Group Health Education
by Health Visitors

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for the degree of Master of Philosophy

BY

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SUMMARY

This study reviews the history and development of the training of health visitors in the United Kingdom; and it compares work of a similar nature undertaken in the public health field in other parts of the world.

It considers the development of health education and also that of midwifery with special reference to preparation for parenthood in relation to the health visitor's role.

The method adopted was to select items considered to influence the health education functions of the health visitor and to carry out a study designed to see whether the present training fits the health visitor for the group work she may be required to do. A survey was made of interest in health education and a descriptive analysis of work actually carried out within a twelve month period in the year 1971.

The returns showed that in the areas selected health visitors are concerned with a wide variety of group health education projects. In many instances however they felt that they were not wholly prepared for this aspect of their work and voiced the opinion that they should receive further training to reinforce the basic principles of teaching studied during health visitor training.
The study of the literature reflects the finding that there is considerable variation in the amount of group health education undertaken. In particular health visitors are becoming increasingly involved with school children. In many instances their work with expectant mothers is carried out in collaboration with other interested practitioners.

A review of the work and training of the public health nurse in countries outside the United Kingdom reveals that the training syllabus, as laid down by the Council for the Education and Training of Health Visitors, prepares the British health visitor for a function that is unique.

Finally the study surveys the work undertaken by the health visitors who qualified between 1968-71 in 36 employing authorities including those who trained at Croydon College of Design and Technology. It appears that the training lays a foundation for the work that health visitors are required to do, and that there is a bias in training at Croydon towards health education amongst expectant mothers and parents with young children.

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Part I - The Birth of Health Visiting
Health Visiting

The development of the health visiting service is closely linked with that of the nursing profession. However, the service was not founded to take on duties delegated by the medical profession but rather to meet the needs of the poor, the products of the migration to the cities in the early and mid 19th Century. The industrial revolution increased the inequality between the very rich and the very poor, and in many instances the impact of the new environment on family life produced poverty, overcrowding, disease and misery. The efforts of Lord Shaftesbury and the popular writers of that period began to arouse public interest and sympathy. The publication of Kingsley's "Water Babies" was largely instrumental for the passing of the Chimney Sweeper's Act (1864), and the writings of Dickens and his appeals for funds for the Hospital for Sick Children in London successfully drew the attention of the public to the sufferings of children. According to Trevelyan (1942) the awakening of public sympathy for the plight of the poor child was one of the Victorians' chief contributions to civilisation.

The work carried out by Dr. John Bunnel Davis is considered to be the forerunner of present day public health nursing. An early pioneer of the care of sick children, he established in 1816 the Universal Dispensary for Sick Indigent Children, London. District Committees of benevolent ladies were organised to visit the homes of sick children, to distribute leaflets advising on child management and report back on the health of the young patients. Later on pioneer activities of the Medical Officers of Health, appointed under the
provisions of the first Public Health Act (1848), were reflected in the development of voluntary visiting societies. But many Bible Societies were already involved in schemes of home visiting to spread the Gospel and instruct in simple matters of health and hygiene.

Trevelyan's view was that the growth of the social conscience arose from the concern for the welfare of the poor. Another perhaps less meritorious factor could have been the fear of infectious disease. At the suggestion of Farr (1807-83) the London Obstetrical Society investigated infant deaths for the period 1867-1869, and the report highlights the annual epidemics of gastro-enteritis. The findings of a further enquiry by the Society pointed to the home where poor standards of hygiene were revealed and were caused by ignorance, low standards of maternal care and overcrowding. The results of these enquiries led to the formation of voluntary groups of workers destined to play an important role for the next half century.

It is generally agreed that the birth of health visiting took place in Manchester and Salford in 1862 with the work of the Manchester and Salford Ladies Sanitary Reform Group. This was initially carried out by the united efforts of ladies of some social position together with working women who had a knowledge of the poor they visited. The whole area was divided into districts, in each a volunteer lady superintendent supervised the work of both the ladies of social position who distributed tracts and leaflets and the working women who were responsible for health teaching and practical help. Recognition
of the work came in 1890 when Manchester Corporation invited the Sanitary Group to work under the direction of the Medical Officer of Health. One of the first municipal welfare services in the United Kingdom was thus formed when 6 members of the Group were appointed as members of the local authority staff. In contrast to the work of the nurse, the functions of these workers were recognised to be those of health teacher and general counsellor.

A parallel development took place at Steeple Claydon, in Buckinghamshire, where Florence Nightingale devised plans for visiting the cottagers in rural Buckinghamshire. Although she was keenly interested in the work being carried out in Salford and Manchester, she recognised that rural communities too had health needs and so she advocated the employment of trained workers whom she referred to as "missioners" to advise mothers in their own homes. Nwinston describes how Nightingale believed that only by working with these mothers would the visiting missioners' teaching become more effective. Sir Frederick Verney, an uncle of Miss Nightingale and Chairman of the North Buckinghamshire Technical Education Committee was instrumental in promoting a scheme for training health missioners in 1892. A Dr. De'ath, Medical Officer and Public Vaccinator, was appointed to give a series of 16 lectures to the 16 ladies who enrolled for training. 12 took the examination, 6 qualified as health missioners but only 3, the Misses Denys, Rowland and Bartlett, were appointed to work in Buckinghamshire. Their main functions were to teach the principles of health and disease to the cottage mothers, and then by invitation to visit the homes to
give individual social advice. Nightingale (1893) stressed the importance of teaching health subjects in the home if they were to result in behaviour change. She wrote of the need for a fully trained nurse for every district supported by a Health Missioner whose qualities should include good character, good health and personal fitness for home teaching. These early missioners set the pattern for the development of health visitor training which in the early 20th Century became the subject of legislation. Thus in the very early stages of the development of the service two distinct areas of need were identified: in the cities the flotsam of the industrial revolution presented a challenge of immense proportions, and the rural communities contained families whose poverty was so much an accepted feature that their needs were largely ignored until Nightingale turned her attention to their plight. In both instances the fieldworker appears to have come from the same environment as her clients and so probably had the innate ability to communicate more effectively with the families she visited than her superiors. (This approach is used by many of the under-developed countries today, such a scheme amongst the Navajo peoples of North America is described on page 154.)

In this way health visiting proved its worth, and gradually government machinery took over the emerging service. Unfortunately it has never been able to keep pace with the increasing demands of an industrial society. Staff establishments have always been too small, but in spite of this the service has still tried to cover the whole ground instead of restricting its range of activities
to areas of specific need. Perhaps this latter tendency
is a legacy inherited from its nursing background. Records
show that all too frequently the health visiting service has
been over-extended and, as a consequence, ill-equipped to meet
changing needs. Although it has benefited from the support of
some Medical Officers of Health it has lacked strong internal
leadership. The profession has tended to concentrate on guarding
its boundaries only to find them eroded away by other more powerful
emergent para-medical and social work groups. It has been bedevilled
by an ambivalent attitude towards the full acceptance of its role
in society and, by remaining under the direction of the Medical
Officer of Health for over a century, the doctor-nurse relationship
has been perpetuated. Until the last decade the profession was
unable to initiate discussion with the medical profession about
client needs in relation to available resources. That the doctor
has the ultimate responsibility for his patients' clinical care is
beyond dispute, but this should not prevent the health visitor*
from using her professional talents and skills in matters relating
to health education and social advice.

During this period up to the beginning of the second world war
the tenuous links with medicine as a basic entry requirement were
severed and nurse training became firmly established as the pre-requisite

* The health visitor is generally referred to in this study as "she".
But this is for convenience only because most health visitors are
women - no discrimination is of course intended or implied.
for health visiting. Although the pattern was being set for training courses to be held in educational establishments rather than in association with schools of nursing, nevertheless students experienced difficulty in moving away from the clinical orientation of nursing care to the much wider interpretation of the provision of health visiting care. Despite the move away from the influence of nurse training many of the courses were both heavily reliant upon and influenced by the medical profession. This overt control was in part responsible for the delay in recognising the range of perceptual, intellectual and social skills required of the health visitor in addition to those motor skills which, in the past, have received so much attention in basic nurse training. For too long has the nursing profession concentrated on a task orientated service. This approach has impeded recognition of the critical factors which determine the degree of responsibility undertaken in any one given situation as well as the related degree of independent judgment required of the nurse. Although many health visitors are justifiably proud that their training is built onto the foundation of nurse training, it could be argued that, in its present form, this base has proved to be too narrow and inflexible and has led to attitudes which cannot easily be modified in a course lasting only 6 months. This legacy may have hindered the development of health visiting towards a true professional status.

The major factors which have influenced the development of the service are described in the following parts of this chapter.
Part II - From the Boer War to the Second World War
Historical Development

One notable development in the growth of the profession occurred in Huddersfield in 1905, when the Medical Officer of Health, Dr. S.G.H. Moore, was deeply concerned by the problem of the high infant mortality rate. He prepared a plan to reduce the appalling waste of life and recommended Huddersfield Corporation to appoint two experts to advise mothers in their own homes on infant management. They appointed two medical officers whose primary function was to make one visit to the home of each newborn baby. However, birth notifications were both sporadic and late. The Huddersfield Act (1906) which required the notification of each new birth to the Medical Officer of Health within 36 hours overcame this difficulty and a fee of one shilling was paid for each notification. To supplement the work follow-up visits were made by a corps of 80 voluntary workers. It was organised on the same administrative pattern as the Manchester scheme with a lady superintendent responsible for the workers within her own district.

Other authorities soon followed the lead given by Huddersfield. The Notification of Births Act was passed in 1907 giving them permissive powers to adopt the Act but not to pay a fee! By 1915 almost 80% of the country had already adopted this procedure when the Notification of Births (Extension) Act made it a mandatory requirement throughout the land. This one requirement helped to bring about a spectacular drop in the infant morality rate, from 163 per thousand in 1899 to 51 per thousand by 1939 (Rosen). In addition, the 1915 Act widened the scope of the health visitor's work by requiring notification
of the birth of any viable infant (that is one born on, or after, the 28th week of pregnancy) whether alive or dead. The purpose of the service, which was optional for those visited, was not to give charity but to visit the newborn child.

As a result of the early statutory notification of births there was an increase in the number of health visitors employed by local authorities and voluntary agencies. Prior to the onset of the Boer War only 14 were in post, by 1914 there were 600 and this rose to 3,038 by the end of the first World War. Gradually the numbers increased until there were 5,384 in 1933 and, of these about 50% were still working in a voluntary capacity. This figure was almost as high as 20 years later when 6,702 qualified health visitors were known to be in post.

One example of the value placed on this emerging service is seen in the annual report of 1909 by the Medical Officer of Health for Aberdeen, a Dr. Hay, who paid tribute to the work of his health visitors who in his opinion constituted "one of the most valuable branches of the work of the Health Department". While admitting that their teaching would make slow progress, he continued: "I entertain no doubt as to its ultimate value, not merely in regard to the care of infants, but as concerns the whole sphere of domestic hygiene - a sphere which the main part of future progress in public health must be looked for".

The 1914-18 war gave impetus to the maternity and child welfare movement, and attention was increasingly focused on the health of the expectant mother. A memorandum issued by the Local Government Board
in 1914 stressed the importance of ante-natal care, and in the following year 6 experimental clinics were set up around the Royal Free Hospital, London. By 1918, 120 ante-natal clinics had been provided by voluntary agencies or the local authorities, a figure which rose to 1,417 by 1933. Health visitors were expected to give advice on matters of hygiene and distribute "Advice Leaflets" to the mothers attending the clinics. When necessary they made follow-up visits to the homes. The midwife was still concerned with the high maternal mortality rate and therefore concentrated on the physical aspects of care. While separate ante-natal clinics were being provided, many infant welfare centres incorporated ante-natal work into their existing schemes. By 1918 some 700 maternity and child welfare centres were provided by the local authorities with a further 578 by the voluntary agencies. Again this led to an expansion in the number of health visitors. By the end of 1933 2,938 were to be employed by local authorities and 2,546 by voluntary organisations, about an 80% increase of health visitors over a period of 15 years.

In 1918 the Local Government Board issued a memorandum urging authorities to provide care for expectant and nursing mothers, and extend facilities for the young child to cover all those of pre-school age. Despite the increase in the numbers of health visitors employed to cope with the additional work, McCleary states that England was still 645 short of establishment on the basis of the Local Government Board's recommendation of one health visitor per 400 annual live births (1918).
The expansion of health facilities for mothers and young children in this period culminated in the Maternity and Child Welfare Act, 1918. The Act formally recognised many of the varied functions carried out by different local authorities, and it also required local government to establish Maternity and Child Welfare Committees. Grants of up to 50% were available for approved expenditure and for some approved experimental schemes. The Annual Report of the Local Government Board (1917-18) gave an outline of the functions which were permitted under the Act, as follows:-

1. to provide a health visiting service, on the basis of one to 400 annual live births, to be responsible for:
   a. maternal and child welfare in the homes,
   b. infectious disease control, and,
   c. giving assistance at welfare centres,

2. to provide Maternal and Child Health Centres for each health visitor's district,

3. to provide food and milk,

4. to provide a midwifery service,

5. to supply medical aid in pregnancy,

6. to provide a home nursing service for illness in pregnancy and childhood infectious diseases,

7. to arrange for hospital beds during pregnancy, confinement and for sick children,

8. to provide maternity homes and homes for malnourished infants who are not eligible for hospital care,

9. to provide convalescent and rest homes,

10. to provide accommodation for one-parent families,

11. to provide day nursery accommodation to the children of working mothers,

12. to supply home helps during confinement.
Gradually authorities assumed responsibility for a wide range of services aimed at the prevention and cure of ill-health amongst mothers and young children. It would appear that the work of the health visitor was the most important element in this field of work, their concern in combatting infant mortality and morbidity soon became identified in the role of the "well-baby nurse". Wherever the local authorities implemented the functions permitted by the Act, more health visitors were required, and training courses began to develop.

**Professional Development**

From the inception of the service in 1862, attempts were made to train salaried visitors. The best known example was the course held in North Buckinghamshire Technical College at the instigation of Florence Nightingale in 1892. However there is no evidence of its survival and the need for a professional training began to emerge at the turn of the century. Two of the first courses started in London, both were held at the Battersea Polytechnic in 1907: one was a two-year course in physical and social sciences for educated women, and the second a course of 6 months duration for trained nurses. Some of the other early training centres included the Liverpool School of Hygiene, the University College of Wales and 2 Women's Colleges in London - Bedford and King's College.

The first move towards uniformity in the profession took place in London with the passing of the London County Council (General Powers) Act, 1908, which legalised the appointment of health visitors. In the
following year the Local Government Board issued regulations stating that a health visitor should possess a medical degree, or be a trained nurse, or be in the possession of the Certificate of the Central Midwives Board, or have a modicum of nurse training, together with an approved certificate, or have carried out similar (health visiting) duties in a local authority service. This restricted the field to those with medical, nursing or sanitary experience and/or training, but outside London these requirements did not apply.

The examining body of that time was the Royal Sanitary Institute, founded in 1876 and later to become the Royal Society of Health. In addition to being the examining body, it ran a health visitor course and promoted training in other institutions. By 1918 22 courses were recognised by the Institute and the number rose to 29 by 1923. In 1916 the Local Government Board recommended that a health visitor should possess any two of the following qualifications: a sanitary inspector's certificate, nursing experience, or the certificate of the Central Midwives' Board. However, this requirement was not adequate to maintain the quality of work required and the standard of work was very mixed, particularly outside London. To improve the situation after the enactment of the Maternity and Child Welfare Act, 1918, exchequer grants towards health visitor salaries were paid only in respect of those who met the requirements stipulated for the London area.

Health visiting was formally accorded professional status in
1919, the year in which the Ministry of Health superceded the Local Government Board and the Nurses' Act established a statutory qualification for nurses. The Board of Education (Health Visitors' Training) Regulations were passed making provision for three schemes of training:—

a. a two-year course for candidates without either the pre-requisite education or acceptable experience,

b. a one-year course for graduates,

c. a separate one-year course for qualified nurses.

A midwifery qualification was not required until 1925 when the full 6 months course in midwifery was stipulated; in 1937, when midwifery training was divided into two equal parts, only the Part I Certificate of the Central Midwives Board was required. A preliminary block of 6 months hospital nursing experience was later added to the two-year course but eventually the two-year course was dropped in 1944.

By 1919 health visiting had reached a turning point. The service could have expanded along an ever-widening avenue of service, but instead it was confined to a narrow but still important area of need. The nation was still suffering from the aftermath of the Great War and the knowledge that there was still much to be desired in the standard of care for mothers and young children. The trend towards specialisation was almost inevitable. In 1925 it was decided that, in future, entry requirements for health visitor training should include midwifery training. The Ministry of Health,
which by now was responsible for the training of health
visitors, promptly reduced the length of the course to
6 months. In one stroke the field of work was restricted to
maternal and child care, a step which diminished the health
visitor's knowledge and expertise in preventive and social
measures, and kept men out of the profession for another half-
century. In the short term the concentration on maternity and
child welfare aspects of the work may have been beneficial
for the nation but in the long term it was disastrous for the
profession. There was a danger that the public and the profession
would so identify the work of the health visitor with infant care,
to the exclusion of health education and social support, that
given the continuing decrease in infant mortality health visitors
would be in danger of working themselves out of a job. However
the onset of the Second World War and the events immediately
following it proved otherwise.
Part III - The Welfare State
During the Second World War plans for social reform were prepared, based on the recommendations of the Report on Social Insurance and Allied Services (1942) of the Committee chaired by Sir William Beveridge. At this time a Joint Consultative Committee composed of the Standing Conference of Health Visitor Training Institutions, the Royal College of Nursing, and the Women Public Health Officers Association, put forward proposals in which they outlined the health visitor's range of duties. Apart from her now traditional role in maternal and child welfare, they proposed that she should be concerned with the school medical service, tuberculosis visiting, the control of infectious diseases and social work. The Committee seized the opportunity to advocate a broadening of the health visitor's work away from her concentration on child welfare to concern for the family as a whole.

A series of Acts of Parliament in the immediate post-war period provided for the re-arrangement of services and institutions on the lines envisaged by Beveridge. For example, the National Health Service Act, 1946, was intended to provide a comprehensive health service available to all citizens in England and Wales according to need, but without direct cost or insurance qualification; though these principles were subsequently modified to some extent. The Act led to great changes in the organisation of the hospital, family practitioner, and public health services of the local authorities. In particular, it opened up the health visitor's work to care for the whole family and re-emphasised her role in the preventive and
social fields.

Part III, Section 24 of the Act states that:-

"It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their own 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 the measures necessary to prevent the spread of infection."

The qualifications of the health visitor were set out in a Statutory Instrument (No. 1415), the National Health Service (Qualifications of Health Visitors and Tuberculosis Visitors) Regulations, 1948, which stated that:-

"'health visitor' means a woman employed by a local authority for the visiting of persons in their own homes ... and also includes a woman so employed by a voluntary organisation under arrangements with a local health authority."

These Regulations incorporated the qualifications specified by statutory rules and orders under the Local Government Act, 1929. Since 1948 the health visitor must be

a. qualified before 5th July 1948 to hold the appointment of health visitor, or

b. have the approved Health Visitor Certificate of the Royal Sanitary Institute.*

The health visiting service became the statutory responsibility of the Counties and County Boroughs to the exclusion of the District Councils, and voluntary effort tended to disappear. The health visitor's title and function was laid down by statute and her work widened to include the health of the whole household. On the other hand the work of the health visitor in the School Health Service

*See page 35.
remained almost unchanged by post-war legislation. In addition the amalgamation of the mental health services with the National Health Service and the provision of care and after-care powers opened up a new avenue of work for the health visitor. Two enactments greatly reduced the work of the newly recognised profession. As a direct result of the Curtis Report (1946) the Children's Act, 1948, concentrated responsibility in a single department for the continuous care of children under 18 years deprived of a normal home life. In effect it relieved the health department of the administration of child life protection and adoption procedures, apart from the provision of health and medical care. This meant that the health visitor had a specific but restricted function. The National Assistance Act, 1948, removed the last vestiges of the Poor Law and laid down principles for the welfare of handicapped persons and the provision of care for the aged, infirm and those in need of care and attention; these duties were to become the responsibility of the welfare departments.

Perhaps it is not surprising that the changes gave rise to feelings of dismay and frustration amongst the health visiting profession which on the one hand had to expand its area of expertise, and on the other hand was confined by the overlapping of its work with that of the new service departments for children and welfare. Furthermore, of the three employees, the health visitor was the only worker required at that time to hold a statutory qualification in order to practise.

In order to implement the principles of health care laid down by post-war legislation it became necessary to increase the establishment
of qualified health visitors. An amended health visitor syllabus came into force in 1950 to prepare students for this widening field of work within the National Health Service. To be effective the courses needed to be longer than the current 6 months training period, at least until basic nursing training was improved sufficiently to raise the/previous professional experience of intending health visitor students. In order to meet the demand more training courses were set up and consequently more tutors were required. The Royal College of Nursing (Education Department) started a 9 months training course for health visitor tutors in 1948. The course, approved by the Ministry of Health, was organised in conjunction with the City of Birmingham Public Health Department. During 1950 the councils of the 2 professional organisations representing health visiting interests produced a revised edition of the pamphlet setting out the duties of the health visitor. In it they reiterated that her duties were those of:

"health education and social advice ... within the family group, and co-operation with other health and social workers ...".

They acknowledge the health visitor's responsibility for group teaching and the necessity to have a thorough knowledge of her catchment area when planning programmes for mothers' groups, parents' clubs, and schools. Furthermore they emphasised her role for organising the teaching of parentcraft: this should include a fathers' night, relaxation classes, and preparation for labour. They recommended
that she should function either alone or jointly with the midwife whether it be in a local authority, general practitioner group, or hospital ante-natal clinic. They emphasised the importance of instruction in educational psychology, teaching techniques and the use of visual aids. The health visitor was to be the link between all services geared to meet the needs of the expectant mother. Other areas of responsibility included the prevention of infectious diseases, dealing with physical and mental illness, mental subnormality, the elderly, and research.

By 1950 some health visitor training courses still continued for the stipulated minimum of 6 months, but many covered an academic year to accommodate the amended syllabus, preparing the students for their function as visitors to "the whole family" according to the Statute. By 1965 most courses had extended their training to one academic year plus 11 weeks of probationary practice. Despite these moves the profession remained under-staffed and there were still some doubts over the true interpretation of the role of the health visitor. At that time the professional organisations put pressure on the Central Government Departments to set up an inquiry into health visiting.

To sum up, the situation following the enactment of the National Health Service Act, 1946, was similar to that which occurred in 1918 with the Maternity and Child Welfare Act. Once again the profession was not prepared for the rapid expansion of its duties, and only/1956 had most of the training schools extended the period of training to accommodate the amended syllabus introduced
6 years earlier. Most of the legislation was permissive, and in many areas the service was impeded in attempts to enlarge its establishment by the competing claims of other interests in local government. For example, there was an increase in appointments to local authority Children's and many Welfare Departments of social workers/of whom had no professional training.

The health visitor course started by the Royal College of Nursing in 1948 to meet the increased training needs was instrumental in providing the extra tutorial staff required. However, as the RCN's function was primarily that of a professional organisation it could be said that the training was biased towards professional content rather than concentrating on educational methods and practice. In recent years the course has been strengthened by its association with the Department/Adult Education, at the University of Surrey. In 1967 another training course for health visitor tutors was established at Bolton College of Technology. It had a different philosophy and focused on educational technology. As a result there was a much needed infusion of tutors with a different approach into a somewhat inbred circle of tutors. The effect of the 2 different training schools' philosophies on the attitudes of tutors towards teaching, and group health education in particular, would merit further investigation.

Was the service now to be allowed a period of time for consolidation?
Part IV - Recent Developments
Introduction

For many years those in charge of the National Health Service were aware of major shortages and differences in the quality of the service provided throughout the regions. In order to improve the service and combat the problem of rising costs, much more information was required about the existing service before future arrangements could be forecast. A careful assessment had to be made in order to determine priorities and improve management skills. All these factors led to a number of surveys within the health and local authority services, starting in the mid 1950's and continuing to the present time.

The Jameson Report

One of the first of these surveys, and the most important one for the health visiting profession was initiated by the then Ministers of Health and Education and the Secretary of State for Scotland in 1953. A working party was appointed under the chairmanship of Sir Wilson Jameson, G.B.E., K.C.B., M.D., F.R.C.P., to advise on the proper field of work, the recruitment and training of health visitors in the National Health Service and School Health Service. Two of the 6 members were public health nurses, and, of the others, one was a General Practitioner, another a Medical Officer of Health, and a third the Chairman of a Health Committee. Evidence was taken from employers, professional and educational organisations. The report "An Inquiry into Health Visiting" was published in 1956. The main conclusions and recommendations can be
summarised as follows:—

first, the health visitor's principal functions should be health education and social advice; these should be performed both in relation to family needs and taking account of other workers who may also be involved. While it was acknowledged that health visitors should maintain contact with all families with young children, this should not deter them from providing care for other groups such as the elderly, the mentally sick and handicapped. They should be freed to carry out duties suited to their skills in the School Health Service, for example in health education and with handicapped children.

Secondly, in the past the health visitor's concern in preventive work and the provision of care had been mainly in relation to patients suffering from tuberculosis. They should extend this work, in conjunction with the family doctor, to include after-care for the patient and his family. In fact the health visitor could become a general purpose family visitor working in association with general medical practice where she would be in contact with a wider range of families than any other worker in the community. Her span of work could include general preventive and social aspects of illness amongst the elderly, the handicapped and the chronic sick. She could both extend the scope and improve the quality of community after-care for patients discharged from hospital. The importance of the health visitor's work in the sphere of mental health was stressed.

Then the status of health visitors and their relationships with other workers was discussed. While their work was distinct
from that of both sick nursing and social work, nevertheless co-operation with nursing colleagues, doctors and social workers was considered to be of paramount importance.

Finally recommendations were made to assess manpower needs in relation to the changing pattern of work, the recruitment of an additional 3,500 health visitors over a 10-year period, and the setting up of Central Training Bodies to control the syllabus, examinations and the approval of courses at authorised training centres.

The Committee were convinced that there was substantial overlapping of both the training and functions of community workers, and that this had led to considerable confusion. In their opinion the work of the health visiting service would be ineffective if the field of work was too wide and the functions too diverse and demanding. However, the Committee appeared to be reluctant to express a firm opinion about the form of organisation that would best meet future needs. They avoided the issue by saying that it would be wise to wait until a firm picture of needs emerged. The opportunity to make a detailed study of the health visitor's work was missed and as a consequence the chance to delineate her area of expertise was lost. While it could be argued that this would have set too rigid a framework for the service, at least it would have provided a firm base from which future expansion could develop. By their failure to do this the Committee sowed the seed of uncertainty in the mind of the profession, one which more than 20 years later remains unresolved.
The recommendations of the Jameson Report were accepted and circulars were sent to local health authorities urging them to give health visitors more responsibility in preventing the breakdown of problem families, the management of handicapped children and care of the elderly at home, and the prevention of mental illness. A previous report, the Committee on Maladjusted Children (1955) had recommended the use of health visitors for child guidance.

Another working party was set up in 1956 to examine the field of work, recruitment and training of Local Authority Health and Welfare social work staffs. Although limited by its terms of reference the report stressed the complementary nature of the work of health visitors and social workers. This report known as "The Younghusband Report" was published in 1959. The Government implemented many of the recommendations of this report as well as the Jameson Report. In 1962 the Health Visitor and Social Work (Training) Act provided for the setting up of 2 councils - the Council for the Training of Health Visitors (later to become the Council for the Education and Training of Health Visitors) and the other for Social Work. The executive staff were housed in the same building, the Councils had a joint chairman and some of their members sat on both boards.

Attachment Schemes

In 1961 a joint working party of the College of General Practitioners and the Royal College of Nursing published their report in the Journal of the College of General Practitioners.
The Report stated that both Colleges believed that the future provision of good care lay in a successful working partnership between the family doctor and the health visitor. In suggesting the kind of structural changes necessary to effect an improvement it advocated the attachment of health visitors to general medical practice (this was easier to arrange when two or more general practitioners formed themselves into a group working from the same premises). When this was not possible, then regular communication between them was recommended. The Colleges considered that it would be possible for the health visiting service to work in attachment schemes yet remain within the employment of the local authority and be responsible to the Medical Officer of Health.

A view held by many health visitors is that the relationship between general practitioners and health visitors has not always been cordial. It has been asserted that in many instances general practitioners are poorly informed about other health and social services. Often contact with the health visitor resulted in conflict because the client relayed advice given by one worker to the other, there being no direct communication between them! An initial source of resentment can be traced back prior to 1948 when the health visitor's advice was free in contrast to that of the doctor who usually charged a fee. The claim made by the health visitor that she is an independent practitioner must have been a considerable irritation to some general practitioners. Ignorance, or rather limited knowledge was often the cause of resentment on the part of the general practitioner who undervalued the health visitor's
preventive role and viewed her as an auxiliary to lighten his task, this view can in part be attributed to his lack of specific preparation for general medical practice and also to his traditional primary responsibility to provide a 24 hour service for the treatment of illness.

This joint working party of Rcn and CGPs was a positive step in establishing contact between the two professions most concerned with the provision of primary health care. However, the challenge to move towards a more frank and free discussion about each other's role and functions was not taken up until the mid 1970's. Encouraged by the Council for the Education and Training of Health Visitors several training establishments have participated in tentative schemes for interdisciplinary teaching, notably those at Milton Keynes and Croydon.

Gradually schemes to enable nursing staff and family doctors to work together were developed. The term 'attachment' was first used by Anderson and Draper, Guy's Hospital Department of Community Medicine, and adopted by Abel (1969): it was defined as an arrangement whereby a health visitor became

"responsible for providing local health authority services to all patients on the lists of specified general practitioners with whom she has regular consultations".

It released her from working within the confines of a limited geographical area. Investigating the period from July 1967 to July 1968, Abel found the situation had one outstanding feature -
nothing was static; there was a wide range and considerable variation in the type of arrangement taking place. Of the 50 local health authorities in the chosen sample, 41 had schemes in operation but it was hard to find any specific trends. However it was apparent that schemes for health visitor attachment were in advance of all others, 16 of the health authorities having half or more of their health visitors attached, and this often set the trend for home nurses to follow. The effectiveness of the health visitor's contribution would appear to depend upon the level of opportunity provided by her employing authority, and the provision of adequate supportive services by the local Social Services. Certain conclusions could be drawn from the survey. There was a greater understanding between doctor and health visitor of each other's role which led to a diminution of conflicting advice for the patient and continuity of care, the general practitioner was more aware of preventive medicine and, through the health visitor, was in closer contact with the Social Services. Attachment diversified the health visitor's clientele and increased the number of her visits to the elderly, such visits being initiated by the doctor; other vulnerable groups could be found by direct access to the patients' records. It has been suggested that for both professions the work was more effective and led to greater job satisfaction, although it should be noted that only enthusiasts have been involved in attachment schemes to date. Two potential disadvantages have often been discussed but so far have not been validated: one was the possible misuse of health visiting skills through a tendency to move towards curative care and away from prevention; the other was the possible danger that the health visitor might lose her professional independence when subjected to direction by the
general practitioner. Clark has rightly pointed out that "attachment" does not change the health visitor's work; her clients remain the same and so do her statutory duties. It does not make change, it merely provides the opportunity.

The general view of 171 general practitioners interviewed by Anderson et al (1971) was that while attachment did not save the doctor's time, it enabled a better all round standard of work to be achieved; however of the 57 doctors working in group practice schemes, 61% said that the attachment of health visitors had resulted in a reduction of work load.

A noticeable omission all the studies examined by Hawthorn (1971) in her marathon work on attachment schemes was the assessment of the benefits for practice patients. In a letter to the British Medical Journal (May 1968) a correspondent (Davey) wrote:-

"The full value of any such scheme must surely be measured by the benefits it confers on those whom it serves in relation to its total cost, and its efficient use of manpower rather than by its power to shift a work load or its provision of job satisfaction for some of its participants."

Public health nursing officers of the Department of Health and Social Security visited local health authorities in 1971 to see what progress had been made in schemes for group attachment. They found that the percentage of health visitors working in attachment had grown from 5.7% in 1964 to 50.1% in 1970 and more schemes were developing. The Health Visiting profession was moving rapidly away from the
isolationism of the pre-war period and from the concentration on one specific age group. Health visitors found themselves better informed about their clients and consequently were able to provide a higher standard of care, they were playing a key role in the development of community health teams. By 1975 the figure had reached 80% but in some areas progress was slow, possibly due to a local shortage of staff, a predominance of single-handed or two-man practices with limited accommodation and the needs of some of the inner city areas in the large conurbations.

The Council for the Education and Training of Health Visitors

Following the enactment of the Health Visiting and Social Work (Training) Act 1962, two Councils were set up with a joint chairman and secretariat, and with some of the appointed members serving on both councils. The Council for the Training of Health Visitors was charged with the following functions:

"a. To promote training by seeking to secure facilities for training of persons intending to become health visitors, by approving courses to be attended by such persons and by seeking to attract persons to such courses;

b. To secure further provisions for the training of health visitors if it appears adequate provision is not being made;

c. To conduct or make arrangements for the conduct of examinations in connection with such courses as mentioned above;

d. To carry out or assist in research into matters relevant to the training of health visitors."

The setting up of a Council for the Training of Health Visitors has been referred to as 'the most significant milestone of recent years
in the history of health visiting*. Previously the Royal
Sanitary Institute (later to become the Royal Society of
Health) had been responsible for the syllabus and examination
in health visiting but also had interests in many other professions;
now there was one body with the specific responsibility for the
content of training, the examination, and the maintenance of
standards throughout the United Kingdom.

At that time the Council were faced with a difficult situation:
morale was low and there had not been a central agency from whom
those responsible for the 29 training courses could seek guidance.
Now the establishment of this new body provided an opportunity
to take a fresh look at the whole question of training and examination.
This it achieved by forming small working groups to look at the
syllabus, the examination, and the practical training. Due
consideration was taken not only of the health visitor students’
basic nurse training but also of the limitations imposed upon the
profession by the new body of social workers in local authority
departments. All this presented health visitors with new challenges
and responsibilities. The new pattern of training was published
in May 1964 and came into operation in the following year. The
Council recommended that a greater emphasis should be placed on
practical experience during training, following the example of
general nurse training, midwifery and social work.

The organisation of the qualifying examination was removed from
the approved body and became the responsibility of each training centre
to appoint one external examiner from the list of names approved by
the Council. In addition to the 3 (later to be increased to 5) formal written papers, candidates were required to present at the oral examination 4 health visiting studies of families, together with either a project or day book (recently the project has been replaced by a descriptive study of the student's fieldwork area). A noticeable omission was the formal assessment of group health teaching carried out by the student and which to date has still not been included. Candidates were to be awarded the National Certificate upon the successful completion of training. The Council decreed that the length of the course should be extended by another 3 months, during which time candidates would work in another area with a small case load of about 100 families. This period of continuous practice was to be assessed by experienced health visitors. This assessment was an integral part of the examination and the extended training was approved in 1966. Now called the period of supervised practice, this is considered to be the weakest part of the course and warrants further consideration.

In December 1965 the revised Health Visitor Training Rules, approved by the Minister of Health, set out in detail the content and conditions of entry to training courses and examinations. Pre-requisite qualifications for entry were as follows: the General Certificate of Education of England and Wales at Ordinary level or the Certificate of Secondary Education Grade I in a minimum of 5 subjects, or the equivalent, or to have passed an educational entrance examination set by the training school approved by the Council; professional qualifications were to be the State Registration Certificate, and a
midwifery qualification or obstetric course approved by the Central Midwives Board. The profession remained closed to men! Applicants had to satisfy both the training school, usually based in an educational institution, and the sponsoring authority of their potential ability to complete the course and perform the duties required of a health visitor.

Comments by June Clark (1968) sum up the students' point of view on the revised form of training. The pattern of study was new to most students and the first term was spent in adjusting to it; they found that the new syllabus 'allows of no "textbook of health visiting" which one would have only to learn off by heart and regurgitate to the examiners at the appropriate time to score a good pass.'

It was a new-found freedom to be able to study one chosen subject in depth for the project. Some of the students found the practical experience frustrating because of the poor quality of the fieldwork staff; there was confusion over the reason for visiting 6 to 8 families and the family studies caused more anxiety than any other part of the course. The following paragraph summarised the experience:-

"When I finished my general training I felt what I had learnt bore little relation to what a qualified nurse actually did, and that success "on the job" bore no relation to success in the final examination. I had felt throughout this year, however, that this course was a realistic preparation for the work we would be doing when the course ended, and that the examination - three written papers set and marked by the people who had taught us, a project, four case studies and the fieldwork instructor's reports throughout the year - was a fair assessment of ability to practise as a health visitor.'
Having completed its first task, the Council turned its attention to other urgent matters. For example, the Ten Year Development Plan forecast a need for a 50% increase in whole-time equivalent health visitors, and the Council found in 1965 that 2,000 practicing health visitors were in the 50-60 years age range; it had the immediate task of exploring ways of increasing both the number of training places and courses. Another hurdle to overcome was the acute shortage of health visitor tutors. By 1967 a further 10 training institutions, including Croydon College, had been approved. This made a total of 43 courses in the United Kingdom, and figures from the Council for the Education and Training of Health Visitors (1973) show that the actual student intake had risen from 805 in 1965 to 848 in 1967; by 1969 the student intake reached four figures with a further increase to 1,189 in 1972. A peak was reached in 1975 when 1,532 students enrolled for training.

One more area of need was to identify the role and define the functions of the health visitor. In 1967 a brief definition was given in a pamphlet, "The Function of the Health Visitor". Two years later the Council issued a more detailed edition which clarified the health visitor's contribution and the changes in her professional education. The five main aspects of her work were identified as follows:

'a. the prevention of mental, physical and emotional ill health or the alleviation of its consequences,

b. early detection of ill health and the surveillance of high risk groups,
c. recognition and identification of need and mobilisation of appropriate resources where necessary,

d. health teaching,

e. 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.

All these aspects contributed to the promotion of health. Whereas in the past emphasis had been upon routine visiting of the pre-school child, the health visitor was now to establish and maintain contact with all vulnerable groups in the community. The health visitor's "key role" in health education was stressed: it was accepted that all health visitors undertook individual teaching but group teaching was only for "those who discover they have an aptitude" for it. In considering the health visitor's contribution to the prevention of illness, Caplan's (1961) model of the 3 levels of prevention was used:

'1. Primary prevention is a community concept: ... we require ... a healthy environment.

2. Secondary prevention concerns the early detection of disease and the treatment of conditions associated with particular stages in the life cycle ...

3. Tertiary prevention is an aspect of after care concerned with containing and limiting the effects of a condition ... '

Each level was enlarged upon to identify the skills used by the health visitor and the contribution she could make towards the prevention of illness. Despite the almost universal acknowledgment by educational psychologists of the benefit of group work the Council was still not prepared to accord group health education equal status with other aspects of the health visitor's work.
In conclusion, the most recent of the 3 statutory bodies responsible for nurse training, the Council for Education and Training of Health Visitors differed from both the General Nursing Council and the Central Midwives Board in that it covered the whole of the United Kingdom. In its brief existence it has influenced the development of the profession and has greater responsibility than its sister bodies for the approval of courses, the design of the syllabus, the conduct of the examination and the formation of training rules. This has been possible because of the separation of training from service. In the first decade of the Council's existence progress has been made in the following areas:

i. The complete registration of the syllabus with a greater emphasis on the practical aspects of health visitor training.

ii. The introduction of special arrangements for fieldwork and the introduction of fieldwork instructors.

iii. A complete revision of the examination procedure and consequent delegation of responsibility to individual training schools.

iv. The extension of the course to include a short period of supervised practice to be taken into account when recommending the award of the Council's Certificate.

v. The introduction of minimum entrance standards.

vi. The incorporation of the training programme into the educational pattern of the country so that candidates have the advantage of contact with other students and of shared teaching facilities. Economy has also been effected in the provision of material resources such as accommodation and student amenities. When the Health Visitor Council was established in 1962, 15 out of 25 training schools in England and Wales were established directly by employing authorities: today, 23 out of 32 schools are organised completely by education institutions, and 5 are in very close association with such establishments.
The Council were mindful of the implications for health visitor training in both the Report of the Committee on Nursing, chaired by Professor Asa Briggs, and the proposed re-organisation of the National Health Service. This presented an opportunity to rationalise the training of health visiting and district nursing services, and the Council proposed that the organisation of a single statutory independent body with national responsibilities should be considered for work in the community; and stressed that it was imperative that the improvement in Health Visitor education achieved by Council's policy should not be lost.

Major Developments

The Report of the Committee on Senior Nursing Staff Structure, 1966, (the Salmon Report) proposed a three-tier structure of management for nursing administration in the hospital service. 3 years later a sister report, the "Report of Working Party on Management Structure in the Local Authority Nursing Services" was published: it proposed a similar pattern of management, viz - top (policy forming), middle (programming), and first-line (executive) - which would bring local authority nursing services into line with the hospitals' structure. Senior members of staff were released to attend management courses to prepare them to take their place at top level meetings in the health service - and so began the loosening of the traditional bond forged between the Medical Officer of Health and his nursing staff for over a century. However some of these courses were not geared to the needs of the staff so that the concept of management has unfortunate associations for some nurses.
Like its predecessor, the report gave detailed job descriptions. In the very detailed description of the functions of the health visitor working at field level, "health education" was the first responsibility ascribed to her and included the following:

i. participation in parentcraft teaching and preparation for childbirth;

ii. organisation of parents' groups and mothers' clubs in her area;

iii. undertaking health education in old people's clubs;

iv. carrying out the need for prophylaxis, the prevention of accidents, the dangers of smoking, the early detection of cancer, genetic counselling and any other relevant subjects.'

This report was followed in June 1968 by the Report of the Committee on Local Authority and Allied Personal Services (the Seebohm Report) which made an urgent recommendation for a unified social service department within each local authority. The new department was to be family orientated and community based, using the term "community" to cover both the geographical location and the common identity of a group of people. It was to extend well beyond the responsibilities of the existing local authority departments and include the work of the children's departments, welfare services, education welfare and child guidance services. Some of the existing health department responsibilities were to be transferred, such as the home help service, social work with the elderly, handicapped and mentally sick, together with the day care of children under 5 previously carried out by health visitors. The recommendations were accepted by
the Government and implemented in the Local Authority Social Services Act, 1970. In their deliberations the Seebohm Committee had looked at the work of the health visitor vis a vis the social worker and found that confusion over their respective roles had inhibited collaboration between them; nevertheless they thought that close cooperation was vital. Social workers were dependent upon health visitors for the early detection and referral of the socially deprived, the handicapped and the elderly. However the Committee recommended that a new system of early detection should be set up by the proposed social service department. They stressed the need for close collaboration between the health and social services on the problem of identifying and helping families who make little use of available services. While recognising that health visitors are a highly trained group of professional workers they did not consider it to be their responsibility to show how the health visiting service would develop in relation to developments in community nursing, health education and general practice - not forgetting social work - and expressed their concern at the notion of the health visitor becoming the all-purpose social worker for general practice. In their opinion the professional roles of social workers and health visitors were distinct and incompatible in the same person and furthermore it was uneconomic to combine training. Traditionally health visitors had been concerned with caring for mothers and young children and in the Committee's view the stereotype remained. Thus they firmly closed the door to any attempts at closer collaboration in the foreseeable future; and their view was in effect endorsed by the separation of the two Councils in 1972.
The Council for the Training of Health Visitors in a Memorandum HV/68/31 made comments on the Seebohm Report: while accepting that the Committee's remit allowed only a brief review of the Health Visiting Service they welcomed the recognition of the new department's reliance on "this existing service". Council policy was in line with the view expressed by the Seebohm Committee that the main functions of health visitors and social workers are distinct: but some other statements worried the Council because in their opinion the authors revealed a restricted view of the health visitor's work, this was in fact attributed to Government statistics which have not taken into account the expanding work of the profession over and above that of maternal and child welfare. The Council pointed out that their revised training programme is related to the policy of utilising the Health Visiting Service for a larger section of the population.

Concern was expressed over the omission of the health visitor's extended range of work when attached to general medical practice; the Council considered that she was in a favourable position to detect medico-social needs especially in the prevention of social distress. In its reference to the Seebohm Committee's recommendation that a new system of early detection ought to become the responsibility of the new Social Services Department, the Council categorically stated that

"this responsibility is one of the functions of the health visitor, and she is exceptionally well fitted by training and experience to fill this role ... the health visitor has an important part to play, not only in the early recognition of medico-social need but also in the whole field of prevention and the containment of problems so found."

This is reiterated by Clark who asserts that the health visitor is in
a unique position to recognise a crisis, particularly when attached to general practice. However, she admits that health visitors may not yet be making full use of the increased opportunities for case finding in this work situation. While no specific mention of the health educative function of the health visitor was made, nevertheless it was implied in references to prevention. Finally the Council expressed its concern over the establishment of a new department in advance of changes in the health service and the impending local government reorganisation. In their opinion recruitment and morale in the health visiting service would suffer unless the proposed changes in the fields of social and health care took place simultaneously.

In the meantime the Health Services and Public Health Act, 1968, extended the powers of local health authorities so that health visitors could now visit clients other than in their own houses; in addition they were permitted to work for another authority while remaining an employee of local government which, in effect, regularised their position in attachment schemes.

The Chief Medical Officer of the Department of Health and Social Security (1968) reported that very few local authorities had not started schemes of attachment to general medical practice. A number of authorities had 50% or more staff attached, and in 3 counties all community nursing staff (that is health visitors, home nurses and midwives) were attached to group practice. "Attachment to group
"practice" has been defined as schemes to:

'enable nurses, health visitors and domiciliary midwives to work in partnership with the doctors /general practitioners/, providing personal medical services and preventive services to the population they serve, defined, not by a geographical district, but by patients on the doctors' lists.'

More recently these schemes have been called "Primary Health Care Teams!"

Other major developments were taking place in the 1960's in the health and local authority services which also affected the work of the health visitor. The separation of the social services from health care, the growth of the philosophy of self-help in the community, the changing pattern of local government, and the reorganisation of the National Health Service all posed threats to the stability of the service. The Royal College of Nursing set up a working party to review the role of the health visitor with the following terms of reference:-

a. to clarify the objectives of the health visiting service,

b. to indicate how present health visitor skills should be used now and developed in the changing health service,

c. to make recommendations.

"The Report of the Working Party on the Role of the Health Visitor now and in a changing National Health Service" was published in 1971. While its members were mindful of the need to maintain and safeguard the standards of care and the outstanding quality of health visitor education, they saw the report only as an immediate measure to guide the profession during this period of change.
The working party's recommendations on the nature of the work carried out by health visitors can be summarised as follows:-

In general terms the objectives of the health visiting service are the promotion of all aspects of health and the prevention of ill-health in its widest sense. Modifying Caplan's definition, prevention is classified as:

"a. primary prevention involving action designed to prevent the occurrence of a problem,

b. secondary prevention concerning early detection of illness or deviation from normal, where treatment may cure or control,

c. tertiary prevention, an aspect of after-care concerned with containing and alleviating an established condition."

The health visitor is considered to be in a unique position to promote primary and secondary prevention because of her contact with people before the development of an overt problem. Her particular contribution in tertiary prevention is her ability to recognise and assess both health and social needs, to mobilise resources and reinforce therapy through counselling and health education.

The working party consider that nurse-training must remain a pre-requisite for the practice of health visiting because the core skills of the health visitor are an extension of those learnt in basic nurse training. They are:-

skills of observation and assessment,

skills of communication,

technical expertise in the promotion of health and the prevention of ill-health, and

skills of planning, organisation, and co-ordination.
While such skills do not belong to the profession alone, the working party stress that it is the combination of these skills which is unique to health visiting.

It was recognised that the health visitor will work increasingly within the framework of general medical practice as a member of a multi-disciplinary team; like the general practitioner, the health visitor is a generalist with responsibility for continuity of health care referring those in need of specialist care to the appropriate agency; finally she is a practitioner in her own right, initiating contact with and accepting referrals from other agencies. The working party asserts that it is on these 3 principles that the future functioning of the health visiting profession rests. Furthermore, because of her attachment to general medical practice, she is a major link between the practice and other agencies, and between clients and specialist services. Her liaison role is no less important when she is not working in full attachment but it is considered to be less effective.

The importance of visiting individuals and families in the community before they present a problem is stressed in the report. The health visitor's primary function is to teach the principles of healthy living; other functions include the developmental assessment of non-clinic attenders, the early detection of ill-health, and the support of those affected by the normal life crises. It is recognised that the health visitor is becoming increasingly involved
as a member of the primary health care team (composed of doctors, community nursing staff and other health workers) either in general practice premises or comprehensive health centres. Moreover, she is concerned with developmental assessment; prophylaxis; counselling; advising on child care and management; and the promotion of screening procedures, follow-up care and support. Opportunities are available at clinics for informal health education amongst groups with similar health problems.

Health education is stated to be a first priority in the work of the health visitor whether it be in individual or group situations. In some instances she may be actively engaged in teaching whereas at other time she may act as a consultant or advisor in the planning of courses and campaigns in conjunction with other interested parties. Another important role is that of advisor and health educator amongst a variety of clubs and societies, including voluntary organisations with an interest in community care.

In the School Health Service the health visitor in her advisory capacity is seen to remain a valuable link between the home, school and members of the school health service team, even though many routine duties are now carried out by school nurses. It is interesting to note that no reference is made to the health visitor's role as a health educator in this section of the report, although it is covered in the section on health teaching.
To enable the health visiting service to carry out the very wide and expanding range of work envisaged by the working party 3 requirements are specified: first the allocation of a realistic caseload based on total population needs and not one calculated on the pre-school age group; secondly the provision of adequate resources in personnel and equipment to relieve the health visitor of time-consuming chores; and finally, an increase in the recruitment of health visitors. It is recognised that implementation of all 3 recommendations would depend upon more money allocated to the service.

The working party reiterate the importance of adequate preparation and training for the health visitor, both in her basic (nurse) and post-basic (health visitor) education; they call for a national policy of in-service training and express the opinion that the profession would benefit from access to post-graduate medical centres. In turn all health visitors have a responsibility for the training of an increasing number of students of many disciplines which entails careful co-ordination between hospital and local authority nursing staffs.

The working party call for research into the many facets of health visiting, particularly in relation to the role and function of other care-giving workers. It recommends the establishment of effective channels of communication at administrative and field levels with the Social Services Departments for whom the health visitor is likely to be the most important case finder. And finally,
the report asserts that it is "vital that the development of preventive health services should not be swamped by the more dramatic and easily understood demands of the acute curative services".

This theme was taken up again in the recommendations of the Consultative Document on "Priorities for Health and Personal Social Services in England" (1976), which brings a timely reminder of the value of prevention. Although decisions remain to be taken, the document proposed a 6% p.a. growth rate for health visitors working in collaboration with family doctors to strengthen primary care teams.

What other demands are likely to be made of the health visitor? Yet another report, that of the Committee on Child Health Services (1976) suggested amongst a number of other things a service increasingly orientated to prevention. The first responsibility in both professional education and daily practice was to take prevention seriously, with as much attention paid to this aspect of the work as has been given to treatment over the past 25 years. In recognising the preventive role of the health visitor the Committee recommended that some should become Child Health Visitors with special responsibility for children and their parents. However with only 9,137 whole-time equivalent health visitors in post (1974) this raises the questions from where are the additional staff to be obtained, and, what are the implications for training? It has been said that nationally the health visiting strength is still 50% below the level recommended in the Jameson Report of 1953 and reaffirmed by the Department of Health
Circular 13/72. The already depleted service requires another 7,000 whole-time equivalent health visitors to meet the health surveillance needs of the under-5's alone. At least one other report is likely to make a claim on the profession in the near future, that of the Committee of Enquiry into Special Education, whose terms of reference include the medical aspects of handicapped children, which is due to publish its findings in 1978.

Once again the service finds itself over-extended, but today it does have the benefit of a Council which is vigilant and endeavours to equip the profession for its changing roles at both basic and post-qualification level. Will the service be able to adapt itself to the changing patterns of work to meet health needs? Has it been bedevilled by the claim that health visitors are practitioners in their own right? The time is overdue to consider the health visitor in relation to the Primary Health Care Team. However there is a lack of knowledge and information about primary health care and this makes planning, teaching, and improvements in efficiency difficult. Standards should be developed by which to measure efficiency in relation to changes in patterns of work; for this certain criteria are needed for terminology, functions and activities, resources and constraints, and the division and sharing of tasks. Moreover aims and objectives should be clearly noted in operational terms. Paradoxically there is a large amount of data potentially available for analysis and use. With co-ordination these data could be made available for health
workers to use in a meaningful way. Furthermore all health professionals intending to work in primary health care should have a common core built into their basic training programmes. They should also be encouraged to engage in further interdisciplinary education which should amongst other things prepare them for management, research, health education, teaching, and counselling. I would suggest that it is through teamwork that the health visiting profession can best develop and provide a more efficient service for those whom it serves.
Part V - Health Visitors and Health Education
Scrutiny of the literature reveals very little evidence of group health education carried out by health visitors; however there are numerous reports and papers, some written by workers from other disciplines, arguing that this aspect of their work is an important one.

The Jameson Committee's Report, An Inquiry into Health Visiting (1956), showed that evidence from employers, professional and educational organisations agreed that the two main functions of the health visitor were health education and social advice. All witnesses agreed that health education should take priority in the school health service. Some suggested that the health visitor's role could be that of a co-ordinator, and many wanted her to take a more active part in Parent-Teacher Associations. The Women Public Health Officers' Association (now the Health Visitors' Association) proposed that health visitors should teach parentcraft as part of the school curriculum.

The Committee were of the opinion that health education by health visitors was primarily individual advice given in the homes and elsewhere; far less emphasis was placed on group work by those who had a "special aptitude". While recognising that the improvement in the infant and maternal mortality rates was in part due to the efforts of the health visiting service, the Committee totally disregarded the influence of group health education on the nation's health. The importance of maintaining personal contact between health visitor and client was emphasised whereas the use of mass media as a means of teaching health topics was only regarded as a useful adjunct to individual teaching.
In reiterating the health educative function of the health visitor's work in schools the committee suggested that unskilled work should be given to less qualified staff to free the health visitor to teach. Here was an opportunity for educating the parents and extending her work amongst school children, although the committee accepted the school teacher's ultimate responsibility. They suggested that the most suitable topics for adolescents were those of mothercraft and parentcraft and observed that this work was already being carried out in some schools. The Committee were of the opinion that success was dependent upon the availability of health visitors with a flair for teaching; they suggested that consultation between the health visitor, teaching and medical staff could lead to a more effective programme of work.

While the Jameson Committee recognised the emergence of a new pattern of work within group medical practice only brief mention was made of teaching within this setting. What the Committee did not and possibly could not be expected to foresee was that the attachment of health visitors to general practice eroded their geographical responsibilities and made more difficult the task of locating and offering health advice to those families with problems who are mobile either geographically or in the sense that they frequently move from one group practice to another. The Committee advocated a much wider range of activities for the health visitor but, despite the rapid growth of the behavioural sciences they failed to recognise the implications for the work of the health visitor. The problems which faced the service were first to increase staff-client ratios and second to provide a nationally recognised qualification in health
visiting. The adoption of "new" ways of working however effective in
the long term seemed to the Committee only to dilute the priority objectives
for the immediate future. By their laissez-faire approach to group health
education the Committee introduced an element of doubt about its importance
which was hard to dispel both by tutors attempting to raise students
expectations, and also by some administrators trying to provide job satis­
faction for new staff trained under the new syllabus of 1964. It is
possible that those giving evidence to the Committee did not emphasise this
aspect of the work; some could have been influenced more by their own
professional interests, and many senior nursing staff and medical officers
of health did not recognise the work being done by some field staff.

The general acceptance by the Jameson Committee that group health
education is for those with a flair for the work has been accepted by many
administrators. Health visitors could have been given the opportunity to
develop this specialism amongst a variety of groups in the community.
However more often emphasis was laid on the importance of individual health
teaching by health visitors primarily to families where there are children,
but also amongst all age groups and social classes. Opportunities for
health education have been lost through the conflict of opinion between
those who thought individual teaching to be of value and others who proclaimed
the advantages of formal methods of group teaching. Valuable opportunities
for informal teaching when 2 or 3 clients were gathered together have been
missed - for example, when waiting to see the medical officer or general
practitioner at a child health clinic, or holding informal sessions in a
school staff room or with the kitchen staff.
In the revised edition of the Role and Function of the Health Visitor (1969) the Council for the Education and Training of Health Visitors identified five main functions, in contrast to the Jameson Committee who recommended two. Health education was one of these five and the council recognised the key role played by the health visitor in helping both individuals and groups. However in reinforcing the Jameson Committee's recommendation that only those who showed an aptitude for group teaching should be asked to perform this task, the Council proposed that these health visitors should be given further knowledge and skills. Was this a tacit acknowledgement that basic health education skills taught in health visitor training schools were not considered to be a sufficient foundation on which the newly qualified health visitor could build her expertise? Or was the Council advocating an advanced course in health education for those who wished to practise? However this may be, since 1974 the Council have included courses in Health Education provided by Colleges in their published list of refresher and advanced courses for qualified health visitors.

The Cohen Report (1964) on Health Education stated that more than 80% of the money spent directly on health education was spent on the education of mothers about child care, and that this was carried out by the health visiting profession. The Committee recommended that high priority should continue to be given to mothers, but suggested that careful thought should be given to the amount of time spent by health visitors with mothers in the lower income groups whose needs were not being met. They recommended that local authorities should experiment with the expansion of group discussion in teaching prospective parents. Although they realised that there were certain organisational difficulties in the provision of health education within group practices, nevertheless the Cohen Committee urged the use of
health visitors to assist in this work. Also they pointed out that
subsequently the range of work could be extended to all sections of the
population. The one example cited by the Cohen Report of health visitor
participation in group practice teaching sessions lasted for only one year.
Despite the fact that the six lecture courses were so successful the partners
had to move their venue to the nearby welfare centre, and the services of the
health visitor were withdrawn.

The Committee's remit did not include health education in schools:
nevertheless they considered this to be such an important area of work that
they devoted one chapter to this aspect. The Committee agreed that in
primary schools the class teacher would usually be the most suitable person
to teach health education incorporating it in all aspects of class work.
However in the Secondary Schools they were of the opinion that the
professional health educator needed not only expertise but also enthusiasm
for teaching so personal a subject. They noted health visitors and medical
officers of health already took an active part in school health education
but their impression was that co-operation was variable. While they would
welcome an extension of this team work they emphasised the primary role of
the teacher for much of the work that should arise naturally in the school
syllabus.

An account of the development of health education in the United
Kingdom and the setting up of the two Health Education Councils is described
in Chapter IV pages 92 -131. One recent development affecting the health
visiting service has been the growth of short courses in health education approved by the Health Education Council. These courses enhance the basic skills of teaching and are tailored to meet the requirements of health staff engaged in teaching the general public and in schools.

One Health Visitor Tutor cites the principles which should guide the health visitor in formulating plans for health education in schools. She must make the most effective use of both her time and skills in relation to other priorities, such as her work load and the needs of the school children. Perhaps this can best be done by using current health education schemes (if any) or by co-operating with the teaching staff. The health visitor's expertise lies in her specialist health knowledge, which could be used either for teaching particular topics or in an advisory capacity. In Owen's experience (1968) most people equate the concept of "health education" with formal class teaching, but she points out that both group and individual methods of teaching can be of value.

The Report of the Sub-Committee on Child Welfare Centres (1967) emphasized that health education was an integral part of the Child Health Services. The Sheldon Committee recognised that it could be presented in a variety of ways such as individual teaching, group sessions, visual aids, the distribution of literature and the loan of suitable books. They advocated group discussion in preference to didactic lectures and recommended that the topics should not focus solely on child management. The timing of parents' clubs should be in the late afternoon or evening to allow the fathers to participate; this would require a crèche and they suggested that voluntary
workers could play a useful part. The Report of the Joint Sub-Committee of the Standing Medical Advisory Committee on Hospital Treatment of Poisoning (1968) considered that the incidence of self-poisoning was of "epidemic" proportions and suggested that the answer lay within the sphere of primary prevention. Another report, that of a Sub-Committee of the Standing Advisory Committee on the Organisation of Group Practice (1971), recognised the need for preventive work and health education in group practice. However the recommended caseload of 5,000 patients for each health visitor was unrealistic if she was expected to undertake the full range of health visiting duties including regular health education sessions with a variety of groups in the surgery. Each of these three specialist committees recognised the value of health education and the key role of the health visitor. The evolution of the Primary Health Care Team could provide an opportunity for furthering a team approach to group health education; the health visitor would gain the support of her colleagues and the clients would benefit from the continuity of advice from the team.

MacQueen (1966), Medical Officer of Health, circulated questionnaires to his health visiting staff in Aberdeen to find out their views on possible developments in the service. 88 health visitors replied and the relevant findings can be summarised as follows :-

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74% considered that health education would be one of the major developments within the next 10 years, and 33% advocated specialised posts in health education. Despite the fact that the senior nursing staff agreed with the 59% health visitors who considered that attachment to general medical practice led to a reduction in group health education, an increase in attachment was advocated. Only 47% of health visitors undertook school health education and most of the senior staff were of the opinion that the separation of school health duties would be harmful.

A passionate advocate of health education, MacQueen (1968) argued that a health visitor who does 4 hours group health education a week, plus 2 hours for preparation, may be as valuable to the community as two health visitors doing none. While not decrying the importance of home visiting and individual counselling he asserted that the health visitor unwilling to take her share in group work is a luxury ill afforded today. To reinforce his argument he demonstrated how one health visitor, devoting 1/10th of her time in one year, could give 60 expectant mothers either:

9 x 1 hour classes for 3 groups of 15 mothers plus 1 hour of home visiting time for each mother, and give 6 hours home visiting time to each of the 15 non-attenders,

or, in the same number of hours,

one health visitor could only give each mother 2 hours 51 minutes individual attention at home.
In a similar way he showed how there could be an increase in pupil contact time by health visitors dividing their time between group and individual teaching sessions in schools. These are two examples of the type of factual information that may help to justify the cost incurred for new schemes of health education, rather than unsubstantiated claims for the success of group methods which may not be acceptable to health committees.

Sir Keith Joseph, Secretary of State, Department of Health and Social Security, addressed a conference organised by the Pre-school Playgroups Association in 1972 in which he spoke of "the cycle of deprivation" and subsequently the Department of Health and Social Security published an account of consultations with professional, voluntary and other organisations about "The Family in Society, Preparation for Parenthood" (1974). The publication gives an indication of the wide range of opinions and ideas put to the Ministers of Health and Education to date. As some 62 organisations presented their views and recommendations, it is not surprising that they identified different priorities and possible solutions. The most widely held view was that, despite the limitation of resources, efforts should be made to reach all age groups in order to raise the level of public awareness and understanding about parenthood. Extra attention should be given to those most in need of help. Even to summarise all the views and ideas would be a lengthy task, but certain items are of relevance to the health visitor and her function as a health educator. For example, paragraph 21 of the paper states:—
"the general view was that in the main efforts and resources should be concentrated on the periods in a person's life when they are most likely to be responsive to change, starting with the ante-natal periods, the birth of a child and post-natal period and continuing with interventions aimed at reaching both parents and children during the pre-school years, through the educational system, during adolescence and at times of engagement and marriage".

Many professions and services tended to view their own intervention as coming too late; for example those concerned with ante-natal teaching expressed the view that intervention at the school stage was crucial. This is a reflection of the Royal College of Midwives' Report on "Preparation for Parenthood" (1966) which emphasised the need for such teaching both in the ante-natal period and in the schools. However many organisations recognised that health education during both stages of development were complementary and inter-dependent. The Society of Chief Nursing Officers (Public Health) wrote of the special needs of young parents from deprived family backgrounds; in their opinion a great deal of work with this group was neither adequately planned nor fully comprehensive.

The general message of the publication was that most of the professions and services who were in a position to identify those "at risk" should take part in the task of preparing them for parenthood, and this has wide implications for professional training. A minority view was that a new cadre of professionals, including health visitors, should be specially recruited and trained to do the job.

Other suggestions were made about methods of reaching the deprived as well as those in need of information and advice. One view was that
many professional workers were too authoritarian and punitive in their attitudes towards deprived families; the families wanted to learn and often responded best to advice and guidance geared to their abilities and understanding. It was suggested that perhaps voluntary workers operating under supervision could best fulfil this task.

The health visitor's function as a domiciliary visitor was accepted by a number of organisations. Some considered that the service could be improved either by an increase in establishment or by relieving the health visitor of non-essential tasks. Criticism was voiced that health visitors in a few training schools were not adequately prepared to deal with the emotional and intellectual needs of children. There was a difference of opinion regarding the health visitor's suitability for this form of health education. In common with other professions with responsibilities for deprived families, the health visitor appeared to the families to be critical and authoritarian. The introduction of an educational visitor on the lines of the first health visitor was proposed; however this begged the question from where were these educational visitors that should be recruited? A number of organisations put forward suggestions for a peripatetic teacher.

Various methods of incorporating aspects of preparation for parenthood into the school curriculum for the 5-12 age group were proposed. Several organisations advocated the fusion of the main themes of parentcraft preparation right across the curriculum in the 13-18 age group. The Royal College of Nursing and the Society of Education Officers considered the
worthwhile development of playgroups in some secondary schools where the pupils could gain practical experience of young children. There was also considerable discussion over the type of teacher most suited for parenthood classes in schools: should it be undertaken by school teachers, or by people (including health visitors) brought in from outside, or by both?

A minority view thought that the ante-natal stage was not a good point for intervention as the mothers were idealistic at that time, but most thought that parents were very receptive especially those having their first child. Some organisations considered that obstetricians, midwives and health visitors did not fully exploit the opportunities presented to them. Once again the theme of identification of families "at risk" was raised but in practice the ante-natal clinics were so crowded and the examinations so rushed that it would be difficult to make judgements in respect of families at risk.

To summarise, two important points emerged from the consultations. First there was the need for a fresh look at the training programmes for those professions most closely associated with health education for parenthood. Second there was the need for closer co-operation between all the professions and services engaged in these activities. There were those who supported the introduction of a new cadre of professional workers to specialise in preparation for parenthood activities, but the majority recognised that if a new cadre was to be formed all other professions would still have an important role to play.
In my opinion the assumption that one specialist worker could meet the needs of all expectant parents is a dangerous one, for workers from different disciplines can bring equally valuable contributions. It is more important that the specialist from any of the disciplines involved should not only have knowledge and expertise, but also should be able to establish a rapport with the parents and be sensitive to their needs. In some instances this may entail careful reassessment of teaching methods, new skills may have to be learnt and new approaches adopted. The informal session for a few expectant parents, with time for counselling and personal guidance in an inviting environment, may be more conducive to the formation of healthy attitudes and behaviour changes than the rigid syllabus of classes still followed by some ante-natal teachers today. There is a need for much closer co-operation between the disciplines involved. In the first instance attempts should be made to come to a greater understanding of each other's contribution. Then objective appraisals should be made of the sociological structure of the community and the personal expectations of birth and parenthood: only then could programmes be prepared and later adapted to the specific needs of each new group. The scheme in Georgia (page 146) could be used in certain areas of Britain where there is a current shortage of field workers to provide ante-natal health education or where the social class structure or cultural patterns of a minority group warrants the introduction of a different form of teaching from that normally provided. The answer to the question "who should provide this teaching?" may not lie within any one profession but rather in the choice of the best person for that post in a particular area, although the health visitor with her training in the social sciences should have a most appropriate background for this
specialist work. However health visiting staff with only the minimum entrance requirement of 8-12 weeks obstetric experience would need to study the subject in considerable depth before embarking on a programme of ante-natal health education.

Dowling (1973) has described the early educative function of the Bible Women of London and the spread of this movement throughout the land where it became the instrument to foster the growth of health visiting in the 19th Century. In a paper produced for an exhibition in Chicago in 1893 Florence Nightingale outlined a scheme for "health missioners" in which she included a series of lectures to be given to village mothers by these missioners. The early 20th Century saw an emphasis on group teaching in the "Schools for Mothers" with subsequent follow-up visits to the homes by health visitors.

In more recent times a few small surveys have been produced which give some indication of the amount and type of group health education carried out by health visitors and these are included in Appendix D.
CHAPTER 2 - MEN IN HEALTH VISITING
Until January 1973, there was no legislation enabling men to be trained or employed as health visitors. Records show that as far back as 1963 the Scottish Advisory Committee to the Council for the Education and Training of Health Visitors ascertained that both the professional and the local authority associations in Scotland were not against the employment of men in the health visiting service. In the light of these findings the Council consulted the professional and local authority associations in England and Wales. As they too did not object, the Council then made a formal recommendation to the Minister of Health that men be admitted to the profession. The Minister was unable to find any opposition to this proposal from any of the organisations concerned but another 10 years elapsed before the admission of men became possible.

In 1961 the Aberdeen Health Visitor Training School had accepted a group of male registered nurses. Sponsored by the City of Aberdeen they took a course and examination almost identical to that taken by the female health visitor students. Under Section 24 of the National Health Service Act (1946) it was not possible for these men to be called "health visitors". Many were however employed by Local Health Authorities as health visiting officers and given equal status and salary.

MacQueen (1966) summed up the position first in terms of the traditionalists' views: they still thought of the health visitor as the "well-baby nurse", and some who were hostile feared the
invasion of their own private empires. Against this he argued that they lacked the foresight to recognise the increasing needs of the dependent young and elderly in the community. This argument is reinforced by statistics from the Department of Health and Social Security "On the State of the Public Health, 1971": for example, the numbers of elderly clients visited by health visitors and home nurses keep rising - the figures show that in 1971, 369,290 elderly persons were visited by health visitors, and, 540,464 by home nurses. A press release from the Department of Health and Social Security, No. 71/75 in April 1971 pointed out that although increasing consumer awareness has led to a heightened expectation on the part of many who are eligible, it would seem that those who are most "at risk" still need to be sought out and advised of their rights. This would appear to justify MacQueen’s assessment of the supreme problem of finding enough workers, from all disciplines, to cope with all those in need of care.

The main arguments he advanced in favour of employing men for this work were:

1. they could undertake certain duties more easily than their sisters, such as all aspects of work with boys and men. He also suggested that some men were more successful with elderly ladies, but omitted to back this statement with any factual evidence.

2. that mixed team work was more satisfactory, and

3. that the admixture of men with women students enriched post-basic training courses;

4. that men could raise the recruitment rate by as much as 6%, linking this with the target set for an additional 3,096 health visitors by 1975;

and finally,

5. that men could provide an element of stability
which the young married women staffing the service were unable to provide if they were to meet the demands of marriage and family life. The 6% "wastage" rate for those who had trained at Aberdeen and were working in the U.K. was used to reinforce his argument about stability. However, it should be remembered that these figures relate to a total of only 20 male students who had qualified in the first 5 years of the Aberdeen scheme, who were a selected group and so could hardly be considered as likely to be typical.

To date, a total of 54 male health visiting officers have trained at Aberdeen. They are working in a variety of posts throughout the U.K., many as health visiting officers and others as health education officers and hospital liaison staff.

It is interesting to note that while MacQueen puts forward his arguments for men in health visiting on the strength of working with boys, men and the elderly he avoids raising the issue of their association with expectant and nursing mothers. In March 1971, "Janus" in the Health Visitors' Journal reported on the adverse reaction of male nurses, in particular from those who wished to become health visitors, to their exclusion from obstetric training courses. It is a fallacy to assume that men are only interested in matters pertaining to their own sex: Hinds (1955) records that swine and goat herdsmen acted as midwives to parturient women in Europe in the Middle Ages; Pierre Budin (1882) established at the Charité Hospital in Paris a "Consultation de Nourrissons" where advice was given on infant feeding, and he was followed 2 years later by Dr. Leon Dufour who opened a
"Goutte de Lait" at Fecamp for the same purpose. From my own personal observation it would appear that men have a unique contribution to make and that they add another dimension to the discussions which take place in the classroom. Male students attending both the Community Care Option of the General Nursing Council Syllabus and the post-basic District Nurse Courses at Croydon College of Design and Technology are avid for information on matters relating to the needs of mothers and young children.

Recent correspondence in the Nursing Times shows that men, barred from midwifery and obstetric experience, are becoming more vocal in their demands. However, professional opinion is not yet convinced that men can be successfully assimilated into the labour and post-natal wards.

The midwifery profession has studied this emotive subject with great care and several schemes have been operated, but there still remains the difficulty over intimate nursing care and the necessity for a chaperone to be present during these procedures. The 1972 Annual Report of the Medical Defence Union shows that medical students and doctors still require to be chaperoned when examining women patients.

Circumstances may however force a change in public opinion and at some future date the patient may only have the right to refuse the ministrations of male nurses provided objections are stated on admission to hospital. During the session of Parliament ending December 1972,
when the Anti-Discrimination Bill was discussed in the House of Lords, once again the view was presented that men were unsuitable to train and enrol as midwives even though it was argued that male obstetricians were acceptable to women. The evidence submitted by the Royal College of Midwives in a letter to the Select Committee made clear in no uncertain terms the views of that profession on the subject, stating that "the midwife and obstetrician work as a team with quite different functions to perform and the fact that the midwife is a woman is part of her function".

Meanwhile it is generally agreed that male student nurses should at least be taught in the classroom about reproduction, and given practical instruction in emergency midwifery similar to that given to members of the police, the ambulance service, the St. John Ambulance Brigade and the British Red Cross Society (1973).

During 1972 the professional organisations concerned with health visiting were again requested by the Council for the Education and Training of Health Visitors to review the situation and in particular to consider the implications of removing the midwifery/obstetric qualification as a pre-entry requirement for all health visitor candidates. This would entail the inclusion of a suitable component of midwifery experience in the already very full health visitor course. The feeling of the Royal College of Nursing, Community Health Section (1972) was that those students who had already undertaken a midwifery course were better prepared for their health visitor training. Concern was expressed by Nursing Officers at a Conference held to consider fieldwork
training of health visitor students over the possible lowering of the standard of obstetric experience simply to accommodate male candidates, and already in some quarters the opinion had been forcibly voiced that the present obstetric course did not provide an adequate foundation for health visitor training.

Eventually the Council decided that two steps needed to be taken: on the one hand those men who had either started or completed a health visitor course should be allowed to take a special "booster course" so that they might qualify for the award of the Council's certificate; and secondly a new form of obstetric training for all applicants should be evolved within the health visitor training course. It was noted that great care would have to be taken to avoid giving the misleading impression that standards had been lowered in order to admit men. If, however, obstetric training was not a necessary pre-requisite, then what alternative experience - if any - was considered to be suitable? This question has not yet been answered.

In Circular 48/1972 the Secretary of State intimated that he had decided that provision could now be made to enable men to be trained and employed as health visitors. The National Health Service (Qualifications of Health Visitors) Regulations 1972 came into operation on 1st January, 1973. These Regulations replaced those of 1964 which restricted qualification as a health visitor to women. Men can now train and be employed as health visitors in accordance with the rules of the Council for the Education and Training of Health Visitors;
moreover arrangements have been made for those men who have already satisfactorily completed training to take an additional short obstetric course, so that they can meet the requirements of the Council and be eligible to apply for the award of the Health Visitor's Certificate. Men who are currently employed as health visiting officers, both whole and part-time staff, in local health authorities and by voluntary organisations under agency arrangements are to be informed of this new Regulation.

Special "booster courses" for obstetric training for male nurses started at Aberdeen and Chiswick Health Visitor Schools in 1973, but it is expected that in future any health visitor course may train students of either sex, provided that the candidates hold the necessary pre-requisite qualifications.

In September 1973 the first successful applications were made by 27 male nurses for registration on the Roll of Health Visitors and so ended an era of total female dominance in preventive public health nursing.

Even though the effect of the 1972 Regulations is to open the doors of health visiting to members of both sexes the dilemma still remains. Are male health visitors to be expected to be generic workers covering the same areas of work as those of their female counterparts? If so, even if tacit approval has been given by the professional organisations, are all health visitors equally in agreement? Has not
MacQueen been more realistic in his concept of the men dealing
with men and boys, together with certain family situations,
rather than becoming involved with women and very young children?
How would these women themselves feel, or rather how would husbands
feel about male health visitors visiting their wives, for example
in cases of failing lactation and the necessary physical examination?
From the results of the surveys midwives have argued that men in
midwifery would not be welcome in this country. However, following
the enactment of the Sex Discrimination Act (1975) a few men are
now taking midwifery training.

The concept of the primary care team working in a Health Centre
would certainly leave open the field for each worker to specialise
in certain appropriate areas of work - appropriate to the sex,
interest and experience of the individual worker, and acceptable
to the recipients and their families. The problem of the generic
male health visitor is however more acute in those areas where the
field staff are still responsible for a geographical area, particularly
in sparsely populated rural areas where there is little opportunity
for co-operation between adjacent workers owing to long travelling
distances involved.
CHAPTER 3 - MIDLWIFERY
Historical Development

Any review of ante-natal health education would be incomplete without reference to midwifery. In this chapter I have briefly traced the development of this profession and tried to highlight only those aspects of the work that have a direct bearing on the midwife's educational function, an area where overlap with the health visitor's work can occur. Despite exhortation from a variety of sources it can be seen that only in recent years has this function been more widely acknowledged by the midwifery profession.

The practice of midwifery can be traced back to the beginning of civilisation when the care of the parturant woman was in the hands of those who were untrained, usually uneducated women. So perhaps it is not surprising that the word "midwife" means "a helping woman", derived from the Anglo-Saxon words "mid" (together with) and "wif" (a woman).

Prior to the Reformation, midwives in Christian countries worked under the direction of the Church and had to obtain a licence of good character in order to practise. In effect the bishops were the forerunners of the statutory body of the present day. In 1803, France introduced regulations for the control and training of midwives. Russia had been training midwives for many years, but Britain still lagged behind and for many centuries obstetrics was regarded as an inferior branch of medicine.

The midwife of that day was immortalised by Charles Dickens in...
Mrs. Gamp was, in her highest work of art a monthly nurse, or, as her signboard boldly had it, "Midwife", and lodging on the first-floor-front, was easily assailable at night by pebbles, walking sticks, and fragments of tobacco pipe. She was "neatly, but not gaudily attired", and as she entered a room "a peculiar fragrance was borne on the breeze, as if a passing fairy had hiccuped and had previously been to a wine vault".

Martin Chuzzlewit.

The first Midwives Act for England and Wales received the Royal Assent in 1902. It safeguarded the title of "Midwife" and provided for the setting up of the statutory body, the Central Midwives Board. The Board was charged with the responsibility to protect the public against the ministrations of the untrained midwife. The Midwives Act of 1936 made it compulsory for the Local Health Authority to provide sufficient midwives to conduct home confinements. This was a much needed service, for at that time the majority of mothers in the United Kingdom were confined in their own homes. This same Act provided the final recognition of the midwife by the State, in that it required those midwives who wished to practise independently to notify their intention to do so. A decade later the National Health Service Act (1946) made available full and free maternity services to women. In 1968 the Health Services and Public Health Act widened the scope of the domiciliary midwifery service enabling midwifery skills to be used wherever they were most needed. It provided a means of legalising and fostering co-operation between maternity hospitals and
the domiciliary service. Today the Central Midwives Board is responsible for the training of midwives, the conduct of the examinations, the maintenance of the Roll of practising midwives, and, the practice of midwifery.

The Midwife's Role

What is a midwife? "A midwife is a person who is qualified to practise midwifery." (World Health Organisation Technical Report, 1966). What are the duties for which she is prepared? She is trained to give the necessary care and advice to women during pregnancy, labour, and the post-natal period; to conduct normal deliveries on her own responsibility; and to care for the newly born infant. At all times she must be able to recognise the warning signs of abnormal and potentially abnormal conditions which necessitate referral to a doctor, and to carry out emergency measures in the absence of medical help. She may practise in hospitals, health units or domiciliary service. Implicit in this definition is the relationship with the patient and the midwife's capacity to include within her counselling role the teaching of emotional, social and physical health factors associated with pregnancy and childbirth.

A century ago Florence Nightingale recognised the importance of parentcraft education: "Though everybody 'must' be born, there is probably no knowledge more neglected than this, nor more important for the great mass of women".

Today the importance of health education is recognised by the
Central Midwives' Board, but some midwives still restrict their teaching solely to the practicalities of the birth process. It is open to conjecture how far this bias towards factual teaching is due to inherent attitudes which do not recognise the significance of emotional needs of patients, is the outcome of general or midwifery training, or is caused by any other factors. Students may have been influenced by too rigid an interpretation of the concept of care, based on the kind of midwifery practised and taught by some teachers of the profession. These mentors could have been constrained by lack of time and possibly did not have the advantage of recent advances that are available from the study of behavioural sciences. To some extent the didactic method of teaching is a feature of many professions: perhaps it is more pronounced in nursing. In midwifery a certain degree of control is effected in the guise of a code of practice which limits care within predetermined boundaries and this could stultify professional growth. A more sensitive approach could correlate developments in medical sciences with social and cultural changes in the community.

As an independent practitioner of normal midwifery the midwife has a unique opportunity to provide health education at a time when most expectant parents are psychologically motivated to learn. In addition to imparting factual information and training for relaxation during childbirth, the midwife's knowledge of the usual emotional
changes taking place during pregnancy should help her to relieve some of the discomforts of this period by giving her patients reassurance and anticipatory guidance. Expectant parents should be encouraged to express any worries, feelings of anxiety or even guilt they may have. Counselling, both to help the parents cope with the changes that the birth of a child brings to a family and to reduce stress to a tolerable level, will affect the future mental health of the family unit; it may also help to forge the all important bond between the infant and his family and thus reduce the incidence of deprivation. This type of health education should, in turn, improve the parents' ability to make more effective use of medical and nursing care.

In the post-natal period, the midwife's responsibilities vary, but in the early days she plays a major part in the supervision of the mother and her baby. The Report of the Working Party on Management Structure in the Local Authority Nursing Services /of the U.K./ (1969) refers to the midwife's responsibility in helping the mother to assume her motherhood with complete self-confidence, teaching the mother how to handle her baby and gain confidence in her ability to do so. This is increasingly important in the present climate of care with schemes for the early discharge of patients from hospital now in operation. One of the domiciliary midwife's professional functions which overlaps that of the health visitor is to teach parents the art of child care and thereby inculcate positive attitudes towards family life. Another area of overlap with either the health visitor
Discussion

It is recognised that immediate needs, for example the reduction of maternal and infant mortality rates, will initially take precedence over latent needs such as the achievement of long-term goals through health education. But the developed countries have emerged from this earlier stage and are now attempting to meet needs created by the changing social structure of the community. Alongside recent advances in modern medicine and obstetrics, more emphasis is now laid upon preventive care.

Perhaps it would be useful to look at the major improvements that have taken place since the 1930's as a result of the concerted efforts to reduce the loss of life amongst mothers in childbirth and their infants. The enactment of the Midwives Act, 1936, was a watershed for the midwifery services in England and Wales in that it cut out the handywoman and made midwifery a viable profession, and gave every pregnant woman entitlement to the services of a midwife. The new breed of midwife, together with the members of the newly established Royal College of Obstetricians and Gynaecologists, formed the spearhead of a campaign to reduce maternal mortality rates. In 1931 the maternal mortality rate was 4.11 per 1,000 total live
births; by 1941 it had been reduced to 2.80 and, despite the
war and even because of it, there was an improvement in nutrition,
aesthesia, and intra-venous transfusion. Also within medicine
in general and obstetrics in particular there were advances in
the control of infection and of toxaemia. By 1951 the maternal
mortality rate had dropped to 0.75. In 1952 confidential enquiries
into each maternal death were analysed and the collected data
were published. Practitioners of obstetrics and medicine were
able to identify those patients who were "at risk". As a result
there was a change of social policy and an improvement in patient
care whereby scarce maternity beds were allocated to those high
risk groups. By 1961 the maternal mortality rate was further
reduced to 0.33; a decade later it was 0.14 per thousand live and
stillbirths, and by 1974 it had dropped to 0.10.

At the same time there was a considerable reduction in the
infant mortality rate, the total falling by nearly one half between
1948 and 1968 with the greatest reduction occurring between the ages
of 3 to 12 months as more lives were saved because of improved obstetric,
paediatric and surgical care.

Throughout this period some members of the midwifery profession
remained adamant in the belief that their primary task was the care
of the parturant woman, and so in many parts of the country the health
visitor remained the sole provider of ante-natal health education.
However, there was a change of attitude by midwives of repute who
gradually came to recognise the importance of health education.
Margaret Myles, in the preface to the first edition of her "Textbook of Midwifery" (1953) stated that mothercraft could not be disassociated from midwifery and she devoted a chapter of the text for the midwife’s consideration. She asserted that improvement of a child’s physical and emotional development would result from a combination of ante-natal instruction and child health supervision. While acknowledging that there are also other workers who are willing to teach parentcraft, she urges midwives to accept this responsibility, and she has enlarged the amount of health education material in the sixth edition (1969).

The focus of obstetric care has been on the prevention of abnormalities in both the mother and the child, and on the early diagnosis and treatment of those abnormalities which are unavoidable in order to minimise their effects. In the past only the physical aspect of preventive care had been uppermost in the minds of both midwives and obstetricians. While the importance of ante-natal care had been recognised, only in recent years has the dual concept of psychological as well as physical care become more widely accepted. A report commissioned by the Royal College of Midwives (1966) revealed that in many instances ante-natal care was an inadequate form of preparation for expectant parents. Some of the findings of this report, pertinent to this paper, show that women are still often unprepared for the physical and psychological implications of childbirth and have little knowledge of the growth and development of a baby. Many say they start a family fearful of the birth process or are
concerned that a child may interfere with the marital relationship. They are often anxious that they may have an abnormal infant or be inadequate parents - in direct contrast to those couples who are knowledgeable about the event and consequently approach pregnancy with a greater feeling of confidence. Almost one third of the women interviewed (and predominately social classes 4 and 5 and the younger women) said that they were not given information about ante-natal classes. The survey shows that in many instances the mothers who attended classes benefited from them during their labour and their subsequent handling of the baby, although far too many hospitals were not aware of the instruction the mothers had received.

However as long ago as 1948 a survey of maternity services recommended that greater emphasis should be placed upon the educational aspects of ante-natal care, especially for primipara. Midwives were urged to make use of their unrivalled opportunities to educate expectant mothers and to this end it was recommended that methods of health education and family planning should receive more emphasis in the curriculum.

Twenty years later the Secretary of the Royal College of Midwives proposed that the principles of teaching should be studied during midwifery training. In 1972 directives were issued by the Department of Health and Social Security and the Central Midwives' Board to provide parentcraft instruction for expectant parents and experience in teaching for both trained and student midwives. It can be argued
that a programme of professional training is best judged
by the ability of the recipients to meet the needs of the
community they are being educated to serve, but the late
inclusion of this aspect of the midwives' function could be
represented as being motivated more by a desire for professional
fulfilment and advancement than by a recognition of patients'
needs.

During the past decade the enactment of further important
legislation has had repercussions on the midwifery service. Both
the Abortion Act, 1967, and the National Health Service (Family
Planning) Act, 1967, could be said to have contributed to the
considerable reduction in the live birth rate which fell from a
peak of 18.5 per 1,000 population in 1964 to 13.0 per 1,000 in 1974,
and provisional figures for 1975 show a further reduction to
12.2 per 1,000. At the same time increasing emphasis was laid
on the importance of hospital delivery which effectively reduced
the amount of domiciliary work for the midwife. A reduction in the
expenditure on hospital maternity services and the expansion of
preventive services was proposed in the 1976 Consultative Document
on Priorities for Health and Personal Social Services in England.
There is an urgent need to review the services provided. A careful
reappraisal of the present pattern of midwifery services and their
objectives may reveal the need to replace the current pattern of care
by a more comprehensive approach. On the recommendation of the Maternity
Service Committee Report (1959) the midwife's training has already
been extended to include the care of her infant patients up to the
28th day of life when deemed necessary. Further reorganisation of the service envisaged in the Consultative Document would expand the traditionally accepted role of the midwife to cover further aspects of prevention including certain screening programmes, family planning, genetic counselling, abortion counselling, specialised care of the neonate, and services in relation to sexually transmitted diseases in women. In some instances midwives are already focusing their enhanced skills on certain areas of prevention. This raises the problem of overlap with their health visitor colleagues. If reorganisation took place upon the lines suggested above then surely it would lead to duplication and eventually to the demand for a similar professional preparation to that of the health visitor.

Discussion between the professions concerned would help to clarify the issues raised by the extension of the midwife's role. A recent decision by the Central Midwives Board to reduce the period of obstetric training was made somewhat arbitrarily without considering the implications for the statutory entry requirements for health visitor training. Similarly the extension of the period of surveillance of the normal neonate has impinged on the health visitor's traditional first visit on the 10th day of an infant's life.

The extension of the boundaries of professional knowledge and insight into the complex physical and psychological needs of...
expectant and nursing mothers and their families should be considered in relation to other important factors, such as social and cultural changes in the community. A logical sequence of training to the appropriate level of expertise presupposes a highly developed knowledge base and the further training of teaching staff in post. Discussion at administrative level would have to focus on general principles of care rather than attempting to accommodate individual idiosyncrasies, whereas communication at field level should take note of all factors pertinent to the needs of both the givers and receivers of care. However not all fieldworkers are equally skilled in the perception of individual problems so that the responsibility should rest with the co-ordinator of each primary health care team. A critical appraisal of the degree of expertise and independent judgment required for many areas of midwifery care may reveal the need for a highly trained corps of midwives, independent practitioners of normal midwifery and skilled in management, communication techniques, and preventive health care. They would have to be supported by a larger body of maternity nurses responsible for patient care. Training would have to be reviewed for its continued relevance and effectiveness. While it is difficult to make accurate projections for the birthrate such a scheme should allow for flexibility in the use of resources, provide job satisfaction for staff at all levels of care, and be contained within a limited budget. Good co-ordination and a logical sequence of training to the appropriate level of expertise would result in improved health care for the community. This assumes that the profession will have already determined what basic knowledge is required and trained
its teachers to meet the new demands, and that society will
be prepared to support the practitioners with the equipment and
other resources to enable them to undertake this extended area
of responsibility. What sort of preparation would the elite
group of midwives require? Would it be very similar to that of
health visitor training? Why then not just have a health visitor
co-ordinator in each primary health care team?
CHAPTER 4 - HEALTH EDUCATION
Part I - The Development of Health Education
The Development of Health Education

Throughout human history mankind has been concerned with the problem of ill-health and the battle against an adverse environment. Man's progress in protecting himself and his community against disease was initially by isolating the sick, then by therapeutic care, and finally through attempts at preventive medicine. The growth of public health measures is recorded in terms of environmental sanitation and health education. It is a story of the changing attitudes of society towards the sick and the emergence of schemes for community and individual responsibility for health. How can people be educated to try to achieve this state? One of the earliest health education techniques was the exhortation to follow the rules of health - or rather the rules of how to keep out of trouble! Some of the very early examples can be found in the regimens of Hippocrates and Galen. With strong religious and moral overtones, Mosaic Law too advocated the adoption of a code of practice which would promote community and individual health.

During the Middle Ages, attention was focused on the art of healthy living and this gave rise to the famous medical poems such as the "Regimen Sanitatis Saleritanum" which was published in many languages for over 7 centuries. The development of the printing press released a flood of books, almanacs and tracts giving advice about personal hygiene, nutrition and sleep. One should not decry the
work of the early empirical health educators whose advice was based on experience rather than scientific study. The criteria for measuring the worth of a regimen is its proven effectiveness, and a noteworthy example is the success of Cook who in 1772 became the first man to sail around the world without the loss of any of his crew from scurvy.

The spate of advice on health care continued and the period from 1750 to 1830 was an important era during which the foundations of the 19th Century sanitary movement were laid. During these 80 years numerous attempts were made to teach matters of health. The approach was usually that of a book or home journal listing the rules of health to be followed if the recipients wished to achieve perfect health; the advice was addressed to the upper and middle social classes and totally ignored the conditions imposed by the industrial revolution on the working classes. Despite its limited appeal this movement was an important nursery for future growth and the development of public health nursing is derived from the idealism of that period.

The inter-action of the concepts of self-help and the charitable tradition of caring for the sick poor supported the growth of public health nursing in the U.S.A. and Britain. However the development of health education was hampered by the mistaken belief that one only has to inform the poor on health matters for them to help themselves!
The origin of modern public health can be attributed to the development of understanding and a sense of responsibility in its peoples. Edwin Chadwick (1800-90), Secretary to the Poor Law Commission, was a major influence in the improvement of public health in Britain. His efforts brought about the reform of the English Poor Law and the start of modern local government; and later he was instrumental in forging the first public health legislation. Chadwick was convinced that health depended upon sanitation and saw local government as a potential vehicle for public health administration with a doctor as the specialist advisor. The Public Health Act 1848 set up the General Board of Health (later replaced by the Local Government Board in 1871, and the Ministry of Health in 1919).

The germ theory provided a scientific basis for much public health action and gave rise to a technology of environmental hygiene. Local government was given the responsibility of implementing the many Public Health Acts. In 1872 it became compulsory for every local authority to employ a Medical Officer of Health.

The sanitary reforms of the last century prompted health workers to consider the part played by human reaction to ill-health and led to the innovation of preventive medicine. During the 19th Century there began an active movement in health education within the developing public health service. Men and women of vision recognised the need for change throughout the land; Sir John Simon, Chief Medical
Officer of the Privy Council in London, and Florence Nightingale (who was among the first to realise the value of health teaching in the home) pressed for more involvement on the part of central and local government and a change of attitude amongst the workers responsible for domiciliary care.

Child Welfare Services

Advisory leaflets on infant management were distributed by Dr. John Bunnel Davis (1780-1824) amongst the mothers attending his Universal Dispensary for Sick Indigent Children in the City of London, which was set up in 1817. He advocated district committees of "benevolent ladies" to visit children in their homes and report on their health. There is no record of such work ever taking place but Davis' work represented an intermediate phase in the evolution of child welfare services in Britain. The early health educators were called, by some, the Biblewomen because they came from the City Mission Halls to sell Bibles and distribute tracts and directed their attention towards the poorer families. By the time the Manchester and Salford Ladies Sanitary Association was formed in 1862, there were 134 Biblewomen/Sanitary Missionaries already distributing tracts in London in addition to those in Aberdeen, Brighton and Bristol. The biographer, Woodham-Smith (1952) recalled Nightingale's dream of replacing the "Ladies Bountiful" by trained workers who would understand the needs of the poor. The workers would aim to educate on matters of health rather than alleviate ill-health, and Nightingale claimed that this could be achieved not by lecturing to people but rather by becoming their friend and confidante.
In 1849 Florence Nightingale paid a visit to the Institution for the Practical Training of Deaconesses at Kaisersworth on the Rhine. Here much emphasis was laid on the importance of nursing the sick in their own homes and the atmosphere of pure devotion impressed Nightingale. While she recognised that good nursing cannot be achieved by devotion alone, nevertheless the influence of Pastor Fliedner's work at Kaisersworth on Nightingale's call for health missioners is clearly shown by Baly (1973). "Prevention" is the theme that runs throughout Nightingale's famous "Notes on Nursing" (reprinted 1969) and with remarkable vision, before the advent of the "germ" theory, she advocated the importance of hygiene and health teaching although she admitted that the principles of healthy living were based solely on observation and experience. Indeed in her preface she disclaims any attempt to teach the reader, but puts forward health hints in the hope that the reader will teach herself how to look after the health of others.

In 1862 the first salaried visitors were introduced at Manchester and Salford, they worked under the direction of a Lady Superintendent for each district. Later, in 1890, some of these visitors came under the supervision of the Medical Officer of Health for Manchester and were paid by the same authority; a similar re-organisation followed a few years later in Salford. These salaried visitors anticipated the work of the "Schools for Mothers" by holding weekly meetings for health talks and practical demonstrations on health subjects,
such as infant management, the correct clothes for children, sick nursing and cookery. Brierly (1924) refers to a series of six nursing talks given to mothers and children's nurses in 1894 by members of the Midwives Institute, whose subject matter included "drains" and first aid. In 1892 three health missioners were appointed by Buckinghamshire County Council and in 1897 five were employed by Worcestershire County Council to give home teaching in the care of children.

Budin, a Professor of Clinical Obstetrics at the University of Paris, set up an infants consultation centre at the Charité Hospital in 1892. His intention was to provide a centre for weekly instruction in the rearing of healthy babies, and in this it differed from the normal clinic of the day which provided services for sick children. Emphasis was laid on breast feeding and consequently the health of the mother was of importance. Records were kept of the child's progress and weight for the first two years of his life. When weaned from the breast he was provided with sterilized milk in bottles, one bottle for each feed, to reduce the risk of gastro-enteritis. This innovation was copied throughout France, some centres being attached to maternity hospitals and many more established independently. Most of the children attending the latter had already been weaned so that the distribution of sterilized milk was a prominent feature of the movement. The first consultation set up independently was held at Fecamp in 1894 by a Dr. Dufour who called it the "Goutte de Lait".

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Despite the time and money spent on sanitary reforms during the second half of the 19th Century, the infant mortality rate showed a tendency to increase. These figures and a falling birth-rate gave impetus to the concern felt by Government and citizens alike. The epidemics of summer diarrhoea, which killed thousands of infants annually, were believed to be an important factor. The remedy lay in combating filth together with efforts to improve infant care, especially feeding techniques. Some authorities resorted to the distribution of leaflets on infant feeding and management, while others went so far as to supply medicinal remedies during the epidemic period. One or two, including Worcestershire, employed health visitors to teach the mothers infant management. A Dr. Harris, the Medical Officer of Health for St. Helens, Lancashire, had made inquiries into the work of the "Gouttes de Lait" in France, with the result that in 1889 he opened the first Infants' Milk Depot in England. Run on similar lines to the French centres, his scheme was the forerunner of centres throughout Britain.

Gradually the infant consultation movement began to change in function. One such innovation was introduced at the St. Marylebone clinic which was started in 1906 by Pritchard. His aim was to provide a centre for instruction in health promotion; individual instruction soon gave way to class teaching and the movement became known as the "Schools for Mothers". One of the earliest recorded by McCleary is that of the St. Pancras School for Mothers which opened in June 1907. Follow up visits to the homes were made to evaluate and reinforce class teaching.
The movement for free or cheap meals originated in Paris in 1904 and two years later a Mrs. Gordon of Chelsea provided dinners for nursing mothers. Gradually expectant mothers began to demand similar facilities. Health visitors began making follow up visits to the homes and, in cases of need, enlisted the aid of charitable organisations.

Hay (1909) describes the organisation of the first Mothers' and Babies' Club in Aberdeen. A group of ladies opened a club in the Gallogate area of the city where talks were given on health topics and infant care. It was so successful that they had to provide two sessions a week, each one having an average attendance of 80 members. Free milk was distributed among the very poor mothers and infants. Other important features included the regular assessment of each infant's progress, the availability of free medical advice, and the preparation of expectant mothers for their confinements.

The 1914-18 war also gave a boost to maternal and child health services. In 1914 a memorandum from the Local Government Board emphasised the importance of ante-natal clinics but it is doubtful whether any had then been established. The following year saw the establishment of 6 ante-natal clinics linked to the Royal Free Hospital in London. These were soon followed by other clinics, by 1918 120 were in operation and this number rose to 1,417 by 1933.

A memorandum issued by the Maternal Mortality Committee in 1929 referred to the management and function of ante-natal clinics and stated
that after the doctor's examination the health visitor should give the mother an "Advice Leaflet" and advise her on hygiene. Home conditions should be assessed, and this might necessitate a home visit by the health visitor—the role of the midwife was thought to be concerned with routine physical examinations. The initial difficulty in establishing ante-natal clinics appeared to be a lack of co-operation from general practitioners and the shortage of qualified medical officers to run the clinics; another was the failure to utilise the midwife's potential. The Midwives Institute, which had for 30 years organised lectures and discussions for midwives, nurses and other health workers, was pressing for co-operation amongst health workers. The Institute set up a co-operation Committee whose members included midwives, district nurses, sanitary inspectors and other health workers. Amongst items for consideration was that of an agreed feeding regime for infants—even in 1924 it appeared that health workers were at variance over the principles of infant feeding!

An interesting account of a combined centre for infant welfare and ante-natal care was given by Blaikley (1970) on the occasion of its jubilee. The Governors of Guy's Hospital set up a committee to consider and report on the establishment of "a Welfare Centre for mothers and children connected with Guy's". A maternity and child welfare centre was already working informally in the crypt of the Chapter House, and within the Guy's Maternity District some 10 voluntary
and municipal welfare centres were already in existence. Plans were made and £10,000 was donated from the residuary estate of one Mr. Leopold Salomen on condition that the centre be known as "Salomen's Centre" - this money together with other bequests and a grant from the Ministry of Health ensured the viability of the project. An anonymous article in the Guy's Hospital Gazette of 26th July, 1919 gave the aims of the Centre as "To assist in every way possible the mothers and children of the Hospital Maternity Charity". On registering at the Centre, expectant mothers were to be examined by the Obstetric Registrar and follow up visits to the homes were to be made by the Centre Health Visitors. In addition to the Obstetric Registrar there was appointed in 1919 an Infant Welfare Officer (a doctor), a Sister Superintendent, 6 resident Health Visitors and a secretary. Two years later a second obstetric officer was appointed.

Some indication of the work involved was given by Blaikley who recorded the decision to accept those children who lived around the hospital, i.e. only about 1/10th of those born in Guy's Maternity District. The services provided by the Centre included preventive medicine, immunisation, social advice and health education. In addition it provided facilities for research and tuition for medical students, pupil midwives and student health visitors.
A Dr. Fenton, Medical Officer of Health, Kensington, decided to involve the husbands in the health care of their wives and children. The first council (a seminar on aspects of health care for the husbands) was held in 1921 at the Lancaster Road Voluntary Infant Welfare Centre in the Royal Borough of Kensington. The movement grew until eventually a Central Union of Fathers' Councils was formed and held its first Congress in 1930. The movement lapsed during the war and a post-war revival was short-lived. But recently Parents' Clubs have developed in many areas.

The Maternity and Child Welfare Act of 1918 gave local authorities wide powers to extend the use of welfare centres and health visiting to include children up to the age of 5 — provided they were not already attending recognised schools. Together with the Notification of Births (Extension) Act, 1915, the 1918 Act opened up a much wider field for local authorities and led to an increase in the number of health visitors employed. The attack on infant mortality had proved successful.

General provision for health education was implied in the Ministry of Health Act, 1919 in that it made it the duty of the Minister of Health to secure "the preparation, effective carrying out and the co-ordination of measures conducive to the health of the people". Six years later the Public Health Act, 1925 empowered local authorities to disseminate information relating to health or disease by means which included lectures and visual displays, and to incur
expenses on such activities. The Public Health Act, 1936 (Part V, Section 179) extended the powers of the 1925 Act to include all local authorities from county councils to urban and rural district councils.

Other Developments in Health Education

The historical development of health education in schools runs parallel to events occurring in other parts of the public health movement. Industrial Sunday and voluntary school organisations were, of necessity, concerned with cleanliness, physical environment and hours of work even before the 19th Century. The introduction of domestic subjects into the school curriculum is considered to have assisted efforts to improve health and living conditions. Science became a recognised subject and in 1846 physiology was taught in a London school. That the power of health reform through education in the schools was beginning to be recognised is summed up by Ruskin (1862) in his call for state-run schools to teach children about the laws of health, temperance and a trade. The Education Act of 1870 made elementary education compulsory in this country but another 32 years elapsed before the Education Act 1902 extended its provisions to include secondary schools. The Boer War (1899-1902) had revealed the poor physique of recruits and the subsequent Report of the Royal Commission on Physical Deterioration (1904) made recommendations to improve the lot of poor children. This report together with others (for example Rowntree's "Poverty: A Study of Town Life") led to the Education (Provision of Meals) Act 1906,
and the Education (Administrative Provisions) Act 1907. The latter paved the way for the introduction of an organised school health service whose principles still apply today.

The study of hygiene was an examination subject for the Teacher's Certificate issued in 1894 by the Education Department, London. The Board of Education Annual Report for 1904 reiterated the importance of the subject in the Theory of Education for teacher training courses. In a syllabus published in 1905 and 1909, the subject of hygiene was closely linked with that of temperance. Other pamphlets circulated by the Board included one on the teaching of infant care and management in elementary schools (1910); hygiene and physical training (1913); and, food hygiene (1920). Later developments included a "Handbook of Suggestions in Health Education" published in 1928 with two subsequent revisions in 1933 and 1939. The Education Act, 1944 (superceding all previous Acts) ensured a more uniform and effective service for education and health.

Other Developments

Another facet of health education developed when Sir Robert Philip opened the first chest clinic in Edinburgh in 1887; 2 years later the National Association for the Prevention of Tuberculosis was formed. This voluntary agency published leaflets and journals; supplied lecturers and films; organised refresher courses for doctors, nurses, tuberculosis visitors and social workers; and organised art therapy in sanatoria.
During the 1914-18 war the Government took steps to prevent the spread of venereal disease, introducing the Public Health (Venereal Disease) Regulations 1916 which charged the Counties and County Boroughs with the responsibility to provide treatment. Furthermore exchequer grants were made available to promote specific health education material and lectures on the subject. Much of the work was carried out by the British Social Hygiene Council (1925-1942) on behalf of the local authorities until 1942, when the Central Council for Health Education took over this aspect of their work. Venereal disease was not a notifiable disease so that the principle of voluntary treatment rested heavily on the effectiveness of health education at that time.

During the Second World War 1939-1946, which like all wars aggravated existing social problems, there was an increase in the incidence of sexually transmitted diseases so in 1942, Regulation 33B was added to the Defence (General) Regulations in an endeavour to control its spread. The health education campaign initiated at that time by the Ministry of Health was an excellent example for the future. The Ministry tried to break down the taboos of secrecy and fear, and the ignorance of up-to-date methods of treatment - which under Regulation 33B were compulsory. A series of radio broadcasts was made in conjunction with films and a nationwide press campaign. The Central Council for Health Education convened a conference in London to discuss the problem and a large amount
of publicity material was issued to reinforce the campaign.
The effectiveness of these measures was evaluated by 2 independent agencies. It was found that many people attended clinics for examination who subsequently were found to be free from infection; the measures employed resulted in a considerable increase in demand for the services of health visitors and social workers to deal with contact tracing, follow up work and the resultant health education.

The last link in the chain of secrecy was broken in 1970 when the Indecent Advertisements (Amendment) Act, 1970 replaced that of 1889. It removed the liability to prosecution of anyone who displayed advertisements relating to venereal diseases which could be seen from the public highway, or who handed out leaflets on the subject to people in the street. The Health Education Council was then free to promote its campaign of public information on a more secure basis.
Part II - The Foundations of Current Health Education in the United Kingdom
The Foundations of Current Health Education Activities in the U.K.

Plans for social reform, based on the proposals in the Report on Social Insurance and Allied Services (1942) were drawn up during the Second World War. A series of Acts, beginning with the Education Act (1944), was passed which provided the foundation for an improved Welfare State. The proposals for a new system of social security in 1946 and the abolition of the last remnants of the Poor Law by the National Assistance Act (1948) provided basic financial security for all. Legislation on housing and slum clearance was revised, and a legal framework was created for rebuilding Britain in a more organised way. Provision was made to help the child deprived of a normal home life and a reformed system of justice was enacted with a view to treating offenders both inside and out of prison.

For the purpose of this study the statute of most importance was the National Health Service Act, 1946, which became operative on the 5th July, 1948. The Act was intended to provide a comprehensive health service available to all citizens normally resident in England and Wales according to medical need, without immediate cost or insurance qualification. (Subsequent legislation has introduced certain costs and pre-requirements for specific services.) It led to great changes in the organisation of hospital, family practitioner and public health services. Part III of the Act referred to the provision for public health within the local authority health service:-

Section 21
specified health education as one of the facilities to be provided at Health Centres set up under that Section. It superceded
Section 179 of the Public Health Act (1936) allowing money to be spent on health education.

Section 24 defined the role of the health visitor. Responsibility for health education was implied in these sections, a function carried out by health visitors since the inception of the service in 1862.

It was within Section 28, dealing with the prevention of illness, care and after-care, that most of the scope for health education in local health authorities was to be found, but this was a permissive power and not all authorities put it into effect. The implications of the statute for health education were not clear initially but later the Ministry of Health Circular 118/47 defined the range to include routine work, health weeks and the use of broadcasting and visual aids.

Despite its stated object to provide a service "to secure the improvement of health" and "prevent illness", the Act made health education a statutory duty only of the Public Health Services and not of the Hospital or General Practitioner Services. Provision for health education under the National Health Service Act (1946) was restricted to the Local Health Authorities, that is County and County Borough Councils. The District Councils still carried out this service under the provisions of the Public Health Act (1936). Legislation failed to make a clear definition of health education
and the organisation of the service was fragmented amongst central and local government departments, the Central Council for Health Education and voluntary agencies working in special areas of interest.

Agencies for Health Education

After the war there was no specific section for health education in any Government Department, but three Ministries, those of Health, Education and Labour, were all actively engaged in disseminating information to interested health educators. In the Ministry of Health its Public Relations Division, comprising a Press Office, Publicity, and Intelligence Sections gave advice on technical aspects of publicity and press relations, provided statistics, and gave information to overseas visitors. The Press Office was responsible for maintaining contact with the national press, radio and television services; women's magazines and organisations; and the issue of official statements and notices. The Publicity Section organised campaigns and other means of mass communication. The Ministry of Labour provided a similar service for industry, with emphasis on the use of protective clothing and the implementation of safety regulations.

At local government level, with the exception of urban and district councils who were enabled to do this work under the provisions of the Public Health Act (1936), health education had its statutory origins in the National Health Service Act (1946).
The Health Service and Public Health Act, 1968 extended the powers of local authorities in certain respects:

**Part I, Section II**

made it permissive for a local authority to provide health visitors to visit elsewhere than in the homes, thus extending their sphere of work.

**Part I, Section 12**

allowed a local health authority, with Ministerial approval, to extend its remit for prevention, care and after-care within day and residential institutions.

Thus the 1968 Act prepared the way for local health authorities to collaborate with the new Social Service Departments set up in 1971 under the Local Authority - Social Service Act (1970).

At this time 2 "Green Papers" for discussion on the future structure of the National Health Service were produced. The proposals in the "Second Green Paper, 1970" envisaged an administrative structure which would strengthen the present tripartite service. In the unified structure the prevention of ill-health and health promotion could "be given a fresh and stronger emphasis".

MacMillan (1970) in an unpublished dissertation recalls that prior to 1944 the Birmingham Council for Social Health had carried out formal health education. Most of the work was done by 2 full-time lecturers whose main concerns were those of sex education and the prevention of venereal disease. In 1943 the Health Department took over the responsibility for this service with a view to extending
its range; to this end one lecturer was transferred from
Birmingham Council for Social Health, and together with the
Health Visitor Tutor for Birmingham assumed dual control for the
work. A pioneer Health Education Section was set up in 1947
directed by a Medical Officer and staffed by 4 lecturers and
a typist. As the section developed it achieved the Health
Committee's aim of extending over a much wider field of work in
the City.

By 1958 the Health Committee reviewed its policy and it was
decided to involve other members of staff in the Health Department.
Discussions took place to unify the approach of the Health Education
Section and the School Health Service in the teaching of health
subjects in schools; this was of particular importance in the
deployment of male nurses in Secondary Modern and Grammar Schools
and amongst industrial apprenticeship schemes.

In his paper MacMillan paid tribute to the work of the health
visitors in Birmingham. A small survey of the health education
activities of community health staff in the City revealed that the
contribution of health visitors had been a major one; in his
opinion there was no doubt that the health visiting profession in
Birmingham participated to a greater extent than any other workers
in health education.

Other local authorities, including the London Borough of Croydon,
began to put their health education on a more organised basis in the
1950's.
The development of organised health education in Croydon started in 1956 on different lines from that of Birmingham. While much of the health teaching in the borough had been carried out by the health visiting service, the Health Committee's scheme, approved by the Ministry of Health in accordance with Section 28 of the National Health Service Act (1946), sought to "develop health education in its area by all appropriate means". On the recommendation of Dr. S.L. Wright, the Medical Officer of Health, an experienced health visitor was seconded to train for the Diploma in Health Education at the London University Institute of Education, and later was appointed Health Education Officer. At the same time the Health Committee appointed a special home safety sub-committee to co-ordinate the efforts of the many local organisations and local authorities involved; a senior health visitor was appointed as Home Safety Officer and upon her retirement a few years later the work was taken over by the enlarged Health Education Section.

Successive Annual Reports of the Medical Officer of Health (from 1957 to the present time) show that the Health Education Officer started her work with a survey of both official and voluntary personnel, facilities and resources and expanded the work of the Centre. Displays and exhibitions soon became a regular feature of the service; in 1958 the Infant Welfare Clinics were supplied with teaching aids, and a small library was housed within the Section. In-service training for members of the Public Health Department started in 1958 and in 1970 a scheme of health education training for school teachers, employed by the Corporation, was instituted.
The Health Education Officer worked in close collaboration with the Senior Woman Schools Inspector and this venture resulted in the publication of a school textbook entitled "Health Education" - Elliott D.S. and May, E.T.

The Central Council for Health Education was established in 1927, following the enactment of the Public Health Act (1925) to disseminate information on the maintenance of health and provide a central body of expert knowledge in the sphere of health education. It was originally sponsored by the Society of Medical Officers of Health, the Association of Local Authorities and by insurance committees set up under the National Health Insurance Act. The Scottish Council for Health Education provided a similar service in Scotland.

The "Cohen Report"

The Report of a Joint Committee of the Central and Scottish Health Services Councils on "Health Education" (more often identified as the "Cohen Report") was published in 1964. The Committee stated that "undoubtedly the first requirement is to create a stronger organisation which will put new energy and thrust behind health education, and to review critically its results".

It was suggested that a new and autonomous body should be set up embracing the functions of the Central Council for Health Education and of the central government departments; there should be a parallel
sister organisation in Scotland. The staff would have the freedom to apply themselves solely to health education in a climate more conducive to experimentation than found in a government department. Thus the proposed bodies would be stronger organisations, able to give the impetus required to promote health education in the United Kingdom. The Cohen Report was almost universally recognised as providing a blue-print for future developments in health education.

The Committee paid tribute to the work of the health visitor in the field of maternity and child health. In its list of recommendations it recognised that health education was more than information giving - it must also seek to motivate people. The Committee considered a wide range of health education in the homes, schools, industry and commerce; and identified certain areas of concern including the cancers, mental illness, accident prevention and environmental health. The special needs of immigrants and of mothers were emphasised, as were the behavioural diseases in an affluent society.

The Committee proposed a new profession of Health Educators for which suitable training courses should be provided but at the same time paid tribute to the work of field staff, and stressed the need to include health education in dental and general practice. Although this was not in its terms of reference, the Committee stressed the importance of health education in the field of education and in the training of teachers.
England, Wales and Northern Ireland

Four years later, in 1968, the Health Education Council was established. The aims were to:

"promote and encourage in England, Wales and Northern Ireland, education and research in the science and art of healthy living and the principles of hygiene and the teaching thereof, and to assist Government departments, local authorities and other statutory and voluntary bodies in so far as their work comprises health education ..."

The Council began its development in the shadow of forthcoming change: the uncertainties about the future structure of local government; the reform of the National Health Service; the rapid growth of new ideas in education; and the uncertainties of the economic situation. In addition, to confused the issue, there were many different definitions of the concept of health education.

Originally the Council was composed of 16 members of whom the Chairman and 3 others were appointed directly by the Secretary of State for Social Services. The rest were government appointees on the recommendation of interested organisations and the local authorities who contributed about 15% of the total expenditure, the balance being provided by the Exchequer.

The constitution of the Council is that of a company registered under the Companies Act, limited by guarantee and recognised by the Charity Commissioners. In other words, it is a legal corporate entity
independent of direct Government control, but 2 Government observers are appointed to the Council.

The Annual Reports (1969-70, 1970-71, 1972-73) show that from its inception the Council adopted a critical approach to its work and appeared to be functioning as envisaged by the Cohen Report. Its first task was to re-examine the Cohen recommendations in the light of changed circumstances, and the Council found that most of them were still viable. Another task was to define the role and function of the health educator: this entailed the identification of a job specification, training, numbers and distribution of the specialist health educators; and the assessment of present and future needs of local government.

The Health Education Council took over the health education promotional activities of the Ministry of Health and the work, and staff, of the Central Council for Health Education which it replaced in 1969. Its progress was slow at first as it was hampered by staffing difficulties.

In 1973, in preparation for the reorganisation of the National Health Service, the Council was reconstructed and enlarged to 24 members with Sir Harold Evans as its Chairman. Eight of the original Council, including a Principal Health Education Officer who was a qualified health visitor, continued in membership. A new member of note was Professor W.H. Butterfield, Vice-Chancellor of Nottingham
University and Chairman of the Council for the Education and Training of Health Visitors. Originally there were 5 functional divisions in the organisation, namely those of administration; field services; medical research; communication, research and information services; and education. Despite initial difficulties over the acceptance of the new policy of the Council and the fact that staff were recruited from the diverse fields of medicine, education and administration, the new team began to emerge. By 1974 the Health Education Council had been reformed into 3 Divisions with a total establishment of 63 and an annual budget of £1 million.

The Division of the Council most relevant to this study is that of Training and Education whose Director, Sutherland, described its work at a one-day conference in the South-West Thames Regional Health Area, at Crawley on 21st May, 1974. In addition to the Director there are 7 members of staff, all with expertise relevant to their special responsibilities. It is concerned with the initiation of training schemes at 3 levels: the skills of teaching; advanced professional and advanced academic. It is interesting to note that the provision of scholarships and graduate courses for potential leadership in the United Kingdom became available some 30 years after those in the U.S.A., although courses for the Diploma of Health Education had been run for many years at the London University Institute of Education.

Following the pilot scheme started at Highbury Technical College, Portsmouth (1971) a number of part-time courses have been established
at colleges of further education. The aim of these courses is to enhance the skills of health educators at field level and in 1974 about 24 such courses were either being run or were about to start. However, owing to the economic recession only 8 courses were actually viable in 1976/7.

In 1972 a new post-graduate diploma in health education commenced at the University of Leeds; this one-year course is intended to be of practical use for those who will have health education responsibilities at either administrative level or in the field within the reorganised health and educational services. A similar course started at the Polytechnic of the South Bank in 1976.

The Department of Community Health at the University of Nottingham established in 1972 an elective subject in health education within the two-year degree course for Master of Medical Sciences. It consists of an initial one-year course in Community Medicine followed by an elective programme of guided study, and may be taken in any one of a wide range of higher educational establishments (e.g. medical, dental and nursing schools; colleges of education and university education departments; social and community work departments). It is designed to prepare health education specialists who will assume responsibility for research, policy, management and evaluation of health education in the National Health Service. Four fellowships in the Department of Community Health are awarded annually, for the two-year course, by the Health
Education Council. Another graduate course was established at the University of Manchester. All three types of training in health education have been promoted by the Council, which also promoted short in-service courses where necessary.

A further development of interest is the support of both the Health Education Council and the Schools Council for curriculum development projects. They are intended to assist teenagers and younger children in making rational decisions about their own life-styles. While the Health Education Council will support teachers in schools, even to the extent of providing certain services not available from education authorities, the training of teachers for this work was not the responsibility of the Council but lay within the remit of the Department of Education and Science. Nevertheless it is interesting to note that the Council, following the example of the Cohen Committee, recognises the importance of health education in schools.

Health Education in Scotland

A sister organisation, the Scottish Council for Health Education, was set up in 1967 as a direct result of the Cohen Report. Its main functions are to design, organise and conduct courses for doctors, nurses, school teachers, public health inspectors, social workers and other professions interested in health education. Many of the single and multi-disciplinary courses take the form of non-residential seminars at the Council's headquarters in Edinburgh but others are held as residential schools in various parts of Scotland. Occasionally projects are arranged in conjunction with the Scottish Health Education Unit.
In 1968 the Scottish Health Education Unit was formed. It was created within the Scottish Office, has the support of Central Government finance and administration, and is responsible to the Secretary of State for Scotland. The Unit's remit is to decide on priority of health needs; to prepare programmes for promotion at national level and utilise outside bodies to do this; help health and education authorities in their own local schemes; promote, conduct and evaluate research; and train medical, nursing and other interested staffs to improve their skills in health education.

The Scottish Health Education Unit and the Scottish Council for Health Education exist side by side, each complementing the other's role and function. They provide a national framework within which health education activities have flourished north of the border for nearly 10 years. They have, between them, interpreted the spirit of the Cohen Committee's recommendations for health education at national and local level. They differ from the Health Education Council in that the latter has a policy of delegation in matters of training and research for England, Wales and Northern Ireland.

The Health Education Council recognises the complementary roles of voluntary bodies who provide information and support for health education in their own area of special concern. Amongst these are: The Family Planning Association providing courses for teachers on sex education, as well as leaflets and advice. Local branches will also help with teaching problems peculiar to the area. The National Childbirth Trust providing training courses on psychoprophylaxis for professional staff, through its members
it runs a variety of classes associated with childbirth and distributes leaflets on related advice.
The National Marriage Guidance Council who provide literature and advice together with courses on personal relationships for teachers.
The National Association for Maternal and Child Welfare providing assistance and advice on parentcraft and child development. It has drawn up model syllabuses for the Certificate of Secondary Education Mode 3 courses or for an award by the National Association for Maternal and Child Welfare.
The Royal Society for the Prevention of Accidents provides posters, pamphlets and advice on all aspects of safety. It has a permanent exhibition at Horseferry Row in London and participates in national and local safety campaigns.

DISCUSSION

Who does health education? Apart from health visitors who have a statutory responsibility to carry out health education, all health workers in the N.H.S. are now expected to participate whether they work in institutions or in the community.

In the foreword to the "National Health Reorganisation: England" (1972) the Secretary of State for Social Services stated:

"Everyone is aware of gaps in our health services ...
It is well understood too that there must be more emphasis on prevention - or at least on early detection and treatment."

However, the White Paper left unanswered the question of the future
growth and development of the health education service.

The Report of the Committee on Nursing (1972) recognised the growing importance of health education in Nurse Training. It recommended that the proposed Certificate in Nursing Practice should include an introduction to human relationships and communication in its introductory course; and both hospital and community nursing aspects of preventive medicine and health education should be included in the Higher Certificate course.

In addition, local authority staff in environmental health, education and social services departments have a part to play as do members of the general public whether it be in the course of their work, leisure or home life.

How is this organised?

Following the enactment of the National Health Service Reorganisation Act, 1973, the former functions of the tripartite service were unified into the largest nationalised organisation in the United Kingdom. Section 2(2)(e) removed the responsibility for health education from local health authorities to the 90 new Area Health Authorities. However, local authorities retain the power vested by Section 179 of the Public Act (1936) to carry out health education in environmental health education and personal health services. The Health Education Council has kept its previous role.
Circular H.R.C. (74)27 described the functions of the Health Education Council in relation to the health education activities of the reorganised National Health Service and the local authorities. It is responsible for training; the planning, staging and evaluation of large-scale campaigns in collaboration with the authorities concerned; and it has a supportive role in relation to health education in schools.

The Department's stated long-term objectives are "to expand and improve health education to acceptable standards in all areas", and to this end the circular set out the administrative arrangements for the future organisation of the service. Health education activities include: the involvement of all health workers wherever they may work, the Area Health Authorities being responsible for providing the necessary support in addition to arranging campaigns and distributing publicity material; co-ordination within the National Health Service, and between it and the departments of local authorities and the Health Education Council is emphasised, and the onus for making collaborative arrangements has been placed with the Area Health Authorities; and finally, the growing importance of health education in schools and colleges has been recognised.

How are personnel prepared?

The Department emphasised the need to improve and expand training for specialist workers and for those health workers who are not trained for this aspect of their work. It suggested that suitable staff should be sent to training courses promoted by the Health Education Council throughout the country.
How is co-operation ensured and overlapping prevented?

In considering the future development of the service, the circular recommended that members of the health professions and of the local authority departments should collaborate in the planning, carrying out and evaluation of health education activities. Account should be taken of District requirements and the views of area officers including the Area Health Education Officer. Finally it conceded the need for research studies to be carried out.

Thus it can be seen that not only has the major responsibility for health education been taken away from the local authority but it has now become the concern of the National Health Service at a higher (Area) level. The Area Medical Officer is the responsible officer for health education, advised by his other professional officers and assisted by the Area Health Education Officer. Formal recognition has been given to the 3 levels of training in health education and the need for planning, evaluation and research.

The Circular foresaw that health education was likely to become a more extensive and organised service, and health workers in hospital were expected to participate as well as those working in the community. Recognition was paid to the continuing duties of local authority staff in environmental health, education and social services departments; and the importance of collaboration and planned programmes of care was emphasised. To this end the role of
the Health Education Council was strengthened and its main
functions re-defined.

A Consultative Document entitled "Prevention and Health:
Everybody's Business" was published by the Department of Health
and Social Security at about the same time as the publication
"Priorities for Health and Personal Social Services in England"
(1976). Both documents have been released at a time when financial
resources are severely restrained, but it could be argued that
they provide added impetus to health and local authorities to
consider a previously neglected source of long-term economic saving.
The emphasis on prevention is very heartening for those who are
working in this field. These two Government documents are linked
and the 'Red Book' (Prevention and Health: Everybody's Business)
suggests the preventive approach should "permeate and inform
all aspects of the health services". In addition there are many
other fields of work which have a health education component, such
as environmental health, education, and social services, and the
church and voluntary agencies - and the food trade has a part
to play. Different disciplines have their own special contribution
to the health of the nation, but one factor is common to them
all - communication.

Traditionally, the basic training of professional health
workers, with few exceptions (viz, the health visitor), was centred
on the symptoms of ill-health and its cure. But recently there has
been a gradual change in thinking in health care; there has been a
conceptual change from cure to care, or a change from emphasis on the disease to emphasis on the individual. Implicit in this change should be a new approach on the part of the professional care-givers which considers the recipient's potential to help himself, once he has been given the knowledge so to do. People respond best to advice from those whom they respect and respect cannot be gained without the necessary teaching skills. Only in rare instances are these skills inherited; usually they have to be learnt and practised. How can this be done? The long-term ideal would be for all basic professional training to include in the syllabus the theory and practice of health education - this is already done in health visitor courses. In the short-term there is a slow and rather meagre growth in the provision of part-time courses leading to the Certificate in Health Education. These courses are designed to increase the communication skills and techniques of those whose work involves them in some aspect of health education, at field level rather than in the administration of the service. In view of the current emphasis on prevention, some authorities are maintaining a short-sighted policy and refuse to recognise the worth of such training; they are not prepared to spend money on extra-professional courses when budgets are being drastically pruned to what are held to be the priorities of the service.

The publication of the Consultative Document on "Priorities" brings a reminder of the value of prevention at a time when financial resources are so restrained. The Document, a new departure
for a Government paper, reviews each service in detail and suggests that authorities be guided by the order of priorities given therein. It is hoped that the information will provide health and local authorities with a basis for the careful planning of their services. An important feature of the proposals is the continuation of programmes of training, and it is suggested that these should be increased in certain instances. More emphasis should be placed on the preventive services and programmes of health education are to be preserved. The "Priorities" document both referred to and endorsed its sibling on "Prevention"; it stated that a series of papers is to be published which will look in greater depth at particular aspects of prevention. Meanwhile it emphasised the importance of preventive medicine and health education which it claims could lead to a saving in resources in other areas at a time when budgets are severely limited. However, an increase of about £2 millions by 1979/80 is envisaged for specific preventive services such as the primary care services and, in particular, for health visiting. It is hoped that over a period of years the preventive aspects of health and social care can be strengthened. The limited amount of health education carried out by some authorities is noted and they are requested to review the need for greater effort. Finally the role and function of the Health Education Council is endorsed.

While the emphasis in both Documents on prevention and health education reflects an important trend in Government thinking, much more needs to be done. One positive gesture would be the appointment
of a health education officer at the Department of Health and Social Security, amongst whose duties would be assistance in the interpretation, implementation and monitoring of these proposals. Other forms of practical help in order to spread the health education services more evenly throughout the country would be the provision of grants for candidates taking the one-year course for the Diploma in Health Education, and the subsidising of the cost of the part-time courses. These measures would help to maintain the morale and motivation of both course tutors and health education officers, and provide a basis for the expansion of this work when the economic climate improves.
CHAPTER 5 - THE NEEDS OF CLIENTS
Many conditions and customs which have supported people through their life crises have been lost in modern industrial societies, often without anything being substituted in their place. Home confinements are just one example of the kind of support that pregnant women and new mothers received in the more traditional cultures than in the Western world today. A girl who comes from an extended family in the Orient has probably witnessed many deliveries and taken care of many small children in her young life. Through her experiences she has had more preparation for pregnancy and birth than does the daughter of a Western urban nuclear family. More consideration should be given to the type of support that women need in our own society today. This could well require a major change in the approach of the givers of care. In most instances expectant parents should be actively involved in the process of decision making with the members of the professional team responsible for their welfare. This could be more easily affected by consultants holding routine ante-natal sessions at health centres in place of the present impersonal maternity outpatient departments. However, this would entail a change of attitude on the part of some consultants and midwives towards the needs of women having normal pregnancies, to the need for consultation as well as palpation.

At a time when women are psychologically most receptive to health education on an intimate and personal basis an increased proportion of births have been taking place in institutions. 95.6% in 1975 compared with 64.3% 20 years previously. It is claimed
that this reduces the physical hazards of childbirth. This is true, but it also depersonalises the whole approach to childbirth. In antiseptic and strange surroundings many pregnant women are not allowed to proceed naturally through the phases of normal childbirth but, in the guise of therapeutic obstetrics are hustled through labour with the aid of inductions, episiotomies, and forceps deliveries. The popular press has implied that in some instances inductions may be performed to suit the obstetricians' convenience. In turn this intervention may excite longer, stronger contractions which will require drugs to alleviate the mother's pain and thus weaken her ability to maintain her dignity and some degree of control during the birth process. An additional risk may be that of an asphyxiated newborn child. Are there any chemical reactions that take place during normal childbirth that are affected by these obstetric techniques? Will this accelerated labour affect the psychological bonding between the mother and child? Are these procedures, aimed to protect women from the process of childbirth and its attendant risks, in danger of inducing more serious morbidity in families? If childbirth once again is becoming an experience to be feared by many women, what effect can this have on their mental health? How can the provision of care be improved for these women? Perhaps in the first instance more care should be taken to explain the use of modern obstetric techniques to expectant parents, and secondly the extent to which the emotional and psychological needs of patients are being catered for should be studied.

Different disciplines seek different goals through the provision of ante-natal care. Chertok and Briance, psychosomatic
obstetricians, stress the importance of improving the expectant mother's health to produce a short, safe labour. The pioneers of the physiotherapeutic approach to pregnancy (Randall and Dick-Read) recognised that the triad of fear-tension-pain leads to a lowering of physical performance, and hoped by teaching the mothers how to look after themselves that this would result in freedom from pain and fear during their confinement. However, these approaches only attracted well-educated women.

Nash, a paediatrician, carried out an exploratory survey in the Brighton area in 1970 of 100 mothers who had just had their first babies in hospital, the majority were not only young (i.e. 30 were 16 - 19, and 50 in the 20 - 24 age groups) but they had also left school at 15, the earliest possible age. The results showed that a significant number of the mothers said that they felt unprepared for delivery, were afraid of what was going to happen to themselves and their babies, and after delivery expressed a number of anxieties about the immediate future. Although an effort had been made to inquire into the adequacy of sex education, with dubious results, no review of attendance at parentcraft classes had been attempted, though Nash's stated intention had been to explore the maternal attitudes and psycho-social background of the sample. In Glasgow inquiries have revealed that multiparous women amongst the poorest and least educated mothers of the City do not receive adequate ante-natal care.
What does one hope to achieve through ante-natal classes? Ransom, a consultant obstetrician, in her foreword to Rathbone's "Focus on New Mothers" (1973) asserts that childbirth forms part of ancient myth and imagery. It is an emotive subject for the mother and those responsible for her care. Teachers (of psychoprophylaxis) outside the sphere of medicine are quoted as being "sometimes as fervent in advocating their own mode of ante-natal preparation as are recent converts to a religious sect".

Rathbone, a physiotherapist, investigated claims made by the followers of the cult of the "psycho-physical method" which grew out of the Russian technique, based on the conditioned reflex theory. She found that there were contrasts between those whose aims were to reassure the mothers and those who were more concerned with obstetric management. There was a correlation between women eager to learn about labour through class attendance and their reading patterns. However, a number of mothers either had enough information or did not wish to learn about the details of pregnancy. She found that mothers who attended classes required less analgesia and that they had the best chance of producing babies in good condition. Both the mothers and midwives participating in the survey agreed that confidence is increased by preparation for labour. Of the trained mothers, 25% said that their controlled breathing and understanding of relaxation were most helpful in contrast to 20% of the non-attenders who said that "nothing helped".
However, there was no evidence to support the hypothesis that class attendance made any contribution to a happy experience during confinement. The midwives expressed the opinion that the trained mothers were easier for them (the midwives) to help.

Friedman, an obstetrician, in a survey of 130 women who voluntarily asked for natural childbirth training looked at their motivation and tried to determine other factors important in their psychological preparation for this event (1971). In his experience he found pain is not eliminated but is made more tolerable by training. He attributed most of the success of the training programme to 3 important factors: 41% of the patients had a strong positive transference to the doctor; 25% found education and reality testing helped to diminish fear and anxiety and so develop self-confidence; and 17% of the sample cited the helpful presence and reassurance of the husband as an important factor. Other positive indicators were the expressed desire to prepare for natural childbirth and also to breastfeed the baby. 88% of the sample were successful according to his criteria. While Friedman considers that his present programme produces a high success rate of 93%, this is only for those who are highly motivated. He asserts that most American women are brainwashed from childhood with fears of labour and delivery, and that 9 months training in pregnancy is too little and too late. It may be that the true psycho-prophylactic approach would be one which starts as soon as sex education begins with the young child.
In her book on "An Approach to Ante-Natal Teaching" Kitzinger (1971) approaches the subject from the point of view of a sociologist with extensive study in psychology and related disciplines. She argues that preparation for birth embraces the dual concept of health education and the betterment of community relations. She considers that not only does this provide the under-privileged mother with a better understanding of the birth process but it also makes the event socially significant in a way that is already taken for granted by the middle social classes. Group work in the sorority of expectant women brings a recognition of personal worth which can be helped by the teachers in aiding relations of inter-dependence and mutual support. The ideal method is that of informal discussion but even so it must be directly related to the woman's own expectations of birth and parenthood which are both personal and derived from her membership of society. The teacher must not offer concepts that are identical with those known to be acceptable to middle class mothers, or the advice will be irrelevant.

Teachers of parentcraft from a medical or para-medical discipline might have a different, but equally valid, approach from any of these. There is no one professional task-orientated training for the provision of ante-natal preparation; equally there is no concise formula for a successful journey throughout pregnancy and the puerperium. There are difficulties involved in the much wider interpretation of the teacher's role if she is to be both effective and sensitive in this area of care. There could emerge in the near future a system of training and certification for ante-natal
teachers, but is this the only way to raise standards of care given by professional and lay teachers? An alternative approach could be the regular meeting of all interested parties for the interchange of ideas, and this could lead towards interdisciplinary study of the many and varied methods of communication that can be used to reach a wide spectrum of interests and needs. An effective mechanism for consultation both at national and local level should be set up to review the use of available resources and teaching methods. Membership would be open to all interested professional bodies. In order to harness community effort at local level voluntary organisations should also be represented. Contacts between the givers and receivers of care in a specific geographical area would lead to the provision of a service better equipped to meet the physical, social, and emotional needs of that community. This would entail a departure from the old doctor/patient relationship model of care-giving and a move towards the social or situational model, in which the community is actively involved in planning programmes of care specifically geared to meet its own health needs.
CHAPTER 6 - PUBLIC HEALTH NURSING OUTSIDE THE UNITED KINGDOM
The following chapter briefly surveys the origins and current state of public health nursing in some countries outside the United Kingdom at various stages of economic development. The U.S.A. are fully developed; the member states of the Soviet Union are at various stages of development; and countries like Nigeria and India are still developing.

In the U.S.A. the development of the public health nursing service was prompted as in Britain by the rapid industrialisation of the 19th Century. In the Soviet Union the service was one of the reforms introduced by Communism. The developing countries studied below modelled their services on U.S. or British practice, but have still many problems to overcome; and in Nigeria progress was severely set back by civil strife.
Public Health Nursing in the United States of America
Public Health Nursing in the United States of America

In the United States of America health care has to be bought like any other commodity. In this the system is different from that of the United Kingdom where health care as a right is available for all. However a growing concern for proper health care planning combined with a realisation that community care is cheaper than hospital care have lead to attempts to spread services more evenly throughout the Union. The many large gaps in coverage are a legacy from the historical development of public health nursing.

There was a rapid expansion in the 1890's of public health measures and public health nursing in the United States of America leading to the setting up of full-time health departments staffed by qualified personnel. While the visiting nurses' service developed under private auspices and support in many of the Eastern cities, others were built up through the support of public funds. Each State had a department of health which functioned as part of the state government, and each city, county or district had a health department and an appointed officer with delegated authority. As a result the public health service has been developed according to its own particular needs and resources, and practice varies, in some instances tax-supported public health agencies are to be found at
the various government levels - Federal, State, County, Municipal or township. Privately supported agencies also carry on health programmes at all levels, one example of a private agency at local level being a visiting nurse association. There is no national organisation of visiting nurse associations in the United States such as exist in some other countries, for example, Canada.

The development of Public Health Nursing in the U.S.A. drew inspiration from similar developments some 5-10 years earlier in the big industrial cities of Britain. A paper by Florence Nightingale ("Sick Nurses and Health Nurses") was presented at the Chicago Exhibition of 1893 and greatly influenced the growth of visiting nurse agencies whose purpose was to send graduate nurses into the houses of the poor in large cities such as Boston, Philadelphia and Buffalo. So began the development of home visiting services for mothers, young children, and the sick. From their inception these organisations emphasised the teaching function of public health nursing, and frequently the word "Instructive" appeared in the name of the agency, for example, the "Instructive District Nurse Association of Baltimore".

Some state departments also provided direct public health nursing services to local areas. This was done for demonstration purposes or, especially in remote areas, from necessity because of lack of local facilities or scarcity of staff.

One scheme of particular interest to British nurses is that of the Frontier Nursing Service in Kentucky which was based on the original Scottish Highlands and Islands Nursing Service.
The National Organisation of the Public Health Nurses (later the National League of Nursing) played a key role in improving the educational and service standards of the profession. At the same time, in 1912, the State Children's Nureau was formed to monitor all aspects of child welfare. The Bureau was instrumental in studying the causes of maternal mortality; it recognised the inter-relationship between the health of both mother and child, and it started schemes of health education, reinforced in 1913 by the publication of a pamphlet called "Pre-natal Care". Public recognition of the value of maternity care together with advances in medical knowledge were the two main factors in the reduction of the maternal and infant mortality rates in the U.S.A. However there are still areas and groups in the U.S.A. whose level of care is below that of the majority of its peoples, for example, 25% of the expectant mothers in the U.S.A. did not receive any ante-natal care in 1966. This in part reflects the plight of the midwife who is still struggling for recognition both from her nursing colleagues and the medical profession. The stereotype of the granny-midwife (untrained) is still felt in the U.S.A. today where the word "midwife" retains a connotation that draws resistance even to its use as a title in maternity care. After the second world war schools of nursing-midwifery slowly developed in individual states but standards are not nationally determined. They exist within the framework of a medically directed and supervised health service, indeed in many cases the attitude of obstetricians is that obstetric care is their sole responsibility so that the midwife's role is confined to that of maternity care. It is estimated that under 1% of the total number of women delivered in the entire U.S.A. by midwives or nurse-midwives. However, one development of interest in ante-natal care is the concept of the Maternity Liaison Nurse.
An Experimental Scheme in Georgia

Georgia ranks in the lowest 1/5th of the 50 states for health care, its high rates of reproductive mortality and morbidity being found not only in rural areas but also in the urban communities. Rates for illegitimacy and prematurity are among the highest in the nation, and the latter are continuing to rise for the Negro portion of the population.

In 1964 a Maternal and Child Care Project was begun in the Grady Hospital, a charity hospital for indigent patients in Georgia. An interdisciplinary team was set up to meet the health needs of some 35,000 patients who attend the hospital annually. Amongst the members of this team were ten liaison nurses, all hospital-based, who had their own caseload of patients and liaised with the other members of the obstetric team. Their role was to provide continuity for specialised needs in the outpatient clinic, and to form a link between the clinic and ward situation. They were also responsible to provide health education for each individual patient and her family, and also had to establish a working relationship with the County Health Department so that continuity of care was maintained.

These nurses had to have a baccalaureate degree and some public health experience. Their administrative duties were reduced to a minimum so that they could spend most of their time with their patients even during labour if it was considered helpful. Hours of duty were irregular and at times could be prolonged but the morale of these nurses was high, they considered themselves privileged as they did not wear uniform and were allowed considerable responsibility for their own work. These nurses have put forward many proposals to improve the service, and changes have been made in the reception
and treatment of patients, and in the provision of a 24-hour telephone answering service so that patients can contact their own nurse for help and advice. This particular Maternal and Child Care Project has proved to be most satisfactory, and the standard of applicants for these posts has remained high.

In 1968, the U.S. Maternal and Infant Care Program was sponsoring 51 projects aimed at seeking out high risk mothers and ensuring that they received care. In most instances the nurse-midwives were not delivering babies, though they were expected to be competent in areas where medical staff were unavailable. These nurses were engaged in case-finding, supervision of pre-natal care and giving health education.

Despite the affluence and vast resources of the United States, the existing infant mortality rate in 1966 was roughly comparable to that of some of the developing countries of the world, and so also was the maternal mortality rate for some of the population in parts of the country. The high infant mortality rate was accompanied by other problems, such as the inability to provide an appropriate level of care for all ethnic groups; the lack of comprehensive and universal pre-natal services for all pregnant women; and the failure to provide diagnostic and treatment services for handicapping conditions. Several difficulties have to be overcome before the situation can be improved. First there is the problem of vested interests where professional bodies had turned into protective associations to guard their members' rights at the expense of the patient. Secondly the traditional attitudes on the part of the people and the medical profession have to be overcome by closer collaboration between both parties. A final point is the timidity of government to involve itself in the area of education and training of professionals.
Although the European midwife is the accepted person for normal confinements, the medical view is that the United States could not redress the shortage of doctors in the field by using one category of workers (paramedics) to do another's job. Perhaps the solution lies in the recruitment and training of a new worker to become the physician's assistant but it is doubtful whether the type of workers envisaged would be attracted, unless the recruits were prepared for a well defined role. Midwifery schools in the U.S.A. have declined and the number of midwives is now down to only 200 actually employed as such. One school of midwifery is sited in the Frontier Nursing Service in Kentucky which is described below.

The Frontier Nursing Service - Kentucky U.S.A.

In 1925 the territory in the Kentucky mountains, where the Frontier Nursing Service began its field of operations, was a vast forested area inhabited by some 10,000 people. There was no motor road within a radius of 60 miles, horses and mule teams were the only modes of travel. There was not a single state-licensed physician, typhoid fever was endemic and diphtheria was rife.

Mary Brekinridge, the founder of the service, stated that "to meet the need of the frontiersman's child, you must begin before he is born and carry him through the hazards of childbirth". This meant that the nurses must be qualified as midwives, they must be nurse-midwives. So the Frontier Nursing Service became the first organisation in the U.S.A. to use nurses qualified as midwives.
The service started as a community project to combat diphtheria and typhoid. Its work began in a small log house with a staff of three nurse-midwives in Leslie County, Kentucky. Five years later it had spread to cover an area of 700 square miles of rugged, mountain country. In order to reach the widely scattered population it became necessary to decentralise the work and six outpost Nursing Centres were built with the help of the local citizens. Many prominent Americans generously contributed towards the cost of the service. Each outpost nursing centre had two resident nurses who were responsible for the care of all the families who lived within a five mile radius. Patients who required specialist medical care were referred to the Medical Director of the hospital at Hyden. In the early years most of the work was carried out in the homes of the people, as they were reluctant to attend hospital other than for outpatient care.

The nurse-midwife working under medical direction proved to be the key worker in the Frontier Nursing Service. Until 1939, when the Service set up a School of Midwifery, the nurse-midwives were either British nurses or American nurses who had come to the U.K. to train as midwives. However since the late 1960's each nursing centre now has a public health nurse and a nurse-midwife. Originally the mothers preferred to be confined at home but this practice has changed because neither the insurance companies nor the state medical plan will pay for this service. Expectant mothers started attending for pre-natal care soon after the service began but they could see no reason why medical care was required. This attitude was overcome by a consistent programme of health education and by the provision of a service carefully designed to meet the changing expectations of the community.
Statistics show that by 1955, out of a total of 10,000 women registering for pre-natal care, the puerperal death rate was 9.1 per 10,000 live births compared with an average mortality rate of 34 per 10,000 live births amongst white women in the Union. In the period 1955-1970, when 6,000 deliveries were recorded, the mortality rate was nil. Programmes of Family Planning have been well accepted by the community; and the birth rate, one of the highest in the U.S.A., has declined considerably.

Although the emphasis is on the care of mothers and babies, the work today is designed on a family basis. The small 27 bed general hospital at Hyden, with its busy out-patient clinic, is totally inadequate to meet the needs of the present day community. The district nurses care for many of the sick in their own homes and all members of the family are catered for by the public health nurse. Wide-spread immunisation programmes are preceeded by health education campaigns in the homes and schools.

The success of the Frontier Nursing Service can be attributed to the emphasis on caring for the whole family. But Kentucky is a small area in which the success of task orientated training for community nursing can be demonstrated. However it is not representative of public health nursing in the States and neither is it an acceptable concept for the majority of Americans. Illing (1968) found that the American nurse tended to equate capital expenditure with efficiency and looked down upon schemes which allowed improvisation. The peoples in receipt of the Kentucky service were the poor whites of British stock and considered to be second class citizens. In contrast, the Indian in need could claim on the Federal Government for aid and the Negro was recognised as under-privileged and was therefore not
stigmatized. Attempts at expanding the Kentucky scheme into other areas were frustrated although it was considered to be a useful if archaic form of voluntary service experience.

As the Americans became concerned with programmes of health care for groups with special needs, so official and voluntary agencies became involved in aspects of education. The techniques of previous eras were carried over into the 20th Century, for example, leaflets distributed by the New York City Department gave advice on infant care and the two scourges of that period — diphtheria and tuberculosis. Gradually other methods of instruction evolved: for example the tuberculosis movement set up displays in Baltimore and New York City in 1904 and 1905 respectively. The following year the first of many travelling exhibits was built to tour the county fairgrounds and vacant stores in large cities; it was probably the fore-runner of the health museums of which Dresden (1912) was the most famous of its kind before being destroyed in the Second World War.

Gradually the health departments in the U.S.A. began to place health activities on an organised basis. In 1914 both the State and the City of New York set up similar health education bureaux in their Health Departments and the First World War accelerated the need for such services. The term "health education" was first recorded at a Child Health Organisation Conference in 1919. The following year the Organisation awarded its first fellowship for health education. In 1922 another conference held at Lake Mohouk emphasised the importance of a proper scheme of training for health educators, however this was not achieved until 1943 when the American Public Health Association established qualifications for health educators. Public
health schools began to promote courses including graduate training at eight universities. By 1947 300 of the 460 employees in official and voluntary health agencies were graduates in health education. The Report of a Joint Committee of the Central and Scottish Health Services Council - Health Education (1964) stated that more attention was paid to health education in the U.S.A. than in the United Kingdom or in most of Western Europe. In the U.S.A. health education was carried out by six main types of organisation but the poor co-ordination between these bodies was reflected in the quality of educational and publicity campaigns. The true amount of health education carried out in the States was difficult to estimate. While a specialist profession of health educators existed they were relatively few in number (about 1,000 working for all types of agency) and nurses in full-time health education formed an even smaller group of workers.

The Committee noted that public health nurses performed duties comparable to those of the British health visitor but usually did not visit mothers from the upper socio-economic groups more than once. There was no single equivalent budget for health education equal to the amount spent on health visiting in the United Kingdom and it was possible that the proportion of expenditure in the U.S. was no greater than in Britain.

Health education has become increasingly important because trends in medicine and increasing costs have placed the responsibility for health maintenance into the hands of the citizens.

Public health nursing has long been recognised as an important field of nursing practice in the U.S.A. and many graduate nurses are trained for
But only within the last 20 years has preparation for such practice been included in the basic baccalaureate curriculum, a step which occurred with the shift of emphasis from hospital care to the broader view of total nursing care for the community. Today nurse educators in the U.S.A. believe that basic education in nursing should prepare students to function in a variety of settings. One such scheme by Bryan and Taylor (1961) is outlined in Appendix A. I would recommend that all student nurses should have some community experience during their training, to enrich their understanding of patients' needs and the quality of care provided, in whatever branch of the profession they chose to follow. This experience would help students to realise that a patient's illness is but a phase in his life, and that he should be considered in the context of his family and the community in which he lives and works. Furthermore the student would also gain experience as a member of a multi-disciplinary team whose interests extend beyond that of curative care.

From the account outlined in Appendix A of the baccalaureate programme in community health nursing it would appear that it is similar in many respects to the Degree and Integrated Nurse/Health Visitor training in the United Kingdom. However there are some identifiable differences: the total length of the course is only 16 weeks with a minimum of 30 days practical experience whereas for example, the integrated course run by Croydon College of Design and Technology and Kings College Hospital provides 26 weeks theory and a minimum of 130 days practice. Considerable emphasis is laid upon the nursing care, prevention and control of tuberculosis in Unit III, and the American course also includes aspects of industrial nursing, and civilian emergency and disaster plans in the curriculum. Bryan and
Taylor admit that the graduate public health nurse is ready for only a junior post in the community and even then she requires supervision. They do not produce any scientific evaluation of the training whose primary objective is to prepare nurses "for effective careers" in the profession. However the model used would seem to be well prepared and executed, and the faculty staff are aware of the limitations and the need for very close liaison with the field personnel. It is felt that able students will act as catalysts to improve whatever branch of nursing they elect to follow, a role similar to that advocated by Professor Alwyn Smith for degree courses in basic nurse education in the United Kingdom.

The concept of the American public health nurse as a teacher is increasing in importance and so too is the demand for home nursing care. The service is becoming available to more families than formerly because of the existence of both private and governmental health insurance plans. The subsequent increased demand offers challenging opportunities for both teaching and nursing in the home, and a realisation that primary preventive health teaching is as important as that of tertiary prevention. As a result the role of auxiliary nursing personnel is growing both in the hospital and community health services. Direct contact with patients/clients is often predominantly in the hands of these workers, while the professional and para-medical staff are concerned with actively supporting and helping them with their growth and development.

The Navajo Scheme

An experimental programme in training by using Indian health workers on the Navajo Reservation in South West U.S.A. is described by Brown (1961).
In 1955 the Department of Public Health and Preventive Medicine of Cornell University Medical Centre established a medical centre for some 2,000 Navajo peoples living in a bleak area of 800 square miles. This ethnic group have strong religious and cultural ties, and a firm faith in their "medicine men", and many do not speak English. In the early 1950's half the child deaths occurred under 1 year; the maternal death rate was relatively high; tuberculosis, influenza, and measles with secondary complications were rife compared with the U.S.A. in general; and although congenital dislocation of the hip was a frequent occurrence, it was considered by the people to be more of a blessing than otherwise. The attempt to introduce a service by health workers whose own culture and previous environmental background was totally different posed many questions and unresolved problems.

To try to solve these problems the health centre was staffed by two physicians, three public health nurses, and an anthropologist; and Navajo staff were employed to provide maintenance and laboratory workers, project assistants and four "health visitors". The health visitors' work schedule consisted of 2-3 days in the centre alternating with home visiting. As there were only a few native nurses on the reservation it was decided to train English speaking Navajos to be multi-purpose assistants to the public health nurses. Brown describes how the Tribal Council chose pairs of workers, over the age of 25 and of both sexes, for this project. Initially they received elementary training in anatomy, physiology, nutrition and disease entities. They were then taught nursing skills and the technicalities of immunisation and screening procedures. Instruction in basic health education skills together with interviewing techniques completed their training, and after this they had to practise for six months under supervision.
It is generally agreed that the technical procedures are skillfully carried out, and that the standards of interpretation and explanation of disease processes are satisfactory. However other aspects of teaching especially in the homes are less well done, and there are two possible reasons for this: one insufficient practical experience, the other the difficulty in overcoming a cultural reticence to intrude into personal and family matters - the importance of privacy rates high in the Navajo culture. The terrain and its peoples posed problems of a peculiar nature which have not yet been wholly resolved; perhaps the initial experimental programme using Indian health workers was too ambitious and set goals beyond the grasp of the Navajo pioneers. Nevertheless these workers are proving to be indispensable and Brown hopes that they will, in time, become useful adjuncts to the few public health nurses in the area.

This is another example of a task-orientated training using the indigenous people of the area, a type of scheme for training and using health workers which has been advocated by Fendall (1972) to improve health care amongst the developing countries.

In this account of public health nursing in the States I have tried to demonstrate the piecemeal attempts made to meet a variety of health needs in different localities. Much of the work carried out in the community is still provided by private, non-profit making associations whose incomes are derived from a number of sources and are dependant upon fund raising activities. Although today nearly two-thirds of the total revenue comes from the government most of these organisations still have financial problems. However the inception of the Medicare and Medicaid schemes have helped to provide care
for those who are old or poor, even though these schemes are restricted to "skilled nursing care". Despite the fact that no insurance plan will pay for preventive health care, Visiting Nurse Associations in the cities of Washington and New York are engaged in projects to demonstrate to other community health agencies, and to the government, the value of comprehensive home health care incorporating the concept of primary prevention.
Public Health Nursing in Nigeria
Public Health Nursing in Nigeria

A service of home visiting similar in some respects to that carried out in the United Kingdom began in Nigeria in 1899 but little progress was made in the undeveloped Nigerian health services until after the second world war when the Government proposed the provision of a free medical service for children up to the age of 18. To this end generous support was given by the United Nations organisations, WHO and UNICEF, in setting up paediatric teams to work throughout the country. The Baptist Missionary Society also played an important part by extending its work into the field of child health. One tangible result has been the dramatic fall in the mortality rate of measles which combined with the effects of malaria and protein-calorie deficiency, was the scourge of Nigerian children.

A Modern School of Nursing in Nigeria - Ibadan

Another development in health care in Nigeria introduced in 1952 was the initiation of a school of nurse training at the new University College Hospital, Ibadan in 1952. The importance of the nurse as a health educator is an acknowledged feature of the syllabus and to this end the responsibility for health promotion is constantly demonstrated in all aspects of training, as well as curative care. The inception and first seven years of its work are described by Bell (1961). The nursing school differed from the traditional pattern of British nurse training in that it is a distinct educational entity, although it remains dependent upon the hospital for clinical experience. An executive committee was formed whose terms of reference were to keep the nursing school on a secure and stable economic basis thus enabling it to grow and develop as an educational institution.
The objectives of the school are:

i. to raise the standard of nursing in Nigeria by recruitment and training,

ii. to prepare potential leaders in the profession,

iii. to integrate theoretical and practical training,

iv. to integrate the social and preventive aspects of care, and emphasise the importance of health education, and

v. finally, to establish professional standards comparable to those required by the General Nursing Council for England and Wales.

The school is designed for a maximum intake of 80 students. The basic entry requirements are for well educated young women with 11-12 years secondary education who have passed their school certificate examination. The course covers a 3½ year period with the qualifying examination at the end of the third year, leaving a 6 month period for consolidation and experience as a qualified nurse.

The function of the nurse to teach and promote health is the underlying theme of the curriculum and a domiciliary service unit has been specially developed to provide this experience. The unit is staffed by four health visitor/home nurses: two are qualified tutors who divided their time between the unit and the nursing school, the others being based full-time at the unit to supervise the home visiting experience of students. Practice in group health education is obtained at the child welfare clinic in the paediatric department, and students are required to make home visits to follow up and evaluate their teaching in feeding and child care.
Arranging home visits in a town with no organised domiciliary services raised several problems at the start. Care had to be taken in the selection of suitable patients, the preparation of the patient and his family prior to discharge from hospital, actually finding the patient's home, and the nurse had to be able to adapt without lowering standards to the sparse facilities in often very cramped and unhygienic conditions. Health education formed an integral part of every home visit and often, as news of a visit spread around the neighbourhood, an initial individual session quickly became transformed into group instruction! Teaching had to be simple, direct and frequently repeated to a largely illiterate audience. Nevertheless families were co-operative and ready to learn. The students and their tutor gathered together a nucleus of about 12 older women for weekly meetings to discuss some aspect of health care. On their return home the women spread the teaching amongst the women in their own compound. This became a regular feature known as the "Elders Committee". One important feature was the care of the tubercular patient and his family, and the students showed an interest in this work despite an inherent fear of the disease. A high degree of co-ordination between the wards, departments and this district nursing service in miniature was maintained. Despite its limitations it demonstrated the pattern of total family care to both nurses and recipients alike. It may well be the fore-runner of an overall domiciliary service in Ibadan for which there is a tremendous need.

Students at the school gained other teaching experience by giving talks to their peer group, mothers in clinics, school children, girl guides and youth clubs. Students manned stalls at the annual agricultural show and the Ibadan Health and Baby Week. The school received the support of
the hospital, university medical faculty, health department, district
council and voluntary organisations in the area. Despite the enthusiasm
of all concerned there remained many problems in trying to develop a
domiciliary teaching area within a compact district of Ibadan. However
a teaching area has been developed in Ilora, a village 30 miles away where
the students obtain experience in community care and home visiting for
periods of 3-4 days at a time. During their visits they are concerned
with health centre and school activities, and it is here that the "Elders' Committee" meets each week.

At the time of writing her report Bell stated that no detailed or
scientific evaluation of the nursing school's programme had been carried out. However, this scheme for nurse training incorporated the best of both the
American and British systems. Its success in achieving the five objectives
was in part due to the team of British nurses who joined the staff.

Later Developments

The provision of domiciliary nursing care was only a restricted
service in Ibadan and other means of providing home care had to be considered.
One of these methods was to train auxiliary personnel to extend basic
preventive work in the community. With the help of the World Health
Organisation, an Auxiliary Training School was set up at Ibadan in 1958.
Amongst the auxiliary workers trained at this centre are public health
inspectors, community nurses and family visitors. Some 3 years later, a
field-work centre was inaugurated at Ishara Health Centre to provide
practical experience for these students.
The training for community nurse in the school covers a period of three years: the first comprises 3 months preliminary work followed by nine months of basic science studies; in the next year four and eight months experience is given in paediatrics and maternity nursing respectively; six months is spent in out-patient clinics for the sick child, pre and post-natal care, family planning together with some domiciliary visiting and maternity practice, culminating in a further 6 months at a rural health centre to consolidate learning and gain experience in teamwork. The course is similar in many ways to that of the School of Nursing, University Hospital, Ibadan.
Public Health Nursing in India
Well before the establishment of Western rule in India, Christian missionaries and merchants provided medical relief and some built hospitals. These services were subsequently extended by the British and other European countries who influenced the growth of both medicine and nursing in India. Lady Dufferin initiated a movement to provide care for Indian women and children in the late 19th Century, which resulted in the building of several hospitals known as Dufferin Hospitals and the provision of maternal and child health centres. The hospitals became the nucleus for the modern day training of doctors and nurses in obstetrics and midwifery, and in 1918 the first school for health visitor training was set up in India.

After the Second World War, India was classified as a developing country and so was entitled to help from the various United Nations agencies including the World Health Organisation and UNICEF. She began to develop medical and nursing programmes under a series of five year National Plans, the first concentrating on the development of the rural areas through Community Development Projects, and the initiation of Primary Health Centres in the villages. The concept of the Primary Health Centre was that of a unit supplying each family with services to meet its health needs other than those (curative) supplied by a hospital. They were designed to serve about 20-40 thousand population and were located in rural areas so that patients could be treated in or close to their own homes. Originally Primary Health Centres were not designated "mini-hospitals" but were entirely separate entities with different and complementary functions. However in a subsequent (5th) Five-Year Plan an integrated programme of health, medical,
family planning and nutritional services is to be extended to the villages with Health Centres serving as the nuclei for this work. The Primary Health Centres are to be up-graded to become 30-bed hospitals each with a staff of 6 doctors, 7 nurses and 60 other paramedical staff per 60-80,000 population. In turn they are to be supported by a network of sub-centres each responsible for 10,000 villagers. To encourage trained staff who are unwilling to work in the sub-centres, the Plan includes the provision of good accommodation, protection of the staff and other facilities. One real problem arises from the need to replace local indigenous workers by trained staff which arouses the hostility of the people who cling to the traditions and superstitions of their villages.

There is a critical shortage of medical and nursing staff in India. An Editorial in "The Nursing Journal of India" (1973) revealed the following figures:

- 302 Primary Health Centres function with 2 doctors,
- 2,010 Primary Health Centres function with 1 doctor,
- 143 Primary Health Centres function without a doctor,
- 202 Primary Health Centres sanctioned but not yet established,

in all to serve a country whose population is 560,000,000. There is one trained nurse to every 10,000, and one doctor to every 5,000 people (but in the cities the figure rises to 1 doctor for 4,500 people whereas it drops to 1 doctor per 20,000 in rural areas). About 80% of the total population live in the rural areas and it is here that the indigenous medical practitioners and barefoot doctors (peripatetic and untrained) provide "medical care" together with the untrained midwife or dais. There is only one hospital bed to every 2,000 people, or a total of 255,700 beds for 560 million people.
Other problems of the Health Services in rural India are described, they include a lack of qualified physicians; the size of the nurses' work load which inhibits the initiation of programmes of health education other than those of pre and post-natal care, family planning and nutrition; the limited opportunities for promotion and few training facilities for nursing staff; a lack of security and few incentives for workers to move to rural areas - only male nurses can work in some districts owing to the local social conditions and customs of the people. Transportation over bad or impossible roads from one village to the next, often up to 60 miles apart, puts additional strains on staff; the limited resources are of minimal use when environmental hazards are compounded by ignorance, illiteracy and poverty. Other factors retarding the development of the health services include those of language, status and customs. There are 16 official state languages and 55 known local dialects which restrict the employment of workers to those who speak the local dialect if Hindi, the national language, or English is not in local use. In the past the low status and poor training of the Indian nurse did not help to recruit young women with good education into the service. Customs, religion, the caste system and inbred habits create a barrier between the villagers and health workers who try to impose different values and standards without a true understanding of their clients needs and abilities.

During the early years of Independence several Health Survey and Development Committees were appointed to survey the Health Services in India. One such committee (the Bhore Committee) in 1946 deplored the status and training of the Indian nurse, and in the following year the Indian Nursing Council Act was passed and in 1949 the Indian Nursing Council was established.
with the object of establishing uniformity in nursing education. The curricula for basic nurse training were laid down in 1949 and revised in 1953 to include aspects of public health (as recommended by the 1946 Bhore Committee), with a further revision in 1963 when emphasis was laid upon the inclusion of pure, biological and social sciences. A further revision of the General Nursing Course was made in 1966 following a widely debated project organised by the Indian Nursing Council and the World Health Organisation. These deliberations also led to the preparation of a curriculum for the training of auxiliary nurse-midwives to meet the urgent staffing needs in the rural health centres. The course consists of nine months basic nursing together with a further period of 15 months midwifery training. On completion the auxiliaries are posted to work as midwives in the villages and may, with special in-service training, perform the duties of a health visitor or nurse under supervision. The midwifery training of 18 months duration has been almost completely superseded by that of the auxiliary nurse-midwife.

In India traditional training schemes for public health nursing and health visiting followed closely the British pattern. However by amalgamating the Auxiliary Nurse Midwife and Health Visitor courses, an integrated course of 2½ years is now given in most of the 19 training schools as a preparation for the award of the Health Visitor Certificate. The qualified health visitor is eligible not only to work in the sphere of maternal and child health care, but also to supervise the work of auxiliary nurses and midwives. She is not qualified as a nurse, but her certificate allows her a 12 month exemption should she later decide to take the General Nurse Course. Both health visitors and auxiliary nurse-midwives are qualified to work in the field of family planning - an area of high priority in a country whose annual birth rate is 41.7 (1951-1961), (U.N. 1969).
The initiative for training the public health nurse was taken by the Trained Nurses' Association of India who put forward proposals for curricula following the Bhore Committee's (1946) recommendation that such nurses had an important part to play in establishing the community health services in India. Subsequently in 1952 the College of Nursing in New Delhi started a 10 month course for registered nurse-midwives. Help with the scheme was again obtained from the World Health Organisation. The following year the course was transferred to the All-India Institute of Hygiene and Public Health, Calcutta. At first 20 students were accommodated but the intake quickly increased to 30 per year (with provision for a further 10) because of the demand both nationally and from other South East Asian countries. The aims of the course were two-fold: one to train public health nurses to provide comprehensive health care for families and the community, and the other to prepare the nurses to guide and supervise nursing and para-nursing staff working in health centres. With the inclusion of aspects of community health in the general nursing syllabus a third aim was quickly incorporated, namely to prepare public health nurses to teach aspects of community health in schools of nursing.

There are now five training establishments in India concerned with post-basic courses in public health nursing. A total of 1,200 nurses have been trained, of these 50% studied at the All-India Institute of Hygiene and Public Health in Calcutta. In her analysis of the work of 137 of these nurses, Zacharia (1973) found that only 35.8% (49) were working as public health nurses after completion of the course; a further 33.5% (46) were employed as Public Health Nurse Instructors in Schools of Nursing or Family Planning Training Centres; and 13.1% (12) were found to be in administrative and
supervisory positions. Although the findings showed a low input of qualified staff to primary health centres it was noted that some public health nurses had, after completion of further education or experience in the field, gone on to strengthen the development of public health by taking more senior professional appointments.

Further analysis of the work of the public health nurses in Primary Health Centres showed that they carried out maternal and child health care, family planning, health education, and the control of infectious diseases - the latter mainly by programmes of immunisation linked to those of health education. 53% were concerned with tuberculosis control programmes. More than 88% "do a certain amount of care" of the sick in their own homes and 91% carried out supervisory responsibilities, and 62% visited sub-centres to conduct clinics and supervise para-nursing staff in their work. A total of 41 Public Health Nurses were working in schools of nursing. About 22% of the sample had taken courses in further education and 16% to a first degree level, whereas 62% took one or more courses in further professional education. 41% of public health nurses working in health centres had no facilities to keep their knowledge up-to-date, and one wonders how they could maintain high professional standards in an era of technological change and advancements in medical and nursing sciences.

Despite the fact that the Mudaliar Committee (Health Survey and Planning Committee Report, 1962) highlighted the high incidence of morbidity in Indian school children, only 70% of the public health nurses were involved with school health programmes. Although provision was made in the Second Five-Year Plan for health care in the schools, it was both sporadic in
different Indian States and localised to certain urban areas. Subhadra (1971), in her critical study of school health programmes in Calcutta points out that, in spite of national campaigns, she has been unable to trace a simple pilot study with follow-up records for longitudinal studies on which to base an integrated national school health programme. She contrasts the highly developed concept of school health programmes in the U.S.A. and U.K. with those of her own country and sadly comments: "In India ..... Nursing itself is still in a stage of organisation. Public Health Nursing as a profession is yet to be developed and the School Health Nurse, therefore, will be a concept only of the future".

In a symposium held to consider the structure and training of Indian nurses Powar advocated two levels of training: one to diploma and the other to degree level. Ahad pleaded for second level nursing personnel to provide support for professional nurses in the ratio of 1:3, he also proposed that the auxiliary nurse-midwife course be up-graded to the graduate standard required for public health nurse training and should include a 2 year basic nurse training with an additional 3 months specialism in public health. Three years earlier Subhadra et al (1970) had made similar recommendations in their evaluation of public health nursing services at an urban health centre. They found that the auxiliary nurse-midwife had become the key worker for providing home nursing care in rural areas. The duties of the health visitor and public health nurse often overlapped and their nursing time had to be shared between fieldwork, clinic and teaching commitments. In their view the priority given to maternal and child care together with other commitments resulted in the reduction of general community health care.
Over the three year period of their study they were able to show the limitations on the amount of time available for supervisory and public health duties. A reconsideration of the roles and training of public health nursing was recommended.

Does the answer to India's quandary lie in the provision of more highly qualified nursing staff? Fendall argues the case for health services achieving a "total outreach" to improve standards of health as soon as possible. In his opinion the quality-quantity dilemma of health services in the developing countries is the result of society's inability to utilise its resources effectively. He asserts that the demands for qualitative services result in rising costs, and that they could be better channelled into a more extensive application of current knowledge and techniques to the masses of impoverished people suffering from ill-health. In accepting the concept of the health team he argues that the important role of auxiliary workers - a dilution of health services - is not yet accepted. A country wanting quality will have to pay for it, yet many basic health functions can be performed by workers trained for specific areas of work at a lower cost. Certainly the success of the Indian auxiliary nurse-midwife would support this contention. There would however appear to be a fundamental error in Fendall's thinking. Auxiliary workers could become excellent clinical workers, and by concentrating on routine duties could free the health educator to perform the tasks for which she has been trained. However health education involving attitude change requires the use of the specialist involved at field level to identify need and combat old wives' tales. The use of auxiliary workers for health education carries the disadvantage that they are members of the peer group and therefore likely to reinforce prejudices rather than help to modify them.
Public Health Nursing in the U.S.S.R.
Public Health Nursing in the U.S.S.R.

In 1917 a Government decree was issued to improve state health services and thereby safeguard future generations. A gradual improvement in the health of the population was halted temporarily during the second world war (1939-1945). The infant mortality rate in 1913 was 275 per thousand live births in certain areas of Russia, but had dropped to 40 per thousand in 1960 (WHO 1964) in the same places and there was a further improvement to 26.4 per thousand in 1968 (U.N. 1969). Figures for maternal mortality in the Ukraine showed an improvement from 10 per thousand births in 1913 to 0.5 per thousand in 1960 (WHO 1964).

Today the state health services are organised on identical lines in all fifteen Union Republics and health services are available to all citizens free of charge except those receiving care at home who have to pay a charge for medicaments.

The Maternal and Child Health Services

These services are based on three principles: first, the provision of universal medical supervision; second, the emphasis on child health in its widest sense; and third, the recognition of women as individuals as well as mothers. Priority is given to preventive medicine with emphasis on health education, and maternal and child health care is completely integrated into the health services; maternity care is the responsibility of specialist physicians and midwives in the obstetric and gynaecological section, whereas the separate child health services are provided by paediatricians and nurses working at all levels of the service. In rural
areas where the population is more scattered and the services less specialised are found "medium grade medical staff", better known as the Feldscher-midwives so characteristic of the system in the U.S.S.R. A description of their work is given on page 178.

The Maternal and Child Health Department is linked with complementary services in the Ministry of Health and other government ministries, as well as with voluntary bodies. One such department of importance is the Department of Epidemiology and Sanitation whose Child Hygiene Section has amongst its tasks the control of hygiene standards in the planning and construction of buildings; food and toy safety; infectious disease programmes and health education within its remit. The Red Cross and Red Crescent Societies with their 35 million members in 370,000 local organisations give assistance to health authorities, such as helping with schools for mothers, mass vaccination campaigns and other aspects of health education.

Legislation for maternal welfare covers the entire Union, and all occupations are open to women who are guaranteed the same status as men. They are however also protected by numerous regulations which include the right to cease heavy work or carry on in those trades which may be harmful either to the pregnant woman or her unborn child. Ante-natal clinics are not substantially different from those in other countries but the mothers are expected to attend 8-12 times for routine medical examinations and in addition are visited at home by the district midwife. In the last month of pregnancy the district paediatrician and nurse
visit the home to assess social and economic conditions. They are also required to visit within 3 days of the mother and child being discharged home after the confinement. Health education is carried out both in the home and the clinic, and psychoprophylactic training is commenced 8 weeks before the expected date of delivery. In cases of medical or social need, expectant mothers can be admitted to a Sanatorium (a type of convalescent home) for 12 days, during which time they continue with their psychoprophylaxis and health education in a "school for mothers".

The care of the pre-school child, from birth to seven years, is under the direct supervision of the district paediatrician. Following the initial visit to the home after the confinement the district nurse must ensure that the mother and child attend the poly clinic at regular intervals until the child reaches school age. Poly clinics in general provide all health services pertinent to the supervision of child health and remain open for 12 hours a day. In some instances they provide a milk dispensary, a school for mothers and legal advice. The Poly clinics serve several districts each of which contains 800-1,000 children up to the age of 14. They are staffed by a district paediatrician and 2 district nurses whose working time has to be shared between the clinic and domiciliary visiting in the proportion of 1:2, and at least part of the time must be devoted to health education. In rural areas the infants are supervised by the Feldscher-midwives who, in addition to routine duties, have a case load of 25-30 infants per annum.
Health education is considered to be one of the most effective means of improving public health conditions in the U.S.S.R. and is very widely used in the Maternal and Child Health Services. It forms part of all health programmes at every level from the Ministry of Health, concerned with the planning and implementation of schemes, down to the smallest operational health unit. At the top apex the responsibility lies with a Chief Inspector in the Department of Sanitary and Epidemiological Services. He is assisted by the Central Institute for Research in Health Education (established in 1938) which is subordinate to the Health Ministry. Its function is very similar to that of the Council for Health Education in England and Wales but it has a much larger annual budget and an establishment of some 450 staff.

The pattern is repeated in each Union Republic with a Chief Inspector and a medical committee attached to the Department of Sanitation and Epidemiological Services. There are also Health Education Centres: administratively dependent upon the Ministry of Health but under the technical guidance of the Central Institute. There are some 360 of these centres which organise health education in their own areas and give technical assistance to all workers involved in health education. In addition all large health establishments have a section, or at least an expert, for health education. In the smaller units a "Health Education Organiser" is selected from the medical or nursing staff to organise this work. All members of field staff are expected to participate in health education; for example the physician must devote 1/12th of his working day to this task, and the
A paediatrician is expected to allocate 1/6th of his time plus at least 4 hours a month to group health education. Health education is carried out in the hospitals, clinics and homes, in the latter it can be adapted to the living conditions of the family concerned. In addition it is carried out in maternity homes, creches and kindergartens, rest homes, sanatoria, pioneer camps, schools, factories and offices. A variety of methods are used together with all types of visual aids, and the fact that nearly all the population are literate gives added importance to the written word as a method of dissemination. During training all doctors and para-medical staff are encouraged in this aspect of their work. Health education courses of from 2-6 months are run for specialists who must also attend in-service training and refresher courses every 5 years at the Central Institute for Research on Health Education in Moscow.

The Feldsher

No review of public health services in the U.S.S.R. would be complete without referring to the Feldsher system which dates back to the time of Peter the Great. The earliest feldshers were medical students who repeatedly failed their medical examinations and were drafted into the army as blood letters and army surgeons.

The largest group of health workers in the U.S.S.R. are known as "medium grade medical staff", a category which includes midwives, nurses, feldshers, X-ray laboratory assistants, dental technicians, etc. Dr. E.D. Ashurkov (1961), Director of the Institute of Public Health Organisation and Medical History (Semashko Institute) in Moscow, and his colleagues
A. Zhuk and Y. Lisitsin described the training and duties of feldshers, one of the largest groups of medium grade staff. The training of feldshers in Russia can be traced back to the eighteenth century but their work began to assume great importance in the 19th Century as a result of the development of Zemstro public health services. Sometimes they worked as physician's assistants but in rural areas they were encouraged by the landowners to work as independent practitioners and thus provide a cheaper medical service for the workers. Ashurkov recalls that in 1913 there were 4,284 rural medical districts, 4,518 rural feldsher and feldsher-midwife centres, and about 29,000 feldshers. After the October Revolution in 1917 the system of training feldshers was reorganised, and practising feldshers were given the opportunity of further training to qualify as physicians as standards of second rate medicine were not acceptable in the new regime. At the same time it was recognised that workers were needed in rural areas to carry out preventive measures and give first-aid and medical assistance before the arrival of a doctor. This was seen to be the logical role for feldshers and their numbers began to increase from 8,364 in 1932, to 40,300 in 1936 and up to 75,900 in 1940. By 1958 there were 343,300 feldshers in the U.S.S.R. and at the present time they number about half-a-million.

Today there is a widespread system of feldsher and feldsher-midwife centres throughout the rural areas of the U.S.S.R. These centres are the focus for primary medical care forming part of rural medical districts under the control of the physician in charge. The staff provide a variety of services including free out-patient treatment, first-aid and assistance in home confinements. Expectant and nursing mothers and infants, for whom
they organise regular clinic sessions attended by a visiting doctor, are their special responsibility. Other duties include the regular examination of children in creches, kindergartens, schools and pioneer camps. A special check is kept on patients suffering from infectious disease.

The feldsher is responsible to the health officer for the district for carrying out immunisation programmes, and all routine hygiene procedures similar to those carried out in the U.K. by Public Health Inspectors. In some instances use is made of volunteers and certain voluntary organisations to aid them in their work, especially during peak periods of agricultural work when "field camps" some distance from the farm are in use. The centres are also responsible for carrying out systematic health education amongst the various groups of children and workers. This is reinforced by press articles or wall newspapers, and the issue of bi-monthly health education bulletins.

The work of the feldshers varies according to the type of area: for example in rural areas they can work from a centre as previously described, or they may work in a rural district hospital. Here they assist with therapeutic and prophylactic care as well as domiciliary visiting. In addition they may conduct out-patient clinics in the absence of the physician. In the cities their duties relate to the type of base where they work be it in health centres, industry, first-aid posts, mental hospitals, kindergartens, schools or industrial youth services. Some perform nursing duties in urban or regional hospitals, while others, known as Feldsher Sanitarians, work as assistants to environmental sanitation experts and epidemiologists.
Training takes place in special Feldsher schools under the direction of the Ministry of Health and, for those who have not completed their secondary education, lasts 4 years. About a quarter of the time devoted to theoretical training is given to general subjects including a study in depth of the U.S.S.R., mathematics, science and one foreign language. 20% of teaching time is spent on general medical subjects and about 55% is devoted to the study of special subjects. During the first three years about 11 weeks are spent in blocks of practical experience in hospitals or poly-clinics. A final 10 week period is spent in a district hospital or feldsher-midwife centre at the end of the fourth year. Students who have received their full secondary education (10-11 years) have a reduced period of training lasting 2½ years in which they study general and special medical subjects but their programme on general subjects is curtailed.

The practical value of feldshers has been proved many times. Furthermore there are not enough graduates to cope with the growing and varying needs of the population scattered over a vast area. While their role has changed from that of the Army blood-letter in Peter the Great's time, the concept of patient care has remained steadfast in a period of turbulent social and political change.

It can be said that nurses, midwives and health visitors in the U.K. are already performing many of the duties carried out by feldshers in their own specialist roles. However the first aid function is outside the sphere of British nursing. Loveland (1970) states that feldshers...
differ from health visitors in that they undertake nursing care, but community nurses in rural areas of the British Isles combine health visiting duties with those of nursing and/or midwifery (see page 220). However, it would appear that some instances the work of the feldsher is more aligned to that of the public health inspector. The training of the feldsher in Russia differs considerably from that of her British counter-part in that it only includes 11 weeks experience in hospital and poly-clinic, with a final block of 10 weeks devoted to fieldwork practice in a district hospital or feldsher-midwife centre. The feldsher-sanitarian receives a wider training in hygiene and epidemiology. For those who have not completed a full course of secondary education, the training includes aspects of general education and extends over a period of 4 years.
CHAPTER 7 - HEALTH VISITORS AS HEALTH EDUCATORS:

RESEARCH, SURVEYS AND DISCUSSION.
A - INTRODUCTION

A Pilot Survey based on the questionnaire in Appendix E was carried out in the South London Boroughs of Bexley and Croydon. Of the nineteen health visitors who qualified during the period 1968-71, eleven had trained at Croydon Technical College and the remaining eight respondents at five other training centres.

To test the efficiency of the questionnaire no guidance, other than the instructions on the first page, was given to the participants as to how it should be completed.

B - PILOT SURVEY

The questions were based on the writer's personal experience as a midwife and health visitor, and modified as a result of discussions with some colleagues who were undertaking health education with ante-natal groups, and others who were concerned with health visitor training courses.

Ten health visitors in Croydon and nine in Bexley completed the Survey forms and the results are summarised as follows :-
### Health visitor training school

<table>
<thead>
<tr>
<th>Training School</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>11</td>
</tr>
<tr>
<td>Chiswick</td>
<td>2</td>
</tr>
<tr>
<td>Maidstone</td>
<td>2</td>
</tr>
<tr>
<td>Ren</td>
<td>2</td>
</tr>
<tr>
<td>University of Surrey</td>
<td>1</td>
</tr>
<tr>
<td>Barking</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

### Year of qualification as a Health Visitor

<table>
<thead>
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<td>1969</td>
<td>7</td>
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<tr>
<td>1970</td>
<td>7</td>
</tr>
<tr>
<td>1971</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>19</strong></td>
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</table>
2. **Midwifery training**

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<thead>
<tr>
<th>Midwifery Qualification or Experience</th>
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</thead>
<tbody>
<tr>
<td>S.C.M.</td>
<td>7</td>
</tr>
<tr>
<td>C.M.B. Part I</td>
<td>6</td>
</tr>
<tr>
<td>Obstetric (Pre-S.R.N.)</td>
<td>6</td>
</tr>
<tr>
<td>Obstetric (Post-S.R.N.)</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>19</td>
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</table>

3. **Type of area**

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<tr>
<td>G.P. Attachment</td>
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</tr>
<tr>
<td>Combined practice and geographical area</td>
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</tr>
<tr>
<td>Other</td>
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<tr>
<td>TOTAL</td>
<td>19</td>
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</table>
4. Post certificate training in health education

<table>
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5. Health education in 1971

Table - 5

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
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<td>14</td>
</tr>
<tr>
<td>Expectant parents</td>
<td>7</td>
</tr>
<tr>
<td>Parents' Groups</td>
<td>8</td>
</tr>
<tr>
<td>Schools</td>
<td></td>
</tr>
<tr>
<td>infant</td>
<td>3</td>
</tr>
<tr>
<td>primary</td>
<td>1</td>
</tr>
<tr>
<td>secondary</td>
<td>6</td>
</tr>
<tr>
<td>College of Further Education</td>
<td>Nil</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>None</td>
<td>Nil</td>
</tr>
<tr>
<td>TOTAL</td>
<td>44</td>
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</tbody>
</table>
6. "Did you want to teach health education?"

<p>| | |</p>
<table>
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</thead>
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<td>7</td>
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7. Prior interest in group

<p>| | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>YES</td>
<td>12</td>
</tr>
<tr>
<td>NO</td>
<td>7</td>
</tr>
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</table>

8. Choice of health education

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant mothers</td>
<td>8</td>
</tr>
<tr>
<td>Expectant parents</td>
<td>6</td>
</tr>
<tr>
<td>Parents' Groups</td>
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</tr>
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<td>{ infants</td>
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</tr>
<tr>
<td>Schools</td>
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</tr>
<tr>
<td>{ primary</td>
<td>2</td>
</tr>
<tr>
<td>secondary</td>
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</tr>
<tr>
<td>College of Further Education</td>
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<tr>
<td>Other</td>
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<td>1</td>
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Table - 6
9. Responsibility for health education classes

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<tbody>
<tr>
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<td>6</td>
</tr>
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</table>

10. Identification of responsible officer

<table>
<thead>
<tr>
<th>Officer</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Nursing Officer</td>
<td>Nil</td>
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<tr>
<td>Health Education Officer</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6</td>
</tr>
</tbody>
</table>

11. Venue of ante-natal classes

<table>
<thead>
<tr>
<th>Place</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church Hall</td>
<td>Nil</td>
</tr>
<tr>
<td>Local Authority Premises</td>
<td>10</td>
</tr>
<tr>
<td>Health Centre</td>
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<tr>
<td>General Practitioner Surgery</td>
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<tr>
<td>Maternity O.P.D.</td>
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<tr>
<td>Hospital</td>
<td>Nil</td>
</tr>
<tr>
<td>Other</td>
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</tr>
<tr>
<td>Assistant</td>
<td>Number</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Health Visitor</td>
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</tr>
<tr>
<td>Health Visitor Student</td>
<td>2</td>
</tr>
<tr>
<td>Clinic Nurse</td>
<td>Nil</td>
</tr>
<tr>
<td>Midwife (hospital)</td>
<td>Nil</td>
</tr>
<tr>
<td>Midwife (domiciliary)</td>
<td>11</td>
</tr>
<tr>
<td>Pupil Midwife Part I</td>
<td>Nil</td>
</tr>
<tr>
<td>Pupil Midwife Part II</td>
<td>Nil</td>
</tr>
<tr>
<td>Obstetric Pupil</td>
<td>Nil</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>7</td>
</tr>
<tr>
<td>National Childbirth Trust Teacher</td>
<td>Nil</td>
</tr>
<tr>
<td>Other</td>
<td>Nil</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>23</strong></td>
</tr>
</tbody>
</table>
To show the comparison between midwifery training and the choice of health education

<table>
<thead>
<tr>
<th>Type of Class</th>
<th>S.C.M.</th>
<th>C.M.B. Part I</th>
<th>Pre-S.R.N. Obstetric</th>
<th>Post-S.R.N. Obstetric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant mothers</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Expectant parents</td>
<td>4</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Parents' groups</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>(infant)</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Schools</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>primary</td>
<td></td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>secondary</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>College of Further Education</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>None</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>TOTALS</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>-</td>
</tr>
</tbody>
</table>
To show the comparison between midwifery training and health education carried out in 1971.

<table>
<thead>
<tr>
<th>Type of Class</th>
<th>S.C.M.</th>
<th>C.M.B. Part I</th>
<th>Pre-S.R.N. Obstetric</th>
<th>Post-S.R.N. Obstetric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant mothers</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Expectant parents</td>
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<td>Parents Groups</td>
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<td>-</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>(infants</td>
<td>2</td>
<td>1</td>
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<td>Schools</td>
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</tr>
<tr>
<td>(primary</td>
<td>-</td>
<td>1</td>
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<td>-</td>
</tr>
<tr>
<td>(secondary</td>
<td>3</td>
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<td>-</td>
</tr>
<tr>
<td>College of Further Education</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>None</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTALS</td>
<td>21</td>
<td>15</td>
<td>.9</td>
<td>-</td>
</tr>
</tbody>
</table>
To show the influence of midwifery experience in relation to ante-natal classes either being run by health visitors or chosen by them if given the opportunity.

<table>
<thead>
<tr>
<th>Health Visitor</th>
<th>S.C.M.</th>
<th>Part I</th>
<th>Pre- Obstetric</th>
<th>Post- Obstetric</th>
<th>Ante-Natal Classes in 1971</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>1</td>
<td>-</td>
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<td>-</td>
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<td>1</td>
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<tr>
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<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>003</td>
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<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>004</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
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<tr>
<td>005</td>
<td>1</td>
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<td>-</td>
<td>-</td>
<td>1</td>
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</tr>
<tr>
<td>006</td>
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<td>-</td>
<td>-</td>
<td>1</td>
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<td>007</td>
<td>-</td>
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<td>-</td>
<td>-</td>
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<td>009</td>
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<tr>
<td>011</td>
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<tr>
<td>012</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>013</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
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<tr>
<td>014</td>
<td>-</td>
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<td>-</td>
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<td>1</td>
</tr>
<tr>
<td>015</td>
<td>1</td>
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<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
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<tr>
<td>016</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>017</td>
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<td>1</td>
<td>-</td>
</tr>
<tr>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>019</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
To show the comparison between midwifery qualification and degree of responsibility for ante-natal classes.

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Self</th>
<th>Shared</th>
<th>Other Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.C.M. (7)</td>
<td>6</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>C.M.B. Part I (6)</td>
<td>5</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Pre-S.R.N. Obstetric (6)</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Post-S.R.N. Obstetric</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>13</strong></td>
<td><strong>1</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>
The Pilot Survey revealed that out of the 19 returns, six different training schools were involved. It became evident that, in the definitive survey, the number of training schools could be high and extend throughout the United Kingdom and also that there might not be a direct link between the Local Authority and its nearest training school. This factor had to be considered when re-coding the questionnaire.

1. Year of qualification as a health visitor.

   Table 2 revealed nothing other than factual evidence, but could be useful in association with other factors to identify trends in the definitive survey.

2. Midwifery training.

   Analysis of the figures obtained in Table 3 showed that Health Visitors with full midwifery training, C.M.B. Part I and the Pre-S.R.N. Obstetric course were in almost equal proportions. One item of interest was that no Health Visitor had taken the Post-Certification Obstetric course. In one instance a respondent had taken a Pre-S.R.N. Obstetric course and later proceeded to obtain her S.C.M. qualification - it was decided to discard the first certificate in favour of the higher one for the purposes of this survey. (See note on page 221 in the Definitive Survey).

Influence of midwifery training on health education activities.
(See Tables - 10, 11 and 12)

Six Health Visitors had Pre-S.R.N. obstetric experience, of these, three were involved in ante-natal classes although, if given the choice, only two stated that they would have liked to do so. Another respondent wished to be involved in this type of work, but was not afforded the opportunity during the year under scrutiny.
Three of the six respondents with C.M.B. Part I qualification did not include ante-natal classes as a chosen area of work although two of them were running these classes.

All seven fully qualified midwives were engaged in ante-natal classes and six stated that they would also choose to do this work.

3. Type of area.

In two instances the type of area was classified under "any other" - in one case the Health Visitor was responsible for a new Health Centre in Thamesmead and in the other case the Health Visitor was not attached, but stated that she held "certain cards for General Practitioners in the area". It was decided to keep in this fourth category together with the request "please specify" to enable the researcher to identify the wide variation in types of work areas.

In addition it was decided to insert an extra question to try to identify the geography of the area, this would be of importance in the definitive survey when a range of local authority areas would come under scrutiny.

4. Post-certificate training in health education.

Only five out of fourteen Health Visitors had attended post-certificate training in health education, although all were engaged in this work. (See Table - 5).

It was decided that this question should be extended in the definitive survey and that participants should be requested to specify the type of training they had received since qualifying as Health Visitors.

All respondents took part in group health education activities during the period under review. In many instances the usual pattern is for the health visitor to run a series of from four to six sessions with the target group. The pilot survey showed (see table - 5) that 44 actual classes were held, of these five health visitors organised only one series each, six held two separate series and the remainder ran three or more different series of health education classes.

It was considered advisable to extend the definition of ante-natal classes to include:

a. expectant mothers
*b. expectant mothers with a fathers' night
   * Item (b) being the additional factor.
   c. expectant parents

6. Health visitors willing to teach.

Six respondents intimated that they did not want to teach health education subjects even though they were already doing this work. It was considered that the placing of this question should precede that of Item 5 (i.e. Health education activities in 1971) and in addition that the wording should be more precise and read as follows:

"as a qualified health visitor do you want to undertake health education with groups?"
7. **Prior interest in the group.**

While twelve health visitors indicated that they had had a prior interest in the group they were teaching the remaining seven said "No". The wording of this question in the pilot survey was also considered to be imprecise and so it was re-phased as follows:

"did your teaching arise from your realisation of need or, were you directed?"

This question was to follow immediately after Item 5 relating to Health Education in 1971.

8. **Choice of health education.**

Only one of the nineteen participants said that she did not wish to be involved in group health education activities even if given the choice of a target group whereas, in Item 6, seven health visitors said that they did not wish to teach health education. Out of the remaining eighteen replies, thirteen intimated that they were only prepared to teach one type of group while the others chose two or more different groups.

Again, as in Item 5, it was decided to include the extra ante-natal category to obtain more specific information about the choice of type of ante-natal classes.

9 & 10. **The responsibility for health education classes and the identification of another "responsible officer".**

Thirteen respondents stated that they were solely responsible for their own classes; one health visitor shared the responsibility with a colleague; and of the remaining five, three health education officers and two "others" (nameless) officers, not nursing officers,
were said to have overall responsibility. Table 13 shows that the majority of health visitors with either the full midwifery qualifications or Part I C.M.B. were solely responsible for their health education activities.

It was decided that as both these items were closely linked they should be amalgamated in the definitive survey to form one question - this it was possible to do by a slight rephrasal of the second question. The instructions for the remainder of the second part of this question were rephrased in order to make them more precise and thus reduce the margin of error in interpretation.

11 & 12. Venue of ante-natal classes and assistance with classes.

The majority of classes were held in local authority premises, of these two were in Health Centres and the remaining ten in other premises either hired by or belonging to the authority concerned. Only in one instance was a group meeting in a General Practitioner's Surgery.

Assistance with classes came from domiciliary midwives in eleven instances, seven physiotherapists, three health visitors and two student health visitors.

Again the wording in these questions relating to the venue (Item 11) and help (Item 12) with the teaching of ante-natal classes was altered in order to improve the quality of these items.
Discussion

It was apparent from the survey that the wording of some of the questions was not precise and subsequently required rewording or rephrasing as already indicated. Furthermore the questions did not reveal the full extent of the relevant health education activities of the health visitors in this sample. The information about the health visitors and their training was not adequate, there was no identification of civil state nor of age, and it was considered necessary to distinguish between the various types of health visitor training.

Some of the items were rephrased and new ones inserted. The whole survey was then re-coded on the advice of the punch-card operators to facilitate the tabulation of the data obtained in the definitive survey.

Finally the health visitors were to be given the opportunity of making comments and the last page of the questionnaire was left blank for this purpose.
Method

The aim was to review the current health education activities of health visitors who had trained at Croydon Technical College and had qualified between 1968-1971, and to compare them with as large a sample as possible of health visitors who had trained elsewhere during the same period. Therefore it was not possible to take a random sample of the population.

An approach was made to those South London Boroughs known to employ a high proportion of Croydon trained staff. They consisted of 2 Inner, 3 Middle and 4 Outer South London Boroughs.* Bexley, Bromley, Croydon, Lambeth, Southwark and Sutton all agreed to take part without any reservations. Greenwich only agreed to 75% of their staff taking part, the remainder being either off sick or heavily committed with extra courses. Wandsworth gave no reason why they would only allow a 1 in 4 selection to be made. Lewisham too gave no reason why all the eligible health visitors could not take part. But it was known that the staff of this borough had recently taken part in an extensive internal survey.

A similar selection of Inner, Middle and Outer Boroughs North of the Thames was made. Requests were made to the London Boroughs of Barnet, Ealing, Haringey, Havering, Hillingdon, Kensington and Chelsea, Newham, Redbridge and Westminster. Whilst seven of the boroughs agreed to co-operate in full, one would only agree to the use of 1 in 3 of their eligible staff taking part, and a second chose the staff considered to be most suitable for such a survey.

* See map on page 202
In order to cover the length and breadth of England in the survey the Nursing Officers of County Boroughs and County Councils over a wide area were approached. In each case the staff concerned were either known personally to the researcher or had some contact with the College. The results this time were less encouraging, of the 11 County Boroughs and 14 County Councils approached, only 8 and 10 respectively agreed to take part. The following reasons for refusing were given:

In one authority the staff had been subjected to a survey carried out by a student in Hospital Administration; a second said that she was unable to help; while a third stated that her Medical Officer of Health "is of the opinion that unless surveys are nationally or ministry sponsored, it is not possible to involve staff who are already fully occupied."

A similar reply came direct from a Medical Officer of Health who said in his letter that

"we are, as you will appreciate, a large authority, employing some 200 health visitors and because so many requests for questionnaires to be completed are received nowadays, it is unfortunately necessary to decline to take part unless the survey is being undertaken by a nationally recognised research body ...".

In contrast to this one County Council with an establishment of 149 health visitors offered 41 suitable participants, while yet another authority gave 49 names out of a total establishment of 192.

While one Nursing Officer declined on the grounds that she would soon be leaving the area, another in a similar position said that she was pleased to offer the necessary facilities. Finally a plaintive note crept in to the refusal of a Nursing Officer for an East Anglian County Borough when she wrote
"I have only three health visitors qualified during the period, and two of these are no longer here. I do not think therefore, that it is worth sending this (the survey form) to the lone survivor".

To show approaches made to Local Authorities

<table>
<thead>
<tr>
<th>Type of Local Authority</th>
<th>Number Approached</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>London Boroughs</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>County Boroughs</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>County Councils</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>TOTALS</td>
<td>43</td>
<td>36</td>
</tr>
</tbody>
</table>

Out of a total of 11 County Boroughs approached the following agreed to take part: - Blackpool, Bradford, Brighton, Coventry, Hull, Oxford, Nottingham and Southend. And 4 County Councils rejected the researcher's request leaving 10 who participated without any reservation; they were: - Buckinghamshire, Cambridgeshire and the Isle of Ely, Gloucestershire, Hampshire, Kent, Lancashire, Northamptonshire, Northumberland, Somersetshire and East Sussex.

As stated previously all the approaches were made initially to the Nursing Officers of the local health authorities chosen, and in only one instance was it necessary for the researcher to contact the Medical Officer of Health directly for permission to proceed. With one exception all correspondence was carried out with the Nursing Officer and/or her Area Nursing Officers who all went to a great deal of trouble to identify and list the names of those members of staff who were eligible to take part in the survey.
Map of England and Wales to Show Distribution of County Boroughs and County Councils taking part in the Survey.
There was no specific selection of staff taking part in the survey other than the initial request that only those who qualified during the period 1968 - 1971 should be approached. As stated elsewhere, in some instances all eligible members of staff were allowed to take part and in others only a proportion of the total possible names were given.

Out of a total of 500 forms sent out, 469 were completed and returned in time to be included in the results: four were returned by men employed as health visiting officers and it was decided to keep this small group in the survey. In addition to the 4 returns which were ineligible because they qualified prior to 1968, 25 forms were not returned even after several attempts had been made to trace the staff concerned. The last return was made in December 1972, but was too late to be included in the results.

To show individual response to survey

| Number of survey forms sent out: | 500              |
| Number of forms returned:       | 469              |
| Number of forms too late for inclusion: | 1     |
| Number found ineligible:       | 4               |
| Number of refusals:            | 1               |
| Number ignored or untraceable: | 25              |

The transmission and completion of the questionnaire took place between December 1971 and April 1972.
Survey

The definitive survey, based on the questionnaire overleaf, was carried out in selected boroughs in the Greater London Area, certain County Boroughs and County Councils in England. The survey covered a period of one year ending on the 31st December, 1971.

The questionnaires were sent either direct to the respondents or via the Chief Nursing Officers or their deputies. It was agreed that the respondents should return the completed forms directly to the researcher. As with the pilot survey no additional guidance was given to the health visitors other than that given on the first page of the survey form. The answers to the seventeen questions were coded to enable the results to be transferred on to punch cards. Space was left below questions in instances where additional information was required. Finally the health visitors were asked to comment on or make suggestions about the questionnaire or their training for health visiting. A separate chapter has been devoted to these comments.

The pilot survey did not reveal sufficient information, the definitive survey was therefore extended and the questionnaire in its final form can be seen overleaf.
I am anxious to collect up-to-date information about the health education work patterns of health visitors who have trained during the last five years. This information will form part of a programme of evaluation of present day training which I am undertaking as a piece of research in conjunction with the University of Surrey. Your answers will be treated with strict confidence and will be used only for the purpose of producing statistical summaries.

The number of health visitors is of necessity small and so your completed questionnaire will make a vital contribution to the result of the survey. Thank you for your help.

To help you to fill up the questionnaire:-

Where relevant please circle the appropriate number(s) on the right hand side in each section to indicate your reply. A space is left below those sections where additional information may be requested.

Please return the completed questionnaire to:-

Miss C.P. Hall, SRN, SCM, HV, HV Tutor's Certificate,
Department of Applied Social Studies,
Croydon Technical College, Croydon.

It would help if you could return it to me within two weeks.
<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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</tr>
<tr>
<td>5, 6.</td>
<td>Health Visitor Training School</td>
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<td>In Degree Course</td>
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<td>Age:</td>
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<tr>
<td></td>
<td>26 - 30</td>
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<tr>
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<td>31 - 35</td>
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<td>36 - 40</td>
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<td>41 plus</td>
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</tr>
<tr>
<td>9</td>
<td>In which year did you qualify as a health visitor?</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>1968</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1969</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1970</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1971</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Have you worked continuously as a Health Visitor (full time) since qualification?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If "NO" please specify:
11. What midwifery training have you taken?

<table>
<thead>
<tr>
<th>Training</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.C.M.</td>
<td>1</td>
</tr>
<tr>
<td>C.M.B. Part I</td>
<td>2</td>
</tr>
<tr>
<td>Obstetric (pre-S.R.N.)</td>
<td>3</td>
</tr>
<tr>
<td>Obstetric (post-S.R.N.)</td>
<td>4</td>
</tr>
</tbody>
</table>

12. In what type of area are you working?

<table>
<thead>
<tr>
<th>Type of Area</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographical area</td>
<td>1</td>
</tr>
<tr>
<td>General practice attachment</td>
<td>2</td>
</tr>
<tr>
<td>Combined practice and geographical area</td>
<td>3</td>
</tr>
<tr>
<td>Any other (please specify)</td>
<td>X</td>
</tr>
</tbody>
</table>

13. Is your practice area mainly

<table>
<thead>
<tr>
<th>Area Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>1</td>
</tr>
<tr>
<td>Rural</td>
<td>2</td>
</tr>
<tr>
<td>Combination of both</td>
<td>3</td>
</tr>
</tbody>
</table>

14. Have you attended any post-certificate training in health education?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

If "Yes" please specify: ____________________________________________________________________________________

15. As a qualified health visitor do you want to undertake health education with groups?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>
16. During the twelve months up to 31st December 1971 have you given health education to any of the following groups?

- expectant mothers ........................................ 1
- expectant mothers (with a Fathers' night) ........ 2
- expectant parents .......................................... 3
- parents groups ............................................ 4
- infant (or primary) ................................. 5
- in school ... primary (or middle) ............. 6
- secondary (or higher) ............................... 7
- college of further education .................. 8
- any other (please specify) ......................... X

17. Did your teaching arise from

- your realisation of need ................................ 1
- or, were you directed .................................. 0

18. If you were given the choice which group would you prefer to teach?

- None at all .................................................. 0
- expectant mothers ........................................ 1
- expectant mothers (including a Fathers' night) ... 2
- expectant parents .......................................... 3
- parents groups ............................................ 4
- infant (or primary) ................................. 5
- in school ... primary (or middle) ............. 6
- secondary (or higher) ............................... 7
- college of further education .................. 8
- any other (please specify) ......................... X
19. Are you solely responsible for the planning and organisation of the classes?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td>NO</td>
<td>0</td>
</tr>
</tbody>
</table>

If "NO" then who is responsible?

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Officer</td>
<td>2</td>
</tr>
<tr>
<td>Health Education Officer</td>
<td>3</td>
</tr>
<tr>
<td>Another (please specify)</td>
<td>4</td>
</tr>
</tbody>
</table>

IF YOU ARE CURRENTLY CONCERNED WITH CLASSES FOR EXPECTANT MOTHERS OR/AND FATHERS - OR HAVE BEEN CONCERNED WITH THEM DURING THE YEAR ENDING 31st DECEMBER, 1971 PLEASE COMPLETE THE NEXT PAGE.
20. Where are the classes held?

<table>
<thead>
<tr>
<th>Option</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>in a Church Hall</td>
<td>1</td>
</tr>
<tr>
<td>Local Authority premises (not Health Centres)</td>
<td>2</td>
</tr>
<tr>
<td>Health Centre</td>
<td>3</td>
</tr>
<tr>
<td>G.P. surgery (other than Health Centre)</td>
<td>4</td>
</tr>
<tr>
<td>Maternity O.P.P.</td>
<td>5</td>
</tr>
<tr>
<td>in Hospital</td>
<td>6</td>
</tr>
<tr>
<td>any other (please specify)</td>
<td>X</td>
</tr>
</tbody>
</table>

21, 22. Do any of the following help you with the teaching of your classes?

<table>
<thead>
<tr>
<th>Option</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visitor</td>
<td>01</td>
</tr>
<tr>
<td>H.V. student</td>
<td>02</td>
</tr>
<tr>
<td>Clinic nurse</td>
<td>03</td>
</tr>
<tr>
<td>hospital</td>
<td>04</td>
</tr>
<tr>
<td>Midwife domiciliary</td>
<td>05</td>
</tr>
<tr>
<td>Part I</td>
<td>06</td>
</tr>
<tr>
<td>Pupil Midwife Part II</td>
<td>07</td>
</tr>
<tr>
<td>Obstetric pupil</td>
<td>08</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>11</td>
</tr>
<tr>
<td>National Childbirth Trust Teacher</td>
<td>12</td>
</tr>
<tr>
<td>any other (please specify)</td>
<td>X</td>
</tr>
</tbody>
</table>

THE LAST PAGE HAS BEEN LEFT BLANK FOR YOU TO MAKE ANY COMMENTS/SUGGESTIONS YOU WISH EITHER ABOUT THE QUESTIONNAIRE OR ASPECTS CONCERNING YOUR TRAINING. THANK YOU ONCE AGAIN FOR YOUR HELP.
Results

The records of the Council for the Education and Training of Health Visitors show that a total of 3,337 health visitor students qualified during the period under scrutiny (1968-1971), of these 469 took part in the survey and are included in the results.

To show the comparison between the total number of health visitors qualifying between 1968-1971 and those participating in the survey.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CETHV data</td>
<td>725</td>
<td>834</td>
<td>879</td>
<td>899</td>
</tr>
<tr>
<td>Survey data</td>
<td>68</td>
<td>111</td>
<td>132</td>
<td>158</td>
</tr>
</tbody>
</table>

Out of a total of 500 health visitors who were invited to participate in the survey, 469 completed and returned the forms in time to be included in the results, this was a response rate of 93.8%.

The four hundred and sixty-nine health visitors who took part constituted 12.8% of all health visitors in post in England at that time.*

* figures obtained from Department of Health and Social Security (SR.2(A)) Document (Form L.HS 27/8) stated that there was a total of 6,035 health visitors employed on 30th September, 1971 in England.
Question - 4 : Civil State

The chart below shows the civil state of the participants:

<table>
<thead>
<tr>
<th>Civil state at time of survey</th>
<th>Table - 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of Qualification:</td>
<td>Single: Male</td>
</tr>
<tr>
<td>1968</td>
<td>-</td>
</tr>
<tr>
<td>1969</td>
<td>-</td>
</tr>
<tr>
<td>1970</td>
<td>-</td>
</tr>
<tr>
<td>1971</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1</td>
</tr>
</tbody>
</table>

Four male health visiting officers were included by the Nursing Officers in the survey, and when this was revealed it was decided to retain these figures in the results.

From the information obtained in the survey it is evident that, in those areas chosen for the survey, the proportion of newly qualified married staff to those who are single is in the ratio of 3:2. 
The survey revealed that 32 different schools were responsible for the training of this sample of the population. From Table 17 (below) it can be seen that Croydon Technical College - the school under scrutiny - heads the list with the number of participants in the survey.

<table>
<thead>
<tr>
<th>Training School</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>59</td>
</tr>
<tr>
<td>Maidstone</td>
<td>39</td>
</tr>
<tr>
<td>Chiswick</td>
<td>33</td>
</tr>
<tr>
<td>N. London Poly.</td>
<td>30</td>
</tr>
<tr>
<td>University of Surrey</td>
<td>23</td>
</tr>
<tr>
<td>Manchester</td>
<td>22</td>
</tr>
<tr>
<td>Newcastle</td>
<td>22</td>
</tr>
<tr>
<td>Cheltenham</td>
<td>20</td>
</tr>
<tr>
<td>Oxford</td>
<td>20</td>
</tr>
<tr>
<td>N.E. London Poly.</td>
<td>19</td>
</tr>
<tr>
<td>Southampton</td>
<td>19</td>
</tr>
<tr>
<td>Poly of South Bank</td>
<td>17</td>
</tr>
<tr>
<td>Rcn</td>
<td>16</td>
</tr>
<tr>
<td>Bolton</td>
<td>15</td>
</tr>
<tr>
<td>Bradford</td>
<td>13</td>
</tr>
<tr>
<td>Brighton</td>
<td>12</td>
</tr>
<tr>
<td>Liverpool</td>
<td>12</td>
</tr>
<tr>
<td>Reading</td>
<td>12</td>
</tr>
<tr>
<td>Bristol</td>
<td>11</td>
</tr>
<tr>
<td>Leicester</td>
<td>10</td>
</tr>
<tr>
<td>Hull</td>
<td>9</td>
</tr>
<tr>
<td>Nottingham</td>
<td>9</td>
</tr>
<tr>
<td>Birmingham</td>
<td>7</td>
</tr>
<tr>
<td>Aberdeen</td>
<td>5</td>
</tr>
<tr>
<td>Ipswich</td>
<td>5</td>
</tr>
<tr>
<td>Ewell</td>
<td>3</td>
</tr>
<tr>
<td>Plymouth</td>
<td>2</td>
</tr>
<tr>
<td>Cardiff, Edinburgh, Sheffield,</td>
<td>1 each</td>
</tr>
<tr>
<td>Stevenage and Keele.</td>
<td></td>
</tr>
</tbody>
</table>
Question - 7 : Type of training

To show comparison between health visitors taking post-certificate and integrated/degree courses.

<table>
<thead>
<tr>
<th>Year of qualification</th>
<th>CETHV Data</th>
<th>Survey Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-certificate</td>
<td>662</td>
<td>754</td>
</tr>
<tr>
<td>Integrated/degree</td>
<td>63</td>
<td>80</td>
</tr>
<tr>
<td>TOTAL</td>
<td>725</td>
<td>834</td>
</tr>
</tbody>
</table>

17 health visitors out of the 469 who returned the forms had trained in either the integrated or degree courses. This figure, in comparison to the total number who trained throughout the country (337) during the period under review, was so small that it was decided not to pursue differentiating between the post-certificate and the degree/integrated trained workers.
Question - 8 : Age range

The data obtained in Table - 19 relates to the age of the participants at the time of the survey.

Age of health visitors in 5-year spans.  

<table>
<thead>
<tr>
<th>Age Group</th>
<th>No. of Health Visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 - 25</td>
<td>98</td>
</tr>
<tr>
<td>26 - 30</td>
<td>137</td>
</tr>
<tr>
<td>31 - 35</td>
<td>82</td>
</tr>
<tr>
<td>36 - 40</td>
<td>77</td>
</tr>
<tr>
<td>41 - 45</td>
<td>26</td>
</tr>
<tr>
<td>46 - 50</td>
<td>30</td>
</tr>
<tr>
<td>51 - 55</td>
<td>13</td>
</tr>
<tr>
<td>56 +</td>
<td>1</td>
</tr>
</tbody>
</table>

* following completion of the survey it was decided to differentiate the group of participants aged 41 years and above, all but 5 of the 75 in this group replied to the follow-up letter requesting this information.

The figures relating to the ages of the respondents at the time of the survey show that 50.11% were under the age of 31, 33.9% in the age group 31-40 years, and 15.99% above 40.
Question - 9 : Year of qualification as a health visitor

Number of health visitors in survey qualifying Table - 20
during years 1968 - 1971.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Health Visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1968</td>
<td>68</td>
</tr>
<tr>
<td>1969</td>
<td>111</td>
</tr>
<tr>
<td>1970</td>
<td>132</td>
</tr>
<tr>
<td>1971</td>
<td>158</td>
</tr>
<tr>
<td>TOTAL</td>
<td>469</td>
</tr>
</tbody>
</table>

The data shows that health visitors who trained at Croydon were distributed as follows :-

Croydon trained staff Table - 21

<table>
<thead>
<tr>
<th>Year</th>
<th>Health Visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1968</td>
<td>9</td>
</tr>
<tr>
<td>1969</td>
<td>12</td>
</tr>
<tr>
<td>1970</td>
<td>13</td>
</tr>
<tr>
<td>1971</td>
<td>25</td>
</tr>
<tr>
<td>TOTAL</td>
<td>59</td>
</tr>
</tbody>
</table>
Question - 10 : Full-time employment as a health visitor

Of the sample population 418 had worked full-time as health visitors since qualification, 15 were working in a part-time capacity and of these 10 indicated that they had also had a break in service.

In some rural areas staff are employed for multiple duties such as health visiting and district nursing combined; of the staff employed by the County Councils 36 participants were engaged in triple duties - they were combining the roles and functions of the health visitor, district nurse and domiciliary midwife.

Question - 11 : Midwifery training/experience

In addition to being a State Registered Nurse, the health visitor must either hold a certificate of the Central Midwives Board or have satisfactorily completed an approved obstetric course; the latter may be taken either during or after the period of general nurse training. State Registration and midwifery training or experience are pre-requisites to taking the health visitor course.

Distribution of midwifery qualification or experience

<table>
<thead>
<tr>
<th>Qualification or Experience</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Certified Midwife</td>
<td>209</td>
</tr>
<tr>
<td>C.M.B. Certificate Part I</td>
<td>105</td>
</tr>
<tr>
<td>Obstetric (pre-SRN) (a)</td>
<td>70</td>
</tr>
<tr>
<td>Obstetric (post-SRN) (a)</td>
<td>83</td>
</tr>
<tr>
<td>None (b)</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL :</td>
<td>469 (x)</td>
</tr>
</tbody>
</table>

Table - 22
Question - 11 : Continued

(a) two health visiting officers indicated that they had had this experience.

(b) two health visiting officers had not had this experience.

(x) See NOTE on page 195.

Two-thirds of the respondents had taken either the full qualifying training for midwifery or the 1st Part to the satisfaction of the Central Midwives Board. Of the remaining 1/3 slightly more had taken their obstetric experience after qualifying as a State Registered Nurse. Two male health visiting officers stated that they had not received any obstetric experience at all.

Question - 12 : Pattern of work

Participants were asked to identify the framework within which they practised.

<table>
<thead>
<tr>
<th>Type of working area</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographical</td>
<td>169</td>
</tr>
<tr>
<td>General Practice Attachment</td>
<td>192</td>
</tr>
<tr>
<td>Combined G.P. and Geographical</td>
<td>95</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL</td>
<td>469</td>
</tr>
</tbody>
</table>

It can be seen that 169 health visitors were still responsible for a geographical area regardless of general practitioner lists. Of the 13 health visitors who included themselves in the "other" category, one health visitor in addition to working in a group practice attachment scheme was also
responsible for T.B. visiting in the locality, while another was not only responsible for a group practice attachment but in addition covered a hostel for homeless families, a council owned gipsy camp, and an R.A.F. station with it's constantly changing population.

Question - 13 : Description of locality

<table>
<thead>
<tr>
<th>Locale</th>
<th>Table - 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>303</td>
</tr>
<tr>
<td>Rural</td>
<td>64</td>
</tr>
<tr>
<td>Combination of both</td>
<td>102</td>
</tr>
<tr>
<td>TOTAL :</td>
<td>469</td>
</tr>
</tbody>
</table>
Question - 14 : Post-certificate training in health education

Only 89 health visitors, 18.98%, had taken part in post-certificate training including the following courses.

To show the range of post-certificate courses taken by the population.

<table>
<thead>
<tr>
<th>Type of Course</th>
<th>No. of health Visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation for childbirth</td>
<td>32</td>
</tr>
<tr>
<td>Family planning</td>
<td>4</td>
</tr>
<tr>
<td>Projectionist/audio-visual aids</td>
<td>11</td>
</tr>
<tr>
<td>Technical teachers certificates (a)</td>
<td>9</td>
</tr>
<tr>
<td>Health education course at Highbury (b)</td>
<td>1</td>
</tr>
<tr>
<td>&quot;Special&quot; health education courses (c)</td>
<td>16</td>
</tr>
<tr>
<td>In-service health education</td>
<td>13</td>
</tr>
<tr>
<td>Fieldwork instruction</td>
<td>2</td>
</tr>
<tr>
<td>Royal College of Nursing Refresher Course</td>
<td>2</td>
</tr>
<tr>
<td>Health Visitors' Association Refresher Course</td>
<td>2</td>
</tr>
<tr>
<td>Group discussion methods (c)</td>
<td>3</td>
</tr>
<tr>
<td>Counselling</td>
<td>1</td>
</tr>
<tr>
<td>Health Education Council course on obesity</td>
<td>1</td>
</tr>
</tbody>
</table>

(a) City & Guilds Certificate No. 730.

(b) First field level health education course run at Southampton, recognised by the Health Education Council.

(c) "Health Education in Schools" a two-day course run by the London Boroughs Training Committee who also run the courses on "Group Discussion Techniques".
Question - 15 : Attitude towards group health education

In reply to the question "as a qualified health visitor do you want to undertake health education with groups?" three hundred and ninety-seven said "yes", about 85% of the population surveyed.

Questions 15/16 : Health education in 1971

Answers to Question 15, "... do you want to undertake health education with groups?" showed that 72 health visitors said "no". However answers to Question 16 "... have you given health education to groups during 1971?" the number of negative replies dropped to 46. A total of 423 health visitors (90%) were involved in group activities during the survey year, the wide variation in the type of group(s) is shown in Table 28, pages 226 and 227.

Health education carried out by health visitors in 1971

<table>
<thead>
<tr>
<th>Health Education Groups</th>
<th>No. of Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant mothers</td>
<td>304</td>
</tr>
<tr>
<td>Expectant mothers with a fathers' night</td>
<td>128</td>
</tr>
<tr>
<td>Expectant parents</td>
<td>25</td>
</tr>
<tr>
<td>Parents' groups</td>
<td>84</td>
</tr>
<tr>
<td>Infant</td>
<td>60</td>
</tr>
<tr>
<td>Schools ... Junior</td>
<td>79</td>
</tr>
<tr>
<td>Secondary</td>
<td>189</td>
</tr>
<tr>
<td>College of further education</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>183</td>
</tr>
<tr>
<td>None (a)</td>
<td>46</td>
</tr>
<tr>
<td>TOTAL :</td>
<td>1,072</td>
</tr>
</tbody>
</table>

457 groups serviced by 333 health visitors

348 groups serviced by 256 health visitors

183 groups serviced by 112 health visitors
The total of Table 26, excluding (a's) adds up to more than 100% as health visitors serviced more than one type of group in many instances.

Results show that 423 health visitors were actively involved in health education with groups for the year under scrutiny. By far the highest proportion of health visitors conducted classes for expectant parents. Involvement with school children came next followed by groups organised for the benefit of parents with young children. Another popular group was one identified as "other" which would cover a wide variety of clientele and might not consist of more than one session with one particular group.

The following charts show the relevant data:

<table>
<thead>
<tr>
<th>Type of Class</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante-Natal</td>
<td>333</td>
</tr>
<tr>
<td>Parents' groups</td>
<td>84</td>
</tr>
<tr>
<td>School</td>
<td>256</td>
</tr>
<tr>
<td>Others</td>
<td>112</td>
</tr>
<tr>
<td>TOTAL*</td>
<td>785</td>
</tr>
</tbody>
</table>

* does not add up to 100% owing to degree of overlap - some Health Visitors working with more than one type of class. See Table

The range of group health education activities are shown in the list overleaf:-
To show the range of groups who received Health Education in 1971:

<table>
<thead>
<tr>
<th>Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant mothers</td>
</tr>
<tr>
<td>Expectant mothers with fathers’ night</td>
</tr>
<tr>
<td>Expectant parents</td>
</tr>
<tr>
<td>Unmarried mothers</td>
</tr>
<tr>
<td>Mother and Baby home</td>
</tr>
<tr>
<td>Ante-natal in hospital</td>
</tr>
<tr>
<td>Post-natal in hospital</td>
</tr>
<tr>
<td>Playgroup</td>
</tr>
<tr>
<td>Mothers at playgroup</td>
</tr>
<tr>
<td>Parents’ groups (daytime and evening)</td>
</tr>
<tr>
<td>Infant schools</td>
</tr>
<tr>
<td>Primary schools</td>
</tr>
<tr>
<td>Secondary schools</td>
</tr>
<tr>
<td>Further education</td>
</tr>
<tr>
<td>Parent-Teacher Association</td>
</tr>
<tr>
<td>Meeting with parents re. health education series in school</td>
</tr>
<tr>
<td>Schoolgirls at health centre</td>
</tr>
<tr>
<td>Educationally sub-normal children</td>
</tr>
<tr>
<td>Teacher training college</td>
</tr>
<tr>
<td>Careers convention</td>
</tr>
<tr>
<td>Student Nurses</td>
</tr>
<tr>
<td>- introductory block</td>
</tr>
<tr>
<td>- 1st year block</td>
</tr>
<tr>
<td>- 2nd year block</td>
</tr>
<tr>
<td>Pupil nurses</td>
</tr>
<tr>
<td>Staff nurses</td>
</tr>
<tr>
<td>District nurse students</td>
</tr>
<tr>
<td>Training course for hospital supervisors</td>
</tr>
<tr>
<td>Social workers</td>
</tr>
<tr>
<td>Child care officers</td>
</tr>
<tr>
<td>Welfare assistants' refresher course</td>
</tr>
<tr>
<td>Home helps</td>
</tr>
<tr>
<td>Citizen’s Advice Bureau trainees</td>
</tr>
<tr>
<td>Voluntary groups/voluntary organisations</td>
</tr>
<tr>
<td>&quot;Care groups&quot;</td>
</tr>
<tr>
<td>Houseparents at children’s homes</td>
</tr>
<tr>
<td>Police</td>
</tr>
<tr>
<td>Police cadets</td>
</tr>
<tr>
<td>Fire service cadets</td>
</tr>
<tr>
<td>Handicapped group</td>
</tr>
<tr>
<td>Pre-retirement courses</td>
</tr>
<tr>
<td>Old age pensioners</td>
</tr>
<tr>
<td>Over 65 Club etc., (Elderly in various guises)</td>
</tr>
</tbody>
</table>
Slimming/Obese adults and children/Weight Watchers

Target groups in General Practitioner surgeries

Safety campaign caravan
Cancer groups/Well-Womens' clinic
Coffee mornings with young mothers
Family Planning Clinics

British Red Cross Society
British Red Cross Society Cadets
St. John Ambulance Brigade
St. John Ambulance Brigade Cadets
Girls' Life Brigade
Duke of Edinburgh Award courses
Salvation Army holiday hostel group
Cubs
Scouts
Guides
Rangers
Task Force children
Youth clubs
Youth club leaders

Nuns
Embassies

Young Wives
Mothers' Union
Womens' Institutes
Townswomens' Guilds
Various un-named womens' groups
Church Wives
Church Men
Soroptomists
Rotary luncheon group
British Legion
Professional, and Business Womens' Guilds
Political groups

Telephonists
Factories

Some readers may find the terminology in the list a little strange but it was used by the health visitors to define certain groups of people for whom they arranged classes, for example "Mother and Baby home".
423 health visitors had given health education to groups during the year under scrutiny. It is apparent from the figures below that some respondents were responsible for more than the average of 2 groups in the year. In 157 instances the respondents taught only one group, while 140 said that they had run two different groups in 1971. Fifty-six health visitors ran three separate groups and another thirty-nine were responsible for a total of four groups. A further 26 health visitors claimed responsibility for teaching five groups and, in five instances respondents claimed 6 or more groups to their credit. Only 46 had not participated in group work during 1971.

**Total of different groups run by individual health visitors in 1971.**

![Bar chart showing the distribution of different groups run by individual health visitors in 1971.](chart.png)
Question - 17 : Realisation of the need for health education.

The survey data reveals that in 103 instances the participants said that they perceived the needs of the groups with whom they were involved. In 257 cases the health visitors were directed into teaching target groups during the year ending December 1971. An additional 63 respondents indicated that although they were directed they also recognised the needs of their clients.

Question - 18 : Preference for health education

Preference for health education, related to specific groups if given the choice.

<table>
<thead>
<tr>
<th>Health Education Groups</th>
<th>Number of Preferences</th>
<th>430 choices made by 307 health visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant mothers</td>
<td>197</td>
<td></td>
</tr>
<tr>
<td>Expectant mothers with fathers' night</td>
<td>128</td>
<td></td>
</tr>
<tr>
<td>Expectant parents</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>Parents' groups</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Infant</td>
<td>82</td>
<td>351 choices made by 244 health visitors</td>
</tr>
<tr>
<td>Schools ... Junior</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>115</td>
<td></td>
</tr>
<tr>
<td>College of Further Education</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>None (a)</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>TOTAL*</td>
<td>880</td>
<td></td>
</tr>
</tbody>
</table>

* Excluding (a)
In reply to the question "if you were given the choice, which group would you prefer to teach?" of the 437 who stated a choice, 307 chose work with expectant mothers, 68 with parents' groups, and 244 with educational groups. The 31 who gave their choice as 'other' interpreted this as teaching in the sphere of small groups of clients with specific health needs, in hospitals amongst patients in Coronary Care Units and mothers of child patients in paediatric wards, in youth and geriatric clubs.

All four health visiting officers expressed a preference for antenatal classes even though two had no experience at all in midwifery either during training or subsequent to becoming State Registered Nurses.

Question - 19 : Responsibility for classes

It was decided to try to assess the amount of help available both in the preparation and the presentation of the classes. Table 31 relates to the degree of responsibility and help in the preparation of all types of group work. Table 33 relates solely to the actual assistance given with the antenatal classes.

Table 31

<table>
<thead>
<tr>
<th>Sole responsibility</th>
<th>286</th>
</tr>
</thead>
<tbody>
<tr>
<td>If 'no', then help from:</td>
<td></td>
</tr>
<tr>
<td>a. Nursing Officer</td>
<td>31</td>
</tr>
<tr>
<td>b. Health Education Officer</td>
<td>70</td>
</tr>
<tr>
<td>c. Another</td>
<td>72</td>
</tr>
<tr>
<td>TOTAL (a, b &amp; c)</td>
<td>173</td>
</tr>
</tbody>
</table>

- 230 -
Of the 137 participants who did not assume sole responsibility for their health education, 82 had help from one source and a further 55 had more than one other officer to guide them. As can be seen from the above table, a total of 173 sources of help and guidance were available for those concerned in health education.

In 31 instances a Nursing Officer was said to be responsible for the organisation and planning of this part of the health visitors' work, in others the Health Education Officer had this function, while in the category referred to as 'another' the following agents were included:

1. in the case of ante-natal teaching it appeared that decisions were reached either by the members of the general practice team, or the general practitioner himself; in one area the assistant medical officer of health had the special responsibility while, in another case, she handed over her work to the health visitor after working in partnership with her for a "few months". A "colleague" was named in one return, while the midwife, hospital sister and matron of a maternity hospital were all named as the responsible person for decision making in this area of work.

2. in the case of health education in schools, the headmaster, class teacher and domestic science teacher were all named by the respondents in this context.

Question - 20 : Venue for ante-natal classes.

In response to the question "where are the classes held?" it was found that 304 were held in local authority premises and, of these 92 were situated in Health Centres. The remainder were held in Church Halls, G.P. Surgeries, Maternity Out-Patient Departments and Hospitals, and some were included in the "other" category. The following table shows the relevant data:
### Venue for ante-natal classes

<table>
<thead>
<tr>
<th>Venue</th>
<th>No. of Classes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Authority premises (other than Health Centres)</td>
<td>184</td>
</tr>
<tr>
<td>Health Centres</td>
<td>92</td>
</tr>
<tr>
<td>Church Halls</td>
<td>28</td>
</tr>
<tr>
<td>G.P. Surgeries</td>
<td>20</td>
</tr>
<tr>
<td>Maternity O.P.D.</td>
<td>15</td>
</tr>
<tr>
<td>Hospitals</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>374</strong></td>
</tr>
</tbody>
</table>

A total of 304 classes were held in premises either owned or rented by local health authorities; no indication was given as to the venue referred to as "other" so these figures are not included in the above result which shows that over 80% were under the direct control of the health authority concerned.

**NOTE:** in 34 instances health visitors reported that they were holding classes in more than one place during the year ending December, 1971.

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### Work with Expectant Mothers

Under the National Health Service Act, 1946 (Part III, Section 22) the Local Health Authorities have the duty to make arrangements for the care of expectant mothers. In addition they must provide health visitors to advise expectant mothers in their own homes (Section 24). However it
would seem that the most expedient use of the health visitors' time is to gather together groups of expectant mothers for this purpose, the facilities for group health education being included in Section 21 which relates to the provision and use of health centres. It can be seen from the survey that a total of 457 such groups were run by 333 participants during the twelve months under scrutiny.

Health visitors are not the only workers responsible for the care of the expectant mother and, the National Health Service Act 1946 (Part III, Section 23) makes it the duty of the Local Health Authorities to secure a midwifery service. The report on "Maternity in Great Britain" (1948) stated that the health visitor is the midwife's partner in health education. Table 33 appears to corroborate this statement in that domiciliary midwives partnered health visitors on 205 occasions. In a further 13 instances this partnership was effected between the hospital midwife and the health visitor.

A further study into the involvement of hospital staff with ante-natal classes would provide useful data.

Questions - 21/22 : Help with the teaching of expectant parents.

<table>
<thead>
<tr>
<th>Help with ante-natal classes</th>
<th>Table - 33</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Assistance</strong></td>
<td><strong>Number</strong></td>
</tr>
<tr>
<td>Health visitor</td>
<td>66</td>
</tr>
<tr>
<td>Health visitor student</td>
<td>33</td>
</tr>
<tr>
<td>Clinic nurse</td>
<td>3</td>
</tr>
<tr>
<td>Hospital midwife</td>
<td>13</td>
</tr>
<tr>
<td>Domiciliary midwife</td>
<td>205</td>
</tr>
<tr>
<td>Pupil midwife, Part I</td>
<td>1</td>
</tr>
<tr>
<td>Pupil midwife, Part II</td>
<td>38</td>
</tr>
<tr>
<td>Obstetric pupil</td>
<td>3</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>91</td>
</tr>
<tr>
<td>National Childbirth Trust Teacher</td>
<td>4</td>
</tr>
<tr>
<td>Any other</td>
<td>27</td>
</tr>
<tr>
<td><strong>TOTAL :</strong></td>
<td><strong>484</strong></td>
</tr>
</tbody>
</table>
NOTE: A health visitor may have help from more than one person.

The table on page 233 gives the data obtained from the question "do any of the following help you with the teaching of your classes?" 175 health visitors were solely responsible for their classes, 67 obtained help from other health visitors and in only three cases did the clinic nurse assist. It can be seen that a high proportion of domiciliary midwives co-operated with the health visitors whereas the number of hospital based midwives was comparatively low. In 91 instances physiotherapists were actively engaged in these classes. Contributions from National Childbirth Trust Teachers were minimal.

The data also shows that of the 75 students who assisted with these classes, 33 were health visitor students, one a Part I pupil midwife, 38 Part II pupil midwives and 3 were obstetric pupils. Under the remaining category "any other" the following workers were listed:

- Health Education Technician
- Home Safety Officer
- Cookery Demonstrator (North Thames Gas Board)
- Family Planning Demonstrator (London Rubber Co.)
- Dental Hygienist
Number of Completed Questionnaires

Out of a total of 500 health visitors who were invited to participate in the survey, 469 (94%) completed and returned the forms; the reason for such a very high result could be because the population under review trained under the new syllabus and so were aware of the importance of research in furthering the development of the profession. Another factor could be that many of the health visitors enjoyed this aspect of their work.

Perhaps the nursing officers provided an encouraging and supportive background thus enabling the respondents to participate in the survey. It augurs well for the profession that so many health visitors took a considerable amount of time and trouble to complete the questionnaire accurately, and also that 370 out of the 469 accepted the invitation to send in comments about their training and current work situations (78.9%).

Question - 4 : Civil Status

The replies to the question only show the civil state of the respondents at the time of completing the questionnaire and do not relate to the period of health visitor training.

Of the 4 health visiting officers, 3 were married and, although the number of health visiting officers was infinitesimal, it was decided to keep these returns in the survey. Out of the remaining sample of health visitors, 282 (60.6%) were married, of these 223 (48%) were under 40 years of age and could reasonably be assumed to be of child-bearing age and so may have to leave the service for a period of time in which to raise a family. The questionnaire did not ask for personal family details so that it is not possible to deduce whether the experience of childbirth influenced the attitude of the participants towards any one particular avenue of group health education such as ante-natal care.
Questions - 5/6 : Training schools

Health visitor training is provided by Colleges of Further Education, Polytechnics and Universities. All courses must be approved by the Council for the Education and Training of Health Visitors, the Statutory Body responsible for all training in the United Kingdom.

Although in many instances training schools take students sponsored by the surrounding local health authorities, the cost incurred is met by a national funding scheme and the students qualify for the national certificate. Schools have to meet certain minimal requirements for student selection, interpretation of the syllabus and an examination procedure laid down by the Council. Colleges of Education, Polytechnics and Universities may set their own criteria for accepting students with higher minimal standards of entry than required.

44 training schools were operating in the United Kingdom in 1968. The number increased to 47 by 1971, of these 1 was in Northern Ireland, 4 in Scotland and 1 in Wales. 32 schools were represented in the survey, of which 7 were functioning within Greater London, 2 were in Scotland, 1 in Wales and the remaining 22 in England. 64.6% of the participants trained in schools lying within a radius of 60 miles of London (Charing Cross), and the largest individual number, 12.6% trained at Croydon Technical College.

Question - 7 : The sample population

In the four years from 1968 to 1971, 3,337 nurses qualified as health visitors and, of these, 469 took part in the survey representing 14% of the total.
The Council for the Education and Training of Health Visitors' policy to increase training places both to replace staff lost through retirement and increase the total establishment within the United Kingdom is reflected in both the national and survey data below:

<table>
<thead>
<tr>
<th>Year of qualification</th>
<th>1968</th>
<th>1969</th>
<th>1970</th>
<th>1971</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey data - No.</td>
<td>68</td>
<td>111</td>
<td>132</td>
<td>158</td>
<td>469</td>
</tr>
<tr>
<td>- %</td>
<td>9.4</td>
<td>13.3</td>
<td>15.0</td>
<td>17.6</td>
<td>14.0</td>
</tr>
</tbody>
</table>

Total number of Health Visitors qualifying: 725 834 879 899 3,337

Table - 34

The table shows that the total number of health visitors taking part in the survey increased over the 4-year period.

The increase in the number of participants in the survey could be accounted for by the increasing number of training places available in the schools but also some of the health visitors in the survey who qualified in 1968 and 1969 may have already moved to another branch of nursing or they may have been promoted within the management structure. Another possibility could be that some had left the service to start a family with a view to returning to the profession at a later date. The figures highlight a possible area of concern for those administering the service in that they have a proportion of newly qualified staff who lack experience and therefore may require considerable supervision and support during their first few years in the profession. On the other hand, having trained under the new syllabus, the recently qualified health visitors may prove to be more confident and reliant workers. They have studied the principles of education and group dynamics and have had some experience in health education with groups in the fieldwork practice area.
The total number of integrated/degree participants was minimal and so it was not possible to interpret the figures available and the findings are recorded in numbers only.

Question - 8 : Age range

84% of the participants were aged 40 or under and so must be considered of childbearing age, this could affect accurate forecasting of staffing establishments and also recruitment. In addition it is possible that, among the younger married women, as their husbands progress in their own careers they may have to move to another part of the country or abroad to obtain promotion. Another possibility is that married couples may have to move away from the city centres and London in order to afford a home.

On the other hand, young single women are liable to get married and move away. Those who remain single may have fewer family ties and so be free to change from one employing authority to another unless they obtain satisfaction in their current work situation.

Question - 10 : Full-time employment as a health visitor

The forecast for a 50% increase in full-time equivalent health visitors was one of the earliest concerns of the Council for the Education and Training of Health Visitors. Of the sample population 418 had worked full-time since qualification (89.1%); 36 (7.7%) were working full-time but engaged in triple duties combining the roles of health visitor, district nurse and domiciliary midwife in rural areas; 15 (3.2%) were working only part-time and; of these, 10 indicated that they had also had a break in service. It was not possible to assess the attrition rate caused by a variety of reasons, which could include family committments or transfer to another branch of nursing or work outside the profession. Research into the attrition rate from health visiting and the reasons for so doing would provide useful data which could
help with selection of potential candidates. However this is not to imply
that selection of candidates for the profession should be restricted to those
whose suitability and motivation is beyond dispute. This form of nurse
education provides a degree of insight into the community seldom attained
by any other training scheme.* Those who choose to leave the health visiting
service for another branch of the profession must surely take with them some
of the insights developed during training. This could be helpful for their
nursing colleagues who have not had the advantage of this intensive training.

Question - 11 : Midwifery Training/Experience

It can be seen that 66.9% of the respondents had taken a qualifying
period of midwifery training; that is either the 6 month training for Part I
Certificate of the Central Midwives' Board, or the 12 month course for
certification as a Midwife.

Of the remaining 155 participants, 83 had obtained obstetric experience
after qualifying as State Registered Nurses. The reason for their so doing
could be that they required this experience to become eligible for health
visitor training and it is to be hoped that as mature students they would be
motivated to gain maximum benefit from this course.

32.6% of the participants had received minimal instruction in
obstetric care, the quality of which will have varied from hospital to
hospital. This poses problems for the training schools when planning the
curricula. For example, one health visitor wrote :-

"During a time when all energies are needed for studies, I particularly
felt worried over ante-natal groups as my obstetric training was too
previous, and my knowledge poor. I now enjoy these groups but I
cannot say my course helped at all here, I could not admit to lack
of knowledge at that time, as very few were obstetric trained."

* The term "community" is usually understood to cover both the
physical location and the common identity of a group of people.
However another respondent said:

"I feel my training at "__" included a good background for health education in theory and practice - at least, the maximum possible in a one-year course."

Yet another health visitor voiced the opinion:

"I feel that the teaching I do with expectant mothers is entirely drawn from my midwifery experience, not from any help received during Health Visitor training."

The insecurity voiced by many health visitors over their ability to teach also poses problems for nursing administrators in deciding the amount of support and in-service training required before such staff could be considered competent to advise and teach expectant parents.

This is reflected in a comment made by one health visitor:

"Although I had the necessary knowledge to teach, it was not until I attended a further education teaching night school course that I realised the art of teaching and getting over the subject."

In at least one local health authority it is evident that further training is a pre-requisite for ante-natal health education:

"I should have liked to have undertaken classes with expectant mothers but unfortunately was unable to attend 'Eileen Montgomery' course due to illness in 1971."

wrote a disappointed health visitor.

The value of teamwork with midwives is of even greater importance for this group than perhaps for those who have practised as midwives. As one health visitor commented:

"I gained most from the Health Visitor/Midwife who was in charge of the Mothercraft at "Y" Hospital. She had superb manners with the mothers and her teaching technique was commendable."
Certainly one would expect health visitors with the midwifery qualification to have more insight into the needs of the expectant mother by virtue of their training and subsequent experience as midwives:

"Having worked in the local Maternity Hospital as a midwife, I found this extremely helpful when talking to expectant mothers regarding labour and what happens to them when they are admitted to hospital. The majority of mothers are very worried about what will happen to them when they are admitted. The fear of the unknown."

Another health visitor summed it up by saying:

"Obtaining 1 year midwifery training an asset."

Questions - 11/4 : Midwifery and civil state

Distribution of midwifery qualification related to civil state

<table>
<thead>
<tr>
<th>Midwifery Qualification</th>
<th>Civil State</th>
<th>CIVIL</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>Married</td>
<td>Single</td>
</tr>
<tr>
<td>S.C.M.</td>
<td>108</td>
<td>101</td>
<td>-</td>
</tr>
<tr>
<td>CMB Part I</td>
<td>36</td>
<td>69</td>
<td>-</td>
</tr>
<tr>
<td>Obstetric (pre-SRN)</td>
<td>26</td>
<td>44</td>
<td>-</td>
</tr>
<tr>
<td>Obstetric (post-SRN)</td>
<td>13</td>
<td>68</td>
<td>-</td>
</tr>
<tr>
<td>None</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>183</td>
<td>282</td>
<td>1</td>
</tr>
</tbody>
</table>

NOTE: In 33 instances participants had taken an obstetric course and at a later date had taken the longer certification course, this overlap has been corrected in the above figures and the data relates, in each instance, to the higher course taken by the individuals concerned.

It can be seen that 68 health visitors who were married at the time of the survey took their obstetric experience as post-SRN students.
The data shows that 39.2% were still single at the time of the survey. However a higher proportion of single participants, 58.7% (108 out of 184) had the full midwifery qualification compared with 35.4% (101 out of 285) who were married. It could be assumed that more single nurses were prepared to take the complete midwifery training than those who were married (and therefore had family commitments not able to undertake the inconvenient hours of work demanded by the Midwifery Service). It could be argued that the higher proportion of single nurses who are midwives reflects a form of sublimation amongst those for whom, as yet, marriage and motherhood are not within reach. Further to this it could be inferred that these midwives are not necessarily psychologically capable of providing the best climate in which to incalculc appropriate attitudes to cope with the life crises of pregnancy and childbirth. The converse could be equally problematical, particularly if a health visitor who is also a mother had come through this period of her life crisis with a poor adaptation.

As far as health visitor training is concerned perhaps the midwifery certificate or obstetric experience is of value only as an entry qualification. Far more important than previous knowledge is the motivation of candidates for health education during the ante-natal period. It follows that the school must provide an optimum climate for the education of health visitor students in preparation for this important area of the health visitors' work. The single health visitor may want to keep all job opportunities open or prepare herself for work overseas where the emphasis may well be on maternal and child care. However the final selection rests with administrators in the field who decide which of their staff teach in the ante-natal situation.

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Traditionally the health visitor working for a local health authority was allocated a definable geographical area within which she was responsible for all of 400-500 young families. Her stereotype was that of a maternal and child care advisor and the size of her case/work load was calculated on the pre-school age group although she often had the responsibility of any schools lying within her geographical boundary. Her contact with general practitioners was limited and could include 12 or more different doctors dependant upon the families residing within "her" area. Recently patterns of work have changed and many health visitors now work with groups of general medical practitioners which means that they are responsible for any patient registered with those doctors over an extensive catchment area and the case/work load is calculated on the patients registered with the practice. In certain instances health visitors have an unofficial association with general practice, often visiting the surgery only once or twice a week to confer over matters of concern - this is called liaison.

36% of the health visitors were still responsible for clients within geographical areas compared with 41% working in group practice attachment schemes. 20% worked in liaison with group practices but also worked within a geographical area; the other 30% had additional special responsibilities for communities peculiar to their areas such as a gipsy camp or an R.A.F. Station.

The results show the problems for training schools during the transitional period from the old pattern of work in geographical areas to the new concept of primary health care teams based on group practice schemes. Not only have the schools to teach two different approaches to the management of the health visitors' work, they must also be aware of the changing pattern of demand within an extended range of clientele and referral from workers within the curative services. Anxiety has been
expressed by both administrators and tutors about the increasing emphasis on crisis work with a consequent diminution of routine visiting and primary prevention. The need for students to have the theoretical concepts taught in college reinforced by practical application in the field is of paramount importance in training schemes. In many instances the pressure of work is so great that field staff increasingly concentrate on emergency work because of the nature of need and pressures of society, this together with the heavy case loads carried by many health visitors impose strains which are difficult to accommodate. Health Visitors trained at schools which place great emphasis on health education and who would be expected to accept this as an important part of health visiting duties are unable to put this into practice. Comments returned with the questionnaire put this very plainly:

"There is a great need of Health Education to be done in our field of work, but unfortunately there is acute shortage of staff. I have a lot of ideas for health education, it is very difficult to put these ideas into practice the reason is only staff shortage."

Another remark was:

"If one wants to do health education, there is no time for it, because we have no staff."

And a health visitor who has the Further Education Teacher's Certificate said:

"I enjoy health education, but because of pressure of other work I am unable at present to commit myself to regular sessions. I feel this should be a major part of my work ....".

The strains of working in a rural area are illustrated by, first a health visitor engaged in triple duties:

"My work has been largely nursing and midwifery duties with very little time left for health visiting. In the near future it is hoped that an SRN or an SEN will help me. This will give me more time to delegate myself to health visiting duties, and greater use will be made of my skills."
and secondly by a full-time health visitor who described her rural area:–

"I cover eleven villages as a Health Visitor and find very little demand for health education as compared with the consistent demands of visiting - especially the elderly groups. Each village consists of a population ranging from 200 to 1,000 approximately. My Health Visitor training contained the basic 'rules' of health education which I have remembered when displaying health education material at my clinics.

Professionally I would take the opportunities for more classes on health care per se but I feel I cannot shelve my duties in ventures which I am not sure would be well attended or even welcome. Unfortunately, transport between villages is poor and we have no storage space at suitable centres. This I feel is another 'deterrent' to my health education experience."

The reality of working in group practice attachment and the consequent strains are depicted in the following excerpts:–

"During my first year as a qualified Health Visitor, I organised and held classes for expectant mothers in the clinic where I am based. Subsequently due to staff shortage, it became necessary for me to take on another geographical area in addition to my own. This involved extra clinic commitments, plus coping with a shifting population, and I found my home visits dramatically reduced. I therefore, had to reluctantly give up my ante-natal classes, and the situation has remained stationary to the present time. It would also appear that no improvement is likely to take place in the foreseeable future."

"There are plenty of opportunities for all kinds of Health Education and teaching in _____, the problem is time. During the last 6 months we have become attached to G.P's., and my group of 3 doctors have given me an enormous amount of new work to do, especially with the geriatric age group. I am barely keeping up with this, and only to the detriment of visiting the under 5's."

"I work in complete General Practice attachment, working from the Doctor's premises. With the increasing amount of work this has involved, plus local health authority duties, and the School Health Service I feel that time available to expand or at least improve the health education undertaken is in fact diminishing."
And in one instance a health visitor indicated that the opportunity for group health education was reduced because of the excellence of the health education provision in the county, she wrote:

"Perhaps we do not get as much opportunity as some Health Visitors to do Health Education, because in ___ we have a very 'go-ahead' Health Education Officer with her own staff, and naturally they do much of the Health Education work in the county."

Question - 13 : Locality

For the purpose of this discussion an urban area is a built-up area such as a town or city where there is a high population density. In contrast to this a rural area is one with a pastoral or agricultural community with hamlets or villages. It follows that a combined area is one in which a great deal of agriculture is done in the area but it may include some medium sized towns or parts of towns and areas of high population density.

In contrast to the changing work pattern for health visitors, Question 13 revealed that 86.6% of the respondents were working in urban areas - of these 64.6% worked wholly in urban areas and 22% in a combination of urban and rural areas. Only 13.4% worked in rural areas and of these 36 participants were engaged in triple duties combining the roles and functions of the health visitor, district nurse and domiciliary midwife.

Perhaps the results provide a salutory reminder that 35% of the survey participants were working for at least part of the time among rural communities and the possibility of this needs to be borne in mind by those responsible for curricula planning in national training schools.
The student will need opportunities to examine the nature of the work by means of some preliminary experience and some specific projects to help her to translate the "pipe-dream" of country life into the reality of the situation. This can best be provided by the support and guidance of a tutor who is interested in and concerned about work in rural communities. Secondly it is essential that at least some experience is provided in a rural area, perhaps during the period of alternative practice. Given this climate for learning the student is then better prepared for her work and less likely to suffer from the disillusionment that sometimes occurs. One poignant comment from a health visitor working in a County Council highlights the problems of such a situation:

"My area is very rural and mothers live miles away from clinics etc. Most work in the fields in summer and as many are travellers it is therefore impracticable to run organised Health Education sessions following a regular course. Expectant mothers usually attend the local hospital mothercraft course if one of them has the use of a car. Buses are too infrequent to use for attending afternoon functions."

Question - 14 : Post-certificate training

Only 89 health visitors had taken part in post-certificate training in health education; of these 32 had attended courses for preparation for childbirth, 16 had attended 'special' health education courses, 13 participated in in-service training and 11 had become proficient in film projection and use of audio/visual aids. A further 9 had obtained the City and Guilds Certificate for technical teachers, and one had attended the new health education course run as a pilot scheme by Highbury College in conjunction with the Health Education Council.

It is disappointing to note that only 19% of the participants were interested and able to extend their health education expertise. One reason might have been that the syllabus did not seem to add to their knowledge or
expertise. Another reason might have been the lack of recognition of the need of newly qualified staff by their nursing officers and/or medical officers of health. It could have been the policy of the local health committee not to encourage what has been largely a permissive part of the service. Do health visitors need extra training in health education at this level, might not a special continuation course be of more value for those who wish to improve their teaching techniques? One respondent wrote:—

"Perhaps it would be more realistic if those student Health Visitors who expressed themselves to be very interested in this aspect of our work were given an extra training....."

and another suggested that:—

"a 6/52 or more course be given for Health Visitors who are interested in the subject, just to give a better 'grounding' in the actual 'delivery' of talks etc."

Quite often nursing officers consider that newly qualified staff should be allowed one to two years to "settle in" and get to know their clients thoroughly before becoming distracted by the pressures of formal group health education; and one health visitor wrote:—

"The health visiting course was most enjoyable and informative and at the end of the course people with varied past experience like myself feel receptive to further knowledge.

Unfortunately it is difficult to get seconded from one's employing authority to take further courses—usually for financial reasons. Qualified Health Visitors usually feel it their duty to give 2 years service following qualification before applying to take further courses, e.g. in Health Education or management etc. If one is refused the first few applications to take these courses one is either faced with the prospect of changing one's employment authority with a hope for better opportunities or staying on and becoming a bit apathetic towards further study. 

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The reason I am writing the above viewpoint is:-
At the end of Health Visitor Training course our tutor said that those of us who were keen to take further training should not let too much time elapse before applying for courses we were interested in.

Further analysis of those who had received post-certificate training reveals that 8.3% were working in Greater London, 2.6% in County Boroughs and 8.1% in County Councils. Some of the possible reasons for the low percentages in all areas have already been stated. The assumption that newly qualified staff do not require additional training defeats the purpose of education as a foundation on which to build, but the building a new member of staff needs is opportunity to practice. Another important factor could be that of finance, local health authorities have to apportion funds to various priority schemes while at the same time maintaining other statutory services.

Question 15/16: Attitude towards health education

When assessing the attitude of the sample towards group health education it was found that 84.6% indicated that they wanted to undertake this work, only 15.3% said "no". Out of the 397 who expressed an interest in running formal groups only 88 had received further training to prepare them for this work. Staff who wish to teach would usually be prepared to attend further training courses to extend their competence, and so it is possible that the reason could lie within the policy of the local health authorities or that such courses are not available within what is considered to be a reasonable distance from the health visitor's place of work. However a high proportion of married women may not be prepared to attend courses at their own expense or in their own time. Residential courses may not attract fieldworkers who have family commitments.

Of the 72 who did not wish to participate in health education only 46 were not engaged in this work during 1971 and 11 had attended post-qualification training.
The data shows that 423 health visitors had participated in group health education in 1971. 333 health visitors serviced a total of 457 ante-natal groups; 66.5% of these groups were solely for expectant mothers, 28% included an evening when the husbands were invited to attend, and only 5.5% of the courses catered for both spouses to attend all the classes.

Work with expectant mothers has been a traditional role of the health visitor for over 70 years and 66.9% of the participants have undertaken a qualifying period of midwifery training prior to becoming health visitors. In addition, the attitude of society has been that childbirth was women's work and only recently has there been an interest and a desire on the part of some husbands to share this experience with their wives. All too often staff have maintained the traditional approach without questioning either their own motivation or whether this is what their clients really want. Perhaps nursing officers have been more concerned in providing a service with the minimum disruption rather than attempt to innovate a change of approach which would almost double the numbers of attenders and consequently the number of groups if they are to be kept to a practical size. Both midwifery and health visitor schools may be equally at fault again in maintaining traditions without questioning motivation. Perhaps the introduction of men into the health visiting service may help to break down these barriers and provide a more realistic service. It is encouraging to note that out of a total of 457 ante-natal classes, 128 provided at least one night especially for the husbands and 25 groups were organised for both spouses to attend. Credit for the new trend has to be given to the National Childbirth Trust and a few obstetricians, midwives and health visitors. However, it must be remembered that some husbands would not want to participate and some wives might prefer the relative privacy of an all-woman group. Further investigation into this area would provide useful data for both tutors and health education officers. A recent pilot study carried out by members of the
A health education course at Croydon Technical College revealed different perceptions of need between the consumers and the providers of such a service in the London Borough of Croydon (1974).

Only 84 health visitors organised parents’ groups to discuss the problems associated with rearing young children. It is surprising that a service traditionally associated with maternal and child care can only produce 17.9% of the sample population actively involved in this aspect of the service. The emphasis in training has still been for individual health teaching in respect of the present problems of child rearing. It may be that the students have not seen the relevance of the extended syllabus to health education planning or that they have been too busy learning the difficult concepts of the behavioural sciences, to give enough time to basic growth and development patterns. Perhaps the lack of firm criteria with which to assess the current theories or such aspects of child management as infant feeding and toilet training deter the new teachers. The new health visitor often lacks practical experience and has to spend hours in preparation if she is to feel confident. There are few tangible rewards for this effort either in terms of a time allowance for preparation, book allowance, or payment for extra duty when this teaching involves the use of personal time over many weeks. The additional demands of providing and staffing a creche or play group for the children may daunt all but the most enthusiastic health visitor. Other less interested colleagues and rigid administrative structures may intentionally or unintentionally obstruct the setting up of such sessions by a newly qualified member of staff. The alternative is to run an evening session which may not be acceptable to the clients nor may it fit in with the health visitor’s own family commitments. This difficulty was raised by one respondent:

"I feel that many married Health Visitors are unable to give up free time, necessary for preparation and evening sessions because of home commitments."
Health committees may not be aware of the range of health education that the service could provide. It may be that administrators are not consulted in the formulation of local health authority policy. Mortality and morbidity rates provide evidence of need and can be met by secondary and tertiary schemes of prevention. The cost benefit of primary prevention is difficult to evaluate.

In the field of education, 348 groups were run by 256 health visitors and of these 17.2% groups were in infant schools, 22.7% in junior schools, 54.3% in secondary schools and 5.7% in colleges of further education.

It is interesting to note that health education classes in secondary schools was the second highest group serviced by the health visitors with a total of 189 different classes. One reason may be that teaching staff are unable or unwilling to accept responsibility for health education. Many admit to being ill-prepared to discuss family matters and often interpret health education solely in terms of sex education. The problem of the reluctant learner in the final school year is causing considerable concern and many teachers welcome help from a variety of lay professionals to teach subjects in which they are the experts. Other teaching staff have welcomed the opportunity for a quiet marking session in the staff room while their class has been kept occupied. Although a demanding group secondary school children can also be a very rewarding age-group to teach provided material is presented in an interesting and attractive manner suited to their developmental needs. They provide a captive and enquiring, if somewhat restive, group of tomorrow's parents. It could be that health visitors trained under the new syllabus are able to arouse enthusiasm and maintain rapport with these very young adults, but many feel ill-equipped to do so.
For example, one health visitor recommended that:

"More teaching in Health Education during my training I feel would have been very helpful. We did have 6 very useful lectures on how to teach, but now that I have Health Education sessions in school for girls of 14 and 15 years, I feel that my training was a little inadequate, although I enjoy these sessions and feel they meet a real need."

It would be interesting to survey the motivation and attitudes of health visitors teaching in all four branches of education, particularly as they so often point out that they are not qualified teachers. However they recognise that their expertise lies in health matters although many would say that they needed help to put across such abstract concepts as prevention, and to include such emotive topics as sex education and family dynamics. For example one health visitor made the following comment:

"I feel that Health Education in schools should be undertaken more by health visitors. And with this aim in view I feel that additional practice and teaching instruction would be helpful, particularly for those health visitors with an interest in health education."

while another wrote:

"I can foresee health visitors giving health education talks to secondary schools incorporating sex education, mothercraft, human relationships, responsibilities, etc., etc., (? short curriculum compiled through liaison with domestic science teacher and biology master)."

and a third pointed out that:

"I do realise there is a great need, especially with regard to sex education and certain groups of immigrant children. Many of them desperately need guidance as they are not getting any - either from parents or teachers."

A total of 1,072 groups were serviced by the participants in 1971 and 183 of these (17.1%) were identified as "other". It may be that the health visitors offered their services to provide health education to a wide range of clients, or perhaps approaches were made by the organisations
concerned either directly to an individual member of staff, or to a nursing officer or health education officer. Often these consist of one session only given in the evenings. These can be a demanding form of work because of the need to establish a quick rapport with the group, and there is usually little or no feedback. To conduct such a session demands a different kind of competence from that needed by a health visitor in an on-going group.

Further scrutiny of the figures revealed that 33.5% of the health visitors ran only one group in 1971, a possible reason for this could be the heavy demands made by other areas of work on their time. Perhaps they followed the maxim of "do a little and do it well"; or another reason could be that health visitors were only prepared to service one group which would presumably be the one with which they felt best able to cope.

29.85% ran two different groups in the year, one reason for this could be that with growing expertise and confidence they felt able to cope with the additional work. It is possible that having successfully organised one group they were able to take on more responsibility in health education. One would like to assume that the 11.9% who ran three groups, together with the 8.3% who serviced four and the 5.5% responsible for five groups were well supported by colleagues, nursing administrators and health education staff. However the figures obtained do not reveal how much of this work was shared with others apart from ante-natal classes. One can only assume that the bulk of the work was the responsibility of the health visitor concerned. Back-up and support by colleagues would be essential both in the form of recognition of growing expertise in both the method of teaching and in the content of the teaching, and also the willingness to help with problems that arise during sessions reserved for teaching.
Administrators would need to watch that the health visitor was not unduly biased towards this aspect of her work to the detriment of other routine work and home visiting, the possibility of finding a substitute satisfaction in group health education should not be overlooked. This pre-supposes that one can define criteria to assess how much of a health visitor's time spent in group health education could be considered to be reasonable. Health education staff should be available to help in the preparation and presentation of suitable material including the use of teaching aids.

**Question - 19 : Responsibility for classes**

When asked "Are you solely responsible for the planning and organisation of the classes?", 62.8% of the 427 health visitors actively engaged in teaching classes in 1971 said "yes", 33% said "no", and the remainder were undecided. Further scrutiny of the figures revealed that the age of the respondents appeared to have no direct relevance. It was noted that of those longer in post a slightly higher proportion stated they were responsible for the planning and organisation of their own courses.

It could be assumed that the respondents qualifying most recently were more closely supervised because of their lack of experience and confidence. It could be that more staff are being appointed to posts of responsibility in the organisation and co-ordination of aspects of health education, and presumably new members of staff would automatically be given guidance when embarking on new health education projects. This is possibly reflected in the data obtained in the survey.
Table 31 on page 230 shows that in 31 instances nursing officers were involved, 70 health education officers had the ultimate responsibility and a further 72 "other" workers were also concerned. The last category contained the following agents:

- members of the general practice team,
- an assistant Medical Officer of Health,
- midwives,
- school teachers, and
- other health visitor colleagues.

**Question - 20 : Venue for ante-natal classes**

A total of 457 different ante-natal groups were held in 1971 and of these only 8% were held in maternity hospitals or out-patient departments, presumably under the control of the midwifery staff. Classes held in group practice premises accounted for 5% of the groups. By far the largest group of 304 classes were held in local authority premises, 49% in local authority clinics, 25% in purpose-built health centres, and 8% in church halls leased by the local health authorities. It is likely that the respondents had more direct control over classes held in local authority premises but no information was sought about the suitability or convenience of the venue for this purpose. However the permanence of local authority premises with all their attendant facilities may be an asset in maintaining the health visitor's enthusiasm and energy for her teaching role. In direct contrast her motivation may wane when confronted with classes held in a rented church hall where all the equipment and seating has to be arranged before holding a class, and everything locked away afterwards.
In some instances the 333 health visitors involved in ante-natal classes also received some practical help with class teaching. The figures reveal that the respondents were actively collaborating with other professional workers such as midwives, physiotherapists, and a few National Childbirth Trust teachers as well as health visitor colleagues and clinic nurses. In 75 instances they also accepted the responsibility for students from general nurse training, midwifery and health visitor schools.

The figures from this and the preceding item indicate that the newly qualified health visitors in the survey were prepared to collaborate with other health workers and also work in a variety of venues.

They were also prepared to assist nurse training by providing experience for nursing students from three branches of the profession.
Participants in survey according to type of local health authority

<table>
<thead>
<tr>
<th>Authority</th>
<th>Number of Participants</th>
<th>E S T A B L I S H M E N T</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Full</td>
</tr>
<tr>
<td>North London Boroughs</td>
<td>54</td>
<td>872</td>
</tr>
<tr>
<td>South London Boroughs</td>
<td>121</td>
<td>340</td>
</tr>
<tr>
<td>County Boroughs</td>
<td>62</td>
<td>253</td>
</tr>
<tr>
<td>County Councils</td>
<td>232 *</td>
<td>1,157</td>
</tr>
<tr>
<td>TOTAL</td>
<td>469</td>
<td>2,622</td>
</tr>
</tbody>
</table>

* Includes 36 health visitors working "Triple" duties.

Eighteen of the Greater London Boroughs participated in the survey and, of these, twelve were willing to allow all of their eligible staff to take part. The Inner London Boroughs in particular have to contend with a high attrition rate and many are under the permitted establishments, but all the authorities in the metropolitan area have staffing problems. This may be one reason why only 66% of the Greater London Boroughs permitted all their eligible staff to take part in the survey.

In the County Boroughs, six of the eight produced a 100% population, and in the County Councils eight of the ten taking part also put forward their total eligible establishment.

Those Nursing Officers who only allowed a proportion of the eligible health visitors to take part in the survey expressed their concern for the welfare of their staff who were working under considerable stress. They gave the following reasons - recent illness, retirements and staff shortage for the burden placed on the remainder.
Staff who did participate spoke of the pressure of work in relation to their health education activities:

"an acute staff shortage .......

"because of pressure of work I am unable at present to commit myself to regular sessions."

A health visitor employed by a South London Authority said:

"I am still in the process of organising a group attachment scheme. As soon as it becomes workable I intend starting some discussion groups",

while a North London health visitor who had been running ante-natal classes wrote:

"Subsequently, due to staff shortage, it became necessary for me to take on another geographical area in addition to my own. This involved extra clinic commitments, plus coping with a shifting population, and I found my home visits drastically reduced".

One result was the reduction of group health education sessions:

"I had to reluctantly give up my ante-natal classes ....... no improvement is likely to take place in the foreseeable future".

The pressures on the health visiting service are also found in the County Boroughs, the following comment highlights the problems of changing the pattern of work from a geographical framework to the greater demands of group practice attachment:

"There are plenty of opportunities for all kinds of Health Education and teaching in "__, the problem is time. During the last 6 months we have become attached to G.P's., and my
group of 3 doctors have given me an enormous amount of new work to do, especially with the geriatric age group. Much of the work from the G.P.'s, and district nurse needs immediate attention, and is really within the realms of social work. Unfortunately it is not always possible to hand this work to the social worker, in fact much of it comes from them to us!"

<table>
<thead>
<tr>
<th>Authority</th>
<th>Number of Participants</th>
<th>Number of Health Visitors who failed to reply</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs</td>
<td>54</td>
<td>3 + 1 sent in too late to be included in the results</td>
</tr>
<tr>
<td>South London Boroughs</td>
<td>121</td>
<td>1</td>
</tr>
<tr>
<td>County Boroughs</td>
<td>62</td>
<td>6</td>
</tr>
<tr>
<td>County Councils</td>
<td>232</td>
<td>15 + 1 who declined to participate</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>469</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

* the original population totalled 500 but four returns were ineligible as the respondents had trained prior to the period under survey.

From the above table it can be seen that the response rate for the South London Boroughs was almost 100%. Both Croydon Technical College and the University of Surrey are known to staff working in this area through their health visitor training programmes. Although the highest number of non-participants came from the County Councils the proportion was lower (1 : 15.5) than those of the County Boroughs (1 : 11.33) and the North London Boroughs (1 : 14.50).
Question - 4 : Civil state

In each type of employing authority a large proportion of respondents were married at the time of the survey. Out of 175 health visitors in the London Boroughs, 98 were married of whom 31 came from North of the Thames; 38 and 149 respondents were married out of 62 in the County Boroughs and 232 in the County Councils respectively.

### Health visitors by civil state by employing authority

<table>
<thead>
<tr>
<th>Civil State</th>
<th>Employing Authority</th>
<th>North London</th>
<th>South London</th>
<th>County Boroughs</th>
<th>County Councils</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>No :</td>
<td>31</td>
<td>67</td>
<td>38</td>
<td>149</td>
<td>285</td>
</tr>
<tr>
<td></td>
<td>% :</td>
<td>57.4</td>
<td>55.4</td>
<td>61.3</td>
<td>64.2</td>
<td>60.8</td>
</tr>
<tr>
<td>Single</td>
<td>No :</td>
<td>23</td>
<td>54</td>
<td>24</td>
<td>83</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td>% :</td>
<td>42.6</td>
<td>44.6</td>
<td>38.7</td>
<td>35.8</td>
<td>39.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>54</td>
<td>121</td>
<td>62</td>
<td>232</td>
<td>469</td>
</tr>
</tbody>
</table>

There is no evidence of association between employing authority and the civil state of health visitors.

The data shows that 60.8% of the health visitors were married and many were of child-bearing age; it would appear that employing authorities might be affected by breaks in service for pregnancy and raising a family, or, having returned to the service, mothers of young children may have enforced absenteeism when their children fall sick. It may be that this group are less able to work outside the normal 5-day week or in the evenings, time for preparing health education projects has often to be found outside working hours, and it then conflicts with the demands of family life. Even short courses involving additional daily travel may not be practical and
deter all but the most enthusiastic health visitor. It should be remembered that 26 out of the 36 health authorities allowed 100% of their eligible staff to take part in the survey, and therefore the survey data does not represent all the newly qualified staff in the areas under scrutiny.

Question - 7 : Type of training

To distinguish between those who took the post-certificate training and the integrated course.

<table>
<thead>
<tr>
<th>Authority</th>
<th>Post-Certificate Health Visitor Training</th>
<th>Integrated Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs</td>
<td>51</td>
<td>3</td>
</tr>
<tr>
<td>South London Boroughs</td>
<td>117</td>
<td>4</td>
</tr>
<tr>
<td>County Boroughs</td>
<td>61</td>
<td>1</td>
</tr>
<tr>
<td>County Councils</td>
<td>223</td>
<td>9</td>
</tr>
<tr>
<td>TOTAL :</td>
<td>452</td>
<td>17</td>
</tr>
</tbody>
</table>

The majority of the health visitors in the sample took the post-certificate course of training (96.4%) and, from the above table, it would appear that most of the integrated respondents were based either in the London area or County Council establishments. It could be that some of these young women were either attracted by the excitement of city life, yet others returned to work in their home counties.

There were some 8 integrated and degree courses with a health visiting option in the country of which 6 were in the London area, and the remainder at Manchester and Newcastle.
In comparison there were 44 post-certificate training courses in 1971. (See page 236).

As a consequence most integrated students have to leave home to train. The post-certificate health visitor student has a wider choice of training schools and in many instances is able to study at a centre within daily travelling distance of her own home.

Question - 9 : Year of qualification

The number and percentage of health visitors by employing authority and the year in which they qualified.

<table>
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<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No :</td>
<td>4</td>
<td>6</td>
<td>21</td>
<td>23</td>
<td>54</td>
</tr>
<tr>
<td>% :</td>
<td>0.8</td>
<td>1.3</td>
<td>4.5</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>South London Boroughs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No :</td>
<td>16</td>
<td>28</td>
<td>27</td>
<td>50</td>
<td>121</td>
</tr>
<tr>
<td>% :</td>
<td>3.4</td>
<td>6.0</td>
<td>5.8</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>County Boroughs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No :</td>
<td>14</td>
<td>14</td>
<td>18</td>
<td>16</td>
<td>62</td>
</tr>
<tr>
<td>% :</td>
<td>3.0</td>
<td>3.0</td>
<td>3.8</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>County Councils</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No :</td>
<td>34</td>
<td>63</td>
<td>66</td>
<td>69</td>
<td>232</td>
</tr>
<tr>
<td>% :</td>
<td>7.2</td>
<td>13.4</td>
<td>14.1</td>
<td>14.9</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>68</td>
<td>111</td>
<td>131</td>
<td>159</td>
<td>469</td>
</tr>
</tbody>
</table>

\[ X^2 = 18.9213 \]
\[ P = \lt 0.05 \]
The table shows an increase in the total number of participants who qualified in each of the 4 years under review, the highest total being for 1971. The slightly significant difference ($P < 0.05$) may reflect the policy of the Council for the Education and Training of Health Visitors to increase the intake of candidates for training over the decade.

**Question - 11 : Midwifery qualification/experience**

To show the spread of midwifery qualifications or experience amongst health visitors in the local health authorities.

**Table - 41**

<table>
<thead>
<tr>
<th>Authority</th>
<th>S.O.M.</th>
<th>CMB</th>
<th>Pre-Obstetric</th>
<th>Post-Obstetric</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs (N = 54)</td>
<td>24</td>
<td>11</td>
<td>13</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>South London Boroughs (N = 121)</td>
<td>47</td>
<td>33</td>
<td>21</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>County Boroughs (N = 62)</td>
<td>32</td>
<td>17</td>
<td>4</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>County Councils (N = 232)</td>
<td>106</td>
<td>44</td>
<td>32</td>
<td>50</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL :</strong></td>
<td>209</td>
<td>105</td>
<td>70</td>
<td>83</td>
<td>2</td>
</tr>
</tbody>
</table>

In all four regions more than half of the survey population were either State Certified Midwives or had the Part I Certificate of the Central Midwives' Board. Of the remainder, three areas employed health visitors with only obstetric experience in the ratio of 1 : 1.8 - 1.9 while the County Boroughs employed them in the ratio of 1 : 3.8.

Statistical analysis of these figures show that when the four regions are compared there is no significant difference ($P < 0.25$) in midwifery qualification or obstetric experience. All health visitors are
required to have either a midwifery qualification or have taken a 3 month course in obstetric nursing, this is a pre-requisite for health visitor training. The only exception has been in the training of male health visiting officers.

However there was some variation in the County Boroughs and County Councils between the number of health visitors having midwifery qualifications: in the County Councils 64.6% of the 232 health visitors in the survey had a midwifery qualification, this could have been accounted for by the fact that 64.22% of the staff were married so may have only had the minimum requirement for entry into health visiting, that is obstetric experience. However in the County Boroughs, although 61% of the staff were married, 79% had a midwifery qualification. It could be that opportunities for midwifery training were available in those boroughs so that even married nurses found it possible to take this qualifying training.

**Question - 12 : Type of area**

The number and percentage of health visitors employed by local health authorities with the type of work area.*

<table>
<thead>
<tr>
<th>Authority</th>
<th>Geographical</th>
<th>Practice</th>
<th>Combined</th>
<th>Other</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No :</td>
<td>39</td>
<td>7</td>
<td>8</td>
<td>-</td>
<td>54</td>
</tr>
<tr>
<td>% :</td>
<td>8.3</td>
<td>1.5</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South London Boroughs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No :</td>
<td>80</td>
<td>20</td>
<td>21</td>
<td>-</td>
<td>121</td>
</tr>
<tr>
<td>% :</td>
<td>17.1</td>
<td>4.3</td>
<td>4.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Boroughs No :</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% :</td>
<td>4.0</td>
<td>4.7</td>
<td>3.4</td>
<td>1.1</td>
<td>62</td>
</tr>
<tr>
<td>County Councils No :</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% :</td>
<td>6.6</td>
<td>50.5</td>
<td>10.7</td>
<td>1.7</td>
<td>232</td>
</tr>
<tr>
<td>TOTAL</td>
<td>169</td>
<td>192</td>
<td>95</td>
<td>13</td>
<td>469</td>
</tr>
</tbody>
</table>

* working definition page 243
Analysis of these figures shows that the differences between the four regions were highly significant ($P < 0.001$). Group Practice attachment schemes were well advanced in County Council establishments with a total of 143 health visitors in full attachment; a further 50 in a combination of Group Practice liaison plus work in a geographical area; and only 39 working either in a geographical area or involved in other work - see Table 42. This reflects the policies of these local health authorities where only two were engaged in partial attachment schemes and the remaining eight had a 50% or more involvement with General Practitioners. (See Table 43).

The data revealed that a greater proportion of health visitors working in County Councils were observed to be attached to group practice than in the other areas. One reason may be that the nursing officers and medical officers of health within these local health authorities were able to implement plans to set up primary health care teams.* The fact that 66.8% of the health visitors surveyed and employed by County Council authorities were working within a rural, or combined rural/urban area may have facilitated the move towards the total attachment of staff. The number of general practitioners may have been relatively lower than those working in urban areas and their registered patients would have covered a much wider catchment area. It could be the policy to place newly qualified members of staff into either attachment or less formal association with general medical practice, their training under the new syllabus should have prepared health visitors for this type of work. It is essential to place enthusiastic staff in a situation which stretches them professionally before their motivation and perception of health needs become restricted, with the subsequent narrowing of their interpretation of the health visitor's role and function. Health visitors with a lively awareness of the importance of their contribution to the primary health care team can act as catalysts amongst the other community nurse members. Many general practitioners are already participating in the development of primary health care teams, others are still nervous of losing their independence and the increase in work through referrals from team members, and some regret the disappearance of the single practice.

* working definition page 269
Conversely, in Greater London, more health visitors participating in the survey were still working in geographical areas than in group practice attachment. Many general practitioners in the metropolis still work in isolation and surgery facilities are limited so that there is no room to accommodate extra staff; under these conditions health visitors may be given responsibility for the doctor's patients, she will work from a local authority office or clinic holding her well-baby clinics and other sessions in premises away from the surgery and arrange to meet the G.P. only infrequently, about once a week, to discuss matters. This working arrangement is called "liaison". Some G.P's. do not wish to work with health visitors, in these instances staff are often allocated to work with the families who are registered with certain G.P's., but there is little contact between the doctors and the health visitor. This method is called "alignment" and is a means whereby the framework for the service is uniform within a given local authority. Job satisfaction for the health visitor is limited as is the value of the service to the patients, with the exception of mothers and children for whom the health visitor has a statutory duty to visit.

In the County Boroughs the observed frequency for group practice attachment is higher than other methods of working, while some health visitors are either providing a specific service or working within an unusual framework (defined as "other" in the data); for example in one County Borough a health visitor was wholly engaged in health education while another specialised in tuberculosis visiting, in another area staff were responsible for liaison with the local hospitals.
To show the state of general practice attachment* in participating areas on December 31st, 1971
(Appendix - B )

Table - 43

<table>
<thead>
<tr>
<th>Authority</th>
<th>None</th>
<th>Partial</th>
<th>About 50%</th>
<th>60-79%</th>
<th>80-99%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs (9)</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>South London Boroughs (9)</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Boroughs (8)</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>County Councils (10)</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>3</td>
<td>15</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

In addition to the survey carried out amongst the health visitors, nursing officers were also circulated with a brief questionnaire relating to their policy regarding: -

a. establishment,
b. health education, and
c. group practice attachment schemes. (see Appendix B)

Table 43 sets out the state of group practice attachment schemes in progress on 31st December, 1971. Among the local health authorities concerned it is evident that attachment schemes were more advanced outside the London area. While only one London Borough had an 100% attachment (in North London), two County Boroughs and two Councils also had 100%. In addition the County Boroughs and County Councils between them had a total of seven authorities with a 60% or more attachment, and a further

* working definition page 243
two with about 50% in force. In contrast to this there were four London Boroughs with a 50% attachment scheme and eleven in a partial state.

Three areas had no attachment schemes working at that time, they were in the North and South London Boroughs and one County Borough respectively. Many general practitioners in the London area still work in isolation and some still use lock-up shops. It is neither practical nor physically possible to attach health visitors to these doctors even if they asked for this. However with the advent of new health centres and the reorganisation of the National Health Service in 1974, general practitioners may increasingly be drawn into teams based on purpose built centres providing care for the community. Here health visitors and other community nurses will become attached to groups of doctors although it is debatable whether full 100% attachment schemes will ever be a reality or even feasible in some areas. A popular name for this concept is that of "the primary health care team".

Question - 13 : Type of locality

To relate employment by local health authorities with the type of locality within which the health visitors were working.*

<table>
<thead>
<tr>
<th>Authority</th>
<th>Urban</th>
<th>Rural</th>
<th>Combined Urban and Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs (N = 54)</td>
<td>53</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>South London Boroughs (N = 121)</td>
<td>115</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>County Boroughs (N = 62)</td>
<td>58</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>County Councils (N = 232)</td>
<td>77</td>
<td>63</td>
<td>92</td>
</tr>
<tr>
<td>TOTAL :</td>
<td>303</td>
<td>64</td>
<td>102</td>
</tr>
</tbody>
</table>

* working definition page 246

- 269 -
The table on page 269 shows that many of the participants were working in urban areas (303), some worked in a combination of both urban and rural areas (102) while of the remaining 64 who worked in rural areas, only one health visitor was employed by a South London Borough and the majority worked for County Councils.

The ratio of health visitors working in these three types of locality was 6.5 health visitors in urban areas, to 2.2 health visitors in combined localities, and to 1.4 health visitors in rural areas.

The problems related to working in some rural areas have been graphically described in some of the comments appended to the completed surveys. Describing her area, one health visitor stated that she was responsible for eleven villages with populations ranging from 255 to approximately 1,555. Another told how difficult it was for the scattered population to get public transport to reach essential hospital services. Yet a third pointed out that because she lived in a large village the inhabitants kept her busy by calling on her for advice as alternative sources of help were sited in the nearest town a considerable journey away.

Other comments made by health visitors working in rural areas showed that it was not so much the scattered population and the rigours of travelling as the quality of support given to staff that either sustained or reduced their motivation for health education. One respondent wrote:

"I feel that in some areas (e.g. this area) there is too little liaison and co-operation between health visitors and the County Health Education Officer........."
In asking for some definite policy regarding the health visitor and her function as a health educator, she continued,

"it varies very much from area to area, and those of us who feel that our future lies in the field of education and prevention become confused by the lack of any cohesive policy ...."

In contrast, another health visitor gave a very positive contribution from which it was obvious that she had the support and encouragement of her colleagues and senior nursing staff:

"I consider the amount of health education done in ' ' by the health visitors is above average. This is only achieved by a weekly liaison meeting when all matters are discussed and teaching methods and new information exchanged. Although we are all "attached" we feel that this liaison is essential in order to produce good results. Apart from the liaison with the Maternity Hospital, we work as an independent group, and have always had complete support from our Area Nursing Officer with regard to teaching policy."

Question - 14

<table>
<thead>
<tr>
<th>Post Certificate</th>
<th>EMPLOYING AUTHORITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>North</td>
</tr>
<tr>
<td>Training</td>
<td>London</td>
</tr>
<tr>
<td>Yes No</td>
<td>19</td>
</tr>
<tr>
<td>%</td>
<td>35.2</td>
</tr>
<tr>
<td>No No</td>
<td>35</td>
</tr>
<tr>
<td>%</td>
<td>64.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>54</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 12.752 \text{ with 3 d.f.} \]

\[ 0.005 \leq P \leq 0.01 \]
Almost 1 in 3 of the health visitors from the North London Boroughs had attended a post-certificate training course associated with health education; 1 in 5 from the Southern areas had done so; 1 in 6 of the health visitors from the County Councils and only 1 in 9 had received this training in the County Boroughs.

Analysis of the figures gave a significant degree of difference (0.005 < P < 0.01). More detailed analysis of the data revealed that in the North London Boroughs 35.2% of the health visitors had received post-certificate training, 19.8% in the South London Boroughs and 16.8% in the County Councils. It may be that the policies of these respective areas towards health education is reflected in these results. (See Table 56, page 290).

Another factor may be the many training facilities provided by professional organisations and educational institutions within Greater London. These are used by all the 32 London Boroughs. County Councils employing staff in greater numbers may also have larger budgets and so be able to allocate funds for post-certificate training. The larger the establishment the easier it is to spare staff for additional training and provide relief staff to maintain essential work. The relatively smaller establishments and budgets of the County Boroughs may have influenced their policies towards health education training and this might account for only 1 in 9 of their health visitors attending post-certificate courses.

Question - 15 : The desire to undertake group health education

It is to be hoped that, health visitors training under the revised syllabus are prepared to accept group health education as an important part of their work. The Jameson Report referred to health visitors as health
educators and social advisors; although health education was considered primarily in the context of practical advice to individuals, those health visitors "with special aptitude" were to extend their range to include groups in schools and the community. 85% expressed the desire to teach groups and would appear to indicate that their training has been a positive experience. Other factors could be the support and encouragement given to new members of staff by senior nursing officers and health education officers.

The desire to undertake health education in groups

<table>
<thead>
<tr>
<th>Authority</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs (N = 54)</td>
<td>50</td>
<td>4</td>
</tr>
<tr>
<td>South London Boroughs (N = 121)</td>
<td>98</td>
<td>23</td>
</tr>
<tr>
<td>County Boroughs (N = 62)</td>
<td>53</td>
<td>9</td>
</tr>
<tr>
<td>County Councils (N = 232)</td>
<td>196</td>
<td>36</td>
</tr>
<tr>
<td>TOTAL :</td>
<td>397</td>
<td>72</td>
</tr>
</tbody>
</table>

Nearly 85% of the health visitors expressed the desire to undertake health education in groups. From the above table it can be seen that of the 54 health visitors working in the North London Boroughs, only 4 did not wish to be involved in group health education, whereas in the Southern Region 23 health visitors were not in favour compared with 98 who did; those in the County Boroughs not wishing to run groups numbered 9 out of a possible 62, and out of the 232 working in County Councils, only 36 had no wish to participate.

However analysis of the data showed that there was a slightly significant difference (P < 0.025).
It can be seen that 92.6% of the health visitors in the survey employed by the North London Boroughs wanted to undertake health education. One reason for this could be that, with a response rate to the questionnaire of 86.2%, most of the replies came from those who enjoyed group teaching, another could be that one of the criteria for selection by the employing authority was the candidates motivation for group health education. Table 45 shows that 1 in 5 of the respondents had already attended a post-certificate course in health education. 85.5% of the health visitors employed by County Boroughs, compared with 84.5% of those working in County Councils, wanted to undertake group teaching.

However in the South London Boroughs, with a response rate to the survey of 99.2%, only 81% expressed the desire to perform this function: one reason could be that these health visitors did not feel confident of their teaching ability or perhaps they were more interested in the social content of their work than in group teaching. It should be remembered that the North London respondents represented only 5.8% of the total staff establishment whereas the proportion in South London was 29.9%. It is possible that more pressure was placed on the latter group to teach before they felt able to cope and, as a consequence, they did not enjoy the experience. Only 1 in 5 health visitors had attended post-certificate training in health education.

Question 16 : Health education in 1971

The health visitors were asked to indicate the range of health education activities they were engaged in during 1971. The groups included ante-natal classes, parents' groups, work with school children of all ages, and a final group labelled "others".
To show the actual health education sessions carried out by health visitors in the local health authorities in 1971.

<table>
<thead>
<tr>
<th>Health Education Groups</th>
<th>London North (N = 54)</th>
<th>London South (N = 121)</th>
<th>County Boroughs (N = 62)</th>
<th>County Councils (N = 232)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant mothers</td>
<td>35</td>
<td>53</td>
<td>52</td>
<td>164</td>
</tr>
<tr>
<td>Expectant mothers with a fathers' night</td>
<td>14</td>
<td>34</td>
<td>12</td>
<td>68</td>
</tr>
<tr>
<td>Expectant parents</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Parents' groups</td>
<td>7</td>
<td>37</td>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>infant</td>
<td>3</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Schools ... junior</td>
<td>7</td>
<td>16</td>
<td>4</td>
<td>52</td>
</tr>
<tr>
<td>Other</td>
<td>32</td>
<td>28</td>
<td>24</td>
<td>99</td>
</tr>
<tr>
<td>College of further education</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>None (a)</td>
<td>7</td>
<td>16</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>TOTAL : *</td>
<td>130</td>
<td>221</td>
<td>136</td>
<td>585</td>
</tr>
</tbody>
</table>

a. These figures are not included in the totals

* Columns do not add up to 100% as a health visitor may have been associated with one or more groups during the year.

Health visitors were involved in all areas of group health education in 1971. In all employing authorities the highest numbers related to work solely with expectant mothers, followed by classes in secondary schools and, thirdly, with sessions for expectant mothers incorporating a fathers' night (with the exception of the County Boroughs in the latter instance). See Table 47.
Number and percentage of health education classes run by health visitors in 1971 by employing authority.

<table>
<thead>
<tr>
<th>Type of Health Education</th>
<th>North London</th>
<th>South London</th>
<th>County Boroughs</th>
<th>County Councils</th>
<th>TOTAL</th>
<th>$\chi^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant Mothers</td>
<td>No: 35</td>
<td>53</td>
<td>52</td>
<td>164</td>
<td>304</td>
<td>36.8135</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>%: 64.8</td>
<td>43.8</td>
<td>85.9</td>
<td>70.7</td>
<td>64.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Fathers' Night</td>
<td>No: 14</td>
<td>34</td>
<td>12</td>
<td>68</td>
<td>128</td>
<td>2.5351</td>
<td>0.500</td>
</tr>
<tr>
<td></td>
<td>%: 25.9</td>
<td>28.1</td>
<td>19.4</td>
<td>29.3</td>
<td>27.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectant Parents</td>
<td>No: 6</td>
<td>1</td>
<td>4</td>
<td>14</td>
<td>25</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%: 11.1</td>
<td>0.8</td>
<td>6.5</td>
<td>6.0</td>
<td>5.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>No: 7</td>
<td>37</td>
<td>4</td>
<td>36</td>
<td>84</td>
<td>20.5471</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>%: 13.0</td>
<td>30.6</td>
<td>6.5</td>
<td>15.5</td>
<td>17.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant Schools</td>
<td>No: 3</td>
<td>10</td>
<td>9</td>
<td>38</td>
<td>60</td>
<td>7.5991</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>%: 5.6</td>
<td>8.3</td>
<td>14.5</td>
<td>16.4</td>
<td>12.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Schools</td>
<td>No: 7</td>
<td>16</td>
<td>4</td>
<td>52</td>
<td>79</td>
<td>11.6321</td>
<td>0.010</td>
</tr>
<tr>
<td></td>
<td>%: 13.0</td>
<td>13.2</td>
<td>6.5</td>
<td>22.4</td>
<td>16.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Schools</td>
<td>No: 25</td>
<td>34</td>
<td>25</td>
<td>105</td>
<td>189</td>
<td>11.0673</td>
<td>0.025</td>
</tr>
<tr>
<td></td>
<td>%: 46.3</td>
<td>28.1</td>
<td>40.3</td>
<td>45.2</td>
<td>40.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further Education</td>
<td>No: 1</td>
<td>8</td>
<td>2</td>
<td>9</td>
<td>20</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%: 1.9</td>
<td>6.6</td>
<td>3.2</td>
<td>3.9</td>
<td>4.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No: 32</td>
<td>28</td>
<td>24</td>
<td>99</td>
<td>183</td>
<td>23.4195</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>%: 59.3</td>
<td>23.1</td>
<td>38.7</td>
<td>42.7</td>
<td>39.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Types</td>
<td>No: 47</td>
<td>105</td>
<td>59</td>
<td>212</td>
<td>423</td>
<td>4.3034</td>
<td>0.250</td>
</tr>
<tr>
<td></td>
<td>%: 87.0</td>
<td>86.8</td>
<td>95.2</td>
<td>91.4</td>
<td>90.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL NUMBER OF HEALTH VISITORS</td>
<td>54</td>
<td>121</td>
<td>62</td>
<td>232</td>
<td>469</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Marginal totals are too small for $\chi^2$ tests to be reliable.
Analysis of the data reveals that there is evidence of association between the employing authority and health education for expectant mothers, and parents, education in primary and secondary schools, and 'other' types of health education. There is also evidence of association with infant schools.

For example, most health visitors carrying out 'other' health education sessions are employed by County Councils, but a considerably smaller proportion of health visitors not carrying out 'other' sessions are employed by County Boroughs and a larger proportion by South London. A more detailed analysis of these figures can be found on pages 294 to 328.

Question - 17 : Realisation of need

Realisation of the need for health education in the local health authorities.

<table>
<thead>
<tr>
<th>Authority</th>
<th>Recognition of need by Health Visitors</th>
<th>Direction by Nursing Officers</th>
<th>Number of Health Visitors Practising Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs (N=54)</td>
<td>18</td>
<td>38</td>
<td>47</td>
</tr>
<tr>
<td>South London Boroughs (N=121)</td>
<td>37</td>
<td>80</td>
<td>105</td>
</tr>
<tr>
<td>County Boroughs (N=62)</td>
<td>19</td>
<td>46</td>
<td>59</td>
</tr>
<tr>
<td>County Councils (N=232)</td>
<td>94</td>
<td>158</td>
<td>212</td>
</tr>
<tr>
<td>TOTAL</td>
<td>168 (a)</td>
<td>322 (b)</td>
<td>423</td>
</tr>
</tbody>
</table>

(a) and (b) - Figures add up to over 100% owing to overlap.

There was no evidence of any statistically significant difference between health visitors who recognised need and those who did not. Eighteen of the 47 health visitors practising health education in North London stated that they realised the need for group health education, whereas in a further 38 instances they were directed. Nine health
visitors both recognised the need and also were directed by their nursing officers. In South London the ratio was 37 : 80 amongst the 105 health visitors actively involved and there were 12 instances of overlap. Of the 59 practising staff in the County Boroughs, the ratio was 19 : 46, and, 94 : 158 amongst the 212 health visitors working in County Council establishments, the overlap being 6 and 40 respectively.

The results could indicate that under the new management structure nursing officers are taking an increasing part in identifying the needs of an area and instigating new schemes of health education as well as maintaining those schemes of proven value.

The wording of the questionnaire did not enable the respondents to show whether their realisation of need resulted in the setting up of new groups, or even of instances where the needs of an area remained unmet because of lack of suitable facilities or failure to persuade local health authorities of the value of such work. The importance of the health visitor's role in identifying unmet health needs and her ability to mobilise help in instituting action would appear to merit further investigation particularly in the context of primary prevention. While the amount of health education in relation to secondary prevention is sometimes linked to the policy of the local health authority and the provision of hospital services, for example, cervical cytology or mass x-ray, tertiary prevention in the realms of care and after-care again can be identified so that together with other members of the primary care team, schemes of health education to meet the needs of particular groups could be set up. With the growth of group practice attachment the area of the health visitor's role as health educator in tertiary prevention would also merit further investigation.
Number and percentage of health visitors who would choose to carry out health education by employing authority.

<table>
<thead>
<tr>
<th>Type of Health Education</th>
<th>North London</th>
<th>South London</th>
<th>County Boroughs</th>
<th>County Councils</th>
<th>TOTAL</th>
<th>$X^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant Mothers</td>
<td>No: 21</td>
<td>40</td>
<td>24</td>
<td>112</td>
<td>197</td>
<td>8.2128</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td>% : 38.9</td>
<td>33.1</td>
<td>38.7</td>
<td>48.3</td>
<td>42.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Fathers' Night</td>
<td>No: 13</td>
<td>37</td>
<td>14</td>
<td>64</td>
<td>128</td>
<td>1.6441</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td>% : 24.1</td>
<td>30.6</td>
<td>22.6</td>
<td>27.6</td>
<td>27.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectant Parents</td>
<td>No: 15</td>
<td>28</td>
<td>14</td>
<td>48</td>
<td>105</td>
<td>1.3288</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td>% : 27.8</td>
<td>23.1</td>
<td>22.6</td>
<td>20.7</td>
<td>22.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>No: 6</td>
<td>22</td>
<td>5</td>
<td>35</td>
<td>68</td>
<td>3.9590</td>
<td>0.50</td>
</tr>
<tr>
<td></td>
<td>% : 11.1</td>
<td>18.2</td>
<td>8.1</td>
<td>15.1</td>
<td>14.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant Schools</td>
<td>No: 11</td>
<td>20</td>
<td>7</td>
<td>44</td>
<td>82</td>
<td>2.3899</td>
<td>0.50</td>
</tr>
<tr>
<td></td>
<td>% : 20.4</td>
<td>16.5</td>
<td>11.3</td>
<td>19.0</td>
<td>17.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Schools</td>
<td>No: 10</td>
<td>26</td>
<td>17</td>
<td>59</td>
<td>112</td>
<td>1.9692</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td>% : 18.5</td>
<td>21.5</td>
<td>27.4</td>
<td>25.4</td>
<td>23.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Schools</td>
<td>No: 16</td>
<td>35</td>
<td>25</td>
<td>39</td>
<td>115</td>
<td>17.8493</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>% : 29.6</td>
<td>28.9</td>
<td>40.3</td>
<td>16.8</td>
<td>24.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further Education</td>
<td>No: 8</td>
<td>10</td>
<td>3</td>
<td>21</td>
<td>42</td>
<td>3.6440</td>
<td>0.50</td>
</tr>
<tr>
<td></td>
<td>% : 14.8</td>
<td>8.3</td>
<td>4.8</td>
<td>9.0</td>
<td>8.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No: 5</td>
<td>3</td>
<td>5</td>
<td>18</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% : 9.3</td>
<td>2.5</td>
<td>8.1</td>
<td>7.8</td>
<td>6.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Types</td>
<td>No: 50</td>
<td>112</td>
<td>57</td>
<td>215</td>
<td>434</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% : 92.6</td>
<td>92.6</td>
<td>91.9</td>
<td>92.7</td>
<td>92.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL NUMBER OF HEALTH VISITORS  

* Marginal Totals are too small (or large) for $X^2$ tests to be reliable.
Health visitors were asked to indicate their choice of health education if afforded the opportunity. The data reveals that there is evidence of association between the employing authority and choice of health education for expectant mothers. Health visitors choosing this type of health education tend to be employed slightly more by County Councils and less by South London. It may be that health visitors working in rural areas not only recognise the needs of the scattered population but also the difficulties for mothers who have to travel long distances to attend classes in maternity units. 66.8% of the staff in the survey work in rural or semi-rural areas and, of these, 40.6% work solely in rural areas. The provision of classes within a reasonable distance for these mothers may entail a higher degree of organisation from health visitors working in rural areas in order to meet the demand, and it is apparent this group is a popular choice amongst the survey population (48.3%).

In the South London Boroughs only 40 choices were made (33.1%), it may be that the concentration of teaching hospitals and midwifery training schools in the region filters of a considerable proportion of clients. Another reason could be that many health visitors enjoy this work and so those who have been longer in post are also running ante-natal classes, or the falling birth rate may have affected the demand for classes.

When given a free choice over the type of group or groups the health visitor would prefer to teach it becomes apparent that she is prepared to meet a variety of needs amongst her clients. However only 35 health visitors stated that they would not be prepared to run group health education, a decrease of 11 from those not involved with classes in 1971.

A further detailed analysis was made of the data in tables 40, 41, 48 and 50. However no significant difference was revealed.
To compare the actual health education activities run by health visitors with those they would give if afforded the opportunity.

<table>
<thead>
<tr>
<th>Type of Health Education</th>
<th>North London</th>
<th>South London</th>
<th>County Boroughs</th>
<th>County Councils</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Choice</td>
<td>Actual</td>
<td>Choice</td>
</tr>
<tr>
<td>Expectant mothers</td>
<td>35</td>
<td>21</td>
<td>53</td>
<td>40</td>
</tr>
<tr>
<td>Expectant mothers with a fathers' night</td>
<td>14</td>
<td>13</td>
<td>34</td>
<td>37</td>
</tr>
<tr>
<td>Expectant parents</td>
<td>6</td>
<td>15</td>
<td>1</td>
<td>28</td>
</tr>
<tr>
<td>Parents' groups</td>
<td>7</td>
<td>6</td>
<td>37</td>
<td>22</td>
</tr>
<tr>
<td>infant</td>
<td>3</td>
<td>11</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>junior</td>
<td>7</td>
<td>10</td>
<td>16</td>
<td>26</td>
</tr>
<tr>
<td>Schools ... senior</td>
<td>25</td>
<td>16</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>further education</td>
<td>1</td>
<td>8</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>32</td>
<td>5</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>None *</td>
<td>7</td>
<td>4</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>TOTAL (excluding *)</td>
<td>130</td>
<td>105</td>
<td>221</td>
<td>221</td>
</tr>
</tbody>
</table>
In all types of local health authority only 197 would choose to teach expectant mothers compared with 304 involved in this work in the year under investigation. The figure for running groups for expectant mothers with a fathers' night remained constant but there was an increase from 25 health visitors running groups for expectant parents to 105 who indicated a preference for this type of work. So it would appear that the health visitor trained under the new syllabus is prepared to recognise the husbands' role in childbirth.

Work with parents' groups showed that in the London area 16 health visitors were running these groups but would not do so from choice. In the County Boroughs one additional health visitor said that she would like to do this work, but this was counter-balanced in the County Council regions by one dissident voice.

In the schools, London health visitors and those employed by the County Councils appeared to want to become more involved in infant schools than they were at the time of the survey, but their colleagues in the County Boroughs took the opposite view. At the junior school level more health visitors in all four regions intimated that they would like to do this work:

"In my present situation I can see there could be opportunities for health education in my 2 primary schools .... as on-going projects in conjunction with the teachers."

For those involved in work in secondary schools the observed results indicated that fewer staff employed in the North London Boroughs and the County Councils would wish to teach if given a choice. One reason for this could be the tradition of teaching health subjects only to "D" stream pupils while the other streams studied for their C.S.E. or 'O' Level examinations. With the raising of the school leaving age many of these pupils have yet another year in school which is not of their choosing.
While health visitors have the knowledge many would agree that they do not have the expertise to teach this particular age group and maintain a degree of class control. One North London health visitor wrote of inadequate preparation "to prepare one to face a hostile school group, where class discipline is often an enormous problem."

The problem peculiar to London is the grave shortage of teachers resulting in inadequate pupil-teacher ratios, and the lack of stability caused by frequent changes of staff. In addition many areas have a very high immigrant population and although the children learn to speak English quite fluently the mixture of ethnic groups with different cultural and religious backgrounds can provide a daunting task for even the most highly trained school teacher.

What are the criteria for selecting staff to teach in schools? Comments received from those engaged in the survey would seem to indicate that in some instances the selection of staff is of little importance, for example one health visitor observed :-

"There appears to be a lamentable lack of insight in some Health Education Officers who persuade young and inexperienced health visitors to undertake health teaching in schools when they have little aptitude and no inclination to do so."

Does the answer rest in post-certificate courses in teaching techniques with emphasis on observation and supervised practise?

"In-service training on teaching techniques and assessment of achievements would perhaps be helpful."

suggested one health visitor, but another stated :-

"I feel strongly from experience that health education in schools should be done by the school teacher. I do not find the in-service training for teaching in schools helpful or the suggested methods workable."
"Perhaps the best approach is to collaborate with the teachers."

"I am shortly to be involved in a slimming class at the local girls' secondary modern school together with the P.E. Mistress and Domestic Science teacher."

Forty-two health visitors showed an interest in teaching in colleges of further education as opposed to the 20 who were actually involved in this work, but only 10 health visitors held a recognised certificate enabling them to qualify as a teacher for this purpose. (See Table 26, page 224). This group should be a natural extension for the health visitor who is already teaching adult groups in the community. However, preparation for teaching in colleges of education is much criticised by teachers, many of whom feel that they were not adequately prepared for the task of controlling and teaching a large group of reluctant learners.

Only 43 health visitors gave a preference to teach in the "other" category although 183 actual sessions had been run by 112 participants during 1971. One reason could be that the training did encourage students to assess the needs of their neighbourhood and identify target groups who would benefit from group health education. Alternatively this experience in the field, perhaps in many instances for one session only, may have been unrewarding in terms of the amount of feedback in relation to the time and energy invested in the exercise. As stated previously these sessions demand a different kind of competence from that needed by a health visitor in an on-going group. In some instances however, work with "other" groups would mean a series of 8-10 lectures plus practical work, for example with Red Cross or other voluntary societies. The demands of these groups with a wide age range and varying levels of ability present a challenge to the health visitor who has already worked an 8-hour day for her employing authority.
One health visitor suggested that there should be:

"One health visitor per area specialising in teaching so having time for preparation rather than fitting it in with many other things, and many health visitors teaching without enjoying it."

The sum of the totals for comparison are set out below:

**Question - 16/18**

To show comparison between the total figures for:

a. Range of actual work with groups in 1971
b. Choice of health education

<table>
<thead>
<tr>
<th></th>
<th>North London</th>
<th>South London</th>
<th>County Boroughs</th>
<th>County Councils</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTALS (actual)</td>
<td>(54)</td>
<td>(121)</td>
<td>(62)</td>
<td>(232)</td>
</tr>
<tr>
<td></td>
<td>130</td>
<td>221</td>
<td>136</td>
<td>585</td>
</tr>
<tr>
<td>TOTALS (choice)</td>
<td>105</td>
<td>221</td>
<td>114</td>
<td>440</td>
</tr>
</tbody>
</table>

To show non-participants in:

a. Classes held in 1971
b. If given, a choice of classes

<table>
<thead>
<tr>
<th></th>
<th>North London</th>
<th>South London</th>
<th>County Boroughs</th>
<th>County Councils</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTALS (actual)</td>
<td>(54)</td>
<td>(121)</td>
<td>(62)</td>
<td>(232)</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>16</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>TOTALS (choice)</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>17</td>
</tr>
</tbody>
</table>

In the London area only 152 health visitors were actually involved in group health education in 1971, whereas 162 indicated a preference for this work; similarly in the County Councils only 212 were involved but 215 said that they would be prepared to do this work. However in the County Boroughs two more than the number of health visitors who indicated a willingness for this work were actually organising health education groups.
The Jameson Report recognised that not all health visitors would have an aptitude for group health education and suggested that those who did should be encouraged. But the dilemma of those who do not wish to participate in group health education is cogently expressed by one health visitor:

"I feel I should be more interested and involved in health education; but unfortunately, I do not enjoy the task."

She continued:

"I also feel it is wrong to 'push' health visitors into health education talks if they do not enjoy the work. Surely, more harm can result if the speaker dislikes the work and is unable to put over her message. I believe the job should be left to those who are eager to do this type of work, and that they should also undergo specialised training. There should be greater backing by the administrative officers, with easy access to education materials, visual aids, etc."

Question - 19: Responsibility for sessions

To show the degree of responsibility for the planning and organisation of classes held in 1971.

<table>
<thead>
<tr>
<th>Authority</th>
<th>Responsibility</th>
<th>Help From:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sole</td>
<td>Shared (a)</td>
<td>Nursing Officer</td>
<td>H.Education Officer</td>
</tr>
<tr>
<td>North London Boroughs (N = 54)</td>
<td>35</td>
<td>1</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>South London Boroughs (N = 121)</td>
<td>71</td>
<td>2</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>County Boroughs (N = 62)</td>
<td>39</td>
<td>3</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>County Councils (N = 232)</td>
<td>124</td>
<td>11</td>
<td>.7</td>
<td>44</td>
</tr>
<tr>
<td>TOTAL *</td>
<td>269</td>
<td>17</td>
<td>31</td>
<td>70</td>
</tr>
</tbody>
</table>

* Totals add up to more than 100% as in some instances more than one other member of staff was involved.
In some instances the health visitor was solely responsible for the organisation and planning for one type of group while the same worker had to share the responsibility for the work for a second type of group, e.g. she would be in sole charge for ante-natal work but share the responsibility for school health education with the head teacher.

It can be seen that in all four regions over half the health visitors assumed sole responsibility for the planning and organisation of classes held by them. 64.8% of the participants working in the North London Boroughs assumed sole responsibility for the organisation and planning of their work and this reflects the policies of these boroughs where over half of them encourage group health education. (See page 290 Table - 56). 1 in 3 of the respondents had attended a post-certificate course in health education and so would be better prepared for their work. In addition health visitors represent only 5.76% of the total establishment and so would have the support of many more experienced colleagues, for this reason the newly qualified members of staff may be able to teach groups of their choosing and so enjoy their work.

Health visitors by employing authority by responsibility for health education.

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>North London</th>
<th>South London</th>
<th>County Boroughs</th>
<th>County Councils</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sole</td>
<td>36</td>
<td>73</td>
<td>42</td>
<td>135</td>
<td>286</td>
</tr>
<tr>
<td>%</td>
<td>66.7</td>
<td>60.3</td>
<td>67.7</td>
<td>58.2</td>
<td>61.0</td>
</tr>
<tr>
<td>Shared</td>
<td>11</td>
<td>32</td>
<td>17</td>
<td>77</td>
<td>137</td>
</tr>
<tr>
<td>%</td>
<td>20.4</td>
<td>26.4</td>
<td>27.4</td>
<td>33.2</td>
<td>29.2</td>
</tr>
<tr>
<td>None</td>
<td>7</td>
<td>16</td>
<td>3</td>
<td>20</td>
<td>46</td>
</tr>
<tr>
<td>%</td>
<td>13.0</td>
<td>13.2</td>
<td>4.8</td>
<td>8.6</td>
<td>9.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>54</td>
<td>121</td>
<td>62</td>
<td>232</td>
<td>469</td>
</tr>
</tbody>
</table>

\[ x^2 = 8.0239 \text{ with 6 d.f.} \]

\[ 0.10 < P < 0.25 \]
There is no evidence of any association between the employing authorities and health visitors assuming responsibility for health education. However the figures reveal that in North London 66.7% of the health visitors assumed sole responsibility for health education and 20.4% shared it with other workers. This reflects the policies of those boroughs one of whom strongly recommended health education, four encouraged it including giving in-service training, and the remaining four approved but restricted participation.

In the remaining areas, 60.3% and 67.7% of the health visitors retained responsibility for their work in South London and the County Boroughs respectively; and in the County Councils this degree of autonomy was reduced to 58.2% of the participants in the survey. Only 1 in 5 of the health visitors employed by the South London Boroughs had attended post-certificate courses in health education, and the group under scrutiny comprised 29.88% of the total working establishment so the health visitors engaged in group health education might require more help initially until they felt confident to teach groups.

In South London the figures reflect the policies of approval and encouragement advocated by those authorities (see table - 56). However, in one borough the health education officer and her staff were actively involved in teaching. This may have influenced health visitors to concentrate on home visiting, secure in the knowledge that the group teaching would be performed by the health education staff.

In the County Councils the health visitors represented 16.81% of the total establishment, and 1 in 6 had attended post-certificate training: the very size of these areas demands an effective system of communication and support from nursing officers to maintain an efficient functioning of the service, this is reflected in the data.
Only 58.2% of health visitors working in the County Councils assumed sole responsibility for their health education. This could be accounted for by the fact that some staff were engaged in triple duties and probably would not be so free to become involved in fixed sessions. In rural areas it is possible that peer support is lacking; difficulties with transport, time spent in travelling together with the possible lack of space for classes could also account for this result. It does not reflect the policies of the authorities concerned where 6 approved, 3 encouraged and 1 strongly recommended health education.

67.7% of the health visitors employed by County Boroughs said they were responsible for their group sessions, of these only 1 in 9 had attended post-certificate courses. However this group was only 11.3% of the establishment and the amount of support from their experienced colleagues could well help to ease the new health visitors into this aspect of their work.

Although one County Borough had no policy over health education the observed data for these areas revealed a total of 42 health visitors assuming sole responsibility. Only two authorities encouraged health education to the extent of providing further training and the remaining 5 approved a restricted service. It could be that despite restriction the senior staff provided an encouraging climate for their staff to promote group health education. Alternatively because facilities were restricted the health visitors may have accepted the responsibility to teach selected groups and enjoyed the freedom to do so. Table 48 reveals that 95.7% of County Borough health visitors in the survey were practising health education in 1971.

However, the analysis reveals no significant difference $(0.10 < P < 0.25)$. 

- 289 -
To show the health education policy of the local health authorities taking part in the survey. (Appendix B)

<table>
<thead>
<tr>
<th>Authority</th>
<th>No Policy</th>
<th>Approved but Restricted</th>
<th>Encouraged Including Training Given</th>
<th>Strongly Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London Boroughs (9)</td>
<td>-</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>South London Boroughs (9)</td>
<td>-</td>
<td>6</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>County Boroughs (8)</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>County Councils (10)</td>
<td>-</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1</td>
<td>21</td>
<td>12</td>
<td>2</td>
</tr>
</tbody>
</table>

The figures to show the health education policy of the local health authorities were obtained from the questionnaire sent to the nursing officers (see Appendix B). Only in two areas was this work strongly recommended; in a high proportion of instances it was encouraged but restricted, and in one County Borough it appeared that there was no policy regarding health education.
### Location of Ante-Natal Classes:

<table>
<thead>
<tr>
<th>Authority</th>
<th>Local Authority</th>
<th>Health Premises</th>
<th>G.P. Centres</th>
<th>G.P. O/Pat.</th>
<th>Maternity O/Pat.</th>
<th>Maternity Dept.</th>
<th>Hospitals</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>North London</td>
<td>1</td>
<td>25</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Boroughs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South London</td>
<td>5</td>
<td>37</td>
<td>22</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Boroughs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Boroughs</td>
<td>2</td>
<td>25</td>
<td>21</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Councils</td>
<td>20</td>
<td>97</td>
<td>37</td>
<td>11</td>
<td>6</td>
<td>6</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td>28</td>
<td>184</td>
<td>92</td>
<td>20</td>
<td>15</td>
<td>14</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

Health visitors involved in ante-natal classes worked in premises either owned or rented by their employing authorities as opposed to other locations in the proportion of 2.5 : 1. In 20 instances classes were held in G.P. surgeries and a further 28 organised on hospital premises. Church halls were still being used in 28 instances, of these 20 were held in County Council authorities and might pose problems in terms of availability and the need for time, to prepare and clear away all equipment.
To show amount of assistance obtained by health visitors giving ante-natal classes in relation to local health authorities.

<table>
<thead>
<tr>
<th>Assistants</th>
<th>North London Boroughs</th>
<th>South London Boroughs</th>
<th>County Boroughs</th>
<th>County Councils</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors</td>
<td>4</td>
<td>17</td>
<td>7</td>
<td>38</td>
<td>66</td>
</tr>
<tr>
<td>Health visitor student</td>
<td>6</td>
<td>9</td>
<td>4</td>
<td>14</td>
<td>33</td>
</tr>
<tr>
<td>Clinic nurse</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- hospital</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>- domiciliary</td>
<td>19</td>
<td>37</td>
<td>30</td>
<td>119</td>
<td>205</td>
</tr>
<tr>
<td>Pupil midwife</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Part I</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>- Part II</td>
<td>5</td>
<td>7</td>
<td>10</td>
<td>16</td>
<td>38</td>
</tr>
<tr>
<td>Obstetric student nurse</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>6</td>
<td>24</td>
<td>20</td>
<td>41</td>
<td>91</td>
</tr>
<tr>
<td>National Childbirth Trust Teacher</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>15</td>
<td>27</td>
</tr>
<tr>
<td>1/1 (a)</td>
<td>23</td>
<td>64</td>
<td>15</td>
<td>74</td>
<td>176</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>57</strong></td>
<td><strong>101</strong></td>
<td><strong>83</strong></td>
<td><strong>253</strong></td>
<td><strong>484</strong></td>
</tr>
</tbody>
</table>

* Totals do not add up to 100% as one or more assistants may be involved in the same group sessions; excluding (a).
When running ante-natal classes the amount of help received from other workers was variable, this can be seen from Table 58 on the previous page. The results reveal that despite the trend towards hospital confinement many clients are still using facilities offered by local health authorities. In many instances the convenience of the venue together with the more informal and relaxed atmosphere away from the bustle of a hospital maternity department probably provided a climate conducive to learning. Although details of the syllabuses were not requested, in many instances arrangements were made for expectant mothers to make an observation visit to their own maternity unit in preparation for their eventual admission.

In 484 instances help was obtained from other workers, of this 16% came from health visitor colleagues, 42% from domiciliary midwives and only 4% from hospital midwives. The figures from the midwifery service may be accounted for by the heavy demands made upon hospital midwives who have other priorities as opposed to domiciliary midwives whose work load has been considerable reduced in recent years because of the trend for hospital confinements and the falling birth rate. 20% of the assistance came from physiotherapists who would have been concerned with teaching relaxation skills in preparation for the confinement. In her role as a health educator it is to be expected that the health visitor should extend her range of work to include teaching student health visitors and may even share responsibility for providing experience for pupil midwives. In 72 instances students from post-basic nurse training courses assisted health visitors in running ante-natal classes, and in 3 instances student nurses gaining obstetric experience were present at these classes. Of the total 484 sources of assistance, 32% were student health visitors and 39% pupil midwives.
For the purpose of this discussion Zaki's (1958) definition has been adopted:

"Health education aims at promoting the greatest possible fulfilment ... of the body and mind, and the happy adjustment of the individual to society. It is the educational approach to health problems, and as such is concerned with practical measures for the promotion of health and the control and treatment of disease."

The members of the Cohen Committee found it difficult to define the boundaries of health education and regarded it as teaching groups of people primarily where information or instruction is given to promote health. While accepting that the health educator must do more than this, she must try to invoke attitude and behaviour change, the measurement of the effectiveness of the health visitors' teaching is outside the scope of this definitive survey. The members of the Jameson Committee were of the opinion that health education by the health visitor was primarily individual advice whereas group work was only for those with special aptitude.

Participants in the Survey

Five hundred health visitors who qualified between the years 1968-1971 were approached and a total of 469 returned the completed forms in time to be included in the results. Of these 423 health visitors were involved in group health education sessions, 90.2%. Three distinct categories were defined: ante-natal, parents with young children, and students in educational establishments. 71% of the respondents were teaching expectant mothers, 17.9% with parents' groups and 54.6% in the field of education. However the use of only 3 types of groups would not have covered the full range of work undertaken by health visitors and
so a further category was added to include all those sessions held which came outside the scope of the first three. 23.9% of the health visitors were teaching an assortment of over 64 different types of groups in this last category (see Table 28, pages 226 and 227).

The data revealed that 33.47% of the health visitors ran only one group in 1971; one reason for this could be the heavy demands made by other areas of work on their time, another reason could be that health visitors are wary of taking on too much responsibility until they feel confident in their ability to handle the different types of groups. With growing expertise and confidence health visitors may feel disposed to take on additional work; 29.8% of the health visitors ran two groups in the year and 11.9% ran three, a further 8.32% serviced four, while 5.57% were responsible for five groups during the twelve months under survey. Apart from the ante-natal classes the survey does not reveal how much of this work was shared by other colleagues. It is to be hoped that all these health educators were well supported by their peers, nursing administrators and health education officers. As previously stated one can only assume that the bulk of the work was the responsibility of the health visitor concerned, and that the value of the work was recognised if not by additional monetary reward and time for preparation then at least by due recognition of her developing expertise. 1.07% of the respondents stated that they taught six or more groups during the year, perhaps administrators would need to watch that these staff are not imposed upon because of their enthusiasm and willingness to service a variety of groups: Once involved in health education health visitors find that the work tends to snowball and encroach upon their free time. Because of this some will not take it up. Given a highly efficient health education department to provide teaching aids and help in the preparation of suitable material then the health visitor is free to devote more time to teaching than she would otherwise be able to do.
Responsibility for Health Education

Of the 423 health visitors actively engaged in health education 62.8% said that they were solely responsible for the planning and organisation of their classes and, of these, a slightly higher proportion had been in post for 2 or more years. The age and civil state of the health visitors appeared to have no direct relevance. It may be that health visitors qualifying most recently were more closely supervised because of their lack of experience and confidence. As the management structure of the service was improved so more senior staff became available to support and guide members of staff when embarking on new projects. This is possibly reflected in the data :-

Sole responsibility 286

Help from :-
Nursing officer 31
Health education officer 70 - 173
Another 72

In some instances examples of teamwork was cited, for example amongst members of the Primary Health Care Team, hospital midwifery services and interested school teachers. Hanson (1972) describes a scheme of health education by group teaching and discussion in Lincoln. Health visitors visited the County Hospital Maternity Wing to inform the new mothers of local authority services and gave particular emphasis to the family planning service. Two respondents suggested that their work should extend into the hospitals, there the health visitor could interpret to hospital staff the disruption hospitalisation of a patient can cause in a family; should the health visitor work in a group practice then she could also provide anticipatory guidance for the patient and his family. It is to be hoped that in the future the health visitor will collaborate with other colleagues in the health and education services, and play her part as a member of a team providing health education.
Post-certificate Training

89 health visitors had taken part in post-certificate training in health education and it is disappointing to note that this represents only 18.98% of the participants. Perhaps one reason was that the syllabus did not appear to meet the needs of the newly qualified members of staff. It seems that health visitors do need extra training in health education at this level. 32 of the participants had attended courses for preparation for childbirth, 16 had attended special health education courses, 13 participated in in-service training and a further 11 had become proficient in the use of audio/visual aids. 9 health visitors had obtained the City & Guilds Certificate for technical teachers, and one had attended the pilot health education course at Highbury College. Rather than extra training in health education at this level, might a special continuation course be of more value for those health visitors who wish to improve their teaching techniques. One health visitor suggested that students should have a further block in college following the 3 months period of supervised practice.

Nursing officers often consider that new staff should be allowed one or two years to "settle in" and get to know their clients before becoming committed to a time consuming series of health education. However it is during these formative years that attitudes to the work are formed and the stereotype of the health visitor concerned with only maternal and child care can become imprinted. Hobbs (1973) has noted the link between the health visitors' views and their perception of their authority's view regarding the prestige value of group teaching. Interest and enthusiasm for group health education kindled during training may be lost in the intervening years so that health visitors are hesitant to expose themselves anew to the experience of group work. The assumption that newly qualified staff do not require additional training denies the purpose of education as a foundation on which to build the expertise that comes with practice. The potential for health education can best be brought out to the full in continued education. Williams (1970)
offers the opinion that it is important for health visitors to have a follow-up course after qualification so that methods of teaching can be looked at in more depth.

Analysis of the data reveals that there is evidence of association between post-certificate training and the employing authority, \(0.005 < P < 0.001\). The proportion of health visitors with post-certificate training in health education is highest in North London and lowest in County Boroughs. In the metropolis 35.2% of the health visitors in North London had received training and major factors may be the multiplicity of available health education courses and the ease of access to training centres; however only 19.8% attended in the South London Boroughs and the reason for this may be that more than one authority had health education officers and specialist staff who were actively engaged in teaching, it is possible that this influenced the health visitors' perception of their role as group health educators. In the County Councils 16.8% of the survey health visitors attended courses and these authorities, employing staff in greater numbers, may also have larger budgets and allocate funds for additional training as well as providing relief staff to maintain essential work. It may be the policy of County authorities to provide opportunities for training to support staff many of whom have to work in isolation away from health education officers, or senior nursing staff specialising in health education. However one County Council has a very progressive health education department whose activities led one health visitor to say:

"Perhaps we do not get as much opportunity as some health visitors to do health education, because in "___" we have a very 'go-ahead' health education officer with her own staff, and naturally they do much of the health education work in the County."
In contrast the figure of 11.3% for health visitors working in County Boroughs may reflect the relatively small staff establishments and budgets of those authorities, another reason could be the lack of easy access to centres for training and the difficulty in relieving staff to attend such courses.

In all instances health visitors who had attended post-certificate training courses were either currently engaged in group health education or indicated that owing to pressure of work this aspect of their work was temporarily suspended:

"I am not now taking health education sessions, but I was teaching ante-natal groups and in a secondary school during 1970. This was on a different area....."

"There is ample opportunity here but much 'groundwork' to be done - literally - leaving little time at present for any group education."

Many more health visitors indicated a wish to attend further training:-

"In-service training on teaching techniques and assessment of achievements would be helpful."

"I feel that health visitors who teach should either be given day release or offered a course to learn the art of teaching, voice production, etc."

The position that some newly qualified staff find themselves in, is summed up as follows:-

"I feel that so much emphasis is placed on health education that health visitors should be given much fuller training in the subject especially for work in schools."
"There appears to be a lack of understanding in some health education officers who persuade inexperienced health visitors to undertake health education for which they are not prepared."

and it would appear that while further training would be of value, the practical support and encouragement by senior staff is also an important factor in helping to improve the health visitors confidence in group health education.

Attitude Towards Health Education

Only 15.3% indicated that they did not wish to undertake group health education. But only 89 health visitors out of the remaining 84.6% had received further training to prepare them for this work. Staff who wish to teach are usually prepared to attend further training courses to extend their competence but the syllabus is not always relevant to their needs. It is possible that residential courses may not attract fieldworkers who have family commitments and a proportion of married women may not be prepared to attend courses at their own expense or in their own time. Another reason could lie within the policies of the local health authorities as perceived by the health visitors, or demonstrated in practical terms by the apparent lack of support by both the nursing administration and health visitor colleagues.

Analysis of the data shows there is evidence of association between the health visitors who wished to undertake group health education and the employing authority. The proportion of health visitors was highest in North London (92.6%) and lowest in the South (81%). The reasons for the high proportion in North London could either be that employing authorities select staff who express a willingness to perform this duty or, with a response rate to the questionnaire of 86.2%, most of the replies came from enthusiasts. 1 in 3 of the health visitors had already attended a post-certificate course in health education. However the North London health visitors only represented 5.8% of the total staff.
establishment compared with 29.9% from the South. Here the response rate to the questionnaire was much higher, 99.2%, and only 81% expressed the desire to teach groups: perhaps the health visitors were more interested in the social content of their work or they did not feel confident in their teaching ability as only 1 in 5 had attended post-certificate training in health education. In some authorities thriving health education sections existed and these may have influenced the health visitors perception of their roles as health educators. In the County Boroughs 85.5% wished to teach compared with 84.5% of the health visitors employed by County Councils.

Health Education in 1971

The data shows that 423 health visitors had participated in group health education in 1971. 333 health visitors serviced a total of 457 ante-natal groups; 84 ran groups for parents to discuss problems associated with the rearing of young children; in the field of education 348 groups were organised by 256 health visitors; and 112 health visitors serviced 183 groups identified as "other"; 46 health visitors were not engaged in group teaching during the year under review.

Question - 16

Health education carried out by health visitors in 1971

<table>
<thead>
<tr>
<th>Health Education Groups</th>
<th>Number of Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant mothers</td>
<td>304</td>
</tr>
<tr>
<td>Expectant mothers with fathers' night</td>
<td>128</td>
</tr>
<tr>
<td>Expectant parents</td>
<td>25</td>
</tr>
<tr>
<td>Parents' groups</td>
<td>84</td>
</tr>
<tr>
<td>Parents' groups: infant</td>
<td>60</td>
</tr>
<tr>
<td>Schools ...junior</td>
<td>79</td>
</tr>
<tr>
<td>secondary</td>
<td>189</td>
</tr>
<tr>
<td>College of further education</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>183</td>
</tr>
<tr>
<td>None (a)</td>
<td></td>
</tr>
<tr>
<td>TOTAL *</td>
<td>1,072</td>
</tr>
</tbody>
</table>

* excluding (a's) totals do not add up to 100% as some health visitors were involved in more than one type of group during the year.
Midwifery Training/Experience

A pre-requisite for health visitor training is that candidates must have either undertaken midwifery training or have had obstetric experience during or following basic nurse training. However Table 60 shows that there is no evidence of any association between midwifery training and health education sessions. Neither was there evidence of any association between age or civil state and group health education by health visitors in the survey.

Year of qualification

Analysis of the health education carried out by health visitors in 1971 by year of qualification shows that only in the case of "other" types of health education is there evidence of association with the year of qualification, there being considerably more health visitors qualified in 1968 than expected, and less in 1969 and 1971. Those who have been practising longest would probably be more prepared to tackle work outside their normal range having gained confidence in their ability to cope with different groups, and this is reflected in 39.7% of the health visitors who qualified in 1968 teaching "other" groups. 29% of the health visitors who qualified in 1970 were either prepared to initiate or were invited to service "other" groups, this may be a reflection of the support and encouragement they have received from senior staff or it may be indicative of the improvement in training courses coupled with the provision of better fieldwork experience for this group. Only 17% of the health visitors who qualified in 1971 (during the year under review) were engaged in teaching "other" groups. They would probably be the recipients of the "not until she has settled in" syndrome and not expected to teach groups other than those they already know. The proportion of staff who qualified in 1969 participating in health education projects is low (18%), this could be because 2/3rds are married and not prepared to work in the evenings or perhaps the opportunity for this type of work has not arisen.
Number and percentage of health visitors who carried out health education in 1971 by midwifery training/experience.

<table>
<thead>
<tr>
<th>Type of Health Education</th>
<th>S.G.M.</th>
<th>C.M.B. Part I</th>
<th>Pre-Obstetric</th>
<th>Post-Obstetric</th>
<th>TOTAL</th>
<th>$\chi^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante-natal</td>
<td>145</td>
<td>73</td>
<td>50</td>
<td>64</td>
<td>332</td>
<td>1.8902</td>
<td>0.750</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>69.4</td>
<td>69.5</td>
<td>71.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>34</td>
<td>15</td>
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<td>105</td>
<td>70</td>
<td>83</td>
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* The two health visitors with no midwifery training or experience have been excluded from this analysis.
Number and percentage of health visitors who carried out health education in 1971 by year of qualification.

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<thead>
<tr>
<th>Type of Health Education</th>
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<th>1969</th>
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<th>1971</th>
<th>TOTAL</th>
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<td>16.4</td>
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<td>141</td>
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<td>88.7</td>
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<td>131</td>
<td>159</td>
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Number and percentage of health visitors who carried out health education in 1971 by locality.

<table>
<thead>
<tr>
<th>Type of Health Education</th>
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<td></td>
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<tr>
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<tr>
<td>Parents</td>
<td>59</td>
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<tr>
<td>%</td>
<td>19.5</td>
</tr>
<tr>
<td>Schools</td>
<td>149</td>
</tr>
<tr>
<td>%</td>
<td>49.2</td>
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<tr>
<td>Other</td>
<td>78</td>
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<tr>
<td>%</td>
<td>25.7</td>
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<tr>
<td>All Types</td>
<td>268</td>
</tr>
<tr>
<td>%</td>
<td>88.4</td>
</tr>
<tr>
<td>TOTAL NUMBER OF HEALTH VISITORS</td>
<td>303</td>
</tr>
</tbody>
</table>
Localities

Only in the case of health education in schools is there statistical evidence of a difference in locality. More health visitors teach in a combined urban and rural area than expected, and less in rural areas. Only 38.1% of the health visitors in rural areas were teaching in schools and they may have been influenced by the transfer of many small village schools to the larger comprehensive schools in nearby towns, other factors could be the amount of travelling involved and the priority demands of a wide range of duties, especially for staff engaged in triple duties. One health visitor working in a rural area pointed out that until she was relieved of routine nursing duties by ancillary staff she would be unable to devote any time to fixed group sessions.

Health education is for many school teachers an area of uncertainty. For this reason it could be that health visitors are being invited to teach on health subjects in schools. In combined areas perhaps the pace of work is more manageable, travelling is less arduous and the health visitors feel able to service a higher proportion of schools than expected (80.6%). However in urban areas there are many more schools than health visitors and this could account for only 49.2% engaged in this work, another reason could be the lack of discipline in the classroom.

Frameworks

There is evidence of association between the framework within which the health visitor works and ante-natal sessions, education for parents and "other" types. A higher proportion of health visitors working in group practice attachment (77.1%) and group practice combined with a geographical area (75.8%) were concerned with ante-natal teaching than expected. It may be that these sessions are held for the group practice patients, or the health visitors may be those with a good self-image of their role as health educators. They may be highly motivated to teach this group of clients. It is within the geographical
<table>
<thead>
<tr>
<th>Type of Health Education</th>
<th>Geographical</th>
<th>G.P.</th>
<th>Combined</th>
<th>Other</th>
<th>TOTAL</th>
<th>$\chi^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
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<tr>
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<td>57.8</td>
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<td>53.8</td>
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<td>90.2</td>
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</tr>
</tbody>
</table>

TOTAL NUMBER OF HEALTH VISITORS: 469
framework that 24.9% of the health visitors are running more groups for parents to discuss the rearing of young children. Perhaps the nature of their work may allow staff the time to promote this important area of health education. They have fewer demands made on them from general practitioners and in many instances the health visitors work is still focussed on mothers and young children. In addition the health visitors may have easier access to accommodation suitable for parents groups, an extension of the "schools for mothers" which started about 70 years ago in London.

32.8% of health visitors working in group practice serviced "other" groups, 21.1% worked in combined areas whereas only 16% health visitors worked in geographical areas. Did the health visitors' contact with a much wider range of group practice patients either give them more confidence to initiate group work, or were they better known so that more requests were made for their services?

Employing Authority

Analysis of the data, Table 48 page 276, shows that there is evidence of association between the employing authority and health education for expectant mothers, and parents groups, education in primary and secondary schools, and "other" types of health education. More detailed analysis of these results will be found under the appropriate subject headings in the following pages.

A more detailed statistical analysis of the data in tables 60, 61, 62 and 63 showed that there is no significant difference.
Ante-Natal Health Education

As previously stated, work with expectant mothers has been a traditional role of the health visitor for over 70 years. Until recent years the attitude of society has been that childbirth was women's work, and all too often staff have maintained the traditional approach to antenatal classes without questioning either their own motivation or whether the needs of the expectant mothers and fathers were being met. It could be that many nursing officers have been too concerned in providing a service with the minimum disruption rather than attempt to innovate a change of approach which could increase the number and size of groups. In some areas expectant parents have looked elsewhere for help and guidance, and some have found it in meetings organised by the National Childbirth Trust, a voluntary society promoting natural childbirth. Both midwifery and health visitor training schools may be equally at fault in maintaining traditions without questioning motivation. However the trend towards a more liberal approach to antenatal classes for expectant parents continues and the increasing number of obstetricians, midwives, and health visitors will now be joined by men in the health visiting profession. They may help to break down the remaining barriers and provide a more comprehensive service. Out of a total of 457 antenatal classes organised by the health visitors in the survey, 128 groups had at least one night especially for the husbands and 25 groups were organised for both spouses to attend. Caplan points out the importance of reassurance and anticipatory guidance during pregnancy, in his opinion the future mental health of both mother and child is dependant on positive experiences with the key figures in her environment during this period. Surely this must include the support of an understanding spouse whenever possible? Forbes (1972) suggests that men need support in their new role as fathers and that pregnancy can be a maturing process for the husband as well as his wife.

Rathbone offers the opinion that mothers who attend classes have a better chance of managing their own lives and their babies in a happy and efficient manner. However she suggests that mothers in the lower
social classes would benefit more from regular advice in the post-natal period than from ante-natal classes. This reflects Frommer's view (1972) that health visitors should provide special supervision in the homes of mothers deprived during the formative years of their own childhood.

Analysis of the survey data reveals that there is no evidence of any association between midwifery training, age, civil state or locality and ante-natal group health education carried out by health visitors in 1971. However there is some evidence of association between the framework within which the health visitor operates and ante-natal sessions ($P < 0.01$). A higher proportion of health visitors working in group practice attachment (77.1%) and a combination of group practice with a geographical area (75.8%) were concerned with ante-natal teaching. The association with group practice may have influenced the health visitors concerned to provide sessions for the patients in conjunction with other members of the Primary Health Care Team. It is within the employing authority that a highly significant result appears for health visitors teaching expectant mothers ($P < 0.001$). A higher proportion of health visitors (83.9%) employed by County Boroughs were running classes than expected, one reason for this may be that few facilities are available in the local maternity units. Perhaps more health visitors are prepared to perform this task than midwives and 79% of the health visitors in these boroughs have a midwifery qualification. 64.5% are working within a framework of either partial attachment or in geographical areas and may not have so many demands on their time by other sections of the community. A much lower proportion than expected was found in the South London Boroughs, here only 43.8% of the health visitors were engaged in classes for expectant mothers and the reason may be that this region has many teaching hospitals and midwifery training schools within its boundaries providing ante-natal classes. Only 66% of the health visitors had a midwifery qualification compared with 79% in the County Boroughs and it is possible that other social needs in South London rated a higher priority than preparation for parenthood.
Parents' Groups

Individual teaching in the home to parents of young children has been the main focus of the health visitors' work in the past. However much this approach has achieved in terms of attitude and behavioural change teaching is often more effective in a group setting. The teaching of parents in groups is not a new phenomena, it originated in the "Schools for Mothers" at the beginning of the twentieth century. However the value of group inter-action was only recognised during the second world war by Lewin (1947) in the U.S.A. Today it would seem that increasing demands made upon the health visitors' time would encourage the use of methods that are of proven value and economise in time. Does this have implications for the way in which we teach? We should encourage the students to study group dynamics so that they recognise the development of group feeling. Some nursing officers consider that parents' groups are an excellent starting point for health education for the health visitor. Often groups are already running in an area and the new members of staff can be invited to assist those who are responsible for the sessions, thus staff can be eased into the work.

The data shows that only 84 health visitors in the survey organised parents' groups to discuss the problems associated with the rearing of young children. This represents 17.97% of the total under scrutiny who were carrying on the tradition of the first "Schools for Mothers", (P < 0.001). Could the reason lie in the training where emphasis has largely been focused on individual health teaching in respect of the problems of child rearing? This is reflected in a comment made by one health visitor:--

"I would rather teach parents in their own homes as I visit the children".

Have the students been too engrossed in learning the difficult concepts of the behavioural sciences, have they not given enough attention to the normal growth and development patterns of the young child?
One respondent wrote:

"We did not have sufficient time devoted to the day to day management of children - particularly practical feeding".

And a second was of the opinion that the practical side of basic child care was woefully lacking. Yet a third respondent recommended that student health visitors should spend some time in a Day Nursery to observe the socialisation of young children. However students could learn more about the developmental problems of children by joining parents' discussion groups than probably any other teaching method. This should integrate the practical and other observational work with the background subjects of sociology and psychology.

Have the students been given sufficient practical experience to reinforce the concepts taught in the training school?

"It would have been helpful to have observed health visitors giving advice generally at Child Health Clinic sessions more often during training".

Perhaps the students have not seen the relevance of the new syllabus to health education planning, particularly in respect of primary prevention. The lack of firm criteria with which to assess the current theories or aspects of child management such as infant feeding and weaning, toilet training and temper tantrums may have deterred the inexperienced health visitor.

"I feel that during our training we were not sufficiently prepared for giving advice on feeding and general baby care".

This comment reflects the opinion of many new health visitors, another said:

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"I am doing quite an amount of visiting in respect of behavioural problems .... I am not sure that I know enough about this topic ....".

Other factors influencing the confidence of health visitors in their ability to do this work may be a dislike of informal discussion groups which demand a considerable degree of expertise and knowledge on the part of the group leader. The difficulties associated with the organisation and management of parents' groups can prove a daunting task, especially when left to carry the sole responsibility for the work. Health visitors who do not fully recognise the need for these groups would be tempted to hold group meetings only once or twice a month; the more frequently meetings are held the greater the demands on the health visitors' time for the preparation and running of the group, but regular weekly meetings should improve continuity and the integration of its members. The availability of suitable premises and help with routine duties will reinforce motivation to teach child management, which may well affect not only the future development of the child but also give the parents additional insight into the needs of all the members of the family and local community. From personal experience running a parents' group, four voluntary helpers enlisted from the neighbourhood later enrolled for training either as nurses or infant teachers once their own children were of school age.

"I feel that health education needs some stimulus"

wrote one health visitor. Perhaps the stimulus will come from members of the Primary Health Care Team, in particular the general practitioner who is involved in child health and screening procedures may recognise the value of group health education in primary and secondary prevention as demonstrated by Pike (1965) in a Birmingham general practice. Given the stimulus of this new approach the team may be able to provide a forum for a realistic programme of health education based on parents' groups. The attitudes of colleagues, ancillary staff and caretakers will influence the health visitors' perception of the value of these groups, as will the support of senior staff and health education officers.
The dilemma of choosing between a day-time session during normal working hours and an evening session after a busy day, is of increasing importance with many more married women in the service. If a day session is chosen then the health visitor will have to provide a crèche, the mothers will be distracted by the cries of their children and may also become anxious to get away in time to collect older children from school. The management of a day-time session is more complex and the health visitor is more dependant upon ancillary staff or voluntary workers to run the crèche. However at night there are fewer distractions, the children are looked after at home and the mothers are usually more relaxed. Both parents may be able to attend and a mixed group can be a very lively affair when both fathers and mothers can air their views and discuss family matters. The health visitors' problem may be that of bringing the meeting to a close rather than the difficulty of maintaining interest and attention.

53 of the health visitors running parents groups were married compared with 31 who were single, on analysis there was no significant difference. The year of qualification revealed no significant difference but closer scrutiny of the data revealed that of those health visitors who had been in post for more than two years a higher proportion (41.3%) were engaged in this work than those who qualified more recently (32.4%). It could be assumed that health visitors with more experience feel more confident to run these groups.

On the completion of their training health visitors are expected to be able to assess the needs of their neighbourhood and when necessary propose schemes to help those groups who have some special need. However the influence of other less interested colleagues, a rigid administrative structure, and the policy of the local health committee may obstruct the setting up of such groups for health education. The cost of running an additional weekly session may inhibit the setting up of parents' groups especially if church or other local interest groups are already meeting.
in the area. Finally there are few tangible rewards for either the initial effort required to set up a group, or the amount of preparation and personal time involved over many weeks in the year. Yet parents' groups can provide a focus for activity and learning about the needs of parents with young children. In one County Council it would appear that this is already taking place:

"Being fully attached to a very forward looking group of four doctors who use their health visitors to capacity most of the health education is evening work ....... within the next two years, with a special session set aside for teaching purposes it is hoped to do most of the health education for our patients on the premises .... we are a group who work together and the patients seem to appreciate it".

On being asked which groups they would choose to teach, 26 married health visitors said that they would run parents' groups and so did 19 single respondents. Analysis revealed no significant difference.

It is interesting to note that only 23 health visitors who were running parents groups in 1971 said that they would choose to do so, the analysis showed no significant difference in the civil state of the health visitors.

Groups created for the purpose of problem solving within communities with common problems span health education and social work, both extending their preventive role. Consultation between health visitors, health education officers and community workers is essential if scarce resources are not to be squandered by unnecessary overlap of work. There is a need to identify and define the different professional skills each discipline brings to group work and their relative importance. The clarification of objectives of each group realistically undertaken is of paramount importance; the initial purpose for setting up a group may change, for example a family planning session may turn into an adolescent
advice centre, or a group for parents of spina bifida children may develop into a creche for the children. Movement within society is a current problem which has to be accommodated within the health visiting service. A study of sociology as well as basic health visiting methods may help the student to be more precise in recognising need. As communities change even during the span of one series of meetings so a group will develop and find other needs which have to be jointly met. There is one danger for the health visitor and that is when the group begins to develop as a political pressure group. The health visitor may find herself with divided loyalties, between the aspirations of the group and the policy of her employing authority.

There is no evidence of any association between either midwifery training/experience or locality and health visitors carrying out health education in 1971. But there is some statistical evidence between health education and the framework within which the health visitor works ($P < 0.025$). A higher proportion of health visitors working in geographical areas (24.9%) were servicing these groups than expected. Health visitors working in a geographical area are less affected by demands from a wide range of clientele than those working in the Primary Health Care Team, they could have more time to devote to this area of need.

There is evidence of association between the employing authority and health visitors running parents' groups ($P < 0.001$). The observed data in the South London Boroughs is much greater than expected (30.6%). Possible reasons for this may be found in the emphasis placed on the developmental needs of young children by training schools servicing this area, or the health authorities concerned may recognise the importance of health education for this group. The higher proportion of newly qualified staff employed by the South London Boroughs could mean that more inexperienced health visitors would become involved with this group much sooner than their peers in the other employing authorities. It would have been useful
to find out how many health visitors had run these groups prior to 1971 and were now no longer doing so. Only 6.5% of health visitors in the County Boroughs serviced groups for parents to discuss the rearing of young children. The size of health visitors' case-loads were not requested and there is no way of assessing whether pressure of home visiting young children affected these results.

Health Education in Schools

Some of the earliest records of health subjects taught in schools date back to the 19th century, for example physiology was introduced into the curriculum of a London school in 1846, and almost 20 years later Ruskin called for the laws of health to be taught in state run schools. Today guidance and encouragement for healthy living should be an important and continuing part of education in all schools, and its success will, to a large extent, depend upon the interest and determination of the head teacher who carries the overall responsibility for the place of health education in the curriculum. That the health visitor with a special interest in this work has a part to play is acknowledged in the Jameson Report, but others (including Elliott and Owen) see her more as an initiator, advisor and resource agent rather than engaged in any long-term programme of teaching. She is however the acknowledged link between the home and the school, equipped to counsel both children and adults in health matters. Before embarking on programmes of health education in schools the health visitor should examine the contribution she feels best able to make in relation to her total work situation. What proportion of time can she reserve for this work in relation to her other duties? The provision of ancillary staff would relieve her of routine work to enable her to devote part of her time to use her teaching skills. Although the health visitor is not a qualified teacher she is recognised by the Department of Education and Science as a health educator and, as such, may be invited to teach health subjects in schools. Even so many health visitors in the survey are aware of their lack of expertise in teaching children and suggest a
further period of training to prepare them for this work.

"I do not feel my training was sufficient to cope with teaching in schools. I would like to see courses set up for health visitors if they wish to specialise in health education."

Owen suggests that health education in schools can be carried out by various means, including individual counselling, by example and encouragement, and group teaching. In her opinion schemes of integrated health education between the health and education departments would enable all schools to participate and yet maintain their own philosophy. Schemes should be developed according to the needs of the school and the community it serves. Gallagher (1969) demonstrates the effectiveness of collaboration between the health and education services in Berkshire. In her opinion the health visiting staff have matured enormously and their techniques have altered, from didactic teaching eight years ago to the present day free flowing small group discussions. Another development has been a counselling service for the school children who can visit the surgery on their way home to discuss personal problems with the health visitor.

The schools provide the professional health educator with her only captive audience, once the children have left school the opportunity to reach all of them in adult life is remote. The success of any schemes during school life could influence the attitude of the young generation in its perception of the value of healthy living, and also in its expectations of the health services.

In the survey 256 health visitors organised a total of 348 groups; and of these 12.8% were held in infant schools, 16.8% in junior and 40.3% in secondary schools. A further 4.3% were held in colleges of further education. There is no evidence of any association between the year of qualification, midwifery training/experience, framework and the health
visitors who carried out health education in schools in the year under
survey. Only in the case of the locality within which the health visitor
works is there statistical evidence of a difference \( P < 0.001 \). More
health visitors work in a combined urban and rural area than expected, and
less in rural areas. 71.8% of health visitors working in a combined urban
and rural area were engaged in teaching in schools, the reason for this
may be that health visitors are not working under so much pressure as their
colleagues carrying out triple duties in rural areas or health visitors
coping with a multiplicity of social problems in urban areas.

The 38.1% health visitors working in rural areas represents a
smaller proportion than expected, however many of the village schools have
been closed and children have to bus to the nearby towns to receive their
education. The demands of the public upon the only accessible professional
worker in a country area can transform the health visitors' role into that
of a personal advisor and counsellor; in many instances the initial
approach would be made to the health visitor rather than travel long
distances to seek advice from the general practitioner, hospital or social
worker. Together with her other nursing duties this would leave the health
visitor with little spare time for extraneous work unless she is highly
motivated to teach school children.

In the urban areas 49.2% health visitors could be influenced by
other urgent social needs and the problems associated with fitting the time
for preparation and teaching sessions into an already busy schedule.
Initially the time spent to gain the interest and co-operation of the staff
can be time consuming; for example, a dialogue should take place between
the health and education staff so that both can recognise each other's
professional roles and consider how health education can fit into the
curriculum.
How can training help to equip the health visitor to play her part? The professional image of the health visitor is influenced both by her training and practical experience where the role models of lecturers and fieldwork teachers can influence the student's attitude towards this work. Problem solving exercises in the application of teaching and management skills should help the student develop the ability to assess need and adapt the principles to any situation. In considering the pattern of health education in school she should be able to take into account the overall development of personality during these years. For example, the habits and attitudes formed in the home by the pre-school child are likely to persist and to resist modification. The extent to which health education in school can influence the parents is limited to those who are already providing a positive home environment for the child. The advice and guidance given during the pre-school period by the health visitor is of paramount importance. Does her influence lessen once the child starts school? This will depend upon the willingness of the health and education services to take all opportunities for communication and co-operation between the disciplines so that they can effectively supplement each others' efforts. Health education should relate to the development of personality throughout the total life span.

The Infant School

The pre-school child is dependant upon his parents and continues to do so during his early years at school, in addition he has a dependant relationship to his teachers who function in loco parentis during the school day. The role models provided by the staff are to a large extent imitated, authority is accepted, judgement trusted and attitudes imbibed. The infant is motivated by the approval or disapproval of trusted adults. At this stage health is more a life to be lived rather than a subject to be taught. Health education is largely the provision of a healthy environment and the teaching should permeate throughout both the curriculum...
and daily life of the school. Perhaps it is not surprising that there is no evidence of association between the employing authority and the number of health visitors engaged in health education in infant schools, and only 12.8% of the total health visitors in the survey were teaching this group.

The Junior School

In the junior school the foundations of healthy living are reinforced by an extension of teaching basic health habits and attitudes. However the child is now ready to learn about his own body and, something about his place in the community. The child is inquisitive and shows an intense interest in his environment. He is eager to learn in order to do, and it follows that encouragement within the school community of sound social attitudes towards healthy living is of great importance. Although much of the health education of the junior school child will take the form of incidental training nevertheless there is a place for the planned provision for some health teaching, it should not be left to chance. Perhaps provision should be made each week for a short, informal talk or exercise on a health topic as well as referring to health matters whenever relevant topics are being discussed.

There is evidence of association between employing authority and health education in primary and secondary schools. For example in primary schools ($P < 0.010$) a higher proportion of health visitors carrying out health education are employed by County Councils (22.4%) whereas a considerably smaller proportion of health visitors in the County Boroughs (6.5%) are doing this work than expected. One reason for this may be the policies of the authorities concerned and the total staffing establishment. In the County Councils it is probable that more supportive services are available in terms of practical help and relief from routine duties so that staff are free to initiate work with school children.
The Secondary School

The continuation of health education in the secondary school will increasingly move away from the formal didactic teaching sessions. The most appropriate form of health teaching at senior level may well be the open discussion, in which ideas and opinions about personal relationships and social responsibility can be aired. This method is particularly valuable in helping the adolescent to work out for himself a personally acceptable code of behaviour and of moral judgement. It is of great benefit for all to hear the problems that baffle one thrashed out by others, and attitudes can be modified in the light of collective experience and opinion. Whose responsibility should this be? It may be argued that a specific health education course could provide a focal point and yet integrate with other curricula series. Another view is that health should receive attention in all the different disciplines, however the danger here lies in what is everybody's business may well end up as nobody's business, or that the result might be patchy and uneven with some topics left uncovered.

There is evidence of association between the employing authority and health visitors carrying out health education in secondary schools. For example 46.3% of health visitors in North London and 45.2% of those employed in County Councils were teaching secondary school children, but only 28.1% of South London health visitors were engaged in this work. Could it be that health visitors were not encouraged in this duty in South London or that some of the health education departments were either performing this service themselves or providing in-service training for the school teachers. Did the low proportion in South London reflect the much larger proportion of newly qualified staff in the total establishment?
Of the health visitors teaching "other" groups there is nothing in the results to differentiate between a one only session and a series. The value of a single session except for information giving is debatable. It requires a different type of approach to that for a series of talks with the same group and, unless the audience belongs to the catchment area within which the health visitor works, there is little opportunity for evaluation. Perhaps it is better left to the health education officer to service, unless it is of a topic directly relating to health visiting. However the value of teaching on-going groups of expectant and young mothers should still be within the orbit of the health visitor's function. She has intimate knowledge of the area where she works and has been trained to assess the health needs therein, given these skills the health visitor can identify the appropriate means of health teaching. Fundamentally her role is to teach and support young families. Other work is interesting and exciting but it is often performed at the expense of basic health needs, for example the care of mothers and children during their formative years. If this need is not met by the health visiting service, who else will do it? Many other disciplines will be only too ready to move in, as already demonstrated by the National Childbirth Trust and Social Workers. Health education is a method of work for health visitors and provides an excellent medium for primary prevention and entry into the homes of young families before any problems arise.
Colleges of Further Education

Only 4.3% of the survey health visitors were engaged in sessions within colleges of further education. The marginal totals were too small for $X^2$ tests to be reliable but it is interesting to note that 6.6% of the South London health visitors were engaged in this work.

Teaching Role with Students

All health visitors have a responsibility for providing practical experience and training for an increasing number of students of many disciplines. This entails the very careful co-operation between the training institutions and the local authority staff. While emphasis in the past has been on the provision of experience in the preventive field, work in the Primary Health Care teams should open up avenues of teaching in the areas of curative medicine in the community and the ever increasing demands for the provision of care.

The data shows that in 72 instances students from post-basic nurse training courses assisted health visitors in running ante-natal classes, in a further 3 instances student nurses were also present. 33 student health visitors participated in these sessions and so did 39 pupil midwives reinforcing the Working Party on Management Structure in the Local Authorities reference on the dual roles of the health visitor and midwife in running ante-natal classes.
Choice of Health Education

Health visitors were asked to indicate their choice of health education if afforded the opportunity. The data in Table 50, page 279, shows that there is evidence of association between the employing authority and choice of health education for expectant mothers. Health visitors choosing this type of health education tend to be employed slightly more by County Councils and less by South London. It may be that health visitors working in rural areas not only recognise the needs of the scattered population but also the difficulties for mothers who have to travel long distances to attend classes in maternity units. 66.8% of the staff in the survey work in rural or semi-rural areas and, of these, 40.6% work solely in rural areas. The provision of classes within a reasonable distance for these mothers may entail a higher degree of organisation from health visitors working in rural areas in order to meet the demand, and it is apparent this group is a popular choice amongst the survey population (48.3%). There is also evidence of association between the employing authority and the choice of health education in secondary schools.

In the South London Boroughs only 40 choices were made (33.1%), it may be that the concentration of teaching hospitals and midwifery training schools in the region filters off a considerable proportion of clients. Another reason could be that many health visitors enjoy this work and so those who have been longer in post are also running ante-natal classes, or the falling birth rate may have affected the demand for classes.

Choice by health visitors of health education groups by midwifery training/experience in Table 64 shows that there is evidence that midwifery training has an effect on choice of ante-natal sessions and education in schools. Health visitors choosing ante-natal sessions tend to be better qualified in midwifery than those who do not \(P < 0.025\). Perhaps it is not unreasonable to expect that this should be so as the participants will have received training for health education during both their midwifery and health visitor courses; 73.2% of the health visitors in the survey who are
Number and percentage of health visitors who would choose to carry out health education by midwifery training/experience.

<table>
<thead>
<tr>
<th>Type of Health Education</th>
<th>S.C.M.</th>
<th>C.M.B. Part I</th>
<th>Pre-Obstetric</th>
<th>Post-Obstetric</th>
<th>TOTAL</th>
<th>$\chi^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante-natal No:</td>
<td>153</td>
<td>65</td>
<td>40</td>
<td>47</td>
<td>305</td>
<td>11.118</td>
<td>0.025</td>
</tr>
<tr>
<td>%</td>
<td>73.2</td>
<td>61.9</td>
<td>57.1</td>
<td>56.6</td>
<td>65.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents No:</td>
<td>29</td>
<td>20</td>
<td>5</td>
<td>13</td>
<td>67</td>
<td>4.9991</td>
<td>0.250</td>
</tr>
<tr>
<td>%</td>
<td>13.9</td>
<td>19.0</td>
<td>7.1</td>
<td>15.7</td>
<td>14.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools No:</td>
<td>112</td>
<td>58</td>
<td>21</td>
<td>51</td>
<td>242</td>
<td>17.1823</td>
<td>0.001</td>
</tr>
<tr>
<td>%</td>
<td>53.6</td>
<td>55.2</td>
<td>30.0</td>
<td>61.4</td>
<td>51.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other No:</td>
<td>11</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>31</td>
<td>1.3463</td>
<td>0.750</td>
</tr>
<tr>
<td>%</td>
<td>5.3</td>
<td>8.6</td>
<td>7.1</td>
<td>7.2</td>
<td>6.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Types No:</td>
<td>193</td>
<td>99</td>
<td>64</td>
<td>76</td>
<td>432</td>
<td>0.7105</td>
<td>0.900</td>
</tr>
<tr>
<td>%</td>
<td>92.3</td>
<td>94.3</td>
<td>91.4</td>
<td>91.6</td>
<td>92.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of Health Visitors</td>
<td>209</td>
<td>105</td>
<td>70</td>
<td>83</td>
<td>467 *</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Two health visitors with no midwifery training or experience have been excluded from this analysis.
State Certified Midwives were engaged in teaching ante-natal classes as were 61.9% of those with the Part I certificate of the Central Midwives' Board. In the field of education the data reveals a highly significant association between midwifery training and the health visitor's choice of health education in schools (P < 0.001). However in this instance more health visitors who obtained obstetric experience after qualifying as State Registered Nurses said that they would choose to teach in schools than those who had obstetric experience during their nurse training. It could be that many of the 61.4% in the former group were married and felt more confident in coping with schoolchildren than those in the other groups.

Choice by Health Visitors of Health Education Groups by Locality

Only in the case of health visitors choosing ante-natal sessions is there evidence of association with locality (P < 0.001). There is a higher proportion in combined urban and rural areas of health visitors who choose ante-natal sessions than expected, 88.3% would do so if afforded the opportunity. One reason could be that some degree of flexibility in work routine is possible in this type of area whereas in urban areas, where only 57.1% said that they would choose this group, the pressures of social problems may inhibit health visitors from committing themselves to too many fixed sessions at clinics and for teaching purposes.

When given a free choice over the type of group or groups, the health visitor is prepared to meet a variety of needs amongst her clients. However there is no evidence of association between the health visitor's choice of groups and that of age group, year of qualification, or framework within which she is working. 11 health visitors not currently engaged in servicing health education groups said that they would wish to do so, making a total of 434 or 92.5% of the participants in the survey. It would appear
Number and percentage of health visitors who would choose to carry out health education by locality.

<table>
<thead>
<tr>
<th>Type of Health Education</th>
<th>LOCALITY</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Combined</td>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ante-natal</td>
<td>No:</td>
<td>173</td>
<td>43</td>
<td>91</td>
<td>307</td>
<td>33.4602</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>%:</td>
<td>57.1</td>
<td>68.3</td>
<td>88.3</td>
<td>65.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>No:</td>
<td>41</td>
<td>9</td>
<td>18</td>
<td>68</td>
<td>0.9674</td>
<td>0.750</td>
</tr>
<tr>
<td></td>
<td>%:</td>
<td>13.5</td>
<td>14.3</td>
<td>17.5</td>
<td>14.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools</td>
<td>No:</td>
<td>157</td>
<td>29</td>
<td>58</td>
<td>244</td>
<td>1.6700</td>
<td>0.500</td>
</tr>
<tr>
<td></td>
<td>%:</td>
<td>51.8</td>
<td>46.0</td>
<td>56.3</td>
<td>52.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No:</td>
<td>23</td>
<td>4</td>
<td>4</td>
<td>31</td>
<td>1.7195</td>
<td>0.500</td>
</tr>
<tr>
<td></td>
<td>%:</td>
<td>7.6</td>
<td>6.3</td>
<td>3.9</td>
<td>6.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Types</td>
<td>No:</td>
<td>281</td>
<td>55</td>
<td>98</td>
<td>434</td>
<td>3.5334</td>
<td>0.250</td>
</tr>
<tr>
<td></td>
<td>%:</td>
<td>92.7</td>
<td>87.3</td>
<td>95.1</td>
<td>92.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of Health Visitors</td>
<td></td>
<td>303</td>
<td>63</td>
<td>103</td>
<td>469</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
that the training does provide a foundation for the health visitor's role as a health educator, but it should be emphasised that this survey is only a quantitative analysis, it neither attempts to assess the quality of the service nor evaluates the results of group health education. In addition the survey is not based on a random sample and therefore the results cannot be applied to the National situation.

After detailed analysis of tables 64 and 65 no significant difference was detected.
Health Visitor Training Courses

The survey revealed that 32 different schools were responsible for the training of this sample of the population. Letters were sent to these educational establishments requesting information about the number of sessions in the curriculum devoted to health education, and the amount of teaching practice required of students. Only 20 colleges replied in sufficient depth to be of any value.

15 out of the 20 colleges had a separate series entitled "Health Education" and the total number of hours ranged from 12 to 48. Most of the teaching was by health visitor tutors who devoted from 4 to 41 hours to this subject. Only 9 colleges used the services of an educationalist from a minimum of 3 to 12 hours teaching time. In 12 instances health education officers were involved either in formal teaching sessions at the colleges or, more often, in providing a session in health education units. In some instances the returns distinguished between formal teaching sessions, seminars and tutorials, 7 schools included preparation for teaching practice and assessments were included in the returns. At one college 15 hours were spent on "public speaking" with a further 6 hours on educational technology at the end of which student groups had to script, produce and present a short health education programme. This survey was carried out before the recent emphasis on ante-natal care and child care in radio and television broadcasts, however one college appeared to anticipate this by devoting 48 hours to television studies and another spent 20 hours evaluating audio visual material.
Health education for expectant parents was only specifically mentioned in three of the health education series, it was usually included in the health visiting series. This subject was reinforced by attendance at ante-natal clinics and during fieldwork practice. One college was able to provide only observation visits as the local authority did not allow students to take an active part in parentcraft teaching. Three schools expected their students to include one ante-natal health visiting study for examination purposes. One tutor admitted that she was not entirely satisfied with the format of health education in the curriculum. In her opinion the present syllabus did not allow sufficient time for the development of effective teaching skills.

All schools without exception required health visitor students to undertake at least one piece of instruction in college, in one instance as part of a group project.

<table>
<thead>
<tr>
<th>Number of required sessions</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>College</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fieldwork</td>
<td>2</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Students were expected to participate in formal health education in their fieldwork practice, and this experience was arranged either by the tutorial staff or fieldwork teachers. As can be seen in the above table only in 2 instances was a minimum of one teaching session required. A tutor pointed out how difficult it was to obtain 4 teaching sessions for students whose fieldwork teachers were burdened by very high case loads and consequently had no time to carry out formal health education. An alternative was to undertake this training during supervised practice but this experience was then obtained during an a-typical period and opportunities were limited.
It was decided to look at the top twelve training schools in the survey, these were chosen solely on the basis of the highest number of participants (see page 216). After analysis of the following variables:

- ante-natal classes,
- parents groups,
- school children,
- other groups,

the only significant difference detected was between colleges that used schools as a practice area for health education, and between the various formal groups so used by other colleges. Some of the figures were too small for any analysis to have significance. This survey was carried out when the diversification of formal health education practice was just beginning. While it is still probable that most students start their teaching to ante-natal mothers it would be interesting and useful to repeat this investigation and record the current trends.
59 health visitors completing the questionnaire had trained at Croydon College of Design and Technology, 12.6% of the total returns. During the period under review from 1968-1971, 114 health visitors successfully completed their training at the College and 51.7% participated in the survey. Two had taken the Integrated Course at the College in conjunction with King's College Hospital.

56 of the participants were employed by South London Boroughs (95%) while only one was working in North London, and the remaining two in County Councils.

There is evidence of association between the civil state and training school ($P < 0.001$). A considerably higher proportion of health visitors were married who trained at the College than expected but this reflects the policy of the College in accepting married women for training. However this result should be viewed with caution as the data only refers to the civil state of the health visitors at the time of completing the survey and not during the period of training.

The proportion of health visitors under the age of 35 years who trained at the College was in the ratio 2:1 with those aged 36 and above, this was in keeping with the data for the rest of the participants. There was no evidence of association between the training college and midwifery qualification or experience.

There was some evidence of association between the College and the framework within which the health visitors were now working, ($P < 0.250$). A higher proportion of health visitors were still working in a geographical area than expected whereas a considerably smaller proportion were working in group practice attachment, and combined practice and geographical areas.
One reason could be the difficulty in persuading general practitioners of the value of working in teams, many of whom were still working independently and some holding their surgeries in lock-up shops with minimal facilities. The returns from the nursing officers show that in two authorities was there about a 50% attachment in force, 6 more had only partial attachment of their staff, and in one instance no health visitor was attached to general medical practice within that South London Borough. (See Table 43, page 268). Another reason could be that nursing officers were unwilling to place newly qualified staff into attachment schemes before they had some experience in the field under the guidance of senior staff in a centre. This finding highlights the dilemma of the tutorial staff in teaching the theoretical concepts of working in group practice schemes and the difficulty in relating it to the practical situation which in fact did not exist at that time.

In 54 instances the College trained staff were working in urban areas, 3 in combined rural and urban areas, and the remaining 2 were in rural areas. There is evidence of association between the college and type of area serviced ($P<0.001$). Again this is not surprising as the College lies within the Greater London boundary and takes most of its students from the South London boroughs.

There was no evidence of association between the College and the year of qualification: 49 of the health visitors were working full-time and 10 part-time, the latter having had a break in service for maternity leave.

There was no evidence of association between the College and the health visitors providing group health education in 1971. 55 health visitors who trained at the College were involved in group health education in 1971 and they serviced a total of 129 different groups.
Number and Percentage of health visitors carrying out health education in 1971 by training college.

<table>
<thead>
<tr>
<th>Type of Health Education</th>
<th>Training School</th>
<th></th>
<th></th>
<th>(X^2)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Croydon College</td>
<td>Other</td>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ante-Natal</td>
<td>35</td>
<td>298</td>
<td>333</td>
<td>4.4712</td>
<td>0.050</td>
</tr>
<tr>
<td>%: 59.32</td>
<td>72.68</td>
<td>71.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>22</td>
<td>62</td>
<td>84</td>
<td>17.2605</td>
<td>0.001</td>
</tr>
<tr>
<td>%: 37.29</td>
<td>15.12</td>
<td>17.91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools</td>
<td>27</td>
<td>229</td>
<td>256</td>
<td>2.1189</td>
<td>0.100</td>
</tr>
<tr>
<td>%: 45.76</td>
<td>55.85</td>
<td>54.58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>12</td>
<td>100</td>
<td>112</td>
<td>8.6937</td>
<td>0.005</td>
</tr>
<tr>
<td>%: 20.34</td>
<td>24.39</td>
<td>23.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Types</td>
<td>55</td>
<td>368</td>
<td>423</td>
<td></td>
<td></td>
</tr>
<tr>
<td>%: 93.22</td>
<td>89.76</td>
<td>90.19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of Health Visitors</td>
<td>59</td>
<td>410</td>
<td>469</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Analysis of the results show that there is evidence of association between the training college and health education for ante-natal groups, and parents groups, as well as for "others". For example a smaller proportion of health visitors are carrying out ante-natal teaching than expected ($P < 0.05$), this reflects the data for the South London boroughs who may be affected by the preponderence of teaching hospitals and midwifery training schools within reach of the area. A considerably higher proportion of health visitors trained at the College were running groups for parents with young children than expected ($P < 0.001$), this probably reflects the interest of one of the tutorial staff in this group of clients or perhaps the policies of the employing authorities. In the College group 37.3% of the health visitors were engaged in this work compared with 15.1% who trained elsewhere.

However further analysis shows that there is evidence of association between Croydon trained health visitors and health education groups run for expectant mothers, expectant mothers with a father's night, and expectant parents. There is also some association between Croydon trained health visitors and teaching secondary school groups. A smaller proportion of groups for expectant mothers were serviced by Croydon trained health visitors than expected ($P < 0.005$), 45.8% compared with 67.6% from other schools; however a higher proportion of groups for expectant mothers with a father's night were run ($0.005 < P < 0.001$), 44.1% compared with 24.9% who trained elsewhere, and so were groups organised for expectant parents ($P < 0.001$), 16.9% by Croydon trained health visitors compared with 3.7% elsewhere. This may reflect the emphasis in the syllabus on the family as a unit and the importance of the father's role in the dynamics of family life. The lecturer in human behaviour was a young father himself and his attitudes had a strong effect on many of the students who trained at that time. A smaller proportion of health visitors who trained at Croydon were teaching groups of secondary school children than expected ($0.025 < P < 0.010$), only 25.4% compared with 42.4% from other training schools. This may reflect the bias of some teaching staff to the needs of the very young child, another reason may be the dearth of suitable practical experience for students during the early years of the training course at Croydon.
### Table - 67

Number and Percentage of health education groups serviced by health visitors in 1971 by training school.

<table>
<thead>
<tr>
<th>Type of Health Education</th>
<th>Croydon College</th>
<th>Others</th>
<th>TOTAL</th>
<th>( x^2 )</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
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<td>128</td>
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<td>55</td>
<td>368</td>
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- 334 -
Of the 55 health visitors engaged in group teaching, 26 serviced one group in 1971, 18 serviced two groups and a further 8 were running three groups, four groups a year were serviced by two health visitors and the remaining one was running five groups. There is no evidence of association between these results and the health visitors who trained at the College. Only 4 health visitors were not running health education groups in 1971 and, of these, 2 said that the reason was pressure of work and not lack of interest.

The health visitor course is placed in the Department of Applied Social Studies. Because this department grew out of a social work course, the attitudes of the health visitor tutors which inclined towards giving priority to the needs of mothers and small children were reinforced by their social work colleagues who used the concepts of Freud and Klein in their approach. The lecturer in human behaviour was a powerful influence with the group, his personal experience combined with his professional interests led him to concentrate on the development in early years and the influence that this had on adult behaviour. Allied to this the lecturer in social administration was also very concerned with the provisions made for maternal and child care. In contrast the sociology lecturer had a comparatively weak influence on the class, this was in part due to her anthropological approach which the students found difficult to relate to their practice.

Analysis of the data relating to choice of teaching groups shows that in only one instance is there evidence of a slight association between the College and running groups for parents with young children (0.05 \( < P < 0.025 \)). Slightly more health visitors who trained at the College were prepared to organise and service this type of group than expected, 23.7% compared with 13.2% of the health visitors who trained at other schools. Again this may well reflect the particular interest of the member of staff responsible for
teaching the concepts of health education in the College. The teaching of ante-natal groups reveals that there is a possible association between the College and the number of health visitors prepared to run these groups \((0.1 \leqslant P \leqslant 0.05)\), this may in part reflect the bias of the staff in college towards the importance of this health educative function.

The course organised by Croydon Technical College (since 1974 the Croydon College of Design and Technology) extends over a period of 51 weeks and is in two parts. The first part consists of the three academic terms followed by the second, a period of ten weeks' supervised practice.

The theoretical study covers the five sections of the syllabus laid down by the Council for the Education and Training of Health Visitors. Practical work is carried out in the London Boroughs of Bexley, Bromley, Croydon, Greenwich, Lambeth, Lewisham, Merton, Southwark and Sutton. Students spend a day a week in their practical placements in addition to two blocks of two weeks each in the Autumn and Spring terms. One week's alternative experience is provided at Easter and the students spend one week in a psychiatric hospital. The supervised practice is normally carried out in the area of the student's sponsoring authority.

The examination for the first part of the course includes five written papers with an oral examination for borderline candidates in June. An oral examination based upon a project (since 1972 replaced by a neighbourhood study) and four health visiting studies, is held in September. Continuous assessment is made by tutors, fieldwork teachers and supervisors throughout the total training period.

An individual tutorial system supplements the formal teaching programme.
The curriculum subjects are divided as follows and show the percentage of time spent on each subject under broad headings:

**INTRODUCTION TO STUDY**

A series of three classes designed to introduce the student to a course of study and the problems of learning.

**SECTION I - THE DEVELOPMENT OF THE INDIVIDUAL**

1. **Introduction to Human Behaviour**
   - 37½ hours
   - 11.5%
   - This is a course of 25 seminars based upon extensive reading and case studies presented by the students. The study aims to identify factors influencing the development of personality and the behaviour of the individual throughout life.

2. **Paediatrics and Norms of Development**
   - 36 hours
   - 11%
   - This course of lectures given by general practitioners describes normal development and some deviations observed in public health paediatrics. The lecturers identify vulnerable times in the life of the young child, methods by which early detection of abnormality is made possible and measures to prevent disease and promote health.

**SECTION II - THE INDIVIDUAL IN SOCIETY**

This course is a combination of lectures introducing the students to sociological concepts and less formal classes in which certain topics with particular relevance to the work of the health visitor are studied in depth.
SECTION III - THE DEVELOPMENT OF SOCIAL POLICY

This series of classes is shared with students following, the one year social work course. It is initially a study of social administration and is based on project work undertaken in the first practical placement. Topics concerned with social policy are introduced in the second term and are the basis for inter-disciplinary discussion throughout the latter half of the course.

SECTION IV - THE SOCIAL ASPECTS OF HEALTH AND DISEASE

This section is covered by several short series which are co-ordinated by a health visitor tutor in seminars and in her series in Section V.

Public Health Practice and Epidemiology 9 hours

Geriatrics 9 hours

this course is extended by a teaching round in the hospital.

Mental Illness 9 hours

Diseases of the Chest 5 hours

Venereal Disease 3 hours

Various specialist lecturers introduce the following topics in this series, but the majority of teaching is undertaken by the health visitor tutors:

Marriage guidance, Family planning, Community relations, Obesity and its prevention, Infant feeding, Dental health 20 hours
All the Health Visitor Tutors and Fieldwork Instructors are involved in the teaching of health visiting.

Each student has an individual tutor and a fieldwork instructor who help to identify with her the function and the skills of health visitors.

Informal group teaching includes weekly classes in which the students present family studies for analysis. A programme of films is followed by group discussion with other students in the department, and small study groups are formed to revise or relearn subjects basic to the main course.

The formal classes are divided among the staff members according to their special skills and interests. Each series includes some teaching on methods of work and some on the role of the health visitor. The series is not exhaustive, but the principles are discussed in relation to a range of situations, some common, some topical and some controversial.

1. The Principles and Practice of Health Visiting

Topics covered include:

Health Visiting Skills
- Interviewing,
- District organisation,
- Clinic management,
- Assessment of need in individuals and communities,
- Deployment of community resources.

Special Patterns of Work
- In attachment schemes,
- In hospital liaison,
- In school health,
- Specialist health visiting.

44 hours
13.4%
1. The Principles and Practice of Health Visiting (continued)

Work with Special Groups

Ante-natal care,
Child management,
Developmental surveillance,
Hazards to the young child,
Play,
Preparation for school,
School health,
Adolescence,
Family planning,
Families with multiple problems,
Handicapped people and their families,
Middle age,
The elderly,
The bereaved.

2. Health Education and Nutrition

Health education is regarded as a special method of health visiting. Nutrition is introduced into the course as an example of an important aspect of health and also to demonstrate the selection and preparation of the content of teaching. The series is made up of a course of lectures and a series of seminars. Each student undertakes four pieces of individual teaching, at least two of which are within the context of health visiting and some are to nursing cadets.

The purpose of the seminars is to give the students the opportunity to study methods of communication in greater depth than is possible in the lecture series. For details of the health education syllabus see Appendix - C.

3. Methods of Investigation

This series is designed to introduce the student to the concepts of problem solving and elementary research methods, and to apply them to some contemporary problems of community health care.
4. **Films and Discussion**

Many of these sessions are shared with other students in the Department.

30 hours  
9.2%

In the College the students spend about 36% of the total time available in the academic year on practical work. During the period of supervised practice a further 400 hours are devoted to practical work, but during this time the students are visited at least once by a tutor and spend three study days in the College. The timetable is arranged as follows:—
<table>
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<tr>
<th>WEEKS</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
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<td>4</td>
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</tbody>
</table>

- **Orientation**
- **Autumn Term**
- **Spring Term**
- **Easter**
- **Fieldwork Practice**
- **Written Examinations**
- **Oral Exams**
- **Study Days**

**Timetable to show Fieldwork Experience and Supervised Practice**

- **Holidays**
- **Vacation**
- **Alternative Exp.**
- **Psychiatric Exp.**

**NOTE:**
- The timetable includes weeks 1 to 4 with designated days for each activity.
This takes no account of private study done within the College and at home, or of time spent on project work and the writing of case studies. Neither does it take into account time spent in preparation for teaching practice and evening health education sessions. Some of the teaching hours relating to the concepts of child care, the school health service, district management and group health education are covered in the fieldwork area where the student obtains her practical experience. In addition the student will gain experience and guidance from other disciplines working in the area, for example assistant medical officers in child health centres or general practitioners in group practice. She will also meet social workers, school teachers and many other statutory and voluntary workers associated with families for whom her fieldwork teacher is responsible. She may also meet the Health Education Officer. This can be reinforced and extended during the period of supervised practice.

A pattern of individual tutorials is well established. Each tutor is responsible for the students placed in one or two local authorities for fieldwork experience. She arranges to see the student once every two weeks, visits the fieldwork placement once during each block and at least twice each term. The tutor assists the fieldwork teacher in the planning of suitable experience and the evaluation of the student's health teaching. She is available at any time should the fieldwork teacher or student have difficulties, and may be consulted about terminal assessments. Meetings of fieldwork teachers are held regularly in College, but there is still a minority group who do not attend regularly and who have difficulty in meeting the conflict involved in combining practical teaching with the management of a busy caseload. The new responsibilities for student nurse experience in the community has added to the work-load of the senior health visitors and fieldwork teachers. In some instances this has affected health visitor education as there are few fieldwork teachers and they are all under constant pressure to make time for more teaching activities. In
some cases the fieldwork teachers are unable to participate in formal health teaching owing to this pressure so that students either have to get this experience with other fieldworkers or in contrived situations. Only a minority of students were able to observe their own fieldwork teachers demonstrate a piece of formal teaching or group discussion.

Established in 1967, the theoretical syllabus of the course has been improved and extended by the addition of each new member of staff who brings her own unique experience and skills. While the senior members of the teaching team have remained in post there have been many changes in the full-time and part-time lecturers who teach the background subjects. This means that students are taught by people who do not necessarily know the detail of the health visitor's work and in consequence are not always able to select the most appropriate material. The health visitor tutors must take the responsibility of working with the lecturers in building the syllabus for the background subjects. They must thoroughly understand the concepts that are taught and be prepared to help the student integrate the theory into their study of health visiting to appreciate its application in practice.

The interpretive function of the health visitor tutor is particularly important in relation to the preventive work of the health visitor. Assessment of need in changing communities is not easy; without an understanding of sociology and social administration it can be at the level of guesswork. The tutorial staff are aware of the need to evaluate the success of each course, and to prepare the students for the changing methods of work to meet the needs of society. Thus group dynamics, group discussion and group counselling methods have been included in preparation for work amongst small groups in the community and the hospital service. It is gratifying to be able to invite back as part-time lecturers, former students who are developing special aspects of health education; for example one is counselling adolescents, another is working with the parents of handicapped children and they are able to identify a health content in their work that is distinct from the contributions of social work colleagues, and which they feel is uniquely a function of health visiting.
The second part of the health visitor course at Croydon follows on the successful completion of the written examinations, it consists of a minimum period of 10 weeks supervised practice in health visiting. During this time the health visitor student is given a small case-load of some 100 families for whom she is responsible. However she will acquire more families and clients who have either moved into the area (or registered with the group practice) so that by the time the period of continuous supervised practice is completed, she will often have a full case-load. In certain areas the student will, on qualification, be moved either to another area or become attached to a Primary Health Care Team; this practice is to be deprecated as it unsettles the student and is disturbing for the clients who do not benefit from repeated changes of health visitor. Prior to this period of practice the supervisors are invited to attend a one-day seminar at the College, they are introduced to their students and meet the tutors who are personally responsible for them. Each student placement is visited at least once during the period of supervised practice, and a tutor is available at any time if either the supervisor or the students have difficulties.

It is unfortunate that the period of supervised practice takes place during the summer at a time when staff and clients take their holidays. One result is that the health visitor student's supervisor may be on holiday for part of the time, although another supervisor or health visitor colleague is generally available. Another factor is that the schools are closed and so a whole range of experience in the school health service, including health education, is not available during this final period of training. The amount of formal health education to all groups is often reduced at this time and so the student gets little opportunity to observe this work; alternatively she may find herself committed to running a group session in the absence of a colleague and without support.

The survey relates to staff who trained during the very early days of the training course at Croydon College of Design and Technology. It was a time when practical health education experience was not
available and therefore students had to learn in contrived situations, either teaching groups of young adults or teenagers belonging to cadet groups. Most of the application had to be done theoretically and was the cause of considerable anxiety for the tutorial staff. However the integration of the theoretical and practical aspects of health education has improved. The College is beginning to reap the benefit of having a fieldwork teachers' course in the department; the students from both courses meet several times during the year and the health visitor students become aware of the attention that is paid to the training of practical teachers. Some are able to understand better the constraints that they experience during their fieldwork placements.

The results of the survey did in part reflect the attitudes of some staff members who gave a very high priority to working with mothers and young children. In addition much of the practical experience took place in an area containing a high immigrant population newly arrived in the United Kingdom whose problems directly related to the care of the young child in a strange culture and a very different climate.

The findings do not come as a surprise, the staff had recognised in the early stages of the school certain biases in some areas of work and subsequent appointments to the tutorial staff have increased the diversity of interest and expertise. It is very probable that a subsequent survey would show a wider coverage of vulnerable groups in the work-load of the health visitors who participated in the survey as well as those who have trained more recently; for example a health visitor who trained during the period under review is now organising a group for parents of children affected by spina-bifida, others are counselling mothers requesting abortions and running discussion groups with adolescents. Several health visitors who trained more recently teach regularly in primary and secondary schools, and also lecture to health visitor students and student nurses taking the community care option course at the College. One former student is a health education officer.
This discussion has been limited by the lack of a precise definition of Health Education, a case could be made for all the Health Visitor's work to be classified as health education. It is certainly part of the function of the interview in the home and the consultation at the health centre as well as the formal class. In some instances health visitors have seen as their special skill the individual assessment of need, and the special approach; the content of their subsequent discussion arises directly from this assessment. This derives in part from nurse training where current teaching lays emphasis on the individuality of patients and the subsequent teaching in the health visitor course. The course philosophy is primarily concerned with the variability of human behaviour and the different influences through life that affect for good or ill the process of maturation. The influence of a different philosophy such as taught by learning theorists rather than teachers with a psychodynamic orientation may well influence the student's perception of her teaching role.

As the teaching staff emphasise the relevance of the study of sociology to the assessment of need, they frequently meet with some students who cannot reconcile their feelings about individual differences with the idea of common characteristics among groups, nor the profound effect of group inter-action upon behaviour. For them this has to be resolved before they can begin to build their assessment skills on a secure theoretical basis.

In Croydon at the time of the survey the health visitor tutors placed a very high priority on helping the mother with the very young child and thereby reducing some maternal stress in the hope that the freedom from worry would enable the mother to enjoy her child and that
this relationship would in turn help the child when he or she became a parent. These attitudes were reinforced by a very influential lecturer in human behaviour who was at the time the father of three young sons. He passionately believed that maturation depended upon the very early experiences and, following the teachings of Klien and Freud, dwelt on the basic stages of development and such influences as feeding, toilet training, play and discipline. He passed more quickly through the crisis points of adult life.

Since the survey the tutorial team has been diversified and this lecturer has left the College. There is now a greater sociological influence as a full-time staff member undertakes the teaching of this subject more intensively than was the case previously and a member of the tutorial staff with a particular interest in sociology conducts a series of seminars which integrate theoretical sociology with the role and function of the health visitor. This integrated series does affect the students ability to perceive need and to plan their work with families in order to meet this more realistically.

There is need for more work to be carried out in relation both to the definition of health education as a method of work, apart from the health education that is carried out by the full-time health education officers, or the specialist workers who are concerned with a particular social or medical problem, for example those who work with patients suffering from cancer.

This definition will probably reflect the philosophy and interests of the teaching team and initially therefore the work the newly qualified health visitors will do. While there is no measure for assessing the quality of the individual or group teaching with any precision, very little evaluation is possible. However an attitude survey would seem to be a logical extension of the work already undertaken in order to
determine whether or not a relationship existed between the philosophy of the school, and the emphasis on particular behavioural sciences, the students' perception of their role as health educators. If a difference were identified it might be useful to retest the same students at a later date to see whether their initial preparation was still influencing their thinking, or whether after experience there were greater or less disparity between the perceived role.

It must be made clear that this study is very limited and to elicit further conclusions it would be necessary to compare health visitors who trained at other establishments with those of Croydon College of Design and Technology. It would be wrong to apply this study to the National situation. Equally, no deductions can be drawn regarding the value of training at establishments other than Croydon College for those working in any area. It could well be that training given at other establishments could better fit health visitors for the areas under study in some particulars, but no observations of this kind were made.

It may be in future that the choice of training schools will be made more accurately by potential students recognising that each school produces different practitioners and that some styles of health visitor course are more appropriate both to the work carried out in some areas and to some workers. The Area Health Authorities may well consider whether some schools produce workers who will more adequately fill the vacancies they have or initiate new areas of work. These differences between practitioners have been recognised in the degree courses where some nurses have a predominately medical background, some are scientists, some social scientists. Health Education may well need such a blend among the health visitors who in a reorganised health service will be required to work in Primary Health Care Teams, within various hospital departments and in Health Care Planning Teams.
Uniformity of standard is necessary where possible but diversity of the knowledge base may be the means of promoting health more effectively in the changing society of today.
When designing the questionnaire it was decided to give the respondents freedom to make additional comments and suggestions. The last page of the questionnaire was left blank for this purpose and 370 respondents made use of this facility. The comments were so revealing that it was decided to put some of them in a special section.

Some comments were chosen because they were outspoken or showed initiative and enthusiasm for health education. Others revealed a lack of support from administrative staff, minimal help and an apparent lack of sensitivity to the needs of recently qualified staff. While many health visitors recognised their role as health educators they recognised their short-comings as teachers - particularly in the school setting. In some instances they were critical of the quality of the health education training they had received as students both in training schools and fieldwork practice. Many health visitors made constructive criticisms and suggested ways in which their successors could benefit during training. The wide range of attitudes revealed some of the problems facing both the training schools when planning programmes of teaching experience, and nursing administrators in meeting the changing needs of the communities within the local health authorities.

Health Education

In most instances the health visitors recognised their role as health educators although some interpreted the concept of health education only in terms of formal group teaching:

"I feel that health education is an essential part of our work which cannot always be followed in every field owing to pressures of our other priority work."

"Personally Health Education seems to depend on each individual H.V., her aptitude and interest in the subjects concerned."
"Had I wished to teach I would have taken a teacher training course to fulfil my ambition. I feel Health Visitors are not properly equipped to teach, especially in schools."

One respondent who had moved three times since qualifying in 1968, and was not currently engaged in group teaching wrote:

"The health education I am most interested in is talking to small groups, but rather than talking, I am most interested in making interesting displays for mothers to see while at clinics."

Training

Twelve health visitors considered that their training in no way prepared them to fulfil their roles as health educators:

"Having only just completed my H.V. training I feel I would have appreciated some help and guidance on techniques of teaching."

"It has been really a case of learning by one's mistakes as far as teaching is concerned (that is in my own experience)."

"Health Education and teaching methods were scarcely touched upon in my training and consequently, upon qualification as a Health Visitor, I felt poorly equipped to undertake this important aspect of the work. I have been very thankful of having undertaken the full midwifery training and of therefore having some experience of addressing small groups, i.e. expectant mothers."

"Health Education is part of a health visitor's duties. A 51 week course cannot and did not cater adequately in the field of health education. There are so many aspects of this work to be studied - unless various spheres are covered in reasonable depth - latent potential may remain undeveloped in any student. Enthusiasm can wane."
In particular, some felt that they were ill-prepared to teach in schools:—

"I feel that a health education course taken as a post graduate essential before any health education is undertaken in schools.

During my training, teaching practice was not varied enough and too spasmodic, opportunity only arising when my days at clinic coincided with the occasional suitable groups and subject being available. Teaching skills are built up gradually only by regular and frequent practice with receptive groups."

In 62 instances constructive comments were made to improve this aspect of health visitor training. In retrospect the respondents acknowledged their lack of experience both in teaching practice and also the opportunity to observe an experienced colleague in action. One said:—

"I think students and new health visitors could gain valuable experience by attending sessions where their colleagues and others involved in health education are teaching."

Another health visitor thought that:—

"More supervised teaching practice during training would have been useful. The opportunity to observe experienced teachers at their job would have been very helpful."

Another health visitor was of the opinion that:—

"The whole question of teaching health education is not given sufficient time, when Health Visitors are being trained and that most newly qualified H/V's feel rather inadequate in this field when they approach it for the first time after qualifying. Student Teachers spend 3 years learning how to teach, I think it is a bit optimistic to expect Student Health Visitors to manage it in only a fraction of that time."
Yet another stated:

"During the training period the aims of Health Education were stressed clearly. However methods of teaching, preparation, and techniques of Health Education, were only briefly dealt with. I believe Health Education is vitally important to the community, and if it is to be successful, a more thorough training programme is essential."

Among those who voiced their opinion on their training, 30 stated that they would have appreciated more practice sessions:

"I feel that there should be more times given during training for practical teaching."

"More practical experience of Health Education during training would have been useful."

"I would like to see a little more practical work in Health Education during training. It is only by practising teaching and talking to groups that one gains the necessary confidence to do so later."

Two respondents recommended that a further course of health education techniques should follow soon after qualifying:

"I don't think enough instruction in Health Education is given in the Health Visitors Course .... I would like to suggest that a 6/52 or more course be given for Health Visitors who are interested in the subject, just to give them a better 'grounding' in the actual 'delivery' of talks etc."

"The only other suggestion I have is that health education should be stressed much more during health visitor training than it is. Also I think that all health visitors should have an opportunity of doing post-certificate training in health education as close to qualifying as possible or could this be included in health visitor training? So that also on qualification as a health visitor one also had a certificate in health education."
Of the remainder, health visitors were satisfied with the theoretical content of the course:

"...the amount of instruction on the teaching aspect of Health Visiting was quite adequate, ..."

"The health visitor course was helpful in preparing one for small group teaching and person to person approach."

Another referred to the need for in-service training on the job:

"The help and experience received during the Health Visitors course when preparing and presenting talks to various groups was invaluable.

In service training on teaching techniques and assessment of achievements would perhaps be helpful."

A further 15 considered that the subject was adequately covered during training, and the following selection of comments speak for themselves:

"Much of my training was concerned with health education which I found very interesting and great benefit in practise."

"I think my interest was aroused by excellent teaching on H.E. during my H.V. course and it is at this time that Health Educators amongst H.V's. are either made or squashed, because nurses as a species are naturally reticent to teach.

There is definitely a need for more H.E. in schools, so H.V. students should be encouraged in this aspect of our work."

"....special emphasis was placed on the need for Health Visitors to participate in all aspects of Health Education including talks both in schools and to outside groups. I feel that this is a vital role for the Health Visitor of today and from experience one wonders whether this is stressed to an equal extent in other H.V. training establishments."

The reality of working conditions and lack of time for preparation and running group sessions influenced 32 health visitors, one said:
"The health visitors' course training in health education was excellent - though actual working conditions do not always allow this training to be utilised. However the enthusiasm engendered by the course lingers on - and should still be available for use if - and when - it is needed."

However good the training and the motivation to participate in group work, the question of the preparation of health visitors to make a realistic appraisal of priorities in their work arose, for example one respondent stated:--

"Although we were well prepared in our training for teaching, in practice there is never time to prepare lessons, and teach all groups that one would wish."

Specialist in Health Education

In two instances, participants echoed the Jameson Report in suggesting that formal group work should be given only by those with special interest in this work:--

"Health Education talks to large groups would be better given by someone interested and qualified in this field."

even to the extent of becoming a specialised worker:--

"I feel that health education needs some stimulus, as so much could be achieved through this work. However, I do not feel that every health visitor is suited to this work, and that it would be better if health visitors who are interested in the work, could be given some further training in teaching, and then given an area of their own, solely as health education officers."

Further Training

Sixteen health visitors felt that they still needed more teaching experience and some had taken steps to obtain this in their own time:--
"At present I am attending evening classes on a 2 years course, studying for the Further Education Teacher's Certificate. I feel I needed this extra tuition for teaching formally in secondary schools (as part of the curriculum), and I am far more confident now with this additional knowledge and consider the instruction obtained in the Health Visitor Training Course useful only as a basis."

"Personally I have felt the need for a teaching qualification and am at present taking the City and Guild's Further Education Teacher's Certificate in my own time."

While others emphasised the importance of support from administrative sources. In the following instance the support is good:

"I feel that my training was very adequate to cover the needs of my work now especially with regard to Health Education. However this very vital part of my work would not be achieved without the support of a good health education organiser with up-to-date information."

However all too often the field worker appears to be struggling in isolation. One health visitor said:

"I feel that teaching as part of a team of Health Educators would be agreeable to most Health Visitors but the formidable prospect of being solely responsible for teaching Health Education over a long period of time is the main reason that Health Visitors feel unable to cope with it."

Another stated:

"It seems to me that in the health education would be able to improve if there was more encouragement given from the higher level."

While a third was of the opinion that:

"It is essential they have the guidance of a Health Education Officer to help them or else it is easy to feel "thrown in at the deep end". Perhaps it would be
more realistic if those student H/V's who expressed
themselves to be very interested in this aspect of our
work, were given an extra training and concentrated on
this aspect leaving their other colleagues free to work
in other spheres."

17 health visitors cited various reasons why they were unable
to participate in group sessions. The following comment highlights the
feelings of many of those who wrote expressing their feelings of frus­
tration over this area of their work :-

"Although the Health Visitor during her working day, and her
continued contact with individual families and small groups,
is able to play an important role in Health Education, her
scope is limited. Large case loads, an increase in family
stresses, break-down, and mental depression, particularly
noticeable in my own area, limited the number of persons she
can deal with during a working day. Attachment of general
practice although of great value in some aspects, incurs
greater travelling distances between visits, which ultimately
decreases the number of visits made to each family annually.
Teaching within ante-natal clinics, has been reduced in my
area, due to increased hospital confinements, and difficulties
due to the expectant mothers attending both G.P. clinics and
hospital clinics for their ante-natal care. Teaching in
school is encouraged in my area and there is great co-operation
between health visitors and school teachers, but again this
takes up time, and reduces family visiting programmes.

In my opinion there is a great need for a new specialised
field of highly trained Health Education teams, solely
involved with Health Education, and able to devote solely
their skill and time to teaching."

Another health visitor emphasised the pressures upon the worker
who is prepared to undertake this form of work, she said :-

"Once one gets involved in group Health Education it does
tend to snowball and take up a lot of time particularly with
prepn. of subject, therefore many H/Vs with large densely
populated areas tend to find it time consuming and will not
take it up.

If one is prepared to do Health Education one must keep
abreast of current knowledge. This takes up time ? - during
working hours or out of working hours."
Ante-Natal Classes

Comments directly related to group work in the ante-natal period were received from 34 health visitors. In some instances they were unable to participate as the local maternity hospital or domiciliary midwife were responsible for these classes. It appeared that health visitors with a midwifery qualification were more confident about this aspect of their work:

"I feel that the teaching I do with Expectant Mothers is entirely drawn from my Midwifery experience, not from any help received during H.V. training. Naturally a wider aspect of follow-up care is now included but my talks vary little from those undertaken when a practising midwife."

Those who had only received obstetric experience were not so happy about their ability to run ante-natal groups:

"I particularly felt worried over Ante-natal groups as my obstetric training was so previous, and my knowledge poor. I now enjoy these groups but I cannot say my course helped me at all here. I could not admit to lack of knowledge at that time, as very few were obstetric trained."

One respondent stressed the importance of training in "psychophysical relaxation methods BEFORE ATTEMPTING CLASSES ALONE."

In some instances reference was made to continued classes with the midwife and/or physiotherapist, although in the latter case a sour note crept in highlighting confusion of roles and professional jealousy:

"I think it is an excellent idea for the midwife to participate in the parentcraft classes.

I have worked with 3 different physiotherapists and of these 1 was excellent. She taught the mothers exercises in conjunction with the theory, and she and the mothers worked hard at the exercises. This helped to give the mothers confidence.

The other two physios both gave the impression that they are perfectly capable of doing the midwife's and H.V's. teaching and proceeded to do so, showing very little interest in their own roles."
"I do Parent-craft classes with the Physiotherapist and find it frustrating at times, because the Physiotherapists are forever talking over the Health Visitors teaching. They seem to enjoy talking about the signs of labour, breast feeding, etc. They enjoy talking about these subjects but cannot always answer the questions raised."

---

55 made comments about the health visitor's role in school, some agreed that they were able to teach in an educational setting although they had certain reservations for example:

"I feel health education in Secondary Schools very important but more time should be allocated to small groups of about 15-20 pupils instead of about 40 .... Where possible group discussion should be encouraged and co-ordination with teachers, parents and local G.P's."

Others felt it was better to have health visitors specialising in this work:

"I doubt the value of teaching mothercraft in schools under the present rather haphazard system, this could become a valuable part of the school curriculum, - but from past experience my feelings are that this should be taught by a qualified teacher or a health visitor specialising in this field."

In some instances it was felt that the health visitor's expertise should be used more in the role of an advisor:

"I feel sometimes in school a H.V. could act more in an advisory capacity for teachers own health programmes."

"In my short experience I have found teachers, especially young ones, keen on receiving advice for carrying on their own Health Education programmes, but less enthusiastic about a special person coming in to fill this function with their classes."
Another health visitor stated:-

"It is my opinion that there is no need for health visitors to teach in schools because surely teachers are the better qualified in teaching methods."

Several respondents recognised the need for further training for this sphere of their work, and one considered that specialisation was the solution to the problem:

"I feel that in future - Health Education in the Senior Schools will call for a Diploma of Health Education and in each senior school a Department of Health Education itself - to facilitate a closer link with the rest of the teaching staff. The Head of Department will be a Health Visitor who will be able to devote her time to the programme of one school - in fact a specialist."

Hospitals

Only two health visitors commented on the possibility of expanding health education into the hospital service:

"Throughout my training I had adequate opportunities for health education, but did feel the opportunities for health education in hospitals was sadly neglected. Personally, I do feel health visitors could play a vital role in preventive medicine in both group practice and hospitals and feel it will enhance our job-satisfaction and make our 'role' in society more definitive."

"I have been spending a fair amount of time in hospital and hope to see Health Education opportunities expand in that direction."
Summary

370 out of a total of 469 respondents wrote comments about their experiences in health education either as a student or subsequently while working in the field.

Among the health visitors only 22 said that their training had been adequate; a further 41 stated that it had been adequate but they had reservations about it; and 30 expressed the opinion that they required more practice in running groups as students.

The pressures of a heavy caseload together with the time factor appeared to influence the respondents away from group work although many intimated their disappointment over this.

An equal number (15) suggested a specialist role for those particularly interested in this aspect of work, and, further training to enable staff to reach their potential. Work in schools attracted most attention with 55 health visitors voicing their opinions about lack of training as students and their subsequent involvement amongst school-children.
APPENDICES
OUTLINE FOR COMMUNITY HEALTH NURSING THEORY

UNIT - I - The nurse as a family health worker in the community

1. Synthesis of prior knowledge (sociology, psychology, nursing). New concepts and knowledge as they relate to nursing in families and communities.

2. Health needs of a family (normal and otherwise).

3. Etiological factors and problems (family and community) affecting nursing care and services.

4. Professional health guidance for the nurse as a family health worker in the community.

5. The community health nurse as a family health worker.

Functions of the nurse in special services and in individual care, e.g., tuberculosis, other morbidity services, occupational health, school health programmes.

UNIT - II - The nurse as a member of the health and welfare team.

1. Review of prior knowledge and introduction to new concepts of community health structure and organisation.

2. Critical analysis of team concepts and the varying composition of health and welfare teams.

3. Critical evaluation of the knowledge and skill needed by the community health nurse for team membership.
UNIT - III - The community health nurse in human ecology

The locale of the nurse's professional work is the community - a fluid and complex structure composed of individuals and families whose bonds are constantly forming and re-forming in response to social, economic, political, philosophical and technological stimuli. It is important that the nurse know what these bonds are and perceive the nuances of behaviour that presage change in order to act appropriately.

In effect, this unit summarises the course, deals with aspects that affect the nurse, and gives her an opportunity to re-examine and clarify her philosophy of community health nursing and community health.

1. Re-examination of the philosophy of community health nursing and of the nurse's role as affected by factors in flux such as medical and technological discoveries and changes, demographic facts and predictions.

2. Exploration of current research on community health nursing and outline of the research needed.

3. Utilisation of research on "planned change" in providing nursing care and services.

The nurse as a family health worker in the community

Nursing in the care, prevention, and control of tuberculosis.
The objectives are to study the epidemiology, management and control of tuberculosis as a long-term communicable disease and its implications for the nurse in the hospital and in the community; to show how the nurse can increase the patient's knowledge of the meaning of long-term illness and the underlying psychosocial factors affecting adjustment to illness, treatment and rehabilitation; to develop the nurse's ability to help the tuberculosis patient and his family cope with the problems created by long-term illness; to promote understanding of the role of other members of the health and welfare team in the total care and rehabilitation of the patient.
Appendix - A (cont'd)

I. Individual, family and community aspects of the tuberculosis problem.
   A. Incidence and prevalence of tuberculosis in the community, state, nation and world:
   B. Community care and rehabilitation:
   C. Stresses in long-term illness:

II. Role of the nurse.
   A. Challenges and skills.
   B. Protection and infection.
   C. Attitude of the nurse toward tuberculosis and long-term illness and its influence on patients and their families.
   D. The nurse as a contributing member of the therapeutic team in total patient care and rehabilitation:

III. Medical and scientific knowledge essential to understanding tuberculosis as a long-term illness and a public health problem.
   A. Review of anatomy and physiology of respiration:
   B. Review of bacteriology - the tubercle bacillus:
   C. Review of the pathological processes in tuberculosis:
   D. Classification.
   E. Conditions co-existing with tuberculosis, e.g., pregnancy, diabetes, alcoholism.

IV. Treatment of tuberculosis.
   A. Medical management:
   B. Surgical therapy.

V. The nurse in the community organisation for the care, control and prevention of tuberculosis.
   A. Home care programmes.
   B. Out-patient care.
   C. Case-finding:
   D. Community education.
   E. Immunization.
Practical work, carried out concurrently with lectures on theory, will concentrate on meeting the nursing needs of tuberculosis patients and families wherever they may be. Students will be given practical experience of a long-term communicable disease to help them understand the emotional, social, and economic impact of tuberculosis upon patients, their families and the community. Opportunities will be provided for students to learn how to help patients and their families cope with their many and varied problems and, in the process, relate their nursing services to other services needed by patients and families.

Practical work for the student nurse

The purpose of the course of practical study is to provide the student with opportunities:

1. to learn, through continuous contact with selected families known to a particular community health agency, about the changing nature and the complexity of family and community health concerns and problems;

2. to see how the point of view of the individual family members, the family as a whole, the community, the community health nurse and the health agency influences the kind and extent of nursing participation and also determines the criteria for evaluation of the results of both the individual nurse's efforts and those of the entire nursing service;

3. to bring together old and new knowledge and sharpen the ability of the nurse to put them to use when she becomes a family or community health worker and team member;

4. to increase and extend knowledge and ability to teach groups, to stimulate the formation of groups for health teaching, to interpret community health nursing to special groups, to co-ordinate nursing services to families;

5. to define and meet the nursing needs of tuberculosis patients and families;

6. to understand and participate in civilian emergency and disaster plans and engage in epidemiological investigations.
The student works with a small number of families. These are selected on the basis of the health situation in the family, the student's background, and the knowledge and ability she needs to develop in community health nursing. Although the initial reason for contacting a family may be to meet the nursing care needs of a particular member, the student's concern is with the health of the entire family. She is helped to initiate nursing care in the area and expressly to meet the family's needs. Care will include the health appraisal of the entire family and an attempt to improve its health.

The student is given the opportunity to visit selected occupational health schemes covering the wage earners in the families where she is giving nursing care. In families where there are children of school age, she observes and studies the school health programme and participates in selected nursing activities. In all of these settings, community, home, school and industry, opportunities will be sought to increase her knowledge and provide experience in emergency and disaster nursing. In addition, the student will learn how emergency care is provided through a community hospital and how the community plans for civil defence, and, whenever feasible, she will help where nursing care is needed.

All practical work is under the guidance and supervision of a University faculty, and will include individual and group conferences.
Questionnaire circulated amongst Nursing Officers requesting information about the staffing establishment and Local Health Authority Policy.

**HEALTH VISITOR SURVEY**

1. No. of Health Visitors taking part in survey

2. No. of non-respondents.


5. No. of staff engaged in triple duties on 1st March, 1972.

6. Did the survey sample compose of the total number of Health Visitors in post who qualified in or after 1968? Yes/No
   
   If the answer is No, how was the choice made?

7. Has the authority a policy regarding health visitors carrying out group health education?

8. Has the authority a policy regarding group practice attachment?
Health Education Syllabus 1970-71

Autumn Term

Group Teaching Methods

Introduction to health education; the principles of teaching and learning.

Preparation; presentation, including aspects of group management.

Assimilation, assessment, and evaluation.

Methods of teaching:

- a. lectures
- b. talks
- c. demonstration
- d. group discussion
- e. projects
- f. films
- g. visits of observation
- h. actuality sessions
- i. role play
- j. team teaching

Visual and teaching aids.

Voice production.

Tutorial Group Work

Preparation for teaching practice:

Each student has a minimum of two pieces of teaching practice with British Red Cross Society or St. John's Ambulance Brigade Cadets in the area. A group of ten students are responsible for the planning, preparation and organisation of a series of either Home Nursing or First Aid Lectures.

The groups meet periodically to report on progress and to brief those still to present their work. The tutor responsible for the overall running of the series has additional sessions to discuss the successful outcome of individual teaching sessions.

Stress is laid upon active participation of the cadets.
SPRING TERM

The Concept of Health Education

The development of health education.
Present day aims and scope.
The relevance of various Acts/Reports/Surveys etc.
Public Health Act 1936,
Health Services and Public Health Act 1968,
National Health Service Act 1946,
Jameson Report,
Cohen Report,
Sheldon Report,
Education Reports including Plowden, Newsome, Robins, etc.,
Royal College of Midwives Preparation for Parenthood,
On the State of the Public Health,
Green Papers, 1 and 2.
The role of the health educator :-
a. with individuals
d. in industry
b. with groups
e. mass media
c. in schools
f. the health education officer

Written Work and Group Work

The preparation and presentation of one or more of the following topics :-
a. preparation for parenthood
b. health education in schools
c. parents groups
d. the middle aged
e. the elderly.

This term students have a minimum of two pieces of teaching with on-going groups in their fieldwork area. The F.W.I.'s., are responsible for this experience and send in written reports to the college.

SUMMER TERM

Aspects of Health Education

Specific areas are considered during this term and subjects covered include :-
a. nutrition
e. dental health
b. the cancers
f. drug addiction
c. venereal diseases
g. smoking
d. mental health

A visit is arranged to see the work of a Health Education Department, if possible in the students fieldwork area. Extra visits of observation are arranged for students as required.
Appendix - D

Some Examples of Health Teaching by Health Visitors
The City of Leeds

Akester (1957) describes a scheme started in January 1955 when a Senior health visitor holding a parentcraft teaching certificate was appointed to organise the work. She retained a small case load and was expected to allocate two-thirds of her time to health education. The first 3 months was spent in establishing rapport with health visitors and domiciliary midwives in the clinics. She assessed their interest in health education and gathered suggestions for suitable topics.

Eventually a Health Education Group was formed and regular weekly meetings were held amongst the eight health visitor participants. The service began by meeting requests from interested organisations and approaches were made to groups convened for other purposes. Sessions were held in both local authority and private premises; with the aid of their colleagues and other municipal workers they built up a good stock of visual aids.

In a survey of the work of health visitors in that City, Akester and MacPhail (1963) referred to the development of health education. Nearly all the 60 health visitors, including a group advisor with responsibility for health education, taught groups in the health centres. However the amount of time spent on health teaching was only 0.9% of the total time but it should be remembered that health education in schools was carried out by health visitors employed by the Education Department and not included in the survey. Also the ratio of one health visitor to 8,500 population in the City of Leeds in 1961 is below that recommended by the Jameson Report.
of 1:4,300 population. Staff were also involved in sessions held at youth clubs and women's groups. The group advisor participated in pre-release courses for men in Armley Goal.

In this discussion on the work of health visitors Akester and MacPhail pointed out that in fulfilling their functions as health educators and social advisors a large proportion of their time would consist of teaching on an individual basis in the clinics, homes and elsewhere. This aspect of their work came under the category of "advice or discussion".

In addition to teaching basic facts and principles in the prevention of ill-health at all ages, it included information and guidance on social factors, and follow-up visits to interpret medical diagnosis and the implications for treatment and care. Akester and MacPhail recognised the difficulty in measuring the success of preventive work, particularly in long-term education. However they noted certain trends in this work; for example the efforts of responsible bodies have stimulated sections of the population into a greater awareness of health matters and mothers from "good homes" were now approaching their health visitors for advice on health care. Another trend was the influx of immigrant families with language difficulties and social problems, especially housing. Akester and MacPhail were of the opinion that with the increasing number of chronic sick and elderly the demands on the health visitor's time were likely to increase.

The County of Buckinghamshire

One of the earliest and most comprehensive surveys undertaken of social welfare staff and their clients was undertaken by Jefferys in

- A12 -
Buckinghamshire (1965). She found that during the period under review, 1960-61, there was an establishment of 47 health visitors in the County and their case load was in the ratio of 1:10,300 population approximately. An average of 23.5 hours (55%) of the health visitor's time was spent on home visiting including the follow-up of school medicals and visits initiated by the hospitals, general practitioners and child care officers. Some visited patients with tuberculosis and the chronic sick. Allowing for the subtraction of travelling time from the proportion spent in this way it can be assumed that the Buckinghamshire health visitors spent less time in person to person health teaching than did those in Hertfordshire but more than health visitors in Leeds. Seven hours (16%) of their time was spent in child welfare clinics, schools, and group health education for expectant and nursing mothers, young parents, Secondary school children and mother's clubs. Nearly 80% of all calls were routine visits; in a third, health visitors gave instruction in feeding or child management; and in a fifth, advice on health problems. About 11% of the visits were made to expectant mothers to make arrangements for the confinement.

The County of Hertfordshire

The Hertfordshire policy to attach all domiciliary nursing staff to general medical practice started in 1964 and five years later was virtually complete. A study by Allen, King & Abbott (1970) showed that the health visitors spent 2.6% of their time engaged on health education whereas less than half this percentage of time was spent on teaching by the triple duty staff (1.2%). However, assuming that the category "health education" referred to group teaching then the triple workers, devoting one-third of
their time to health visiting duties, were allocating relatively more time to this function than the full-time health visitors. On the assumption that a major activity of health visiting is that of health teaching whether it be with groups or individuals, then the 59.5% of visits dealt with by advice and discussion is slightly higher than Akester's figure of 55.5% in Leeds; 66% of families with social problems received health advice from the health visitors and 64% from the triple workers. Of the total time spent in sessions allocated to particular activities: 42.2% of health visitor sessions were spent on child health, 21% in school and 10.3% on health education; the triple duty nurse spent 33.1%, 18.4% and 12.2% sessions respectively on these activities.

The following table indicates the types of health education undertaken by the staff:

Table - XVIII from the Survey (page 13)

<table>
<thead>
<tr>
<th>Types of Health Education Undertaken</th>
<th>% of Health Visitors Involved</th>
<th>% of Triple Workers Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching children in schools</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>Other teaching sessions in schools</td>
<td>13</td>
<td>-</td>
</tr>
<tr>
<td>Running parents and mothers clubs</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>Giving talks at ante-natal classes</td>
<td>40</td>
<td>27</td>
</tr>
<tr>
<td>Running specific post-natal mothercraft</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Other talks given in previous year (excluding sessions above)</td>
<td>42</td>
<td>9</td>
</tr>
</tbody>
</table>
The survey revealed that 42% of health visitors were involved in a very wide range of formal health education in addition to sessions held in schools, ante-natal and post-natal classes, and mother's clubs. Only 15% assisted the midwives in teaching ante-natal patients. Of the total health visiting establishment a quarter had not carried out any group teaching during the period under scrutiny.

Summary of Findings from Studies of the Health Visitor's Work:

<table>
<thead>
<tr>
<th>Local Health Authority</th>
<th>Berkshire</th>
<th>Hertfordshire</th>
<th>Leeds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of Survey</td>
<td>1960-61</td>
<td>1969</td>
<td>1961</td>
</tr>
<tr>
<td>Ratio of staff to total population (1)</td>
<td>1:10,300</td>
<td>1:6,098</td>
<td>1:8,500</td>
</tr>
<tr>
<td>Attachment to general practice</td>
<td>None</td>
<td>93%</td>
<td>None</td>
</tr>
<tr>
<td>Average length of working day - (hours minutes)</td>
<td>08.06</td>
<td>08.12</td>
<td>07.14</td>
</tr>
<tr>
<td>Proportion of time for individual teaching :-</td>
<td>55% (2)</td>
<td>59.5%</td>
<td>55.5%</td>
</tr>
<tr>
<td>Proportion of time for group health education :-</td>
<td>-</td>
<td>2.6%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Proportion of time for work in clinics, schools and group health education :-</td>
<td>16%</td>
<td>10.6%</td>
<td>27.4% (3)</td>
</tr>
</tbody>
</table>

Special Features :-

(1) The Jameson Report recommended an average ratio of 1 health visitor to 4,300 population,
(2) Includes time spent on travelling,
(3) Not concerned with school health service, increasing immigrant population.
MacQueen (1969) outlined the basic principles upon which the health education service was founded in 1954:

1. motivation of the public and the means whereby good health can be achieved,
2. recognition of the key role played by the health visitor,
3. integration of group and individual teaching, and the use of mass media,
4. collaboration between the health and social work staff.

In his opinion the health visitor is in a unique position in the preventive field and is the key worker in the health and welfare services. She is the primary health teacher and medico-social counsellor of the whole family, and while a practitioner in her own right yet she should work in association with general medical practice.

Without in any way diminishing the key role of the health visitor MacQueen says that perhaps the most important development in the Health and Welfare Department was the setting up of a Health Education Division, linked with the Health Visitor Training School, in 1956. The development of the health education service was dependent upon the full co-operation between all the branches of the National Health Service and those of the Social Services.

In describing the health visitor's work in Aberdeen, Nairn (1969) emphasised that they carried out the full range of duties identified by the
Council for the (Education and) Training of Health Visitors. 28 full time health visitors were "associated" with general medical practice dividing their time equally between practice needs, the school health service, and health education. This scheme was to be extended and health assistants were employed to release health visitors to teach in the schools. Some male health visitor officers specialised in school health education.

Lamont (1969) gives an account of the development and work of the health education scheme in Aberdeen. As the Director of Advanced Nursing Education and Group Health Education for the City, she emphasised the differences between the work in Aberdeen and that elsewhere: first, the main instrument of health teaching has been the health visitor; and secondly, the Health Education Section has always been closely associated with the Health Visitor Training School. A pilot scheme involving a Home Safety Campaign produced a measurable degree of success in focussing public attention on the hazards depicted - the attitude in Aberdeen being in direct contrast to Akester and MacPhail's claim that the effects of health education cannot be measured! In addition the campaign was useful in testing the health teaching potential of the staff. At the same time two in-service courses on mental health demonstrated the effectiveness of group discussion.

The Section had the following short-term objectives:--

1. to prepare prospective parents by means of a continuous nine-weeks course; as most parents attending were mothers special joint sessions for fathers were included;
2. to promote Parents' Clubs;
3. to provide information on health topics and the use of the health services in the City.

The long-term objectives of the Section were:

1. to introduce formal health teaching into the schools;
2. to extend group health teaching to other age groups;
3. to continue the mass approach through campaigns, combining a "visual attack" with allied group teaching on selected topics to specific groups;
4. to embark upon the detailed evaluation of the work of the health education section and its effect upon the general public.

The team consisted of two health visitor tutors, five volunteer health visitors and an actively committed medical officer of health. With banner headlines in the local press ("1,000 Salvo Blitz on Disease") the work of the Section began. The team started by focussing on the ante-natal relaxation groups; they offered a continuous nine-weeks programme covering nutrition, maternal health, family health services and child growth and development. In the evenings the same team provided a weekly programme on health matters for the Parents' Clubs. The members became actively involved in the sessions and soon began to suggest topics for discussion. Lamont was surprised that the team somehow managed to achieve its target of teaching 1,000 groups in the first year with such limited resources. However they did not achieve their long-term goal, that of teaching in the schools.

The provision of health assistants to relieve health visitors of unskilled work enabled the professional staff to concentrate on health
education in schools, clinics and amongst other groups; by this time every health visitor had some group health education responsibility. Two health visitors were appointed as full-time health education specialists: one was responsible for ante-natal teaching, health education in primary schools and the support of new staff; the other developed health education programmes in secondary schools, organised the distribution of teaching aids and was responsible for displays and exhibitions. A full-time artist and clerical staff were employed. After the Section was fully staffed the Health Visitor Tutors provided support in a consultant capacity, their chief contribution coming from training student health visitors to develop their skills in health education. Both Aberdeen and Birmingham (see page 113 in Chapter IV) owe much to the enthusiasm of health visitor tutors in the planning and organisation of formal schemes of health education.

The current work of the Section covers four main aspects: -

1. The Maternity Hospital Out-Patient Department holds five afternoon sessions for expectant mothers and a further nine sessions are held in clinics; all classes are run by health visitors. Expectant mothers are invited to attend a series of eight classes starting no later than their seventh month of pregnancy. Between 75-80% of the primipara attend and Lamont reports that there has been a significant increase in certain "social class groups".

2. The original intention to provide evening sessions for both parents failed largely because someone had to stay at home and babysit! Many of
these Mothers' Clubs have become self-supporting. Others still require help and Lamont asserts that these have been influenced by the disappearance of the Centre Superintendent and the linking of health visitors to group medical practice; she suggests that the answer may lie in the provision of advertised courses on specific topics.

3. Following the revision of the primary school syllabus there has been a big increase in health teaching in this age group: some 70% of the City's schools have health visitors engaged in this work, either working alone or collaborating with class teachers. The philosophy is one of maximum participating and discussion, with class projects and team teaching backed by a battery of teaching aids supplied by the Health Education Section. In the secondary schools the shortage of health visitors meant that health teaching had to be restricted to the school-leavers, and some of this work is carried out by the health visiting officer.

4. The development of mass communication through campaigns and exhibitions has continued. Finally Lamont emphasises that their most difficult task has yet to be attempted - that of evaluation. Some measurement has been achieved: for example, the expansion of the family planning service resulted in a rise of almost 300 per cent in attendances from 1966 to 1969, and the follow-up visits to the homes in 1956 revealed a 50% cut in the incidence of home accidents following the first home safety campaign.
South Highgate Parents' Club

The Club was established in St. Pancras in 1948. The Medical Officer of Health expressed the hope that it would become a "neighbourhood centre of child interest" run by the parents with the help of his staff. The aims of the club were to provide health education, to establish liaison between the Welfare Centre and the local community, and to organise social activities for parents and children. To mark its twentieth anniversary an anonymous account of its work was given in the Mother and Child Journal, October 1968. The Club was allowed to use the Welfare Centre free of charge but was expected to be financially independent. From its inception the parents took a keen interest in educational matters in the local schools. Health visitors are still involved in the health educational activities of the Club, and although the early classes in sewing and cookery remain very popular, in recent years other subjects have been introduced including family planning, road safety, safety precautions in schools, food hygiene and aspects of environmental health. Other routine health matters have been discussed and a regular keep-fit class has been popular in the evenings. The Club had played an important part in the life of the community during the 20 years it had then been in existence, providing a forum for health education, stimulating an interest in local affairs and enabling social interaction of both parents and children.

East Croydon Toddlers' Club

In an unpublished account of the work of the Club, Hall (1962) describes how the health visitors working in a predominantly working class area of flats and bed-sitting rooms were concerned over the lack of facilities
for toddlers and pre-school age children. So many infants attended the local Infant Welfare Clinics that the toddlers were overlooked in the busy sessions. The aims of this pioneer club in Croydon were to provide the following services: health educational activities for mothers and young children, routine developmental checks for the 2-5 year old children, and social development through play for the children of those mothers attending the Club.

The accommodation consisted of two large adjoining halls in the same building and plenty of smaller rooms in which to expand. The three health visitors were fortunate in having the help of an enthusiastic and knowledgeable band of voluntary workers; while initially the mothers adopted a passive attitude they soon became actively involved in group discussion, and organised rota\'s to help with play activities and the afternoon tea session. Soon mothers with babies asked to be allowed to join and a small room was turned into a pram nursery. An average of some 40 mothers and 50-60 children attended each session, and subjects ranged from sessions on health subjects to those of personal care and cookery. The play activities of the children were used to demonstrate to the mothers the needs of their own children and much informal teaching was carried out by the health visitors and voluntary workers in this way. The Clinic Medical Officer was also involved and when possible participated in group sessions, and so did the health visitors who were responsible for the administration and execution of the work. From time to time outside speakers brought their own expertise to a specific session. A flourishing "Tufty Club" was organised in conjunction with the Road Safety Officer, and an account of this club was given in the Family Doctor magazine.
The success of the scheme encouraged other members of staff to organise similar clubs in the borough. Considerable support was given by the health education section of the Health Department, both in the supply of teaching aids and the co-ordination of the work throughout the borough.

Health Education by Community Health Team

One of the earliest accounts of health education undertaken by family doctors and health visitors was given by Hasler (1968). The practice extended over a semi-urban and rural area, with its 6,800 patients belonging largely to social classes I, II and III. It was decided to make the project a team effort and to focus the first course on a specific group, the parents of children under 5 and expectant parents. Of those invited, 49% said that they wished to attend. The 147 interested couples were divided into two groups, and the first attended in the Autumn of 1967 and the second in 1968.

Most of the meetings were held in the branch County Library and there was an average attendance of 30. The sessions were run by a doctor and health visitor or district nurse, and plenty of time was allowed for discussion which was freely used. The subjects covered in the first course included: the health team; preparation for parenthood; child management; the healthy child; the sick child; family planning; and accident prevention and simple first aid. Occasionally an outside speaker was invited but almost all the parents said that they preferred health education from their own doctors and nurses. In an attempt to evaluate the two courses a questionnaire was circulated to the parents but this met with a poor response. However, Hasler considers that the few forms completed may be representative of the groups. Most parents preferred speakers who were known to them rather than outsiders.
They liked the mixture of lecture and discussion, and they preferred being in a group of from 25 to 30. During the series the doctors became aware of some of their patients views on the organisation of the group practice. In summing up Hasler said that from the response to this pioneer effort it was apparent that there was a need for health education as part of preventive medicine. It was ideal if the surgery staff ran this activity and in his opinion it provided a very useful two-way communication between the practice and its patients.

Health Education in School

Humphries (1967) gave an account of a highly successful attempt at Park Hall High School, Castle Bromwich, to introduce practical experience of child care while she was working as a health visitor in Warwickshire. For several years mothercraft had been taught, mainly to fourth-year girls and sometimes to small groups of fifth and sixth-form girls. It was a popular subject supplemented by practical work in the classroom, visits of observation to infant welfare centres and reception classes in infant schools. However both the health visitor and headmistress felt that this was inadequate and eventually it was decided to run a small nursery for one morning a week in the school. Letters were sent to the girls' parents explaining the new project, and parents with toddlers living near to the school were invited to a meeting to discuss the proposed scheme with the headmistress and health visitor. Eventually 12 toddlers duly arrived for a play session lasting from 9.45 a.m. to mid-day, for which no charge was made, and the fourth-year girls looked after the toddlers. The girls were encouraged to keep diaries and made careful weekly observations of the children's development and activities. The scheme had been running for over a year and was said to be very popular. One unexpected outcome of the scheme was that the girls made a film of the children's play activities.
For some years the London Boroughs' Training Committee, formed to provide post-qualification courses for health and welfare staffs following the reorganisation of Greater London in 1965, have organised special seminars for Health Department staff who participate in the schools' health education programmes. Circular 18/69 from the Department of Education and Science to Local Education Authorities had caused misunderstanding in some boroughs and so clarification was sought by the Committee. The Department of Education and Science replied as follows:-

"Whilst only qualified teachers may be employed as teachers after 31st August 1970, it will be possible for someone who is not a qualified teacher to give instruction in a specialised area or skill providing that no qualified teacher is available to give the necessary instruction and that the instructor shall not be employed in a more general capacity. You may take it that this covers Health Visitors' participating in Health Education programmes".

This information was circulated to all Directors of Nursing Services of all the member boroughs but unfortunately not to all schools.

Other articles by health visitors give details of courses for special groups: for example Watson (1969) used the concept of the Toddlers' Club to start a clinic for the elderly in Sutton where both formal and individual health education was carried out: Clark (1969) described how she widened her scope to teach health subjects and sex education in schools, she claims that if parents and schools fail to provide factual information the children will develop unhealthy attitudes: and in her research into attitudes and social action in two Cambridgeshire villages, Salzberger (1968) emphasised the major influence of the health visitors in promoting attendance at the mobile cervical cytology clinic.
PILOT SURVEY QUESTIONNAIRE

Health Visitor Survey

I am anxious to collect up-to-date information about the health education work patterns of health visitors who have trained during the last five years. This information will form part of a programme of evaluation of present day training which I am undertaking as a piece of research in conjunction with the University of Surrey. Your answers will be treated with strict confidence and will be used only for the purpose of producing statistical summaries.

The number of health visitors is of necessity small and so your completed questionnaire will make a vital contribution to the result of the survey. Thank you for your help.

To help you to fill up the questionnaire:

Where relevant please circle the appropriate number(s) in each section to indicate your reply. A space is left below those sections where additional information may be requested.

Please return the completed questionnaire to:

Miss C.P. Hall,
Department of Applied Social Studies,
Croydon Technical College, Croydon.

It would help if you could return it to me within two weeks.
FOR CHECKING PURPOSES ONLY

<table>
<thead>
<tr>
<th>Name</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visitor Training School</td>
<td>2</td>
</tr>
</tbody>
</table>

1. In which year did you qualify as a health visitor?
   - 1968 ...................................... 3
   - 1969 ...................................... 4
   - 1970 ...................................... 5
   - 1971 ...................................... 6

Have you worked continually as Health Visitor since qualifying, if not please specify.

2. What midwifery training have you taken?
   - S.C.M. ...................................... 7
   - C.M.B. Part I ................................ 8
   - Obstetric (pre-S.R.N.) ........................ 9
   - Obstetric (post-S.R.N.) ...................... 10

3. In what type of area are you working?
   - geographical area ................................ 11
   - general practice attachment .................. 12
   - combined practice and geographical area ....... 13
   - any other (please specify) ..................... 16

Is your area practice mainly urban or rural? or a combination of both?

4. Have you attended any post-certificate training in health education?
   - YES ......................................... 15
   - NO ......................................... 16
5. During the twelve months up to 31st December 1971 have you given health education to any of the following groups?

- expectant mothers .......................................................... 17
- expectant parents ............................................................ 18
- parents groups ............................................................... 19
- infant (or primary) ......................................................... 20
- in school primary (or middle) ........................................... 21
- secondary (or higher) ...................................................... 22
- college of further education ............................................. 23
- any other (please specify) ................................................ 24

6. Did you want to teach group health education?

- YES ................................................................. 25
- NO ................................................................. 26

7. Did you have any prior interest in the group(s) that you were asked to teach?

- YES ................................................................. 27
- NO ................................................................. 28

8. If you were given the choice which group would you prefer to teach?

- none at all ............................................................ 29
- expectant mothers ....................................................... 30
- expectant parents ....................................................... 31
- parents groups ......................................................... 32
- infant (or primary) ..................................................... 33
- in school primary (or middle) ....................................... 34
- secondary (or higher) .................................................. 35
- college of further education ........................................ 36
- any other (please specify) ............................................. 37
9. Are you solely responsible for the planning of content and "ordering" of the classes?

YES ............................................. 38
NO ............................................. 39

10. If no, then who is responsible?

Nursing Officer ........................................... 40
Health Education Officer ................................. 41
Another (please specify) ................................ 42

IF YOU ARE (OR HAVE BEEN) CONCERNED WITH CLASSES FOR EXPECTANT MOTHERS
AND/OR FATHERS DURING THE YEAR ENDING 31st DECEMBER, 1971, PLEASE COMPLETE
THE NEXT PAGE.
11. Where are the classes held?

- in a Church Hall .............................................. 43
- Local Authority premises (not Health Centres) .......... 44
- Health Centre .................................................. 45
- G.P. Surgery (other than Health Centre) ................. 46
- Maternity O.P.D. ................................................ 47
- In hospital O.P.D.
- In hospital ward ................................................. 48
- any other (please specify) ................................... 49

12. Do any of the following help you with the teaching of your classes?

- Health Visitor .................................................. 50
- H.V. student ..................................................... 51
- Clinic nurse ..................................................... 52
  hospital ......................................................... 53
  domiciliary ..................................................... 54
- Midwife ....
- Obstetric pupil ................................................. 57
- Pupil Midwife ....
  Part I ............................................................. 55
  Part II ............................................................ 56
- Physiotherapist ................................................ 58
- National Childbirth Trust Teacher ......................... 59
- Any other (please specify) .................................. 60
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