechnic were invited to participate in the exploratory group interviews on health promotion. The health visitors all lived and worked within a 25 mile radius of London. Just under one third of the group volunteered to participate in the study, and
from the volunteers the researcher randomly selected two groups: one group of three health visitors and one group of four health visitors.

Sociodemographic characteristics of the health visitors participating in the groups may be seen in Table 3.1 and Table 3.2 (see page 48 and 49). Table 3.1 gives personal and professional details of the health visitors including age, date of qualification as a nurse, date of qualification as a health visitor, additional professional qualifications gained, size of case load and description of work base. Table 3.2 illuminates the caseload characteristics of the health visitors and where known, gives the ratio of health visitors to population in the interviewee's employing authority.

It can be seen from the tables, that the majority of the sample of health visitors had completed their health visitor training nine years before the commencement of the research, and in fact a few had trained as health visitors as long ago as fifteen years prior to the study. This had implications for the design of the second part of the research where a more representative sample would be required to enable the researcher to explore whether there are any cohort effects, such as the impact of recent training on selection of priorities or perceptions of health promotion practices.

Health Education Officers

A group of health education officers undertaking a postgraduate full-time diploma in health education at a London Polytechnic were contacted and individuals who had at least two years experience in the post of health education officers were invited to participate in the exploratory group interviews on health promotion. From a cohort of thirty students, twelve students meeting the above criterion volunteered to be interviewed. Two groups of health education officers were selected (i.e. each volunteer was given a number and two groups, one of three individuals and one of four were
randomly selected). Socio-demographic details of the groups are given in Table 3.3 with characteristics of their workloads in Table 3.4 (see page 50 and 51).

It can be seen from the tables, that the majority of the sample of health visitors had completed their health visitor training nine years before the commencement of the research, and in fact a few had trained as health visitors as long ago as fifteen years prior to the study. This had implications for the design of the second part of the research where a more representative sample would be required to enable the researcher to explore whether there are any cohort effects, such as the impact of recent training on selection of priorities or perceptions of health promotion practices.
## TABLE 3.1

**Socio demographic characteristics of convenience sample of health visitors participating in group interviews on health promotion**

*(First stage of research project)*

<table>
<thead>
<tr>
<th>Interviewee No</th>
<th>Gender</th>
<th>Date of Nurse Registration</th>
<th>Date of Health Visitor Registration</th>
<th>Other Qualifications with Date</th>
<th>Age Range</th>
<th>Size of Caseload*</th>
<th>Description of Workbase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group I</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>F</td>
<td>1961</td>
<td>1974</td>
<td>City and Guilds Teaching Cert - 1975 FWT - 1976</td>
<td>35-45</td>
<td>200</td>
<td>Inner City</td>
</tr>
<tr>
<td><strong>Group II</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>1969</td>
<td>1973</td>
<td>FWT Cert 1977</td>
<td>46-50</td>
<td>250</td>
<td>Inner City</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>1971</td>
<td>1981</td>
<td>FWT Cert 1985</td>
<td>35-40</td>
<td>&gt;300</td>
<td>Inner City</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>1955</td>
<td>1977</td>
<td>FWT Cert 1981</td>
<td>46-50</td>
<td>350</td>
<td>Inner City</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>1972</td>
<td>1974</td>
<td>FWT Cert 1977</td>
<td>41-45</td>
<td>No Caseload Held</td>
<td>Inner City</td>
</tr>
</tbody>
</table>

* Assessor = Assessor of supervised practice.
* Caseload = Number of families for whom cards are held.
### KEY CHARACTERISTICS OF CASELOADS AS PERCEIVED AND DESCRIBED BY HEALTH VISITORS PARTICIPATING IN GROUP INTERVIEWS ON HEALTH PROMOTION

#### FIRST STAGE OF RESEARCH PROJECT

<table>
<thead>
<tr>
<th>Interviewee No.</th>
<th>Caseload Characteristics</th>
<th>Known Ratio of Health Visitors to Population in Interviewees Employing Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Traditional 'White' working class; Many single parents; High number of 'Child Abuse' and 'Concern Families'.</td>
<td>Not known.</td>
</tr>
<tr>
<td>2.</td>
<td>Diverse social characteristics but above average number of young families and over 60 year olds.</td>
<td>50 Whole Time Equivalent Health Visitors to a population of 240,000.</td>
</tr>
<tr>
<td>3.</td>
<td>Principally under 5's, 50% of whom have single carers; Large number of ethnic minorities; Mixture of all social classes - some elderly.</td>
<td>Precise population not known but acute shortages with managerial acknowledgement of a deficit of 12 trained staff.</td>
</tr>
<tr>
<td>4.</td>
<td>Mixed population of 0 - 5's and elderly; Social classes I - IV mostly English speaking.</td>
<td>59 WTE to 250,000 population.</td>
</tr>
<tr>
<td>5.</td>
<td>Predominantly mothers and under 5 year olds; Screening undertaken of well adults; Clientele mainly consists of clinic attenders - this gives time for more group work.</td>
<td>1.5 WTE to 8000 population.</td>
</tr>
<tr>
<td>7.</td>
<td>In management post.</td>
<td>50 WTE to 250,000 population.</td>
</tr>
</tbody>
</table>
### Table 3.3

**SOCIO-DEMOGRAPHIC CHARACTERISTICS OF CONVENIENCE SAMPLE OF HEOs/HPOs PARTICIPATING IN GROUP INTERVIEWS ON HEALTH PROMOTION**

*(FIRST STAGE OF RESEARCH PROJECT)*

<table>
<thead>
<tr>
<th>Interviewee No.</th>
<th>Title</th>
<th>Gender</th>
<th>No. of Years in Post</th>
<th>Age Range</th>
<th>Qualifications Held</th>
<th>Description of Workbase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group III</td>
<td>8</td>
<td>HEO</td>
<td>F</td>
<td>3</td>
<td>25-34</td>
<td>B.Sc Social Sciences 1979</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CQSW</td>
<td>Dip. Ass 1982</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dip. HE 1988</td>
<td>Community based in Urban Environment</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>HEO</td>
<td>F</td>
<td>4</td>
<td>25-34</td>
<td>BA Hons Politics/French 1979</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PGCE 1982</td>
<td>Dip. HE 1988</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rural Area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>HEO</td>
<td>F</td>
<td>2+</td>
<td>Under 25</td>
<td>BA Health and Community Studies 1985</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dip. H.Ed.</td>
<td>Rural Area</td>
</tr>
<tr>
<td>Group IV</td>
<td>11</td>
<td>HEO</td>
<td>F</td>
<td>2+</td>
<td>Under 25</td>
<td>BA Home Economics 1986</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>FE Teaching Cert. 1988</td>
<td>Urban Centrally Based.</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>HPO</td>
<td>F</td>
<td>3</td>
<td>25-34</td>
<td>BA(Hons) Home Economics 1985</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Further Education Teaching Cert. 1986</td>
<td>Rural Area</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>HPO</td>
<td>F</td>
<td>4</td>
<td>25-34</td>
<td>BA(Hons) English Literature 1985</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Urban Hospital Based Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>HPO</td>
<td>F</td>
<td>4</td>
<td>25-34</td>
<td>Teaching Cert. 1971</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cert. in Health Education 1987</td>
<td>Urban Community</td>
</tr>
</tbody>
</table>

HPO = Health Promotion Officer  
HEO = Health Education Officer
**TABLE 3.4**

**KEY CHARACTERISTICS OF WORKLOAD AS PERCEIVED BY HEALTH EDUCATION OFFICERS/HEALTH PROMOTION OFFICERS PARTICIPATING IN GROUP INTERVIEWS ON HEALTH PROMOTION**

*(FIRST STAGE OF RESEARCH PROJECT)*

<table>
<thead>
<tr>
<th>Interviewee No.</th>
<th>Workload Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Patch Based. HEO in Health Authority Headquarters in a rural environment. Part of a small department of 3 HEO's with special responsibility for Coronary Heart Disease Prevention and Occupational Health Promotion.</td>
</tr>
<tr>
<td>9</td>
<td>Patch based in rural environment. Major emphasis on disease prevention.</td>
</tr>
<tr>
<td>10</td>
<td>Located in northern part of UK. Major part of work focuses on disease prevention.</td>
</tr>
<tr>
<td>11</td>
<td>Generic. Centrally based location. Health Authority comprising 250,000 population in a mixed New Town environment. Unit comprises 1 HEO and 2 HEO's all of whom are generically based but may take responsibility for special interest. Large ethnic communities.</td>
</tr>
<tr>
<td>12</td>
<td>Generic health promotion activities. Specific responsibility for Health Promotion in the Workplace, including the NHS, Local Authorities and Industry.</td>
</tr>
<tr>
<td>13</td>
<td>Central office based. 250,000 population. Mixture of middle class highly education and scattered rural population. Main emphasis of work - community health work (funded project), school work places, local authorities.</td>
</tr>
<tr>
<td>14</td>
<td>Attached to a multidisciplinary community care team based at a health centre and a Health Officer given support by a health promotion unit. Population of community 25 - 30,000.</td>
</tr>
</tbody>
</table>
All but one of the HEO/HPO group interviewees hold a first degree. Some degrees at first sight appear more relevant to health education/health promotion than others although the researcher considers that the educational process is probably more important than the content. For example, the researcher would argue that knowing where and how to get information about health issues, and how to identify and analyse the health needs of a community is more helpful than knowing, for example, that coronary artery disease per se is a major health hazard. It is therefore about the process of undertaking a degree rather than the content of a degree that equips individuals to develop certain methods of enquiry that can only enhance their work in whatever field they operate.

The tables also suggest the possibility of gender bias, in that all the group interviewees are female. Having seen in Chapter Two that initially a large number of HEO recruits came from a nursing background this may have explained the gender bias, however none of the respondents in these groups were nurses. They may, however, have chosen not to declare their nursing background. Information on the Polytechnic Course revealed a gender balance of 70% female intake, 30% male intake, so on the whole, the predominance of female participants tended to reflect the course in general.

General Practitioners

One of the major problems in the first stage of the research was to find a sample of general practitioners who would agree to take part in indepth/group interviews. The researcher was fortunate in being given the name of a practice manager in a nearby health authority whom it was thought might be able to assist in the quest for a sample of general practitioners. The researcher was given a list of group practices with asterisks placed by the names of those, which the practice manager felt, were most likely to co-operate in the
research project. The researcher wrote letters to ten of the GPs in asterisked practices but disappointingly no replies were received. Further efforts were made by the practice manager and eventually two general practitioners offered to participate in the research. Given the criterion of the group size (page 44), it was decided to proceed with a group interview of the two general practitioners. Socio-demographic details of the two general practitioners are given in Table 3.5 (overleaf). Workload characteristics are outlined in Table 3.6 (page 55).

One can see from the tables that these two general practitioners appear very different from an 'average GP'. The list size of 20,000 per 7 principals (2,857 each) is higher than the average GP list size in 1987 (Haines and Iliffe 1992:22). Both of the GPs appear to be heavily involved in teaching activities. Their surgery attendance's and number of home visits appear on face value to be fairly low, but evidence would suggest that patient contact below 12 hours per week is not uncommon among general practitioners (Allsop & May 86:51). The age range of the two general practitioners is relatively close to the model age of general practitioners (ie. 30 - 40) also identified by Allsop & May (86:47).

THE GROUP INTERVIEWING PROCESS

Prior to the group interviews the researcher spent time with all groups encouraging verbal and social interaction within the group. This was partly to overcome any shyness felt by individuals, but also to help increase rapport with the interviewer before the interview was tape-recorded.

Informal discussion with all groups took place over coffee to reiterate the purpose of the meeting, namely to explore the concept of health promotion. Reassurances were given to all groups that the researcher had few preconception
TABLE 3.5

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF A CONVENIENCE SAMPLE OF GENERAL PRACTITIONERS
PARTICIPATING IN GROUP INTERVIEWS ON HEALTH PROMOTION

(FIRST STAGE OF RESEARCH PROJECT)

<table>
<thead>
<tr>
<th>Interviewee No.</th>
<th>Gender</th>
<th>Age Range</th>
<th>Qualifications Held</th>
<th>No. of Years in Post</th>
<th>Description of Workbase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group V</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>M</td>
<td>25-34</td>
<td>BM, BS DCM</td>
<td>5</td>
<td>Inner City Practice</td>
</tr>
<tr>
<td>16</td>
<td>F</td>
<td>25-34</td>
<td>BM, BS MRCP MRCOG</td>
<td>6</td>
<td>Inner City Practice</td>
</tr>
</tbody>
</table>
### TABLE 3.6

**KEY CHARACTERISTICS OF WORKLOAD AS PERCEIVED BY GENERAL PRACTITIONERS PARTICIPATING IN GROUP INTERVIEWS ON HEALTH PROMOTION**

*(FIRST STAGE OF RESEARCH PROJECT)*

<table>
<thead>
<tr>
<th>Interviewee No.</th>
<th>Workload Characteristics</th>
<th>Practice Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>One of 7 principals. Teaching undergraduate medical students, post-graduate training of general practitioners, training receptionists, practice nurses, very involved in multi-disciplinary education. Routine 2 x 0.5 days per week for surgeries. Regular practice meetings. Few home visits.</td>
<td>20,000+</td>
</tr>
<tr>
<td>16</td>
<td>Principal in group practice of 7 principals. Teaching member of practice with 2 - 3 GP trainees, medical students, practice nurses, midwife. 1 day per week spent in major teaching hospital.</td>
<td>20,000</td>
</tr>
</tbody>
</table>
regarding the process, content and outcome of the interviews, and that confidentiality would be maintained at all times regarding individual and group identity. Permission was obtained from all groups to tape record the interviews. A final chance to withdraw from the situation was given to each group but all interviewees agreed to the interviews proceeding. Immediately before the interviews, the room was prepared by arranging a circle of five chairs of similar height with the recording equipment placed on a central table.

The researcher commenced each of the group interviews in a similar way by starting with some fairly simple opening questions (a discussion guide can be seen in Appendix 1). Although certain pre-planned areas of questioning were introduced, such as how health promotion was carried out in the interviewee's workplace, the researcher was keen to allow the groups as much freedom as possible in order to elicit more insightful and meaningful responses.

On a small number of occasions, the researcher tested the reactions of the interviewees by introducing one or two provocative statements concerning opinions in current professional publications. One example of this type of input was the researcher's questioning of a group's knowledge on the World Health Organisation's publication *Health for All*, since this report had already been seen to influence health promotion policies in a number of district health authorities' strategic plans (*Bloomsbury Health Authority Strategic Plan 1987*).

Another such statement, testing the reaction of the groups, involved introduction of the notion of 'victim blaming' as part of the Government's ideology in its shift of health policy. It has to be stated that the notion of victim blaming was not necessarily a view espoused by the researcher; but it had been identified during discussions with a number
of health care professionals as a topic worthy of consideration. (Please see example of transcripts in Appendix II).

Overall few provocative issues and/or ideas were introduced by the researcher. With only minor exceptions, the group interviews flowed freely over a range of topics and ideas. The researcher was therefore fortunate in being able to take a reasonable stance of balanced neutrality as recommended by Hedges (1986) and Hoinville, Jowell and Associates (1987).

RECORDING GROUP INTERACTIONS AND PROCESSES

All group interviews were recorded and the researcher kept a special notebook to record any significant non-verbal cues, group incidents etc, which were not directly observable from the transcripts. Notes were completed at the end of each interview whilst the session was fresh in the researcher's mind.

From the researcher's perspective the group interactions yielded both similarities and differences within and between the professional groups. The health visitor interviewees took longer to get into any meaningful discussion, one group of health visitors being particularly hesitant to enter free discussion. This may have been due to the perceived threat of the researcher who was known by name, and in a professional capacity, to some of the interviewees.

Once initial reservations were overcome there appeared to be a number of individual differences between health visitors in the groups concerning how health promotion was perceived. Some individuals were clearly unsure of its conceptual dimensions and had a limited view of the way it was operationalised in practice.

One or two health visitors did appear to have a greater grasp of the subject and its dimensions than others but there was some reticence on their part initially to discuss it in
their groups. This was perceived by the researcher to be due to the 'knowledgeable
individuals' sensitivity to the relative lack of awareness of health promotion exhibited by
their health visitor colleagues. This has been identified as one of the problems in using
group techniques (Bales 1958).

When the health visitors who had little grasp of the concept had shared the
insights of those who had, the atmosphere became much more relaxed and the new
perspectives on health promotion contributed to a more lively discussion. Lofland and
Lofland comment "something that one person mentions can spur memories and opinions
in others" (1984:15).

Individual differences in health visitors' attitudes towards the subject matter were
also perceived by the researcher. These were evidenced by grimaces, sighs and shrugs of
shoulders. Individuals appeared so immersed in management issues surrounding their
current work and practices, that to even discuss health promotion as an issue of practice
was assessed by the researcher, to be considered superfluous by some of the health visitor
interviewees.

Paradoxically, whilst individuals within the health visiting groups appeared to have different levels of understanding about the concept, there appeared to be a genuine
belief by all the health visitor interviewees that health promotion was routinely practised
by most health visitors in all their interactions with the public, both on an individual and
community or group basis. This was questioned in the group interviews and is a subject
that was identified as being important to follow up in the next stage of the research.

The HEO/HPOs demonstrated greater cohesion in their groups than the health
visitors. This may have been because unlike the health visitor group, they knew each
other better having all been on their postgraduate diploma course for a longer period of
time than the health visitors had been on their inservice education course. The
HEO/HPOs also portrayed a wide range of opinions and perspectives on health promotion without being inhibited in any way. Individually and collectively however, the HEO/HPOs expressed a perceived and felt lack of status attached to their position and role in health education/health promotion. This may be partly explained by some of the respondents' feeling marginalised in having their work bases located far away from the hospital and other health care professionals. It may also be explained by the comparatively small number of HEO/HPOs (compared to doctors and health visitors) and that as a new and small professional group they appeared to be seeking a corporate identity to promote and publicise their expertise and skills.

Whereas in the health visitor interviews no individual member came over as a 'leader' of the group and the contributors seemed to come evenly from across the group, in the Health Education Officers/Health Promotion Officers groups, a clear leader became evident within ten minutes of the start of each group of HEO/HPO interviews. Whether this is significant or not remains to be questioned. It could be the result of the strong emphasis placed on group work/group techniques in HEO courses.

It was regrettable that the group of general practitioners comprised only two individuals, however, an overwhelming impression left with the researcher was the level of confidence with which the whole notion of health promotion was discussed by these two doctors. The general practitioners appeared knowledgeable about the subject matter and openly discussed their own personal, situational and career limitations regarding health promotion strategies and practice. They both appeared committed and enthusiastic about the development of health promotion activities in future work programmes. In reality, although the general practitioners appeared to have articulated constraints which might inhibit their health promotion activities (such as caseloads of 2,500 individuals); their obvious enthusiasm for work of this nature appeared very evident. These two GPs
may be very unrepresentative of all GPs in that they were interested and willing to participate in the research, unlike other GPs. This was despite both of them having teaching commitments and having responsibility for patients.

ANALYSIS OF THE GROUP INTERVIEWS

After investigating various methods of data analysis for the content matter of the group interviews, the researcher decided to use the method of cognitive mapping to analyse the transcripts. Cognitive mapping is a "method of modelling persons' beliefs in diagrammatic form" (Jones 1985:59). It was considered by the researcher that this approach would be most appropriate in enabling the researcher to identify concepts which have direct relationships to the interviewees, their work and the world in which they were located. Cognitive mapping facilitates coding of data into categories, which, according to Jones (1985:60), seek to represent the respondents' explanatory and predictive theories about those aspects of their work being described to the researcher.

Before producing cognitive maps for each of the group interviews it was felt necessary by the researcher to contextualise the position of the interviewees, to help explain the concatenation of circumstances surrounding the responses given by the three groups of professionals.

THE CONTEXT OF THE WORKPLACE OF THE HEALTH PROFESSIONALS

All the health care professionals participating in the qualitative stage of the research were working in full time posts within the National Health Service. The health visitors without exception were working within community divisions of inner city district health authorities. All individuals had experienced and were continuing to experience the impact of change within the health service, both in general and in their particular working
situations. At the time of the group interviews (1987) the health service had recently experienced the advent of a new managerialism which had generally expounded the need for all its workers to work in a way deemed to be 'efficient and effective'. In reality this had meant a close scrutiny of the work undertaken by health care professionals resulting in the questioning by those in authority of a range of routinised practices.

The health visitors had already experienced considerable change in their work patterns and practices as a consequence of the report of a community nursing review (Cumberlege Report, HMSO 1986). This resulted in a number of individuals having to adjust to a new form of locality organisation and a new system of line management. In addition to a new management philosophy within the health service, and the impact of the Cumberlege Report, the health visitors were currently experiencing the imposition of quality assurance strategies which focused once again on the organisation of workloads, methods of practice and the measurement of health visiting outcomes. The health visitors were also seeing the emergence of the new practice nurse and wondering if this role would threaten their seemingly unrivalled position in health promotion. As an observer, the researcher considered the health visitors' anxieties to be perfectly justified and thought that these views would certainly influence the health visitors' responses.

The HEO/HPOs were also working within the reorganised National Health Service and experiencing similar management changes to those experienced by the health visitors. Uncertainty existed concerning whether the health service would continue to exist under a government committed to market forces. A number of HEO/HPOs in the sample had experienced changes in the structure and management of their work, although at the time of the group interviews, they were able to look on the situation relatively more dispassionately than the health visitors. This may have been due to the fact that all the HBO/HPOs were currently on a course full time and therefore they were somewhat
distanced from the realities of the work scene. It may also have been because of the increasing publicity concerning AIDS which had provided a strong political emphasis on the prevention of disease and the need for health education/health promotion, thus making their jobs relatively secure. Findings by Rawson and Grigg (1988), discussed in Chapter Two which showed an increase in the number of new HEO/HPO appointments, support this view.

The general practitioners were atypical in the sense that both doctors were attached to a famous London teaching hospital. One general practitioner did not hold a conventional general practitioner caseload although he did practise. Nonetheless, both doctors appeared sensitive to the effect government policy was having on the health care services and they demonstrated increased awareness concerning the issues of resourcing a modern health service, and the effect that existing policy was already having and would be likely to have on patients in their catchment area.

All groups of professionals were aware at this time that new government proposals on the health service were to be announced shortly, and the researcher gained the impression that there was a feeling of unease amongst all the health care professions regarding their current roles and the way these would develop in the future.

These preliminary insights into the changing work context of the health care professionals were very useful to the researcher for the following reasons. First was the increased recognition that to conduct research at a time of great change and uncertainty would need to be handled sensitively; for example by assuring participants of their anonymity so that their views could be expressed openly. Secondly, it was important to acknowledge that these insights into the world of the professionals had occurred as a result of the process of the research rather than as a result of any preconceived ideas or
any formal approach into these perceptions. Chapter Four will present an analysis of the data.
PART THREE - DEVELOPMENT OF A CONCEPTUAL FRAMEWORK
FOR THE QUANTITATIVE PHASE OF THE STUDY

CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF THE QUALITATIVE DATA

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<tr>
<td>Summaries of 'cognitive maps'.</td>
<td>69.</td>
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<tr>
<td>Delimiting the theory.</td>
<td>79.</td>
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<td>Political perspective and beliefs.</td>
<td>79.</td>
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<td>Theory knowledge base of health promotion.</td>
<td>82.</td>
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<td>Notions and realities of health promotion practice.</td>
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<td>85.</td>
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<td>Aspirations for the realisation of health promotion.</td>
<td>102.</td>
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<td>Concept modification by theoretical coding.</td>
<td>103.</td>
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</table>
PART THREE - ANALYSIS AND INTERPRETATION OF THE
QUALITATIVE DATA

CHAPTER 4

THE APPROACH TAKEN TO ANALYSIS OF THE TRANSCRIPTS

After investigating various methods of analysing the data collected in the group interviews, the researcher decided to use the method of cognitive mapping to facilitate the explication of constructs, concepts and theories. Cognitive mapping facilitates coding of data into categories, which, according to Jones (1985:60), seek to represent the respondent's explanatory and predictive theories about those aspects of their work being described to the researcher.

The first stage of the analysis involved listening to the tapes with the transcripts in front of the researcher for annotation. Reference was also made to the field notes which described non verbal responses and reactions occurring in each group interview. The researcher was then able to build a picture of each individual in the group interview, identify consistencies or inconsistencies in beliefs or views about particular issues and note any ambivalence or depth of feeling expressed on any given issue related to health promotion. Examination of the tapes and transcripts provided the researcher with a knowledgeable feel for the data providing good preparation for interpretation of the transcripts through cognitive mapping. According to Jones (1985:60) "a cognitive map provides two main projections - a person's concepts or ideas in the form of description of entities, abstract or concrete in the situation being considered; and beliefs or theories about the relationship between them". These are shown on the cognitive maps by an arrow or line. Examples from the health promotion data are given below:-

Terminology of Health Promotion It seems to have become a a redefinition new term for health education of terms

64
An arrow or line is used, as in the example above, to indicate a simple relationship where one thing leads to another. A positive (+ve) or negative (-ve) sign is used to indicate a relationship across poles (i.e., across the concept being identified and the belief attached to it). An example of a concept and beliefs attached to it from health promotion data is given below:

**Health Promotion** __---__ **The work has not changed** __+__ **Its broader than**__ but the label has__ **health education**

The process of cognitive mapping involves constant comparative analysis (an essential feature of grounded theory) which Glaser and Strauss (1967) describe as having four stages; these comprise:

1. Comparing incidents applicable to each category (1967:105). (The authors were referring to incidents observed during participant or non-participant observation. With cognitive mapping, concepts or constructs identified in the transcripts of interviews were compared for their applicability to emerging categories).


3. Delimiting the theory (1967:109). This involves theoretical coding and memoing (see page 79).


These four stages are discussed as the research progresses.

Having listened to the tapes and carefully read the transcripts the researcher spent considerable time coding the data on large sheets of paper identifying the concepts and constructs emphasised by the groups and noting any differing beliefs about the concepts/issues under analysis. (An example of an initial cognitive map is shown in Figure 4.1 overleaf).
Figure 4.1

Initial Cognitive Map of Health Visitor Groups' Transcripts

1. New Term for Health Education
2. A Redefinition of Terms
3. I think it is just a change in terminology.
4. Seeing Jobs Advertised as health promoters - suddenly things being called health promotion programmes.
5. Now a capital letter job.
6. +
7. It feels to me like health education.
8. +
10. Change from telling people what to do. Gets them to take more of the onus for Health Care.
11. I think Government aims are ambivalent about Health Promotion. I'm not sure whether the Health Service per se is costing too much.
12. Promotion - Moving forwards.
13. Interventions trying to stop things getting worse.
14. I would suppose that as a health visitor one promote health within the home. That's where we have a significant input.

Code (Based on the work of Sue Jones 1985):
1. Numbers are used to identify constructs.
2. Outlined constructs represent potential category labels from the constructs of the interviewees.
3. Underlined concepts indicate potential 'Second Order' categorisations. Grounded in those of the interviewees (but also reflect the interests of the researcher).
4. Dashes indicate inferences.
The process continued with the researcher searching the data for comparative groups of constructs related to ideas, beliefs, possible hypotheses and pronouncements relating to health promotion. At this point the researcher had identified a large number of constructs, and one of the problems experienced was when to stop identifying more. Glaser and Strauss (1967:61) state: "The criterion for judging when to stop sampling the different groups (constructs) pertinent to a category is the category's saturation. Saturation means that no additional data are being found whereby the sociologist can develop properties of the category".

Once satisfied that saturation of the data had been achieved, each construct was compared with other constructs to see how they clustered or were connected. Schatzman and Strauss (1973) call these connections linkages. As the linkages emerged from the data, the researcher was able to reduce the findings into more embracing 'core conceptual categories' which according to Glaser and Strauss (1967) explain the action in the social scene. The process of comparing incidents/constructs applicable to each category as evidenced in Tables 4.1 - 4.3 demonstrates completion of the first stage of constant comparative analysis described by Glaser and Strauss (1967:105). These tables refer to health visitor discussion groups, the HEO, and the GP group discussions respectively. (Discussion of the data in Tables 4.1 - 4.3 is undertaken in the section on 'Delimiting the Theory' on page 79).

The second stage of constant comparative analysis involved integrating categories and their properties. These all embracing categories are described by Jones (1985:59) as superordinate or sensitising concepts, in that they are developed from the important constructs and concepts highlighted by the research participants and "raised to a more abstract level away from the empirical evidence which generated them".
In the integration and development of the health promotion categories, (See Tables 4.1 - 4.3) the question when is a category a category? had to be addressed. Glaser (1978:95) suggests a number of criteria by which a core category can be identified:

1. It normally takes more time to saturate than other categories.
2. It recurs frequently in the data.
3. It is central to the research study.
4. It links easily and meaningfully to other emerging categories.
5. It offers an immediate and obvious link to formal conceptual theory.
6. It forms a dimension of the research problem.
7. It is totally variable and carries through to other parts of the theory.
8. It can be any kind of theoretical code: a process, a condition, a consequence or two dimensions etc.

As seen in Tables 4.1 - 4.3 a number of core conceptual categories which emerged from the data were common to at least two or all three groups of professionals, these are shown in Table 4.4 together with categories to emerge from a single professional group but thought by the researcher to be significant to the research problem.
<table>
<thead>
<tr>
<th>SECOND ORDER CATEGORISATIONS</th>
<th>CONSTRUCTS OF INTERVIEWEES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Terminology</strong></td>
<td></td>
</tr>
<tr>
<td>5. First heard of as health education.</td>
<td>6. It feels to me like health education.</td>
</tr>
<tr>
<td>7. I think its just a change of terminology.</td>
<td></td>
</tr>
<tr>
<td><strong>Political Perspectives.</strong></td>
<td></td>
</tr>
<tr>
<td>10. Change from telling people what to do. Gets them to take more of the onus for health care.</td>
<td>11. Health Authority has responded.</td>
</tr>
<tr>
<td>12. I think government aims are ambivalent about health promotion. I'm not sure whether they are actually concerned about the health of the population or whether the health service is costing too much.</td>
<td>13. Its a cheap option for the government.</td>
</tr>
<tr>
<td>14. The onus falls back on individuals regardless of their social circumstances.</td>
<td></td>
</tr>
<tr>
<td><strong>Individualism</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Health Promotion Practice</strong></td>
<td></td>
</tr>
<tr>
<td>17. Response to a need. Identify within each person the work they have.</td>
<td>18. In areas of feeding, safety, hygiene, immunisation.</td>
</tr>
<tr>
<td>19. Hygiene, immunisation, all things I have always done as a health visitor.</td>
<td>20. I would suppose that primarily as health visitor one promotes health within the home, thats where we have a significant input.</td>
</tr>
<tr>
<td>21. Influences over professionals as well.</td>
<td></td>
</tr>
<tr>
<td>SECOND ORDER CATEGORISATIONS</td>
<td>CONSTRUCTS OF INTERVIEWEES</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Knowledge Base/ Theory of Health Promotion.</td>
<td>I didn't hear about it in my nurse training. I don't remember hearing about health promotion on my health visiting course. An extension of primary prevention. Nil</td>
</tr>
<tr>
<td>Obstacles/ &quot;Vocabulary of Complaints&quot;.</td>
<td>To the detriment of health visitors We are poorly established yet have suffered cuts. Lowest ratio of health visitors - cutting back on allocated work. Got to meet budget targets. Feel under a lot of pressure. Crisis work of inner city. Areas of short resources. Overloading.</td>
</tr>
<tr>
<td>Meeting never happen.</td>
<td>Recommended length of visits now 8 - 10 minutes. Timing.</td>
</tr>
<tr>
<td>Getting statistics rather than the quality of work that you are doing when you are there.</td>
<td>Alienation of clients. What did they expect anyone to do in eight minutes.</td>
</tr>
<tr>
<td>Measurement</td>
<td>Will disappear unless we can show it is effective. Need to have consumer feedback. It's what concerns me about Korner. What you do is never recorded. Emphasis on statistics and immunisation.</td>
</tr>
<tr>
<td>SECOND ORDER CATEGORISATIONS</td>
<td>CONSTRUCTS OF INTERVIEWEES</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Health Visiting Skills.</td>
<td>Communication skills</td>
</tr>
<tr>
<td>(Existing or Required)</td>
<td>particularly listening.</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Equal role for all</td>
</tr>
<tr>
<td></td>
<td>health professionals.</td>
</tr>
<tr>
<td></td>
<td>Implicitly understood</td>
</tr>
<tr>
<td></td>
<td>in health visiting.</td>
</tr>
<tr>
<td></td>
<td>I think the younger GP's</td>
</tr>
<tr>
<td></td>
<td>do more.</td>
</tr>
<tr>
<td></td>
<td>I'm not sure the older GP's do</td>
</tr>
<tr>
<td></td>
<td>I think they see themselves as treating disease.</td>
</tr>
<tr>
<td></td>
<td>In reality doesn't happen.</td>
</tr>
<tr>
<td></td>
<td>Some people don't do it at all in a conscious sense.</td>
</tr>
<tr>
<td></td>
<td>Non priority for GP's.</td>
</tr>
<tr>
<td></td>
<td>Not impose values.</td>
</tr>
<tr>
<td>SECOND ORDER CATEGORISATIONS</td>
<td>CONSTRUCTS OF INTERVIEWEES</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Change of Terminology</td>
<td>1. First heard of as health education.</td>
</tr>
<tr>
<td></td>
<td>2. Department changed its name from health education to health promotion.</td>
</tr>
<tr>
<td></td>
<td>3. Work hasn't changed label has.</td>
</tr>
<tr>
<td></td>
<td>4. With promotion and education we've just changed our names.</td>
</tr>
<tr>
<td></td>
<td>5. It's broader than health education.</td>
</tr>
<tr>
<td>Knowledge Base/ Theory of Health Promotion</td>
<td>6. Three overlapping areas of activity: Health protection/ Fiscal policy/ Education/Prevention/ Health Education.</td>
</tr>
<tr>
<td></td>
<td>7. Andrew Tannerhill model.</td>
</tr>
<tr>
<td></td>
<td>8. We've all been working in ignorance for about ten years. I don't suppose we had really heard of health promotion until we came here.</td>
</tr>
<tr>
<td></td>
<td>9. Basically it includes everything from one to one health education right through to health promotion.</td>
</tr>
<tr>
<td></td>
<td>10. A lot of people think its (HP) you know what it is, the need for another model another taxonomy.</td>
</tr>
<tr>
<td></td>
<td>11. I certainly wasn't employed on my knowledge of health education. I knew nothing about it whatsoever.</td>
</tr>
<tr>
<td>Health Promotion Practice</td>
<td>12. Still in health education.</td>
</tr>
<tr>
<td></td>
<td>13. In a broad way working with groups.</td>
</tr>
<tr>
<td></td>
<td>15. Local politics.</td>
</tr>
<tr>
<td></td>
<td>16. Its mainly group orientated.</td>
</tr>
<tr>
<td>SECOND ORDER CATEGORISATIONS</td>
<td>CONSTRUCTS OF INTERVIEWEES</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Health Promotion Practice (continued)</td>
<td>17. I think it is very much not traditional health education but community development 18. Group empowerment. 19. Strengthen the community and in so doing strengthen us, the individual and you enhance the individual’s ability to have access to health care.</td>
</tr>
<tr>
<td>Political Perspectives</td>
<td>20. A very conservative Health Authority and anything that I could do seems slightly political, which health promotion has to be. 21. We pay lip service to the principles of community development. 22. You can’t just focus on women because that’s being too pro feminist. 23. A lot of people in the hierarchy are older and they seem to be more conservative. 24. There is a fear all the time of not doing anything that is going to be controversial.</td>
</tr>
<tr>
<td>SECOND ORDER CATEGORISATIONS</td>
<td>CONSTRUCTS OF INTERVIEWEES</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Skills for Health Promotion</td>
<td>25. Being fairly autonomous.</td>
</tr>
<tr>
<td></td>
<td>26. You have to be able to boost their confidence. It is very difficult when you are not that confident in yourself.</td>
</tr>
<tr>
<td></td>
<td>27. Basic things like group work skills, some concept of community development.</td>
</tr>
<tr>
<td></td>
<td>28. Its empowering groups to get the best.</td>
</tr>
<tr>
<td>Obstacles/ Vocab of Complaint</td>
<td>29. There are just not enough of us. I feel - just stretched and they expect me to deal quite happily with individuals.</td>
</tr>
<tr>
<td></td>
<td>30. I still cover 25,000 people working in the NHS.</td>
</tr>
<tr>
<td></td>
<td>31. They wouldn't let me into my office for two and a half days a week which was totally unbearable.</td>
</tr>
<tr>
<td></td>
<td>32. We have had a cut in our establishment.</td>
</tr>
<tr>
<td>Empowerment.</td>
<td>33. Working in the NHS.</td>
</tr>
<tr>
<td></td>
<td>34. Channelled into a medical way of working.</td>
</tr>
<tr>
<td></td>
<td>35. Restrictions on what I can really do.</td>
</tr>
<tr>
<td></td>
<td>36. Because of the nature of the unit I work in, we are unable to work in a way that we feel best.</td>
</tr>
<tr>
<td>Measurement of Health Promotion</td>
<td>37. It depends on what you are trying to measure.</td>
</tr>
<tr>
<td></td>
<td>38. Yes I think it can be measured but sometimes we are asked to measure in a most arbitrary way. Numbers rather than......</td>
</tr>
<tr>
<td></td>
<td>39. I think it's a problem not having a baseline to start.</td>
</tr>
<tr>
<td></td>
<td>40. It takes a long time.</td>
</tr>
<tr>
<td></td>
<td>41. The whole question of whether there are such indications of wellbeing is a big debate.</td>
</tr>
<tr>
<td></td>
<td>42. It is impossible to say what the outcome really is but there are ways of measuring the processes involved.</td>
</tr>
<tr>
<td>SECOND ORDER CATEGORISATIONS</td>
<td>CONSTRUCTS OF INTERVIEWEES</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>Aspiration for Health Promotion.</td>
<td>Increase in the number of people working as HEO/HPO's.</td>
</tr>
<tr>
<td></td>
<td>More involved with other professionals.</td>
</tr>
<tr>
<td>SECOND ORDER CATEGORISATIONS</td>
<td>CONSTRUCTS OF INTERVIEWEES</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Perceptions of Health Promotion.</td>
<td>1. Individual experiences in childhood.</td>
</tr>
<tr>
<td>Knowledge Base/ Theory of Health Promotion.</td>
<td>3. Not included in training.</td>
</tr>
<tr>
<td>Political Perspectives</td>
<td>7. Seen as Policy Matter Housing/social conditions.</td>
</tr>
<tr>
<td>Health Promotion Practice.</td>
<td>9. Agenda matters to policy committees health authorities.</td>
</tr>
<tr>
<td>Teamwork</td>
<td>17. Ethical problems. Need to scrutinize leaflets.</td>
</tr>
</tbody>
</table>
### TABLE 4.4

Core conceptual categories to emerge from cognitive maps of health visitors, HBO/HPOs and general practitioners relating to Health Promotion.

<table>
<thead>
<tr>
<th>CORE CATEGORIES</th>
<th>SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminology</td>
<td>All Groups</td>
</tr>
<tr>
<td>Political Perspectives</td>
<td>All Groups</td>
</tr>
<tr>
<td>Measurement</td>
<td>All Groups</td>
</tr>
<tr>
<td>Theory/Knowledge Base</td>
<td>All Groups</td>
</tr>
<tr>
<td>Practice of Health Promotion</td>
<td>All Groups</td>
</tr>
<tr>
<td>Obstacles/Vocabulary of Complaint</td>
<td>All Groups</td>
</tr>
<tr>
<td>Individualism</td>
<td>All Groups</td>
</tr>
<tr>
<td>Empowerment</td>
<td>HBOs</td>
</tr>
<tr>
<td>Skills</td>
<td>HVs and HBO/HPOs</td>
</tr>
<tr>
<td>Teamwork</td>
<td>GPs, HVs</td>
</tr>
<tr>
<td>Aspirations</td>
<td>HEO/HPOs</td>
</tr>
<tr>
<td>Status</td>
<td>HEO/HPOs</td>
</tr>
</tbody>
</table>

In this second stage of constant comparative analysis in which the integration and development of categories occur, one of the practical problems to the researcher was whether to subsume some of the emerging categories into larger, more embracing ones. An example of this sort of dilemma is seen with the categories 'Political Perspectives' and 'Individualism'. In one sense Individualism could have been subsumed into Political Perspectives, but as Individualism met nearly all the criteria suggested (by Glaser 1978) for identification of categories it was included in the list (See Table 4.5 overleaf).
### TABLE 4.5

Checklist to determine whether the two categories Political Perspectives and Individualism meet the criteria identified by Glaser (1978) for core categorisation

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>POLITICAL PERSPECTIVES</th>
<th>INDIVIDUALISM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recurs frequently in data.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. Central to the study.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Links meaningfully to other categories.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. Forms a dimension of the research problem.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. Takes more time to saturate than other categories.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6. Offers an immediate and obvious link to formal conceptual theory.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7. Is totally valuable and carries through to other parts of the theory.</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Integration and development of the categories as shown in Table 4.4 provides an example of the second stage of constant comparative analysis. The third stage in constant comparative analysis involves delimiting the theory. The reduction of the data into sensitising categories (as illustrated in Table 4.4) concurrently reduces the research terminology allowing the researcher to focus once again on the properties/dimensions of the categories generated from the data. According to Glaser and Strauss (1967:114) constant comparison tends to result in the creation of a developmental theory which can be discussional or propositional in nature, although these two types of theory are not necessarily mutually exclusive. Discussion of the categories generated from the data will now take place leading to a summary of the emerging theory.
DELIMITING THE THEORY

In undertaking research using a grounded theory methodology, Glaser and Strauss (1967) recommend that the researcher begins the study without recourse to the literature. This is to avoid any contamination of the emergent categories. Once an analytic core of categories has emerged from the data, similarities and convergencies with the literature can be sought (Glaser and Strauss 1967:37), which also forms part of the process of continuing comparative analysis.

At the outset of the research, as indicated in Chapter One of this thesis, the literature on health promotion was very sparse. At the writing up stage of the research the literature is almost too voluminous to handle, although the researcher has found that much of the literature tends to encompass global and policy issues rather than practice ones. The core categories generated from the world of the practitioners will now be discussed with reference to existing literature whenever possible and/or appropriate.

POLITICAL PERSPECTIVES AND BELIEFS

As can be seen from the cognitive maps and the emergent categories (Tables 4.1 - 4.3) political dimensions of health promotion recurred frequently in every group discussion. The perceived shift from health education to health promotion was understood by some health visitors to be part of a government directive. Although the World Health Organisation (1985) Targets for Health for All and the World Health Organisation (1986) Ottawa Charter for Health Promotion had been published before the group discussions in 1987; their messages, strategies and proposed policies appear not to have permeated to the health visitors, the very professionals identified as having a key role in health promotion (UKCC 1986; Gott and O'Brien 1990). As indicated in Chapter Two it subsequently became policy that GPs are to be the main providers of health
promotion. A number of interviewees described health promotion as a cheap option for the government. They suggested that, by changing job titles to Health Promotion Officer in advertisements and substituting health promotion labels on doors of health education departments, it would seem to the public that new departments of health promotion had been set up and that the UK government could be seen to be supporting European Policy of health targets for all. Any real changes in practice or policy at that time (1987) were perceived by the professionals to be either half hearted or intangible.

The health visitors suggested that the government was ambivalent about health promotion. It was not clear to them whether the government really did care for the health of the population or whether, as the health service per se appeared to be costing too much, a shift towards health promotion was seen as economically desirable. According to the health visitors, a shift to health promotion, in the way in which it was perceived to be happening, would also place more responsibility on individuals rather than government (see also 'Individualism' discussed below), and there appeared to be genuine concern about this. According to the health visitors, the government perceived a shift to health promotion as costing less money by supposedly preventing illness rather than paying for costly care. Whilst this particular perspective did not emerge from the discussion with the general practitioners, they made the point that health promotion did not merely involve advice about health care, but involved political decisions on matters such as housing, transport and social conditions. Although this view, encompassing the social dimensions of health, discussed in Chapter Two, is well supported by the literature (Milio 1986; WHO 1984; Draper 1991) it was not articulated by the health visitors in the group interviews.
The political perspectives emanating from the HEO/HPOs suggested some perceived opposition by management to HEO/HPO working practices (see also Practice). Involvement with women's groups was said to be regarded by some managers as too pro-feminist, and community involvement, aimed at empowering people to help themselves, was said to be perceived by managers as controversial ("ban the use of words like co-operative it's too contentious", see Cognitive Map). O'Neill (1989:222) acknowledges the political dimension of health promotion, identifying the power relationships that occur when certain groups or individuals have the capacity to influence or constrain individuals or groups to behave in certain ways (see also Empowerment). Farrant (1991), in discussing community health initiatives in health promotion also makes the point that empowering people to engage in community participation is frequently described as community manipulation.

Rejection of community participation by health officials may go some way to explain why so many governments of industrial nations tend to enhance the power of the medical profession, and in doing so focus health promotion/education training on biomedical disciplines thus moving away from the socio/political sciences.

Empowering people to engage in community participation may also be seen as a more societal interpretation of causes of illness rather than individualism and such an interpretation, together with actions emanating from it, are likely to be seen as threatening the status quo of governments. An interesting parallel can be drawn with the Community Development Projects (CDPs) developed in the early 1970s and which foundered, seemingly because they became too political/community activist (Jones and Mayo 1975).

As seen in the above discussion similarities existed within and between all three groups of professionals in that all groups expressed awareness of political influences on
the development of health promotion. The groups did, however, discuss very different
issues, largely reflecting differences in individualistic versus societal orientations.

Most health visitors appeared to confine their remarks to operational matters, the
HEO/HPOs emphasised empowerment and community participation as methods of health
promotion, recognising that both of these perspectives had obvious political dimensions
and implications. The general practitioners were extremely aware of the need for
national and local policies to promote health on a societal as well as an individualistic
level but they may have been very atypical GPs as indicated in Table 3.5.

THEORY/KNOWLEDGE BASE OF HEALTH PROMOTION

It was clear both during the interviews, and on analysis of the transcripts, that any
theoretical understanding of health promotion or what theory might have guided health
promotion practice, was either non-existent, unable to be articulated, or decidedly limited.
The majority of all interviewees claimed they had not heard mention of the term 'health
promotion' during their training, one or two HEO/HPOs excepted. A fair proportion of
the interviewees saw and expressed health promotion as synonymous with health
education (see also Terminology).

A few professionals felt that they knew intuitively what it was all about, a small
number of individuals acknowledged feeling that they were working in ignorance. On
completion of the interviews and on analysis of the transcripts it appeared at face value
that health promotion, to most of the professionals, was fairly meaningless. These
perceptions are supported in the literature, and Tannahill (1985:165) made the statement
as early as 1985 that "health promotion although a fashionable term has acquired so many
meanings as to become meaningless".

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One individual in each group of HEO/HPOs did comment on the model of health promotion advanced by Tannahill (1985) which suggests that there are overlapping dimensions of health promotion involving health education, prevention and health protection, but only one interviewee was able to expand in any depth on this particular model. The author cited was in fact in charge of a health promotion team close to the vicinity in which the interviewee worked.

The apparent absence of any meaningful theoretical understanding of health promotion doesn't mean that theory doesn't exist but that it is not articulated. The fact that health professionals suggest that they are working in ignorance of any theory related to health promotion, does give rise to a number of questions. For example, do professionals appreciate that a whole process of consciousness raising, and carefully thought out approaches to giving health information, may be necessary to maximize the acceptance of information whether offered on an individualistic or societal basis? (Anderson 1986; Graham 1984).

NOTIONS AND REALITIES OF HEALTH PROMOTION PRACTICE

Closely related to theoretical understanding or non understanding of the concept of health promotion is its operationalisation. In their project investigating the training and development needs of health education officers, Rawson and Grigg (1988) discuss the appropriateness of using models to help achieve goals in professional practice. They describe and discuss iconic and analogic models. Explained simplistically, iconic models encompass representation of actual practice making generalisation inappropriate, analogic models encompass more abstract or hypothetical notions of practice, such as what activities or dimensions health promotion might embrace.
The responses of the interviewees to questions on practice in this initial stage of the research covered many dimensions, all of which might contribute to the development and discussion of both iconic and analogic models of health promotion. Concrete examples of preventive practice such as encouraging the uptake of immunisations, advising on safety issues, hygiene, dietary advice etc. were given representing iconic models. Other activities, such as those involving communities in health campaigns, initiating community work, agenda setting in local government and health authority committees, and working in local politics, were realities for some group members and hypothetical types of health promotion activities for others. Actions such as developing intersectoral health goals, and proposing alternative health promoting policies, represent analogic models of health promotion in that they appear not to have been attempted by health visitors, HEO/HPOs and general practitioners as yet but offer alternatives to existing practice.

It is significant that public health in the early twentieth century focused on issues such as hygiene, immunisation, child care etc. (Bunton and MacDonald 1992; Ashton and Seymour 1988; Farrant 1991). The empirical data in this study seems to suggest that some health visitors are still working in an early twentieth century mode, while HEO/HPOs and general practitioners are, at least, recognising how their practice might change.

The researcher equates an early twentieth century mode of practice with the model described by Farrant (1991). Analysing the reasons why health professionals at all levels have failed to successfully implement community development, in this case in the third world, Farrant suggests "they, i.e. the professionals, were trained to know the answers not to assist others in searching for them" (1991:428).
Although a number of studies have demonstrated that health visitors are increasingly becoming involved in a wide range of community projects/initiatives (Orr 1991; Drennan 1986), the researcher suggests that although the education and training of health visitors has changed radically during the late 1980's and early 1990's a cultural lag in methods and approaches in health visiting practice does appear to exist. Put in simple terms it is suggested that recently trained health visitors are more likely to be involved in group and community initiatives, while those who trained on earlier courses are more likely to perceive themselves as information givers rather than information seekers. This is not to say that one approach should eclipse the other, in fact Tones (1990) has argued strongly that health education is part of health promotion. However, it might indicate the need to have a variety of approaches to individual and community health at any one time, and this could well affect the education and training required by all groups of health professionals.

An important dimension of the way the health visitor interviewees saw themselves as practising health promotion was the belief that professionals engaged in health promotion need urgently to identify the strengths of their clients as individuals and groups in order to foster the strengths to effect health promotion. This is clearly an articulation of the need for self empowerment of the individuals and families served by the health visiting profession.

PERCEIVED SKILL REQUIREMENTS FOR HEALTH PROMOTION ACTIVITIES

The subject of skill requirements for health promotion activities arose in a number of contexts in the group interviews. In general there was a high degree of consensus about the nature of skills required and whether or not the respondents considered themselves to be practising health promotion or not. On reflection it may have been
appropriate to enquire whether interviewees felt they needed to improve their existing skills or whether further training was necessary.

The general practitioners did express the belief that other health professionals for example, health visitors and district nurses, were better prepared than most doctors for a health promotion role. The skills identified as necessary for health promotion by the interviewees included in-depth communication skills, particularly listening, having group work skills which would facilitate community groups to get the best results, ability to work as a member of a team, and community networking skills. Each group of interviewees felt they had some, but not all, of these skills.

Analysis of these skills suggest very different requirements, listening for example, fits well within a medical individualistic model, and group work and networking within a societal community action model. Referring back to the cognitive maps (Tables 4.1 - 4.3) health visitor interviewees expressed the need for both individualistic and societal skills whereas HEO/HPOs focused predominantly on the need for societal skills.

Another seemingly important skill identified by the HEO/HPOs was the ability to work autonomously (see also vocabulary of complaint). As indicated in the early chapters of this thesis, neither health visitors nor HEO/HPOs have had the opportunity to work really autonomously, their work patterns being largely determined within a medical framework. With the advent of Health of the Nation (DOH 1991) and the Health Education Authority's Operational Plan for 1992/94 (HRA 1992) it is hardly likely to change. Educational issues relating to skill requirements are discussed later in this chapter.
OBSTACLES TO HEALTH PROMOTION/VOCABULARY OF COMPLAINT

Of all the data to emerge from the group interviews about health promotion one of the most interesting and perhaps significant was the 'vocabulary of complaint', highlighting perceived obstacles to the practice and progress of health promotion. The term 'vocabulary of complaint' arose spontaneously from the data but on searching the literature, Melia (1984), and Turner (1987) have previously identified this phenomenon. The 'vocabulary of complaint', has so far been seen as a phenomenon peculiar to nurses but this study suggests it goes beyond the nursing profession. In relation to nurses, Turner (1987:153) explains that not only are nurses' complaints socially determined but they give "articulate utterance to this structural hiatus between their skill and their lack of autonomy within the medical bureaucracy". As can be seen from the Cognitive Maps (Tables 4.1 - 4.3) some complaints/obstacles were specific to each profession, others were shared between them. Examples of the types of complaints are given before returning to the subject of the 'vocabulary of complaints' per se.

The health visitors expressed concern over cuts in the health visiting establishment. Two individuals described a cutting back on all allocated work with some of the most deprived families. They also identified the ratio of health visitors to the population as being at the lowest level for many years. The fact that cuts had been made in health visitor staffing, even where the establishment was already poor, resulted in the belief that it would be hard to attempt to cope with existing workloads let alone cope with the intricacies of health promotion work.

In one health district, an interviewee reported that an instruction had been given to limit the time spent on home visits to families to 8 - 10 minutes. All these resource issues reinforced the health visitors' beliefs that there was little time left to work on health promotion when much available time was in reality spent on crisis situations. The
management practices of their health authorities had exacerbated professional anxieties and staff expressed feelings of being under great pressure. Lack of available time, work overload, collecting statistics which did not particularly demonstrate the nature of health visiting work, were perceived as impediments to the development of health promotion practice.

There appeared to be some consensus amongst health education officers that actively working within the framework of the NHS was an obstacle to health promotion. Some saw the task of health promotion as overwhelming, partly due to the adherence to conservative/traditional models of practice displayed by their profession, which tended to focus on the individual rather than introducing radical change. Other issues believed to create obstacles to health promotion work included the work site or location of health education officers. It was seen by them as preferable that practice bases should be among people rather than in district health authority offices. The perceived dominance of the medical profession in the way the work of HEO/HPOs was managed and organised was also a major cause of concern to some of the HEO/HPOs.

The general practitioners found the size of caseloads, and the limited time available to them, were major impediments to health promotion practice. An important obstacle to health promotion practice emerging from the GPs interview was the GPs recognition of the limitations of their own skills. A particular area of concern was the GPs' self perception of feeling poorly prepared for giving specific advice to patients. Examples of situations where they felt poorly prepared included aspects of health giving advice such as child care and nutrition, although this could possibly be a rationalisation for not wishing to do what is considered low status and routine work. It is in this context that the GPs interviewed expressed the opinion that other primary health care members
were probably better equipped to perform health promotion activities than they are themselves (see also Perceived Skill Requirements).

Another obstacle seen by GPs to inhibit health promotion practice was the time and space needed to read and scrutinize health promotion literature normally provided by health education/health promotion departments. The GPs perceived that a number of questions had to be asked regarding the type, credibility, and content of literature available for them to give to the public; in addition, they expressed lack of time to read the literature both thoroughly and critically. The GPs also drew attention to the ethics of drug firms or advertising agencies providing health education literature to patients/clients. An example of a common ethical issue was whether the information provided by such companies contained a bias to certain products which would not be beneficial to the patients.

Although the GPs being interviewed tried to be selective over the type of material they made available to patients, they were aware that not every GP would rate selection or rejection of health education material a priority in his/her work.

From this analysis of the main complaints to emerge from the three groups of professionals it can be seen that all groups perceive inadequate resources in terms of manpower, health education material, and the time to undertake health promotion activities. All HEO/HPOs and some health visitors saw lack of autonomy as a major obstacle to health promotion work. As suggested earlier, this is hardly likely to change given the government's current policies related to health promotion.

Returning to the 'vocabulary of complaint', Turner (1987:153) made the point that previous research had shown that complaints from nurses typically devalued the function and significance of the doctor ("GPs don't practice health promotion"). Although Turner was referring to studies involving hospital doctors, the complaints specified in this study
involving health visitors and general practitioners, suggest it may be possible to
generalize the findings to community settings as well. Another function of the
complaints suggested by Turner (1987:154) is the delegitimization of the system of
authority. Complaints from the HEO/HPOs and health visitors about lack of managerial
support and understanding go someway to uphold this view.

Finally, Turner (1987) sees the consequence of the vocabulary of complaint as
'somewhat conservative'. Despite the identification of nurses' complaints in studies cited
(Melia 1984), the subordinate position of nurses within the hospital was identified as a
factor ensuring that they would remain powerless. The researcher suggests that within
the new market ideology the power base of nurses is likely to diminish even further. The
market forces outlined in the White Paper (DOH 1989) have pre-empted the erosion of
the pay and working conditions of nurses. Pay and working conditions of nurses are now
likely to depend on the Trusts for whom nurses work (rather than on nationally
negotiated pay scales). Changes in the skill mix of all nurses, whether hospital or
community based, means that the power base of nurses will be considerably weakened;
partly through a reduction of students entering professional education and training and
partly through the gradual downsizing of the professional nursing workforce. Articles
and letters in the current nursing press provide evidence of a variety of complaints made
by nurses about the degeneration of their position (HV Journal 1992:292; Nursing Times
1993). The researcher perceives these complaints to be indicators of the process of
deprofessionalisation resulting from government strategy to create a smaller and less well
educated public sector workforce.

According to Turner the only benefits to be seen from the 'vocabulary of
complaints' are that it acts as a safety valve for nurses and it strengthens their solidarity in
facing the requirements of a very demanding job. Evidence of the caseloads and
workloads of the health visitors and HEO/HPOs in the study (Tables 3.1 - 3.4) illustrate similarly demanding jobs where professional solidarity and safety valves seem equally important.

TERMINOLOGY

All groups of interviewees, when asked about their perceptions of health promotion, alluded to the term in itself as being problematic. Whilst not being able to define the term health promotion, some interviewees expressed it as being broader than just health education, and others saw it as totally synonymous with health education. The researcher suggests that there is an important relationship between the way work is defined, and the way it is carried out. It can be argued that, if health care professionals see and interpret health promotion as synonymous with health education, their working practices are hardly likely to change. Also, as discussed in the section 'Theory/Knowledge Base', unless health care professionals understand the philosophy, disciplines, dimensions and scope of health promotion, and how it complements and augments health education, individuals and communities in the UK are likely to be disadvantaged compared with individuals and communities in other countries. Australia and Sweden for example promote intersectoral health policies where health professionals, nutritionists, representatives of the food industry, etc. work together to determine strategies for health in relation to food (Milio 1986; Svensson 1992).

When exploring notions and realities of health promotion practices (page 83) mention was made of iconic and analogic models of working which, according to Rawson and Grigg (1988), often help practitioners to achieve goals in professional practice. Conversely, French and Adams (1986), in their review of health education models, suggest that the sequence of development is ideology-theory-model. The
researcher contends that without a real understanding of the definition of health promotion, ideologies, theories and models are hardly likely to progress very far, if at all. Since this research began, definitions of health promotion have abounded, as can be seen in Table 4.6 (overleaf).

It can be seen from Table 4.6 (overleaf) that definitions of the concept of health promotion have been modified over time showing movement from a relatively simple and unidimensional individualistic approach to a more complex multidimensional societal approach. This may go some way to explain why the groups of professionals in this study, who were interviewed in 1987, experienced difficulties with their articulation of health promotion.

MEASUREMENT OF HEALTH PROMOTION

The issue of attempting to evaluate or measure health promotion practice emerged spontaneously in every group of interviewees. As can be seen from some of the constructs in the cognitive maps, a number of professionals saw some kind of measurement as vital to the survival of their profession.

As indicated in Chapter Two, the advent of Thatcherism produced the policy to commit the NHS to market forces. At the time of this research study many groups of health care professionals had been party to a number of meetings and discussions in response to the publication of proposals to restructure local health services. The proposals introduced the concept of purchasers and providers, with the onus on the providers to offer 'value for money'. It was clear during the first stage of the research that the professionals were unsure of how purchasing and providing would affect existing practice.
<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>YEAR</th>
<th>DEFINITIONS OF HEALTH PROMOTION</th>
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<tbody>
<tr>
<td>Green L W</td>
<td>1984</td>
<td>&quot;any combination of health education and related organisational, economic and environmental support for behaviour conducive to health&quot; (1984:190)</td>
</tr>
<tr>
<td>Tannahill A</td>
<td>1985</td>
<td>&quot;a realm of health enhancing activities which differ in focus from currently dominant curative, high technology or acute services. This is not to say the realm is not irrelevant to workers in these health care fields. Rather it is necessary to delineate its boundaries so that it may compete more effectively with traditional power bases for resources so that we can improve the overall balance of services&quot; (1986:4)</td>
</tr>
<tr>
<td>O'Donnell M</td>
<td>1986</td>
<td>&quot;the science and art of helping people changes their lifestyle to move towards a state of optimal health&quot; (1986:4)</td>
</tr>
<tr>
<td>Tones K</td>
<td>1986</td>
<td>&quot;Health Promotion is conceptualised as any deliberate intervention which seeks to promote health and prevent disease and disability. It incorporates health education and gives prominence to the influence of legal, fiscal, economic and environmental measures on community health&quot; (1986:3)</td>
</tr>
<tr>
<td>Pender N</td>
<td>1987</td>
<td>&quot;activities directed towards increasing the level of well being and actualising the health potential for individuals, families, community and society&quot; (1987:27)</td>
</tr>
<tr>
<td>Griffiths &amp; Adams</td>
<td>1991</td>
<td>&quot;The promotion of health must therefore of necessity be linked to the transformation of social structures, policies and conditions that create illness, disability and premature death. Such change in social structures requires a redistribution of power and wealth and handover of control from the wealthy and powerful minority to the majority&quot; (1991:220)</td>
</tr>
<tr>
<td>Bunton R &amp; MacDonald J</td>
<td>1992</td>
<td>&quot;a unifying concept which has brought together a number of separate, or even disparate fields of study under one umbrella&quot; (1992:6)</td>
</tr>
</tbody>
</table>
The publication of the Health of the Nation (DOH 1991) reinforces the UK government's determination to measure health outcomes, and all health care professionals will be expected to participate in developing appropriate indicators and measurements of health outcomes (Killoran 1991).

All groups of respondents agreed that their activities should be evaluated and the comment made by one of the GPs that "its the only way to succeed" personifies sentiments of a collective response, although in some interviews the acknowledgement of this necessity was more grudgingly made than in others. Conill and O'Neill (1984) indicate that in western society where the dismantling of a welfare state occurs, professionals are not keen to develop skills which would make them even more vulnerable to critics, and in consequence expose them to further cuts. A number of interesting perspectives related to measurement appeared in the cognitive maps, each needing careful exploration and analysis. HEO/HPOs expressed a dislike of the quantitative types of methods used to evaluate their worth, believing that outcomes in terms of numbers, such as the number of families participating in programmes, and immunisation uptake rates, were of limited value. Other important beliefs to emerge were that health education officers felt disadvantaged in having no particular data base on which to compare the outcomes of their practice; for example, the number of smokers on which to target a health promotion campaign so that they could assess its success or failure. In common with other health promotion workers, HEOs also considered themselves to be at a serious disadvantage, in that there appear to be few reliable or valid indicators of wellbeing.

Yet another belief to emerge from the HEO/HPOs interviews was that the whole approach to measurement of their work hinged, once again, on the perceived and/or felt dominance of the medical profession. For example, whilst the HEO/HPOs felt their
efforts should be more geared to group work and community development activities, their managers were directing their energies to disease prevention and requesting quantitative data such as the number of educational activities undertaken on heart disease.

Quite a strong consensus emerged from the HEO/HPOs that there was a real need to develop more qualitative measures, although the view was put forward that any type of formal evaluation/measurement in health promotion was contrary to the philosophy HEO/HPOs were trying to promote, that is that individuals and groups should be empowered to measure their own activities. The Research Unit in Health and Behavioural Change, University of Edinburgh (1989:23-29), endorses the views of the HEO/HPOs, emphasising the problem of construct validity indicating that successful measurement of, for example, health enhancing behaviour, would only be revealed by qualitative research after a long-term longitudinal study because of, for example, the recidivism identified in the behaviour of smokers, alcoholic, dieters, etc. Researchers in this Unit also suggest that a further problem remains with the actual method of data collection and the effect that this has on the validity of the study.

The general practitioners who were interviewed appeared convinced that measurement/evaluation of health promotion work was necessary in order to justify the use of scarce resources. An interesting question about the nature of evaluation was raised, and an attempt to encourage patients to use diaries so that general practitioners could ask for feedback on their advice/treatment was suggested as a possible approach to adopt. The question which then emerges is what happens if patients don't comply with treatment or fail to complete their diaries, are they then abandoned or are they given focused attention?

The health visitors' beliefs about measurement identifies a number of conflicting issues. The view that some form of evaluation of health promotion activities was
necessary was expressed repeatedly even to the extent that "health visiting will disappear unless we can show that it is effective" (Table 4.2). The view that consumer feedback was an important element of any evaluation programme was also supported by the health visitor interviewees.

Negative views about the measurement of health visitors' health promotion work included the beliefs that there was too much emphasis on statistics and collection of immunisation rates, and that the real work health visitors considered themselves to be doing, was never recorded in any official return. This is clearly an area which needs further investigation.

From the analysis of the core category 'measurement' the principal findings/questions to emerge are that:

1. Measurement/evaluation of health promotion work is seen as necessary by all groups of professionals.

2. Health visitors and health education officers are of the view that too much emphasis is placed on the collection of quantitative data. This raises a question about the type of data which actually does reflect the work thought to be relevant by the professionals.

3. Given that the view has been expressed that the medical profession dictates the nature and measurement of health promotion activities, what alternatives are possible?

4. Another question which emerges from this analysis is who should decide on what methods of measurement are used: the consumer, the practitioner, the new management or all three?
TEAMWORK

The subject of teamwork emerged from all of the interviews although in differing contexts. The general practitioners perceived the successful practice of health promotion as being dependent on good teamwork, having a common aim and working collectively to achieve that aim. Although this view was expressed by the GPs they recognised that teamwork as such did not happen in their own practice, largely because of the limited time available to get to know each other. District nurses and health visitors were named specifically by the GPs as being valuable members of a primary health care team.

There was not a great deal of consensus in the views of the health visitors regarding teamwork. While some health visitors expressed the view that health promotion could be done equally well by all members of the primary health care team, it was believed by others that it was not practised at all by some members of the team. Some health visitors expressed the belief that whilst younger, more recently trained general practitioners were more likely to value and practice health promotion, older general practitioners were thought not to see it as a priority in their own work. Screening was considered by the majority of health visitors as the area in which most GPs would work. The reason for this was that, although screening forms an important part of secondary prevention, it still focuses on the detection of disease, a classic medical model approach to health promotion. Health Visitors may also have thought that GPs would be more likely to undertake particular screening procedures where cash payments were related to their completion.

The health education officers appeared to agree that teamwork was necessary to be effective in health promotion, but there were varying views as to who should constitute the significant team members. General practitioners and health visitors identified doctors and nurses as the most appropriate workers; whereas some of the health
education officers considered non medical or non nursing staff, such as teachers, nutritionists, other graduates etc, as more appropriate. This is probably because HEO/HPOs wish to avoid the dominance of the medical profession and the subservience of themselves, and nurses to doctors.

Cumberlege (1986) in her review of community nursing, recommended the promotion of primary health care teams and emphasised their importance. The reason for this recommendation may have been partly due to the fact that Cumberlege perceived some community nurses as working in isolation to the detriment of patients. Another explanation may be the government's desire to curb the growing autonomy of health visitors, district nurses and other community nurses by reinforcing the role of the general practitioners as team leaders in health promotion. This would ensure that the work of community nurses remained within a medical framework, with the emphasis clearly on the lifestyle and health behaviour of individuals.

Ashton and Seymour (1988:52) in their discussion of organisational initiatives for health promotion also recommended a team approach, but teamwork from a societal perspective. The very nature of intersectoral action in health implies committed teamwork to achieve improved quality of life and wellbeing for local communities and national populations.

**EMPOWERMENT**

As seen in the discussion of the core category 'Political perspectives of health promotion' and in the section on 'Skill Requirements', the concept of empowerment was seen to be central to the achievement of health promotion. Tones (1986) suggests that to achieve the self empowerment of individuals or groups, a necessary prerequisite may be the modification of an individual's self concept, such as enhancing self esteem. Tones
(1986) gives the example acquiring the life skill of assertiveness which he suggested would facilitate a decision to get help from a doctor, lawyer or someone else in authority. In terms of this study, it was clear to the researcher that some HEO/HPOs and health visitors appeared to lack personal self esteem. An example of this may be seen in the cognitive map item 26 on Table 4.2, where one of the HEO/HPOs states explicitly that she is not confident in herself. This raises questions as to whether health care professionals need assertiveness training in their initial professional preparation and/or continuing education before they can be expected to help clients and/or groups to be more assertive.

It is also significant that while health visitors and HEO/HPOs expressed the need for both self empowerment and empowerment of others, the subject of empowerment did not surface at all in the interviews with general practitioners. This may be because of the socialisation of doctors in which they see themselves as the expert and patients as more passive.

INDIVIDUALISM

The concept of individualism surfaced recurrently in the cognitive maps and it can be seen from the discussion so far that individualism interrelates closely with approaches to practice, definitions of health promotion, and political perspectives. All groups of professionals acknowledged that much of the responsibility for health was seen by government to rest with the individual. A report from the DHSS (1977b) clearly identified that changes in the attitudes and behaviour of the public could be achieved by "a regular flow of information and advice from the top down" but many authors have been sceptical of this approach seeing it as naive and victim-blaming (Tones 1986; Navarro 1984). Other work has shown that, many people only respond to a health
message if it is directly meaningful to them. The message must either concur with their beliefs concerning health and health care, or they must perceive that their life is threatened significantly by not taking health advice (Becker 1974; Cornwell 1984; Calnan 1986).

It was disappointing to the researcher that none of the professionals interviewed identified health beliefs, lay perspectives of health, environmental issues etc as influencing the success or failure of health promotion; either in the context of the limitations of individualism, the context of practice, obstacles to health promotion or in relation to the knowledge base required for the advancement of health promotion. This could have been because the interviews were not specifically focused to elicit discussion on these matters.

Analysis of the transcripts and cognitive maps suggests that 'individualism' is not only central to the meaning of health promotion but it relates closely to other concepts such as skill requirements, current health promotion practice, empowerment, and medicalisation.

The differences within and between the three groups of professionals are interesting in that although the general practitioners acknowledged the importance of policy issues such as housing, they appeared in their responses to support an individualistic approach to practice, commenting uncritically that 'health promotion puts the onus on the individual'. The health visitor interviewees gave conflicting responses, some regarding the onus for health on individuals as positive, others seeing it as negative. Only the HEO/HPOs were unequivocal in their view that empowerment of others, community development and intersectoral policy making were essential to the achievement of health promotion.
STATUS

The group interviews with HEO/HPOs revealed a perceived and felt lack of status by most of the interviewees. Throughout the interviews both direct and indirect statements regarding status were made. An expressed need for a 'proper' professional training incorporating a stronger professional base and for the health education/health promotion profession to have a clear view of what it was aiming for and where it was going was reiterated on a number of occasions. It would seem that there is a relationship between the lack of autonomy experienced by HPOs, their inability to articulate health promotion and their expressed need for clear professional objectives. Freidson (1974:234) suggests that any diminution of autonomy and dominance destroys the capacity of professionals to do their work 'properly'. Freidson (1974:235) also suggests that "a profession's greatest ally is its own demonstrable knowledge and skill". Questions which arise from these statements, include whether HEO/HPOs have the appropriate knowledge and skills required for successful health promotion? Is the health education/health promotion profession able to demonstrate to the public its knowledge and skills? As can be seen from this discussion the relationship between status, skills and measurement becomes more significant.

Reference to the dominance of the medical profession in the context of obstacles to health promotion work, and the suggestions that non medically or non nursing trained individuals would be more appropriate to advance health promotion in teamwork, reinforces the identification of a perceived lack of status by HEO/HPOs.

Interestingly, health visitors and general practitioners did not mention status. Possible explanations for this include the fact that because of their professional socialisation health visitors are likely to accept their role/relationships with the doctors. GPs are unlikely to feel a lack of status, many coming from middle class backgrounds
and being seen by patients and significant others as being members of an old and prestigious profession. The fact that patients are often deferential to the doctor on account of his/her knowledge and expertise may also contribute to their status and sense of importance.

ASPIRATIONS FOR THE REALISATION OF HEALTH PROMOTION

Closely linked to the HEO/HPOs perception of the status of their profession was their aspirations to improve their present position and by doing so hopefully improve the practice of health promotion. Agreement on the need to increase the number of people working as HEO/HPOs was supported by all the interviewees. The need to focus more on community development work rather than individual/one-to-one interaction with the public was also considered to be desirable.

Aspirations were elicited concerning major changes in the way HEO/HPOs work. These included the need for HEO/HPOs to become catalysts for the development of initiatives and intersectoral activities, and the desire to become involved in some central policy making areas such as housing, town planning or the environment.

When questioned by the researcher about the background from which HPOs should be recruited both groups of interviewees supported the recruitment of teachers, social scientists and people from a diversity of backgrounds. It was felt that such a diversity of backgrounds would provide a range of abilities and skills capable of addressing appropriate societal issues for the advancement of health promotion in society.

Interestingly the concept of aspirations for the realisation of health promotion appeared only relevant to HEO/HPOs. This may have been because their level of consciousness, regarding effective health promotion practice, has been raised by
CONCEPT MODIFICATION BY THEORETICAL CODING

It can be seen from Table 4.4 that 12 core categories emerged from analysis of the group interviews. Discussion of those core categories, with an exploration of the literature, formed part of the third stage of continuous comparative analysis. In concert with this stage of the analysis, two other processes were used to delimit the theory, namely, theoretical coding and memo writing.

According to Stem (1980:23) "Codes provide a way of thinking about data in theoretical rather than descriptive terms". This involved applying a variety of analytical schemes to the data to raise their abstraction and thereby enhance the level of discussion (see Chapter Five). Glaser (1978) presents a selection of schemes and codes which he calls a 'conceptual out' (1978:119). The researcher took each of the core categories; measurement, terminology, empowerment, status etc and considered them in terms of function, role, consequences, contexts, causes and covariances. The four codes, causes, consequences, contexts and covariances, were identified in the work of Stern (1978) and the codes role and function were two of the codes within the 18 families of theoretical codes suggested by Glaser (1978). These six theoretical codes were selected by the researcher because of their apparent fit with the health promotion data. Figure 4.2 (overleaf) demonstrates how the codes helped the researcher to explore the theoretical and pragmatic issues associated with the concepts identified in the qualitative research.

Some core categories generated more dimensions than others, when applying the six theoretical codes (see Figure 4.2), but this process enabled the researcher to increase the depth of questioning about the category under analysis. Figure 4.2, for example
<table>
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<th>CORE CATEGORY</th>
<th>FUNCTION</th>
<th>ROLE</th>
<th>CONSEQUENCES OF</th>
<th>FOR</th>
<th>COVARIANCE/ RESULTS</th>
<th>CONTEXT</th>
<th>CAUSES</th>
</tr>
</thead>
</table>
shows the application of theoretical coding to the core categories 'Measurement', 'Skills' and 'Status'. During the various stages of constant comparative analysis, cognitive mapping, saturation of concepts, reduction of the categories and theoretical coding, the researcher made copious notes as the data emerged or even hours after the data had emerged. For example, is there a relationship between measurement and status? What is the relationship between skills, individualism and empowerment, does one determine the other or is there a hierarchical relationship within the categories? Is there a difference between categories? Some are social processes, others ideational (aspirations). This process called memoing is "a method of preserving emerging hypotheses, hunches, abstractions and questions" (Stern 1980:23).

Writing up the theory, both discussional and propositional, from these memos formed the final stage of constant comparative analysis. It also provides the substantive material from which the researcher is able to develop a theoretical framework for the next stage of the research.

Chapter Five concludes the qualitative stage of the research and identifies the aims of the quantitative phase of the research which is underpinned by the emergent conceptual framework.
CHAPTER FIVE

DEVELOPING A CONCEPTUAL FRAMEWORK

Developing a Conceptual Framework

Core categories to emerge from grounded theory on health promotion.

Theme 1. Political perspectives and health visiting practice of health promotion.

Theme 2. Terminology.

Theme 3. Measurement.

Theme 4. Skills and practice of health promotion.

Theme 5. Professional status.

Theme 6. Personal health behaviour and obstacles to health promotion.

Aims of the Quantitative Stage of the Research.
CHAPTER FIVE
DEVELOPING A CONCEPTUAL FRAMEWORK FOR THE
QUANTITATIVE STAGE OF THE RESEARCH

The final stage of constant comparative analysis in this research study involved writing up the emergent theory in order to develop a theoretical framework for the quantitative stage of the research. As indicated earlier, constant comparative analysis as conducted throughout the qualitative stage of the research, results in developmental theory which can be discussional and/or propositional in type (Glaser and Strauss 1967:32).

In the third stage of constant comparative analysis, namely delimiting the theory, discussion took place on the emerging categories with recourse to existing literature, addressing the categories and substantive issues as they emerged from the data. Subsequent theoretical coding and memoing enabled the researcher to look more critically at the data and to rework it, exploring the relationships between and within the core categories. Figure 5.1 (see overleaf) illustrates graphically the suggested positioning and interrelationship between the core categories inducted from the data.

Three categories which appeared central to the study included 'political perspectives', 'terminology' and 'measurement'. The reasons for the emergence of these three categories may be both conceptual and pragmatic. Beattie (1991) for example, considers that health promotion strategies do tend to accord with different political orientations, he comments "The persistent invocation of persuasion tactics I cannot avoid seeing as commonly bound-up with a traditionalist broadly 'conservative' political ideology which perhaps finds in campaigns directed at individual behaviour modification an acceptable 'minimal' role for the state" (1991:83).
Figure 5.1

Core Categories to emerge from Grounded Theory on Health Promotion
Given that the health visitors participating in the group discussions were working in a health service undergoing radical operational, managerial and economic change, it seems likely that their consciousness and experience of the political ideology behind the changes may have influenced their answers.

In relation to the category 'terminology' the cognitive maps (Chapter Four) suggest that the health visitors had witnessed few, if any changes in health education practice. From their perspective they may have regarded the term health promotion merely as a change in nomenclature. From a theoretical perspective a change in terminology may well herald a change in direction, involving new work strategies, deployment of staff, and re-casting of roles (Beattie 1991).

With regards to the category 'measurement' part of the new NHS culture emphasises quality, audit and value for money. It seems likely that many of the health visitors in the group interviews viewed some form of measurement as necessary to make their work, and the value of their work, more visible both to the public and to potential purchasers of their services. However, whether this is the case for a representative sample of health visitors remains to be tested.

It would appear that the nature of the three categories 'political perspectives', 'terminology' and 'measurement' will depend on the policies prevailing at any given time. For example, if the existing government policies promoted an individualistic approach to health promotion it could be argued that the skills, knowledge base and practice of health promotion professionals would, to a great extent, emanate from the prevailing philosophy. Health promotion in this case would be executed through a health care/health promotion organisation and management system in which health promotion activity would focus on advice giving to individuals, concentrating on topics such as the
reduction or cessation of smoking, weight loss, healthy eating, avoidance of substance abuse, all of which can be seen as victim blaming targets.

Should the prevailing political perspectives encompass a societal approach to health promotion, one would predict more emphasis on group and community empowerment, community participation, and intersectoral activities in which health care professionals interact more frequently with other policy making departments and professionals. Whereas a political perspective which encompassed a pluralistic approach to health promotion would result in provision of both individualistic and community approaches in practice.

It is possible to present these core categories as single or composite themes which can offer a theoretical framework for the quantitative stage of the research. The rest of this chapter focuses on selected themes with appropriate hypotheses, propositions and questions. Originally it was hoped that the research would address issues related to the health promotion work of general practitioners, HEO/HPOs and health visitors, however on reflection, the researcher decided, for the following reasons, to concentrate solely on health visitors.

First, experience during the qualitative stage of the research had shown that getting a good response rate from general practitioners might be difficult, especially from general practitioners working in single handed practices. Allsop (1986), for example, found that 34% of London GPs were single handed practitioners compared with 27% in Manchester. The researcher assumed that in a random sample of general practitioners, single handed practitioners would, because of their heavy workloads, be unlikely to regard completion of a questionnaire as a high priority. Secondly, in light of the lack of response to the researcher's requests to general practitioners in the first stage of the study,
it was felt that general practitioners might not perceive research conducted by a nurse as of sufficient importance.

Thirdly, it was known that a large research project, exploring the role of general practitioners in relation to health promotion, was currently being undertaken (Williams 1990), and the researcher did not wish to duplicate work at this stage.

With regard to HEO/HPOs it was felt that as Rawson and Grigg (1988) had only recently completed an analysis of the work of HEO/HPOs, there seemed little point in revisiting the profession so soon. Added to this the health education/health promotion profession, as a whole, represents a relatively small number of professionals compared with GPs and HVs.

The reasons for undertaking the research with health visitors appeared convincing. First, the researcher had access to a national sample of health visitors. Second, previous research using a national sample of health visitors was undertaken 38 years ago (Ministry of Health 1956). Thirdly, health visiting has been described by the nursing profession itself as having particular skills in health promotion (UKCC 1986), and this research would enable the researcher to explore this claim. Fourthly, given the imminent changes in the health service and the Government's declared commitment to health promotion (DOH 1991) it was thought that a health visiting perspective might provide a grass roots view of what was happening and enable the researcher to explore a range of hypotheses with a representative sample of health visitors. Hypotheses, questions and propositions are presented below according to the six themes identified in Figure 5.1.

THEME 1 - POLITICAL PERSPECTIVES AND HEALTH VISITING PRACTICE OF HEALTH PROMOTION.

The preceding discussion concerning the interrelationships between political
perspectives, individualism and empowerment, enables the researcher to put forward the following hypotheses and pose a number of questions.

**Hypotheses**

1. Because of the existing framework of the NHS, its organisation and management, health visitors are more likely to focus their work on individuals and families rather than on group and community issues.

2. Because of health visitors' initial socialisation as nurses (working within a medical framework) they are most likely to view the onus for health as resting with the individual.

3. Health visitors are likely to consider that if individuals and families are given appropriate health information they can choose or reject a healthy lifestyle.

These hypotheses will be explored in the context of the health visitor's work (see also Theme 4). Political perspectives which impinge directly on health visiting, and which are likely to influence practice (as discussed in the opening chapters), are also pursued across all six themes emerging from the qualitative work.

**THEME 2 - TERMINOLOGY**

Closely related to political perspectives affecting the way health promotion is defined and operationalised is the terminology used to clarify or make explicit the nature, scope and dimensions of the theory and practice of health promotion. Discussion in the previous chapter concerning the confusion expressed by health care professionals about terms such as health education and health promotion suggests that there may be little depth of understanding about what health promotion involves, what practice models or modus operandi exist in order to achieve health outcomes, and what knowledge base is
required to underpin successful practice. This leads to the proposition that there is likely to be a relationship between the terminology of a subject and the nature of health promotion practice.

The following hypotheses are suggested:

1. That health visitors perceive no difference between the terms health education and health promotion.
2. That where health education and health promotion are seen as synonymous, work priorities will remain embedded in a traditional individualistic mode of practice.
3. That where health promotion is perceived differently to health education, health visitors are less likely to see that the responsibility for health rests with the individual.

**THEME 3 - MEASUREMENT**

Alongside 'political perspectives' and 'terminology' the third category which appears to be central to all the others is the concept of 'measurement'. First, it can be seen that measurement is clearly related to political perspectives. For example, measurement is currently an important plank of the UK Government's new managerialism in the NHS in that professional activity must be measured in order to demonstrate efficiency and effectiveness (Killoran 1991). The argument is that, without some form of measurement/evaluation of health promotion activities, managers cannot know whether money is well spent.

Measurement is closely related to terminology, as the way in which health promotion is defined/interpreted has implications for how health promotion is measured. If, for example, health promotion is perceived as providing appropriate health knowledge, measurement may include merely assessment of knowledge and perceived
health risks. Thus the interpretation of health promotion has implications for the type of skills required by practitioners, who determines those skills, and who undertakes the measurement/evaluation of health promotion activities.

Although the government may require the measurement of health promotion activities, and professionals may see it as an essential requirement for their professional survival, Downie et al (1990) perceives measurement of health promotion as problematic. Reasons for this include the difficulty of isolating the effects of a specific health promotion activity, lack of acceptable terminology, lack of specific health promotion objectives, time factors and other problems (Downie et al 1990:75). But what of the health visitors? Do they consider health promotion is measurable? If they do, what methods of measurement do they see as appropriate to justify not only existing models of practice, but also the recognition and continuation of their own work.

Although no specific hypotheses regarding measurement are put forward, exploration of health visitors' views on this subject is clearly desirable, if only to understand their awareness and perceptions of this concept.

THEM 4 - SKILLS AND PRACTICE OF HEALTH PROMOTION

As discussed in Themes 1 and 2 it is suggested that the government political policies and terminology used to define and influence the dimensions and scope of health promotion will, to a large extent, determine the types of knowledge, skills and attitudes required by particular groups of health care professionals such as health visitors, school nurses and district nurses. The researcher knows of very few studies that have studied the skills of health visitors per se, or those of other community nurses in any depth. This study, therefore, will attempt to explore the views of the health visitors about their own
knowledge and skills in relation to the practice of health promotion. Questions which stem from the qualitative stage of the research include:–

1. Do health visitors perceive that they require new knowledge and skills to practice health promotion?
1a. If so, what new knowledge and/or skills would they wish to acquire?

2. Do the skills that health visitors would like to have correspond with prevailing ‘market type’ health policies?

3. Do health visitors consider that they are currently developing new skills in their practice of health promotion?

In the earlier discussion of Theme 1 it was hypothesised that health visitors were likely to exemplify a traditional mode of practice (ie. mainly one to one interaction). Skills and practice of health visiting will inevitably depend upon factors such as organisational structures, management policies, existing custom and practice. It is important therefore to understand existing workloads, caseload priorities and the nature of the workbase so that any health promotion activities can be viewed in context. Information is required as to the nature of any practices which health visitors regard as health promotional. In order to acquire this information it is proposed to use a modified form of critical incident technique in which health visitors will be asked to identify any health promotion activity they have undertaken within their last ten days of practice. (See Chapter 6).

Practice of Health Promotion

The need for teamwork has been identified not only in the Report of the Community Nursing Review (Cumberlege 1986), but in the fact that the very nature of health promotion implies intersectoral working in which professionals from diverse
backgrounds contribute to both policy making and operational health promotion activities (Milio 1986).

It is suggested that the quality of teamwork may well depend upon how individuals and groups of individuals perceive each other's skills and appropriate abilities, and what status they ascribe to each other's work. If non-medical health care professionals are able to articulate knowledge of the theory and practice of health promotion, and demonstrate health promotion skills which can be verified by measurable outcomes, it can be argued that the various roles and functions of professionals in health promotion would become clearer than is currently the case. This in turn should promote a greater understanding of each profession's respective roles, enhance co-ordination and collaboration between the professions, and, hopefully, improve skills and services to individuals, groups and communities through the medium of teamwork.

Questions which emerge from the analysis include:

1. Do health visitors perceive themselves, other health visitors, and general practitioners, as practising health promotion?

2. If health visitors do perceive themselves, other health visitors, and general practitioners, as practising health promotion, is it all of the time, some of the time or only occasionally?

THEME 5 - PROFESSIONAL STATUS

Although the core category professional status was only given prominence by the HEO/HPOs in the qualitative interviews, it seems likely to be a category of importance generally. Given the introduction of a new market system in the NHS, and its likely impact on health visitors and health visiting, Luker and Orr (1992:10) have made the statement "it is clear that the world of community nursing will never be the same again".
The qualitative interviews indicated that the status of health visitors (as well as HEO/HPOs) was currently being undermined. It was also suggested that the new management in the NHS (both at Manager and Senior Nursing Level) appeared to demean or fail to recognise the value of the health visitor’s work.

Another issue affecting the perceived status of health visitors is the claim made by the statutory bodies of nursing (UKCC 1986 and personal observation) that future Project 2000 students will be able to function effectively in health care and health promotion both in the hospital and community setting. This belief, clearly appears to have negative implications for the status of health visiting.

Questions arising within this theme include:

1. Do health visitors perceive that their work is valued or understood by NHS managers in the restructured health service?
2. Do health visitors feel that the future of health visiting is seriously threatened by the advent of the new market system health service as described in the White Paper?
3. With the advent of project 2000 nurses, do health visitors perceive that the importance of the health visitors’ role will diminish.

THEME 6 - PERSONAL HEALTH BEHAVIOUR AND OBSTACLES TO HEALTH PROMOTION

The final theme of this conceptual framework will address two key issues, namely the personal health behaviour of health visitors and perceived obstacles to health promotion practice. ‘Personal Health Behaviour’ is included with ‘Obstacles to Health Promotion’ since it may highlight obstacles to health visitors putting into practice their health knowledge.
Personal Health Behaviour

It has been shown earlier in this thesis that health professionals often bring their own beliefs and biographical/life experiences to their work (Kratz 1978). For this reason, it was thought appropriate to explore the professionals' own health behaviour. To what extent, for example, do health visitors, all of whom have knowledge of appropriate health behaviour, conform to their knowledge? According to Blaxter (1990:24) "beliefs are not very good predictors of behaviours". Questions will therefore be framed to explore how, if at all, health visitors look after their own health and the health of their families and/or partners, and, whether their responses address undimensional elements of health such as physical aspects or, multidimensional elements of health including psychological, social, environmental and occupational aspects of health. The issue of whether health visitors consider that they do anything detrimental to their own health will also be explored. In a study of health and lifestyles, Blaxter (1990) found that some people led healthy lives without having health promotion as a motivation, whilst other (well educated) individuals did not regard health as an important issue of their lives. Given the complexities of health behaviour, if the health visitors do admit to engaging in harmful behaviour, the researcher thinks it important to explore the reasons why they do so.

The researcher recognises the personal and sensitive nature of probing the health behaviour of respondents, however, it is thought that careful piloting of the questionnaire will obviate potential difficulties in this area of questioning.

Obstacles to Health Promotion

The final issue proposed in this conceptual framework for the quantitative study is obstacles to health promotion practice. Many of the perceived obstacles which emerged as a result of cognitive mapping have been discussed in Chapter Four. Obstacles such as caseload size, lack of managerial support etc, will be pursued in the quantitative study to
ascertain whether the findings can be generalised to practising health visitors. The respondents will be asked to identify what, if any, difficulties they have encountered in their practice of health promotion. A synopsis of key issues to be explored in this research are shown in Figure 5.2 (see overleaf).

AIMS OF THE QUANTITATIVE STAGE OF THE RESEARCH

The reworking of the core categories enabled the researcher to summarise the key research questions and hypotheses to be pursued in the quantitative phase of the research. The aims and objectives of the quantitative stage of the research as follows:-

Aims

1. To explore how health visitors perceive and practise health promotion.

2. To investigate, analyse and evaluate issues outlined in the conceptual framework.

Objectives

a) To test the set of hypotheses identified from the focused interviews.

b) To pursue the questions emanating from the focused interviews (see Figure 5.2).

c) To explore the nature of health visitors' health promotion practice by modified critical incident technique.

d) To explore if and how professionals practice health promotion in relation to their own health behaviour.

e) To develop a research instrument to achieve the objective outlined above.
### Figure 5.2

#### SUMMARY OF KEY HYPOTHESES AND QUESTIONS IN THE CONCEPTUAL FRAMEWORK

**Qualitative Stage of the Research**

<table>
<thead>
<tr>
<th>THEME 1</th>
<th>THEME 2</th>
<th>THEME 3</th>
<th>THEME 4</th>
<th>THEME 5</th>
<th>THEME 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political Perspectives and Practice of Health Promotion</td>
<td>Terminology</td>
<td>Measurement of Health</td>
<td>Health Visiting Skills and Practice</td>
<td>Professional Status</td>
<td>Personal Health Behaviour and Obstacles to Health Promotion</td>
</tr>
<tr>
<td><strong>H1</strong> Health Visitors are likely to pursue an individualistic model.</td>
<td><strong>H1</strong> Health visitors will perceive the terms Health Education and Health Promotion as synonymous.</td>
<td>Questions</td>
<td>Questions</td>
<td>Questions</td>
<td>Questions</td>
</tr>
<tr>
<td><strong>H2</strong> Health visitors are likely to see the onus for health as resting with the individual.</td>
<td><strong>H2</strong> Where health visitors do perceive the terminology as synonymous. Work priorities will remain within a traditional mode of practice.</td>
<td>Do health visitors believe that health promotion can be measured?</td>
<td>Do health visitors have to contribute to health promotion?</td>
<td>Do health visitors perceive their work as valued by their managers?</td>
<td>Do health visitors feel threatened by the new market NHS?</td>
</tr>
<tr>
<td><strong>H3</strong> Health visitors perceive that individuals and families have an element of choice in accepting or rejecting a healthy lifestyle.</td>
<td><strong>H3</strong> Where the terms health education and health promotion are perceived as different working practices will be defined differently.</td>
<td>If health visitors believe that health promotion can be measured, on what criteria can this be done.</td>
<td>If health visitors do perceive new skills are required, what is the nature of those skills?</td>
<td>With the advent of P2000 do health visitors perceive the importance of their role diminished by others.</td>
<td>Do health visitors perceive any obstacles to health promotion practice?</td>
</tr>
</tbody>
</table>

**Questions**

- **Personal Health Behaviour**
  - What if anything do health visitors do to promote their own health. Do they engage in negative health behaviours.
  - Do health visitors perceive any obstacles to health promotion practice?

**Is there a relationship between perceived obstacles and workload, environmental location etc?**
<table>
<thead>
<tr>
<th>PART FOUR - THE QUANTITATIVE PHASE OF THE RESEARCH</th>
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<tbody>
<tr>
<td>CHAPTER SIX</td>
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<tr>
<td>PAGE NO.</td>
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<tr>
<td>Methodological Approach and Sample Characteristics.</td>
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<tr>
<td>Obtaining a sample.</td>
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<td>Preliminary developmental work.</td>
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<td>Pilot study.</td>
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<tr>
<td>The main survey.</td>
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<tr>
<td>Initial analysis of responses to the questionnaire.</td>
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<tr>
<td>Sample characteristics.</td>
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</tbody>
</table>
PART FOUR - THE QUANTITATIVE PHASE OF THE RESEARCH

CHAPTER SIX

METHODOLOGICAL APPROACH AND SAMPLE CHARACTERISTICS

The researcher had developed the conceptual framework and identified the aims and objectives of the quantitative study (In Chapter Five). In order to accomplish these aims it was most appropriate to obtain a nationally representative sample of practising health visitors. After much consideration it was decided to undertake a postal survey. The reasons for this choice include the following:-

1. It cost far less than interview surveys.
2. The sample size can be considerably larger than a comparable interview sample.
3. Postal survey would be the only feasible method for a national sample by a sole researcher.
4. The range of respondents able to be reached by a postal survey would enhance the representativeness of respondents available to researchers (Hoinville, Jowell & Associates 1987:124).

The above authors also claim that "postal surveys allow respondents time to reflect on the questions, and possibly to look up records, so that they can give more precise answers" (1987: 124).

The advantages of postal surveys outlined above were thought to outweigh such disadvantages as possible poor response rate, the inability to probe answers and the fact that various answers to questions cannot be regarded as independent because the respondent can see all the questions in advance of answering them (Hoinville, Jowell & Associates 1987:125; Nachmias and Nachmias 1976:108; Moser & Kalton 1971).
The next objective was to gain access to a representative sample of health visitors. The researcher considered that the most appropriate action would be to approach the professional organisation most likely to have the largest number of health visitors registered as members, that is the Health Visitors' Association (HVA). The Royal College of Nursing does have health visitor members but these form a minority group within the total membership of the Royal College of Nursing and cannot easily be identified. The researcher wrote a letter to the General Secretary of the Health Visitors' Association requesting access to the total population of health visitor members so that a simple random sample could be selected (see Appendix III).

Permission to sample the HVA membership was agreed by the Finance and General Purposes Committee and the researcher visited the organisation to obtain details of the membership. The researcher was informed that the organisation had just (1990) updated its membership and had removed unpaid members from the records. The total population of health visitors was registered on computer and numbered just in excess of 10,500 at the time of the request. The researcher decided to select about 10% of the membership as a national sample. A complete sampling frame comprising all members of the organisation was obtained and each member was given an identification number starting at one. The required sample was 1000. A thousand numbers were selected from a table of random numbers and these were input into the membership database to select the sample. An additional 50 names were selected randomly so that a pilot study could be completed in advance of the main survey. (Details of the sample are given in analysis of the data page 129).
Names and addresses of the members forming the sample population were transferred to sticky labels in preparation for mailing the questionnaire for self completion.

PRELIMINARY DEVELOPMENTAL WORK

Once the decision was made to undertake a postal survey and a representative sample gained, the next objective was to develop an appropriate questionnaire. Preliminary qualitative research was done in order to formulate the questions which would give a valid measurement of relevant concepts, test the design/layout of the questionnaire, and ascertain that the vocabulary used in the questions was not ambiguous but clear and understandable to all potential respondents.

Twelve health visitor volunteers attending a course at the researcher's workplace agreed to participate in this developmental process. This preliminary work gave the researcher the opportunity to assess whether the questions pertaining to personal health status were perceived as threatening. This appeared not to be the case although it was recognised that this might be different using a postal survey.

The preliminary work on the questionnaire also enabled the researcher to identify ways of precoding some of the questions and to some extent to check the validity and reliability of the items used. As a number of questions were answered in a similar way on repeated occasions by the same health visitor volunteers, the researcher considered the items to be reliable. Similarly content validity was verified by the researcher when answers to questions concurred with the researcher's subjective assessment of appropriate responses (Babbie 1976:60). The pilot study would provide the researcher with another opportunity to check the reliability and validity of the research instrument.
Question 13 on the questionnaire (see Appendix IV) attempted to capture at least one example of health visiting health promotion activity which the respondents had undertaken up to ten days prior to completing the questionnaire. The ten day period was chosen by the researcher as it was felt that respondents would be able to remember any activity undertaken within that time scale. It was also thought that a ten day period represented a long enough period in which health promotion activities would be carried out during routine health visiting practice.

Question 13 was modelled on the critical incident technique approach used widely to demonstrate and investigate nursing practice (Cormack 1992). Although examples of health promotion activities would be self selected by the respondents and there would be no way of verifying they had actually been undertaken, it was considered that a first step would be to analyse given examples of health promotion activities and classify them according to the nature of the responses. Cormack (1991:247) states that "analysis of data usually takes the form of inductive classification of incidents. This means that a classification system is constructed as the data are being analysed rather than before". Despite the limitations of this method it was felt that various examples of health promotion activities given by health visitors would at least demonstrate the scope and potential for health promotion opportunities.

Work with the twelve health visitor volunteers related to the modified critical incident approach, and all other areas of development of the questionnaire helped considerably with preparation for the pilot study.

PILOT STUDY

When the initial questionnaire design was completed (see Appendix IV) and 50 names and addresses had been selected to pilot the research tool, a covering letter was
composed to accompany the questionnaire. The letter explained the purpose of the survey and assured the recipient of confidentiality at all times (see Appendix V).

Fifty questionnaires with index numbers for identification were posted to the appropriate individuals with a stamped addressed envelope for reply. Of the fifty questionnaires sent out forty were returned within one month.

Although the researcher had had some initial doubts as to whether the respondents would bother to answer some of the open ended questions, this fear appeared to be groundless as most of the open questions elicited comprehensive responses.

Careful analysis of the pilot responses found only a few minor problems with the research instrument. The researcher was surprised at the openness and depth of some of the responses. Minor modifications were made to the questionnaire and the final version is shown in Appendix IV.

**THE MAIN SURVEY**

Once the pilot study was completed, the researcher sent out 1000 questionnaires for the main study. Each envelope contained a questionnaire, the explanatory letter and stamped addressed envelope (Appendix V). Once the sample had been selected by random number technique the researcher entered every name and address in a special code book in alphabetical order. All questionnaires were given a code number and these were entered against the name of the sample members in the code book. The sample addresses covered all parts of the country, in some cases extending beyond the U.K. (see below). The sample included the border counties of England/Scotland but did not include the whole of Scotland because most health visitors practising in Scotland belong to the Scottish HVA, which is based in Edinburgh.
The questionnaires were dispatched in batches of 100 mainly for reasons of convenience. The first posting commenced in September 1991 and the last posting was completed by the first week in November 1991. The researcher was keen to receive the questionnaire returns before commencement of the Christmas mail period. Table 6.1 gives details of responses to the first mailing and to a second (follow up) mailing to non respondents.

<table>
<thead>
<tr>
<th>Table 6.1</th>
<th>Details of Initial Response Rates to Postal Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numbers</td>
</tr>
<tr>
<td>Total population of Sample</td>
<td>1000</td>
</tr>
<tr>
<td>No. of responses (1st mailing)</td>
<td>616</td>
</tr>
<tr>
<td>No. of responses (2nd mailing)</td>
<td>94</td>
</tr>
</tbody>
</table>

n = 1000

In response to the first questionnaire 616 replies were received. Given the initial response rate it was decided to send a follow up request. A second covering letter was written (see Appendix VI) and the 384 non respondents were sent a further questionnaire. A further 94 health visitors responded. Some of the responses were received within two days of posting, others took several months. Two questionnaires were returned a year after posting.

Hoinville, Jowell and Associates (1987:142) suggest that in most postal surveys two reminders are normally sufficient to produce an acceptable response rate. In this research, because of the relatively low number returned in the second mailing and because over half of these were ineligible because of age, non HV status etc, it was felt that one reminder would suffice.

In view of the context in which many of the respondents were working, namely in a health service undergoing radical restructuring and that morale in the profession was
perceived by the researcher to be very low at the time of the research, it is suggested that the actual response rate is reasonably good.

With the ineligible respondents (illustrated in Table 6.2) removed from the original sampling frame ie. $1000 - 137 = 863$, the 557 respondents constituted a 65% response rate as shown in Table 6.3. However, it is likely that many of those who did not reply were also ineligible, so in practice the actual response rate and therefore representativeness of the sample is likely to be higher. Polit and Hungler (1983) estimate that 50% or over is satisfactory for this type of design.

| Table 6.2 Categories of Respondents considered ineligible to include in analysis of data. |
|---------------------------------|-----------------|----------------|
| Category                        | Numbers | % of Sample |
| A Retired too long to make a meaningful reply. | 47      | 6.6          |
| B School Nurses (Non HVs)       | 42      | 5.9          |
| C Other non qualified HVs (RSCN/DN) | 8   | 1.0          |
| D Severe Illnesses              | 10      | 1.4          |
| E Defined by Post Office as "gone away" or "unknown" | 26 | 3.3          |
| F Living Abroad                 | 2       | 0.2          |
| G Deceased                      | 2       | 0.2          |
| Totals                          | 137     | 19           |

$n = 137$

Respondents in the sample came from nearly every county in England, Wales and Northern Ireland and included some respondents from places such as the Irish Republic, BFPO Germany and Cyprus. Of the 616 responses to the first questionnaire only 509
(83%) responses were thought appropriate to include in the analysis. Of the responses to the second questionnaire nearly half, 46 out of 94 were excluded. Those excluded comprised non health visitor school nurses, members of the association who felt that they had been retired too long to make a meaningful response (these included octogenarians and nonagenarians), and respondents suffering from severe illness who felt unable to fully complete the questionnaire. In addition, the GPO returned a number of envelopes marked 'unknown' or 'gone away'. Other categories of respondents excluded from the analysis included 'deceased', 'gone abroad' and 'baby due now'. Details of the final response rate to the postal survey are shown in Table 6.3.

<table>
<thead>
<tr>
<th>Table 6.3 Final Response Rate to the Postal Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers</td>
</tr>
<tr>
<td>Original Sample</td>
</tr>
<tr>
<td>Ineligible Respondents</td>
</tr>
<tr>
<td>Total Population of sample with ineligible members removed</td>
</tr>
<tr>
<td>No. of Eligible Respondents</td>
</tr>
<tr>
<td>Overall Response Rate</td>
</tr>
</tbody>
</table>

n = (863)

Numerous authors have identified problems in using postal surveys (de Vaus 1986; Nachmias and Nachmias 1976; Babbie 1992). One of the main problems is in obtaining an adequate response rate. A typical response rate for an interview survey is 70 - 80%, whereas for a postal questionnaire it may be as low as between 20 - 40% (Nachmias and Nachmias 1976:167). Hoinville, Jowell and Associates, however, suggest that although high response rates (ie over 70%) may be achieved in postal surveys "they
sometimes drop to around 50% for reasons that are not always clear" (1987:130). The reasons for the relatively low response rate in this research include:

1. The fact that the register did not in all cases provide up to date information about members (ie. current addresses, age of members etc.).

2. Many of the potential respondents had either gone abroad, moved, or gone away from their initial addresses.

3. There were legitimate reasons for exclusion from the analysis including illness, death and old age.

4. Some respondents were ineligible in the first place by not being registered health visitors ie. school nurses, honorary members etc. (The information supplied gave only personal names, addresses and the name of the centre to which the individual members belonged).

INITIAL ANALYSIS OF RESPONSES TO THE QUESTIONNAIRE

The researcher spent many hours going through all the responses on the 557 questionnaires. Each questionnaire was examined meticulously for the breadth and depth of response to questions, the nature of responses to specific and thematic questions, and for the quality of particular and general answers. A number of notebooks were used to make comments and observations about the responses, patterns etc. Patterns of responses, similarities and differences in responses, and prevailing attitudes about some of the items used were noted. Any particularly insightful comments were recorded and referenced for use in the analysis of data and for later comment.

One of the most time consuming tasks was the coding of open questions. Codes are categories: "they are retrieval and organising devices that allow the analyst to spot quickly, pull out, then cluster all the segments relating to a particular concept or theme"
(Miles and Huberman 1984:56). Of the 27 questions in the questionnaire, 12 questions were open ended (see Appendix VII). The responses to the majority of open questions proved manageable in that most answers fitted into easily observed categories. For example, answers to question 20, (What if anything do you do to maintain or promote the health of your family/partner?) fell into four main categories. These were information giving, healthy lifestyle advice, providing a healthy diet, and raising consciousness of environmental hazards. (Coding categories are included in Appendix VII).

Responses to questions 26 and 27 appeared more wide ranging and diverse to the extent that the data was examined by two independent judges who agreed with coding of the responses into five main categories (see Appendix VII). Both independent judges were experienced health visitors and educationalists with knowledge of the research process but neither were currently practising. Both individuals came to the researcher's home to examine the questionnaires and confer on the categories, in all, about five hours was spent examining the questionnaires.

When the coding of the open questions was completed and all data had been appropriately scrutinised and assembled, data from the completed questionnaires were entered on to the main frame computer at the University of Surrey. Analysis of the results was undertaken on micro computer using the SPSS statistical package.

SAMPLE CHARACTERISTICS

Practising and non practising health visitors

As indicated earlier in this chapter 557 respondents, or 65% of the sample respondents, were included in the analysis of the study, and these included both practising and non practising health visitors. It was decided to include both groups of health visitors for the following reasons. First it was essential to include practising health
visitors in order that a true reflection of current practice and perceptions of health promotion might be obtained. Secondly, non practising health visitors were included because it was considered that their views and perceptions of health promotion were equally valid and could be of importance to the research. Thirdly, it was thought that comparisons between and within the practising and non practising health visitors might yield some significant findings in terms of the two groups having different work patterns, responsibilities, and lifestyles.

<table>
<thead>
<tr>
<th>Table 6.4 Practising and Non Practising Health Visitors by Age (Columns %'s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Status</td>
</tr>
<tr>
<td>Practising health 100% visitors</td>
</tr>
<tr>
<td>Non practising 100% health visitors</td>
</tr>
<tr>
<td>Totals 100%</td>
</tr>
</tbody>
</table>

The proportion of practising health visitors to non practising health visitors and their age is shown in Table 6.4. As shown in the table, 29% of the sample are non practising health visitors. Nearly half of whom are in the 46+ age group. It is interesting to note that 70% of practising health visitors are over 35 years and similarly 80% of non practising health visitors are over 35. This finding supports the profession's own view that health visiting is perceived as an "ageing" profession. Further support for this claim is given in a new set of community nursing workforce figures (DOH 1992, so far unpublished) which show a steady decline in the number of health visitor recruits ie. from
1130 in 1981 to 810 in 1990. This contrasts sharply with the increase in recruitment of
practice nurses from 2502 in 1986 to 8776 in 1991 as discussed in Chapter One.

With regard to non practising health visitors, there is very little, if any, research
available to show what health visitors do when they leave the profession. Three quarters
of non practising health visitors in this study were in paid employment and it is important
to note the diversity of jobs/positions in which this group of health visitors are now
working. See table 6.5.

<table>
<thead>
<tr>
<th>Occupation/Present Post</th>
<th>Numbers</th>
<th>% of non practising health visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Management NHS</td>
<td>21</td>
<td>13%</td>
</tr>
<tr>
<td>Lecturer/Senior Lecturer (HE/FE)</td>
<td>13</td>
<td>8%</td>
</tr>
<tr>
<td>Private Sector</td>
<td>13</td>
<td>8%</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>12</td>
<td>7%</td>
</tr>
<tr>
<td>Nurse Teacher NHS</td>
<td>7</td>
<td>4%</td>
</tr>
<tr>
<td>Child Protection Adviser</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>Research Post</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>School Nurse</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Geriatric Nurse</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Health Adviser to Trust</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Paediatric Visitor</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Minister of Religion</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Others</td>
<td>35</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>123</td>
<td><strong>75%</strong></td>
</tr>
</tbody>
</table>

n = 123
The majority of non-practising health visitors who were in employment, were occupying relatively important posts, for example, 13% of respondents described themselves as senior managers in the National Health Service. Senior management posts were defined as directors of nursing services/providers, chief nurses, purchasers/providers or unit general managers in directly managed units/trusts. The fact that health visitors in this study fill top management positions may indicate the merits of health visitor training particularly when health visitors form only 4% of the total nursing workforce for England (DOH 1993).

Some 8% of non-practising health visitors worked in the private sector the majority as managers of nursing homes, including two respondents who were proprietors of private nursing homes. Another 8% were employed in the education sector, the majority in higher education working in either universities or polytechnics.

Given that 47 (28%) of the non-practising health visitors occupy senior positions in education, management or the private sector, it is suggested that the health visiting profession provides women (because the sample is 100% women) with an important career pathway in which diversity from nursing per se is accepted and not seen as detrimental to the profession.

Of the non-practising health visitors, 7% were employed as practice nurses, maybe because they had already seen the possible demise of health visiting as it currently exists, or possibly because they saw more scope in working with fundholding general practitioners.

A further 5% of non-practising health visitors in the sample worked as nurse teachers in Colleges of Nursing. Their future seems fairly secure, as despite there being an apparent surplus of general nurse teachers, there is currently a shortfall in teachers with community backgrounds (ENB 1992).
A small number of respondents (3%) work in research posts, two being attached to universities and two working in health authority posts. Four groups of 3 health visitors (2%) each were working as geriatric nurses, health promotion advisers, school nurses and paediatric liaison visitors. 3% of non practising health visitors were employed as child protection advisors. All of these posts can be seen to carry a great deal of responsibility.

The largest category for working but non practising health visitors is that of 'other'. This category yielded some very interesting posts, including family planning nurse, respiratory nurse, psychotherapist, nurse practitioner, special nurse ethnic elderly, medical receptionist, bank nurse, medical audit facilitator, a clinical nurse specialist and a Marie Curie nurse.

It is important to note that the vast majority of these former health visitors were still working in nursing related occupations and had not turned their back on nursing/the health service.

Of the 25% non practising health visitors who were not working (but included in the study because of their relatively recent involvement in health visiting), 10% had retired, 13% had labelled themselves as housewives and/or mothers, and 2% were unemployed.

YEAR OF QUALIFICATION

The year in which the sample population qualified as health visitors ranged from 1946 to 1991. The histogram (figure 6.1, page 134) demonstrates the year of qualification of all respondents.
Figure 6.1 shows that the greatest number of respondents trained between 1980 and 1990 reaching a peak in 1990. By comparison, the health visitor workforce for England reached its peak of 10,800 in 1986 (DOH 1992). The number of health visitor students entering training from 1986 onwards shows a steady decline.

**LENGTH OF TIME IN POST**

The length of time respondents had been in their current posts ranged from under 1 to 29 years. Table 6.6 demonstrates the similarities and differences between practising and non practising health visitors.
When comparing the two groups it can be seen that the longest time in post for both groups is 1 - 5 years with both groups having the majority of respondents in post for 10 years or less. As might be predicted the number of practising health visitors who had been in post between 11 and 29 years was 15% compared with 10% for non practising health visitors. Whether the length of time in post has a bearing on attitudes towards health promotion will be explored later.
MARITAL STATUS

The marital status of the sample population is shown in Table 6.7.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Numbers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>388</td>
<td>72</td>
</tr>
<tr>
<td>Single</td>
<td>77</td>
<td>14</td>
</tr>
<tr>
<td>Divorced</td>
<td>37</td>
<td>7</td>
</tr>
<tr>
<td>Separated</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>542</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 6.7 reflects the fact that the vast majority of women aged 35+ are married. As the marital status of the respondents has little bearing on the overall research it was felt unnecessary to probe the answers further.

CHILDREN

Two-thirds of respondents had one or more children. The age range of children spanned from under one year to thirty-nine years of age, 10% of respondents had children under five years of age, 17% of health visitors had children aged between five and ten years.

In conclusion, the sample population appears fairly representative of health visitors. Respondents were drawn from all parts of the country, all age groups, qualified over a broad time scale and having been in post anything from under one year up to twenty-nine years.
PART FIVE: ANALYSIS OF THE QUANTITATIVE DATA

CHAPTER 7

THE WORK BACKGROUND/GEOGRAPHICAL LOCATION OF
HEALTH VISITORS AND THEIR PERCEIVED MODE OF PRACTICE

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Geographical details and perceptions of work. 143.

Selection of priorities. 146.

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PART FIVE - ANALYSIS OF THE QUANTITATIVE DATA

CHAPTER 7

THE WORK BACKGROUND/GEOGRAPHICAL LOCATION OF HEALTH VISITORS AND THEIR PERCEIVED MODE OF PRACTICE

This Chapter sets out to explore and discuss details of the working backgrounds of the practising health visitors and their selection of priorities. The propositions that health visitors are likely to pursue an individualistic mode of practice, and that the nature of health visiting practice will be influenced by their geographical locations are explored.

a) THE WORKING BACKGROUND OF THE PRACTISING HEALTH VISITORS

In order to examine any of the hypotheses outlined in the conceptual framework (Figure 5.2), one must first understand the contextual world in which health visitors are located. Bucher and Strauss (1961) in their analysis of the development of the medical profession have commented on the importance of the work situation. They claim that the workbase can be important for a number of reasons. First, it is an environment where roles are forged and developed. Second, the work base may determine the way the profession is moving in terms of priorities and the development of skills. Third, the work situation may throw professionals into new situations and relationships.

The advancement of health promotion by health visitors is most likely to emerge from their existing roles. The researcher suggests the reasons for this include the following. First, few existing health visitor courses place sufficient emphasis on health promotion per se to prepare a new worker solely for health promotion work. Second, although new UKCC proposals for Community Nurse Education are imminent, it is highly unlikely that a shortened curriculum will provide the diversity and quality of knowledge, skills and confidence needed for the successful implementation of
sophisticated health promotion programmes. Third, as there is little money available for inservice training realistically health visitors are likely to be left to their own devices to extend their role in health promotion, whether in an individualistic or community mode.

An exploration of working background and current health visiting practice is thought necessary by the researcher in order to identify the scope of health visiting practice. This should reveal possible opportunities for, or impediments against, the development of health promotion activities.

Health visitors were asked about their workbase, whether they were general practice based, working in a health centre or located elsewhere. (Question 8, Appendix IV).

<table>
<thead>
<tr>
<th>Table 7.1</th>
<th>Workbase of Practising Health Visitors (PHVs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Workbase</td>
<td>No of PHVs</td>
</tr>
<tr>
<td>General Practice</td>
<td>136</td>
</tr>
<tr>
<td>Health Centre</td>
<td>182</td>
</tr>
<tr>
<td>Other</td>
<td>50</td>
</tr>
<tr>
<td>Totals</td>
<td>368</td>
</tr>
</tbody>
</table>

n = 368

A small number of the practising health visitors explained that they were working in both health centre and general practice. These were classified as based in health centres. In fact, half of the sample of practising health visitors work from health centres and this could be significant in the way health promotion roles develop (Bucher & Strauss 1961).

In Table 7.1, of the 50 health visitors who were not based in general practice or health centres, the most common description of workbase included 'clinics, 'maternal and
child health clinics', or 'newly converted victorian buildings'. Some unconventional work base descriptions were given. These included 'chest clinic in hospital', 'converted ex-hospital', 'converted detached house', 'converted bank', 'portacabins in hospital', 'use of room in child development team base', and a 'disused ward of community hospital'.

Although some of the accommodation may be quite good e.g. 'converted detached house' the fact that a number of health visitors still remain in dubious surroundings, some isolated from other professionals, some in unconventional accommodation gives cause for concern. Although this is not a new phenomenon (Chapman 1979), some of the descriptions above reflect the event of ward closures and the demise of hospitals which have occurred over the past few years.

The fact that a bank has been converted for health authority use would probably have been inconceivable a few years ago. It is suggested that as well as giving a contemporary description of the workbase of health visitors, this research also provides insight into the results of prevailing government policy and the low priority placed on the community services. The reasons for the fact that little money has been spent on accommodation for some health professionals working in the community, when compared to the number of new hospitals being built, may be that future care in the community will shift to the responsibility of the Social Services (National Health Service and Community Care Act 1990). This being the case, it may explain why the Department of Health has been slow to move money from the acute sector into primary care.

b) MAIN CHARACTERISTICS OF HEALTH VISITORS' WORKLOADS

Practising health visitors were asked to describe the main characteristics of their workload (Question 9). Three criteria were addressed, namely, social class distribution, ethnicity and the age range of their clientele. Although it was recognised by the
researcher that respondents could give multiple answers to these questions, from a practice perspective it was thought important to identify the complexity of the health visitors' workload. It could, for example indicate the type of skills and knowledge needed for health promotion work. Figure 7.1 demonstrates the social classes mentioned by health visitors as characterising their workload.

**FIGURE 7.1 SOCIAL CLASSES MENTIONED BY PRACTISING HEALTH VISITORS AS CHARACTERISTIC OF THEIR WORKLOAD**

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Professional</td>
<td>42%</td>
</tr>
<tr>
<td>II Intermediate</td>
<td>55%</td>
</tr>
<tr>
<td>III(N+M) Skilled Non Manual</td>
<td>75%</td>
</tr>
<tr>
<td>IV Semi Skilled</td>
<td>80%</td>
</tr>
<tr>
<td>V Unskilled</td>
<td>73%</td>
</tr>
<tr>
<td>UNEMPLOYED</td>
<td>11%</td>
</tr>
</tbody>
</table>

Key to Social Class Classification. (Source: Registrar General)

Social Class

I Professional
II Intermediate
III M Skilled Manual
IV Semi Skilled
V Unskilled.

N.B. Percentages come to more than 100%, because any number or combination of class could have been mentioned.
It can be seen in Figure 7.1 that the majority of health visitors, 75% and 80% respectively perceived their families to be in social class III (skilled manual and non manual workers) and social class IV (semi skilled). Much of the research on the health, diet, illness and well being of these families shows that the lay beliefs of family members are more likely to have an effect on health behaviours, than the views and advice of any health care professionals. (Calnan 1986; Graham 1984). This immediately suggests that health visitors, and other professionals, will have to be very creative and selective in the health promotion approaches they choose to adopt.

Of the practising health visitors, 73% mentioned having families in social class V, with 42% of practising health visitors mentioning visiting families from social class I. A further 11% of respondents mentioned unemployed individual/parents as constituting part of their caseloads for whom they expressed concern. As social class is normally determined by the occupation of the male, the position of single mothers, women living alone etc is unclear.

Although one may question the validity of the social class ascribed to their clientele by the respondents, the picture outlined suggests that health visitors do require knowledge and skills which are acceptable to a diverse range of clients in order to achieve successful health promotion outcomes. Health promotion skills are explored in more detail in Chapter 11.

With regard to the ethnic composition of their localities/caseloads, 92% described the ethnic composition of their caseload as multicultural. The fact that as many as 92% of health visitors work within a multicultural community means that from a practice perspective, this requires health visitors to familiarise themselves with cultural norms such as dietary habits, religious practices, health behaviours etc of diverse cultures. In some cases, specialist knowledge, interpreters, and other health care personnel, such as
hakims, for example, may need to be included in the development of health promotion plans and activities. A majority of respondents (92%) identified their communities as multicultural, of these 11% practising health visitors said they worked mainly with Asian families, and 6% respondents identified other ethnic minorities. These included Vietnamese, Chinese and Italians.

When asked about the age range of their clientele, perhaps predictably, 93% respondents mentioned 0 - 5 years, and 40% respondents specified the elderly. Adults with special needs were named by 9% of respondents. Only 3% respondents mentioned adolescents. To some extent, the responses to Question 9 on the characteristics of the workload overlaps with Question 10b which asks respondents to identify their caseload priorities. These issues are therefore discussed in the following two sections on health visitors caseloads and caseload priorities.

c) HEALTH VISITORS' CASELOADS

Respondents were asked to identify the size of their current caseloads (Question 10). Table 7.2 shows the variety of caseload size held by respondents.

<table>
<thead>
<tr>
<th>Number of families for whom cards are held</th>
<th>Number of Health Visitors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 200</td>
<td>82</td>
<td>21</td>
</tr>
<tr>
<td>200 - 250</td>
<td>118</td>
<td>31</td>
</tr>
<tr>
<td>251 - 300</td>
<td>111</td>
<td>29</td>
</tr>
<tr>
<td>301 - 399</td>
<td>71</td>
<td>18</td>
</tr>
<tr>
<td>&gt; 400</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>385</td>
<td>100</td>
</tr>
</tbody>
</table>

n = 385
Eight of the 393 practising health visitors worked as locality managers in their health authorities and did not hold a specific caseload although two of these respondents indicated that they intended to have a working caseload in future. Of the remaining 98% of practising health visitors, 21% held cards for less than 200 families, 31% held cards for 200 - 250 families, 29% held cards for 251 - 300 families, and 18% of health visitors held cards for between 300 - 399 families. Three respondents (1%) stated that their caseloads exceeded 400 families, one being in excess of 600.

Orr (1992:78) describes how health visitors possess considerable information both about their own caseloads and the local community, (Luker & Orr 1992:78). Some health visitors' caseloads are derived from a general practitioner's practice population and other caseloads are derived from a defined geographical area. Orr also suggests that the latter offers health visitors more opportunity for community involvement (Luker & Orr 1992). The origins of caseloads in this study, for example, whether from general practice or a geographical area, were not pursued but the findings demonstrate considerable differences in the number of families for whom the health visitors hold cards. There is no doubt that size of caseloads is an important variable in the selection of priorities for health visitors, it may also influence the amount of time available for health promotion activities and/or normal health visiting duties. The next section examines the geographical characteristics of the working environment of health visitors.

d) GEOGRAPHICAL DETAILS AND PERCEPTIONS OF WORK

Health visitors were asked to describe the geographical nature of their practice base (Question 11). Replies showed that of the 36% of the respondents worked in urban areas, 38% worked in mixed urban/rural areas, 20% were based in inner city areas, with a further 15% respondents based in rural areas. Five health visitors described their
workbase as 'other', these included a naval base, an army organisation (two respondents),
a deprived council estate, and a 'whole city'. Table 7.3 shows the relationship between
the health visitors caseload size and geographical base.

<table>
<thead>
<tr>
<th>Caseload Size</th>
<th>Inner City</th>
<th>Rural</th>
<th>Mixed Urban/Rural</th>
<th>Other</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;200</td>
<td>24%</td>
<td>20%</td>
<td>16%</td>
<td>0</td>
<td>21%</td>
</tr>
<tr>
<td>200 - 250</td>
<td>31%</td>
<td>40%</td>
<td>28%</td>
<td>20%</td>
<td>31%</td>
</tr>
<tr>
<td>251 - 300</td>
<td>28%</td>
<td>20%</td>
<td>36%</td>
<td>40%</td>
<td>29%</td>
</tr>
<tr>
<td>300 - 399</td>
<td>14%</td>
<td>20%</td>
<td>21%</td>
<td>40%</td>
<td>18%</td>
</tr>
<tr>
<td>&gt;400</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>0</td>
<td>1%</td>
</tr>
</tbody>
</table>

| Column n = | 74 | 137 | 55 | 107 | 5 | 378 |
| Column n = | (20%) | (36%) | (15%) | (28%) | (1%) | (100%) |

It can be seen from Table 7.3 that there appears to be little evidence that health
visitors' caseloads differ in size according to the geographical nature of the health visitors' working environment. One might have expected that the pressures of working in an inner city with high rise housing, environmental and social deprivation, as well as disadvantaged families from ethnic minorities, might have merited reduced caseloads for the health professionals. This is clearly not the case. In fact one respondent commented that although she worked in an area rated 7 on deprivation scores identified by Jarman (1983) she still had a caseload which exceeded 400 families.

Given the complex nature of the health visitors clientele as demonstrated in their selection of caseload priorities (section e), and in view of the size of health visitor caseloads, it was thought appropriate to explore whether health visitors perceived their
time as being spent on planned preventive work or crisis work. The relationship between perceived crisis work and the health visitors geographical base is examined below.

**Perceived crisis work by Geographical Base**

When health visitors in the sample were asked whether they agreed or disagreed that health visiting comprises more crisis work than planned preventive work (Question 17k), the relationship between their response and their geographical base was found to be statistically significant. (see Table 7.4).

<table>
<thead>
<tr>
<th>Crisis Work</th>
<th>Inner City</th>
<th>Urban</th>
<th>Rural</th>
<th>Mixed Urban/Rural</th>
<th>Other</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>64%</td>
<td>34%</td>
<td>26%</td>
<td>37%</td>
<td>0%</td>
<td>152 (36%)</td>
</tr>
<tr>
<td>Neither</td>
<td>5%</td>
<td>10%</td>
<td>12%</td>
<td>11%</td>
<td>20%</td>
<td>38 (10%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>31%</td>
<td>56%</td>
<td>62%</td>
<td>11%</td>
<td>80%</td>
<td>199 (51%)</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>139</td>
<td>57</td>
<td>113</td>
<td>5</td>
<td>100%</td>
</tr>
</tbody>
</table>

n = 389  \[ x^2 = 16.5 \]  P < .01

Table 7.4 shows that whereas a majority of health visitors from urban, rural and mixed urban/rural geographical locations disagreed with the statement that health visiting comprises more crisis work than planned preventative work, only 31% of health visitors working in inner city areas disagreed with this statement. 64% of health visitors working in inner cities agreed that health visiting comprises mainly crisis work. Perhaps not unpredictably a majority of health visitors (61%) working in rural areas disagreed with the statement.
e) HEALTH VISITORS' SELECTION OF PRIORITIES

The first theme in the conceptual framework outlined in Chapter Five was concerned with the political perspectives and practice of health promotion. It was suggested that a medical model of health was supported by government because the onus for health was placed on the individual and not society. The first hypothesis outlined was that health visitors are likely to pursue an individualistic model of health promotion. This section will analyse whether health visitors pursue an individualistic mode of practice.

The question was addressed by the researcher in a number of ways. Practising health visitors were asked to describe their caseload priorities (Question 10b). Their answers to this open question were wide ranging but the researcher was able to identify six main categories to code the data. The categories appear in Table 7.5; it should be noted that respondents could provide any number of priorities.

<table>
<thead>
<tr>
<th>Table 7.5</th>
<th>Health Visitors' selection of Caseload Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseload Priority</td>
<td>No. of Health Visitors Mentioning</td>
</tr>
<tr>
<td>1. 0 - 5 years</td>
<td>341</td>
</tr>
<tr>
<td>2. Families with special needs regardless of age.</td>
<td>281</td>
</tr>
<tr>
<td>3. Elderly Clients</td>
<td>94</td>
</tr>
<tr>
<td>4. Child Protection</td>
<td>80</td>
</tr>
<tr>
<td>5. Bereavement Visits</td>
<td>20</td>
</tr>
<tr>
<td>6. Community defined and other health promotion.</td>
<td>211</td>
</tr>
</tbody>
</table>

n = 392
It can be seen in Table 7.5 that the categories of caseload priorities of health visitors are not mutually exclusive. Examples of this are the fact that child protection cases frequently involve the 0 - 5 age range. What is significant, however, is that 22% of health visitors singled out child protection as a major caseload priority. Another example of the categories not being mutually exclusive is that families with special needs may come into any age or client group. The categories shown in Table 7.5 may at first glance appear rather mundane. When the qualitative details supplied by the respondents, were examined by the researcher, this was certainly not the case. Each category is examined below in order to examine whether health visitors pursue an individualistic model of practice.

(i) Category 1: 0 - 5s

As indicated earlier it seems highly significant that 88% of practising health visitors put under fives high on their list of priorities although they were not asked to put their priorities in rank order. There are a number of possible explanations for this. First the category 0 - 5s was included as an example in the questionnaire statement. It could therefore have lead the answer. On the other hand, a second example of a caseload priority was given, ie. community health education (see question 10b) and this appears not to have influenced the answers. A second explanation for the 0 - 5 category being high in the health visitors' priorities is that these professionals are still working in their traditional role. Clark (1981) for example found that in her analysis of 32 health visiting studies, the major component of the health visitor's clientele was families with very young children. Although one might question the continuance of prioritising work with 0 - 5 year olds, many informed practitioners would argue that the needs of families with young children remain as great if not greater then they ever were. Furthermore, it could be argued that successful health promotion begins with the establishment of good dietary,
safety and developmental norms early in life. Also, although health visitors identify 0 - 5 as the priority category, it has to be reiterated that young children are part of a family and therefore as Clark (1973) stressed, the health visitor should be seen as a family visitor.

A third explanation as to why health visitors continue to prioritise the 0 - 5 age group is that probably very few managers of their work have considered a change of focus. Evidence to support this view may be seen in one of the replies.

"My caseload priorities are largely influenced by the policy of the health authority who request a minimum number of visits to the under fives. However, after I have achieved this I can decide my own priorities if I have any spare time left (not very often)".

The reason why managers are reluctant to change focus may be because time and resources are needed to implement change, and these are presently in short supply.

The qualitative details in the replies demonstrate why 0 - 5s were seen as priorities. Health visitors identified a range of activities incorporated in the 0 - 5 visits, including 'developmental assessments', 'between pregnancy dietary advice, for mothers', 'parentcraft education', 'reducing isolation experienced by young mothers', 'new babies 0 - 6 weeks', 'first time mothers especially, and child protection work'.

It is important to demonstrate the complexities of 0 - 5 visits. When recorded simply as a 0 - 5 visit, an uninformed observer such as a non-nursing manager or a non-professionally trained manager, may have no conception of what is involved. Interpretation of only quantitative information may reduce not only the data but also reduce the value put on the activity itself. For example, using a Komer data set, a visit to or interaction with a family with a child under 5 years old is normally coded simply as a visit and is interpreted in statistical returns as one frequency. This recording gives no
indication of the content of the interaction such as dietary advice, developmental assessment, etc. which may have taken place during that visit or interaction. Hence the method of recording reduces the data, making it impossible to make any sort of judgement on the quality of the visit or nature of the outcome. An example of one respondent's concern exemplifies the problem.

"There is little time to do anything except newborn visits and follow ups, Denver and medical assessments at 8/52, 15/12, 3 years pre-school clinic and clinic work. The rest is crisis work. I have a clinic everyday".

It can be seen from the preceding discussion that the caseload priority category 0 - 5s poorly describes the nature of health visiting interaction on the one hand, and equally negative, portrays a traditional mode of practice on the other. Little appears to have changed in health visiting since the ministerial enquiry of the mid fifties (HMSO 1956) which stated that health visitors spent the majority of their time with 0 - 5 year olds.

(ii) Category 2: Families with special needs

Many of the practising health visitors (72%) identified families with special needs on their list of priorities. This category encompasses all age ranges and client groups and therefore, is not a mutually exclusive category. A number of respondents recognised the all encompassing nature of this category using the term without being specific. Other respondents defined more specifically individuals, families or groups whom they perceived merited a special needs label.

The Warnock Committee Report on Special Educational Needs (HMSO 1978) advocated the maximum possible measure of integration of children with special needs into normal schools. For children with specific problems, the report recommended that categories of handicap should be abolished and replaced by a wider concept of special educational needs. In this research, health visitors appear to be using the special needs
category in this way. Table 7.6 (overleaf) shows the types of individuals/groups identified by the respondents.

Table 7.6 (overleaf) shows similarities with the health visitors' clientele identified by Marris (1971) and later by other authors (Clark 1973; Ellwood and Jeffreys 1976; Henderson 1977). In the earlier studies cited people served by health visitors included unsupported mothers, handicapped or tubercular patients, the mentally ill, and mother and baby family units (Marris 1971:16). Although unsupported mothers and first time parents, are still considered by health visitors to have very special needs, there is some evidence in this study to show an increase in the range and type of individuals, families or groups perceived by health visitors to have special needs.

Awareness by health visitors of the needs of families with illnesses such as cancer, heart disease, AIDS and other degenerative conditions is also evident as is the considerable empathy for the needs of carers which is exhibited in the responses.

"My concern is for the carers of really sick people. Those suffering with AIDS, cancer etc. More and more is expected of them by this Government to the extent that they need psychological support as well as just physical support".

Of interest to the researcher was the concept of behavioural problems. Examples of these included children with sleep problems, eating disorders and drug related behaviours. A number of health visitors identified menopausal women and those suffering from depression, for whatever reason, as meriting health visiting time. Individuals and families experience of problems such as alcoholism, homelessness, and unemployment were also included by a number of health visitors on their special need lists. Self referrals by the public as well as GP referrals were identified as special needs. These are a different sort of concept of 'special needs' but in light of the fact that GPs or
members of the public saw their referrals as having special needs they were included in the 'special needs category'.

<table>
<thead>
<tr>
<th>Special Needs Definition</th>
<th>No. of HVs for whom these are priorities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handicapped children/adults.</td>
<td>17</td>
<td>6.0</td>
</tr>
<tr>
<td>Families with illness</td>
<td>18</td>
<td>2.8</td>
</tr>
<tr>
<td>Carers/supporters</td>
<td>10</td>
<td>4.0</td>
</tr>
<tr>
<td>Behavioural problems</td>
<td>8</td>
<td>2.8</td>
</tr>
<tr>
<td>Homeless individuals/families</td>
<td>6</td>
<td>2.1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>14</td>
<td>4.9</td>
</tr>
<tr>
<td>TB contact tracing</td>
<td>2</td>
<td>.8</td>
</tr>
<tr>
<td>Alcoholics</td>
<td>8</td>
<td>2.8</td>
</tr>
<tr>
<td>Mental illness/depression</td>
<td>20</td>
<td>7.1</td>
</tr>
<tr>
<td>Transfer in/travellers</td>
<td>12</td>
<td>4.0</td>
</tr>
<tr>
<td>Self referrals</td>
<td>13</td>
<td>4.6</td>
</tr>
<tr>
<td>Family Dynamics</td>
<td>6</td>
<td>2.1</td>
</tr>
<tr>
<td>Menopausal women</td>
<td>20</td>
<td>7.1</td>
</tr>
<tr>
<td>GP referrals</td>
<td>5</td>
<td>1.7</td>
</tr>
<tr>
<td>First time parents</td>
<td>10</td>
<td>4.0</td>
</tr>
<tr>
<td>Lone parents</td>
<td>16</td>
<td>5.6</td>
</tr>
<tr>
<td>Student supervision</td>
<td>8</td>
<td>2.8</td>
</tr>
<tr>
<td>Undefined</td>
<td>98</td>
<td>39.8</td>
</tr>
</tbody>
</table>

Totals                                   | 281                                      | 100  |

n = 281
Finally, but significantly, eight of the health visitors perceived student supervision whether health visitor or P2000 students as meriting special attention. Perhaps the most important issue is that some health visitors recognised that students do have particular needs. This makes them a priority for some of the health visitor's time.

Overall, identification of these individuals, groups, and/or families reveals great diversity in the perceived priorities of work of health visitors and the need for a sophisticated skills and knowledge base. Despite this, the majority of evidence supports the proposition that health visitors continue to pursue an individualistic approach to health promotion. This inference is drawn because so far the data indicates that a great deal of interaction with 0 - 5s and families with special needs is focused on individual problems rather than on their collective needs or how society at large might help them.

iii) Category 3: Elderly Clients

As shown in Table 7.5, 24% of respondents included elderly clients on their list of priorities. Once again, the frequencies alone provide little evidence of the type of involvement health visitors have with elderly people. Table 7.7 (overleaf) identifies the nature of involvement from information provided by the respondents.

The examples in 7.7 (overleaf) are not exhaustive of the type of activities undertaken by health visitors with elderly patients/clients. More research is needed into the value of such work but studies have shown that health visitors do contribute significantly to the quality of life of elderly people (Vetter, Jones and Victor 1986). A number of respondents who did not include elderly clients in their caseload priorities indicated their wish to do so but in some cases their health authority policy required that health visitors' time was spent exclusively on the 0 - 5 age range. This will be discussed later in the summary of caseload priorities.
Table 7.7  Key caseload priorities with the elderly

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Running of clinics for the well elderly.</td>
</tr>
<tr>
<td>2</td>
<td>Elderly referrals from the GP.</td>
</tr>
<tr>
<td>3</td>
<td>Elderly carers support groups.</td>
</tr>
<tr>
<td>4</td>
<td>Assessments of those over 75 years.</td>
</tr>
<tr>
<td>5</td>
<td>Elderly screening 60+.</td>
</tr>
<tr>
<td>6</td>
<td>Cardiac rehabilitation group (mostly elderly).</td>
</tr>
<tr>
<td>7</td>
<td>Music and movement for the elderly.</td>
</tr>
<tr>
<td>8</td>
<td>Visiting hospital discharges 65+.</td>
</tr>
<tr>
<td>9</td>
<td>Support for those with memory loss.</td>
</tr>
<tr>
<td>10</td>
<td>Elderly extend exercise groups.</td>
</tr>
<tr>
<td>11</td>
<td>Regular visiting of frail elderly, elderly with dementia.</td>
</tr>
<tr>
<td>12</td>
<td>Teaching students service to elderly clients.</td>
</tr>
<tr>
<td>13</td>
<td>Continence promotion.</td>
</tr>
<tr>
<td>14</td>
<td>Routine visiting to elderly on a weekly basis.</td>
</tr>
</tbody>
</table>

With regard to screening and/or assessment of the elderly, there is evidence to show that health visitor involvement may result in a lower average length of stay in hospital (Tullock and Moore 1979). This is surely a fact which managers should be aware of, which is discussed in the summary of caseload priorities at the end of this section.

When one considers the range of activities of health visitors with elderly clients outlined in Table 7.7 there is little doubt of their value to the individuals concerned.
iv) **Category 4: Child Protection**

As stated earlier, child protection is not a mutually exclusive category as it forms an integral part of any health visitors work with children aged five or under and their families. Despite this, 20% of practising health visitors specifically identified child protection in their list of priorities. Some of the responses to the questionnaire gave evidence of health visitor involvement in support groups where domestic violence was present and perceived risks to children anticipated. Child protection is not only concerned with physical, sexual and emotional abuse of children, it incorporates other conditions such as failure to thrive, accident prevention, and the facilitation of happy/normal development of children.

Although it is generally agreed that the health visitor should not be nominated as the key worker in cases of child abuse (British Association of Social Workers/Health Visitors' Association 1982), there is no doubt that because of their universal service to the under fives health visitors have a unique role in contributing to the prevention of child abuse. Should changes in the National Health Service precipitate the demise of the health visitor, one wonders what might happen to the many hundreds of children currently identified by health visitors as 'giving cause for concern' or at risk of possible abuse. As with many of the other vulnerable groups, very little qualitative work has been done to ascertain the implications of withdrawing specific services.

v) **Category 5: Bereavement visits**

Twenty practising health visitors (5%) identified bereavement visits/grief counselling as one of their caseload priorities. Comments about bereavement visits frequently overlapped with the special needs of families coping with illness such as cancer, AIDS, Motor Neurone Disease etc. Some of the health visitors identified the
need for bereavement visits to families who had experienced stillbirth, the death of a child or a spouse.

vi) Category 6: Community defined and other health promotion

Whereas all the previously discussed caseload priorities tend to focus on individuals or individuals and their families, 211 (60%) of health visitors identified community defined health education/health promotion as one of their main priorities. Many of the respondents highlighted the need for local communities to define their own problems. Examples of health visitor involvement in locally defined problems revealed a diverse range of group activities and group initiatives with local people. Table 7.8 (overleaf) identifies the nature of group work which health visitors had either initiated or participated in.

Analysis of the health promotion priorities demonstrates a balance between conventional health visiting activities such as parentcraft, postnatal support (albeit in group work) and more psycho/social activities. Examples of the latter include support work for survivors of sexual abuse, domestic violence and para-suicide. Other health promotion activities identified in the respondents' caseloads included support groups for bed and breakfast families, stress management, family therapy, post-surgery patients, and sex education with groups of abused children.

The health visitors' selection of priorities predictably shows that health visitors continue to work largely with families and young children in a traditional mode of practice. Health visiting caseloads appear to have changed very little over the past few decades in terms of numbers, age, range of clientele, and social class composition. It does appear however that the workloads of health visitors have changed marginally in terms of the range, type, and situation of individuals and clients visited. Further
discussion of these issues will be undertaken in the summary at the end of this Chapter.

The next section considers the relationship between the health visitors' selection of priorities, geographical base, and their perceived mode of practice.

Table 7.8 Examples of community defined health education/health promotion activities

<table>
<thead>
<tr>
<th>Nature of Health Education/Health Promotion</th>
<th>Number of time mentioned by HVs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity</strong></td>
<td></td>
</tr>
<tr>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>Post natal support</td>
<td>82</td>
</tr>
<tr>
<td>Stop smoking</td>
<td>21</td>
</tr>
<tr>
<td>Look after your heart</td>
<td>15</td>
</tr>
<tr>
<td>Well women</td>
<td>25</td>
</tr>
<tr>
<td>Survivors of sexual abuse</td>
<td>7</td>
</tr>
<tr>
<td>Healthy living/slimming</td>
<td>20</td>
</tr>
<tr>
<td>School Liaison</td>
<td></td>
</tr>
<tr>
<td>Well teenagers club</td>
<td>8</td>
</tr>
<tr>
<td>Healthy eating</td>
<td>8</td>
</tr>
<tr>
<td>Clinic work</td>
<td></td>
</tr>
<tr>
<td>Parentcraft</td>
<td>19</td>
</tr>
<tr>
<td>Collaboration with Voluntary Sector</td>
<td></td>
</tr>
<tr>
<td>Age concern</td>
<td>4</td>
</tr>
<tr>
<td>Domestic Violence Forum.</td>
<td>3</td>
</tr>
<tr>
<td>Health Stalls</td>
<td></td>
</tr>
<tr>
<td>Accident Prevention</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Health Promotion</td>
<td>122</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>342</td>
</tr>
</tbody>
</table>

f) SELECTION OF CASELOAD PRIORITIES BY GEOGRAPHICAL BASE

The hypothesis that the nature of health visiting practice will be influenced by the geographical location of health visitors is pursued in this section. First, crosstabulation of caseload priorities by geographical location was undertaken. Statistically significant
relationships were found in the caseload priorities 0 - 5s, child protection, the elderly and community defined health education/health promotion needs as shown in Table 7.9.

Table 7.9 Percentage mentioning each Caseload Priority by Geographical Base

<table>
<thead>
<tr>
<th>Priority Significance</th>
<th>Inner City</th>
<th>Urban</th>
<th>Rural</th>
<th>Mixed</th>
<th>Row</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5 years</td>
<td>78</td>
<td>88</td>
<td>95</td>
<td>89</td>
<td>87</td>
<td>P&lt;.05</td>
</tr>
<tr>
<td>Child Protection</td>
<td>34</td>
<td>17</td>
<td>10</td>
<td>20</td>
<td>80</td>
<td>P&lt;.05</td>
</tr>
<tr>
<td>Elderly Clients</td>
<td>16</td>
<td>21</td>
<td>39</td>
<td>27</td>
<td>24</td>
<td>P&lt;.05</td>
</tr>
<tr>
<td>Community Defined Health Promotion/Health Education</td>
<td>42</td>
<td>48</td>
<td>70</td>
<td>61</td>
<td>54</td>
<td>P&lt;.01</td>
</tr>
<tr>
<td>Bereavement Visits</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>P=.74</td>
</tr>
<tr>
<td>Special Needs</td>
<td>81</td>
<td>71</td>
<td>60</td>
<td>69</td>
<td>71</td>
<td>P=.12</td>
</tr>
<tr>
<td><strong>n =</strong></td>
<td><strong>77</strong></td>
<td><strong>139</strong></td>
<td><strong>57</strong></td>
<td><strong>119</strong></td>
<td><strong>392</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Column Total %</strong></td>
<td><strong>20</strong></td>
<td><strong>36</strong></td>
<td><strong>15</strong></td>
<td><strong>30</strong></td>
<td><strong>100%</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Footnote: Question 10b asked respondents to describe their caseload priorities. This was a multi answer question.

As discussed earlier in this chapter, Table 7.9 shows that the under fives are priorities for health visitors wherever they are located. It is interesting that 95% of health visitors in rural areas identify 0 - 5s as priorities compared with 78% of health visitors based in inner cities. Given a typical socio-demographic profile of any inner city it is not surprising that 22% of health visitors working in inner cities have additional priorities.

Table 7.9 shows that of the respondents who identified child protection as a caseload priority proportionately more come from inner city areas. Explanations for this may include the knowledge that children are more vulnerable when living in adverse
social conditions, for example numbers of lone parents, levels of unemployment and stress are likely to be higher in inner city areas (Jarman 1983). In some cases these factors may either singularly or cumulatively contribute to the event of child abuse. Another explanation for more inner-city health visitors identifying child protection as a caseload priority, is that inner cities child protection policies maybe more stringent than elsewhere.

Relatively few health visitors (10%) working in rural areas identified child protection as a priority. This could be because families living in rural areas are likely to be more visible to their local communities and to health visitors, unlike their city counterparts, some of whom live in high rise buildings away from the public and professional gaze. Families living in village communities are usually more close knit than city dwellers and there is likely to be social support available to parents, although this is changing (Mitchell 1991).

In this research, the smallest number of health visitors identifying elderly people as a priority came from inner city (16%) and urban areas (21%). These findings probably reflect health authority policies which require health visitors to focus their work on screening and developmental assessment programmes for children under five years of age.

Table 7.9 shows that over half of the health visitors based in both rural and mixed urban/rural locations identified client led health promotion/health education activities as a priority. Particularly encouraging was the fact that as many as 42% of health visitors based in inner city locations identified client led health promotion/health education as a priority despite all the other demands likely to be placed on them.

Although a high proportion of health visitors from all types of geographical location mentioned ‘individuals and families with special needs’ as a priority, the cross
tabulation with their geographical base was not statistically significant. Neither was the cross tabulation between the percentages mentioning elderly clients by geographical base statistically significant.

g) GEOGRAPHICAL LOCATION AND PERCEIVED MODE OF PRACTICE

Health visiting practice is both complex and multidimensional. Robinson (1992) states that "any particular instance of practice will be a negotiation between occupational knowledge, the idiosyncratic personal knowledge and style of the practitioner and the client's expectations, values and beliefs" (1992:24). The health visitor's occupational education and training promotes not only an awareness of the physical and mental dimensions of any individual, group or community situation, but also an awareness of the sociological, environment, psychological and political elements of that situation. To work holistically therefore would take account of these dimensions in any analysis or assessment of individual, group or community needs. To work in a focused way, health visitors would normally function in a unidimensional manner, for example, focusing their attention on a particular objective or set of objectives such as screening, immunisation, or stop smoking campaign. Respondents were asked to rate their performance in health promotion on a continuum from 0 - 10 (Question 16) with 'holistic practice' performance at 0 - 3 and 'focused practice' performance at 7 - 10. Health visitors rating their performance on either 4, 5 or 6 of the continuum were perceived by the researcher to encompass both types of practice.

The ratings on the holistic/focused continuum were crosstabulated with the geographical base of the respondents. Table 7.10 shows a statistically significant relationship at the five percent level.
Table 7.10: Health visitors' performance ratings on an holistic/focused continuum by Geographical Base.

<table>
<thead>
<tr>
<th>Self Rating Score</th>
<th>Inner City</th>
<th>Urban</th>
<th>Rural</th>
<th>Mixed Urban/Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic Practice</td>
<td>36%</td>
<td>42%</td>
<td>41%</td>
<td>37%</td>
<td>147 (39%)</td>
</tr>
<tr>
<td>Both Approaches</td>
<td>52%</td>
<td>31%</td>
<td>36%</td>
<td>45%</td>
<td>149 (40%)</td>
</tr>
<tr>
<td>Focused Practice</td>
<td>12%</td>
<td>27%</td>
<td>23%</td>
<td>18%</td>
<td>77 (21%)</td>
</tr>
<tr>
<td>Column (n)</td>
<td>75</td>
<td>131</td>
<td>56</td>
<td>111</td>
<td>343</td>
</tr>
<tr>
<td>Total</td>
<td>20%</td>
<td>35%</td>
<td>15%</td>
<td>30%</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

\[ n = 343 \quad \chi^2 = 14.7 \quad p = <.05 \]

Table 7.10 shows that over half of inner city based health visitors rated their performance as a combination of 'holistic' and 'focused' approaches, whilst only 12% rated their performance as focused (see below). The self rating of rural based health visitors was similar to urban and mixed urban/rural health visitors in that the majority of health visitors perceived their performance as either 'holistic' or a 'mixed mode'.

Overall, Table 7.9 shows that a variety of approaches are used in all geographical locations. The fact that most practitioners rate their performance as holistic or a combination of holistic and focused work is noted.

Particularly encouraging is that only 12% of inner city based health visitors rate their performance as focused. Combining the facts that a relatively high proportion of health visitors from inner cities identified client led health promotion/health education opportunities as a priority (Table 7.9) and that the majority perceived their practice as 'holistic or mixed' adds evidence to their claim.
SUMMARY

It was shown in the first part of this Chapter that the clientele of health visitors has changed very little since the nineteen seventies. What has changed is the nature and range of the work undertaken (more group activities, client identified issues). What is clearly demonstrated in the analysis of caseload priorities is the fact that the health visitors' knowledge and expertise continues to be very widely spread. This can be to the advantage of the public at times but it can also be to the disadvantage of the profession. This is exemplified, for example, by criticism sometimes being placed on health visitors for their lack of involvement in the care of elderly people and, at the same time for failing to identify potential child abuse. Sometimes health visitors also experience adverse comment from their nursing peers and others for their lack of involvement with the chronically sick and/or other special needs groups (Cumberledge 1986, Kerkstra 1991). Many of the critics perceive an artificial division between the healthy and the ill and they cannot understand why health visitors do not provide a hands on/clinical nursing service (Verheij and Kerkstra 1992).

The major dilemma facing health visitors appears to be the conflict between health authority defined priorities and those priorities defined by individuals and communities themselves. Verheij and Kerkstra (1992) end their analysis of community nursing in the UK by stating "The generation of patients that grew up with the National Health Service in particular seems to feel that the NHS is responsible for their health, not them" (1992:154). This value laden statement makes a number of assumptions that are central to this thesis. First, that individuals/clients are responsible for their own health. This ignores social, environmental, educational and other factors with impinge upon health. Second, even if a generation of patients that grew up in the National Health Service do perceive that the Health Service has a responsibility for their health this surely
indicates that help/education is needed to reorientate public perceptions to self responsibility. Third, no matter what ideology is expounded, the reality is that health needs exist and if ignored the cost to a relatively poorly resourced health service could be cumulatively increased (Verheij and Kerkstra 1992).

The health visitors are clearly in a 'catch 22' position. On the one hand they are regulated and controlled by government, on the other hand, health visitors would like to prioritize and deliver the type of health promotional advice and support needed/articulated by their clients. To this extent it may be the case as Bucher and Strauss (1962) suggest that the work situation does determine how a professional role develops, and what skills emerge.

It can be argued that the traditional mode of health visiting needs to change but this has to be done strategically and operationally with the help of NHS managers, (a topic which will be discussed in the conclusions to this thesis).

Finally, the relationship between the respondents caseload priorities and their geographical base was examined. Statistically significant relationships were found with the caseload priorities of under fives, elderly clients, child protection and client led health education/health promotion activities. These findings support the proposal that the nature of health visiting work is influenced by geographical location.
CHAPTER 8

HEALTH VISITORS' PERCEPTIONS OF CLIENT CHOICE AND THEIR INTERPRETATION OF HEALTH PROMOTION

H₁ That health visitors are likely to see the onus for health as resting with the individual. 163.

H₂ That health visitors are likely to perceive that if given appropriate advice, their clients can accept or reject a healthy lifestyle. 165.

H₃ That health visitors are likely to perceive the terms health education and health promotion as synonymous. 168.

Terminology and Practice. 170.

Health visitors' perceptions of health promotion in practice. 172.

Summary. 173.
CHAPTER 8
HEALTH VISITORS' PERCEPTIONS OF CLIENT CHOICE AND THEIR INTERPRETATION OF HEALTH PROMOTION

The first part of this Chapter pursues two hypotheses, first, that health visitors are likely to see the onus for health as resting with the individual. Second, that health visitors are likely to perceive that, if given appropriate information and advice, individuals/clients have an element of choice in accepting or rejecting a healthy lifestyle.

The second part of the Chapter addresses the hypothesis that health visitors perceive the terms health education and health promotion as synonymous. The relationship between the respondents' interpretation of the term health promotion and how they describe their practice is explored. Finally, health visitors' views of whether health promotion is practised by themselves, by health visitors in general and by general practitioners is investigated.

a) H1. THAT HEALTH VISITORS ARE LIKELY TO SEE THE ONUS FOR HEALTH AS RESTING WITH THE INDIVIDUAL.

In Chapter Two of this thesis concern was expressed regarding the Government's focus on victim blaming. This is supported to some extent by the Government's consultative document The Health of the Nation (DOH 1991) which identifies specific diseases as targets for attention by health professionals and simultaneously looks at the behaviour of individuals as a major contributing factor in the cause of the disease.

All the health visitors in this study will have been socialised into a medical model of care during their nurse training. Furthermore, as explained in Chapter Two, with general practitioners becoming the fund holders for health promotion, the work of health visitors is likely to be influenced, even driven, by the priorities of the GP and indirectly the government who shift priorities via differential funding/reimbursement. This will
probably only serve to reinforce the narrow clinical approach to health promotion which was described earlier. Given that health visitors will probably have to work to the health promotion priorities of GPs this may precipitate the claims by Bucher and Strauss (1961) that the workbase determines the priorities and skills of the profession. Furthermore, it probably means that an individualistic approach to health is actively encouraged particularly at a time of economic recession when any collective action is likely to be seen as unwelcome by the Government. Even if health visitors have been socialised into an individualistic interpretation of health care, has their health visitor education, which embraces subjects like social policy, epidemiology, inequalities of health, etc. had any influence on how they perceive the social dimensions of health?

Respondents were asked whether they agree or otherwise, with the idea that the responsibility for health rests largely with the individual (Question 17b). Table 8.1 shows that 61% of all respondents agreed that the responsibility for health rests primarily with the individual. Only 31% respondents disagreed with this statement with 8% of the sample undecided. When the views of the practising and non practising health visitors are compared, marginally more non practising health visitors disagreed with this statement.

<table>
<thead>
<tr>
<th>Table 8.1</th>
<th>Health visitor responses to the statement that the onus for health rests with the individual (Column %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>Practising HVs</td>
</tr>
<tr>
<td>Agree</td>
<td>63%</td>
</tr>
<tr>
<td>Undecided</td>
<td>8%</td>
</tr>
<tr>
<td>Disagree</td>
<td>29%</td>
</tr>
<tr>
<td>Column Totals</td>
<td>71% (390)</td>
</tr>
</tbody>
</table>

n = 553
When answers to the proposition that the onus for health rests with the individual were cross tabulated with geographical base, the results were similar to those described above. 69% of health visitors working in urban, mixed urban/rural, or rural areas agreed that the individual was responsible for his/her health, compared with 58% of health visitors practising in inner city areas. These results were not statistically significant but they do suggest that working in adverse social conditions may increase the likelihood that health visitors perceive that social factors influence health although still only a minority subscribe to this view.

b) H\textsubscript{2} THAT HEALTH VISITORS ARE LIKELY TO PERCEIVE THAT IF GIVEN APPROPRIATE HEALTH EDUCATION ADVICE, THEIR CLIENTS CAN ACCEPT OR REJECT A HEALTHY LIFESTYLE

The central principle of this hypothesis is that of choice. Tones (1986) has written extensively on this topic stating that to attempt to educate people to make informed choices is "not only ineffective but unethical" (1986:8). Criticism also exists of the 'educational model' per se (Brown and Margo, 1978; Tones 1986) and yet much of the nursing literature suggests that if patients are given information about medication, healthy eating etc. then the assumption is that patients' behaviour will somehow change (Latter et al 1992).

There are many factors which influence health choices. Research into perceived locus of control has demonstrated that there are some individuals who perceive that external factors such as genetic inheritance, fate, luck etc. diminish the effect to be gained by individual intervention (Wallston & Wallston 1978).

Even if a person wishes to change their behaviour they may be unable to do so because of the belief that they cannot perform the desired behaviour (Bandura 1987). The health belief model as discussed earlier (Chapter Four) proposes that people are
influenced by beliefs about their susceptibility to a health problem, about its danger and about the effectiveness of any proposed changes in their behaviour (Becker 1974; Rosenstock 1974).

Despite these reservations referring to the value of attempting to educate/coerce individuals to change their health behaviour, two alternative methods of approach have been identified. These are the notions of self efficacy and self empowerment. Self empowerment as discussed in Chapter Two involves raising the self esteem and assertiveness of individuals and groups so that they are more able to resist social pressures to engage in negative health behaviour and to seek appropriate health and social advice. Self efficacy increases an individual's chance of achieving a desired behaviour. General practitioners have recognised that the least effective way of promoting self efficacy in patients is by verbal persuasion (Campion 1991). Favoured methods of achieving a person's self efficacy is by 'modelling' where the individual is introduced to others achieving the desired behaviour. Perhaps the general practitioners have at last begun to recognise the effectiveness of methods employed by Weight Watchers, Alcoholics Anonymous and other self help groups.

It can be seen from the preceding discussion that there are many factors influencing health choices. How do health visitors perceive the statement that if appropriate information and knowledge is given to clients/groups they can choose or reject a healthy lifestyle (Question 17c). Table 8.2 (overleaf) shows that three-quarters of health visitors agreed with this statement, 20% disagreed and 6% of respondents were undecided.
Table 8.2  Health Visitors' responses to the statement that if given appropriate health information clients/groups can choose or reject a healthy lifestyle (Column %)

<table>
<thead>
<tr>
<th>Response</th>
<th>No. of Practising HVs</th>
<th>No. of Non-Practising HVs</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>74%</td>
<td>72%</td>
<td>74%</td>
</tr>
<tr>
<td>Undecided</td>
<td>7%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Disagree</td>
<td>19%</td>
<td>23%</td>
<td>20%</td>
</tr>
<tr>
<td>Column Totals</td>
<td>393 (71%)</td>
<td>163 (29%)</td>
<td>556 (100%)</td>
</tr>
</tbody>
</table>

n = 556

The above answers are very similar to those obtained when looking at the perception that the onus for health rests with the individual, in that the majority of health visitors perceived that individuals/groups are able to choose or reject a healthy lifestyle if given appropriate information.

Explanations for this view may include the idea that health professionals are likely to answer the statement according to their own biographies (Kratz 1978) and/or their own perceived locus of control. If for example individuals have been socialised into believing that health depends on their own health behaviour they may genuinely believe that individuals are responsible for their own health. This ignores the aetiology of occupational diseases or environmental hazards which may affect health. Alternatively, it may be that health visitors actually do see a considerable amount of behavioural change over a period of time of giving health advice. There is ample evidence to support this view across a wide spectrum of clients' needs (Appleby 1991). Appleby cites a number of examples where it is suggested that health visitors have contributed toward behavioural change in individuals and families. Colver and Pearson (1985) for example, have shown that health visiting intervention can influence individuals' responsiveness to making their homes safer. Barker and Anderson (1988) have suggested that early health
visiting intervention with first-time parents can promote behavioural change in parents resulting in improved nutritional status of their babies and improved parenting. Although one may question the reliability and validity of such studies, because of the methodologies used, other studies have used more scientific methods, applied tight controls and come up with the same results. Holden, Sagousky and Cox (1989) in a controlled study of health visitor intervention in the treatment of postnatal depression found that counselling by health visitors promoted the recovery of sufferers.

The preceding discussion has shown that health visitors genuinely believe that individuals/clients are in a position to accept or reject a healthy lifestyle, although again taking an individualistic perspective. In summary, the two hypotheses identified in section (a) and section (b) of this Chapter have been supported by the evidence in this study. However, if health visitors support an individualistic approach this does not mean that they reject a societal approach. It can be argued that if health promotion is to become reality it needs to be tackled on several fronts and health visitors are in a good position to participate in a variety of health promotion initiatives (Gott & O'Brien 1990).

The next section considers health promotion terminology.

c) $H_3$ THAT HEALTH VISITORS ARE LIKELY TO PERCEIVE THE TERMS HEALTH EDUCATION AND HEALTH PROMOTION AS SYNONYMOUS

Earlier in this thesis it was found in the group interviews that all groups of health professionals had difficulty in defining health promotion. It was suggested in Chapter Five that part of this difficulty was due to moving conceptually from an individualistic approach, as frequently used in health education, towards an approach involving critical consciousness raising, community activism and demedicalisation. The researcher suggested that unless health education was seen as complementary to, but different from,
health promotion, skills and practice were unlikely to change. Statement 17(a) in the questionnaire asked all respondents to agree or otherwise that health promotion is normally interpreted by HVs as another term for health education. A second more direct statement was put to the respondents in question 17(i). Respondents were asked to agree or otherwise that health education and health promotion are the same thing. Responses to these statements are given in Table 8.3 and Table 8.4.

<table>
<thead>
<tr>
<th>Table 8.3</th>
<th>Health Visitors' responses to the statement that health promotion is normally interpreted by HVs as another term for health education.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>No. of HVs Responses</td>
</tr>
<tr>
<td>Agree</td>
<td>386</td>
</tr>
<tr>
<td>Undecided</td>
<td>49</td>
</tr>
<tr>
<td>Disagree</td>
<td>120</td>
</tr>
<tr>
<td>Totals</td>
<td>555</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 8.4</th>
<th>Health Visitors' responses to the statement that health education and health promotion are the same thing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>No. of HVs Responses</td>
</tr>
<tr>
<td>Agree</td>
<td>103</td>
</tr>
<tr>
<td>Undecided</td>
<td>92</td>
</tr>
<tr>
<td>Disagree</td>
<td>360</td>
</tr>
<tr>
<td>Totals</td>
<td>555</td>
</tr>
</tbody>
</table>

n = 555

Table 8.3 shows that 70% of respondents agreed that health promotion is normally interpreted by health visitors as another term for health education. Interestingly however, when the issue was put more directly, i.e. that health education and health promotion are the same thing, only 19% agreed with this statement (Table 8.4). Respondents perceived that their peers interpret health promotion and health education as synonymous terms, yet, when asked directly, they denied that the two terms meant the same thing. Perhaps the respondents did recognise intellectually the broader dimensions of health promotion, but in the context of their work they had perceived little evidence of
changing practice by their peers which might account for the seeming contradiction of their responses.

In summary, the hypothesis that health visitors are likely to perceive the terms health education and health promotion as synonymous is not supported. Although 70% of respondents believe that their peers interpret health promotion as another term for health education, when asked directly if the terms are the same 65% respondents thought not, with only 19% agreeing that health promotion and health education are the same thing. Although the researcher is unable to support the hypothesis, one must ask the question - If the majority of health visitors do not see health education and health promotion as the same thing, why do they perceive that their peers do so?

d) TERMINOLOGY AND PRACTICE

Earlier, in Chapter Five of this thesis it was suggested that where the terms health education and health promotion are viewed as synonymous by health visitors, their working practices are likely to remain fairly traditional and individualist in mode.

Respondents were asked to indicate their performance in health promotion on a continuum from 0 - 10, with individualistic skills performance ('individualistic mode') at 0 - 3 and community skills ('community mode') at 7 - 10 (Question 5). Respondents who rated their skills on 4, 5 or 6 were perceived by the researcher to practice both on an individualistic and community level (a 'mixed mode').

When the performance ratings were cross tabulated with responses to the statement that "health as promotion is normally interpreted by HVs as another term for health education", the results were statistically significant at the five percent level. Table 8.5 (overleaf) shows that of the respondents who rated their performance as individualistic 72% agreed that their peers normally interpreted health education and
health promotion as the same thing, 10% were undecided while 18% disagreed with the statement. However the fact that over three quarters of health visitors who described their work as community orientated, also agreed that the terms were perceived as synonymous by health visitors does not support the proposition that where the terms are seen as synonymous, working practices are likely to remain fairly traditional and individualistic in work. On the other hand, the higher percentage of respondents from all groups agreeing that the terms are perceived as synonymous by health visitors suggests that they perceive relatively large numbers of their peers work to a traditional/individualistic mode of practice.

Table 8.5  Respondents' perceptions of whether health visitors in general perceive health education and health promotion as synonymous by self ratings of their work performance on either an individualistic mode, community mode, or mixed mode.

<table>
<thead>
<tr>
<th>Health Visitors' Responses to the statement that health education and health promotion are perceived by health visitors as synonymous.</th>
<th>Self Ratings of Health Visitors Performance</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individualist Mode</td>
<td>Mixed Mode</td>
</tr>
<tr>
<td>Agree (69%)</td>
<td>72%</td>
<td>63%</td>
</tr>
<tr>
<td>Undecided (9%)</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Disagree (22%)</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Column n =</td>
<td>194</td>
<td>220</td>
</tr>
<tr>
<td>Total</td>
<td>(39%)</td>
<td>(44%)</td>
</tr>
</tbody>
</table>

\( n = 498 \quad \chi^2 = 17.4 \quad P = .05 \)
The next section of this Chapter examines health visitors' perceptions of the degree to which they see health promotion being undertaken in practice.

e) HEALTH VISITORS' PERCEPTIONS OF HEALTH PROMOTION IN PRACTICE

Health visitors were asked the extent to which they undertook health promotion in their every day work (Question 12). They were asked, first, about their own practice, second, to what extent they thought health promotion was carried out by health visitors in general, and third, to what extent they perceived health promotion was carried out by general practitioners. Table 8.6 shows their responses.

<table>
<thead>
<tr>
<th>Table 8.6</th>
<th>Extent to which health visitors see health promotion being undertaken by GPs compared with that being undertaken by health visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column %'s</td>
<td>No. of HVs views on GP health promotion practice.</td>
</tr>
<tr>
<td>All of the time</td>
<td>15%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>70%</td>
</tr>
<tr>
<td>Rarely</td>
<td>14% (100%)</td>
</tr>
</tbody>
</table>

Table 8.6 shows that whereas the majority of practising health visitors (84%) saw themselves carrying out health promotion 'all of the time', proportionately fewer of all respondents (68%) perceived health promotion being undertaken 'all of the time' by health visitors in general. This could have been the effect of the researcher on the researched, incorporating the fact that the respondents wished to be seen in a good light. However, the fact that only 2% of the respondents perceived health promotion was rarely undertaken by health visitors in general suggests any bias caused by the research is
minimal. Of significance is the fact that most health visitors perceived GPs undertaking health promotion 'sometimes' with a minority of respondents (14%) perceiving that health promotion was only rarely carried out by general practitioners (further discussion on the health promotion skills of GPs is undertaken in Chapter 11).

SUMMARY

The first part of this Chapter pursued two hypotheses. First, that health visitors are likely to see the onus for health as resting with the individual. Secondly, that health visitors are likely to perceive, that, if given appropriate education advice, their clients can accept or reject a healthy lifestyle. Both hypotheses have been supported by the evidence in this study which is hardly surprising since much nursing and health visitor education and training has been focused on individualised care, health behaviour and traditional health education approaches.

The second part of this Chapter first addressed the hypothesis that health visitors perceive the terms health education and health promotion as synonymous. This was found not to be the case although the majority of health visitors perceived that their peers would normally interpret the terms as the same. Further research is needed to explore this lack of congruence between how health visitors perceive themselves and how they perceive their peers. The relationship between how health visitors define health promotion and how they describe their practice was then explored. The findings did not support the proposition that where the term health education and health promotion are viewed as synonymous by health visitors working practices are more likely to remain fairly traditional and individualistic in mode.
Finally, the health visitors' views of health promotion in practice were explored. A majority of practising health visitors (84%) perceived themselves as undertaking health promotion 'all of the time'.

The next chapter will examine health visitors' perspectives on the measurement of health promotion.
CHAPTER 9
HEALTH VISITORS' PERSPECTIVES ON THE MEASUREMENT
OF HEALTH PROMOTION

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Health visitors' perceptions of the criteria by which health promotion can be measured.

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Other Methods 187.

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CHAPTER 9
HEALTH VISITORS' PERSPECTIVES ON THE MEASUREMENT OF HEALTH PROMOTION

In the qualitative phase of the research, health visitors in the group interviews appeared acutely aware of the need to demonstrate value for money by producing visible health promotion outcomes as a result of their practice. In the earlier discussion on measurement (Chapter Five) some doubt was expressed by the interviewees as to whether health promotion through health visiting intervention actually could be measured or evaluated. This was on account of the perceived sequential nature and long term process of health visiting practice.

As a result of the group discussions and the fact that 'measurement' emerged as a core category in the cognitive mapping process, the researcher identified two key questions. Do health visitors consider it is possible to measure health promotion? If the answer is in the affirmative, on what criteria can health promotion be measured? Questions 23a and 23b address these issues.

a) IS IT POSSIBLE TO MEASURE HEALTH PROMOTION?

Table 9.1 Health Visitors' responses to the question: Is it possible to measure health promotion?

<table>
<thead>
<tr>
<th>Response</th>
<th>No. of Respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>343</td>
<td>63</td>
</tr>
<tr>
<td>No</td>
<td>93</td>
<td>17</td>
</tr>
<tr>
<td>Don't know</td>
<td>110</td>
<td>19</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>547</td>
<td>100</td>
</tr>
</tbody>
</table>

n = 547
Table 9.1 shows that 63% of respondents thought it possible to measure health promotion. Many of the respondents, however, qualified their 'yes' answers. A selection of typical comments is shown below.

"with difficulty" [0011]

"yes, but difficult" [0406]

"yes but long term" [0165]

"yes, some, but do you measure all the promotion carried out by a HV or do you get into the game of HVs only promoting those issues in which they can achieve a measurable effect?" [0242]

"In short term outcomes in which habits/lifestyles which affect health studies are negatively changed". [0314]

"Cannot measure effect of promotion, can measure how it is carried out". [0163]

"yes but not the outcome". [0636]

"yes but not always easy". [0104]

"yes but one cannot be sure statistics are true". [0299]
It can be seen that many of the respondents who thought it is possible to measure health promotion had reservations about how it could be done. One of the major difficulties of providing evidence that health promotion interventions of any kind are effective is the number of variables which may affect an outcome. On an individual level, how can one, for example, claim that dietary advice from a health visitor is a significant contributory factor to a client's weight reduction? Other factors such as the client's motivation, dietary intake, family support etc. may all be equally influential.

On a societal level, however, it is suggested that measurement may be easier in that the effects of new policies, environmental improvements, intersectoral planning, community participation etc. may be more visible.

Respondents who replied that they 'didn't know' whether it was possible to measure health promotion also made a number of comments, such as:

"I would like to say yes, but I really can't be sure". [0489]

"you can measure mortality rates, immunisation uptake rates etc. but, is it possible to measure the more intangible aspects of our work, e.g., caring which nevertheless affects the quality of a person's life". [0360]

"I have found this difficult in the past. It is easy to get a general response but almost impossible to obtain statistically meaningful data unless a detailed programme was undertaken with follow up after a time period to compare effect". [0067]
"Very difficult to measure as so many things affect health both mental and physical. [0451]

At present, owing to the recession, families are not able to provide proper food and comfortable homes for their children. Stress is a major factor. Some things can be measured e.g. heart disease - mortality and morbidity decreasing over a long period of time e.g. 10 - 20 years". [0916]

"don't know, I'm still looking for clues". [0075]

"I feel there should be a way but I do not know how". [0358]

It appears that both the respondents who think it is possible to measure health promotion and those who don't know have similar perceptions of the difficulties any sort of measurement might incur.

Only 17% of health visitors thought it was not possible to measure health promotion, and few of these respondents commented on their 'no' answers.

In summary there is complete agreement between the health visitors who think that health promotion can be measured and those who don't know, in that measurement of any kind is likely to be complex, multidimensional and needs considerable expertise.

b) HEALTH VISITORS' PERCEPTIONS OF THE CRITERIA BY WHICH HEALTH PROMOTION CAN BE MEASURED

Respondents who felt it possible to measure the success of health promotion activities were asked how it might be done (Question 22b). Answers to this open ended
question were coded into 6 categories (see Appendix VII). Table 9.2 shows the health
visitors' replies to which many HVs gave more than one response.

| Table 9.2 Health visitor responses to how the success of health promotion activities
| might be measured among those who thought it could be measured. |
|---------------------------------|------------------|-----|
| **Suggested Criterion**          | **No. of Health Visitors** | **%** |
| 1. Target Setting | 80 | 14% |
| 2. Evaluation | 194 | 35% |
| 3. Morbidity Statistics | 173 | 31% |
| 4. Mortality Statistics | 119 | 21% |
| 5. Questionnaire/Surveys | 85 | 15% |
| 6. Other methods | 180 | 67% |

\( n = 343 \)

i) **Target Setting**

Target setting was identified by 14% of respondents (who agreed that health
promotion could be measured) as a method of measuring the success of health promotion
activities. Perhaps not unpredictably a common example of how target setting was
perceived as a relevant outcome measurement was in relation to immunisation rates and
uptake of screening opportunities. Examples of the qualitative responses included in the
category target setting are set out below.

"we are meeting government targets for immunisation/screening". [0247]

"we measure the number of breastfed babies in our practice". [0468]
"attendance at immunisation clinics". [0496]

The above responses demonstrate the degree of medicalisation attached to some HV perceptions of successful health promotion outcomes. Other examples of target setting provide more information about the way target setting is perceived.

"run a health promotion exercise for a certain length of time, prepare well and find out if there is a real need amongst clients e.g. smoking groups before embarking on the course". [0531]

"you would have to set objectives with discernible outcomes, within a timespan ie. cutting down smoking, lowering cholesterol levels, changes in lifestyle i.e. more exercise, less TV, changes in sexual habits". [0006]

"one must acquire increased knowledge of the target population of the subject promoted". [0294]

"possibly in relation to specific groups targeted and their subsequent behaviour against expected behaviour by age, class, educational levels, understanding". [0440]

It is quite conceivable that, with the current management ethos and practice in the NHS, target setting is here to stay. The evidence above demonstrates that most target setting comes under a medical remit.
Evaluation was identified by 35% of respondents as a way to measure the success of a health promotion activity. Luker (1992:160) suggests that the word evaluation is "widely used" and she elaborates on the distinction made by Suchman (1964) (cited in Luker & Orr 1992) between evaluation and evaluative research. The health visitors' perceptions of evaluation differed considerably in sophistication, supporting the view put forward by Luker (1992), that the term evaluation is frequently used in a general way to refer to the process of assessment or appraisal of worth. Examples of evaluation used in a general way are given below:

"monitor the GP contacts and the increase and decrease in medication". [0056]

"Quizzes on health topics to evaluate base prior knowledge". [0299]

"evaluation slip after course of lectures". [0387]

"review group, set time after (e.g. 1 year after stopping smoking)". [0765]

The above responses demonstrate a fairly traditional approach to the evaluation of conventional health education topics with some mention of outcome evaluation but with little comment on process or impact evaluation (Candias 1991). Evaluation of the type suggested above also makes the assumption that telling people what is good or bad for them, makes changes in health behaviour naturally follow. This is a gross over simplification of the process.
Some respondents did demonstrate a different perspective of evaluation which fits Suchman's (1964) definition of evaluative research, this involves the use of scientific methods and statistical techniques for the purpose of making an evaluation. Examples of awareness of this type of evaluation are demonstrated below.

"Only possible by doing a properly researched evaluation project and taking a sample population, studying their behaviour before and after a health promotion activity and seeing what effect it had". [0315]

"I feel this could be achieved with health promotion carried out in schools ie. comparing the number of 16 year olds who smoked in (a) a school who has undertaken health promotion to school (b) that hadn't. - school a and b being matched as near as possible. It is difficult to prove health promotion had prevented an 'unhealthy lifestyle' etc. unless prepared to wait for overall reduction in - for example coronary heart disease deaths". [0801]

"It is difficult, but analysis of health needs should lead to targets for improving, maintaining changing health behaviour criteria for measuring target achievements can be set up and by use of statistics and other research methodology measured and evaluated". [0711]

These responses demonstrate awareness of the complexities of undertaking any valid and reliable evaluation of health interventions. Candeias (1991) in a paper on evaluating the quality of health education programmes in Brazil, makes an excellent
point. She comments "Evaluation seen not as an end in itself but rather as a means to an end should be an integral part of health education activities from its initial planning throughout its implementation. Evaluation may be defined as the process of determining the value or degree of success in achieving predetermined objectives" (1991:40). This comment identifies the link between the category target setting, discussed above and evaluation. Although some of the respondents identified the relationship between the two concepts, most did not.

iii) Morbidity Statistics

Morbidity statistics were mentioned by 31% of respondents as a method of measuring the success of health promotion activities. Different types of statistics were identified, for example:

"morbidity statistics - the reduction of working days lost through illness". [0487]

"profiling of families in localities comparing epidemiological morbidity figures". [0016]

"from GP lists observe morbidity, identify reduction of blood pressure, cholesterol levels, overweight etc.". [0702]

"attendance at GP clinics or surgery, hospital admissions etc.". [0496]

"reduction of accidents in the home". [0681]
"less stress related illness, migraine, irritable bowel syndrome, alcohol abuse, domestic accidents", [0239]

Whilst the limited value of monitoring morbidity rates per se is recognised, the suggestion of profiling morbidity rates of families in the social context of their localities is sound. This would enable targeted preventive policies such as rubella protection to be implemented in local communities. From the researchers observations it seems a pity that most health visitors learn skills to undertake community profiling during their training, yet few extend these skills in their work places.

iv) Mortality Statistics

A reduction in mortality rates was seen by 21% of the respondents as another possible way to measure the success of health promotion activities. Typical responses regarding mortality statistics are given below.

"reduction of mortality", [0304]

"mortality statistics", [0047]

"SMR's", [0118]

"General health of the nation by use of statistics", [0287]

"general decrease in mortality figures", [0446]
"statistics but final figures would not be in my lifetime".

Most of the comments identified mortality statistics as an appropriate measure of the success of health promotion without qualifying their use. Mortality and morbidity rates offer a way of describing and comparing the frequency with which people die or become ill or disabled in defined populations. They derive from aggregating data relating to individuals taking little account of their social context. Although mortality rates are somewhat more reliable than morbidity rates, because the state of death is definitive, the classification of the cause of death is often complex and may be inaccurate.

Although mortality and morbidity statistics may form the basis of preventive programmes, critics have described their use in health promotion programmes as too disease orientated. Tannahill (1992) for example suggests that epidemiology should focus on health rather than disease.

Given the fact health visitors are likely to have some of their health promotion services purchased by general practitioners, it appears timely for them to consider more appropriate ways of addressing how health might be measured.

v) **Questionnaires/Surveys**

Another suggestion as to how the success of health promotion might be measured was by questionnaires and surveys. This view was supported by 15% of respondents. How the questionnaires might be used varied as the following comments demonstrate.

"Techniques such as questionnaires, surveys, interviews would be needed to ascertain outcomes". [0006]
"Questionnaires before and subsequent to the activity". [0998]

"Questionnaires handed out to participants". [0299]

The preceding responses are not dissimilar to some of those given about evaluation in that they tend to focus on outcomes.

Other responses demonstrated insight into wider perspectives of health promotion, not just disease. Examples are given below.

"Use something like a census to assess peoples attitudes to health and the choices they feel can improve their well-being". [0299]

"Individual questions to each participant to ascertain age, sex, weight, height, smoker, area of residence, general health status etc.". [0299]

"In the short term by local research, questionnaires etc. into the communities, towns, localities asking the population what they need, want, and by providing this and by measuring each health promotion activity in terms of how the local population feel about it". [0272]

The findings suggest that health visitors perceive the use of evaluation and questionnaires in two ways. The first is an educational approach in which individuals and groups were asked to provide written comments on any activity, intervention or programme provided by health professionals. This approach gives feedback to the professionals and may indicate some evidence or otherwise of client satisfaction and
understanding of the issues covered. The second perspective involves more research based evaluation in which appropriate methodologies are identified and where input, process and outcome can be critically assessed. Perhaps attention needs to be focused on the merits and disadvantages of both approaches and a planned strategy for health promotion evaluation developed.

vi) Other Methods

Nearly two-thirds of the respondents (65%) mentioned other methods of measuring health promotion. These interesting alternative responses broadly divide into two main groups 'medical criteria' and 'social/psycho processes':-

a) Medical Criteria include fairly predictable ones such as blood pressure, cholesterol levels, peak flow meter recordings, clinistix etc., all medical tools. Only 5% of the 65% respondents included these measures in their answers.

b) Social/Psychological Processes The majority of responses in the 'other methods' category demonstrated some appreciation of social awareness, group empowerment, behavioural and attitudinal change and the process involved. Examples demonstrating this broader interpretation of health promotion and how its success might be measured are given below.

"By increasing public awareness and being aware of public awareness". [0457]

"Self esteem, self worth, recognition of children's worth is all measurable to a degree. Positive parenting images rather than good enough parenting needs to be quantified". [0375]

"Council improvements to the environment e.g., renovating housing, provision of
"Fluoridation in water, accessible leisure facilities, self help groups lobbying for changes in own community". [0291]

"Community groups working to help themselves, community development, environmental work". [0541]

"Feedback from clients, feedback from colleagues". [0973]

"Very difficult question. Can be measured on several criteria but really needs Government support to co-ordinate appropriate measures. Health professionals can impact upon lifestyles but the approach is minuscule. Need to look at structures of health care and empowerment which takes place in the schools. Ethically there are questions as to whether coercing individuals to change their lifestyles is fair or just". [0422]

"Very complex area of work crucial question is how to measure the enabling of families to make choices". [0406]

"I think the child development programme educates families by empowerment and the children have less accidents, better nutrition and hearing and eye defect one generally picked up earlier. Health promotion in the above case could be measured by having control groups that were not on any particular programme". [0422]
"By asking the clients involved to tell you how they have changed and recorded this. This may involve changes in self confidence as well as changes in behaviour. It is important to take a wide and holistic view of each individual to measure change as narrowly focused promotion activities which urge people to make specific lifestyle changes are often unsuccessful. It is important to explore with people why changes are difficult and let them discover the best health options for them". [0941]

It can be seen from the examples cited that many health visitors are aware of the need to look at health promotion more holistically and away from a narrowly focused disease framework. They are also aware of the many inadequacies and often naive attempts to evaluate any sort of preventive work. A respondent who said that she could not answer the question on whether it was possible to measure health promotion qualified her answer by saying:

"it is too difficult to assess success because success can mean anything from a slight change to an enormous one - how can one judge fairly? [0947]

Tannahill (1992) advocates the development of an epidemiology of health which he asserts "must recognise health together with ill health; it must use subjective measures alongside the objective, it must investigate the distribution and determinants of good health as well as bad, it must seek to identify not only health problems but also health opportunities" (1992:105).
Some health visitors, but regrettably not the majority of respondents, advocate Tannahill's recommendations. Perhaps the crucial question is why do some health visitors take this approach and not others?

SUMMARY

This chapter has addressed two questions - Is it possible to measure health promotion, and if so, on what criteria can health promotion be measured? Two-thirds of the respondents thought that health promotion could be measured, 17% of respondents did not think it could be measured, and 19% of respondents replied 'don't know'.

Many of the respondents who thought it was possible to measure health promotion acknowledged a number of difficulties associated with any sort of measurement. Perceived difficulties included the scale of health promotion activities, whether on an individual, group or societal level; the complexities of examining health promotion activities, which would include input, outcomes and evaluation processes, the choice of appropriate methodologies, and selection of time scales over which health promotion activities could appropriately be evaluated.

In response to the question, about the criteria by which health promotion can be measured; five criteria were identified by the respondents, namely, target setting, evaluation, morbidity statistics, mortality statistics and questionnaires/surveys. Target setting, questionnaires/surveys and evaluation may be interrelated and they are often used in health related research. Morbidity and mortality statistics indicate current trends in illness and disease, but they focus on the individual and have little relevance to health per se. Only 35% of the respondents identified the need to look at social/psycho processes as well as environmental, social policy and public health issues.
The researcher suggests that the measurement of some health promotion activities is possible but is likely to be very costly. Research into health behaviours for example, has been shown to be extremely complex and multidimensional involving variables such as attitudes, education, lay beliefs, locus of control, responsibility and group influences on behaviour (Blaxter 1992, Kickbusch 1988). Taking these issues into account any research would need to be done collaboratively and using multidisciplinary perspectives. Ideally, the research would incorporate a variety of methodological approaches including action research, retrospective and prospective studies, and care studies. It would also need to be undertaken on a short, medium and long term basis. There is scope for less ambitious research and the researcher suggests that health visitors have very good opportunities to use many of the criteria they have identified. Target setting in for example, the promotion of breast feeding, or weight reduction might be achievable but much would depend upon the motivation of the clients themselves. The researcher is of the opinion that simple approaches such as ongoing interviews with willing clients might yield important insights into health beliefs and lifestyles which may be fundamental to healthy promotion strategies. These suggestions tend to take an individualistic stance but most health visitors have been found to excel in one to one situations with their clients (Robinson 1982).
CHAPTER 10
HEALTH PROMOTION ACTIVITIES UNDERTAKEN BY
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CHAPTER 10

HEALTH PROMOTION ACTIVITIES UNDERTAKEN BY
PRACTISING HEALTH VISITORS

Theme 4 of the conceptual framework (Chapter Five) questioned what skills if any, existing health visitors have in health promotion. Health visiting skills and practice per se will be examined more fully in Chapter 11 but this chapter aims to examine examples of health promotion activities identified by the respondents.

In Chapter Five it was explained that a modified version of critical incident technique would be used to identify the types of health promotion enterprise in which health visitors are engaged.

According to Cormack (1991:245) there is no way of knowing in advance as to how many incidents need to be collected. In this case, practising health visitors were asked to describe two examples of any health promotion functions they had carried out within 10 days prior to completion of the questionnaire (Question 13). Two examples of health promotion practice were requested by the researcher as it was thought that this would enable a greater range of activities and/or approaches to be identified. In using critical incident technique classification systems for coding the data are usually developed while the data are being analysed rather than beforehand (Cormack 1991:247). Hence any conceptual discussion of how the findings might be interpreted will take place at the end of the Chapter rather than at the beginning.

HEALTH PROMOTION ACTIVITIES

Answers to the open ended question 13 were coded into ten categories (see Appendix VII). The health promotion categories and the percentage of health visitors undertaking each area of practice are shown in Table 10.1 (overleaf).
Table 10.1 Categories of health promotion activities undertaken by practising health visitors when asked to describe two health promotion activities undertaken within ten days prior to completion of questionnaire.

<table>
<thead>
<tr>
<th>Categories of Health Promotion</th>
<th>No. of Health Visitors</th>
<th>% undertaken each activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advice on healthy lifestyles</td>
<td>206</td>
<td>54%</td>
</tr>
<tr>
<td>2. New health initiatives.</td>
<td>111</td>
<td>29%</td>
</tr>
<tr>
<td>3. Accident Prevention</td>
<td>106</td>
<td>28%</td>
</tr>
<tr>
<td>4. Parent and Child health issues.</td>
<td>93</td>
<td>24%</td>
</tr>
<tr>
<td>5. Nutrition and Dietary Advice.</td>
<td>79</td>
<td>21%</td>
</tr>
<tr>
<td>6. Ante and post natal health promotion.</td>
<td>56</td>
<td>15%</td>
</tr>
<tr>
<td>7. Other womens' health issues.</td>
<td>51</td>
<td>13%</td>
</tr>
<tr>
<td>8. Dental health</td>
<td>36</td>
<td>9%</td>
</tr>
<tr>
<td>9. Family planning</td>
<td>20</td>
<td>5%</td>
</tr>
<tr>
<td>10. Other health promotion activities.</td>
<td>47</td>
<td>12%</td>
</tr>
</tbody>
</table>

n = 385

The categories in Table 10.1 are not mutually exclusive. Parent and child health and nutritional and dietary advice, for example, may well overlap with advice on healthy lifestyles. As Parent and Child Health Issues and Nutrition and Dietary Advice were mentioned specifically by a significant number of respondents i.e. over 30, a separate category was included. Some respondents provided more than two examples in their replies, and all examples were coded and included in Table 10.1.

a) Advice on healthy lifestyles

Examples of advice on healthy lifestyles were wide ranging as shown in Table 10.2. A number of these activities conform to the government targets for health
promotion. Look after your heart, weight reduction, cessation of smoking and breast examination for early detection of cancer, are prime examples. These activities involve both individual and group activities and once more they focus on disease prevention.

Table 10.2 Examples of health visiting activities promoting healthy lifestyles

<p>| | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>'Drop in' session for under 25s to deal with health issues.</td>
</tr>
<tr>
<td>2</td>
<td>Look after your health sessions.</td>
</tr>
<tr>
<td>3</td>
<td>Stress management classes.</td>
</tr>
<tr>
<td>4</td>
<td>Smoking cessation groups.</td>
</tr>
<tr>
<td>5</td>
<td>Weight loss evening classes.</td>
</tr>
<tr>
<td>6</td>
<td>Well persons clinic's</td>
</tr>
<tr>
<td>7</td>
<td>Exercise and relaxation to elderly clients.</td>
</tr>
<tr>
<td>8</td>
<td>Women's group breast examination for early detection of cancer.</td>
</tr>
<tr>
<td>9</td>
<td>In store health promotion in Boots the chemist advising on health issues.</td>
</tr>
<tr>
<td>10</td>
<td>Women's self help groups - self selected topics.</td>
</tr>
</tbody>
</table>

b) New Health Initiatives

Analysis of the data showed that 29% of practising health visitors mentioned that they had undertaken activities which were new health initiatives. The activities included in this category were considered new health initiatives in the sense that they were perceived by respondents, as new initiatives, or that they had been recently started by the health visitors in response to local needs. Table 10.3 (overleaf) gives some typical examples.
Table 10.3 Examples of perceived new initiatives by practising health visitors in health promotion activities.

1. Health bus.
2. Parent support group for child HIV sufferers.
3. Workshop with council playgroups or play development.
4. MOT clinic for 35 - 64 age groups.
5. General health promotion day using several themes based at shopping centres.
6. Talks to workers taking redundancy. Regular sessions to prepare them for health maintenance.
7. Meningitis awareness.
8. Market stall on HIV and AIDS. Promoting World AIDS day.

Some of the perceived new initiatives in health promotion reflect events happening at the time of the research. Regular sessions on redundancy, for example, are now more commonplace and this service should undoubtedly be extended. The health bus demonstrates an attempt to provide an outreach service to clients which goes to their own homes and communities. Consciousness raising and support for HIV and AIDS sufferers is also a service for which demand is likely to increase. These activities differ considerably from traditional health visiting work but they do demonstrate the multipurpose and diverse nature of health visiting, also the need for a flexible and multi-skilled professional practitioner. Further discussion on some of these issues is included in the summary at the end of this Chapter.

c) Accident Prevention

General accidents are the most common cause of death in people under 30 and
accidents in the home are the biggest single cause of injury (DOH 1991). Children in particular are known to be vulnerable. The value of health visitors in promoting home safety has been recognised for many years although the way in which safety is promoted is still a topic under debate (Luker & Orr 1992:149). The comment noted earlier made by Campion (1991), that telling people what to do is the least effective approach, can be applied here. One of the respondents actually stated that Esther Rantzen could probably do more health promotion in one programme than many health visitors could do in one month.

Twenty eight per cent of health visitors chose to mention accident prevention as a health promotion activity in which they had been engaged in the ten days prior to completion of the questionnaire. This doesn't mean that 72% of health visitors had not been concerned with accident prevention as the question asked for only 2 examples of health promotion to be given. Some typical comments on accident prevention are demonstrated below.

"Safety display ie. November 5th and fireworks in Health Centre waiting room". [0402]

"Discussing safety measures in the home". [0607]

"Facilitating parents to consider aspects of home safety appropriate to toddlers during home visit and providing information on resources available to achieve their objectives (e.g. loan of stairgate). [0487]

"Leading discussion on cot death after television programme" [0967]
"preventive measures to avoid cot deaths". [0918]

"home safety to parents of twins". [0903]

"home safety - areas of danger for under five's and ways of reducing risks". [0001]

"arranging an accident prevention study day for health visitors in own district". [0009]

"an 18/12 assessment linking child development to accident prevention in the home". [0619]

"accident prevention focus in all visits to reinforce T.V. programmes". [0372]

"individual counselling to a young couple on hypothermia and home safety, both have been in care - have no support and no parenting skills passed on to them" [0374]

These examples show that consciousness raising on accident prevention does take place both on an individual level and in groups. The fact that some health visitors link the subject to topical television programmes and/or child developmental assessment is noted as is the vulnerability of some of their clients.
d) Parent and Child Health Issues

Responses in the Parent and Child Issues category were included because of their focus on health issues per se rather than parenting skills. Some typical examples of the type of responses given are demonstrated below.

"one to one counselling and providing positive attitude to mental health". [0610]

"Discussed social activities and healthy exercise with a young mother who is becoming isolated to promote mental/psychological health. [0743]

"I consider most visits I make have a health promotion input. By talking to a young first time mother on the matters of a large family I can promote many aspects of health for the whole family e.g., family planning". [0997]

"Home visit to new parents; topics include benefits of monitoring baby's progress and parents' approach to keeping healthy". [0861]

"Visit to family with two children with phenylketonuria. Social counselling support - identifying strategies to cope with or help to allay difficulties in family dynamics". [0528]

Analysis of these responses demonstrates a fairly personal and individualistic approach and the examples cited indicate evidence of families with special needs.
e) Nutrition and Dietary Advice

Alwyn Smith and Jacobson (1988) comment that one of the key objectives towards a strategy for health for the 1990's is to increase public, professional and political awareness of what constitutes a healthy diet (1988:242).

Nutrition and dietary advice was identified by 21% of the practising health visitors as an area of health promotion in which they had been involved. Some of these examples of typical responses provide insight into the type of dietary advice offered to clients and families.

"exploring with the over 65's their perception of a healthy diet and then looking at ways of enhancing their diets if thought to be appropriate by all concerned". [0268]

"weight loss evening clinic. Individual assessment and programmes. Used by 30 - 40 people weekly". [0132]

"Family with 4 children. Dad (Gout) attends hospital. Discussion with mother gradually directed conversation towards Mum's own acknowledgement that a special healthy low fat, low alcohol diet prescribed by the dietician would eventually benefit the whole family long term. Perhaps start Gout self help group". [0620]

"Diet awareness, cholesterol control. Group sessions offering individual advice at end with dietician. Sample of low fat foods available". [0348]
"establishing healthy eating patterns in the weaning child on a one to one basis".

These five examples demonstrate the range of opportunities health visitors have to promote healthy eating and include all age groups. Whether advice is taken or whether health visitors do achieve any of the expected health outcomes associated with healthy eating is beyond the remit of this research.

f) Ante and Post Natal Health Promotion

A typical time for health visiting involvement is during the antenatal and postnatal periods (Appleby 1991). Dunnell and Dobbs (1982) in the OPCS survey also found that the health visitor's routine work was with babies and mothers. However, only 15% of the respondents mentioned the antenatal and postnatal period as a time in which they were involved in health promotion activities. Responses illustrating the type of activities engaged in are given below.

"Drop-in antenatal group open to partners, relatives and friends. Totally client led"

"input to young mothers group for pregnant and postnatal school girls". [0365]

"antenatal visit discussed dangers of passive smoking on the foetus and in the future care of self and new born infant". [0120]

"antenatal booking clinic, meeting new mothers and fathers individually and preparing and planning aspects of frequency". [0610]
"post natal classes including positive parenting". [0124]

"video's at postnatal group on feeding practices". [0204]

"new mum's group (with children under 1 year) to promote their parenting skills and promote health awareness". [0076]

"group meeting for first time parents with children up to nine months". [0311]

These are fairly typical examples of perceived health promotion activities with antenatal and postnatal parents and significant others. Analysis of these examples suggest they differ very little from traditional health education activities which health visitors have performed over many years (Clark 1981).

g) Women's Health Issues

Although many of the examples of health promotion already discussed are orientated towards women's roles and family interaction, 13% of health visitors identified examples of health promotion activities in areas specifically geared to women's health. Typical responses are given below.

"advice and support to a breast feeding mother enabling her to continue breast feeding and therefore promoting both her own health and the health of her child". [0115]

"Group work with women, looking at self esteem/assertiveness, and self
"empowerment". [0887]
"advice on relieving pre-menstrual tension".

"miscarriage support". [0415]

"well women talk to x remand centre (this was outside of my present responsibilities - a huge demand for education in this area)". [0176]

"discussed women's health in relation to cervical smears, early detection of cervical cancers and early treatment". [0069]

"discussion with a mother with postnatal depression". [0480]

"visiting a women threatening to commit suicide. Encouraging her to see positive aspects of her situation. Giving information support and helping agencies in her area".

"encourage a mother to self examine breasts (using a rubber model). [0477]

"menopausal support groups, 18 evening sessions (3 courses) a year. Information giving and discussion structured programme. [0259]

It can be seen from the above responses that women's health issues incorporate much of substance advocated in The Health of the Nation (DOH 1991). Within these 9 examples some degree of awareness is demonstrated about issues such as early detection
of cancer, promoting physical and mental health, promotion of self esteem, assertiveness etc. Again the effectiveness of health visitors in these areas is largely unknown but it does seem that their efforts are worthy of appropriate evaluation and demonstrates a movement away from the traditional health visitor role (see Chapter 14).

h) Family Planning

According to Alwyn Smith and Jacobson (1988) "family planning has been demonstrated to be highly cost effective; every £100 spent by the NHS on it can result in a £500 saving by preventing unwanted pregnancies" (1988:195).

Only 5% of respondents specifically mentioned family planning/contraception as one of the two examples of their involvement in health promotion activities. As explained earlier it doesn't mean that the other 95% practising health visitors were not actively involved in the promotion of family planning.

i) Promotion of Dental Health

The Nations Health (Alwyn Smith & Jacobson 1988:266) recommends that a programme for dental health should be linked to the promotion of a healthy diet and reducing tobacco consumption. In advising the public more emphasis on the link between dental health and the intake of sugar is also recommended.

Dental health was an area of health promotion which 9% of health visitors chose to mention. The examples selected demonstrate a variety of approaches used by the practitioners.

"Discussing dental health/use of fluoride drops with mother". [0085]
"Dental hygienist visited nursery to talk to children aged 2.5 - 4.5 years about dental health, care of teeth, correct diet".

"Dental health and diet in pregnancy to a group of antenatal mothers". [0151]

"Promoting good dental health practices to all mothers when visiting 0 - 5's e.g., fluoride drops, brushing and toothpaste and giving snacks". [0390]

"encouraging parents to take small children to the dentist. Involvement in local dental health project". [0290]

"Discussing the importance of dental care with a mother of a toddler (including diet)". [0315]

The idea that health visitors should act as promoters of dental health was first suggested by King (1976) cited in Quinn and Freeman (1993). King recognised that health visitors not only had access to a whole range of members of the public, but, they also had acceptability by clients, a view reiterated by other researchers (Dingwall & Robinson 1993). Quinn and Freeman (1991) undertook a study of health visitors as dental health educators, involving 82 health visitors, (84% of those working for the Western Health and Social Services Board). Although the authors found that 66% of the sample made value judgements about which mothers they would advise they also found that the health visitors' level of dental health knowledge was high (Quinn and Freeman 1991). In a later paper, exploring health visitor - dentist co-operation, Freeman (1993)
supports the view that health visitors "are valuable as disseminators of dental health information" (1993:10).

In this study, the evidence does suggest that health visitors do link their dental health information with factors such as tooth brushing, diet, fluoridation etc.

j) Other Health Promotion Activities

12% of practising health visitors gave other idiosynratic but interesting examples of perceived health promotion activities such as:

"Advised Asian mother not to rinse bottles with tap water after sterilising them". [0206]

"Promotion of publicity about sexual abuse to other professionals". [0098]

"Overactive child - advice given and followed which resulted in a change of child's behaviour". [0441]

"Talk to school girls on rubella". [0112]

"Advice to family who have recently lost their first baby. Family has familial hyperlipidaemia". [0194]

"Talk to staff and parents at community home for alcoholic/drug addict families on first six months of life". [0194]
"environmental discussion to promote research into local conditions". [0332]

The examples cited above illustrate on the one hand the individualistic nature of many of the activities in which health visitors engage. On the other hand they also indicate a strong orientation towards group work, talks and discussions, promotion of publicity and an environmental focus. Perhaps above all, they demonstrate the vulnerability of many of the health visitors' clients.

SUMMARY

Analysis of the health promotion categories and of the substantive examples within them provide evidence of a wide range of health promotion activities. These require, from the health visitors, a diverse range of knowledge and in particular communication skills. The categories themselves show fairly conventional health topics. In fact all the programme areas outlined in the Health Education Authority Operational Plan 1992/94 (Health Education Authority 1992) are included in the emergent categories.

As to whether the examples given by the respondents actually constitute health promotion activities it is necessary to compare them with various taxonomies of health education. Tones (1981), Slavin and Chapman (1985), and French and Adams (1986) developed taxonomies which demonstrated stages of developmental progression. Tones' (1986) taxonomy of health education, which according to Rawson and Grigg (1988:59) "subsumes health education under the rubric of health promotion and isolates some of the broader influences on changing strategies in health education", contains five models of practice (Tones 1981; Tones 1986). These include:

a) The Education Model
b) The Preventive Model.

c) The Self Empowerment Model.

d) The Radical Agenda Model.

e) The Radical Consciousness Raising Model.

These models were developed in an evolutionary manner from methods used in health education practice (Rawson and Grigg 1988). In a similar way, Appleby (1989) has developed a taxonomy of health visiting practice which demonstrates seven models of practice (See Figure 10.1, page 210). These include:

a) Medical Model.

b) Psycho analytic Model.

c) Educational Model.

d) Socio Environmental Model.

e) Partnership Empowerment Model.

f) Community Development Model.
g) Radical Social Change Model.

Examining the responses within all of the categories and comparing them with the models of Tones (1986) and Appleby (1989) it appears that health visiting practice fits into the 'education', 'preventive' and 'self empowerment' model suggested by Tones, and the 'medical', 'educational', partnership/empowerment and socio/environmental models suggested by Appleby, although some of these models overlap. From the examples given, many responses fit the medical model in that the advice is seen as relatively prescriptive; is aimed at changing individual behaviour and to some extent suggests simple solutions to problems (Appleby 1989). A single example follows:--

"advised children to clean their teeth".

Proportionately more of the responses fit the 'preventive model' identified by Tones (1986):--

"helping mothers to manage own prevention of ill health and promoting good dental health practices to all mothers when visiting 0 - 5's.

A majority of the examples given by respondents fit the 'Education Model' in that health visitors seek to give information so that if possible clients can decide for themselves, for example:--

"meningitis information campaign, poster and leaflet display in Health Centre.
Informal talk to mother and toddler group with distribution of leaflets to reinforce
information”.

A small, but nonetheless significant number of examples fit into either Tones' (1986) 'self empowerment model' and/or Appleby's (1989) 'partnership model' as shown below.

"every home visit aims to empower mothers to take control of their lives, improve their self esteem and stimulate their interest in their own and their child's health".

This example demonstrates the partnership/empowerment model suggested by Appleby which "seeks to empower clients by building self esteem so that they can be self directed and seek their own solutions" (Appleby 1989:1).

None of the examples given in this study approximated the radical agenda model or radical consciousness raising models identified by Tones (1986). Only two responses fitted the socio/environmental model in which the professionals recognised the effects of social and environmental conditions and sought to improve the individual's situation.

Explanations as to why health visiting practice tends to remain within the 'medical', 'educational' and 'self empowerment' models include health visitors' early socialisation in a disease framework, the agenda setting of NHS management, promotion of traditional roles, the influence of the workbase, and the relative powerlessness that health visitors have to radically change their practice even if they wished to do so.

In conclusion, the categorisation scheme used by the researcher does not adequately differentiate the individualistic/medical model versus self empowerment/community development model. On reflection, the majority of examples may be contained within a single category, namely, parent and child health issues.
# Taxonomy of Health Visiting Practice

<table>
<thead>
<tr>
<th>Medical Model</th>
<th>Educational Model</th>
<th>Psychoanalytic Models</th>
<th>Partnership/Empowerment Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essentially prescriptive/authoritative. Relying on the EXPERT. &quot;Doing unto&quot;</td>
<td>Seeks to give information so clients can decide for themselves.</td>
<td>Assumes that most problems which have their roots in previous life experience and current coping mechanism. A good quality of relationship with professional may effect coping abilities by developing personal insights and may ignore effects of current stress.</td>
<td>Seeks to empower clients by building self confidence and self esteem so that they can be self directed and seek their own solutions. Professional takes a back seat.</td>
</tr>
<tr>
<td>suggests &quot;simple&quot; solutions. Aims to change individual behaviour.</td>
<td>Assumes that people are willing and able to make changes in their lives. May set up the educator as THE EXPERT.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>by persuasion/coercion. May imply victim blaming.</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

These models of practice operate largely on a one to one basis, in the home or in the clinic or surgery. They may involve group activities.

<table>
<thead>
<tr>
<th>Socio/Environmental Model</th>
<th>Community Development Model</th>
<th>Radical Social Change Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essentially recognises the effects of social and environmental conditions and seeks to improve an individual's situation.</td>
<td>This model addresses issues such as resources and distribution of power. It raises questions about the nature structure and process of society and encourages and supports grass roots activities aimed at identifying needs in the community. It relies on change to be brought about by collective action.</td>
<td>Looks at social relationships in our society and the damage they may do e.g between Man and Woman, Employer and Employee, Black and White communities. It looks at who holds the power and makes decisions in our society and the effect of this on the recipients. It seeks Social Change. The HV as an agent of Social Change and Social Control.</td>
</tr>
</tbody>
</table>

These models look at ways of working with groups of communities.

F Appleby 1989. Adapted from models proposed by V Chapman and H Slavin.
### CHAPTER 11

**HEALTH VISITING SKILLS AND PRACTICE IN RELATION TO HEALTH PROMOTION**

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CHAPTER 11
HEALTH VISITING SKILLS AND PRACTICE IN RELATION TO HEALTH PROMOTION

The first part of this chapter examines why it is relevant to analyse health visiting skills and then questions what existing skills health visitors have to contribute to health promotion activities. The second part of the chapter addresses the questions relating to further development of health visitors' existing skills and the acquisition of new skills outlined in the conceptual framework (Figure 5.2).

a) WHY ANALYSE HEALTH VISITING SKILLS?

In the qualitative stage of the research during the group discussions, the subject of skills in practice emerged many times and in many contexts. It is important to discuss skills because they are pivotal to issues such as expertness, professionalism, perceived credibility of practitioners, work efficiency, cost effectiveness and others.

Skills are multidimensional, for example, nurses in primary health care are perceived by their professional organisation, the Royal College of Nursing, to possess skills in case finding, assessment, provision of direct care, teaching families and individuals to manage their own health, and training and supervising health care support workers to provide continuity of care in the nurses' absence (RCN 1987).

A skilled practitioner is frequently seen by patients and significant others as 'expert' in their chosen area of work. This brings to the practitioner an achieved status and perceived credibility by patients, clients, peers and other professionals.

To acquire a high level of skill and competence usually requires the practitioner to spend considerable time in training and to have access to repeated practice of performance. Although skills acquisition is seen as desirable by the Government, at the
same time, the cost of education and training for professionals is also seen as prohibitive and the introduction of skill mix into the traditional territory of health professionals is now official Government policy. Skill mix refers to skills and experience of staff within grades of sisters, staff nurses, enrolled nurses, and auxiliaries required (Carr-Hill et al 1992).

Skills are also important in the context of teamwork. A clear understanding by each team member of his or her own role, function and skills and those of his/her colleagues brings mutual respect, peer group recognition and contributes towards the definition of common objectives for comprehensive patient care (London Health Planning Consortium, 1981).

Thus for any study of professionals, an exploration of existing skills and perspectives on the development of new skills and perspectives appears critical. In the context of this research, study skills will be explored in relation to the development of health promotion.

b) WHAT EXISTING SKILLS DO HEALTH VISITORS HAVE TO CONTRIBUTE TO HEALTH PROMOTION?

All health visitors are registered general nurses and on entering health visiting education have the professional competencies required by their statutory body for registration as a nurse. The 1965 syllabus for health visiting was divided into five broad headings (CETHV 1965). These included:-

2. The Individual in the Group.
3. The Development of Social Policy.
5. Principles and Practice of Health Visiting.

This syllabus was designed to prepare students "to select the best method of health education likely to be the most successful in any particular instance" (CETHV 1977:18). Since 1977 the 51 week course which prepares nurses for health visiting practice requires successful students to be able to plan activities aimed at the promotion of health and prevention of ill health (CETHV 1977:8). Health visitor training according to the Council for the Education and Training of Health Visiting, "thereby contributes substantially to individual and social well-being, by focusing attention at various times on either an individual, a social group or a community" (CETHV 1977:8).

There are very few empirical studies which have examined specific skills of health visitors, although, in a study of fieldwork teachers, Chapman (1979) identified that possession of knowledge and skills on their own were of little significance to practice. It was an overall understanding of health issues and the application of appropriate knowledge and skills to any given situation which was deemed important. Dingwall (1977) (cited in Luker & Orr 1992:25) similarly found that health visitor tutors and other health visitors considered the qualities of each health visitor were more important than skills per se.

In a consultation paper exploring the nursing, midwifery and health visiting contribution to health and health care (DOH 1993), it is recognised that health visitors have made a particular contribution to the prevention of illness and promotion of health and "it is envisaged this will continue" (1993:6).

Killoran (1993) also recognises that health promotion is an important part of health visitors' work and she suggests that the contribution of health visitors towards the reduction of coronary heart disease "should not be underestimated" (1993:6). In her analysis of what contribution might be made by the primary health care team to meet The
Health of the Nation target of 40% fewer deaths from Coronary Heart Disease, Killoran (1993) advocates the need for multidisciplinary training to prepare for the replacement of health promotion clinics (mostly run by practice nurses in the surgeries of fundholding GPs), with health promotion programmes in general practice. The skills Killoran (1993:27) perceived to be needed by members of the primary health care team will be compared with those identified by the health visitors themselves later in this Chapter.

c) **DO HEALTH VISITORS PERCEIVE THAT NEW SKILLS AND COMPETENCIES ARE REQUIRED AND WHAT IS THE NATURE OF THESE SKILLS?**

Health Visitors were asked "In the context of health promotion please identify any new skills and competencies needed by health visitors to function more effectively" (Question 25). Respondents were requested to list up to six examples. The professional experts involved in the coding of the data agreed with the six categories of skill requirements identified by the researcher, and a seventh category was used to contain "other" replies (see Appendix VII). Table 11.1 (overleaf) demonstrates the categories of skill requirements with the percentage of health visitors mentioning each type of skill required.

Although all the sample respondents were asked to complete Question 25, with a few exceptions, it was answered only by practising health visitors. The responses in Table 11.1 (overleaf) are therefore included as a percentage of all the practising health visitors. Analysis of each category follows:

1. **Regular Updating of Existing Skills and Knowledge**
   
   Over half of practising health visitors commented that they needed regular updating in many areas of work. It was also expressed by some respondents that unlike
midwives, health visitors have no statutory requirement for them to attend refresher courses. The Post Registration and Professional Practice requirements of the UKCC do require staff to keep updated in practice but it is suggested that the number of days stipulated is minimal. As to the nature of the updating that needs to be done, some of the responses typically demonstrate the range of requirements perceived by health visitors.

<table>
<thead>
<tr>
<th>New Skill/Enhanced Skill Requirements</th>
<th>No. of PHVs Mentioning</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Regular updating of existing knowledge and skills.</td>
<td>221</td>
<td>56</td>
</tr>
<tr>
<td>2. Group work/empowerment skills.</td>
<td>210</td>
<td>53</td>
</tr>
<tr>
<td>3. Research/evaluation skills.</td>
<td>127</td>
<td>32</td>
</tr>
<tr>
<td>4. Teaching/communication skills.</td>
<td>174</td>
<td>44</td>
</tr>
<tr>
<td>5. Publicity and marketing skills.</td>
<td>97</td>
<td>25</td>
</tr>
<tr>
<td>6. Confidence and assertiveness.</td>
<td>205</td>
<td>52</td>
</tr>
<tr>
<td>7. Other skill requirements.</td>
<td>90</td>
<td>23</td>
</tr>
</tbody>
</table>

n = 393

"update on recent reports/white papers etc., updating on how/why people are motivated to change". [0741]

"The skills and competencies needed by the HVs to function more effectively will need continual revisiting in the light of a new population moving into the areas. (I refer to inner cities). In this way she can be informed of cultural habits of his/her clientele and can advise accordingly rather than impose British habits which the clients will not understand and consequently they will have no effect."
As can be seen from the data, practising health visitors felt the need for regular updating in several areas of their work. Typical examples of requirements included updating on national and local policy matters. An example given of a national policy was the **Children Act 1989**, and locally, health authority health promotion policies. Other requirements identified by respondents included the results of local health promotion initiatives, presumably those taken by HEOs/HPOs or other members of the primary health care team, particularly GPs. Sociological research and health promotion research which could contribute to improved practice was also identified, as was the need for updating in community profiling and epidemiological studies (see section 7 of this Chapter).

2. **Groupwork/Empowerment Skills**

   The need for more training in groupwork/empowerment skills was identified by 53% of respondents. The fact that over half of practising health visitors specifically
mentioned groupwork indicates a realisation of the need for this method of work and a felt lack of skills by the practitioners. Of the 18% of practising health visitors who had been in post for under 2 years, 60% mentioned the need for groupwork skills. This may indicate a need for more practical skills in groupwork or that this group of practising health visitors are more conscious of the need to emphasise this aspect of health promotion work. Ironically it may be that they actually need less but perceive they need more groupwork skills. Typical comments to emerge from the data on skill requirements and groupwork in particular are given below:-

"develop empowerment skills". [0365]

"skills in the facilitation of groupwork and empowerment of clients". [0336]

"more emphasis on importance of groupwork". [0087]

"health visitors need to be more sensitive and less directive. Need to listen more. Many women have low self esteem. HVs have to learn how to enhance self esteem particularly through groupwork". [0206]

"advocacy skills on behalf of client groups". [0611]

"group dynamics, understanding and managing these". [0702]

"skills in the facilitation of groupwork, empowerment of others". [0336]
It is significant that a number of respondents perceived empowerment of others happening through groupwork. Advocacy skills on behalf of client groups was mentioned by some respondents. It seems to the researcher that although group work is included in both nursing and health visiting curriculae, more opportunities are needed for groupwork activities. The felt needs of the professionals may also reflect lack of confidence in their social/interaction skills.

3. Research/Evaluation Skills

The fact that 32% of respondents identified research and evaluation skills as a current requirement for effective health promotion practice, may have been influenced by the questionnaire which addressed the issue of measurement in previous questions. On the other hand, as Killoran (1991) indicated, evaluation is required in the health service to give evidence of 'value for money'. The perspectives on research and evaluation given by the respondents however, provide a number of dimensions which may prove useful to practitioners and managers of the community services. Examples of responses are given below:

"collection of data needs to be improved to identify unmet needs. Computer and research techniques would be useful". [0006]

"research knowledge to get our facts together". [0396]

"research skills to collect relevant data for planning and evaluation of effectiveness". [0611]
"learn how to use research, be critical and implement projects as required". [0833]

"research skills to research the needs of communities". [0456]

The above examples suggest some recognition by health visitors of the value of research techniques, not only to assess health needs of individuals and communities but also to evaluate them. A third of health visitors would clearly like to extend their existing skills and acquire appropriate research knowledge and tools for their work. A number of respondents perceived the need to make their work appear more visible, not only to their managers but also to the public and other professional groups. This could be interpreted in two ways. First it could indicate health visitors' consciousness of a need to impress managers that health visiting services are worth purchasing because they give value for money. Second it could simultaneously demonstrate political motivation to enable pressure group activity to acquire public support for health visiting work.

4. Teaching/Communication Skills

Teaching techniques and methods as a subject has been included in the curriculum of both nurses and health visitors for a number of years. While the amount of time spent and the quality of teaching on this subject may vary enormously, most nurses and health visitors have a number of experiential opportunities to extend their existing teaching skills and develop new ones. It was therefore relatively surprising to find that 44% of the respondents identified the need for further education and training in teaching skills. A few of the respondents linked teaching skills to being able to communicate more effectively with clients and other professionals, although most respondents did not specify this association. Typical examples of respondents' replies follow:-
"teaching techniques". [0104]

"better teaching skills". [0064]

"more teaching skills, e.g., for presentation". [0261]

"teaching skills". [0174]

"ability to teach in schools on AIDS". [0187]

"help in preparing visual aids". [0390]

"teaching skills to improve communication with other professionals". [0110]

The examples given above appear relatively simplistic and suggest that health promotion is viewed by the practising health visitors largely in the context of the educational model in which information is offered to others more or less as an end in itself.

Anderson (1986) believes that self empowerment of individuals is essential if health promotion is to succeed. Rather than just information giving, he identifies five other criteria which should occur concurrently within an educational model approach. These include raising awareness of self, and others, facilitation of commitment to goals and outcomes, exploration of both individual and societal values, and lastly development of life skills.

One cannot infer from the data whether health visitors are aware of these processes as this was not within the remit of this particular study. It does seem to the
researcher, however, that any future investigation into the beliefs of professionals who claim to promote health should explore whether the five criteria outlined by Anderson (1986) exist within their work agenda.

5. Publicity and Marketing Skills

One of the core tenets of the reconstruction of the National Health Service is the shift away from Government provision towards privatisation and a market driven health service. With the introduction of purchasers and providers of health care the onus rests on competition between providers to achieve effectiveness and efficiency. At the commencement of this research project the position of health visitors in relation to purchasers and providers was unclear. Debate ensued as to whether health visitors would remain in the employ of district health authorities, whether they would move to newly formed trusts, or whether they would transfer to the employ of local FHSAs. As soon as it was generally known that general practitioners would become fund holders for health promotion, many health visitors were alerted to the necessity to make their skills more visible both interprofessionally and to the public. In the context of these developments it is not surprising to find that 25% of the respondents identified the need to develop publicity and marketing skills. (Further discussion on how publicity and marketing is defined follows the examples given). Examples of typical responses are given below:

"training in publicity skills e.g., posters, captions etc. relevant to a particular area". [0031]

"increased use of media and local radio". [0014]
"use of the media". [0938]

"advertising and publicity skills".

"We need training in how to communicate with the general public in the open ie. the market". [0568]

"marketing skills, campaigning". [0121]

"ability to speak at public meetings". [0006]

"lobbying skills". [0336]

"more practice in dealing with the media". [0994]

Although the examples above can be interpreted in a variety of ways, it seems that two perspectives emerge. First, the need to get a message across, that health visitors have skills.

Second, the ability to speak at public meetings and 'lobbying skills' implies some sort of collective activity. The researcher suggests that the health visitors perceive the need to gain both public and political support for their work at a time when job security is highly uncertain for everyone, not least health visitors. There may also be other explanations.
6. Confidence and Assertiveness

A lack of confidence and self esteem by HEO/HPOs was identified in the qualitative stage of the research (Chapter Four). Although this was not the case in relation to the health visitors' group discussions, confidence and assertiveness was mentioned as a skill requirement by over half of practising health visitors in the self-completion questionnaires.

The comments made by the respondents are again open to various interpretations. One set of responses seems to identify personal needs by the professionals to have assertiveness training. Whether these needs are biographical or due to insufficient training in competence based skills or other reasons is unclear. Typical responses include:-

"presenting oneself positively". [0372]

"self awareness image". [0440]

"self promotion". [0138]

Another set of responses seemed to indicate the need to promote the image and confidence of health visitors in general.

"increased public profile image". [0256]

"health visitors must feel confident in holding health promotion clinics, classes, or events with the necessary backup from other professionals". [0979]
"recognition and confidence within peer group". [0900]

A third set of responses indicated a need for self assertiveness and confidence to take the profession forward in health promotion. This assertiveness was in relation to general practitioners, other health professionals and managers. Typical responses to support this interpretation are given below:

"confidence to go beyond the boundaries of the health service, e.g., not follow the medical model of care". [0082]

"confidence to move away from medical model to more client expressed need, social radical model, need training in this to explore our own attitudes". [0053]

"being more assertive looking at this (health promotion) in a broader perspective". [0402]

"person assertiveness in negotiating directly with GPs, group assertiveness with other HVs to negotiate with managers regarding size of caseload, home visiting pattern and development of group work". [0424]

From this data it does seem that a lack of assertiveness/confidence among health visitors exists on an individual, and group level. Reasons for this will be suggested and further analysis will be offered in the conclusion to this thesis.
7. Other Skill Requirements

A seventh category of skill requirements was included in the analysis of data to encompass the assortment of individual skill requirements identified by 23% of respondents. One of the sample respondents rightly perceived that many health visitors would have individual skill requirements and that these would need to be addressed on a personal, rather than collective level so that individuals could gain both confidence and competence in their practice. At the time of the research, individual performance review (IPR) was not widely implemented in the area of community nursing. In future, however, when the system of (IPR) is in operation it will be essential for managers to convey to professional organisations and educational institutions perceived skill needs of professionals, so that these might be addressed, where appropriate, in initial and/or ongoing courses.

A small number (5%) of respondents identified profiling skills as necessary. Community profiling involves a detailed analysis of a community or geographical location. The analysis draws upon epidemiological, sociological, environmental, socio-economic and other data and requires a sophisticated synthesis and evaluation of the information. Health visitors are then expected to prioritise health needs and plan their work strategies accordingly. It is conceivable that many of the respondents who trained longer than ten years ago do not have these skills in the required depth. Counselling skills were perceived as necessary by about 5% of respondents. There was no elaboration given by these respondents on the nature or purpose of the counselling skills one can only assume these were required for various individuals and/or families with social/health needs and problems.

Teamwork skills were mentioned by only 2% respondents, as one respondent commented:-
"increased ability to work in a team before we lose our place in it".

Other skill requirements identified by individuals included quality assurance, time management, stress management and political awareness. This skills identified in this section will now be compared with traditional health visiting skills.

d) IF HEALTH VISITORS PERCEIVE NEW SKILLS ARE REQUIRED, ARE THESE SIGNIFICANTLY DIFFERENT TO TRADITIONAL ONES?

Analysis of the skill requirement of health visitors in Section c of this Chapter shows that many of the skills identified by the respondents are fairly traditional and normally taught in basic courses. Teaching, communication skills, and group work skills for example all command a significant amount of teaching time in current health visiting curriculae. The fact that over 50% of respondents perceive they need more of these skills suggests that perhaps more practice or inservice education is required to provide practitioners with more confidence in the every day use of these skills. Research and development skills are relatively new skills for health visitors, particularly their application in practice. The type of initial training, inservice, and continuing education required to provide any level of research competence depends very much upon the breadth, depth, type and range of research and evaluation skills needed as well as available funding. With the government's present policy to change the skill mix to a combination of trained staff and support workers, this may indicate a reluctance to promote any additional knowledge based learning as opposed to competence based training. The Profession could however, argue that research skills form an essential competence.
With regard to publicity and marketing skills, this involves the use of TV, local radio, newspapers, and journals etc. For many health visitors this would involve the enhancement of verbal, written and communication skills which would inevitably take time to develop. Whether managers would support health visitors acquiring marketing and publicity skills is questionable.

The requirement for confidence and assertiveness training is open to interpretation. It is probably seen by the respondents as an aid to self empowerment on three separate levels; the individual, professional and societal level. On an individual level, lack of confidence may result from social and educational factors as well as early socialisation. It may also be a gender issue as research on the position of women in society has shown that many women lack confidence and self assurance in social situations (Abbott and Wallace 1990). On a professional level, the position of nurses and their deference to the medical profession has already been discussed (Freidson 1970:143). On a societal level, community action has been shown to influence policies far more than individual effort. The recent demonstrations by miners on potential pit closures, which resulted in the government having to review its policy well illustrates the point.

As to how confidence and assertiveness can be developed in these professionals, it seems that this would have to be addressed on either an individual, professional and/or structural level or on all three levels concurrently, but quite how remains uncertain.

e) ANALYSIS OF HEALTH VISITORS' PERCEIVED SKILL REQUIRED COMPARED WITH HEALTH PROMOTION SKILL REQUIREMENTS IDENTIFIED BY KILLORAN (1993)

Earlier in this chapter the need for health promotion training programmes was discussed. It was proposed that the skills identified by Killoran (1993) as being essential to members of the primary health care team for effective health promotion practice would
be compared with the skills identified by practising health visitors as skills they want but do not feel they have.

Common training requirements identified by Killoran (1993), are planning and organising health promotion, audit, evaluation, research and areas of clinical knowledge. Only evaluation and research in this group of requirements is identified as important by health visitors as skills they do not currently possess.

Killoran’s analysis of health promotion and the skills required focuses entirely on the practice setting and principally on the needs of practice nurses. What is clearly evident in comparing the needs of practice nurses and health visitors, is that practice nurses pursue solely individualistic approach to health promotion unlike health visitors who pursue a mixed approach, although practice nurses do recognise the need to extend their work into the community, for example, visiting the elderly in their own homes (Killoran 1993:26).

Results from research into the prevention of coronary heart disease and health promotion using a nationally representative sample of GPs in England, demonstrated that whereas 87% of GPs received in-service and continuing education in health promotion, 60% of those GPs still felt that diagnosis and treatment of patients was more interesting (Calnan 1991; Cant 1992; cited by Killoran 1993). This finding reinforces the need to question whether GPs should be the fundholders for health promotion, because it could be argued that entrenched orientation to the medical model will inhibit their potential success in health promotion.

The need for additional training in health promotion for all health professionals is not in question (O’Neill 1989; Heller 1992). Health visitors in this research were asked to agree or disagree with two statements, first, that GPs have not had enough training in
health promotion, second that HVs have not had enough training in health promotion. Results of their responses are shown in Table 11.2.

<table>
<thead>
<tr>
<th>Response</th>
<th>Responses relating to GPs</th>
<th>Responses relating to HVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>87</td>
<td>45</td>
</tr>
<tr>
<td>Undecided</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Disagree</td>
<td>3</td>
<td>41</td>
</tr>
<tr>
<td>Column Totals</td>
<td>100% (549)</td>
<td>100% (554)</td>
</tr>
</tbody>
</table>

Table 11.2 shows that 87% of health visitors perceived that GPs do not have sufficient training in health promotion skills. This lack of skills is recognised by the profession, for example, Wiedersheim and Muller Busch (1992) advocate a new approach to medical education in which medical students participate in social aspects of medical care and health promotion (1992:352). Heller (1992) similarly recommends a shift in medical education towards more teamwork, more skill based learning, e.g. assessment and interviewing and introduction of record systems which focus on preventive as opposed to curative care.

Whereas 87% of health visitors perceived that GPs do not have sufficient training in health promotion skills, only 45% of them thought that health visitors do not have enough training in health promotion (Table 11.2). It may be that the health visitors were comparing their performance to that of GPs. Under half of all health visitors perceived that health visitors have enough training in health promotion, with 14% of the sample undecided. The large proportion of health visitors (45%) who believe they have not had
enough training and the 14% who are undecided may partly explain the lack of confidence expressed earlier in this Chapter.

f) DO HEALTH VISITORS PERCEIVE THEY ARE ALREADY DEVELOPING NEW SKILLS IN HEALTH PROMOTION PRACTICE OR DO THEY PERCEIVE THEIR SKILLS ARE LARGELY UNCHANGED?

Health visitors were asked to rate their performance on a scale from 0 - 10; a score of 0 indicating that they perceived themselves to be developing new skills in the area of health promotion and 10 indicating that respondents perceived their skills as staying the same (Question 16c). Analysis of the responses showed that 52% of health visitors saw themselves as developing new skills, 36% perceived themselves as using old skills but also developing new, whilst 20% health visitors perceived their skills as changing very little. On reflection it would have been more sensible to have defined the parameters of developing new skills and staying the same. Nevertheless, if 52% respondents perceive themselves as developing new skills this is encouraging in any area of work.

SUMMARY

The questions relating to skills as identified in the qualitative phase of the research and outlined in the conceptual framework (Figure 5.2) have been addressed. A number of researchers have identified the need for interprofessional and intraprofessional education and training in health promotion (O’Neill 1989; Heller 1992; Killoran 1993). Health visitor practitioners in this study identified a number of skills and qualities needed to practice health promotion effectively.
The choice of skills demonstrated individual, group and community perspectives which raise an issue as to whether the organisation and planning of the health visiting service should be diversified to encompass all three perspectives comprehensively.

About 20% of health visitors expressed a strong commitment to one-to-one, individualistic, health visiting. This is illustrated by the following comments:

"I feel that there is a lot of pressure on health visitors at present to get out into the community responding to its needs and we are encouraged to set up groups for the benefit of the locality and community. Somewhere along this course the needs of the individual are going to be neglected". [0307]

"must be personal or people just switch off". [0117]

Some health visitors commented that they felt more confident in dealing with one to one situations rather than group or community issues. Others explained that with existing work responsibilities it would be difficult to focus sufficiently on health promotion work. The following comment exemplifies this viewpoint.

"It is still the case that in the inner city the focus of most health visitors' efforts is on child health promotion and surveillance. Yet this is the population with the highest mortality and morbidity. Having tried unsuccessfully to focus more on health promotion tailored to the needs of the area, I believe there is a definite case for community health visitors without traditional caseload responsibilities to concentrate on health promotion activities targeted at specific groups". [0532]
Over 50% of health visitors indicated the desire to develop new skills in group work but as discussed earlier, many needed additional groupwork skills. A small but significant number of health visitors (18%) indicated the necessity to work on a community level:

"I think health promotion should be much more political and we should be more prepared to politicise our activities especially in regards to child poverty, housing and lack of community resources". [0357]

The preceding evidence suggests that the practitioners themselves are suggesting a range of changes in the way their work is determined and organised. Similarly the practitioners are requesting enhanced or additional skills to facilitate change in their methods of working. The key question remains, will management and government facilitate that change?

Finally, a major issue to emerge from the data was the fact that over half the practitioners felt the need for confidence and assertiveness training, both individually and collectively.
CHAPTER 12

ASPECTS OF THE PROFESSIONAL STATUS OF HEALTH VISITORS

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CHAPTER 12

ASPECTS OF THE PROFESSIONAL STATUS OF HEALTH VISITORS

The qualitative phase of this research identified that the subject of professional status preoccupied a number of health professionals in the group discussions. Theme five of the conceptual framework in Chapter Five identified specific questions to be pursued in the quantitative phase of the research, these will be addressed in this chapter.

PROFESSIONAL STATUS OF THE RESPONDENTS

Status is a position occupied by a person in a system relative to others (Mitchell 1979:93). Symbolic interaction theory suggests that "an individual's statuses are his own view of his location in various systems and the assignment is made by the individual himself in the process of interaction with others" (Brooks 1972:71). Brooks also states that "status results from the way others behave towards him and the way he interprets that behaviour". (1992:71). Much has been written about the status of nurses, both in their interaction with doctors and in relation to their position in the health service, Katz (1969) for example referred to the 'caste' like subservience of nurses to doctors. Freidson, similarly stated "The nurse is typically subordinate both to the physician and to the hospital where she works" (1970:20). Mackay (1989) writing some twenty years later, quotes the response of a ward sister when questioned about her relationship with doctors.

"One doctor, I think she's very rude, her manner leaves very much to be desired -
I feel she belittles you. You know for minor things that aren't really that
important, she'll make you feel very small in front of junior staff......." (1989:44)
If, as symbolic interaction theory suggests, the assignment of status is made by the individual her/himself, it is little wonder that many health visitors in this study identified the need for assertiveness training in their continuing education. This could be partly because of low self esteem acquired through the health visitor's early socialisation, and partly because of a gender issue since the majority of health visitors and nurses are female, and they work in a traditionally paternalistic health service where much of the work they do is perceived merely as "women's work" (Stacey 1988).

In contrast to the symbolic interactionist view, Weber (1965) identifies status as a dimension of power seen by the way the organisation of society bestows different amounts of prestige or social honour on different groups. Social control is usually wielded in the interest of these status groups which are normally organised for the purpose of influencing or running the systems of the state (Cuff, Sharrock and Francis 1992). Doctors working in the health service represent a good example of a controlling status group in a system of the state which in Weber's terms seek to legitimise their power through professionalisation (Freidson 1970) and the process of medicalisation (Illich 1976) to achieve authority over subordinate groups. Even in the late 1980s after many years of professional education, Mackay cites the response of a staff nurse when questioned about relationships between nurses and doctors.

"You've trained to be submissive, really you've trained not to buck! Not to make a noise, to do everything quietly. I don't think there is enough assertiveness training in the actual training..... It's because its a very hierarchical system and the hierarchy tend to pass it down all the time (1992:42).

This perceived low status of nurses in the health service per se has been the subject of numerous accounts (Turner 1987; Stacey 1988; Mackay 1998). Currently, despite the new managerialism in the health service, relatively few nurses and health
visitors are represented in the management hierarchy even though nurses comprise the greatest proportion of the NHS workforce (DOH 1992). Government policy to introduce a change of skill mix in the NHS implies that much of the work currently done by nurses can be done by less qualified staff. Even if this were true, it still questions the existing currency of a nurse's worth. Senior executive nurses in Regional Health Authorities are among the first casualties in the Government's policy to reduce the number of staff working in Regional Health Authorities. Some chief nurses are finding themselves excluded from decision making committees (South West Thames Regional Health Authority Discussion Paper; 1993). Events such as those described above are likely to further diminish the self esteem and status of the nursing workforce and health visitors are not excepted. It is important for health visitors to feel and see that their role is valued because this is likely to give them the confidence to interact freely with their clients and with other health care professionals.

The status of health visitors in general, and relating to health promotion in particular, has been relatively high (UKCC 1986; Cork 1990; Killoran 1993). For example, in their proposals for Project 2000, the UKCC acknowledged the expertise of the health visitors in this area of work (1986:52). Whilst acknowledging that health visitors already had an involvement in and commitment to health promotion, Cork (1988) in an address to the National Standing Conference of Representatives of Health Visitor Education and Training Centres, suggested that with additional management support and more interprofessional education, the health visitor of the future could truly be a specialist in health promotion.

Four years later, how do health visitors think they are perceived by the new managers and do they feel threatened by the new market system? These questions and

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others outlined in the conceptual framework relating to professional status are now examined.

a) **DO HEALTH VISITORS PERCEIVE THEIR WORK IS VALUED BY THEIR MANAGERS?**

A number of factors affecting the position of health visitors were discussed earlier. These included the increase in recruitment of practice nurses (Ross 1992); the gradual decline of students entering health visitor education (UKCC 1992); the current changes in the NHS including the introduction of Trusts, purchasers and providers; the development of 'Project 2000' nurses and the expectation by senior managers that these nurses will be able to undertake acute and community care at the expense of traditional district nurses and health visitors. All of these factors were seen by the researcher to have the potential to undermine the self perceived status of the health visitors. The fact that 52% of practising health visitors in this research said they required confidence and assertiveness training, may possibly support this view.

At the time of the research, health visitors were part of a restructuring in the health service and, as a new managerialism was being introduced, it was considered appropriate to explore whether health visitors perceived their work to be valued by their managers. Question 18e asked respondents to respond to the statement that a health visitor's work is generally undervalued by NHS managers.

Table 12.1 (overleaf) shows that 79% of all HVs agreed with the statement that the work of the health visitor is undervalued by managers, 10% were undecided and 11% disagreed. Marginally more non practising health visitors agreed that managers undervalued the health visitor's work, but overall both groups of respondents have similar perceptions of the situation.
The fact that most health visitors perceive their work to be undervalued by managers must surely undermine their confidence and indicate a need for greater communication between management and staff. As to who their managers are, in most cases, health visitors are managed by Directors of Nursing Services (Community), some of them are qualified health visitors, some are not. In other cases, managers of health visitors are not necessarily professionally qualified. The researcher is of the view that the type of manager ie. professionally qualified or otherwise did not really matter. It was more important to identify whether the practitioners felt undervalued by managers rather than pursue the characteristics of the manager per se.

b) **DO HEALTH VISITORS FEEL THREATENED BY THE PROPOSED NEW 'MARKET' NHS?**

Question 24e asked respondents to comment on the statement that "with the implementation of the NHS White Paper, the future of the health visiting profession is seriously threatened". Although, at the time of formulating the questionnaire, the researcher was aware of reservations expressed by health visitors as to who would pay for...
health visiting services in the new market system in late 1991, the full impact of the new market system in health was difficult for many health visitors to envisage.

| Table 12.2 | Health visitors' responses to the statement that with the implementation of the White Paper the future of health visiting is seriously threatened. |
|---|---|---|
| Response | No. of Health Visitors | % |
| Agree | 277 | 50 |
| Undecided | 139 | 25 |
| Disagree | 139 | 25 |
| Totals | 555 | 100 |

\[ n = 555 \]

Table 12.2 shows that 50% of all health visitors in 1991 perceived that health visiting as a profession was seriously threatened by the Government proposals for a new market system NHS, with 25% of respondents undecided and 25% disagreeing with the statement.

Of the respondents who were either undecided or disagreed with the statement a majority had been in post for 6 years or less, although these findings are not statistically significant. To some extent one might expect recently qualified professionals to be more optimistic about the future of health visiting, particularly with a government policy of health promotion. Conversely however, one might have predicted that many more experienced health visitors would disagree with the statement that the future of health visiting is threatened, given that the role of the health visitor has been questioned many times before, and the White Paper is one of a series of issues which have been seen as likely to impact on the profession (Ministry of Health 1956; Jefferys 1965).
The fact that half of health visitors perceived that health visiting as a profession was seriously threatened, can do little for professional confidence in general and may contribute to the need for confidence and assertiveness training as identified in Chapter 11.

When asked to respond to the statement that health visitors are better placed than most nurses to practice health promotion effectively, the respondents were very positive in their replies. Table 12.3 demonstrates that no fewer than 85% of respondents felt that health visitors were better placed than most nurses to practice health promotion with only 12% of respondents disagreeing and 3% of respondents undecided.

<table>
<thead>
<tr>
<th>Table 12.3</th>
<th>Health Visitors responses to the statement that health visitors are better placed than most nurses to practise health promotion.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>No. of Health Visitors</td>
</tr>
<tr>
<td>Agree</td>
<td>470</td>
</tr>
<tr>
<td>Undecided</td>
<td>20</td>
</tr>
<tr>
<td>Disagree</td>
<td>65</td>
</tr>
<tr>
<td>Totals</td>
<td>555</td>
</tr>
</tbody>
</table>

Similarly, when asked to respond to the statement that health visitors normally perceive themselves to be leaders or potential leaders of health promotion activities in community care (Question 17e), 76% of health visitors agreed with the statement, 14% were undecided and 10% disagreed.

The fact that 85% of health visitors perceive themselves as better placed than most nurses to practice health promotion and 76% of respondents perceive their profession to view themselves as leading or potential leaders in health promotion clearly...
demonstrates a professional dilemma. On the one hand the profession considers itself to have potential leadership in health promotion, on the other hand it sees its future as seriously threatened. It appears to the researcher that some policy decisions are essential if the dilemma is to be resolved.

**PROJECT 2000: BENISON OR BANE?**

c) **WITH THE ADVENT OF PROJECT 2000, DO HEALTH VISITORS PERCEIVE THAT THE IMPORTANCE OF THEIR ROLE WILL DIMINISH?**

It is generally thought by a number of nurses and other health professionals that the Project 2000/Diploma in Nursing Education equips students to work both in hospital and community settings (UKCC 1986). From the researcher’s experience, it is frequently suggested by community nurses, community managers and some nurse teachers that these newly trained nurses will eventually take over the work of district nurses and health visitors without further training, albeit in a modified form. Much of the preparation of Project 2000 nurses for working in the community is seriously questioned by district nurses and health visitors. The idea that P2000 students could eventually replace existing community nurses (HVs, DNs, CPNs) is hotly disputed (ENB 1993:2).

Should this conjecture receive managerial and/or government support, the researcher suggests the status of health visitors will be adversely affected. As status was one of the concepts to emerge from the qualitative data, the researcher felt it appropriate to explore whether health visitors believed that, with the advent of P2000 nurses, other nurses would see the role of the health visitor as diminishing. The question (24c) put to the respondents is shown in Table 12.4 (overleaf) with their replies.

The responses show that 37% of respondents agree that, with the advent of P2000, the importance of the health visitors role will be seen by other nurses to diminish and
32% disagree with the statement. Perhaps most significant is the fact that 31% of respondents are undecided about the issue. The evidence suggests a degree of uncertainty about how other nurses are likely to perceive the role of the health visitor in relation to P2000 trained nurses working in the community.

Table 12.4 Health visitors' responses to the statement "with the advent of Project 2000 the importance of the health visitor's role will be seen by other nurses to diminish".

<table>
<thead>
<tr>
<th>Response</th>
<th>No. of Health Visitors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>203</td>
<td>37</td>
</tr>
<tr>
<td>Undecided</td>
<td>177</td>
<td>31</td>
</tr>
<tr>
<td>Disagree</td>
<td>175</td>
<td>32</td>
</tr>
<tr>
<td>Totals</td>
<td>555</td>
<td>100</td>
</tr>
</tbody>
</table>

n = 555

SUMMARY

The preceding analysis has demonstrated that as many as 79% of health visitors' perceive that their work is undervalued by managers, 50% consider that, with the introduction of the White Paper, the position of health visitors is seriously threatened, and 37% believe that, with the advent of P2000 nurses, the health visitors' role will be perceived by their nurse peers to diminish.

Despite these somewhat negative findings, 85% of respondents perceive health visitors to be the best placed nurses to practice health promotion, and to some extent the research of Gott and O'Brien (1990) supports this view. Similarly 76% of respondents perceive a leadership role for health visitors. Thus we have a potential contradiction in that health visitors perceive their role as threatened, yet at the same time they believe they are well placed and capable of leading health promotion activities. Further discussion of
this potential contradiction and the professional status of health visitors will take place in
the conclusion of this thesis.
CHAPTER 13

PERSONAL HEALTH BEHAVIOUR OF THE HEALTH VISITORS

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Health visitors' 'harmful' behaviours. 253.

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CHAPTER 13
PERSONAL HEALTH BEHAVIOUR OF THE HEALTH VISITORS

As a great deal of the health visitor's work is carried out through an individualistic framework with much emphasis on the health behaviour of individuals, the researcher thought it appropriate to explore the health behaviour of the respondents. What if anything, do health visitors do to maintain their own health? Do they for example, practice what they preach? Do they have insight regarding their own behaviour, and, what influences their actual practice in promoting their own health?

THE CONCEPT OF HEALTH BEHAVIOUR

Anderson (1988), writing about definitions of health behaviour, describes how a review of research in health behaviour, undertaken by Dowie (1975) revealed that many authors and researchers had used the term 'health behaviour' rather indiscriminantly. They had, for example discussed diverse behaviours related to illness as well as health. Anderson also acknowledged that it was Kasl and Cobb (1966) who first separated health behaviour from illness related behaviour defining health behaviour as "any activity undertaken by a person believing himself to be healthy for the purpose of preventing disease or detecting it at a symptomatic stage (Kasl and Cobb 1966:246). Anderson also suggests that Dowie (1975) made an important conceptual point namely, that until the emergence of Kasl and Cobb's (1966) definition of health behaviour, the public had always been seen as consumers of health services rather than 'producers' of health.

The question as to what influences individuals to adopt health behaviours to 'produce' health has been the subject of numerous studies (Cox et al 1987, Blaxter 1990, Becker 1974), Becker (1974), for example, attempted to explain health behaviour through a 'health belief' model which suggested that individuals only respond to a health message
if it is directly meaningful to them. According to Becker (1974) the message must either coincide with the individual's beliefs concerning health and healthcare, or, the individual's life must be threatened significantly by not taking health advice. Although modifications have been developed to enhance Becker's health belief model, Blaxter (1992:149) explains that whereas these models have had some success, for example, in relation to the uptake of screening tests, their overall predictiveness regarding general health behaviour has been questioned.

Several authors have also identified the importance of other influences such as education, socialisation, responsibility and control etc. on the way health is perceived (Cornwell 1984, Graham 1984), thus the whole issue of health behaviour is extremely complex.

In relation to health visitors, these professionals undoubtedly have knowledge about appropriate health behaviour, and a large part of their work is concerned with giving health advice to individuals, families and groups (CETHV 1977). But how do health visitors take care of their own health and what influences their actual health behaviour? Questions 19 - 21 of the questionnaire address some of these issues.

a) WHAT DO HEALTH VISITORS DO TO MAINTAIN OR PROMOTE THEIR OWN HEALTH?

All respondents were asked "What if anything do you do to maintain or promote your own health?" (Question 19). Although this was recognised by the researcher as a 'sensitive' question because of the personal nature of the enquiry, over 80% of health visitors responded, giving anything from one to five examples of their health behaviour. Table 13.1 (overleaf) shows the categories which emerge after subsequent coding of their verbatim answers.
Table 13.1 Health visitor responses to the question "What if anything do you do to maintain or promote your own health?"

<table>
<thead>
<tr>
<th>Health behaviours reported by respondents.</th>
<th>No. of Health Visitors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eat a healthy/balanced diet.</td>
<td>485</td>
<td>87</td>
</tr>
<tr>
<td>2. No Smoking</td>
<td>180</td>
<td>32</td>
</tr>
<tr>
<td>3. No alcohol or restricted alcohol intake.</td>
<td>130</td>
<td>23</td>
</tr>
<tr>
<td>4. Take regular exercise.</td>
<td>411</td>
<td>74</td>
</tr>
<tr>
<td>5. Practise stress reduction.</td>
<td>102</td>
<td>18</td>
</tr>
<tr>
<td>6. Idiosyncratic pursuits.</td>
<td>223</td>
<td>40</td>
</tr>
</tbody>
</table>

1. **Healthy/balanced diet**

As many as 87% health visitors replied to this question and all of them claimed to eat a healthy/balanced diet. Examples of the responses will demonstrate the respondents' interpretation of such a diet.

"Balanced nutrition of no fat, high fibre, fruit, vegetables" [0477].

"low fat, reduced sugar, reduced salt" [0282].

"0.5 fat milk, brown bread, low fat cooking" [0967].

"try to eat a healthy diet, low in fat, wholemeal bread, fresh fruit and vegetables, not much red meat" [0965].
"no frying, no chips, muesli, yoghurts, plenty of fruit, no puddings" [0159].

"largely whole food, organic diet, vegetarian" [0712].

Where details of a healthy diet were offered by the respondents, the main focus appeared to be on the need to reduce fat intake. A few respondents mentioned restriction of red meats and/or reduction of sugar and salt. Three respondents specifically advocated vegetarianism. A number of respondents were less informative in their responses as shown in the two examples below:

"Try to maintain a balanced and varied diet" [0188].

"sensible eating" [0900].

In the context of healthy lifestyles, many of the health visitors appeared to comply with dietary recommendations outlined by Alwyn Smith and Jacobson (1988:243). There was evidence, for example, of awareness of the need to reduce the total energy intake derived from fats, the need to increase total dietary fibre intake and to reduce sugar and salt intake. In a study of family health, Graham (1989) found that the consumption of fresh fruit, vegetables, wholemeal bread and other 'healthy foods' was significantly higher in high income families, whereas the consumption of white bread and a generally nutritionally poorer diet was significantly higher in low income families. One of the dietary recommendations in The Nations Health is "to reduce the socio-economic disparity in intake of high fibre foods and sugar intake" (Alwyn Smith & Jacobson 1988:243).
This suggests that health visitors may have a complex task in effecting long term changes in the dietary habits of some of their vulnerable families. However, since "diet before conception holds the key to health" (Crawford 1993), no one is better placed than health visitors to support mothers and their unborn infants. This is because health visitors normally visit mothers between pregnancies when the laying down of nutritional stores is most important to mother and child's health status (Wynn & Wynn 1979).

2. No Smoking/Stopped Smoking

One of the targets for health to be achieved by the year 2000 is an increase in the percentage of adult non-smokers (including ex smokers) by at least 80% (Alwyn Smith and Jacobson 1988:239). The expected outcomes for the health of women in particular, include a reduction in coronary heart disease mortality in the under 65s; a reversal in the upward trend in incidence of lung cancer among women over 55, a small contribution towards a reduction in the number of low birthweight babies and in perinatal mortality. It is also estimated that the cessation of smoking will contribute to a reduction in the incidence of stroke and coronary heart disease associated with oral contraception (Alwyn Smith and Jacobson 1988:239).

Of the 32% respondents who incorporated 'smoking' in their answers about half stated they did not smoke, and the remainder stated they had given up smoking. Whether the health visitors who said they did not smoke had ever done so is not known, but the fact that some of the respondents had given up smoking is encouraging with regard to their own health. The responses given below demonstrate typical answers from the non-smokers.

"Do not smoke" [0294].
"Given up smoking" [0920].

"I stopped smoking" [0220].

3. No alcohol or restricted alcohol intake

The government's targets for health in primary care include the reduction of alcohol consumption within each practice population (Smith and Jacobson 1988:249). Without limiting alcohol intake completely, government objectives propose to promote patterns of alcohol consumption that minimise alcohol's harm without jeopardising its benefits. Also, interestingly is that there is official recognition of the need for the type of environment which minimises pressures to drink whether at home or at work or in society generally (Alwyn Smith and Jacobson 1988:246). This suggests societal action such as recent proposals to allow families and children into pubs.

Of the respondents who included alcohol in their replies 10% claimed they simply didn't drink, while 90% of the respondents indicated self regulation of the amount consumed. Typical responses are given below:-

"limit alcohol" [0121].

"have few alcoholic drinks" [0247].

"ration alcohol intake" [0097].

"keep to recommended units of alcohol" [0987].
It is encouraging to find many of the health visitors practising what is recommended for their own health promotion. Later, in the chapter we will explore how many respondents perceive their drinking habits to be harmful.

4. Regular Exercise

A majority of health visitors (74%) claimed that they exercised in order to maintain and/or promote their own health. Physical activity is named by the Government as another target for health by the year 2000 (Alwyn Smith and Jacobson 1988:249). The health outcomes associated with physical activities for men and women include a decrease in obesity, coronary artery disease, diabetes, possibly osteoporosis and promotion of stamina, strength and suppleness in old age.

The nature of the responses identifying exercise as a health behaviour by some health visitors is shown below:-

"I walk 2 - 3 miles a day" [0927].

"exercise - aerobics weekly, swim weekly" [0134].

"play golf" [0432].

"swim regularly, 2 - 5 times a week" [0997].

"exercise 3 times a week" [0812].

"walk and attend an exercise class" [0955].
The above responses indicate to some extent the motivation of the respondents to undertake such physical activities. Whether their clients would have the time, inclination, resources (cars and money) and similar facilities at their disposal is questionable.

5. Stress Reduction

Research has shown an association between stressful life events and physical and mental illness (Kessler 1979:259-72; Sparacino 1982). Critical analysis of studies exploring the relationship between stress and illness, however, have shown that although the relationship is statistically significant it is consistently low (Rabkin and Struening 1976; Wilcox 1981).

Developments in the multidisciplinary field of stress have led to the identification of moderators of stress, these include social support (Norbeck, Linsey and Carrieri 1981), locus of control (Williams 1990), a sense of coherence (Antonovsky 1979) and other factors.

It has been shown in chapter Seven that health visitors are involved with many socially deprived and needy people. This undoubtedly places the health visitors in demanding circumstances. Other evidence in this thesis revealed that the health visitors feel undervalued by health service managers, and similarly, many feel threatened by the advent of P2000 students. These issues are highly likely to affect both the sense of coherence health visitors have with their profession and the amount of social support given to them in the work situation. It was hardly surprising therefore to find that 18% of respondents mentioned their efforts to reduce stress. The following comments are illustrative of the majority of responses.
"Practise stress reduction" [0982].

"Try to escape or deal with stressful situations" [0177].

"Avoid confrontation where possible" [0268].

"Relaxation, Yoga, Meditation" [0053].

"Know how to say 'No' i.e. avoid stress" [0302].

"Time for relaxation" [0036].

The researcher has identified likely stressors in the work situations but recognises that people have private lives which may also produce stress. This makes it very difficult if not impossible, to make further comment at this juncture on the likely causes and incidence of stress.

How health visitors might help and advise communities, families and individuals on stress reduction is fraught with difficulties because the causes of stress are both complex and multidimensional. Potential causes of stress such as poor housing, unemployment, noise, pollution can hardly be alleviated by a health visitor working in isolation from other professionals and excluded from policy decisions on health.

6. Idiosyncratic Pursuits

Forty percent of respondents offered highly individual approaches toward the promotion of their own health. Examples of responses are given below:
"avoid doctors if I can" [902].

"keep home and car in good condition to minimise safety risks" [0532].

"stay happy" [0047].

"keep an active intellect by attending German language group" [0019].

"I'm a member of the Labour Party" [0357].

"a balanced and varied lifestyle, with a single attitude towards one and all, wit and wisdom with experience, moderation in all things and a strong faith to crown it all" [0918].

"general lifestyle, limit all excesses" [0392].

Many of the responses as illustrated above, range from common sense and pragmatic approaches to philosophical and ideological responses. This demonstrates the multidimensional nature of health promotion per se. It is gratifying to find that so many of the health visitors engage in health promotion activities but how many of these professionals engage in behaviours which could adversely affect their health. What is the nature of such behaviour and why do health visitors engage in such behaviours?
b) WHAT DO HEALTH VISITORS DO WHICH MIGHT HARM THEIR HEALTH?

The first part of this chapter identified a number of health behaviours practised by the health visitors. Blaxter (1992), however, has shown that an individual's health behaviour can often be inconsistent. For example, an individual can eat wisely but smoke at the same time. Cameron and Jones (1985) have also shown that sometimes behaviours regarded as undesirable by health professionals may contribute to an individual's coping strategy. There are therefore both professional and personal reasons as to why it is important to study the health behaviour of health visitors. On a professional level it may be very difficult for a health visitor who is overweight to advise clients on weight reduction because, as a role model, she may lack credibility with clients, and possibly also with her peers. More important, however, is the possibility that some health visitors may engage in 'risk behaviours' which Kickbusch (1988) suggests "may constitute a way in which the individual can deal with conflicts that arise in everyday life and regain the physical and psychological ability to face up to them again" (1988:240). Kickbusch (1988) also identified that feelings of powerlessness are a major factor in understanding risk behaviour. This study has already shown (Chapter 11) that health visitors perceive themselves as lacking confidence and assertiveness and this may well be reflected in their health behaviour. The powerless of health visitors in being able to help many of their disadvantaged clients may also be a significant influence on their behaviour.

But what, if any, harmful behaviours do health visitors engage in? Question 21 asked the respondents "what if anything do you do which could be seen as bad for your own health?" Table 13.2 demonstrates the categories of perceived harmful behaviour to emerge from the data with the proportion of respondents acknowledging such behaviours. (The number of responses from each health visitor varied from one to four, the majority
of respondents giving two behaviours). Overall, 35% of health visitors identified harmful health behaviours. Only 3% of the respondents said "none".

### Table 13.2 Categories of self imposed harmful health behaviour(s) reported by the respondents.

<table>
<thead>
<tr>
<th>Harmful health behaviour acknowledged by Health Visitors</th>
<th>No. of Health Visitors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary Related Behaviour</td>
<td>184</td>
<td>35</td>
</tr>
<tr>
<td>Sedentary Lifestyle</td>
<td>125</td>
<td>24</td>
</tr>
<tr>
<td>Get Stressed</td>
<td>95</td>
<td>18</td>
</tr>
<tr>
<td>Adverse Environmental Related Behaviour</td>
<td>74</td>
<td>14</td>
</tr>
<tr>
<td>Alcohol Related Behaviour</td>
<td>70</td>
<td>13</td>
</tr>
<tr>
<td>Smoking</td>
<td>59</td>
<td>11</td>
</tr>
<tr>
<td>Nil</td>
<td>15</td>
<td>3</td>
</tr>
</tbody>
</table>

n = 524

1. Dietary Related Behaviours

Whereas 87% of respondents had earlier claimed to contribute to their own health by eating a healthy diet, when asked if they did anything bad for their own health as many as 35% gave diet related responses. The responses fell into a further set of categories which are elaborated below with illustrative comments. Examples of the explanations given for such behaviour accompany the answers.

a) Overeating

About a fifth of respondents admitted to overeating even though most respondents normally ate healthy foods. Examples of typical responses include:
"Probably eat too much, approximately 1.5 stone overweight".

At the risk of blaming someone else, I feel my eating habits have evolved when I was younger - I tend to pick and eat between meals [0188].

"Eat too much, even the right foods".
"Stress and habit" [0697].

"Eat too much"
I enjoy food and have been conditioned to reward myself [0138].

The above examples typify the majority of respondents who admit to overeating. The most common explanations for overeating include habit, socialisation, stress relief and eating for comfort or pleasure.

b) Eating the wrong sorts of foods

The second most common dietary related response given by 10% of health visitors included consumption of the wrong sorts of food as seen below.

"Overweight, eating cakes - especially cream cakes" [0496].

"Tend to comfort eat" [0496].

"Eat chocolates"/"addiction in stress" [0150].

"Buying snacks over the counter e.g. chocolate or crisps when not finding time for
lunch" (The reason for this behaviour was suggested below).

- Overemphasis by management to do too much routine developmental
  surveillance as well as health promotion activities - not enough time [0009].

Again the most common explanations offered for eating the wrong sorts of foods included habit, stress (mostly work related) and pleasure.

c) Being overweight

The third most common dietary related response given by 5% of health visitors was the acknowledgement of being overweight. This was clearly seen by the health visitors as harmful to health. Further examples and explanations are shown below.

"About 1 stone overweight
Full time work and 3 children = stress.
Occasional drink! (below 14 units)" [0914].

"I need to lose weight"

"I eat to relieve stress" [0586].

"I'm still overweight"

"At times of stress, I eat" [0997].

"I am overweight"

"Hurried meal at work, long periods not eating during day then eating too much in the evening" [0029].
Although the category of overweight could probably be subsumed into the "overeating" category, it is included in this analysis as yet another dimension to health. Although some of the health visitors claim to eat healthily, at the same time, some of them eat too much food, or, knowingly eat the wrong food. This supports Blaxter's (1992) view that health behaviour is inconsistent. The health visitors' explanations are multidimensional but many are work and/or stress related. This has implications not only for their own health needs, but also for their health and safety at work.

2. Sedentary Lifestyles

Earlier in this chapter 74% of respondents described exercise as one of the activities they pursued, to promote their own health. Perhaps not surprisingly, 24% of respondents explained they did not get or were unable to get enough exercise. Examples of typical responses with fairly typical explanations are elaborated below.

"Not enough physical exercise/laziness" [0927].

"Not enough exercise/back problem" [0324].

"Not enough exercise/Tiredness" [0007].

"Lack of exercise/lack of motivation" [0392].

"I could do with attending aerobics more often to improve cardio-vascular health/lack of childcare for 2 year old, whilst undertaking any activities during the day" (Bank HV) [0294].
"Lack of exercise - job too sedentary and little found time to have regular exercise. I have an hour's drive to work" [0315].

It can be seen that many of the respondents were aware of having too little exercise. The main explanations given were lack of time, lack of motivation to exercise, laziness and tiredness. Again many of these are related to the health visitor's job and how it interfaces with domestic obligations.

3. Get Stressed

Although only 18% respondents admitted 'getting stressed' as a harmful health behaviour, many of the respondents who did acknowledge this phenomenon wrote quite extensively about it. The explanations given for getting stressed related to two dimensions, namely, work-related induced stress, personal/family induced stress, and/or a combination of work stress and family commitments. Typical responses are given below.

a) Work related stress

"Don't relax sufficiently, mainly due to situation within our own profession at the moment" [0673].

"like most health professionals, I suffer from stress from time to time due to shortage of staff, lack of resources, mainly lack of good clerical help and more paperwork" [0374].

"Stress, having my job devalued and being required to do excess clerical work. Constantly nagged by top management to prove our worth with no suggestions
and encouragement as to how to do this" [0978].

"stress at work, no management support" [0053].

"Too much stress/I don't feel able to say no when taking on too much" [0980].

b) Personal/Family induced stress

"lack of relaxation, allowing anxiety to take over sometimes (all part of my longterm sickness, post natal depression)" [0153].

"high expectations of self, stress/I have difficulty in asking for help (at home or work) but I do not know why" [0910].

"I take on too much and don't relax enough" [0882].

"A desire to be active and feel guilty if I'm not" [0555].

c) Combination of work related and private stress

"Not enough quality time for me, stress of husband's job (GP), changes in the NHS, needs of my own children, step children and poor health of my own mother" [0932].

"Fail to control stress levels as effectively as I would sometimes prefer/pressures
of work, clerical responsibilities, demands of home" [0924].

"Stress, work related and financially induced" [0496].

Analysis of the stress related responses pinpoint a number of issues. First, for many practising health visitors the demands of work appear overwhelming with a lack of management support and resources recurring in the responses. Second, many practitioners find the demands of both home and work extremely difficult to combine, with the result that their health is likely to suffer. Third, some of the explanations offered suggest a tendency to victim blame themselves for not managing their stress. Whether this blame is appropriate or not is unclear and further exploration is needed. The fact that some health visitors feel so pressurised begs the question as to whether they can adequately support some of their most vulnerable families at a time of great societal change. It further begs the question who supports the supporters?

4. Environmental Hazards

Although most of the harmful health behaviours reported by the respondents were individualistic behaviours, 14% of the respondents identified environmental hazards as harmful to their health. There was little variation in these responses as the illustrations below show.

"using car so polluting the atmosphere/necessity of modern life style" [0461].

"fast cars/pollution" [0760].

"cycle in London/Co2" [0053].
"driving to work/exhaust fumes, pollution [0808].

All of the respondents in this category identified environmental pollution as a major risk to their health. The main explanations for environmental hazards were modern lifestyle and/or pleasure e.g. driving fast cars or cycling for pleasure.

5. Alcohol related harmful behaviour

Responses to question 19 regarding health promotion behaviours found that 23% of health visitors either did not drink alcohol or they restricted their alcohol intake. Responses to Question 21 enquiring about harmful health behaviour found that 13% of respondents identified a problem which was alcohol related. Examples of responses are given below with attached explanations for this behaviour.

"Drink 14-21 units of alcohol - working too much - sleep disturbance".

"I get tired and irritable because I work very hard. I work hard because it raises morale to see things happen. I won't lie down with the rest. Because I get tense I drink 2 glasses of wine, then I get mad because I've let myself down health wise" [0082].

"I could easily drink too much wine/alcohol if I didn't keep a check on myself especially after a hard, emotionally draining day at work/stress in the work situation" [0134].

"Drink too much alcohol/bad habits" [05231].
"Drink alcohol - lifestyle of busy working mother, encouraged by NHS management to do too much in too little time" [0361].

As with many of the other perceived harmful health behaviours the main explanations for alcohol related problems included stress at work.

6. Smoking

Whereas 32% respondents claimed earlier that one of their positive health behaviours was that they did not smoke, 11% of respondents admitted they did smoke and they perceived this as harmful to their health. Other health visitors may have smoked, but did not admit it as a harmful health behaviour. The responses were all fairly similar and these are illustrated below.

"Smoking/stress" [0421].

"Smoke/addiction, character weakness" [0493].

"Smoke/7 children, previously widowed not much personal time" [0323].

"Yes I smoke/habit" [0091].

"Smoking (15-20 cigarettes per day)/I started smoking at age 22 when I started nurse training - don't like to analyse reasons for this. I seem to smoke more when under stress, also to care less about whether I have more to drink then. I have to
As with explanations for other categories of harmful health behaviour, reasons given for smoking behaviour include stress, character weakness, enjoyment, habit, and personal circumstances. Although nearly all explanations suggest an individualistic reason for such behaviour, many of the comments reflect the constraints of the health visitors' working lives and their methods of coping are similar to those found by Graham (1984) in her study of Women, Health and the Family. A recurring phenomenon in the responses was 'the need for quality time and more space'. Only two respondents identified reasons for their behaviour outside their own locus of control. These responses are shown below.

"Overeat/too many adverts/media generally of attractive and tempting recipes"

[0697].

"Probably drink too much - awareness of the state of the world" [0619].

c) HEALTH VISITORS' HEALTH BEHAVIOURS COMPARED WITH CAUSES OF ILL HEALTH IDENTIFIED BY MEMBERS OF THE PUBLIC

Blaxter, writing about self definition of health status states "it is difficult to frame simple questions with no possibility of bias in either direction" (1985:151). The survey subjects in this research were therefore asked about their health behaviours in both positive and negative ways (Questions 19 and 21).

Although one cannot make direct comparisons between the responses given by health visitors in this study and those given by members of the public in Blaxter's (1985)
study (because questions put to each set of respondents were different and because of time lapse between the studies), the similarities and differences between the two groups are still worthy of observation and comments. Questions posed by Blaxter (1985:150) included "What do you think are the things in life nowadays which are most harmful to people's health?"; and "What do you think are the most important things in keeping yourself healthy?". The questions put to health visitors were "What if anything, do you do to maintain or promote your own health?" and "What if anything, do you do which could be seen as bad for your own health?". The health visitor questions relate to the respondent's own health and are multi answer. The questions posed by Blaxter (1985) relate to 'main causes of ill health' and sum to 100%. Table 13.3 (overleaf) shows positive and negative health behaviours reported by members of the public and health visitors as causing health or ill health.

Analysis of Table 13.3 (overleaf) reveals some interesting points. First, and importantly, the health visitors responded in a similar way to members of the public in that they identified predominantly physical behaviours (Some respondents did identify environmental issues but very few i.e. 2%). It is suggested that the reasons for both groups identifying physical behaviours is partly due to increased media attention on these subjects, partly due to the medicalisation of health which tends to focus on body matters, and partly due to the individualisation of health care which reverts the onus of health on to the individual.

Secondly, in her study, Blaxter (1985) explained that although her survey subjects had clearly received health education messages about diet, alcohol abuse, smoking and exercise, they appeared generally less aware of health issues such as pollution, stress and food additives. This was not entirely the case with health visitors, because 18% of the
respondents identified stress/stress reduction as a major potential cause of their own ill
health/health.

<table>
<thead>
<tr>
<th>A. Behaviour thought to cause health</th>
<th>Respondents mentioning as a cause of health</th>
<th>B. Behaviour thought to cause ill health</th>
<th>Respondents mentioning as cause of ill health</th>
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<td>Smoking</td>
<td>MGP 61 HVs 11</td>
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<td>MGP 19 HVs 13</td>
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<td>Health Diet</td>
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<td>Exercise</td>
<td>MGP 45 HVs 74</td>
<td>Lack of Exercise</td>
<td>MGP 10 HVs 24</td>
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<tr>
<td>Anything in moderation</td>
<td>MGP 7 HVs -</td>
<td>Anything in Excess</td>
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<td>Stress Reduction</td>
<td>MGP - HVs 18</td>
<td>Stressful Lifestyle</td>
<td>MGP - HVs 18</td>
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<tr>
<td>Totals (n)</td>
<td>MGP 211 HVs 485</td>
<td></td>
<td>MGP 211 HVs 485</td>
</tr>
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</table>

Code:
MGP = Members of the General Public

Thirdly, and of note is the difference in response of the two groups in relation to
smoking/non smoking. Whereas 61% of the general public respondents identified smoking
as a cause of ill health in general, only 11% of health visitors reported that behaviour in
themselves. This is probably because the survey subjects in Blaxter's study were only
questioned about their knowledge of the causes of health/ill health, whereas the
health visitors were asked to divulge their own adverse health behaviours. Also of significance is that whereas only 5% of Blaxter's respondents identified non smoking as a cause of good health, as many as 30% of health visitor respondents identified non smoking as contributor to health.

Finally, although 10% of Blaxter's sample identified illegal drugs as a cause of ill health in general. Drugs were not mentioned by health visitors in relation to their own health. There the difference in question wording has had an important effect on the results.

SUMMARY

In conclusion this Chapter has demonstrated that many of the health visitors attempt to pursue a healthy lifestyle. Despite their aspirations, about a third of the respondents also engage in one or more health behaviours which they perceive as potentially harmful to their own health. It is clear from these responses that many working health visitors appear to be under domestic and work led pressures. For these women, one must appreciate the difficulty of changing these element of their own lives, and, similarly of those of their clients. These findings draw into question a simple health knowledge, health belief model. As Kickbusch suggests, such health behaviour may well reflect a feeling of powerlessness (1988:241).

Since the publication of the Health of the Nation (DOH 1992) health promotion initiatives are being planned and/or implemented. Frequently, these programmes are focused at the individual, to some extent reinforcing blame and guilt which many smokers, drinkers, overweight persons and others express. Perhaps by identifying causes for overweight, smoking and drinking, etc. rather than just identifying symptoms of these harmful behaviours, other health promotion strategies and approaches could be
developed. These might include the formation and support of more self-help groups and the development of more effective preventive services for health and social issues identified both by the public themselves and by local needs analysis.

A number of surveys have shown that the public would favour more government intervention particularly in policies such as prohibiting smoking in public places, banning the sale of alcohol at various functions, regulating the amount of fat and sugar in prepared meals etc. (Roberts & Smith 1987:1230).

In the case of the health visitor per se the findings in this research suggest that the health promotion of health visitors themselves needs to be tackled both on an individual and structural level. Very few health promotion opportunities exist for health workers within the National Health Service, for example when compared with the expansion of gymnasiums and provision for corporate membership of health farms/sports clubs in the private sector. Perhaps this is because the largest proportion of workers in the NHS are women, whereas, the private sector, at least until recently, has comprised more men.

This research has shown that on an organisational level health visitors perceive that they get little managerial support in their work. It is suggested that considerable organisational change is needed if the health visitor is to be alleviated from some of the stressors of health visiting. Stress in the workplace will be elaborated in the concluding Chapter.
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CHAPTER 14

OBSTACLES TO HEALTH PROMOTION PRACTICE

The final theme in the conceptual framework (Chapter Five, Figure 5.2) addresses the proposition that health visitors experience certain obstacles which prevent them from practising health promotion activities. The discovery of a 'vocabulary of complaint' in the qualitative part of the study was discussed in Chapter Four and it was decided to explore whether health visitors currently perceive any obstacles which might inhibit or preclude health promotion activities.

The concepts of 'obstacles to health promotion' and 'vocabulary of complaint' are not seen by the researcher as the same thing. It is suggested however, that there could be an association between them, for example, if practitioners experience obstacles which hinder or obviate their work, then job satisfaction may be adversely affected, thus precipitating a vocabulary of complaint. Much will depend, however, upon the nature, number and magnitude of such obstacles as to whether a vocabulary of complaint will ensue or not. Conversely, it could be argued that if staff frequently complain about various aspects of their work, then they are more likely to incur obstructions which could adversely affect job satisfaction. (A person who moans incessantly about running clinics for example may receive little help from colleagues, thus the moaning is reinforced).

The purpose of this part of the research was therefore to elicit whether health visitors do perceive any obstacles to their health promotion activities, and if so, what the nature of those obstacles might be.

Health visitors were asked "What are the main difficulties you have encountered, or anticipate in the future in developing health promotion in practice? (Question 15). Table 14.1 shows the types of obstacles perceived by health visitors as likely to hinder the development of health promotion practice. The categories are not mutually exclusive,
as in many cases, more than one response was given by the health visitors. Also, the
categories of responses are often interrelated. Sixty five percent of practising health
visitors replied to this question, only one respondent declared that she perceived no
obstacles to practising health promotion.

Table 14.1 Obstacles perceived or anticipated by practising health visitors in
developing health promotion in practice.

<table>
<thead>
<tr>
<th>Obstacles perceived or anticipated</th>
<th>No. of Health Visitors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too little time</td>
<td>255</td>
<td>65</td>
</tr>
<tr>
<td>Too few resources</td>
<td>207</td>
<td>53</td>
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<td>Workload</td>
<td>113</td>
<td>29</td>
</tr>
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<td>Health Authority Policy</td>
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<td>33</td>
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<td>Non-cooperation by the public</td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
<td>7</td>
</tr>
</tbody>
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n = 391

1. TOO LITTLE TIME AVAILABLE

As shown in Table 13.1, 65% of practising health visitors stated that, in the
context of their current work, they had too little time to devote to the development of
health promotion. Examples of typical responses are given below.

"Not enough time" [0285].
"Finding adequate time" [0990].

"Lack of time, due to caseload commitments" [0331].

"Time, being available regularly each week, - no relief for holiday or sickness, therefore continuity difficult" [0760].

"Lack of time to prepare programmes adequately" [0120].

"Lack of worktime, most organisation is done in own time" [0423].

About 30% of the respondents who identified time as an obstacle to health promotion mentioned the size of their caseloads, their caseload priorities or overall workloads. About half of the respondents gave no particular explanation for the lack of time. About 10% mentioned they had no worktime for the preparation of group work, publicity materials or public speaking.

2. **Too Few Resources**

Over half, (53%) of the practising health visitors complained of lack of resources for health promotion practice. The nature of the shortage of resources fell into three main types; staff, equipment and funding. Some respondents gave one of these examples, some two examples, and some gave examples of all three types of resource deficit. Typical comments include:

a) **Staff shortages**

"Staff shortages, prioritising is ineffective due to lack of courage in cutting out
"Commitments" [0987].

"Shortage in staff" [0285].

"Lack of staff, lack of resources, lack of time" [0360].

b) Equipment

"Obtaining video's etc" [0472].

"Cut backs on literature from Health Education Departments" [0787].

"Lack of health promotion materials, no back up ie. technicians, lack of health visitors" [0607].

c) Funding

"Without more recognition of social conditions and more finance from Government, health promotion is like putting a plaster on a cut and not removing the object that caused it" [0061].

"The Government and local managers should not pay lip service but facilitate and make resources available for health promotion" [0104].

"Lack of Government funding - a political issue. The Government gains vast amounts of revenue from cigarettes and alcohol, both associated with heart diseases and other illnesses costing vast sums of money" [0702].
“Funds will be made randomly available by Government for some concerns e.g. AIDS, coronary heart disease etc. but how can the extensive generic health promotion work carried out by health visitors be measured, valued and financed?” [0242].

These responses also suggest that the government lacks commitment to health promotion except in those areas which have strong lobbyists and pressure groups, eg. AIDS and Heart Disease. It can also be seen from the examples above that the health visitors’ responses cover individual, organisational and political perspectives, issues which will be revisited at the end of this thesis.

3. WORKLOAD

To some extent, the category workload, overlaps with the category too little time. Workload, however provides more insights into the working context of the respondents as the examples below demonstrate.

"Heavy caseload commitments" [0987].

"Main difficulty is time and the pressures of managing caseloads and the work this generates - planning, setting up and cultivating groups" [0309].

"With such a large caseload there is lack of time for organisation and preparation" [0006].

"Increasing demands, busier caseloads and picking up work from other
colleagues, health visitor cuts, increasing numbers of child protection issues"

A number of the responses incorporating pressures of workload make reference to cuts in staff, existing staff taking on more responsibilities, and/or the additional complexity of the workload. It is difficult to analyse these comments and put them in context since current statistical data available to the public from the Department of Health on the nursing workforce do not differentiate between nurses, midwives and health visitors except in the case of total entrants to training.

Given the steady decline of entrants to training over the past few years (UKCC 1992), and the normal attrition rate of health visitors, through retirement, resignation and redundancies, it does seem that fewer health visitors are being expected to undertake a similar volume of work to that which would have been undertaken with a full complement of staff. So perhaps their complaints are justified.

4. HEALTH AUTHORITY POLICY

As many as 39% of respondents identified their Health Authority Policy as a major obstacle to the development of health promotion. Responses encompassed a variety of perspectives which are discussed below.

One of the most frequently mentioned problems was the role/relationship between the health authority's health education/health promotion department and the health visitors. This issue is elaborated later in this Chapter. Another concern was the perceived failure of health authorities to recognise, promote and manage change in existing working practices to allow health promotion in group/community form to happen. A third issue to emerge was recognition by health visitors that in many cases,
there appeared to be no clear health promotion policy at all emanating from management.

Examples which typify these various issues are given below:

a) Role of Health Education/Health Promotion Departments

"The Health Promotion department is not geared to community health promotion" [0077].

"Poor support from local health education department who are chronically sort of funding" [0031].

"Insufficient support from management, lack of backing from Health Promotion Department" [0834].

The first example above raises certain questions. If a health promotion department, as in this case, is not geared to community health promotion what is it geared to? The researcher suggests that current cut backs and staff shortages may prevent any expansion or diversification of the health promotion department's work. Alternatively, it could be that HPOs are having to focus on Health of the Nation (DOH 1992) targets which tend to require medicalised approaches rather than community action. The fact that some health visitors perceive they get little support from HPOs may be due to lack of resources per se, HPOs having other priorities, or animosity between HPOs/HEOs and health visitors. A minority of respondents (10%) specifically mentioned professional rivalry between the HEO/HPOs and health visitors as a reason for lack of support for health visitors from HEO/HPOs. The following comments crystallise the views held by respondents.
"My experience of Health Promotion Departments is very poor. They appear to be too protective of their own knowledge and resources. If they were more open and accessible - not only to professionals, but also to the general public, then maybe we would start to get the message of health promotion across". [0286]

"I sometimes feel that Health promotion Departments have taken over so that health visitors feel undermined. Encouragement and support is lacking when health visitors want to do a project. I feel there is a lot health visitors would do in Health Promotion but at times do not make their voices heard". [0358]

"Health Promotion Unit appears to think it has exclusive access to clients. Very poor at providing useful tools for us. No longer acting as a resource to us but as a separate entity". [0870]

"I feel that there is too much friction between HPOs, health visitors and other nurses. A positive cohesive approach from a united community staff must be encouraged". [0936]

"In some cases there is an uneasy relationship between health promotion departments and health visitors. Health promotion departments sometimes want to decide what health promotion activities should be carried out by health visitors and are reluctant to support health visitors who have identified local health needs and want to set up a programme/or other health promotion initiatives. This is further complicated
when health promotion departments are part of the purchaser division. Whether health visitors are practice or GP based has a strong influence on whether they focus on community health issues (patch health visitors) or individual issues related to disease or age, or sex (GP based). [0207]

The fact that professional rivalry was specified by about 10% of health visitors is not really surprising. In a recession when jobs are threatened occupational groups tend to be even more protective of their roles than usual. Furthermore as Friedson (1970:153) suggests "the occupation being the source and focus of his commitment, the individual is naturally concerned with the prestige of the occupation and its position in the class structure and in the market place". The researcher contends that whereas the two professions worked relatively co-operatively in the past, the new market style NHS now threatens collaboration, as jobs may be at stake if particular expertise is shared. It could be argued that the very nature of the market place creates competition which in turn prevents collaborative working within and between professions. Regrettably this is often to the detriment of individuals, groups and communities whom the professions claim to serve (Friedson 1970).

The illustrative comments above, suggest that some health visitors perceive Health Promotion Departments merely as resource providers. The fact is that HPOs have their own agendas, as demonstrated in the Health Education Authority Operation Plan 1992/94 (HEO 1992). Both groups of professionals now find themselves in the market place and a key question is whether purchasers will buy health promotion from health promotion departments, health visitors, practice nurses, school nurses a combination of these, or from whom?
With GPs as the fundholders for health promotion it is likely that some HPOs see health visitors in an advantageous position, partly on account of their nursing background and their general acceptance by GPs, and partly on account of territorial advantage, many health visitors being general practice based for their work. HPOs may also feel vulnerable in the light of recent Government policy proposing the withdrawal of funds from AIDS prevention which many HPOs are employed to do. Whilst both health visitors and HPOs are busy being protective of their own roles, the recruitment of practice nurses continues (Ross 1992, DOH 1992), and it seems to the researcher that by working together health visitors and HPOs could achieve far more in terms of both community orientated health promotion and professional development then they can by fighting from similarly entrenched positions.

In the end, however, as respondent [0207] suggests, the workbase of these professionals and their position in the purchaser/provider divide may well be the major determinants of how and where these professions develop their health promotion work.

b) Failure to promote/manage change towards health promotion

Of the 39% of respondents who identified health authority policy as an obstacle to health promotion, 15% of health visitors specified the failure of health authorities to promote or manage change towards health promotion. This assertion probably reflects not only the structural organisational and managerial constraints of the NHS per se, but also on a micro level the managerial elements of the health visiting profession. Typical comments from health visitors serve to illustrate this proposition.

"Biggest problem is the curative face of managers in the NHS" [0492].
"Red tape by management restricting branching out" [0597].

"In management priorities health visiting practice is still mainly with under fives" [0281].

"Told by management that we (HVs) must meet epidemiological needs of an area - indeed do a practice profile - but requirements of the 0-5's still paramount and nothing much changes at present. Minimal inservice training, negative support by managers" [0669].

"Nurse managers appear anxious that health visitors in the area follow guidelines somewhat traditionally, i.e. eighteen month checks, newborn visits, screening, having a rather negative attitude to changing the approach to health and health issues" [0435].

The comments above illustrate precisely the assertions made by Harrison, Hunter & Pollit (1991) in Chapter 2 that the NHS is essentially a sickness service. Despite the advent of the Health of the Nation (DOH 1992) and the NHS and Community Care Act (1990) a shift in the allocation of resources within the NHS from the acute sector to primary care and health promotion has not yet happened. This is not to say that a shift of scarce resources is easy for any Government. The current concern of particular groups to preserve and maintain entities such as Harefield Hospital, the traditional teaching hospitals, etc. is politically, professionally and perhaps morally, perfectly justified. Conversely, in a nation which has limited resources, there is surely equal justification in seeking to promote health and thereby avoiding some of the costs of curative care. The
central question is how to provide sufficient cost effective cover for both preventative and curative care. The researcher suggests that a shift away from medical dominance of preventive care would allow any Government more flexibility at a reduced cost. This would, however involve a transfer of power away from the medical profession to the semi professions, namely, nurses (district nurses, health visitors, nurse practitioners), HPOs and others.

On a micro level some of the comments above draw attention to the organisation and management of the health visiting profession per se. The fact that the profession is predominantly organised and managed to deal with under fives and their families in a largely individualistic manner clearly prevents innovations in health promotion activities. This issue will be addressed in the concluding Chapter.

c) Perception of Health Authorities having No Policy for Health Promotion

Whereas 15% of health visitors perceived the role and function of their local health promotion departments in a negative way overall and 15% of health visitors suggested an inability of health authorities to promote/manage change towards health promotion, a further 9% of health visitors perceived their health authority as having no health promotion policy at all, at least not in relation to health visiting. The following examples are illustrative of the health visitors responses.

"There is no clear indication of management policy on health promotion and very little encouragement from management" [0259].

"Health Authorities see no need for a health promotion policy for health visitors as health promotion is usually seen to be done by health education department"
"We are politically in a transition stage. Not knowing what the outcomes will be, therefore the structure is unstable so forward planning is difficult" [0281].

"Management is not serious about supporting it" [0022].

"The Green Paper "The Health of the Nation" stresses the importance the Government places on health promotion but I don't see any evidence of them putting their money where their mouth is. We are still a Cinderella service and until that changes we won't realise our potential. Along with this major changes in social policy will be needed for health promotion to achieve maximum benefit" [0036].

With reference to health authority policy, which normally embraces the role of health promotion departments, management of change towards health promotion and health authority strategies for health promotion per se, it can be seen that these three issues are very much interrelated. If, for example, a health authority is reluctant for whatever reason to support changes in existing health visiting organisation and practices, it follows that they are unlikely to have a policy or operational strategy to support the role of health visitors in community orientated health promotion activities. As suggested in one of the examples given above it could be that managers perceive health promotion as solely the work of health promotion departments, perhaps because it appears more visible to them.
5. NON-CO-OPERATION BY HEALTH CARE PROFESSIONALS AND OR BY MEMBERS OF THE PUBLIC

A number of the practising health visitors identified non co-operation either by members of the public (7%), or by other health professionals (such as GPs, district nurses and practice nurses), as an actual or potential obstacle to health promotion. Difficulties with these professionals were perceived by 33% of health visitors. Some of the responses suggested reasons for non co-operation. Examples of typical responses are elaborated below followed by further discussion. Comments on practice nurses per se are discussed later in the Chapter.

a) Perceived non co-operation by health care professionals (excluding practice nurses)

"Peer group suspicion and almost disapproval" [0259].

"GP wants to be involved but wants to employ own staff who are not necessarily skilled in this area" [0102].

"General disinterest by some GPs. Restrictions of new GP contracts" [0412].

"Staff co-operation in maintaining health promotion activities and also in trying to maintain some uniformity in various policies e.g. weaning etc." [0441].

"Co-operation from other community nurses" [0165].

"Support from other colleagues" [0331].
Much of the evidence attached to the responses regarding non-cooperation by health care professionals, seemed to suggest an expectation or desire by these respondents that all professionals should be involved in health promotion activities. One respondent summed up the majority of views saying: -

"I strongly feel that health visitors should be part of a co-ordinated community initiative especially in relation to Health Disease Prevention, AIDS etc" [0466].

It is interesting that on a conceptual level a fifth of practising health visitors identified a need to work collaboratively with other health care professionals. The health visitors may have recognised the complexities of achieving health promotion outcomes, as indicated in Chapter 13. They may also have recognised their own inability to progress their work because of organisational constraints, or perceived the negative influence and restrictions of the existing division of labour and its consequent rigid definition of roles and responsibilities. The researcher can only speculate possible explanations for the given responses.

b) Perceived non co-operation by the Public

A small but significant number of respondents (7%) saw individual or public disinterest as an obstacle to health promotion. The examples below are illustrative of typical comments.

"People are reluctant to come out in the evenings after dark to attend sessions".

[0359].

282
"Lack of interest by general public, those who are most at risk of ill health rarely take up opportunities available to them" [0085].

"Motivating the client" [0491].

"Are people reaching saturation point regarding health promotion?" [0056].

Whereas the above comments could be regarded as individualistically orientated, some respondents are very aware that the individual might be a victim of circumstance as the following example demonstrates.

"It is often a very apparently unrewarding task working with groups and individuals who have no desire to change to a health lifestyle, or are unable to do so for reasons such as unemployment and poverty" [0184].

The perceived non-cooperation by the professionals and the public may also be related to the other variables identified by the respondents as obstacles to the development of health promotion.

6. OTHER OBSTACLES TO HEALTH PROMOTION

A small group of respondents identified other obstacles to the development of health promotion in their work. The most common 'other' response was-

"conflict between the practice nurse and health visitor" [0098].

"the practice nurse" [0261].
The developing role of the practice nurse in health promotion was perceived as both an obstacle and threat to the health visiting profession by 5 of the respondents. The fact that the practice nurse was perceived by some health visitors as an obstacle to them developing the health promotion aspects of their work is hardly surprising given the number of GPs employing practice nurses to undertake the health promotion activities in their surgeries.

Other obstacles identified by 2% of health visitors included language barriers, social conditions, and family health beliefs.

SUMMARY

In conclusion it has been shown that many of the health visitors do perceive a number of obstacles to the development of health promotion practice. Workload, perceived shortage of staff, health authority policy or lack of policy, and lack of co-operation, sometimes by staff, sometimes by clients are seen as the key problems. Another area of concern is the perceived rivalry between health visitors and HEOs/HPOs. As many of these problems are related to other findings in this thesis many of the issues identified in this chapter will be revisited in the conclusions in the final Chapter.
### PART SIX - CONCLUSIONS

#### CHAPTER 15

**HEALTH PROMOTION - WHOSE RHETORIC IS IT ANYWAY**

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HEALTH PROMOTION - WHOSE RHETORIC IS IT ANYWAY?

The final chapter sets out to integrate and discuss the main findings of the research, embracing four themes. The first theme will contextualize health promotion within current political ideology. The second theme will use the research findings to discuss the present position of health visitors in relation to their existing work and the development of health promotion. The third theme will revisit the health behaviours of health visitors. The final theme attempts to answer the question posed in the introduction to this thesis: health promotion - whose rhetoric is it?

HEALTH PROMOTION IN THE CONTEXT OF CURRENT POLITICAL IDEOLOGY

Political dimension refers to "the existence in any group of human beings of power relationships that influence (in a very significant although not exclusive, manner) the behaviour of individuals, groups, communities or nations" (O'Neil 1989:222). This section will consider the power relationships of both the government and the medical profession in their apparent efforts to promote the 'health of the nation'.

In Chapter Three it was shown that over the last decade, definitions of health promotion have both proliferated and expanded. No attempt was made earlier to discuss theoretical perspectives of health promotion because the researcher wanted to examine the perspectives offered by practitioners rather than theoreticians. The first part of this chapter will attempt to address issues of health promotion from an operational perspective and theoretical perspectives are examined later.

From an operational standpoint, at its most basic level, health promotion depends on whether one pursues an individualistic or structuralist (fiscal/economic) approach to health. Numerous attempts have been made by academics, pressure groups and others to
convince Governments of the links between health and societal issues such as housing, occupation, parenting and industrial/environmental pollution (Townsend and Davidson 1982; Whitehead 1987; Conway 1988). Whilst it could be argued that the government has not totally ignored this evidence, it can be seen through recent policies that government has chosen to promote an individualistic approach to health and health promotion (DOH 1991).

WHY SHOULD THE GOVERNMENT PROMOTE AN INDIVIDUALIST APPROACH TO HEALTH PROMOTION?

From a structuralist perspective there is already much evidence to suggest an ongoing dismantling of the National Health Service (DOH 1989a, DOH 1989b). The new market style NHS is dependent upon contractual arrangements between purchasers and providers and the amount of money available to purchasers, although currently regarded by many as insufficient (Keen 1991), is likely to diminish further as a consequence of government attempts to curb public sector borrowing. Resources are thus diminishing while demand is increasing, how then can government divert demand? Perceiving the individual as the focus for health not only places blame on the individual for getting into a negative health state to begin with (Crawford 1977), but, it now also identifies him or her as less worthy of treatment in the hierarchy of demand. Although so far, only one consultant, has publicly announced his refusal to treat a patient who smokes, the message is clear, namely that people who smoke, drink, overeat, indulge in addictive behaviour, or indulge to excess, no matter for what cause, may all be viewed as responsible for their ill-health. It follows therefore that they could, in future, be disenfranchised from some aspects of health care, thus saving government money. Put in the context of monetarist philosophy there is every reason for the government to pursue an individualistic approach to health promotion in that it is a potential money saver.
Another reason why the government should promote an individualistic approach to health promotion is because it diverts public attention away from societal dimensions of ill-health such as poverty, poor housing, industrial and environmental pollution. Instead, attention focuses on the ability or inability of the individual to look after him/herself. Furthermore, not only are health behaviours such as healthy eating, weight reduction and exercise regimes being prescribed by government and the media, but also, many individuals are being persuaded, via advertisements in local and national newspapers, to pay for their own health care through private insurance. Monetarists would argue that if more members of the public subscribe to private health insurance schemes, then more money becomes available to spend on those who cannot afford such protection. The researcher contends, however, that even if money did become available because of an increased uptake of private health insurance it would most likely go back to the acute sector. It is suggested that the reason for this, is because of the emotive nature of illness and the political sensitivity which would result from government ignoring it.

HOW DOES GOVERNMENT PROMOTE AN INDIVIDUALIST APPROACH TO HEALTH PROMOTION?

It could be argued that the political decision to place funding for health promotion in the hands of general practitioners has reinforced a number of government policies. First, giving GPs the responsibility for health promotion ensures that health care professionals, including practice nurses, district nurses, and health visitors will remain subordinate to the medical profession. The most recent publication, New World, New Opportunities (NHSME 1993) confirms this by proposing commitment of all community nursing services to GP management. Not only will management by GPs reduce the autonomy of these professionals, but it will also confine health promotion activities to medical parameters of care, the very opposite of what was intended in the World Health
Organisation's initial pronouncement on health promotion (elaborated in Chapter Two). GP management is also likely to limit further professional specialisation by community nurses except in areas acceptable to the medical profession, such as issues emanating from the GPs practice list. Any reduction in autonomy and/or curtailment of specialisation is likely to deskill the profession and contribute significantly to the deprofessionalisation of these workers (mostly women). In economic terms, deskillling of the profession leads to reduced training needs, and subsequently to lower wages (a requirement of current economic policy). Thus the medicalisation of health and nursing care supports and promotes the government policy of deprofessionalisation of the semi-professions, and individualism practised by the medical profession promotes the depoliticisation of health. Both trends clearly suggest an ideological stance to conserve the present social order.

THE CURRENT POSITION OF HEALTH VISITORS IN RELATION TO HEALTH PROMOTION

It was shown in Chapter One that health visitors have long been anxious about their role and function. Goodwin (1988) outlined some imperatives for change if the health visiting profession was to meet the health care needs of the 1990s and beyond. Although Goodwin did not refer to health promotion specifically, she did suggest that the WHO Targets Health for All by the Year 2000 (WHO 1985) should form an agenda for action in the way health visiting prepared itself for the future. Where appropriate the researcher will discuss the key findings from this research study in the context of Goodwin's imperatives for change. It is suggested that such analysis will help to explain why health visitors find themselves in the position they are in and how it impacts on their role in health promotion.
One of Goodwin's (1988) imperatives for change was health visitors' preoccupation with traditional, routine child centred home visiting, also, the need for health visitors to respond to other client groups and changing patterns of disease. Chapter Seven of this research explored the work background of health visitors and their mode of practice. Predictably, 88% of practising health visitors identified visits to under fives as a health visiting priority. Whilst visits to the under fives fulfil an important function in terms of providing services such as parent support, development assessment, and nutritional advice to families, a health visiting focus on this particular age group is seen to preclude role expansion or diversification in areas such as health promotion and community profiling. However, a wide range of other priorities were identified supporting the findings of a number of researchers that health visitors are less restricted to the under fives than most critics believe (Marris 1971, Clark 1973). The fact that 60% of health visitors were involved in community defined activities such as self help groupwork, market stalls, and health campaigns (Table 7.8), illustrates this.

An explanation for the health visitors' preoccupation with under fives is complex but the following reasons are suggested. First, the increased occurrence of child abuse and the requirements of the Children Act 1989 have made visiting the underfives not only a professional priority but also a managerial imperative. Secondly, many mothers with young children are in need of advice and support, many are physically, socially and/or emotionally vulnerable and therefore on a personal relationship level, it makes it very difficult for health visitors to reduce or withdraw their services. The researcher suggests that until structural changes are implemented by managers to support the development of new initiatives, the priority of visiting the underfives is likely to continue.

Barker (1993:202), describes how a health visiting manager, has proposed three areas of activity for health visitors, namely, public health, child health surveillance and
crisis intervention work. This Director of a university based, early child development unit, has also suggested that health visitors should specialise and work either as practice health visitors employed by fundholding GPs, or as community health visitors employed by Family Health Service Authorities (Barker 1993:203). Even now, the notion of a community health visitor is questionable, particularly if, as discussed earlier, GPs are to manage health visitors' work and influence its direction.

In Chapter Seven, the researcher identified that 86% of health visitors were already either health centre or general practice based. Taking this into account, it is difficult to imagine how health visitors can respond to other client groups and changing patterns of disease unless they can be given more time to spend in local communities with self help groups and other potential consumers of health care. The researcher is of the opinion that health visitors will only be able to address new client groups comprehensively, and tackle different types of disease if they return to local authorities where their workload can be based on the social and epidemiological needs of local communities as Cumberlege (1986) and Goodwin (1988) suggest.

Another imperative for change identified by Goodwin (1988) was the inexorable demands of existing workloads. This research confirms not only the unmanageable size of some health visitor caseloads, but also, the demanding nature of the work itself. Nearly half of the sample held cards for 300 families or more. Evidence from the health visitors' priorities showed that in addition to having responsibility for large numbers of clients, health visitors were involved with some of the most socially deprived, physically/mentally disabled and potentially vulnerable individuals, families, and groups in society. This applied particularly to many of the health visitors working in inner city areas some of whom described their jobs as "routine crisis work", evidence which supports Goodwin's (1988) assertion that the relentless workloads of health visitors have to change before any variation in their work patterns can be established.
In relation to health visitors mode of practice, findings reported in Chapter Eight revealed that 39% of health visitors rated their approach as "individualistic", 44% claimed to use both community orientated and individualistic approaches and only 17% rated their performance as community orientated. These claims were borne out by the examples of health promotion activities given by the practising health visitors and reported in Chapter Ten.

Evidence that health visiting work patterns can vary according to caseload size and location was discussed in Chapter Eight where it was shown that health visitors working in rural communities were more likely to view community/client led activities as a priority than health visitors working in other locations. The fact that 60% of all practising health visitors prioritised client led or community defined activities in addition to their traditional routine work is reassuring.

The imperative to change workloads raises a host of questions, in particular what happens to those vulnerable individuals, families and groups if the health visiting service is reduced or withdrawn? Who decides on new health visiting priorities and how can a change in orientation be managed and implemented? Who, if anybody, will pay for a restructuring of the health visiting service (apart from its clientele)? Quintessentially, a restructuring of the health visiting service based on the WHO's vision of the Ottawa Charter e.g. group empowerment, intersectoral collaboration, does not really fit with current government policy, as suggested in the latest Department of Health publication (NHMSE 1993). Although an extension of clinical autonomy and professional scope of nursing, midwifery and health visiting practice is advocated, there is no directive or discussion on the management of nurses, midwives and health visitors. If health visitors are to respond to the challenges of health promotion then strong nursing/health visiting leadership is required to identify and implement preventive and health promotional policies and services, but this is not happening.
It is recognised that all of these questions are posed on the assumption that health visiting will continue, although several indications suggesting otherwise were discussed in Chapter 12. To the researcher a metamorphosis in health visiting seems inevitable. It is conceivable that government will encourage Trusts to provide services according to local needs. This would not only enable the Trusts to continue their radical rationalisation of health service provision it could also threaten the existing national pay structures by putting the case for local rather than national pay negotiations. It would also occur if health visitors were employed by GPs who do not subscribe to health visitor pay scales. In all events, this would have the effect of fragmenting the profession still further.

Given the range of conditions in which the health visitors in this study operate and given the political, professional and managerial uncertainties that accompany them, their health visiting workloads and routine are unlikely to change in a way the profession would like them to, that is, by increasing health visitor autonomy and employing additional staff to help reduce workloads and provide health visitors with clerical support.

HEALTH VISITORS' ASPIRATIONS FOR CHANGE

In their evaluation of the role of the nurse in health promotion, Gott and O'Brien asserted "we have fought shy of identifying a 'basket of skills' for health promotion work, but it seems to us that nurses will not impact upon health promotion policy and practice unless they identify, develop and use appropriate skills" (1990:158).

The health visitors in this study demonstrated little difficulty in identifying their own skill requirements for health promotion activities. With the new market style National Health Service, the health visitors appeared very conscious of the need to demonstrate 'value for money' and to be able to achieve consumer satisfaction. Over half of the respondents identified themselves as requiring more groupwork/empowerment
skills and 44% of respondents wanted to be more proficient in teaching and communication skills. This relates to another imperative for change identified by Goodwin (1988), namely, that health visitors should recognise the need for more participative and less directive relationships with clients and develop group and community responses. There is little doubt from the evidence cited above that the health visitors in this study aspire to achieve these goals. In her evaluation of health visiting, Goodwin (1988) also indicated that health visiting had no objectives or targets which allowed outcomes to be monitored.

The evidence from this study demonstrates an awareness by the health visitors of a need for targeting activities and for developing a variety of evaluation skills and methods (Chapter Nine). Over 30% of practising health visitors identified a desire to acquire appropriate research skills in order to be able to evaluate and monitor their work effectively. Despite the fact that 45% of the respondents felt that they received insufficient health promotion skills training such as individual and group empowerment skills, group techniques and methods, health project management etc, in their initial health visitor courses, a large percentage (85%), perceived themselves better placed than most nurses to carry out health promotion work. A small group of health visitors (18%) expressed the desire to work on a community rather than an individual level of functioning. These respondents also identified a need to develop political skills to contribute to the politicisation of health in order to keep it on the public agenda. Thus, the research revealed that many of the health visitors (nearly 80%) were very conscious of how they as individuals must modify their practice, and how the profession in general could and should change. The research also revealed, however, a real tension between the readiness of the health visitors for change and factors mitigating against change.

Goodwin (1988) predicted that the introduction of Project 2000 nurses would introduce practitioners prepared on a similar health based curriculum as the health
visitors and that this would inevitably impact on the health visiting profession. The respondents were beginning to observe the emergence of Project 2000 nurses and the evidence showed that just over half of them felt that their future was threatened by these nurses. The sample health visitors were also witnessing a burgeoning of practice nurses and a marked reduction in health visitor recruitment. To compound these changes, as many as 79% of health visitors felt that their work was undervalued by NHS managers and, furthermore, the research identified some hitherto unnoticed professional rivalry between health visitors and health promotion officers (Chapter 14). Given these developments perhaps it was not surprising to find that over half the sample of health visitors requested confidence and assertiveness training to prepare them for the future.

The study illuminates that health visitors, both individually and collectively, are in a 'catch 22' position, and the role of the health visitor in relation to health promotion personifies this. Health visitors represent a minority group within a semi-profession, struggling to maintain their professional and societal position. The health visiting profession has long trained nurses to specialise in health promotion, health maintenance and the primary, secondary, and tertiary prevention of ill health of individuals, families, groups and communities, albeit in a largely individualised/parent-child way. Now that health promotion is rightly every health professionals' business, health visitors find themselves devoid of some of the skills they need to demonstrate and make saleable their expertise.

Recent proposals by the United Kingdom on Central Council for Nurses, Midwives and Health Visitors (to be published Autumn 1993) suggest that all community nursing will come under one umbrella of 'community health care nursing' and all courses will be transferred to a shortened six months period. It seems highly unlikely therefore that the type of skills training and research expertise identified as needed by the health visitors in this study will be adequately provided for in a course of this length. Concern
has already been expressed within the profession that the proposed six months post registration training will not be long enough for nurses to reach required standards. Thus when the cumulative effects of diminishing autonomy, truncation of courses, cuts in recruitment and restriction of role diversification are viewed objectively, they amount to a subtle form of deprofessionalisation, back to the 'caste like' subservience discussed in Chapter 12. Identification of this process of deprofessionalisation goes some way to explain the potential contradiction highlighted in Chapter 12, namely, that although health visitors perceive themselves as well placed and capable of professional leadership in health promotion, at the same time they feel that their professional position and status is threatened. It appears to the researcher that no amount of assertiveness training will remedy the structural versus professional dilemma facing the health visitors.

HEALTH VISITORS' PERCEPTIONS AND PRACTICE OF HEALTH PROMOTION

A key aim of this study was to explore how health visitors' perceived and practised health promotion and to explore whether they had experienced or anticipated any difficulties in this work. Despite traditional working patterns, heavy caseloads, and a range of demanding priorities all of which have been identified in previous studies (Clark 1973, Marris 1974) some encouraging findings emerged from this study. First, not surprisingly, the great majority of health visitors (86%) considered they were carrying out health promotion activities all of the time as an integral part of their existing work, and only 1% thought that health promotion was rarely practised by health visitors in general. GPs were perceived to carry out health promotion 'sometimes' by 70% of health visitors.

Examples of health promotion practices (Chapter Ten) comprised a range of conventional activities such as mother and child support groups and immunisation clinics, but, they also comprised a diverse range of 'new initiatives' which had clearly involved
the development of new skills, new methods of working, and new client groups. Examples of such activities included group work with adolescents on healthy living, a series of campaigns based on the assessment of local health needs, support groups for victims of child abuse or domestic violence, and various group activities, including music and drama with elderly people to enhance their health and quality of life. Such efforts to enhance the physical, psychological and social health of the recipients should not be underestimated, because on both an individual and practical level they often provide the means of support for many vulnerable families, groups and individuals.

A small minority of health visitors (under 10%) expressed a keen desire to become community based where they could identify health promotion priorities and plan more strategically in a needs orientated way. Beattie has suggested that new strategic directions for health promotion produce marked shifts in the way people work, and the examples of community activities, local campaigns and setting up of various support groups serve to demonstrate a type of 'recasting of role' which typifies such a shift (Beattie 1991:187). Given the managerial proposals for health visitors discussed earlier in this Chapter it seems that health visitors will have to fight very hard to acquire or retain a community base despite the fact that it could be seen to be in the best interest of potential consumers of their services.

THE HEALTH BEHAVIOUR OF HEALTH VISITORS

As the recipients of a four year professional education it was assumed that health visitors would possess and personally utilise considerable knowledge of appropriate health behaviour. One of the most important aspects of this research therefore, was to explore the extent to which health visitors conformed to their knowledge in relation to their own health behaviour. Over 80% of the health visitors reported engaging in health promoting behaviours, including eating healthy foods, taking regular exercise, avoidance
or restriction of alcohol, not smoking and trying to reduce stress. When these positive
behaviours were compared with those behaviours mentioned by the general public as
causing good health (Blaxter 1990), the main difference between the two groups was that
the health visitors demonstrated a greater awareness of stress as a cause of ill health than
their counterparts. Blaxter (1990), has commented that people's behaviour is often mixed
and this was demonstrated in this study with some health visitors engaging
simultaneously in both positive and negative health behaviours. One respondent, for
example, reported given up smoking but admitted to over indulging in fatty foods at the
same time.

A third of the health visitors knowingly engaged in one or more harmful
behaviours such as smoking, overeating or exceeding recommended alcohol levels. The
evidence from this study throws doubt on a simple health belief model (Rosenstock 1974;
Becker 1974) by demonstrating that despite the health visitors' knowledge of the
consequences of their actions, other factors such as work or domestic demands had a
greater influence on their behaviour (see Chapter 13).

Regarding negative health behaviour, 20% of respondents acknowledged that they
got very stressed. The majority of these respondents admitted finding their work
situation very demanding. Many of the stressors mentioned by the health visitors
coincided with issues/factors identified by them as obstructing their personal practice of
health promotion. The main stressors identified included, excessive workload, lack of
time, too few resources, professional rivalry and lack of management support. All these
indicators link back to the political context elaborated in the first part of this chapter, and
to the difficulties facing health visitors who aspire to new dimensions of health visiting of
health visiting and health promotion work such as community and public health
involvement yet are prevented from doing so because of the traditional organisation,
structure and management of their service. Evidence in Chapter 13 showed that about
half of the practising health visitors who complained of feeling stressed thought it was due to a combination of stress both at work and at home. In this context, the health visitors provide an example of the demands placed on women in dual roles, namely, women striving to cope with the role of a wife, mother/carer in the domestic arena, and equally coping with a multitude of demands in a highly bureaucratic health service.

In The Health and Lifestyle Survey (Cox et al 1987) it was found that those who indulge in harmful lifestyle habits are usually most conscious of the links between health and disease. This consciousness and the possible guilt associated with such consciousness may in fact reinforce the health visitors’ negative behaviour. Another explanation for harmful health behaviour, as discussed in Chapter 13, may be because of a feeling of powerlessness experienced by health visitors in visiting many people living in circumstances of deprivation, for whom they can do very little.

Since the publication of Health of the Nation (DOH 1991) information has been sought by a number of Regional Health Authorities enquiring how the recommendations of Health of the Nation (DOH 1991) are being implemented by Health Authorities and Trusts and how National Health Service staff are involved in their implementation. From the researcher’s observations a number of Trusts have implemented ‘no smoking’ policies whilst others have introduced a range of healthy foods into their cafeterias and restaurants for both their patients and staff. Whilst these policies are commendable in that a ‘no smoking’ policy prevents potential damage to others from passive smoking, and the provision of healthy food provides a choice of meals for consumers, reasons for any negative behaviours of individuals and groups have never been questioned.

Although 61% of health visitors perceived the onus for health as resting with the individual, over a third of respondents did not agree with this view. A small, but significant number of health visitors (8%) suggested a number of policy changes were necessary to help health promotion succeed. Suggested changes included reduction of
environmental pollution, increased taxation on cigarettes at the point of manufacture, a
review of housing policy to phase out high rise building and the creation of more leasing
schemes to address problems of homelessness and substandard housing. The following
statement epitomises the dilemma faced by many health visitors.

"It is often a very apparently unrewarding task working with groups and
individuals who have no desire to change to a healthy lifestyle, or are unable to do
so for reasons such as unemployment and poverty".

Although 74% of the health visitors perceived that people have a choice in accepting or
rejecting a healthy lifestyle (Chapter Eight), the fact remains that choice is restricted by
living and working conditions. The evidence regarding the health visitor's own behaviour
supports this view.

HEALTH PROMOTION: WHOSE RHETORIC IS IT ANYWAY

The introduction to this thesis adopted the suggestion by Conill and O'Neill
(1984) that when a new rhetoric emerges one should always attempt to understand which
interest groups promote it, for what reason, for whose benefit and why it happens. The
researcher has attempted to show that part of the view of health promotion espoused by
the World Health Organisation (1984) envisaged collaborative intersectoral working
within and between organisations, professions, and government departments in order to
develop strategies for the promotion of health of whole populations. The WHO's vision
for health promotion also embraced the demedicalisation of health, empowerment of
individuals, groups and communities, and increased autonomy for non-medical health
care professionals. It was thought that increased autonomy for these professionals would enable them to develop new strategies and methods of approach in health promotion
practices. According to Bunton and McDonald (1992), the concept of health promotion emerged alongside developments in health education and the new public health
movement', (new because it changed its focus from the health of individuals to concerns about structure, ecology and social environment). Thus a number of professional groups, academics, policy makers and others have become increasingly involved in health promotion to the extent that "health promotion has emerged in the 1990's as a unifying concept which has brought together a number of separate, even disparate, fields of study under one umbrella" (Macdonald & Bunton 1992:6).

Despite the aspirations of WHO to demedicalise health care it has been shown in this study that the medical profession in the UK have not only expressed interest in this sphere of work but they have also been instrumental in developing health promotion policy for the National Health Service (DOH 1991). One can only surmise that their reason for such interest in health promotion was to retain power and medical dominance in this developing area of work. As to whose benefit involvement in health promotion by the medical profession is, the answer seems clear. General practitioners have become fund holders for health promotion work as part of new Government policy and as such, they are in a position to buy or promote health promotion services in a manner they see fit. Whilst the fundholding role of general practitioners retains medical control of health promotion, and possibly increases the status of generalist doctors working in a specialist dominated health service, it concurrently subordinates nurses, including health visitors, to increased medical managerial control. It has to be acknowledged that many GPs are reluctant to take on this work, for example in a nationally representative sample of GPs it was found that 60% of GPs felt diagnosis and treatment were far more interesting than health promotion (Killoran 1993:27). Perhaps in situations where these attitudes prevail it would be possible for health visitors to promote their services, although as indicated earlier, a GP may prefer to delegate this type of work to a practice nurse.

From a theoretical perspective, the researcher's analysis supports the work of Beattie (1991:163). Beattie suggests, for example, that health promotion policies have
swung between "poles of social theory and political actions: between individualist and collectivist models of intervention, and, between paternalist 'imposed' and consultative 'participatory' forms of authority" (1991:179). Rawson (1992) acknowledges the usefulness of theoretical models such as Beattie's in attempting to understand the socio-political and other dimensions of health promotion, but, Rawson also suggests that such theoretical abstractions may require future interpretation to be of benefit to practitioners (1992:211).

As to the question of why this new rhetoric emerged, in addition to the concepts of deprofessionalisation and medicalisation it is suggested that the feminist perspective is important. By using health promotion in a way which places the onus for health on individuals and with the withdrawal of a number of hospital/respite care services (DOH 1990) it is inevitable that women will be held even more responsible for the health of the nation through caring for the health of their partners, families and children. Women will not only bear the brunt of Government savings through their role as unpaid informal carers, but also through the deprofessionalisation of nursing women will be affected through loss of pay, status and terms and conditions of employment.

Despite the ambiguities and uncertainties of their position, this study has shown that health visitors and health visiting still have much to offer in terms of health promotion. At no time in our history has the need for health promotion of individuals, families, groups and communities been greater.
GUIDELINES FOR GROUP INTERVIEWS

A  PREPARATION

PREPARE VENUE - Make congenial/provide social context
Arrange seating in non-threatening way
Place recording equipment unobtrusively
Test before commencement
Ensure privacy

PREPARE INTERVIEWEES
Introductions
Give time to get to know each other
Ensure group confidentiality
Explain procedure and process
Get permission to record
Group discussion:
Answer any questions prior to recording

PREPARE SELF - Be ready to introduce subject in non-threatening way
Identify simple questions to get group discussion moving
Be prepared to encourage ‘talk’
Take stance of ‘passionate neutrality’
Give access to information to see how interviewees respond
Be prepared to bring shy individuals into the discussion
Also be prepared to steer the conversation into meaningful channels

B  PROCESS - Record, observe, encourage interactions
Allow to proceed until group indicates subject almost exhausted
End on positive note

C  POST INTERVIEWS - Thank respondent
Reassure on status of information
Transcribe tapes
Appendix II

Transcripts of interviews conducted with Health Visitors

Perhaps I could start by saying that I would like to hear when each of you heard about health promotion in the first place and what it actually means to you?

Would you like to kick off Sue?

S. It just seems to have become a new term for health education. My own feelings about it is that the health educationalists have become very concerned with certain topics, sometimes I feel to the detriment of the health visitors themselves who try to work on things that they feel they need help for.

V. You think it's a new term for health education but when did you first hear about it in your professional training?

S. It was not so much hearing about in professional training as opposed to seeing jobs advertised as health promoters - suddenly things being called the health promotion programme.

V. Oh right. So you feel it's a new term that's just come up.

S. It feels to me that that's what the health education has become, is being called, health promotion.

V. O.K. That's an interesting view Gina what do you feel.

G. Well I have heard of it with small letters, small capital letters, as opposed to the capital ones which are used now, during my training as a health visitor.
V. So what is the difference between these capital letters. I don't know anything about this. I have heard people say this, it's something in capital letters. But what does it actually mean.

G. I think it's just a change in terminology.

V. Anybody else like to say anything about it.

A. It's an interesting question. I have found myself using that to lay people that part of my job is to promote good health therefore I promote. I am a health promoter. But now of course there is a new body of people who are now health promoters. Which is relatively recent. I don't think I had heard the term "health promotion" for ages.

V. Yes. How long? you say for ages. How long?

A. I don't know. I

V. I mean did you first hear of it in university and training?

A. Probably not. I should think definitely not. I would say it was since I did my health visitor training really it is one of the terms that had most certainly been used. That was twelve years ago. But lately I personally have been using it in describing myself in the last four or five years.

V. That's interesting, we'll come back to that. Jean?

J. I didn't hear about in my nursing training, general training. I don't remember hearing about it on my health visiting training. I think I first heard of it when they appointed a nursing officer in my last job. Her job description included the term "health promotion". and I perhaps wrongly rather took it for granted that it was a new revamped term meaning health education, prevention of disease and
illness. Thereby promoting good health. I just saw it as a recaption of something that's been implicitly understood in health visiting, I think, for a long time.

V. Any views on that.

A. I feel my views are very similar to Joan's. It does seem that health education is now aiming at specific things like AIDS, coronary care, coronary prevention. It seems that their money is all spent on these and to try to get any resources for separate things for what you are doing and maybe wanting to set up things in the clinic....

V. O.K. So how would your work demonstrate health promotion as opposed to these particular groups that you have mentioned. Where do you see health promotion activities in within your practice as a health visitor?

A. hygiene, vaccination, diet. All the things that I have always done as a health visitor.

B. And influencing other professionals as well.

C. I would suppose that primarily as a health visitor that one promotes health within the home and that's where we have got a very special specific or significant input as opposed to the health educators who do it to groups of professionals in order to educate the professionals to take it into the home.

B. I feel perhaps it's in response to a government political directive.

V. Say more about that!
B. Well the emphasis has changed over the last few years. So instead of trying to mop up illness and disease the government has latterly latched on to the idea that if we prevent these things, it will therefore cost less money in the long run. And the health authorities have responded in a somewhat abstract way and created a lot of health promotion posts and I don't feel their work is any different than it was before in the National Health Education Departments. It's just that it's become very topical. If you haven't got one somebody wants to know the reason why. It's like a lot of things in the Health Service a lot of the people who are in these posts are probably fairly ill-equipped for it and have no more idea of what they are doing than the next person.

V. So if you were to set up a health promotion unit, what would you see as the fundamental requirements for it to be effective?

B. I think there needs to be a response to short term, I suppose short term problems, which are also long term in that you can't ignore them. You can't ignore AIDS although that's not going to be a short term illness in the long run, if you don't respond to that now somebody would think it very strange within the Health Authority if you were ignoring it. That you haven't tackled the longer term problems of people's eating habits improving so that they are not going to need surgery. Diet. Self inflicted. Self inflicted problems. Health problems later in life.
A. I think government aims are rather ambivalent about this because I'm not sure whether they are actually concerned about the health of the population or whether they are concerned whether the health service per se is costing too much and its a cheap option out of it by diverting care of every one, in terms of look after yourself, or unpaid help or voluntary help in the community. Which is poorly funded.

V. So you think they are conflicting groups. I don't want to put words in your mouth....

A. No not entirely that. No I don't think its entirely that. I think that the overall cost of health is so high and so increasing because of normal development that it seems to be a cheaper option. I don't like to be fickle.

V. You don't have to be fickle.

B. You say that the government blaming each one of us for our self-imposed diseases?

V. There is a tendency for this to happen. That its because we eat too much or we smoke, or we drink alcohol, that we have heaped the whole illness on ourselves. When I think that the fundamental question is why do people drink, smoke, do these things in the first place. These are things that have to be asked. I mean in that particular perspective there is an element for want of a better term of victim....
On this promotional thing, smoking, drinking all this is quite true. But what has been overlooked is the basic problem of why people are totally incapable of changing their lifestyle. It's all very well to ask them to look inwards and ask them how they feel about things. Most of them live in such appalling conditions. The last thing they want to think about is giving up smoking, diet and anything else. If they were to have decent housing in the first place it might promote their good health, and more money, a lot better than any of these health education programmes, health promotion programmes.

How do you see the relationship between disease, prevention and health promotion? Is there a difference?

To some extent you can promote good health even in a poor environment. We are supposedly the experts and we do have some knowledge to impart to those people who often don't understand very simple things but on a larger scale you can't do a lot on to promote preventive health or that comes from living in poor conditions, with very little money...

Poor health is not necessarily a disease, is it?

Well you tell me! I mean that's an interesting comment.

I mean it can just be a low quality of health which is not necessarily frank disease.

Right. I agree with that.
C. Which is connected more with more, as you would say, with social conditions, social problems than it is with health and care. It's just that the poor social conditions reflect upon the health and quality of life.

V. I accept that. So given that, at the moment any way, health promotion seems to be the in word, with most professions, do you think every health profession, by that I mean doctors, nurses, health visitors and other groups have an equal role to play in that? Or who do you see as being most centrally placed to pursue this notion of health promotion?

A. I think they should have an equal role. In practical terms, I doubt that they do! And I think that the people working in huge hospitals are there at the sharp end, and it's their job to try and mop up illnesses and diseases they see, and it's up to somebody else out there (inverted commas)
I don't think they see hospitals doing it, I don't think the people in hospitals are actually able to recognise
I don't think they regard health visitors as the people who can be doing that job. I don't who they think should be, but I don't think they include us in it, I think they see a special person, one designated post within the health authority.

V. How realistic is that.

I mean one designated person?

A. It's very unrealistic!
V. Are any of you placed with GPs. Do your GPs perceive themselves, in your view, as being concerned with health promotion?

S. I think the younger ones do more. I think it's coming more into training. I'm not sure that the older ones do. I think they see themselves as treating disease and medical prevention. But I do think it's coming into medical training. On the other hand I don't think they really see it as being a prime priority.

A. I think one of the problems is actual timing. The amount of time they have. 2 or perhaps 3 of our GPs are very interested in that. As a result they'll heap upon us, as the health visitors that is, those who are needing counselling or whatever it is. So that's almost going back to the health promotion bit. One of the essential things that I feel that "what am I promoting when I talk about health promotion" is actually identifying within each person, the worth that they have, and pulling that out and letting that go, because there isn't much else that many of these people have as regards awful shocking housing, absolutely no chance at all, unemployment, overcrowding and this sort of thing. The identification of what they are good at. And there is good in everybody. And to try and identify it, and to look at other avenues of raising their self-esteem. I think that's is one of my most essential jobs as opposed to talking about health education. (Certainly one does throw in health education, cleaning your teeth, accident prevention, better diet, that sort of thing). And maybe that's the significant part of work that one is doing in this particular area. Maybe all of
us. But perhaps it is no different for everybody. The actual stresses, the difficulties, isolation, frustrations, people's expectations that are being put upon them nowadays, push them beyond their own realistic goals and so really people fall around in little heaps. And it's to bring down if you like their goals or change their perspectives so that it becomes realistic.

V. Interesting. Do you feel that within your work, how much emphasis can you yourself put on health promotion or are you are doing that all the time.

B. You are doing that all the time wherever you are and whatever you are doing.

V. I mean are there any obstacles to your increasing your involvement on health promotion?

A. Time, overloading.

B. You could actually alienate them, doing too much with health promotion issues.

V. Why should that be?

B. They could see it as interference with their lifestyles. I know its how you go about doing it. You can't go in and say do it this way not that. It is very difficult to suggest ways of how people can change without being judgmental about their lifestyles. Over the years I have been able to become more certain about it. You needed to stress the issues of don't do this. Present them with a reason. There are certain things that I now just ignore because it's better not to say anything, just ignore, rather than alienate the people.
V. I know full well what you are telling me. The group that I had last week felt that much of their own work was involved with crisis as opposed to really being able to do the health promotional work. Do you think that would apply in your situation. It's a leading question.

A. Certainly when it happens to cover three major areas as well as our own work it's very difficult to be able to do at all. I think if we retrace our steps a bit ... I think the recent cervical smear campaign. There's lots of that in the press. There has been for the last five years. And they talk about having a national recall system as people haven't been informed, people dying as a result. I think that we need a recall system. I wouldn't say for one minute that we didn't. I also think that we don't place enough time placing responsibility on people because they are poorly informed or poorly educated. I had a woman recently in the Family Planning Clinic and asked her when her last smear was. And she said "I'm all for having as many smears as possible" and I thought about it afterwards and what she is saying is yes I will come and have smears as often as I should but I also thought I wonder if she really knows what the other dangers are. And most of the time we don't spend enough time elaborating on things. They get this very short message of smears and they don't realise what the other things are. And I think that a lot of health promotion, health education is too short really. I think they are looking for easy options, easy answers.

They are very poorly educated about their own bodies
OK It's sound to me that it would be unrealistic for any one or two or three professions alone to cope with all the issues. Because that's a major educative role that's needed and that doesn't have to begin in adulthood. It should start much earlier.

It should begin in school. Secondary school.

Primary school I should say. They need it as a regular subject.

How many of you are familiar with the WHO document. Health for All. have you seen that.

No. So only Sarah out of four of you have seen it. Can you remember the document what its advocating. Sarah.

Yes. I have. And I actually did read it. But not critically. Overall it is talking about prevention of disease and promotion of health. Looking at it this is what we've been doing as health visitors and these are our aims and objectives. These are precisely the aims and objectives of health visiting.

But I'm sure there are other things.

If I could digress for a moment. This is not so much an interview. Could I just pick you up for a moment.

You say that the things in that document, and I would concur with you, are things that health visitors have been doing for as long as I can remember, probably as long as you can remember. Now would you say that your work today is any different now, that applies to all of you, than it was when you actually started health visiting. How has it changed if it actually has changed?
A. I don’t think my work has changed very much. I think my perceptions of what I do, my attitudes on a variety of topics, has changed and the way I discuss certain topics with clients has changed. Whether that’s for better or worse I’m not always sure.

V. But given that we are increasingly as a profession having to be more accountable for what we do, and many of the management systems are attempted to measure the value of what we are doing, what are the things in your work that are valued by management in what you are doing at the moment?

B. Things have cropped up certainly in the last four years maybe have changed. Say more specific emphasis on child surveillance. And focusing more clearly on specific things that are done on to. Now that has got pros and cons to it. It certainly helped me to focus a bit more on some of the issues that I was possibly a bit fuzzy on but now what has happened is that they have done away with most of the CNOs so guess who’s doing the work!

V. You are doing the screening....

B. You are doing the screening... So as a result one is doing an awful lot of things like the screening, so its become more task-orientated.

V. Jean you are nodding your head.

J. Yes well we have got visiting guidelines, minimum contacts which are tending to skew the way that you approach your work, your priorities, particularly within the qualified health workers. When you get older you tend to disregard them as...

V. So in general what are the main things to emerge from those new guidelines. Where are they putting their values on?
A. They are putting it on actually getting statistics on immunisations. On getting statistics on how many times you see people regardless of the quality of work that you are doing when you are there. And that is a great disadvantage. I think quantity is useless as regards quality.

B. Regarding a project in Tower Hamlets, I think, or Hackney, and they have decided that a recommended length of time for each visit would be 8.2 minutes. And we just looked aghast. And the nurse manager said it reminded her of her early days when she worked up north and you went up one street, and the houses were back to back, so you climbed over the garden walls. Two for the price of one. You were sent out at ten o'clock and not allowed back until half past twelve, like in a boarding house system. And that way you did ten in the morning and ten in the afternoon. And she just said that it reminded her of her early days and it was such a retrograde step. And they seemed to feature this in Tower Hamlets as the way forward. And we were just appalled. 8.2 minutes.

B. The concept that just by seeing people something was happening, and it doesn't.

V. Of course not. It's total naivety.

B. What did they expect anyone to do in 8.2 minutes.

V. O.K. I don't want to prolong this unnecessarily, I just want to come back to Health for All and the targets. That document has been out now for some time and really what it says is that health promotion cannot be tackled on one front, it's got to be multisectoral. For example there's no point in even beginning to think that one can
enhance health unless one gets the concurrent social modifications made, environmental, educative. So that one has to approach Health for All through a whole load of channels because that is so important. So I would agree with Sarah that years ago that many health visitors were the prime instigators of that sort of activity. But certainly given today's needs in society right across the world it can't be tackled on the basis of one profession. It's impossible. But nonetheless I do think that the points that you have raised about introducing measurements into what we are doing can be detrimental.

B. It's what concerns me about Korner. Because in some districts it can be very narrow. You just have one item that can be recorded. And as everyone knows you never ever cover only one item. So that what you are doing is never recorded.

V. So how can we as a profession get over that item.

A. To some extent to record how many times we go out on visits can be a help especially in areas where health visitors enter into social work dealing with all sorts of social problems. You can back into getting to your clients, seeing them all and not just seeing a small section who you see all the time and actually achieving nothing because you are dealing with housing problems, social problems, benefit problems when there are every other agency imaginable able to deal with all those problems and should direct them in the right way. Frankly I just don't get into all these issues ... well I have to deal with them occasionally. I do believe that having guidelines as to how many visits at least the ordinary population is being seen and everybody has an opportunity of health education whereas it can be
that just a small proportion, caseload, has a lot of input and has very little to do with health promotion but to do with their own problems anyway.

A. I think it comes down to enthusiasm. And I think that people when they start in a job that somebody was interested in them, and they are keen that this person who they are newly employing should achieve, should have a sense of fulfilment. And that they would be encouraged to try and find some special issue that this person would be interested in, that they would foster this interest by allowing him to go on a study day, that they were advised that they would be expected to take ten study days a year and that five of those days would be related to a special issue within the area in which this person was going to be working where there is a need. And that by encouraging somebody, I think 100%, I think this person’s enthusiasm would actually rub off on to the other sections of the population. And that they become so keen that they want to impart all this then we might actually make some impact, it might actually be quite small, on a section of the population. You would target it on a small area. I’m not suggesting that you should try to change the world. But I feel that the lack of interest towards the employees doesn’t actually help them to achieve their best.
Appendix II

Transcripts of interviews conducted with Health Education/Health Promotion Officers

So ....Perhaps if I just throw a straightforward question in the pot to get us started: When did you first hear about health promotion?

A.

mmm

I suppose I first heard about it at college. It was sort of part of my college course. It was a component of health education course. We looked at things like fluoridation of water and stuff, heart disease, and that was when I first heard the term. Health education.

Val

Right.

A.

Health education

V.

Was that when you were at school?

A.

No its was when I was doing my degree.

V.

When you were doing your degree.

B.

I was the same. I heard it when I was doing my degree. And that's when I started to get an interest in it because we did have a component on our course which was actually called health education.
V. Right. It was health education.

B. Yes

V.

And how long ago did you do your degree?

B.

I suppose that was, when I first heard about it would be 1984.

V. Right. Does that apply to you (C)?

C.

No. I came across it much later. Late starter. It was only three years ago when I was working, as part of a social service team, in a community care team, and a health education officer was attached to us and I got very interested in what he was actually doing and health education per se was the first time I had actually heard about it.

V. Right

D.

I am trying to think because I got into health education, health promotion, about five years ago and I think it was just at that point when the department in Cambridge had changed its name, because it had a new manager,

V. Oh!

D.

so what had been the health education dept. had just become the health promotion dept.

B.

So it was just a change in terminology really for you?
No. That isn't not how I interpreted it. However, that's certainly how it was. Nothing really changed about the work that was going on at that time as far as I could see. The name changed.

V. mm mm

D.

But I would perceive them as being different things. But at the time it was all new to me. laughter.

v. Right

D. I hadn't a clue what any of it was.

V. Right. So can I take you from there then. How do you perceive it. Health promotion. as being different.

Laughter

Gosh

V. Well I mean I ask as you said...

D. Well yes. It's just as you said. Well I think it is something a lot broader than health education.

V. Sure.

D.

It's a much wider sphere of activities and the kind of model... I'm sorry about this ...we have just been talking about this ... the kind of model that is being spread around. In East Anglia

V. hm hm

D. its Andrew Tannerhill's

V. Yes.
D. I hear of it being three overlapping areas of activities
Health protection, which is all the legal side
V. Yes
D. and Fiscal policy and then the education itself, which is the
sort of traditional health education area and then the third bit
is prevention
V. Right
D. and if you think about them being three overlapping circles
which have sort of areas - they all overlap with each other - you
could being doing health education which has a preventive focus
V. Sure
D. or you could be doing mmm health education with policy makers
which might sort of lead you to some kind of protective measure,
some kind of social policy change. Mm So that, I mean for me,
that's a perfectly satisfying definition of what health promotion
is.
V. Sure
A. And I would probably say the same. Maybe we are not a good
sample because we are all actually from East Anglia.
MM laughter
A. although we work in different units.
V. Right
A. If it hadn't had been he had quite an influence mm I think
upon our region, Andrew Tannerhill, and his model, and we all
quite welcome him.
V. Right. So is he instituted in East Anglia, Tannerhill?
D. He was. Not any more!
   And was he, he's a doctor isn't he.
C. mm He's an SCM of the Regional Health Authority
V. Oh right.
C. with a brief mm for health promotion and I think mm was it
   children's services.
concerted yes
V. Oh right
C. But although he was a doctor, he had actually done an MSc in
   Health Education.
V. mmm
C. And this is where he formulated his theory.
B. And I think it's quite interesting to think whether the theory
   which we are all familiar with and in a way it's a sort of model
   in which we work but whether its actually influenced what we do
   is another question.
D. Ah well. it certainly influences what we think it is but it
   may not influence what we actually do.
V. Right. Could I then from that because actually its led on
   to the next topic of what I was going to say. Do you, would
   you actually think that you are actually practising some type of
   health promotion and if so how can you explain or articulate that
   practice to me?
A. Well I don't know whether we were. I mean in Heeston we
   were a very small unit, and we still are, health education, and
   so we didn't really go over, health promotion we are still very
much within the health education part of that model
V. hm hm
A. er so I don’t really know a lot about sort of the health promotion that comes into my work
V. So you don’t really feel you are actually practising it at all.
A. No (quiet response)
   Not .... well er
B. Em We’ve recently become a health promotion unit and again really its been a change of name rather than a change of emphasis but at the same time em we have got more staff and we are changing a little bit. We are looking a lot more at policies and we having more em work in the workplace and differing policies and that sort of thing. And more work with environmental health and to look at things like road safety. but it is a very small part. Again its an educational role in the side of protection really.
V. Right
That’s useful.
D. I suppose perhaps I can see myself as being lucky because I think its semantics again
V. MM
D. with promotion and education we’ve just changed our names too. and I can’t see that we’ve changed the way we work at all. On the other hand since I have been working in health education I have been pretty able to be quite autonomous and I have been able
to work in the way that I have felt best.

V. mm mm

D. Whether that has been right or not I’m still not quite sure, but I work in the community setting and mm I have been trying to work in a very broad way in working with community groups

V. mm mm

D. and I think I feel more satisfied doing that, I see that more beneficial in a way than in the way I see other people being channelled to work in sort of campaigning elements, things which I don’t think are very valuable.

concerted yes (quietly)

D. I have come to that because of the setting that I work in and because of the nature of the unit that I work in that we are able to work in the way that we feel best without perhaps having a very broad policy about it.

V. That’s useful. Do you have any, do you see any obstacles to prevent you from working more in say health promotion?

D. I think working within the NHS is a very big obstacle.

V. em Fine, Yes, In what way?

D. I feel very channelled into a medical way of working

V. hm

D. and there are restriction on what I actually can take on. Perhaps politically as well. I’m never sure, I’m never quite sure I am stepping over a line, or whether I imagine that line is there or not, I’m never quite sure whether I’m just pushing things a little bit too far sometimes.
V. mm
D. I feel those restrictions. and I don’t know whether – I think it is one of the reasons its because I work in the NHS but there are probably a couple of other things that I have not really thought through.
V. Mm Would you all agree with that?
A. Yes I think so. Because our district medical officer has quite an influence on our district health education officer. So therefore things still get pushed and however much we fight this medical role.

Cups clattering
we still tend to be pushed into that way.

V. so if you were given total freedom, that you didn’t have any medical officers sort of overseeing or any particular medical policies, how would you like to see your own work diversify, grow em how would your practice differ if you were given complete freedom?
B. I think it depends on what level you are talking about hesitation because I think if we are talking about departments’ being given complete freedom to develop in a particular direction
V. mm Sure
B. rather than individual work, then one way that I would see us being potentially fruitful would be to have mm to increase the number of people working as health education officers and perhaps use something like the model that they have in Norfolk with people based in localities em as well as people at the centre
because I think it is quite important to have a sort of central department

V. hm

B. as well. But just to increase the number of people on the ground not to be necessarily doing face to face work but to be doing sort of community development, co-ordination, not actually doing it themselves but acting as a catalyst for initiatives in local areas but connected into some kind of central policy making department.

A. I would agree on that. I think we definitely need more staff and again so that you could perhaps work in a geographical base but you could be much more involved with other professionals you know like we were talking about before me. You could perhaps have more influence in housing department if you have got more time to spend working with people in housing, in planning. You know, I am looking at say the council side of things

B. Oh yes.

A. The side of things. I mean in influencing some of the things that go on there. We definitely need more people. In our area we have only got three health education officers so

V. For how many population, roughly?

A. em 195, 000

V. It doesn’t give one much - its a drop in the ocean isn’t it really.

A and B and C Hm

A. and the added problem is that it is a rural area and very
dispersed.
V. Yes I understand that. It is tricky.
Who do you think. I mean - Obviously one has got to have a
certain multifactorial approach as you have alluded to, but if
you were recruiting health education officers or health promotion
officers where do you think the best recruits would come from?
D. I'd get them from social sciences.
V. Right.
D. giggle That's just my prejudice. And I think that I feel
quite strongly that I would like to see it become more
professional
V. Hm
A. I don't mean that I wouldn't take people from other
disciplines because I come from ***** what the hell do I know
about --- help - giggle
Laughter whilst we're at it
but I think that - well we went to the Netherlands - and got an
idea of what kind of training programme they have - I think there
are problems in that as well. They have cut down on the people
who go into the profession. I think there is a need if we are
actually saying we are going to be tackling these really large
areas there is a need to understand what the implications are of
working in, oh its local politics really
V. em
A. and I do feel very strongly that we need to have a stronger
professional base and things like the diploma are a starting
point but basically they are not more than that and that there is a need for a proper professional training. No they are not - no it shouldn’t be something that people go into straight from school I think that is wrong, it should be available to people throughout their careers. No The flexible way of allowing it to happen. I think it is very important that people, that the health education profession has a clear idea of where it is going and what it can really offer. I think we are slightly uncertain about both those things.

V. Yes.

B. It sounds a contradiction, I mean, in that in health education there is a lot of emphasis being put on training and sitting back and looking at what you are doing but there isn’t training, training for that education is appalling

V. Yes.

B. For people who come into the profession from lots of different areas

V. Yes.

B. ther is hardly any initial training given, em apart from the diploma course and one or two other bits about

V. Yes that’s right

B. its very ad hoc.

V. Yes

B. and that’s, I think that’s what gives us a very low professional status or that’s what contributes to it.

V. Yes
C. And we’ve all got, I mean different ideas, I mean I’m not saying that different ideas are wrong, but you look at different units, they have got very different philosophies, it gets very confusing.

V. Yes.

C. You know, you try and get some idea of what health education is about and then you move somewhere else. I mean I have moved twice to different units with very different philosophies. So it’s even more confusing as to what you should be doing.

V. Yes.

D. The first week on the course you get a really good idea of how diverse the way of working actually is and where and what everybody is trying to achieve.

V. Yes.

A. I think also if you took a lot of recruitments from one particular area in health education you would lose that again because it’s good to work with people from very different disciplines, like you say social sciences.

Laughter

Social science but also I found that what I did in my degree is very relevant and teachers are very relevant and I get a lot from all that. And that would be lost. I think that would be a real shame for health education if that diversity is lost.

C. No perhaps I had better cancel that comment about social...
science because as far as I am concerned that seems to me in a way I wish I could do that now because it would take me down the road that I want to follow.

B. Perhaps it doesn’t matter about what background people have as long as there is something we - hesitation - can build in somewhere - may be after they have chosen to come in

*****

- Yes and the other skills and knowledge they could learn there

C. Because I certainly wasn’t employed on my knowledge of health education, I knew nothing about it whatsoever.

B. No I wasn’t either

C. Nor me.

V. I find it quite interesting. I mean I am not going to comment. I will come in afterwards.

I don’t want to hear myself on the tape but obviously there are two things that spring to mind from what’s emerged during this discussion. One of them is that you tend to all nod when one of you mentioned that it was a constraint really to be within the NHS, so following from that where do you think health education should be located if it is not within the NHS.

A. Well I don’t know whether I would want to see it specifically in anything, because I think immediately you do that you impose that restriction on it again.

V. fair enough

D. It’s something I haven’t really thought through
Ms Catherine Burns,
General Secretary
Health Visitors' Association,
50 Southwark Street,
London SE1 1UN

5 June 1990

Dear Catherine,

Research into Ideologies of Health Promotion

I am currently undertaking some important research exploring the role of health visitors in health promotion. I have already completed stage one of the research and would be most grateful if the HVA Professional Development Committee would give me permission to forward a questionnaire to a sample of health visitors drawn randomly from the HVA membership.

Members would of course have an absolute right not to participate in the study and I would write an accompanying letter with the questionnaire explaining the purpose of the research and why it is so important to make explicit the very valuable work which many health visitors are undertaking.

I can assure the committee that all responses will be treated with the utmost confidentiality and I do hope that they find my request for access to the membership list acceptable.

Yours sincerely,

Miss Valerie Chapman
Head of Department
SELF COMPLETION HEALTH PROMOTION QUESTIONNAIRE

This questionnaire aims to collect information about ways in which health visitors perceive, interpret and undertake health promotion in everyday work. Your co-operation in this important study would be very much appreciated.

All the information you give will be treated as strictly confidential.

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<td>years</td>
</tr>
</tbody>
</table>

For office use only

8-9

332
### Section 1: Personal Details

**6. Are you married?**
- [ ] Yes
- [ ] No

**7. Do you have children?**
- [ ] Yes
- [ ] No

If yes, please give their ages:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1st (14-15)</th>
<th>2nd (16-17)</th>
<th>3rd (18-19)</th>
<th>4th (20-21)</th>
<th>Other(s) (22-23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Group</td>
<td>(14-15)</td>
<td>(16-17)</td>
<td>(18-19)</td>
<td>(20-21)</td>
<td>(22-23)</td>
</tr>
</tbody>
</table>

### Section 2: Your Practice Base

**8. Are you General Practice based?**
- [ ] Yes
- [ ] No

**Are you Health Centre?**
- [ ] Yes
- [ ] No

**Are you Other purpose built premises?**
- [ ] Yes
- [ ] No

Other please describe:

**9. Please describe the main characteristics of your health visiting workload?**

- **a) Social Class distribution**

- **b) Ethnicity**

- **c) Age Range (e.g. predominantly 0-5 years)**

  0-5 plus elderly; please comment
10 a) What is the size of your case load? (Number of families for whom you hold cards)

<table>
<thead>
<tr>
<th>Size of Case Load</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 200</td>
<td>1</td>
</tr>
<tr>
<td>200-250</td>
<td>2</td>
</tr>
<tr>
<td>251-300</td>
<td>3</td>
</tr>
<tr>
<td>over 300</td>
<td>4</td>
</tr>
</tbody>
</table>

b) Please describe your personal case load priorities eg 0-5s; community health education

Please list up to six categories

11 Would you describe your practice base as any of the following?

<table>
<thead>
<tr>
<th>Practice Base</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner City</td>
<td>1</td>
</tr>
<tr>
<td>Urban</td>
<td>2</td>
</tr>
<tr>
<td>Rural</td>
<td>3</td>
</tr>
<tr>
<td>Mixed urban/Rural</td>
<td>4</td>
</tr>
</tbody>
</table>

If other please describe - (5)
SECTION C

12 Thinking about HEALTH PROMOTION, which of the following statements come closest to how you see health promotion

a) FIRST IN YOUR OWN PRACTICE with your current case load
   It is happening in own practice all the time □ □ 1
   Sometimes it is included in own practice □ □ 2 54
   It is rarely included in own practice □ □ 3

b) SECOND IN Health Visiting Practice generally
   It is happening in health visiting practice all the time □ □ 1
   Sometimes it is included in health visiting practice □ □ 2 55
   It is rarely included in health visiting practice □ □ 3

c) THIRD IN General Practice by GPs
   It is happening in GP practice all the time □ □ 1
   Sometimes it is included in GP practice □ □ 2 56
   It is rarely included in GP practice □ □ 3

13 Please describe two examples of any health promotion activities/practices you have carried out in the last ten days.

(1) 57-6

(2) 62-67
14 Please give details of any other preventative care and health promotion activities you have been involved in or intend to develop in the future (other than those already covered in the questionnaire.)

68-72

15 What are the main difficulties you have encountered, or anticipate in the future, in developing health promotion in practice?

73-77

16 Would you please indicate your performance in health promotion in relation to each of the following continua: -
(Please circle the figure you perceive nearest your work.)

<table>
<thead>
<tr>
<th>holistic</th>
<th>focused</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>individualistic</th>
<th>community</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>developing new skills</th>
<th>staying the same</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
</tr>
</tbody>
</table>
Below are a number of statements about health promotion. What response best represents your view?
(Please circle or tick box)

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Health promotion is normally interpreted by HVs as another term for health education.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) The responsibility for health rests largely with the individual</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c) If appropriate information and knowledge is given to clients/groups they can choose or reject a healthy lifestyle.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d) HVs time is probably better spent in collective action with local communities than having interaction with individual families</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e) Health Visitors are normally perceived by themselves to be leaders or potential leaders of health promotion activities in community care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f) Health professionals should endeavour to get involved with community issues which influence health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Below are another set of statements about health promotion. What response best represents your view?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>(g) Health Promotion depends to a large extent on teamwork</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>(h) Health Promotion is more likely to be practised by recently trained practitioners than more experienced ones</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>(i) Health education and health promotion are the same thing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>(j) Health Promotion is seen as desirable by the government</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>(k) Health visiting comprises more crisis work than planned preventative work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Please indicate the extent to which you agree or disagree with each of the following statements:

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Health Visitors are better placed than most nurses to practise health promotion effectively</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) Health Visitors could work more effectively in health promotion if they targeted their visits on patients with identified causes of disease</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c) I do not have enough time to practise health promotion effectively</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d) Health promotion is supported by the government</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e) A Health Visitors work is generally undervalued by NHS managers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f) GPs do not have enough training in health promotion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g) HVs do not have enough training in health promotion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h) People’s lifestyles are determined by their culture and environment. There is not much individual HVs can do to change them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
SECTION D
This short section in the questionnaire asks you as a health professional about your own health care. (All information is totally confidential)

19 What if anything, do you do to maintain or promote your own health?

20-25

2C What if anything do you do to maintain or promote the health of your family/partners?

26-31

21 What, if anything, do you do which could be seen as bad for your own health? (e.g. smoke)

32-37

22 If you responded to Question 21, can you suggest any reasons for your health behaviour?

38-42
SECTION E
This final section explores your perceptions of the current status of health visiting in relation to the development and practice of health promotion.

23. a) In your opinion is it possible to measure health promotion?

[ ] YES

[ ] NO

[ ] DON'T KNOW

b) If yes, how would you measure the success of health promotion activities?

43

44-49
Below is another set of statements. What response best represents your view?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Health visitors should remain generalists in their work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) Health visitors would have greater job satisfaction if they retained a clinical element in their role.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c) With the advent of Project 2000, the importance of the health visitors’ role will be seen by other nurses to diminish.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d) The strength of health visiting is its universal service to the public.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e) The weakness of health visiting is probably in offering a universal service to all instead of targeting its clientele.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f) With the implementation of the NHS White Paper the future of health visiting as a profession is seriously threatened.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g) The future of health visiting is no more precarious than it always has been.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
25. In the context of health promotion, please identify any new or increased skills and competencies needed by health visitors to function more effectively. (Please list up to six categories)

26. From your own experience, please identify what strengths you see health visiting having to contribute to health promotion as a whole.

27. We would be interested to hear any other comments you would like to make on the subject of health promotion.

Please check that you have answered all the questions and return the enclosed questionnaire in the enclosed pre-paid envelope.

Thank you very much for taking the trouble to co-operate in this research.
Dear

I am currently undertaking research into professional views and practices in Health Promotion.

The research involves a national sample of over 1000 health visitors and aims to help the general public, the professions and health service managers understand the valuable contribution made by health visitors in preventive health care and health promotion.

Your name has been drawn randomly in the sample of health visitors and I write to ask if you would be willing to participate in this important project.

Enclosed is a self completion questionnaire which has been carefully developed following a number of in depth interviews with both groups of health visitors and individual health visiting practitioners. This part of the research is aimed to follow up some of the issues highlighted by them.

The research has the approval of the HVA and is being conducted under the auspices of the University of Surrey. It is hoped that the results will be published in book form in 1992/93.

I should be most grateful for your support in this work and earnestly request your co-operation in completing the questionnaire and returning it to me in the stamped addressed envelope as soon as possible.

Confidentiality of the information will be maintained at all times.

With thanks in anticipation

Yours sincerely

Val Chapman
RGN RHV MSc

Enc
Date as Postmark

Dear

A few weeks ago I wrote to you asking if you would be kind enough to participate in my research project which aimed to look at health visitors' perceptions and in some cases, their practice of health promotion activities.

You may like to know that the response rate to date has been very encouraging but it would help even more if I could improve the response rate even by 10% as this would enhance the credibility of the research.

I have been overwhelmed by the quality of information given me by most of the respondents (whether currently practising or retired), and feel I have an obligation to them to present the research in as professional a way as possible.

To this end, I make a second request for your co-operation and do hope you will feel able to respond.

I enclose a second questionnaire and a stamped addressed envelope.

Once again, many thanks.

Yours sincerely,

Valerie Chapman
RGN RHV MSC (SOCIAL RESEARCH)
ENCS
### APPENDIX VII

**CODING CATEGORIES FOR OPEN ENDED QUESTIONS**

#### Question 9a (Social Class)

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Social Class I</td>
</tr>
<tr>
<td>28</td>
<td>Social Class II</td>
</tr>
<tr>
<td>29</td>
<td>Social Class III</td>
</tr>
<tr>
<td>30</td>
<td>Social Class IV</td>
</tr>
<tr>
<td>31</td>
<td>Social Class V</td>
</tr>
<tr>
<td>32</td>
<td>Unemployed</td>
</tr>
<tr>
<td>33</td>
<td>Other classification</td>
</tr>
</tbody>
</table>

#### Question 9b (Ethnicity)

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Caucasian</td>
</tr>
<tr>
<td>35</td>
<td>Afro-Caribbean</td>
</tr>
<tr>
<td>36</td>
<td>Asian</td>
</tr>
<tr>
<td>37</td>
<td>Multicultural</td>
</tr>
<tr>
<td>38</td>
<td>Jewish</td>
</tr>
<tr>
<td>39</td>
<td>Other ethnic groups</td>
</tr>
<tr>
<td>40</td>
<td>Other age groups</td>
</tr>
</tbody>
</table>

#### Question 9c (Age Range)

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>Under fives</td>
</tr>
<tr>
<td>41</td>
<td>Elderly (65+)</td>
</tr>
<tr>
<td>42</td>
<td>0 - 12</td>
</tr>
<tr>
<td>43</td>
<td>13 - 19</td>
</tr>
<tr>
<td>44</td>
<td>20 - 64</td>
</tr>
<tr>
<td>45</td>
<td>Other age groups</td>
</tr>
</tbody>
</table>

#### Question 10b. Caseload Priorities

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>Underfives</td>
</tr>
<tr>
<td>48</td>
<td>Bereavement visits</td>
</tr>
<tr>
<td>49</td>
<td>Child protection</td>
</tr>
<tr>
<td>50</td>
<td>Elderly people</td>
</tr>
<tr>
<td>51</td>
<td>Special needs</td>
</tr>
<tr>
<td>52</td>
<td>Client/community led needs</td>
</tr>
</tbody>
</table>

#### Question 13.1 to 21 Health Promotion Activities

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>57</td>
<td>Dental Health</td>
</tr>
<tr>
<td>58</td>
<td>Parent/child health issues</td>
</tr>
<tr>
<td>59</td>
<td>Ante and postnatal HP</td>
</tr>
<tr>
<td>60</td>
<td>Accident prevention*</td>
</tr>
<tr>
<td>61</td>
<td>Advice on lifestyles</td>
</tr>
<tr>
<td>62</td>
<td>Other Health Promotion</td>
</tr>
</tbody>
</table>

#### Question 14. Planned HP Activities

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>63</td>
<td>Campaigns</td>
</tr>
<tr>
<td>64</td>
<td>Accident Prevention</td>
</tr>
<tr>
<td>65</td>
<td>Parentcraft</td>
</tr>
<tr>
<td>66</td>
<td>Health Promotion</td>
</tr>
</tbody>
</table>

#### Question 15. Main Difficulties/Obstacles

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>73</td>
<td>Lack of time</td>
</tr>
<tr>
<td>74</td>
<td>Resources</td>
</tr>
<tr>
<td>75</td>
<td>HA Policy issues</td>
</tr>
<tr>
<td>76</td>
<td>Other</td>
</tr>
</tbody>
</table>

#### Question 16. Negative Health Behaviours

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Diet related</td>
</tr>
<tr>
<td>33</td>
<td>Alcohol related</td>
</tr>
<tr>
<td>34</td>
<td>Stress related</td>
</tr>
<tr>
<td>35</td>
<td>Other behaviour</td>
</tr>
</tbody>
</table>

#### Question 17. Reasons for Health Behaviours

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>Exercise related</td>
</tr>
<tr>
<td>37</td>
<td>Smoking related</td>
</tr>
<tr>
<td>38</td>
<td>Other behaviour</td>
</tr>
<tr>
<td>39</td>
<td>Work related</td>
</tr>
<tr>
<td>40</td>
<td>Home/Work related</td>
</tr>
<tr>
<td>41</td>
<td>Modern living</td>
</tr>
<tr>
<td>42</td>
<td>Other</td>
</tr>
</tbody>
</table>

#### Question 18. Positive Health Behaviour

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Target setting</td>
</tr>
<tr>
<td>44</td>
<td>Evaluation</td>
</tr>
<tr>
<td>45</td>
<td>Mortality stats.</td>
</tr>
<tr>
<td>46</td>
<td>Morbidity stats.</td>
</tr>
<tr>
<td>47</td>
<td>Questionnaires</td>
</tr>
<tr>
<td>48</td>
<td>Other measures</td>
</tr>
</tbody>
</table>

#### Question 19. Skill Requirements

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>49</td>
<td>Regular updating</td>
</tr>
<tr>
<td>50</td>
<td>Groupwork skills</td>
</tr>
<tr>
<td>51</td>
<td>Research skills</td>
</tr>
<tr>
<td>52</td>
<td>Teaching/communication</td>
</tr>
<tr>
<td>53</td>
<td>Publicity/marketing</td>
</tr>
<tr>
<td>54</td>
<td>Confidence/assertiveness</td>
</tr>
</tbody>
</table>

#### Question 20. Practice

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>Existing skills</td>
</tr>
<tr>
<td>56</td>
<td>Results/behaviour change</td>
</tr>
<tr>
<td>57</td>
<td>Access to public</td>
</tr>
<tr>
<td>58</td>
<td>Knowledge of public health</td>
</tr>
<tr>
<td>59</td>
<td>Knowledge of lay beliefs</td>
</tr>
<tr>
<td>60</td>
<td>Other reasons</td>
</tr>
</tbody>
</table>

#### Question 21. Practice

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>Medical model</td>
</tr>
<tr>
<td>62</td>
<td>Quantity</td>
</tr>
<tr>
<td>63</td>
<td>Static role</td>
</tr>
<tr>
<td>64</td>
<td>Resource</td>
</tr>
<tr>
<td>65</td>
<td>Intersectoral</td>
</tr>
</tbody>
</table>

#### Question 22. Practice

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Category</th>
</tr>
</thead>
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### References

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<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appleby F</td>
<td>(1991)</td>
<td>&quot;In pursuit of excellence&quot; Health Visitor Journal, Vol 64, No 8 254-6</td>
</tr>
</tbody>
</table>


Barker W & Anderson R (1988) "The Child Development Programme: an evaluation of process and outcomes" Bristol, Early Child Development Unit, University of Bristol


Bloomsbury Health Authority (1987) Bloomsbury Health Authority Strategic Plan London, University College Hospital

348


Calnan M (1986) "Maintaining Health and Preventing Illness: A comparison of Women from different Social classes" Health Promotion Vol 1, No 2, Oxford University Press 167-177

Cameron D & Jones I G (1985) "An epidemiological and sociological analysis of the use of alcohol, tobacco and drugs of solace" Community Medicine 7 18-24


Candeias N (1991) "Evaluating the Quality of Health Education Programmes" Hygie Vol X 40-45

Cant S et al (1992) "The role of the community nurse in coronary health disease prevention in primary care" London, Study commissioned by the Health Education Authority


CETHV (1977) An Investigation into the Principles of Health Visiting London, CETHV


Clark J (1973) A Family Visitor London, Royal College of Nursing


Conill E & O'Neill M (1984) "La notion de santé communautaire: éléments de comparaison internationale" *Canadian Journal of Public Health* 75(2) 166-175


Corbin J & Strauss A (1990) "Grounded theory research: Procedures, Canons and Evaluative Criteria" *Qualitative Sociology* 13:1 3-21


Crawford P (1993) "Diet before Conception Holds Key to Health" *Observer Newspaper* 14/3/93 9

Crawford R (1977) "You are dangerous to your health: the ideology and politics of victim blaming" *International Journal of Health Services* 7.4 663-680


DHSS (1968) Report of the Committee on Local Authority and Allied Social Services (Chairman: F Seebohm) CMND 3703 London, HMSO
<table>
<thead>
<tr>
<th>Author/Institution</th>
<th>Year</th>
<th>Title/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dingwall R</td>
<td>1977</td>
<td>The Social Organisation of Health Visitors Training London, Croom Helm</td>
</tr>
<tr>
<td>Dingwall R</td>
<td>1977</td>
<td>&quot;What Future for Health Visiting?&quot; Evidence to the Royal Commission on the NHS, Occasional Paper, Nursing Times Vol 73 77-79</td>
</tr>
<tr>
<td>Department of Health (DOH)</td>
<td>1989a</td>
<td>Working for Patients London, HMSO</td>
</tr>
<tr>
<td>DOH</td>
<td>1989b</td>
<td>Caring for People London, HMSO</td>
</tr>
<tr>
<td>DOH</td>
<td>1992</td>
<td>NHS Workforce in England DOH Unpublished</td>
</tr>
<tr>
<td>DOH</td>
<td>1993</td>
<td>The Nursing, Midwifery and Health Visiting Contribution to Health and Health Care Draft for Consultation Department of Health (Feb 1993)</td>
</tr>
<tr>
<td>Dowie J</td>
<td>1975</td>
<td>The portfolio approach to health behaviour Social Science and Medicine 9 619-31</td>
</tr>
<tr>
<td>Downie R S, Fyfe C &amp; Tannahill A</td>
<td></td>
<td>Health Prevention Models and Values Oxford, Oxford University Press</td>
</tr>
<tr>
<td>Drennan V</td>
<td>1986</td>
<td>Developments in Health Visiting Health Visitor 59(4) 108-110</td>
</tr>
<tr>
<td>Ellwood M &amp; Jefferys M</td>
<td>1976</td>
<td>Unplished work summarized and reviewed in Hicks D (ed) Primary Medical Care London, HMSO 285-288</td>
</tr>
<tr>
<td>ENB</td>
<td>1993</td>
<td>Research Highlights London, No 2</td>
</tr>
</tbody>
</table>


French J & Adams L (1986) "From Analysis to Synthesis" Health Education Journal 45 (2) 71-73


Gilmore M (1963) "A Pilot Study of the Work of the Nursing Team in General Practice" Medical Officer 124, 18, 238-243

Gilmore M (1970) "A Pilot Study of the Work of the Nursing Team in General Practice" Medical Officer 124, 18, 238-243


352
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title</th>
<th>Publisher/Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hannay D R</td>
<td>1980</td>
<td>&quot;The Patient's Point of View: The Iceberg of Illness and Trivial Consultations&quot;</td>
<td>Journal of the Royal College of General Practitioners 30, 551-554</td>
</tr>
<tr>
<td>Harrison S, Hunter D &amp; Pollit C</td>
<td>1990</td>
<td>The Dynamics of British Health Policy. The State of Welfare</td>
<td>London, Unwin Hyman</td>
</tr>
<tr>
<td>Health Education Authority</td>
<td>1992</td>
<td>Operational Plan 1992/94</td>
<td>London, Health Education Authority</td>
</tr>
<tr>
<td>Health Visitors' Association</td>
<td>1975</td>
<td>Report of Annual General Meeting</td>
<td>Health Visitor 48, 252-254</td>
</tr>
<tr>
<td>Hedges A</td>
<td>1985</td>
<td>&quot;Group Interviewing&quot;</td>
<td>In Walker R (ed) Applied Qualitative Research, Aldershot, Gower Publications 71-91</td>
</tr>
<tr>
<td>Heller T</td>
<td>1992</td>
<td>Developing Professional Knowledge and Skills&quot;</td>
<td>In Kaplun A (ed) Health Promotion and Chronic Illness, WHO (Europe) 356-359</td>
</tr>
<tr>
<td>Henderson J</td>
<td>1977</td>
<td>Health Visiting in Hampshire</td>
<td>Unpublished MSc Thesis, Guildford, University of Surrey</td>
</tr>
<tr>
<td>HMSO</td>
<td>1979</td>
<td>Nurses, Midwives and Health Visitors Act</td>
<td>London, HMSO</td>
</tr>
<tr>
<td>HMSO</td>
<td>1919</td>
<td>Nurses Registration Act</td>
<td>London, HMSO</td>
</tr>
<tr>
<td>HMSO</td>
<td>1946</td>
<td>National Health Service Act</td>
<td>London, HMSO</td>
</tr>
<tr>
<td>HMSO</td>
<td>1990</td>
<td>National Health Service and Community Care Act</td>
<td>London, HMSO</td>
</tr>
<tr>
<td>Hicks D</td>
<td>1976</td>
<td>Primary Health Care: A Review</td>
<td>London, HMSO</td>
</tr>
<tr>
<td>House of Commons</td>
<td>1989</td>
<td>The Children Act</td>
<td>London, HMSO</td>
</tr>
<tr>
<td>Author</td>
<td>Date</td>
<td>Title</td>
<td>Source</td>
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<td>--------</td>
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<td>-------------------------------------</td>
</tr>
<tr>
<td>Honigsbaum F</td>
<td>1985</td>
<td>Reconstruction of General Practice: Failure of Reform&quot;</td>
<td>British Medical Journal 290 823-826</td>
</tr>
<tr>
<td>Illich I</td>
<td>1976</td>
<td>Limits of Medicine</td>
<td>London, Marion Boyars</td>
</tr>
<tr>
<td>Jackson C</td>
<td>1993</td>
<td>&quot;Beyond Project 2000&quot;</td>
<td>Health Visitor Vol 66 153-154</td>
</tr>
<tr>
<td>Jarman B</td>
<td>1983</td>
<td>&quot;Identification of Under Privileged Areas&quot;</td>
<td>British Medical Journal 290 823-826</td>
</tr>
<tr>
<td>Jones S</td>
<td>1985</td>
<td>&quot;The Analysis of Depth Interviews&quot;</td>
<td>In Walker R (ed) Applied Qualitative Research Aldershot, Gower 56-70</td>
</tr>
<tr>
<td>Kasl S &amp; Cobb S</td>
<td>1966</td>
<td>&quot;Health behaviour, illness behaviour and sick role behaviour&quot;</td>
<td>Archives of Environmental Health 12 246-266</td>
</tr>
<tr>
<td>Keeley Robinson</td>
<td>1987</td>
<td>Health Education/Promotion in the NHS. Post Griffiths</td>
<td>London, Health Education Authority</td>
</tr>
<tr>
<td>Keen H</td>
<td>1991</td>
<td>&quot;A view of what life is about&quot;</td>
<td>Health Visitor Vol 64 10</td>
</tr>
<tr>
<td>Kerkstra A</td>
<td>1991</td>
<td>&quot;Allround, gedifferent tierd of gespecialiseerd, lessen uit net buitenland&quot;</td>
<td>Maatschepelijk Gezondheidzorg 19, 2 24-28</td>
</tr>
<tr>
<td>Killoran A</td>
<td>1993</td>
<td>&quot;Pacemaker&quot;</td>
<td>Health Service Journal Vol 103, 5340 26-27</td>
</tr>
<tr>
<td>King J</td>
<td>1989</td>
<td>&quot;Educating Patients, a change of approach&quot;</td>
<td>Horizons Vol 3, 3</td>
</tr>
<tr>
<td>Kirby R</td>
<td>1981</td>
<td>The recruitment, training and development of health education officers. Report of the National Staff Committee for Administration and Clerical staff</td>
<td>(Kirby Report)</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Title and Details</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Kratz C</td>
<td>1978</td>
<td>Care of the Long Term Sick in the Community particularly patients with stroke Edinburgh, Churchill Livingstone  22-30</td>
<td></td>
</tr>
<tr>
<td>MacDonald G &amp; Bunton R</td>
<td>1992</td>
<td>&quot;Health Promotion Discipline or Disciplines&quot; In Bunton R and MacDonald G (eds) Health Promotion Disciplines and Diversity London, Routledge 6-9</td>
<td></td>
</tr>
<tr>
<td>MacKay L</td>
<td>1989</td>
<td>Nursing a Problem Milton Keynes, Open University Press</td>
<td></td>
</tr>
<tr>
<td>Marris T</td>
<td>1971</td>
<td>The Work of Health Visitors in London Greater London Council (Department of Planning and Transportation, Research Report No 12)</td>
<td></td>
</tr>
<tr>
<td>M cleary G L</td>
<td>1935</td>
<td>The Maternity and Child Welfare Movement Westminster, King &amp; Son Ltd</td>
<td></td>
</tr>
<tr>
<td>McKeown T</td>
<td>1979</td>
<td>The Role of the Medicine, Dream, Mirage or Nemesis Oxford, Basil Blackwell</td>
<td></td>
</tr>
<tr>
<td>Melia K</td>
<td>1984</td>
<td>&quot;Student Nurses Construction of Occupational Socialisation&quot; Sociology of Health and Illness 6 132-151</td>
<td></td>
</tr>
<tr>
<td>Milio N</td>
<td>1986</td>
<td>&quot;Multisectorial Policy and Health Promotion: Where to begin?&quot; Health Promotion Vol 1, No 2 129-132</td>
<td></td>
</tr>
<tr>
<td>Milio N</td>
<td>1981</td>
<td>Promoting Health through Public Policy Philadelphia, F A Davis</td>
<td></td>
</tr>
<tr>
<td>Ministry of Health (MOH)</td>
<td>1913</td>
<td>The Mental Deficiency Act London, HMSO</td>
<td></td>
</tr>
<tr>
<td>Author/Editor/Title</td>
<td>Year</td>
<td></td>
<td></td>
</tr>
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<td>---------------------</td>
<td>------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOH (1946)</td>
<td>The National Health Service Act London, HMSO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOH and Scottish Home and Health Department (1966)</td>
<td>Report of the Committee on Senior Nurse Staff Structure (Salmon Report) London, HMSO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Nursing Times (1993) "Staff levels inadequate says RCN" London, News Comment, Nursing Times Vol 89 No 20 9


O'Neill M (1989) "The Political Dimension of Health Promotion Work" In Martin C and McQueen D (eds) Readings for a New Public Health 223-234


Poulton K (1977) "Evaluation on Community Nursing Service". Unpublished report Wandsworth and East Merton Teaching District

Quinn G & Freeman R (1991) "Health Visitors as Dental Practitioners: their knowledge, attitudes and behaviour" Health Education Journal 50.4 191-194

Rabkin J G & Struening E L (1976) "Life Events, Stress and Illness" Science 194 1013-1020

Rawson D & Grigg C (1988) Purpose and Practice in Health Education. The training and development needs of Health Education Officers. Summary report of the SHER Project London, Southbank Polytechnic


Research Unit in Health & Behaviour Change RUHBC (1989) Changing the Public Health Chichester, John Wiley and Sons


Rosenstock I M (1974) "Historical origins of the health belief model" Health Education Monographs 2 328-335

Ross F (1992) A Study of Practice Nurses Working in South West Thames Regional Health Authority London, St George's Hospital Medical School

Royal College of Nursing of the United Kingdom (1987) Response to the Consultation of Primary Health Care initiated by the UK Health Departments London, RCN Publications


Seymer L R (1955) Selected Writings of Florence Nightingale Macmillan

Silverman D (1985) Qualitative Methodology and Sociology Aldershot, Hants, Gower


South West Thames Regional Health Authority (1993) Reshaping the Intermediate Tier in South West Thames Letter sent from Regional General Manager to Chief Executives of DHAs, FHSAs, Trusts and DMUs 24 March 1993

Sparacino J (1992) "Blood Pressure, Stress and Mental Health" Nursing Research 31(2) 89-94


Stern P N (1980) "Grounded Theory Methodology. Its uses and processes" Image Vol XII, No 1 33-36

St Ives I F M (1981) "At the Crossroads of Primary Healthcare" Royal Society of Health Journal 101, 1 33-36

Strong P M (1979) "Sociological Imperialism and the Profession of Medicine" Social Science and Medicine Vol 13a 199-215
Suchman E A (1967) "Evaluation Research" New York, Russell Sage Foundation
Sutherland I (1979) Health Education: perspectives and choices London, Allen and Unwin
Tannahill A (1985) "What is Health Promotion?" Health Education Journal Vol 44, No 4 167-168
Tannahill A (1992) "Epidemiology and Health Promotion" In Bunton R and MacDonald G (eds) Health Promotion London, Routledge 86-107
Tuckett D, Boulton M & Williams A (1985) Health Education and General Practice: General Practitioners Perceptions of Difficulties and Constraints Paper given at study day on Health Education in General Practice. London, King Edward's Hospital Fund for London
Tulloch A J & Moore V (1979) "A Randomised Controlled Trial of Geriatric Screening and Surveillance in General Practice" Journal of Royal College of Practitioners 29 733-742
UKCC (1992) District Nursing Joint Committee and Health Visiting Joint Committee. Implications of the Downward Trend in Student Numbers and Secondments for Health Visiting and District Nursing Courses. Agendum 5.2 December 1992
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vetter N, Jones D &amp; Victor C</td>
<td>1986</td>
<td>&quot;Health Visiting with the Elderly in General Practice&quot; In While A (ed) Research in Preventive Community Nursing Care Chichester, John Wiley &amp; Sons 215-217</td>
</tr>
<tr>
<td>Walker R</td>
<td>1985</td>
<td>Applied Qualitative Research Aldershot, Hants, Gower Publications</td>
</tr>
<tr>
<td>Wallston B S &amp; Wallston K A</td>
<td>1978</td>
<td>&quot;Locus of control and health: a review of the literature&quot; Health Education Monographs 6 107-116</td>
</tr>
<tr>
<td>Wilensky H L</td>
<td>1964</td>
<td>&quot;The Professionalisation of Everyone&quot; American Journal of Sociology Vol 7 No 70 137-158</td>
</tr>
<tr>
<td>Williams A</td>
<td>1990</td>
<td>Unpublished study of Health Prevention in General Practice Centre for Primary Care. London, Steels Lane Health Centre</td>
</tr>
<tr>
<td>Williams S J</td>
<td>1990</td>
<td>&quot;The Relationship among Stress, Hardiness, Sense of Coherence and Illness in Critical Care Nurses&quot; Medical Psychotherapy 171-186</td>
</tr>
<tr>
<td>Woods N F &amp; Catanzaro M</td>
<td>1988</td>
<td>Nursing Research. Theory on Practice St Louis, C V Mosby</td>
</tr>
</tbody>
</table>

360
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO</td>
<td>1984</td>
<td>Health Promotion Concept and Principles: A Discussion Document</td>
<td>Copenhagen, WHO Regional Office for Europe (ICP/HSR 602)</td>
</tr>
<tr>
<td>WHO</td>
<td>1985</td>
<td>Targets for Health for All</td>
<td>Copenhagen, WHO Regional Office for Europe</td>
</tr>
<tr>
<td>WHO and Canada and</td>
<td>1986</td>
<td>Ottawa Charter for Health Promotion An international conference on</td>
<td>Copenhagen, WHO/Europe</td>
</tr>
<tr>
<td>Canadian Public</td>
<td></td>
<td>health promotion.</td>
<td></td>
</tr>
<tr>
<td>Health Association</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zola I</td>
<td>1973</td>
<td>&quot;Pathways to the Doctor: from person to patient&quot;</td>
<td>Social Science and Medicine 7 677-689</td>
</tr>
<tr>
<td>Zola I</td>
<td>1975</td>
<td>&quot;In the Name of Health and Illness&quot;</td>
<td>Social Science and Medicine 9 83-87</td>
</tr>
</tbody>
</table>