UNIVERSITY OF SURREY

THE CONTINUING EDUCATION
OF AN EMERGING
PROFESSIONAL GROUP
WITH PARTICULAR REFERENCE
TO
HEALTH EDUCATION OFFICERS

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ABSTRACT

This thesis reports research into an aspect of the education and training of health professionals; it was undertaken between 1977 and 1980.

The main focus of activity is in developing and evaluating models and interventions which will encourage continuing education provision for workers in the health fields. The main study was undertaken with a single group, health education officers and an intervention was identified which was piloted, trialled ad evaluated. Using experiential methods it enables a group to take responsibility for the initiation, implementation and evaluation of their own continuing education.

Evaluation strategies are described. An action research model was adopted and the evaluator took a semi-participative role within the continuing education activities.

The main findings relate to method, presentation, support and implementation. They will have general implications for the professional development of other groups such as environmental health officers, health visitors and social workers.

Continuing education contributes to professional development. Its success or failure is influenced by the process used, by the context in which it is carried out, and by the content of the teaching. The evaluation demonstrates the successes and addresses the problems identified. Particularly it demonstrates the importance of collaboration and of using activities which enable groups to participate energetically in determining their own training needs.

I will suggest that this method, and the tools developed, should be seen as an important contribution to the continuing education process on two counts; that of enabling the occupational group to take this responsibility for themselves, and that of providing them with a learning environment which is capable of enhancing their own training skills.
ACKNOWLEDGEMENTS

It is almost impossible to thank adequately and acknowledge properly the many individuals and institutions who have been involved in the growth of this project and in the development of the thesis.

I would however like to make special mention of the health education officers on the three pilot courses who co-operated and collaborated so cheerfully; the Health Education Council (as an organisation) for financial support; colleagues within and outwith HEC for their unstinting patience, encouragement and forebearance; the institutions in which the pilot courses were mounted for the help they gave so willingly; James Kilty and Ian Sutherland for constructive and searching comment and criticism which challenged me frequently and, I hope, creatively; Marguerite Nunn and Susan Hackett for patiently interpreting illegible drafts into neat typescript; and finally my family and friends whose help and support has been essential.
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1.1 Introduction

1.2 Training for Health Education Officers

1.3 Project Intentions

1.4 Project Objectives

1.5 Project Outcomes

This chapter starts by describing the professional context of the research and goes on to show how the objectives of the project emerged from concerns about training in the profession. The chapter ends with a guide to the place in the text where particular objectives are tackled.
CHAPTER 1  THE PROJECT: INTENTIONS, OBJECTIVES AND OUTCOMES

1.1 Introduction

Occupational and professional groups all have an interest and an investment in education and training.

First it prepares them for the tasks they are required to carry out; additionally it may have an authenticating function in that, without the qualification that success in the training experience confers, individuals cannot progress in the discipline. It may well be staged either as a straightforward progression through the intricacies of the discipline or as a series of options which depend on the particular aspect of the discipline that is followed.

Second it contributes to the development of the individual within the group that comprises the profession or occupation. The experience of working with others, of having opportunity to observe, comment and discuss, affects the individual both personally and professionally. The benefits that individuals receive from this interaction are probably difficult to measure, may be little appreciated by them or their employers and may not be included in any assessment of training provision. Activities such as professional seminars or workshops and personal involvement in distance learning may be acknowledged; the concept of continuing education, which incorporates all these elements, including creative assessment and which seeks not only to appreciate 'what is' but seek out 'what needs to be', is apparently little regarded.

1.2 Training for Health Education Officers

The experience of health education officers (HEOs) in this matter seems to be little different from many others and in some respects rather worse. The existing training provision is reviewed in some detail in Chapter 2 (p 15). In essence it consists of the Diploma in Health Education which is not yet a statutory requirement and a variety of ad hoc in-service
opportunities (which are surveyed at 4.2.5).

Health Education Council (HEC) is given the responsibility, by central government to '... encourage and promote training in health education work; and to provide to other bodies advice and guidance on the organisation and content of courses of training, together with such practical help as may seem appropriate and within the resources of the Council: (Annual report (1979/80)). Although HEC has neither statutory nor administrative control of health education officers it enjoys a lively professional liaison with them; it has been active, since 1970, in seeking to develop and extend their training provision; this is summarised in annual reports (1970 to present day).

This study is derived from a project which was developed as a response to numerous health education officers who asked Health Education Council for 'more training'; informal discussions held by the author, Health Education Council staff and health education officers brought some detail to the request. This consisted of requests for up-dating on their information base (i.e. what is the latest on cancer, immunisation, school health education), on the techniques of health education (i.e. how to run a group successfully, better use of CCTV), or on administration (i.e. how to liaise successfully, how to gain management skills). This presented HEC with a diffuse picture that did not easily demonstrate the relative strength or importance of the needs being expressed. It was not known if these requests represented the views or perceptions of those with an interest in and involvement with the health education officers; in the main these comprise their managers (mostly the Area Medical Officers of Area Health Authorities) and those with whom they have lateral collaborative professional links (nursing officers etc. who manage those who health educate and who will be part of the very wide group that forms the bulk of field health educators).
Health Education Council consulted with the Department of Adult Education, University of Surrey and posed two questions.

A. How best could Health Education Council determine accurately the in-service training needs of health education officers.

B. How best could training be instituted within the constraints that currently obtained (financial, manpower).

1.3 Project Intentions

The outcome of the consultation was an experimental project designed by the University (1978) to '... enable a training module to be designed and tested under realistic conditions'.

The experiment, in the manner first described by Stufflebeam (1977), was divided into four stages, these corresponding to the four kinds of decision relevant to satisfaction of training requirement:

Stage 1. **Context evaluation** in which the needs of the health education officers will be assessed.

Stage 2. **Input evaluation** in which training objectives will be developed, content defined, teacher skills assessed and appropriate alternative methodologies enumerated.

Stage 3. **Process evaluation** in which the continuous monitoring of the courses will be defined.

Stage 4. **Product evaluation** in which the extent to which the training requirements are met is explored.

The intention therefore was to gain a better understanding of the needs of this occupational group, to develop training objectives based on this knowledge, to develop in-service training to meet the objectives, and to assess the outcomes. The rationale behind this model together with a more detailed examination of the concepts is set out in Chapter 3.
The scope of the project relates to the size of the experimental field, the resources available, the constraints that confined us and the support that could be anticipated from those with whom we would wish to collaborate. The objectives of the project are stated later in this chapter.

The total experimental field comprises the in-post health education officer population of England, Wales and Northern Ireland; at January 1978 this was 303; the author was seconded part-time as research worker to co-operate with the project director at University of Surrey Department of Adult Education:

There was inevitable constraint on the project because of limited available resources. The author, who was the evaluator, was not as unbiased as an independent evaluator would have been, nor was she able to devote as much time to field visits as she would have wished; the need for considerable travelling to carry out field visits provided this constraint. Health education officers, who themselves carry heavy work loads, were similarly constrained in the amount of time they could make available to the project; this will be discussed more fully in Chapter 4. The issue of bias related to the evaluation will be dealt with initially here and again in Chapter 5. Where the evaluator recognises the threat of bias it is important that checks are constructed and used to guard against both under- and over-compensation.

However, it is not wholly negative; because I brought considerable experience to the project, because as an HEC officer I had an overview and wide knowledge of the field being studied and because I could incorporate the pilot courses and evaluation work in with HEC responsibilities, the range of regional groups that could be studied was wide and I had comparative freedom to carry out project tasks at times that were most convenient to the experimental groups.
1.4 Project Objectives

The objectives were developed in response to the training need. These were

a. to identify models for the in-service training of health education officers.
b. to test the models on three pilot groups.
c. to develop a system which would enable the model to be disseminated, adopted and used by health education officers.

During the development of the project it became apparent that two other factors were important. First, there was the appearance of secondary or subsidiary objectives which had limited but significant importance; and second, the project was perceived to be fulfilling a number of definable functions which were not enumerated at the time of its initial development.

Secondary objectives

(a) to improve the continuing education provision for health education officers.
(b) to gain an improved understanding of health education officer needs.
(c) to develop, test and publish practical training activities which might be presented in a modular form for subsequent use by others.

Functions

(a) to enable health education officers to participate in the process of identifying personal and group training objectives.
(b) to assist health education officers in the improvement of an enhanced identity as an occupational group.
(c) to assist with the development of an appreciation of the health education officer's role and function.
(d) to enable participants to improve self awareness and understanding.
(e) to consider how best the model here developed might be transferred to other occupational groups.

Evaluation is an important part of the process and an integral part of all objectives and functions. While this will be explored in some detail in Chapter 3 as will some of the many relevant and interesting theories and models examined, perhaps a little healthy scepticism as promulgated by Scriven (1971) can be advanced here. "... almost all classroom transaction analysis is irrelevant to evaluation ... there are two types of exception. The first concerns the morality of the process and the second its enjoyability". Scriven goes on to talk about the long time during which intervention can be expected to have effect, about what he sees at times as the irrelevance of terminal evaluation and about the importance both to participant and project of observing, recording and if necessary acting upon the intermediate observations. It is the purpose of the evaluation incorporated in this project to take note of the intermediate transactions as well as the terminal outcomes.

This suggests an action research (Elliot, 1978) model of development which will be explored in Chapter 3; this model was developed after Scriven (1971) made these comments which presumably were aimed at the then more traditional research models. In this project action research became part of the protocol at the time the second pilot course was developed and continued to be used during the rest of the project; it built action into the strategy and protocol used thus far and enriched the research.

1.5 Project Outcomes

The purpose of this section is to provide a brief overview related to the stated objectives (p. 6) and to direct attention to those parts of the thesis in which the detail appears.
A model for a continuing education unit was developed, in two instances collaboratively, and was tested on three Regional groups of health education officers: the system by which the development took place, an examination of the process and a critical appraisal of its usefulness are in Chapters 6 and 7. It is shown that the results of the continuing education process, the context in which it occurred, and the needs of HEOs are now better appreciated; recommendations are made concerning the expansion and development of continuing education provision.

The role of continuing education (in developing not only individual but corporate skills and in enhancing the professional identity of the group) is explored; so also is the essential nature of professional identity to successful functioning in the health education officer group and of health education in a Region.

The modules used within the continuing education activities are replicable else-where and suggestions are made for this.

The nature of the training intervention as a catalyst with the group is explored, as is one function of the training; that of attempting to improve and enhance self awareness.
CHAPTER 2  HEALTH EDUCATION OFFICERS AND HEALTH EDUCATION

2.1  Historical context

2.2  Health Education Officer Role

2.3  Becoming a Health Education Officer

2.4  Training and Qualification

  2.4.1  Managerial concepts
  2.4.2  Training concepts
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2.5  A possible National Training Body

2.6  In-Service Education and Training

2.7  Summary

Annex I  Model job description for a health education officer

Annex II  Diploma in Health Education

Annex III  Courses for Health Education Officers

This chapter starts by showing the historical basis of the activity called health education and goes on to describe the establishment of Health Education Officers as an occupational group; how they are trained; how they are distributed through England, Wales and N. Ireland; and what they now see as the key issues in their educational development.

These are important background details for the thesis as a whole since later chapters use this material to build up elements of the teaching model.
CHAPTER 2 HEALTH EDUCATION OFFICERS AND HEALTH EDUCATION

2.1 Historical Context

Health education, as part of health practice, appears in the Old Testament (1952) but only recently has it become formalised and recognised as a component of professional practice for many health professionals. The General Nursing Council (1977) demonstrate this in their training syllabi and many other health and welfare disciplines include an element of health education in initial training and in professional development.

It is interesting to speculate on the reaction of the great sanitary reformers, like Chadwick and Snow, to the scope and breadth of health promotion and disease prevention today. Just as Stephenson might be astounded by the 125 high speed train, so might Chadwick and Snow wonder at the technological innovation which ensures such progress in disease control and prevention. It is rare to find anyone, at least in the west, personally concerned about clean water, waste disposal or killer communicable diseases (these are, of course, of continual concern to those who have a professional responsibility). Working, as Snow and Chadwick did, in an era in which legislation was one aspect of the reform, and obedience to professional expectation another, they might be equally surprised at the complex and sophisticated machinery now developed to assist us, often not very effectively, in enabling people to understand and adopt healthy life styles. They would no doubt be equally surprised by the sophisticated society which makes such strategies necessary.

It was in the 1930s that local health authorities first conceived the idea of having a responsible person to organise their health education activities. The model then was a simple information one in which the medical officer prescribed a treatment for the community or the susceptible part of it. The prescription was most often in the form of information transmitted via posters, leaflets or campaign and it was the health education officer's job to administer this.
The findings of the Cohen Committee (1964) led to the development of the health education services that exist today and are reviewed by Sutherland (1979).

Publications by the Department of Health and Social Security (DHSS) (1974, 1976) following the Cohen Report have attempted to formalise and strengthen health education within the health service, within patient care, and by the institution of health education units within the newly constituted Area Health Authorities (AHA) at the reorganisation of the National Health Service in 1974. At that time the post of Area Health Education Officer was created and health education units were staffed by senior health education officers and health education officer; some of these posts had been in existence, prior to reorganisation, within the health departments of local health authorities.

The function of the health education officer is to organise and promote health education and to encourage, train and support field work health educators. A wide variety of job descriptions exist for health education officers; they can be derived historically or be the result of local development; more recently the work of the Kirby Committee (1980) has resulted in model job descriptions for all grades of HEO which reflects the analysis of HEO function undertaken by that committee. This most recent job description is at Annex I.

Health education officers come to health education most usually from another occupational group (health visiting, teaching, nursing, environmental health) and with a need both to be trained for this new occupation and to be socialised appropriately towards it. The Kirby (1980) job description is derived from the accumulated experience of a number of years. Development has been sporadic, episodic and is unequal throughout the country. While health education organisation is the responsibility of health education officers many health professionals carry out health education tasks of some kind. It is usual to say that these are 'health
educators'; they carry out their health education role as part of their main professional role. Thus health educators are distinguished from health education officers who have the full-time organisational responsibility.

2.2 Health Education Officer Role

The first health education officers (circa 1950-1960) had a role that was mainly to do with supporting health educators by providing audio visual aids and by being health educators themselves. The health education officer's role has expanded and changed and this is clear from the current job description. Socialisation into the health education officer role must take place and this can be complicated when health educators become health education officers; there is need then to move away from the educator role and towards the health education officer role. For some this is not an easy transition.

Tones (1975), undertook an examination of the role and function of health education officers and sought to identify these aspects of role and function that were appropriate to the 'COR' function (Consultative/Organisational/Research).

The matter of the role of the health education officer is important both for professional development and for day to day practice. Ruddock (1972) postulates (from Spiegal) the concept of 'complimentarity' in which roles are seen as 'culturally patterned ways of unthinking interaction'; cues, he suggests, are offered and accepted in line with the expected behaviour. As the health education officer role is evolving from that of service (as novice health professional) through health educator (within professional practice) to that of independent, semi autonomous practitioner, the cues offered cease to be appropriate in the relationship; new, more relevant cues have to be developed. Appropriate to the first and second role the cues might be to do with 'a client requesting positive health information', 'a group looking for a speaker', 'a bare clinic wall
needing a poster'. The cues of the health education officer role could be 'a professional group not using their health education opportunities fully', 'lack of necessary information', 'inadequate organisation of audio visual aid distributors'. Complimentarity may break down and what Ruddock terms 'cognitive discrepancy' (not knowing what is required of one) appear. I will show later that health education officers, as they seek to determine and define their role and function, are experiencing this difficulty. From discussion with, and comment from, health education officers, other role discrepancies are seen to exist; those that are to do with lack of agreement over task, those to do with discrepancy of goals between health education officer and manager and those to do with rejecting the task allocated by the manager. Taken together they show an occupational group struggling through a role metamorphosis contributed to partly by the rapid development of the service they work with and partly by the expectations of health education officers by certain others whose role model for them does not change. (For example; health educators may expect sophisticated audio-visual aids service and be unco-operative when asked by the health education officer to consider how relevant this is to effective communication about health; members of the primary health care team or the Area Management team may expect results from a health education initiative which are unrealistic within the context of personal and material resources and within the time span being surveyed).

Current training based on variable initial previous professional qualification to which may be added a one year specialist Diploma in Health Education can be a period in which a cohesive and coherent role model is developed. However, this model will suffer attack and reduction once training is completed. Poor role definition induces insecurity and uncertainty in carrying out health education officer duties and is a matter identified by the pilot course groups as being in need of clarification.
2.3 Becoming a Health Education Officer

The training and development of any professional or occupational group can not be accurately viewed as a finite process restricted to certain qualifying or enabling courses and examinations. Rather it is the sum total of the many experiences which contribute directly and indirectly to the wholeness of each participating individual. While it is usual for some of these experiences to take the form of qualifying courses with terminal examinations, other elements are to do with the use of available, relevant, continuing education opportunities; additionally there is the effect of life experiences and the socialisation processes which are unique to each individual. Thus many parts go to make up the unique whole.

Within a professional or occupational group conformity appears to contribute to a clear professional identity. The converse may also be likely as is demonstrated in some of the discussion here presented which shows an occupational group with a rich and varied previous experience.

The purpose of this section is to review the training that contributes to HEO development; in Figure 1 a diagrammatic representation shows the matters that are considered significant. First there is the primary and secondary socialisation towards health and illness which Tones describes (1978) in which family and peer interaction, beliefs, attitudes and behaviour will be developed and accepted and become the basis on which much future health and illness activity will be based. This early socialisation is an essential process within each of us; it has significance for the professional role when that professional role, in whole or in part, is about working with individuals and communities. The group then, that is attempting to identify training needs is going to require role clarification as an important aspect of that training.

Second there is the initial qualification be it degree or
Time scale (Approx.)

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- In-service education having health education input
- Certificate in Health Education for those with identified health educator role

Primary and secondary socialisation
To do with models of health, disease, environment, society and culture

Socialisation into adulthood
Acquisition of relevant formal knowledge within and out-with a planned curriculum

Initial professional training
- develop health education awareness
- encourage health education involvement

1st and 2nd degrees
Health and specific professional training
Health education content likely to be highly variable

Trainee REO
2-5 years
Modular system recommended

M.Sc.
Health education elective

M.Phil
Health education specific

Figure 1. THE HEALTH EDUCATION OFFICER
Diagrammatic representation: training and development
professional course which, for many HEOs, is the forerunner to becoming an HEO. Kirby (1980) states 'Traditionally recruitment to health education has been from a variety of professions, mainly nursing . . . and teaching. . . . It is to the benefit of health education that recruitment should continue to be from a range of backgrounds . . . . We take this view because the training, experience and maturity gained by members of these professions has prepared them well for work as health education officers in the past . . .' (p. 14).

Third there is the development or adoption of a 'positive health' stance which is a feature of health education. In that much of current 'health' service provision is actually 'illness' service, and much perception of health is to do with 'not being ill', those who adopt a health education role do so through a growing awareness of the need to perceive health as important and to seek ways which enable people and communities to recognise and respect health as a positive aspect of their life. A usual outcome of this shift of perception in professionals is involvement in health education activity as part of their total professional duties. Thus the teacher will incorporate health education into the curriculum, the nurse will explore with patients how, together, the 'health' of the patient may be enhanced, the health visitor will seek individual and group outlets for health education intervention, and so on.

Fourth there is the desire to be involved totally in health education activities and there is then the move into the organisational aspect of health education which is an officer of the AHA working within a health education unit and having administrative and organisational responsibilities for the delivery of the health education service.
2.4 Training and Qualification

It is usually the case, and is generally accepted, that HEOs, being recruited from another profession, and therefore already professionally trained, will undertake additional training which will contribute to both their knowledge and skills and to their socialisation into this, a new professional role. In a survey carried out by Tones (1975) information was sought concerning previous training and experience; Figure 2 shows the response.

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</tr>
<tr>
<td>Dietetics</td>
<td>3.29</td>
</tr>
<tr>
<td>Public Health Inspector</td>
<td>2.63</td>
</tr>
<tr>
<td>Artist</td>
<td>2.63</td>
</tr>
<tr>
<td>Nil response</td>
<td>12.50</td>
</tr>
</tbody>
</table>

PREVIOUS TRAINING AND EXPERIENCE OF HEOs: TONES 1973

Figure 2.

A theoretical continuum at Figure 3 seeks to demonstrate the development of training and the likely contribution that specific training makes to this development. To date there has been no statutory requirement for health education officers to be qualified in any particular way though conventionally the Diploma in Health Education (Annex II) has been an accepted mode. Additionally, the emergence of Master's Degree courses having health education content or as an elective has broadened the education opportunities available. Data concerning HEO employment and qualification are set out in Figures 4, 5 and 6.
Enters full-time health education service

Continuing education modules

Seminars, Workshops, Refresher Courses

Open University Self selected study

develops health education awareness: this is highly variable and dependent on curriculum and trainers

initial professional training

Statutory and other refresher courses

Health education certificate.

Modules for trainee HEOs

MSc Health Education

HEOs: TRAINING AND PROFESSIONAL DEVELOPMENT

A continuum representing a usual progression

Figure 3.
HEALTH EDUCATION OFFICERS IN EMPLOYMENT OVER AN EIGHT YEAR PERIOD
(ENGLAND, WALES AND NORTHERN IRELAND)

Figure 4.

<table>
<thead>
<tr>
<th>Area health education officers</th>
<th>Number</th>
<th>Diploma in health education</th>
<th>Related Masters Degree</th>
<th>Without either of these qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>63 (100%)</td>
<td>30 (48%)</td>
<td>7 (11%)</td>
<td>26 (41%)</td>
<td></td>
</tr>
<tr>
<td>Senior health education officers</td>
<td>56 (100%)</td>
<td>23 (41%)</td>
<td>1 (2%)</td>
<td>32 (57%)</td>
</tr>
<tr>
<td>Health education officers</td>
<td>155 (100%)</td>
<td>19 (12%)</td>
<td>-</td>
<td>136 (88%)</td>
</tr>
<tr>
<td>All health education officers</td>
<td>274 (100%)</td>
<td>72 (26%)</td>
<td>8 (3%)</td>
<td>194 (71%)</td>
</tr>
</tbody>
</table>

HEALTH EDUCATION OFFICER QUALIFICATION BY DIPLOMA IN HEALTH EDUCATION AND RELEVANT MASTERS DEGREE: 1976

Figure 5
<table>
<thead>
<tr>
<th>Area health education officer</th>
<th>72 (21.0)</th>
<th>32</th>
<th>44</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior health education officer</td>
<td>79 (23%)</td>
<td>36</td>
<td>46</td>
</tr>
<tr>
<td>Health education officer</td>
<td>172 (50%)</td>
<td>40</td>
<td>23</td>
</tr>
<tr>
<td>Trainee health education officer</td>
<td>19 (6%)</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>All health education officers</td>
<td>342 (100%)</td>
<td>105</td>
<td>31</td>
</tr>
</tbody>
</table>

HEALTH EDUCATION OFFICERS QUALIFICATION BY DIPLOMA IN HEALTH EDUCATION 1978

Figure 6
Four surveys of HEOs have been carried out.

The first was by the HEC (1971), in which ninety-eight local health authorities responded and indicated that 191 health education officers were currently in post; no information was requested in this survey about qualification by diploma in health education though the original qualification or expertise of the officer was described.

Tones (1975) carried out the second in 1973; his field comprised 151 HEOs which was estimated to be an 80% response rate. Within this group 23% were specifically (Diploma in Health Education) qualified, 4.6% failed to respond to the question leaving 72.4% having no specific qualification.

The third survey was carried out jointly by DHSS and HEC (1976) and Figure 5 shows the qualifications held by the several grades. Although the number of officers has increased by more than \( \frac{1}{3} \) the percentage of officers qualified has risen only from 23% in 1973 to 26.3% in 1976. If we further consider that the 1976 survey was a full one while the 1973 was estimated to be only 80% then it is possible that 23% holding the Diploma is a deflated figure. This indicates little real change in the level of qualified HEOs in the field despite the emergence of Diploma courses in 1972, 1974 and 1981.

The fourth and most recent survey was carried out to gather evidence for the National Staff Committee of the DHSS working group on health education officer training under the chairmanship of Kirby (1980); the results of this are set out in Figure 6. They show an increase of health education officers in employment of approximately 25% over the 1976 total and an increase in qualifications to 30% (an increase of approximately 4%). However, their survey did not seek information concerning two qualifications; the original London University Diploma in Health Education and qualification by Master's Degree. The evidence is therefore incomplete on two counts; first it shows only a partial picture of qualified staff and second it debases, by implication, both the qualifications it omits.
These figures show an emerging occupational group with an apparently low overall level of qualified staff; however, in this context 'qualified' is used as Kirby uses it and it excludes those holding the first London Diploma in Health Education (see Annex II) and those qualified, whether or not Kirby accepts this, by relevant Master's degree. If parallels are drawn from the 1976 results, in which MSc were counted, they contributed less than 3% to the total who are qualified; it seems unlikely in that short period of time that this figure will have changed substantially though other MSc courses with health education relevance are becoming available. Additionally due regard must be paid to those HEOs who, while not qualified by diploma or degree, are extensively experienced having worked in health education for many years.

A further constraint in acquiring qualification is the limited financial resources currently available in the NHS. Health education does not command high status and monies, either for running health education units or for seconding officers to diploma courses, have been and are strictly limited. Since 1977 HEC has made available study grants comprising up to two thirds of an Area Health Authority's expenditure when seconding an HEO to recognised diploma courses; twelve such grants are available in respect of each of the Diploma courses annually and this financial incentive and intervention has gone some way towards assisting the individual HEO, the health education units and the authorities. There is circumstantial evidence at HEC that many authorities rely on this financial support and that, on those occasions when there have been more applicants than grants, potential students have been unable to take up the place on the course offered to them.

From observations and personal experience and from comment and discussion in a variety of settings, four major factors emerge to explain the low level of qualification.
These are:

- managerial concepts and expectations of health education officers and health education services.
- concepts of training and training adequacy.
- staff turnover.
- staff motivation.

2.4.1 Managerial concepts

HEOs, as an emerging occupational group, servicing an area of professional and lay activity (health and education) which has not so far achieved the status of a discipline would appear to need time and opportunity to develop firmer and more accepted concepts of role and function (developed in Chap. 5.8). Until that has come about there will be lack of clarity on many matters; training may well be one of these and, although a training provision is available, it need not be seen as urgent if the status of the occupation, in this case health education, is low, threatened by often stronger disciplines, and not yet able to be an eloquent advocate for its own advancement. In part this is due to the breadth and diversity of health education and difficulties consequent upon managers failing to appreciate the need for such breadth and diversity.

2.4.2 Training concepts

The training to meet the needs of the occupational group will evolve over a period of time. The many factors involved include the needs of the discipline, the existing competences of the individuals, the base line of knowledge and skills from which recruitment comes and the perceptions of those who provide the training. In the early stages, and before standards are set or criteria developed no particular training process is identified and accepted, and a variety of qualifications are deemed relevant. Within health education the diploma course is not yet a
statutory qualification; it appears in many job specifications as a
necessary attribute of candidates.

The evolution of another professional group, health visiting,
can indicate the time scale of similar development. From their inception
in 1862 in Salford until the first training course was developed in 1892
they had no training and no single qualification was recognised as
essential. In 1909 their training was recognised by statute and in 1919
health visiting was formally established as a profession and the Board
of Education (Health Visitor Training) Regulations were passed. Thus
with this professional group thirty years elapses before training was
available, a further 17 years before the training was recognised and a
further ten years before they were afforded professional recognition:
in total fifty-seven years.

The professional association for health visitors (the Health
Visitor Association) now takes responsibility for a proportion of their
continuing education through refresher courses, re-entry courses and
special interest courses. As yet HEOs take little direct responsibility
for this aspect of their training though their representatives are
incorporated into HEC initiated planning and development activities.

The first known chief health education officer post existed before
1940 with a further one appointment up to 1944 and four more by 1950;
training posts became available in 1959 and as yet there is no
relevant statute. If health education follows a similar pattern to
health visiting, acquiring full professional recognition and status
remains some years distant.

2.4.3 Staff turnover
A rapidly growing, or a mobile occupational group needs the support of
trained staff. The number of trained staff can only advance by the
number of courses available to carry out the training. A surge in recruitment (see Fig. 4) such as occurred with HEOs between 1976 and 1980 can only be trained within the capacity of the available courses; if, additionally there is high staff turnover then the ratio of trained staff to untrained staff is unlikely to change. In a survey carried out by Fleming (1978) in one NHS region it was shown that the average time in post at the time of the survey for all HEOs was nine months. It can thus be deduced that, in this region which may not be typical, many HEOs were likely to have been in post for too short a time to be eligible for training; additionally the effect of constant change on the remaining staff cannot be insignificant.

2.4.4 Staff motivation

The second reorganisation of the health service has apparently lowered motivation generally; the various matters to do with location of the post, status of health education units within new health districts and making relationships with new managers has affected health education staff morale.

2.5 A possible National Training Body

The eventual development of a training body for health education, invested with statutory powers and able to determine the regulations for qualification, will in due course ensure a qualified discipline having an accepted standard of entrance qualifications, specified probationary period, qualifying training and terminal registration; the Kirby report foreshadows this.

Health education-linked Master's degrees, available in a number of centres, are currently seen by some line managers and some HEOs as acceptable alternatives to the Diploma in Health Education. Within the discussion set out in the Kirby Report they are seen as an additional
and enhancing qualification but not one that replaces the Diploma in the preparation of HEOs for their role and function. In the HEC/DHSS paper (1976) 3% of the HEO population were qualified by MSc. The contribution that is made by those thus qualified has not yet been quantified in any way nor has any study been carried out to show how this differs, if it does at all, to the contribution made by the person qualified by Diploma. In view of this lack of knowledge and understanding it would seem that there is a need for particular investigation to be carried out soon to clarify the contribution made by the various training opportunities.

2.6 In-Service Education and Training

Apart from the full-time and part-time courses so far described HEOs may participate in a variety of in-service and refresher type trainings. In-Service education and training (INSET) was surveyed over a six month period and the opportunities available and used are detailed in Chapter 4. Additionally HEC, in collaboration with the HEO group, develops and organises annual seminars for both AHEOs and HEOs. Each of these is developed with a framework of educational objectives, around specified subject areas and is designed both as a meeting point for the discipline and as a contribution to the skills of the HEO; for example, the 1980 seminar, taking as its theme 'Research related to health education', enabled delegates to attend two out of a choice of four workshops each covering a specific element of research related activity and to make further other choices from a wide range of options.

2.7 Summary

Health education officer training is composed of a variety of elements as yet unsystematised into a nationally recognised pattern of
qualification and refreshment. Less than 40% of the HEO population is qualified by Diploma; there is an intention, formulated by a national body, that, in due course, the Diploma will be the accepted qualification for all HEOs. Other qualifications, such as master degrees, will be acceptable enhancement of the initial training; opportunities exist both nationally and locally for HEOs to attend a variety of INSET courses; finance is a limiting factor but HEC grants are enabling at least twenty four HEOs to attend Diploma courses annually.

This evidence demonstrates a lack of adequate provision within the field of continuing education. While considerable energy has been devoted to the development of diploma courses little systematic attention has been given to other aspects. The HEO group have themselves identified this need; the evidence here supports their identification. Examination of the provision for other professional groups (midwives, health visitors, doctors, teachers) shows an attention to this provision which is lacking for the HEO group. The intention of this project is to do with continuing education provision both within the framework defined for the project and, through the information gathered and knowledge identified, for others who seek to make complementary provision.
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
ANNEX II
Diploma in Health Education

i. In 1959 the Institute of Education of London University offered for the first time a Diploma in the content and method of health education; it was developed to meet, in the first instance the needs of students from the third world. Gradually UK students were recruited as well until, at it's closure in 1969, they comprised approximately 50%. This qualification, currently held by some UK HEOs was not included in the Kirby survey.

ii. Leeds Institute of Education in conjunction with the University of Leeds and supported by Health Education Council, initiated a Diploma in Health Education in 1972. This Diploma continues; it takes predominantly UK HEO students though there are a proportion of overseas students and UK students from teaching etc.

iii. Polytechnic of the South Bank (London) supported by Health Education Council initiated a Diploma in Health Education in 1974. The student recruitment is similar to the Leeds course.

iv. Polytechnic, Bristol, supported by HEC initiated a Diploma in Health Education in 1981. The student recruitment is similar to the Leeds course.

N.B. Validation of the existing diplomas is undertaken by the Council for National Academic Awards.
ANNEX III

Courses for Health Education Officers

Provision existing: 1980

1. Certificate in Health Education: developed for health educators; undertaken by some HEOs prior to becoming a trainee HEO. One year part-time day release. Available at thirty centres.

2. Diploma in Health Education: designed specifically, though not exclusively, for health education officers; one year full-time or two years part-time; available at two centres with a third in development for 1981;
   i. Leeds Polytechnic
   ii. Polytechnic of the South Bank
   iii. Bristol Polytechnic.

3. Masters Degree with Health education elective: designed as a post graduate course and for a wide variety of professionals only some of whom may become health education officers; available at two centres; Universities of Manchester and London (Chelsea College).

4. Masters Degree subsequent to Diploma in Health education; part-time courses for those having a satisfactory level diploma; available in conjunction with Leeds Polytechnic.
CHAPTER 3 RESEARCH AND EVALUATION FOR CURRICULUM DEVELOPMENT: A REVIEW

3.1 Introduction

3.2 How can Research and Evaluation contribute to Curriculum Development

3.3 A review of the literature

3.4 The Evaluation Tools

3.5 The Barriers to Evaluation

3.6 The constructive use of Evaluation

This chapter starts by exploring the value of research and evaluation in curriculum development; it reviews the relevant literature and the available evaluation tools. It acknowledges the barriers that exist and that can make the task less easy and effective; it suggests ways in which evaluation can be used constructively.
3.1 Introduction

Evaluation is a tool by which information about educational projects and programmes may be extracted. The information is required to aid decision making by those responsible for the development and continuation of either project or programme. It can be the vehicle for experimental work which can, if successful and accepted, be incorporated into normal professional practice.

It will seek to understand more completely and wholly the system in which the activity under study is set; to use the innovations studied in and created by the research as effectively as possible; and because those who may use the innovations (the teachers, managers, leaders) will have a less than complete understanding of the concepts and rationale that informed the decisions it must attempt to have an educative function as well; participation should be sufficient to lead to an informed client.

3.2 How can Research and Evaluation contribute to curriculum development

Research and evaluation can only properly and usefully contribute to curriculum development if they are accepted and used by practitioners as a means of improving, enhancing and developing their work.

Tawney (1976) suggests that the consumer has free choice to adopt or reject the research outcome and that however excellent the product, it is wasted if there are no buyers; he emphasises the need to inform extensively and if at all possible (and he recognises the inherent difficulties) to ensure that as much contact between project staff and
potential users carries over into the dissemination phase. I would suggest also that implementation of research outcomes implies a change in professional posture and practice and that change is more likely to come about if participative training is available. A dichotomy between that part of a teacher that is his 'professional' self and that part that is his 'employee' self is postulated by Eraut (1972) which I suggest has a parallel here. He sees the in-service training that is made available (possibly as an outcome of research) as having three functions; that which is about the transmission of new knowledge, that which facilitates professional discussion among participants and that which promotes innovation in response to educational problems: the first two are necessary functions but are not always and usually sufficient in themselves: they address the 'employee' part of the teacher: the third stimulates the teachers in exploring problems and seeking solutions and addresses his 'professional' self.

There has been recently a growing awareness of the problems, the gulf that exists between the protagonists in the research dialogue. This has led to a desire to understand better the system in which we function (Coffey and Golden, 1973), the political and societal pressures under which we work (Glass, 1972), and the essential and rightful role which the participants in the activity should play (Reason, 1977, Rowan, 1981); a new paradigm is being developed.

Cowley (1980) would go as far as to say that practical tests within their work place linked to in-service education increase its effect on the way people work. Hamilton (1977) while agreeing with this and previous statements looks also for a research model that is '... flexible enough to allow for response to unanticipated events': this he sees as '... progressive focussing rather than pre-ordinate design'. The model in this project has that quality of 'progressive focussing'. In part this is to do with both formative (Stake, 1977) and transactional (Rippey, 1973) evaluation which are used throughout the project and in
part it is to do with the emerging nature of health education as a discipline and a growing body of knowledge.

The outcome of research strategy and its related evaluation process is to do with change whether actual or latent; change in individuals, in institutions and in the processes that occur within both of these. Stake (1967) in 'the countenance of educational evaluation' suggests that if '...we want to effect change, we must influence definition and bring about a reconstruing, a renegotiation ...by the actors concerned ...(this) becomes less a matter of values and styles of management and much more a process of helping individuals and groups examine their processes of interaction in order to accelerate or facilitate changes ...'

3.3 A review of the literature

In exploring the curriculum development that could be seen as relevant to this project, I shall seek both to set out the arena from which choice could be made and to justify the activity that was pursued.

In the first instance the project was to do with the expressed felt needs of the health education officer group. Eisner (1971) and Hirst (1975), in exploring separately the role of the student in determining
curriculum content suggest that if this freedom was allowed it would fail to produce the results desired by those who judge the outcomes of the educational process; Hurst argues for '... accept(ing) the fact that we must plan and specify ourselves which educational objectives we are after'.

On the other hand Freire (1976), in his examination of education, society and the struggle of an emerging population suggests that people need to be assisted in the often painful process of self growth '... the important thing is to help men ... help themselves, to place them in consciously critical confrontation with their problems, to make them agents of their own recuperation'. He goes on to describe and denounce 'assistancialism' which '... offers no responsibility, no opportunity to make decisions, but only gestures and attitudes which encourage passivity'. He believes that this method '... cannot lead ... to a democratic destination'. In developing this theme of movement from a passive recipient role to one of active involvement and self determination Freire seems to be setting the progression and development within a framework not unlike Maslow's (1966) hierarchy of need; only when the more basic and pressing needs of the individual and community are met (needs of biological necessity) can the opportunity to press for self determination, for critical response, be experienced and realised; that realisation is not always personally or politically acceptable and, in the later discussion on the outcomes of this project and the associated recommendations, this will be explored.

Goodlad (1966) puts forward three levels at which planning for the curriculum can take place; he sees them all, in some degree, as remote from the learner and, although he is discussing curricula for schools it would seem that the nature of the activity is most usually similar to that which obtains in adult and continuing education.
The first level of Goodlad is instructional in which the teacher of the course, alone, determines the curriculum; the second level is institutional in which the faculty of the educational establishment makes the decisions; it is possible that at least some of the information base on which the decisions will be made will come from the teachers, the instructional level. The third level, he suggests, is societal in which the decision makers are out-with the professional boundaries of teacher or faculty and are those who represent the community through the politicians, the board members, the educational governors. While Goodlad is not apparently ranking these in any order he is concurring with both Eisner and Hirst in having the decisions determined by the institution, the administrator or politician.

Within the health service, and within much curriculum development serving professional training, learning objectives are determined in this manner; this is done for identified accepted reasons to do with specialist knowledge to be acquired, standards of performance, safety and well being of clients and statutory requirements to be met. This model however may extend beyond the realm of the statutory requirement for professional qualification, and into the arena of staff growth and development. Eraut (1972) discusses the traditional form of INSET which is more usually to do with the transmission of solutions rather than the study of problems; he suggests that it is more creative to be helped to apply the knowledge you already possess to the problems which confront you. He goes on to demonstrate three models for in-service innovation (after Have lock, 1975). The first of these is a research, development and diffusion model, the second a social interaction model and the third is a problem solving model.

In this last one, which Eraut sees in ' . . . the group tradition', problem solving is seen as ' . . . a patterned sequence of activities'.
These are '. . . need, sensed and articulated by the user/client, which is translated by him into a problem statement and diagnosis. When he has thus formulated a problem statement, the client-user is able to conduct a meaningful search and retrieval of ideas and information which can be used in formulating or selecting the innovation'. The final stage is to do with '. . . adopting the innovation, trying it out and evaluating its effectiveness in satisfying his original need'. In all of this activity the role of the outsider is consultation and collaboration. Attempts by INSET course organisers or tutors to move from the traditional mode to the problem solving one are neither easy nor successful; the organiser of a potential recent health education officer training innovation, cast in the traditional mode, found discussion of any other model (participative, problem solving) threatening; all support offered was resisted and it was apparent that '. . . the cult of the expert is so dominant that . . . expectations of in-service education are expressed largely in terms of receiving solutions rather than solving problems' (Eraut, 1972).

It is perhaps unwise to generalise about this and to advocate that student participation in the decision making process would at all times, be beneficial; A.S. Neill (1968) and other educational reformists have suggested this and experimented extensively without it being adopted into the main stream of educational practice.

There are perhaps two reasons why progress in this matter has been so slow and why it is viewed with such suspicion. The first I would suggest is to do with power; the power that can be vested in the individual, institution or society (as represented by Councillor, MP etc.) who make decisions on behalf of the group and who are reluctant to see that power diminished. The second is to do with resistance to change or something akin to it which stems from knowing that a change
in the process of decision making will alter and extend substantially the process by which the curriculum decisions are reached.

Reason (1977) sees participants in a research process (in this project the health education officers as temporary students) as researchers themselves; '... These are the people who have to integrate understanding and action, who use concrete concepts as a basis for intelligible action'. This requirement of their professional self, this challenge to their skills and abilities is not necessarily one that is either acceptable to them or seen as feasible by their manager, the administrators or the funding organisations. The traditional view, with the roles of teacher, student, researcher clearly defined is known and accepted and fits with the clinical approach and with the role model held by the individual.

Reason, in general terms, and Kilty (1976), in relation to research in nursing, argue from their personal and professional viewpoint for a more creative use of research by those who are participants in training '. . . people are often uncritically submerged, as passive victims of the circumstances they collude in creating.' Heron (1973) and certain third world projects explored and developed the notion of participative research in which the 'subjects' stop being the objects of an outsider's investigation and take a much more active part in the discovery of information and building of theory (Reason, 1977).

3.4 The Evaluation Tools

'Evaluation is the process of ascertaining the decision areas of concern, selecting appropriate information, and collecting and analysing information in order to report summary data useful to decision-makers in selecting among alternatives.' (Alkin, 1972).
Evaluation consists of the collection and use of information concerning change; in educational evaluation the change is about student behaviour, thought, feeling, action and cognition and the decisions consequent upon these which may be directed towards alterations in the educational programme. The most basic kind of evaluation is dependent upon there being objectives for the Programme which are determined prior to its inception. The styles of evaluation, the modes and methods, have grown and developed since formal evaluation was first recognised; from some sources there is scepticism about one's ability to know how to measure change, or '... whether it is even proper to make the attempt'; from others a recognition that evaluation and the skills of the evaluator are undergoing a metamorphosis, and that the discipline is moving towards identifying other more comprehensive methods of evaluating; '... that past efforts to evaluate these practices have, on the whole, not adequately served the needs of those who require evidence . . .' (Hamilton, 1977).

This quotation comes from a manifesto from a working conference (1972) which set out to explore 'non-traditional modes of curriculum evaluation'. The manifesto goes on to suggest the form of future evaluative practices and suggests that these may be

'. . . responsive . . .'
'. . . illuminative . . .'
'. . . relevant . . .'
'. . . reported in a language accessible to their audiences'.

Further the authors make recommendations to do with using carefully validated observational data, with flexibility in the face of unanticipated events and, with the position of the evaluator.

This project employed evaluation methods that were grounded in much of the thinking and activity that has followed this 1972 conference; the methods used take account of the need to be both relevant and illuminative;
the need to use comprehensible language and to respond to the needs of the group being examined: it has attempted to be flexible.

The development of evaluation over the years and through the many metamorphoses can be represented on a simple continuum: at one end there is the agricultural/botany model of evaluation in which everything is counted/weighed and measured at all stages of development: at the opposite end lies illuminative evaluation and grounded theory in which the emphasis has moved away from counting and measuring and is focussed on the proaction and reaction of the participants.

Atkin (1970) believes that it is usual and expected that there will be '... clear statements of anticipated behaviour'... and that these will be developed '... at the start ...'; he suggests that it is only the slipshod that develop objectives later; if however, illuminative and responsive evaluation demonstrate other originally unrecognised objectives then these should be incorporated into the protocol so enriching the design and the spread of investigation. Eisner (1969) for his part would place a measurable value on the objectives, classifying them as either instructional (which are the traditional and well known objectives) or expressive; these he relates to the environment in which the participant works, the problems they encounter, the tasks and situations and so on. He suggests that it enhances the evaluation of the learning; he recognises that it does not take place in a vacuum divorced from the influence of the micro or macro environment. This concept I suggest is important and a stage on the continuum from the agricultural/botany model. Eisner (1972) later develops and extends this concept by suggesting that those procedures so successfully used in art criticism to heighten perception by seeing the interplay of the elements that constitute the whole and then interpreting this for others who may be less perceptive, could be successfully used within education. If so used he suggests not only does it '... restrict
itself to the primary surface of a situation; the secondary surface, that is, the situation's expressive and underlying qualities, is also a candidate for description and interpretation (Eisner, 1972). Later Eisner (1975) comes back to this 'holistic' approach to evaluation in what he terms 'thick description'; that is making links that are significant between the behaviour that is being evaluated and the '... cultural network saturated with meaning' in which it is situated. I would suggest that an examination of some of the complex networks of knowledge, attitude and behaviour that affect the utilization of training by HEOs may be better understood in the context of Eisner's 'thick description'. Stake (1972) illuminates another facet of this discussion when he suggests that '... every aspect of an educational programme holds at least as many truths as there are viewers'. At this end of the continuum where evaluation is not about statistical analysis or measuring, but about the behaviour of the participants then '... each will see value in a different light' (Stake, 1972). Some of this 'different light' will be to do with cultural influences, some with the insights that can be afforded by the evaluator as a constructive critic and some by the collaborative experience of being within a learning milieu with others having similar goals.

Tyler (1949) proposed an evaluation that is goal centred; that '... the process of evaluation is the process of determining to what extent the educational objectives are actually being realised ...'; he sought to identify the goals, to examine the appropriateness of the methods used and to measure whether or not the goals were achieved at the conclusion of the activity. He provided an acceptable framework and a reasoned philosophical approach that the educationalist and the practitioner could grasp and use as a tool for developing the curriculum by responding to the needs identified.
The task of identifying objectives and of using them significantly in both the methods of developing curriculum and of constructing evaluation strategies was subsequently explored in greater detail by among others Bloom (1956), Mager (1962) and Krathwohl (1964).

Additionally Tyler's concept of feeding back evaluation outcomes to enable and support curriculum improvement was explored and more clearly demonstrated by Scriven (1967) who proposed the terms formative and summative evaluation for this purpose, and by Stake (1972) who explored and added to the debate. Scriven suggests that formative evaluation is evaluation used to improve the course while it is still fluid and that summative evaluation appraises a course already completed. He also explores the function of evaluation and sees it having two parts; that which is to do with goals which is about '... how well does this instrument perform ... is it better than this other instrument ... is the use of this instrument worth what it is costing ...' and so on; and that which is to do with its role in a particular context which he sees as '... enormously variable'. He suggests it may be '... part of teacher training activity ... improvement of learning theory ... data gathering ... investigation about purchase or rejection of material ...' and so on (Scriven, 1967).

He goes on to suggest that goals and roles are often confused to the detriment of the service that evaluation should provide and that when the particular merits of each are not recognised evaluation may be seen as some sort of judgement under which the progenitors of the programme being evaluated are unhappy to sit. Part of this problem he identifies as being '... a legitimate objection to a situation in which an evaluation was given a role quite beyond its reliability or comprehensiveness ...' (Scriven, 1967).

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It would appear that those who commission evaluation endow it, sometimes unreasonably, with the ability to authenticate and validate totally and with certain unrealistic properties; this can be expressed perhaps as having a valid project if you've got evaluation built in!

Later Scriven (1971a) develops his thinking further in an imaginary dialogue on 'goal free evaluation'. Is the only choice for uncontaminated and pure evaluation one in which the evaluator divorces himself from all that precedes and is involved in the activity to be evaluated? Certainly we can assume 'contamination' in that interactions between teachers and evaluation inevitably influence in some respect the relationship and the subsequent evaluative outcome. Scriven (1971c) confronts this when he considers the change agent role of the evaluator and wonders to what extent he needs to be, self-consciously, a 'moral' agent. The discussion is not carried further by Scriven but Stake illuminates it in a different way when he explores evaluation in terms of antecedents, transactions and outcomes; this tool will be explored in Chapter 5 and an example of its use in the project included. Examination of the 'outcomes' at each stage of the educational process can provide formative evaluation immediately accessible to the participants. Thus the 'moral' role of the evaluator at this formative stage is to do with ensuring that this accessible information is made available and is understood. However, if we accept Macdonald's (1976) analysis that evaluation is 'political' then it is possible, depending on the nature of the evidence, that whatever the evaluation it will not be used.

3.5 The Barriers to Evaluation

Evaluation is or should be carried out in order that the educational process can be understood, so that new knowledge about the process, whether positive or negative can be gained and so that improvement can be striven.
for. Tyler (1949) was one of the first (in the USA) to make educationalists aware of this need and to influence their thinking. He posed four questions. . .

1. What educational purpose should the school seek to attain?
2. What educational experiences can be provided that are likely to attain these purposes?
3. How can these educational experiences be effectively organised?
4. How can we determine whether these purposes are being attained?

. . . which provided the practitioner with a framework in which to examine and improve his work. This process, designed to be creative and progressive, is in itself a threat to some of the participants in the interaction. Amslon and Sherwood (1967) noted the many barriers that appeared to prevent evaluation occurring or sought to control the way it occurred; MacDonald (1976) has explored, in a similar manner, the political framework within which any programme and its evaluation is set.

He suggests that evaluation is political on two counts; first, because the information that the evaluators produce ' . . . functions as a resource for the promotion of particular interests and values'; and second, because those who should act upon the information often have to choose between competing claims for resources or have to function within particular systems. He suggests that this is demonstrated in three political styles of evaluation. First, that which is bureaucratic, which requires unconditional service to the agency or government (that is the employer) and which works on a basis of power; the knowledge that will come from the evaluation is 'power' which can be used, or not used, in any way that the 'power holder' decrees. Second, that which is
autocratic, which requires conditional service to the agency or government (that is the employer), which allows the evaluator independence in his judgements, although he must provide proof, and which works on a basis of responsibility; the knowledge that comes from the evaluation must be handled 'responsibly' by the evaluator, requiring for example that if evidence is suppressed for political or economic reasons it cannot be independently published or leaked for alternative political reasons. And third, that which is democratic, which sees the information coming from the evaluation as being a service to the community who have a 'right to know'.

The political nature of making information accessible and available is part of the philosophy of Friere (1976) which has already been discussed; Wilson (1975), in the context of health service provision makes a similar point '. . . the question of priorities . . . raises matters of political choice; political because health concerns the quality of our life together, in a family, a neighbourhood, a nation and internationally; a choice because our resources are limited'.

That the outcomes may fail to fit into the system as it is established, and that the activities prescribed may 'offend' the participants are but two of the barriers to useable evaluation outcomes that need to be acknowledged. As Aranson and Sherwood (1967) found, the effect of the political framework could diminish the initially accepted evaluation programme to a shadow of its original self.

It may appear strange to thus comment on the milieu of evaluation; to suggest that, however honest the motives of the evaluator, the forces ranged against him are such as to make his task difficult. To illuminate this I would refer back to the material appearing earlier in this chapter; I explored the continuum of evaluation and when regarding the non-statistical aspect, that part which is illuminated by a holistic approach.
From the time that Tyler first posed his set of questions there have been explorations, developments, expansions, criticisms, discussions which have contributed severally and collectively to the current state of evaluation activity. Theories have been developed, hypotheses proposed and tested and the outcome is a perspective of richness and diversity.

3.6 The Constructive Use of Evaluation

How then is the evaluator to use his skills to ensure that he contributes constructively and creatively to development; perhaps his role primarily is not to prove anything (though within the agricultural/botany paradigm this is expected of him) but to aid, at all times, improvement of the activity. Glaser and Strauss (1967) in their development of 'grounded theory' (or theory in process) suggest that theory cannot be divorced from the process whereby it is generated and it must be accessible to those outside the project. Rowan (1981) postulates models of development and growth which break away from the conventional model that is the continuum referred to earlier and which reduce the distance between evaluator and the persons under study.

He demonstrates a number of models in which the significant factor is that the end point of any activity is but the new beginning for the next cycle. Evaluation which is illuminative (Parlett and Hamilton, 1972) is part of this process seeking to utilise description and interpretation rather than measurement and predictions, discovering and documenting the experiences of the participants in the scheme and discussing the significant features of the innovation and of its critical processes.

Haverlock (1973) explores the process whereby the client system recognises and deals with a disturbance in the status quo. Like Rowan he examines the role of the change agent identifying four separate but
not necessarily mutually exclusive aspects. He suggests that these are
process helper
solution giver
resource linker
and catalyst.
These change agents, in their various modes seek to assist the client system in the change process. The extent to which the change agent treats the client subjectively or objectively, the 'closeness' of agent to client in terms of enabling the client to explore choices and make his own decisions depends on the mode that is chosen. The Haverlock theory is set out as a model at Figure 7; the choice of modes can be ranged along that continuum ranging from totally non-participative (on the part of the client) to totally participative. For instance, the 'solution giver' can be seen as providing the answers to the problems in a prescriptive 'I know what is good for you' manner. 'Resource linker' and 'process helper' each move some way along the continuum each giving the client more involvement in the process. 'Catalyst' lies at the opposite pole of the continuum and places the change agent in a true facilitative role where the power remains with the client.

Research and evaluation theory and models are developing and growing. There is a shift in emphasis, particularly in the sphere of sociology, psychology and education, for that research to be more within the domains of the experiential and collaborative; there is a tendency for the client to be regarded as a partner and collaborator rather than an object. However, the questions posed by Tyler - questions about purpose, provision, organisation and attainment - remain essential; the questions that the work of recent years has added are about involvement and transferring. Involvement of the clients in the process and the transferring of the outcomes successfully into their practice.
The role of the change agent (after Have lock R.G. (1973))

Figure 7.
The work that health education seeks to support lies at this latter part of the continuum with client involvement and collaborative approach. It is both logical and essential that the process, (for the continuing education of those who administer this service) is developed in a manner which illuminates and upholds this conceptual framework.
CHAPTER 4  GATHERING THE EVIDENCE, CHOOSING RESEARCH STRATEGIES AND SETTING UP THE MODEL.

4.1 The Curriculum needs of Health Education Officers.

4.2 Gathering the Evidence

   4.2.1 The health education officer group
   4.2.2 Managers and others
   4.2.3 The literature
   4.2.4 Project steering group
   4.2.5 A review of inservice education and training activity.

4.3 A summary of the evidence

   4.3.1 Content
   4.3.2 Process
   4.3.3 Context

4.4 Choosing the research model

4.5 Setting up the research model

4.6 Summary

Annex I  Flow chart of project development
Annex II  Pro forma

This chapter explores the various sources from which evidence was drawn, describes the methodology for the INSET review and sets out the evidence so gathered; it concludes by reviewing the variety of research models available and identifies the key factors of the model used.
4.1 The Curriculum Needs of Health Education Officers

The literature specific to health education officers is sparse. Tones (1975a) undertook a survey of health education officers in 1973 in which he examined the group as an emerging profession and identified what he termed the COR (Consultative/Organisational/Research) function which he suggests is '. . . a prerequisite to the development of a fully 'professional' community health education organisation'. Subsequently Tones has published a number of papers dealing with education need (1973), ethics and professionalisation (1974a), professionalism and the health education officer (1975b), and the role of the Community health education specialist (1977).

The professional organisation of health education officers (Guild of Health Education Officers, 1972) undertook a small descriptive study concerning health education practice and health education officers in 1972 and more recently a working party has further explored recruitment training and development and published a report (Kirby Report, 1980) which for the first time seeks to define not only role and function but to capture this in a detailed job description. This report is a consultative document and, at the time of writing, is subject to amendment in the light of commentator reaction.

More generally, several authorities have sought to explore wider aspects of health education relating to the teaching of behavioural sciences in health education (Baric, 1972), the exploration of particular aspects of the health educator's role (Green, 1973), a systems approach (Tones, 1974b) to health education and a review of theory and practice related to effectiveness and efficiency (Tones, 1978).
From this material came evidence concerning perceived role and function, training requirements, the network within which the health education officer worked, the search for professionalism and acceptance, and the detail of delivering health education. All these studies had implications both implicit and at times explicit, for training; the curriculum of the current Diploma in Health Education (Council for National Academic Awards 1978) is a statement of what is currently the acceptable pattern for health education officer training; Kirby (1980) challenges this at times.

From this evidence it should perhaps also be possible to deduce training needs of health education officers that are not being met in the Diploma course; all the identified needs however appear in the course; they are knowledge and understanding of behaviour, health education officer role and function and administrative and research skills.

If Goodlad's (1966) model were to be adopted (institutional, instructional, societal) it would have been possible to use the knowledge and understanding of the existing teachers on higher level health education courses (Diploma, Master Degree); that is the instructional level; it would have been possible to have taken the problem to one or more facilities with known sympathy to and understanding of health education (institutional level); or it would have been possible to have taken instruction from managers, local and national administrators, AHA members and so on (societal level). The outcomes of their recommendations could have then been checked with health education officers and, based on this evidence, courses could have been constructed, run and evaluated.

Except in a token fashion (check with health education officers) needs as perceived by themselves are minimally explored in any of these conventional approaches. With Reason (1977) and with Freire (1976) the
researcher felt it important that students participated in the developments leading to the courses; the evidence for course design was gathered to support this decision and to ensure, as far as was possible, that students were involved in the activity at all stages.

4.2 Gathering the Evidence

In gathering the evidence on which to develop courses I have tried to cover all these elements; while the health education officer field is small (currently less than 500) the network represented by organisations and individuals is large; this may be partly because, as an emerging discipline, the ties of health education officers with previous disciplines are both personally and administratively evident and because health education itself is part of a very wide network involving many of the well established disciplines.

In order to maximise the information on educational needs, I gathered data from five different sources; these were
1 the health education officer group
2 the managers of health education officers and those having substantive lateral professional relationships
3 the literature on health education officer role, function and practice and the knowledge and expertise of the trainers
4 a project steering group
5 a review over a six month period of existing INSET activity for, with and by health education officers.

These will now be explored separately; the method by which information was gathered will be stated for each activity together with any observations on significant aspects of the activity. The evidence thus obtained will then be presented.
4.2.1 The health education officer group

i. A letter was sent to all Area Health Education Officers and officers in charge setting out the purpose of the project and asking for their perception of INSET training for health education officers and of its nature and content.

ii. Both the project director and I attended the annual national health education officer seminar and a national colloquium for Area Health Education Officers; this provided opportunity for informal discussion about the project and for the project team to extend and deepen their perception of health education officer training needs. This came about both by contributing to the events in a trainer capacity and by observing some of the group and seminar interactions.

iii. I carried out structured informal interviews with as many health education officers of all grades as was possible and practicable, including those at the Seminar and Colloquium.

4.2.2 Managers and others

i. A letter, explaining the project, was sent to all Area Medical Officers (line managers for health education officers) in the Region in which the first pilot course was to be held; I asked to meet with the Area Medical Officers to discuss the proposals and to explore their perception of INSET training need for health education officers.

ii. Interviews were sought with those having substantive lateral professional relationships with health education officers both in the statutory and voluntary services; these include hospital and community nurses, managers, local authority education officers,
community health council secretaries and so on.

Similar interviews were carried out with those in national statutory organisations with a concern for health education.

4.2.3 The literature
A literature review was carried out with especial reference to that which is to do with health education officer role and function, with the health education officer job description and with existing training provision. This has already been discussed.

4.2.4 Project steering group
A representative project steering group was convened; its brief was '... to assist the research team in its work, facilitate the development of appropriate communication channels and informally advise on the appropriateness of proposed research strategies and methods'. This "extended team" approach has been used successfully in other projects (Kilty, 1977). The group comprised
Course director: Diploma in health education
Training officer: DHSS
District Nursing Officer (DNO)
Area Health Education Officer
Area Medical Officer (AMO)
Director: Health Education Council
Education Advisor: Local Education Authority
Project director
Research officer.

The group were selected to bring to the project both a representation of the lateral and vertical relationships that health education officers experienced within and outwith the health service and a similar representation from those who provide, support or who initiate training
for them. Thus the AMO is the line manager for the AHEOs and the health education officers, the DNO and LEA advisor represent two of the many lateral relationships HEOs experience; the HEC Director, Diploma Course Director and DHSS Training Officer represent some facets of HEO training and development. The AHEO and research officer represent the health education service and the project director the continuing education field. Additionally the members of the Group provided an extensive knowledge and understanding of the health and education services; the varied and rich experience and expertise they could and did bring to the project provided a compendium of information on which course planning could be based and gave continuing support to the project throughout its life.

4.2.5 A review of INSET activity over a six month period

In an attempt to understand more clearly those inservice training activities that were available to and used by health education officers a postal survey was carried out.

A letter was sent to all AHAs asking that they

(a) describe inservice training undertaken by HEOs in their Area during a 6-12 month period.
(b) comment on the place of health education office staff meetings in INSET. Respondents were not asked to make any assessment of either quality or effectiveness of the activities they attended.

Responses were gathered together; sixty-seven authorities responded (Figure 8) and 57% were involved in some sort of training activity (Figure 9).
<table>
<thead>
<tr>
<th>Training Activity</th>
<th>No Training Activity</th>
<th>Total Responding to Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AHEO in post</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>replied</td>
<td>49 (48%)</td>
<td>75 (73%)</td>
</tr>
<tr>
<td>no reply</td>
<td>26 (25%)</td>
<td></td>
</tr>
<tr>
<td><strong>HEO in post</strong></td>
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<td></td>
</tr>
<tr>
<td>no AHEO</td>
<td>5 (5%)</td>
<td>12 (12%)</td>
</tr>
<tr>
<td>replied</td>
<td>7 (7%)</td>
<td></td>
</tr>
<tr>
<td><strong>No health education staff in the AHA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>replied</td>
<td>13 (13%)</td>
<td>15 (15%)</td>
</tr>
<tr>
<td>no reply</td>
<td>2 (2%)</td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>67 (66%)</td>
<td>102 (100%)</td>
</tr>
<tr>
<td>no reply</td>
<td>35 (34%)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 8. Survey of HEOs in Area Health Authorities 1978: Response

<table>
<thead>
<tr>
<th>Training Activity</th>
<th>No Training Activity</th>
<th>Total Responding to Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AHEO in post</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>replied</td>
<td>34 (51%)</td>
<td>49 (73%)</td>
</tr>
<tr>
<td>no reply</td>
<td>15 (22%)</td>
<td></td>
</tr>
<tr>
<td><strong>HEO in post</strong></td>
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<td></td>
</tr>
<tr>
<td>no AHEO</td>
<td>4 (6%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>replied</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td><strong>No health education staff in the AHA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>replied</td>
<td>0 (0%)</td>
<td>13 (19%)</td>
</tr>
<tr>
<td>no reply</td>
<td>13 (19%)</td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>38 (57%)</td>
<td>67 (100%)</td>
</tr>
<tr>
<td>no reply</td>
<td>29 (43%)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 9. Survey of HEOs in AHAs: Involvement in training
a) **In-service training**

Much of the activity could be described as seminars or a similar activity occurring over a limited period of time and having specified objectives; for 80% of respondents the activity included other disciplines besides HEO. For instance a seminar on the Schools Council Health Education Project had an audience that comprised school teachers and HEOs; the HEC's annual seminar audience included many of the health service professions (environmental health officers, health visitors, doctors, dieticians) as well as HEOs. These activities were organised mainly by national bodies though locally organised and initiated events were possible. For audiences that were solely HEOs a number of organisational structures were shown to be possible,

- an AHEO acting on behalf of a group of colleagues
- the regional chapter of the Guild of HEOs incorporating an educational element into a business meeting
- the Regional Education and Training Officer (NHS) acting in consultation and collaboration with a group of HEOs.

Numerically less activity significant was described as 'courses' in which respondents had made a definite commitment usually over a long period of time (a day a week for an academic year). Such activity often had an award at its conclusion.

Respondents were asked to demonstrate the process by which the training was developed. Responses tended on the whole to be to do with the construction of the training programme (lecture, discussion) rather than the process by which it was developed.

Where process was identified it was to do with 'making provision to meet perceived needs'; 'responding to staff requests', 'convening a specialist planning group to develop training' and 'using trainers within the NHS'. One Regional group of HEOs developed an instrument
whereby the needs of the whole group could be gathered, analysed and, where possible, provided for.

The means whereby a training programme is developed (the 'process' of development) is important, including as it does the setting of objectives, assessing implications and resources, organising the activity and evaluating the outcome. A model for the process appears at figure 10.

![Diagram of A Training Cycle: A Model](image)

* The passage of time causes change; what of significances has happened between the time the objectives were set and the time implementation was completed.

Figure 10

A Training Cycle:

A Model

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Although the evidence from this pilot investigation is not rigorous, and the design of the questionnaire admits of improvement, it would seem, from this and from additional personal observation, that the trainer role of the HEO is poorly perceived both by the HEO and by those with whom they have lateral or line relationships; it would seem that the HEO is perceived and perceives himself as an administrator of training rather than participating in the training process.

The content of the in-service training provided reflects both the perceived needs of individuals or groups and the bias of interests of the providers. For participants it was often a case of Hobson's choice there being very little that they could attend that bore the health education label; on the other hand where particular skills were required it was not always possible to gain access to relevant courses within the system (personal communication (Quigley 1977) shows that, whereas the majority of AHEOs would wish to and have identified a personal need to attend senior management training, course places are allocated on a Regional basis and it is not unusual for there to be only one AHEO place available in a Region in any one financial year; in a Region with a full complement of AHEOs management training for some is a long way away).

More emphasis appeared to be given to the subjects which concern HEOs; these have a wide range including as they do disease groups, social ills such as alcoholism, life crises such as bereavement and the normal and abnormal of human growth and development; less emphasis seems to be given to the process by which an HEO functions professionally: this can include management skills, interpersonal skills, teaching/training skills and so on. Other evidence collected during the project, and which is referred to in chapter 5 and 6, demonstrates the need for a
greater understanding of the HEO function. It will be demonstrated at that point that a structured, organised approach to determining priorities for training enables participants to move from the cognitive, laissez-faire approach into the affective and skills domain where training needs, hitherto unperceived and unrecognised, become apparent.

This is the existing pattern of HEO INSET; it is responsive to perceived needs and to a considerable degree is influenced by what is available.

b) **Staff meetings**

Fewer responses were recorded (Figure 11) and a number of respondents indicated their inability to hold staff meetings because they were the sole HEO in post in that Area. No significant pattern

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bi-monthly</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Monthly</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Weekly</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Bi-weekly</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Not stated</td>
<td>14</td>
<td>44</td>
</tr>
<tr>
<td>Ad hoc</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Not held</td>
<td>6</td>
<td>19</td>
</tr>
</tbody>
</table>

*Figure 11. Frequency of staff meetings*

emerged as to frequency, the range being from weekly to ad hoc. Sixteen respondents saw staff meetings as having value for training purposes. Seven respondents mentioned other activities (Regional meetings, professional meetings, induction training) which they regarded as equivalent to staff meetings and to have a training function. The most frequently mentioned activity was to do with
exchanging or acquiring information either between themselves or by previewing educational material. Almost as frequently matters to do with the content of policy and administration were discussed; the other elements were to do with guest speakers, led discussion around an identified focus and meeting with those within other disciplines.

Respondents were invited to comment on the contribution of routine staff meetings to in-service training and a selection of these comments follows.

Extracts from the responses on staff meetings

'I consider the meetings vital - they must contribute to the educative process'

'... was a firm advocate of routine staff meetings ... now have mixed feelings ... very interested to hear opinions of colleagues'.

'... Colleagues join us from other disciplines ... a successful venture ... talk about Economics, Health Education ... invited the DCPs to this session'.

'... this is the most important mode of continuing education'

'... if planned as a training exercise could be one of the most effective ways of providing a continuing education for staff ... but tends to become bogged down on small administrative problems'.

'... formal staff meetings are few ... regular meetings to discuss finance/purchasing ... do not provide a focus for staff training'.

'... staff who have attended any in-service training to report back ... acts as a basis for discussion out of which common policy emerges'.

'... consider that the informal exchange of information ... discussion of policy/methodology ... play a very important part in the development of staff'.
'... the interchange ... is invaluable in establishing a co-ordinated service'.

'... staff meetings ... are useful as a training adjunct in the first few months of an HEO's time ... afterwards tend to become more administrative in nature'.

'... in the main discussions are of a functional nature related to the activity of health education. I feel they are of limited value in developing a theoretical basis which should be provided by a prolonged study of the subject'.

'... will always include an element of education, but such outcome is incidental rather than planned'.

4.3 A Summary of the Evidence

An exercise in gathering evidence, such as this was, is complicated by the varying interpretations put on the term 'health education' by the participants in the exercise. Within health education practice this difficulty is acknowledged; however, it has the power to make the analysis of responses less accurate than is desirable and this in itself defines another need.

Health education, and the carrying out of HEO role and function and the meeting of HEO training needs can be to do with the content of the health education message (information will be given about ... ) with the process by which the health education message is given (how the information is presented about ... ); or with the context in which the message is given (the social/economic/political environment). It is also to do with the HEO either being the purveyor of the message, or the administrator who ensures that the message is purveyed by the most appropriate means or the facilitator who ensures that the interaction, however conducted, takes place in a manner that allows the client or client group to make maximum use of available opportunities.
Any evidence gathered from the various groups needs to be accepted in these several contexts and while, in personal interviews, it was possible to probe carefully to determine the extent of the respondents understanding of the HEO role and function, within some of the written evidence (letters from AHEOs for instance) different assumptions as to the meaning were being made; whenever possible these general assumptions were checked by personal interviews. At all interviews, and in interaction with the steering group, the various components of the evidence were checked for congruence or dissonance and matters of uncertainty were explored.

Further checking on the outcomes of the preliminary collection of evidence came from the needs exercise (Chapter 5) carried out with the second and third pilot groups.

When all the evidence was collated the predominating need was to do with process; from some HEOs there was an emphasis on content but the evidence from the INSET exercise shows that the strength of this activity lies in meeting needs of a cognitive kind; context was less frequently identified, and this appears to be common among health professionals generally.

These will now be described.

4.3.1 Content

There was an expressed need to know more about many topics (cancer, nutrition, human biology, sexuality) where either respondents felt their knowledge inadequate or managers required a knowledge based officer. The literature (Tones, 1975a; Kirby, 1980) shows that, because HEOs come from a variety of other professions or occupational groups their knowledge base may not be consistent or standardised; whether or not this is necessary is a matter that is currently debated, though the
consensus seems to be that process and context are more important than a standardised content base. The evidence from the INSET investigation showed considerable knowledge based activities but this may be more to do with what is available than what is needed.

4.3.2 Process

Matters to do with process appeared consistently during the whole of the investigation. They can be loosely categorised though the categories are often interdependent.

Personal growth and development

- understanding and personally developing skills of self-directed learning.
- handling anxiety
- understanding role appraisal
- developing and enhancing inter-personal skills and 'openness'.
- understanding self assessment
- developing positive attitudes to responsibility

Communication skills

- working in committee
- chairmanship
- running small groups
- skills in verbal and written presentation
- public speaking
- using language comprehensibly

Training skills

- classroom teaching
- training other professionals in health education matters
- course development and organisation
Management skills
- assessing priorities
- budgeting
- management of resources
- decision making skills
- staff development
- skills of delegation

Research and evaluation
- the cost effectiveness of research in relation to practice
- incorporating it in ongoing work
- research appreciation
- organisation, management or collaboration with large scale research

4.3.3. Context

This element was less clearly articulated by the investigation; it showed as concern to do with concepts of health and health education; to do with the ethics of health education either in general or to do with a particular aspect; to do with the role of the health education officer as a member of a much larger social/political/economic scheme which sought to determine health standards and health behaviour.

The 'needs' exercise carried out with two of the pilot courses identified similar matters. Some of the matters identified are within the curriculum for HEO training as contained in the syllabus of the Diploma in Health Education; however, with only 40% of HEOs so qualified there is a demonstrable lack of this particular training. Additionally the structure of the current syllabus does not, and would find it difficult to, incorporate all these elements.
The evidence we had gathered appeared to show a considerable perception of 'process' needs by all the actors in the arena. The strength of the perception of individuals was difficult to assess as was the depth of the understanding of the various processes by the contributors but, when statements of need were checked from one section to another there was agreement. What was less clear, and this lack of clarity appeared later in the programme as well, was exactly how accurately each group's form of words was appreciated by others and, when trainers were called upon to translate this into a programme, how successfully they succeeded in meeting the needs of the participants as perceived by them.

As will be shown in the final discussion, there is considerable variation even between HEOs over the interpretation of phrases and concepts. I will be suggesting that an important early task in the search for acceptable role and function and equally acceptable definitions of HEO tasks, will be for HEOs to reach some measure of agreement on what they mean when they use phrases such as health education.

The exercise to gather evidence for curriculum development provided us with areas for development. Within the constraints discussed only a proportion of these could be met in the current continuing education project; what is demonstrated is the breadth of need which can be met by such a project and the opportunity available to HEO to - identify needs for training

- select that which they wish to work on
- organise the necessary training support
- evaluate or assess the outcomes.
4.4 Choosing the Research Model

A number of research models were reviewed and the one to be used for this project was selected.

The models were as follows

A. One or more experimental training groups would be set up with and equivalent number of control groups. The training provided would be determined by institutions and managers with the student playing a passive, non-interventionist role. Evaluation would be summative, concerned with determining overall programme effectiveness, and comparatively, concerned with proving best value among alternative approaches.

B. One or more experimental training groups would have their training provided initially in the same non-participative manner. Formative evaluation, concerned with programme improvement, would consult members of each training group about all relevant matters. There would also be summative evaluation, proving effectiveness and providing a product, or proven training design.

C. One or more experimental training groups would have training developed collaboratively; the content and method would be identified by and with the student group and the means of training to meet both content and method would be developed as collaboratively as possible by each group. The result would be one or more proven designs and would include a series of modules from which experienced trainers and staff development persons could assemble future courses.
Each model was examined in the context of the needs of the project as defined by HEC; this was then related to the characteristics of the target population (the HEO groups), the nature of the short programmes envisaged, the likely participants, the various line managers who were to be satisfied by evidence of valuable outcomes, and the likely training staff available. Model A was rejected as out of date and impossible to implement. The trainer centred nature of decision making was contrary to any idea of the professional as reflective (Schon) or of these professionals as educators. Participation in design would at least ensure ownership of the courses and at the most the development of awareness of good staff development practice. The identification and administration of effective control groups could not be easily achieved. This classic, pre-ordinate design with its' agricultural-botanical paradigm (Parlett and Hambilton) has been eliminated as a valid experimental design. Comparative evaluation research of this nature has also been proven invalid (Stufflebeam).

Model B was chosen for the first course for a variety of reasons. Firstly, it was a classic tried-and-tested and widely used design for evaluation research (see for example Nuffield 5 - I3 Science Project). It would conduct repeated trials of courses designed as successive approximations to a unique product, suitable for this professional group. The first trial would be conducted by the project supervisor in order to

* maximise both control over the course and the generation of information and learning about evaluation requirements;

* minimise costs;
provide the most adaptive first design; and

be in a geographically convenient setting.

Evaluation would guide decision making about good course design and practice.

The second reason for choosing model B was that the size of the field on which this was to be carried out is limited; at the time of the experimental activity there were less than 500 health education officers in total and at the time the project commenced there were just over 300. The original design envisaged a viable group of participants being recruited from any health service Region, within which there would be the sort of structural links, both vertical and lateral, and formal and informal, that would ease the formation of a coherent staff group. In the first instance however, insufficient members were made available from the S.W. Thames Region and further members were sought from an adjacent Region.

The nature of the goals for the project were reframed as the enquiry proceeded; this because the need had to be translated into action; and the action had to be acceptable to the participants within the project.

---

The Project Cycle

- Project goals
- inputs from enquiry
- check acceptability to target
- translate needs into action
- reframe goals

Fig. I2
This was carried out positively and responsively; the problem was redefined, a course was constituted with member defined characteristics, and then further refined as the group moved towards greater autonomy. The framing of the problem changed, therefore the methodology or working also changed. Thus the Regional HEO group came to have a distinct identity.

The nature of student involvement and participation altered as the project developed. Initially and both prior to and in the early stages of the first Pilot course, there was considerable consultation and exploration to determine training needs; this took place with managers, colleagues, others in lateral professional relationships and trainers. Later, and as the project and project team became more recognised and accepted, students were closely involved not only in exploring their possible training needs but in determining the agenda for training and contributing to its development. A democratic, participative involvement was possible and the constraints that inhibited its greater development will be explored in Chapter 7.

Thus model C emerged and was quickly established. Implicit in models A and B was that the research would answer the questions "Is there a curriculum design which will meet the developmental needs of this group?" and "Is there a particular curriculum which can be replicated anywhere in the country?". The idea or hypothesis that such a curriculum existed to be found was considered true at this point and was put to the test. Model C would widen the research to include the process of curriculum development and thus would aim to develop a suitable process. It asked, "If there is not a specific curriculum, is there a procedure which can be used to produce a curriculum responsive to membership, location and time?". Again this idea or hypothesis was considered true by this time and put to the test.
The application of model C used initially a centralised model of curriculum design and development Havelock which would demonstrate to and within the institution that "something was being done" to address the training needs of HEOs on a deficit model. Additionally it could have been applied in a 'laboratory antisepsis' way, which Stufflebeam criticises; he argues that the 'laboratory' technique produces a situation in which '....treatment must accommodate the evaluation design' rather than one which supports the continuous improvement of the programme. In practice, it will be shown that it had no such limitations and eased the way into a model D or action research model discussed later in section 4.5. It engaged prospective members as participants of a consultative process in defining and refining their perceived and felt needs. The initial course design was put as a proposal to the pilot one group. It was accepted, and as was the intention, modified and developed during the life of the first trial.

Model C is not a new design, and variations have been widely used in business education and in facilitator training. The Peer Learning Community version of this model \[model C\] has been used in counsellor training (eg SW London College) and is currently the basic model of facilitator training in the Institute for the Development of Human Potential. It was new for the training and development both of HEOs and in allied fields of health education, nursing and medicine, except in relatively isolated instances. These considerations may be illustrated using the models by Heron (1973) and Rowan (1981). Heron's model is represented here as a horizontal continuum showing the degree of participation in decision making against a vertical list of decisions. The full implications of Rowan's model, the research cycles and the authenticity of the encounters between research and subjects are considered in Chapter 6.
<table>
<thead>
<tr>
<th>Membership</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
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</thead>
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<td>D</td>
<td>?-----C'C B A</td>
<td></td>
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<tr>
<td>Specific Purposes</td>
<td>DC'</td>
<td>?--C B A</td>
<td></td>
</tr>
<tr>
<td>Content</td>
<td>DC'</td>
<td>?--C B A</td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>DC'----</td>
<td>?--C B A</td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>DC'</td>
<td>?--C B A</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>DC'</td>
<td>--C B A</td>
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</tr>
<tr>
<td>Management</td>
<td>DC'</td>
<td>C B A</td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>DC'</td>
<td>?--------CBA</td>
<td></td>
</tr>
</tbody>
</table>

**Participation in decision making**  

Figure I3

N.B. In this version of Heron's scheme, high participation assumes an appropriate blending of hierarchy, parity and autonomy, in which the facilitator defined boundaries and inputs to decisions are blended with individual inputs and freedoms and group negotiation of boundaries, norms, procedures and practical decisions.

4.5 Setting up the Research Model

Gathering the evidence from those identified as significant in the development shows not only the breadth of learning needs perceived by a wide range of respondents but also the lack of clarity and understanding among them (4.3). It may be argued that the participants, as an emerging discipline, currently poorly located in the health service structure, only slowly identifying a satisfactory personal and corporate health education role, could not yet be reasonably expected to offer readily a consensus of learning needs; this will be explored further in chapter 7. In addition, the Research team were very aware of the constraints of time and money and so the most appropriate model possible
for the situation was devised. As the project developed so the model was revised and improved particularly in respect of the participative nature of the interaction.

Provision of training through the project is only one element of the overall potential education and training that can be accessed by HEOs; much of this has been described in detail earlier (2.4; 4.2) The Research team's responsibility was to create a learning environment that was first broadly complementary [in terms of identified need] to other provision and, second, gave participants every opportunity to take responsibility for using project outcomes for future learning opportunities; this both for themselves and their colleagues.

To achieve this it was seen to be helpful if the potential course members comprised a unit that was already naturally grouped together and might be expected to meet together on occasion. The Regional nature of the NHS lends itself to this and it was agreed that HEOs should be approached in Regional groups. All pilot courses involved consultation with the AHEOs and with their line managers; the fruits of these consultations contributed to the structure and content of each course. This was achieved for the second and third courses using firstly meetings with the regional AHEO group to negotiate the course.

A second major way in which the model was set up was the subsequent study day, which in each instance was to assist not only in the determination of needs for learning, but also in the framework, location and interpretation of these needs; additionally it sought to maximise managerial support and transference and to win participation in the learning activity by all (Chapter 5).
It was the intention to demonstrate and participate in an humanistic, collaborative model of course design and implementation, helping the participants to meet both as equals and individuals each with an important contribution to make and each with important learning needs to be met. This is not, within a traditional service such as the NHS, a usually accepted and understood model; it is not one that was currently within the experience of the majority of participants and therefore was one which, before any learning activities took place presented a challenge both to individuals and the group. The effect of this challenge will be explored in chapter 6.

Argyris and Schon (1974) see action research as an intervention activity and suggest that there are three basic requirements for this.

* the generation of valid information
* the client system maintains its discreteness and autonomy (free informed choice)
* the client has internal commitment to the choices made.

The arguments of Elliot (1978) as well as Argyris and Schon, show a client centred activity, one in which informed, intelligent participation is essential and one in which the 'actors' in the interaction are in control of the activity.

The criteria of the final model were

* that it should be action research
* that the learning should be part of a continuum of continuing education
* that the group should assume responsibility for the educational initiatives, and

* that the process undertaken should be both collaborative and humanistic,

This involves a high degree of consultation and negotiation in the early stages. The overall strategy was to be devolution of responsibility to the HEO group who could be expected to design and develop their own training starting from a consultative model, through a co-operative design model, to a model in which support and encouragement were provided to the group to continue on a peer-directed basis.

These possibilities were seen at the beginning to the second pilot, when the AHEO group was being approached about mounting a course. The researcher's interventions after this point [and three further supportive interventions from the supervisor] were designed to these ends, particularly the peer continuation phase, the creation of which became the main criterion of success. Thus the main questions of model D were "Can HEOs be empowered to take on their own continuing and/education?",/later, "How can this be best enabled to happen, first locally, and then nationally?" The ideas of hypotheses considered true by this time were that they could and that there were ways to be found to help them. These ideas were tested in practice, during and after each training cycle.
Evidence was gathered from sources that are significant to HEO practice. It was demonstrated that considerable congruity exists between these sources when identifying training need; those seen to be of priority and importance were interpersonal, training and managing skills.

A course was established; this provision was identified as an appropriate way forward. Through the research and development a range of potential models were explored.

An action research model was eventually adopted as the most appropriate and feasible and the process of development was both collaborative and process centred.

Responsibility for the post-project training would, it was intended, devolve through the processes of the project on to the HEOs; it would thus become peer directed and sustained.
ANNEX I
FLOW CHART OF PROJECT DEVELOPMENT

Objective 1
To identify models for the inservice training of health education officers.

- Project submitted to Health Education Council for approval and funding: this granted.
- Protocol developed: preliminary visits made
- Steering group identified, invited.
- First meeting of the steering group.
- Interviews, observations carried out to obtain first stage data, with area medical officers; area health education officers; health education officers, relevant health and education service personnel.
- Correspondence with academic and educational institutions with a potential contribution to make.
- Survey of clinical nurse tutors
- HEQ survey on current inservice training provision: Article in 'Guild News'.
- Second article in 'Guild News'.
- Paper presented to Xth International Conference on Health Education.
- 'Kirby' Committee reports.
- Appointment of project disseminator

Objective 2
To test models on 3 pilot groups.

- Pilot I
  - Initial work
  - 'Needs' exercise
  - Course
  - Post course interviews

- Pilot II
  - Initial work
  - 'Needs' exercise
  - Course
  - Post course interviews

- Pilot III
  - Initial work
  - 'Needs' exercise
  - Course
  - Post course interviews

Objective 3
To develop a system which would enable the models to be disseminated and used by the health education officers.

- Continuation through 81-83

Legenda
- Pilot Course assessment
- = Continuation active
- --- = Continuation dormant
- \( \checkmark \) = Continuation proceeding through 81-83

JR 12/83
UNIVERSITY OF SURREY, Department of Adult Education.

Health Education Council Research Project: Continuing Education of H.E.Os.

ENQUIRY into In-service Training for Health Education Officers.


Please complete a separate sheet in respect of each item of training.

Please tick in appropriate boxes.

<table>
<thead>
<tr>
<th>Description of the training (1) activity.</th>
<th>(2) Is there a programme? Yes No D/Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of training . . . .</td>
<td>If 'Yes' could you attach it please?</td>
</tr>
<tr>
<td>Which organisation provided (4) the training?</td>
<td>Were there stated training objectives? Yes No D/Know</td>
</tr>
<tr>
<td>Was the training for:--- (6)</td>
<td>If 'Yes' could you summarise them (3) please? (or attach a copy)</td>
</tr>
<tr>
<td>H.E.Os</td>
<td>Multidisciplinary only</td>
</tr>
<tr>
<td>What category &amp; numbers of staff were involved?</td>
<td>How many whole-day equivalents were used?</td>
</tr>
<tr>
<td>AHEO</td>
<td>Less than 1.</td>
</tr>
<tr>
<td>SHEO</td>
<td>up to 2 days</td>
</tr>
<tr>
<td>Dist.H.E.O</td>
<td>up to 3 days</td>
</tr>
<tr>
<td>H.E.O</td>
<td>up to 4 days</td>
</tr>
<tr>
<td>Trainee</td>
<td>up to 5 days</td>
</tr>
<tr>
<td>H.E.O</td>
<td>more than 5 days</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>(7)</td>
<td>(8)</td>
</tr>
</tbody>
</table>

U of S/JR/1 Date ..........................
CHAPTER 5 THE RESEARCH MODEL IN ACTION

5.1 Introduction

5.2 Developing the training activity

5.3 Gathering evidence

5.4 Protocol for a needs determination exercise

5.5 The needs determination exercise in action

5.6 Models of teaching and learning

5.7 Choice of educational establishment

5.8 The content and development of pilot courses
   5.8.1 Pilot course one
   5.8.2 Pilot course two
   5.8.3 Pilot course three

5.9 Data summary

5.10 The role of the evaluator

In this chapter the way in which the training activities are developed is described together with detailed exploration of some aspects of each pilot course. The data gathering process is described and the results and consequences are reviewed as is the influence of the evaluator.
CHAPTER 5  THE RESEARCH MODEL IN ACTION

5.1 Introduction

The characteristics of this model are that it is collaborative and consultative; that is, the various people interested in and related to the process were involved as much as possible in the exploration and decision making. It is developmental; that is, the method and content of later courses used earlier experiences to effect improvements. It is experiential in that the group participated in the design and in the learning experience rather than being detached observers of it; and it is incremental in that participants could, and in two instances did, take over the course at the completion of their involvement in the project and continue it on a peer directed basis.

5.2 Developing the training activity

Two elements are present in the development of training activities which Cowley (1980) calls strategy and form. Strategy embraces the means and methods whereby courses are planned and put together and form is about what actually takes place. Cowley's work recommends modular learning units which can be put together in a way that is helpful to the participant; the ones described here have this facility as one eventual outcome of the activity.

The form of the project was to do with three separate six day courses based in three separate and differing NHS Regions; it was organised from mid-'78 to the end of '79.

Three courses were organised to give the project sufficient evidence from which to draw conclusions and to make informed comments that should be useful to the field. Six whole days, with usually either one or two weeks separating each day, was acceptable to the participants in respect of their work load and the time allowed for INSET by their employers. The three NHS Regions were chosen to provide a number of different contrasting
factors such as North, Midland, South; rural, urban; and good versus poor HEO recruitment.

The strategy of the project, the means and methods by which the courses were planned and put together, has been explored in chapter 4. Within the Region proposed for the first Pilot course attempts to gather enough HEOs for a viable course were unsuccessful; managers appeared reluctant to release staff members and it was necessary to approach a second adjoining Region to recruit a viable course. A similar response to a later innovatory training activity in this Region, but separate from this project, was experienced (Satow 1980). The second Pilot course was enthusiastically supported; the third less so, though there was always a viable number of participants.

Further examination of the nature of the response to training activities need to be carried out to determine how much an innovative approach deters either the HEOs or their managers or, how much there are inherent difficulties in releasing a number of staff at the same time. In my experience, there is little consistency in this aspect of Regional approaches to training; in at least two Regions virtually all the staff can attend INSET at the same time, while in others only a proportion can be released. In a discipline having a small (less than 500) work-force overall, recruiting viable courses at Regional level can be difficult.

5.3 Gathering evidence

The evidence gathered on training need, both during the preliminary investigation (Chapter 4) and with the second and third pilot courses showed a satisfying congruity. While investigations prior to the courses neither could nor did rank its evidence by 'strength', the two needs identification exercises did; this exercise is described at 5.4 and 5.5 of this chapter. This 'strength' was shown by rating the needs
on a 1-5 scale; for the purpose of this exercise only those respondents who rated items at the high end of the scale were counted. Figure 14 shows the ratings assigned by the participants of Pilot course II and III respectively during the needs identification exercise.

<table>
<thead>
<tr>
<th>Management - executive</th>
<th>Pilot II (N = 17)</th>
<th>Rating</th>
<th>Pilot III (N = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13</td>
<td>16</td>
<td>Management skills</td>
</tr>
<tr>
<td>Role - definition</td>
<td>12</td>
<td>11</td>
<td>Inter-personal skills</td>
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<tr>
<td>- conflict</td>
<td>11</td>
<td>8</td>
<td>Role awareness</td>
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<td>- barriers</td>
<td>12</td>
<td>10</td>
<td>Credibility</td>
</tr>
<tr>
<td>Development of professionalism</td>
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<td>11</td>
<td>Professional development</td>
</tr>
<tr>
<td>Group work skills</td>
<td>11</td>
<td>11</td>
<td>Group dynamics</td>
</tr>
<tr>
<td>Communication skills</td>
<td>13</td>
<td>13</td>
<td>Communication skills</td>
</tr>
<tr>
<td>Committee work</td>
<td>10</td>
<td>4</td>
<td>Committee procedure</td>
</tr>
<tr>
<td>Liaison with other bodies</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practical planning</td>
<td>10</td>
<td>14</td>
<td>Project design</td>
</tr>
<tr>
<td>Questionnaire design</td>
<td>8</td>
<td>13</td>
<td>Research and evaluation</td>
</tr>
<tr>
<td>Democracy at work</td>
<td>9</td>
<td>4</td>
<td>Industrial relations</td>
</tr>
</tbody>
</table>

Each group expressed their needs in their own words. Despite slightly differing phraseology, checking revealed that both groups had similar intentions and I have 'matched' the lists to show contiguity and
similarity. The items shown are rated highly and are those which attracted the majority attention. Each group identified between 18 and 20 items at this level. In as much as it was not possible in the time available to cover all of them, those in the upper two thirds were selected.

5.4 Protocol for a 'needs determination' exercise

For a training programme to be constructed the 'needs' of the potential or prospective participants should be identified. A 'problem' or problems are shown which imply desired solutions and solutions are effected through activity which requires that alternatives are generated, choices among them are made and decisions implemented based on those choices (Stufflebeam 1977). The criterion for this rests on the standards that are applied to the choices available and on the variables that occur in both the real and ideal world and these are yardsticks for values. Stufflebeam suggests further that the ideal form of the variable is the value which in turn provides 'a means for measuring the variable to see whether it matches the ideal form'.

However, selecting from alternatives is influenced by more than one value: knowledge, values of the institution, values external to the institution, sub-system maintenance values and private values all impinge on the establishment of criteria (ibid).

Within the health education officer system this concept can be illustrated thus.
Knowledge held by the health education officers, their trainers and managers concerning their training needs is available and can be identified; this understanding may be affected however by the limited view of the usefulness of continuing education for field staff (values of the institution), by the restricted educational and financial resources available (values external to the institution) by scepticism among health education officers concerning training (sub-system maintenance value) or by the needs of the research worker/evaluator to turn out a good continuing education model (private values). (NB. in this context the institution is represented as being that of the health education officer network and the health education officer is seen not only as an integral part of that system but also, because the work is both experiential and collaborative, as part of the sub-system in which they are co-workers with the research workers).

By whatever strategy 'needs' are identified (and the methods used are explored both later in this section and elsewhere) at some stage
the reality of the options must be weighed against the various constraints peculiar to the particular exercise, and choices made.

Stufflebeam suggests that one possible model (Figure 15) is to do with the balance between the 'should be' state of affairs and the 'real' state of affairs.

<table>
<thead>
<tr>
<th>'should be'</th>
<th>'real'</th>
</tr>
</thead>
<tbody>
<tr>
<td>state of affairs</td>
<td>state of affairs</td>
</tr>
<tr>
<td>model</td>
<td>performance</td>
</tr>
</tbody>
</table>

\[ \uparrow \text{steady state} \uparrow \]

Figure 15 Comparison of intents and achievements (after Stufflebeam 1977).

Where there is balance between the two sides then performance is congruent and no need exists to change the programme.

In the case of the health education officer group, if their model role and function are congruent with their performance then no training is needed. However, if the fulcrum shifts so that a discrepancy appears and performance no longer reflects the model then change by intervention such as training is indicated.

This theoretical model was applied to the HEO matrix to determine the degree of congruence between model and performance; the information elicited from the various 'value' groups (see Chapter 4) as postulated by Stufflebeam demonstrated discrepancy. The 'value' groups evidence contributes to the check applied by triangulation (as set out in Chapter 6). Because the mode of training was identified as both experiential and collaborative especial emphasis was placed on the criteria for training identified by the HEO group. Informal consultation and work carried out
by NE Thames Region HEO group and by a trainee HEO (Fleming 1978) showed congruence in some identified needs.

The knowledge of the groups accumulated by me during several years of professional contact identified further apparent areas of need. Hall (1974) in developing the Johari awareness model provides a useful illustration of the 'known' and unknown; he identified four quadrants in the 'window' (figure I6).

\[
\begin{array}{c|c|c}
\text{GROUP} & \text{Things they know} & \text{Things they don't know} \\
\hline
\text{SELF solicits feedback} & \begin{array}{c}
\text{Things I know} \\
\text{Arena} \\
\text{Hidden area}
\end{array} & \begin{array}{c}
\text{Things I don't know} \\
\text{Blind spot} \\
\text{Unknown}
\end{array}
\end{array}
\]

Figure I6 The 'Johari' window

The arena is known and accepted; in both the 'blind spot' and the 'hidden area' are matters which a variety of techniques, strategies and exercises can bring to the arena where they can be accepted and used. The 'unknown' may also have its boundaries diminished though it is likely that by its nature this will be a slow, maybe imperceptible process.
At Figure 17 the effect of using techniques to bring hidden matters into the 'arena' is represented; as the arena increases, other matters may become available from the unconscious.

Figure 17 The 'Johari' Window II

The needs determination exercise was designed by me in collaboration with the research director to enable participants to push back the barriers and raise their awareness of the factors within their role and function which obscured or deterred successful functioning. They were encouraged to explore successes and failures, to recollect achievements and problems, to identify concerns and educational needs and with their colleagues, through a series of exercises, list and rank-order these matters so that priorities of need could be identified. The needs were then translated into educational tasks with, where appropriate, the collaboration of the group. The way in which this was achieved is set out in 5.5 and is
examined at 6.5.

Two examples drawn from one of the pilot groups may illustrate these points.

First, it was revealed, when undertaking task V (5.5) that problems believed to be personally specific were, in reality, shared by others with all the concomitant frustrations and irritations; for many, being made aware that they were not unique in this respect, was a liberating experience.

Second, to succeed as a group in identifying an issue for exploration, to be able then to set up the event which allowed the issue to be explored, and further, to run an assessment on the event which demonstrated that the objectives had been achieved, did much for autonomy and cohesiveness within the group as well as for personal autonomy.

The intention was to help participants lift matters from the 'hidden area' into the 'arena' so that they were recognised and perceived as being relevant to training activities. At the same time the research officer grew in awareness of matters in the blind spot; for all participants there was perhaps a shifting of boundaries in the 'blind spot'. An illustration of this phenomenon is the way in which, prior to the needs determination exercise with one pilot group, some participants expressed scepticism concerning a training element called interpersonal skills. The exercise demonstrated the need and the matter was then accepted by the majority. In another group, while the same element was identified and accepted, by the time the relevant training module was dealt with the membership of the group had changed considerably; the acceptance by the original group meant little to the existing group and this appeared to be one factor which militated against positive participation; 'I don't see why we need to do this'.

- 59 -
The exercise as it was carried out on two occasions is now explained. A critical examination of the process, which incorporates constructive comment, (some of which has been implemented in a programme subsequent to this experiment) is explored in Chapter 6 (6.4 and 6.5).

5.5 The needs determination exercise in action

The exercise was facilitated by the research officer who has field experience in health education and who normally works collaboratively with health education officers. The objectives were two-fold; within the process of the exercise were matters to do with increasing interpersonal trust, providing support in disclosing and discussing matters that could be personal and sensitive, aiding the lowering of personal and professional barriers to facilitate communication, and encouraging critical examination of professional activities in a supportive climate. Within the content of the exercise were matters to do with enabling the group to accept the matters raised that concern them, to rank order them as to priority and urgency and to move from matters of concern to training inputs which will attempt to meet the needs so expressed.

The method employed in each instance was

(a) A preliminary introduction in which the previously distributed time table for the day was discussed and any ambiguities or misconceptions raised and dealt with.

(b) The mode of work for the day was explored and the need for openness, gentleness, support, trust, constructive challenge and sensitivity discussed.
The tasks are described using the second person.

(c) Task I: choose a person who is relatively unknown to you, of a different grade, and share personal information for 5 minutes each.

(d) Task II: work with the same person and review work experiences over the past few months that are satisfying, successful, well done, giving you a sense of achievement: take 5 minutes each, listen silently apart from making encouraging remarks.

(e) Task III: pairs join into quartets (not usual colleagues if this is possible) and spend 2 minutes each in sharing personal achievements.

(f) Task IV: continue in the same quartet and discuss how it felt to share successes.

(g) Task V: choose a partner of similar grade, experience, responsibility and sit facing each other: in turn for 5 minutes each share supportively but listening with care recent problems, major concerns, pressing difficulties (colleagues, managers, tasks allocated, self, clients etc.). While you are doing this observe two things about yourself - what are you holding back? (it may be a matter someone else will bring out and share) and how honest are you being?
(h) Task VI: when you have both finished take time (about 5 minutes) to write your own personal, private check list:
- all that you talked about
- anything you held back
- anything you have subsequently thought of.

(i) Task VII: go into groups of the same grade keeping your partner if possible; appoint a scribe and brainstorm for 10 minutes approximately on the first list of questions suggested. Draw from what you have already discussed but try not to spend time on lots of detail at this stage.

When this task is complete move onto the second list of questions.

(j) Task VIII: consult your private lists and see if you now wish to identify matters which before you were not able to disclose; also check to make sure that all the matters you and your partner identified appear. Complete the chart, mark up with appropriate title (AHEOs, HEOs etc) and post up for the other groups to read.

(k) Task IX: on fresh sheets of paper, bearing in mind the questions that provoke the answers now posted up, identify your impression of the kinds of educational need they demonstrate in the varying seniority groups. This should be carried out bearing in mind job requirements, role expectations, managerial and other responsibilities and so on. These sheets are now posted up.

(l) Task X: the whole group together with the Facilitator now groups the various statements into acceptable 'poly' statements which attempt to express adequately the intentions of the contributors: these are written up, numbered and posted up for the group to accept.
(m) Task XI: form into groups of 5 or so across the grades and mixing Areas: using the form provided rate each item on a 5 point scale of strength of need.

(n) Task XII: in the same group now disclose in turn the rating given to each item; be prepared to question and be questioned about decisions but be gentle, supportive and constructive. Be open to altering your rating if the reasoning of colleagues is acceptable. Try to make any comment supportively 'I don't understand what you are saying'; and relate comments to yourself rather than projecting them onto others; use 'I' instead of 'you' or 'one'.

(o) Task XIII: re-group into one Area groups so that you are now with close colleagues; again share the ratings and be open and supportive: this is an exercise to discover needs and raise awareness not to find fault and lay blame. Be supportive of a colleague who feels they can't, at this time, talk about any matter.

(p) Task XIV: in the same group gather together, for each item the total number of high ratings; be prepared for some items to have no high ratings and some a lot.

(q) Task XV: put up a master chart for all items and collect all the high responses.

(r) I now have a master list on which probably some 10-12 items will have high scores and the rest lower ones. The whole group are now asked to discover, first informally among themselves and then in an open plenary session what they feel is meant by the various high rated items, what can be undertaken using existing educational resources and what is in need of development for a tailor-made course.
(s) I conclude with a review of the decisions made, make appropriate comments about the process experienced during the day, identify (if appropriate) those parts of it which can be used by the health education officers in their work, provide relevant references, and identify, if possible, a steering group who will help with the course planning.

5.6 Models of teaching and learning

Two models of teaching/learning were possible for each course:

a) The developmental model. Each training day had several recurring and linked themes. Participants experimented in real life with new strategies and skills, reported on their experiences, received comment and support from the group and thus refined their ideas and approaches. One of the trial courses used this model.

b) The thematic model. Each training day was complete in itself with one or more themes being examined once only. While opportunity for experiment and reflection was thus considerably diminished, it could and still did take place. In two of the trial courses this model predominated.

For each of the three courses a programme was developed using the evidence as the information base.

Correct interpretation of the needs expressed by the group to the trainers is essential and, as became apparent, hazardous. The exact interaction between participants and trainers, the length of time between the exercise and the commencement of the course, the knowledge of health education and the health service held by the trainers, the amount the research worker was able or allowed to be involved, the active links between trainers and HEOs contributed variously to the course development. The lack of common understanding between HEOs about their role and function and the
difficulty they have in accepting a common spokesperson was also a potent affector. The effect of these many factors was apparent in the design of the courses and the strength of satisfaction that participants felt with them.

In one instance, where the course occurred less than three months after the exercise, where representative HEOs liaised with the trainers, where the trainers knew the health service well (though health education less well) and where there was apparently an identifiable regional identity, the course was deemed a success by participants. In another instance where the gap between exercise and course was six months, where there was minimal contact between HEOs and trainers, where the trainers only appeared to know health education and the service, and where regional identity was less clearly defined, the course was less successful. Though these matters will be dealt with more fully when writing about both the consequences and recommendations they are brought in here to indicate the many factors that affect the degree of success when a course is mounted.

5.7 Choice of educational establishment

The educational establishments were chosen, in two courses out of three, with the help of some of the HEOs. They were chosen from a basis of local knowledge and previous involvement and were assumed to meet the criteria needed by the project on the basis of HEO information and a meeting between the project director/research worker and staff of the institution.

The nature of the effect of this choice on the courses and therefore on the outcomes will be explored in chapter 7; however, post course interviews with teaching staff show that they came to the course knowing well either education theory and practice or aspects of health service management and function; these were their disciplines and they were and are the local identified 'experts'. They understood health education, HEOs
and the organisation and management of health education only slightly and needed to adapt and modify their teaching to the needs of the group. This group of teachers gained an appreciation of the health education service, an understanding of the HEO role (however marred that was by HEO lack of agreement) and an improved ability to link the health education service to the services they most usually trained for; there was an overt appreciation of this '... we now understand much better how the service works and can appreciate the constraints placed upon it by certain factors'. This positive outcome should reflect a better understanding of training needs and provision in the future. There is a negative outcome, I believe, related to the perception the trainers have gained of HEOs. Because of the interactive nature of the training, because learning opportunities were designed which lowered barriers and which encouraged participants to reveal themselves, the trainers saw, perhaps too clearly, the uneven quality of personnel within units, the range of abilities even within those holding senior posts, the inadequacies of some participants, the very 'parish' nature of some approaches and the guarding and defensiveness evident in many situations that posed a challenge or threat.

What new problems will the solutions found here create? What, to the various actors in the action, will be the effects, the repercussions, the consequences? Will any current activities (of collaboration, of consultation) be affected? Will individuals be affected and will this be positively or negatively? It is likely that ongoing evaluation married to close involvement with the HEO group and its C.E. activities will show us in part, if not in whole, what the effect of the intervention has been. In the discussion an attempt will be made to answer these questions.
5.8 The content and development of the pilot course

5.8.1 Pilot Course One

In this, the first pilot course, the strategy for developing the course content was in the first instance without the support of the course members. The training needs of HEOs as identified by managers, by AHEOs and by significant others (as described in Chapter 4) was the knowledge base from which the organizer worked. As soon as course membership was defined the content was checked with the members and each new element was checked against their perceived needs. A constraining factor, explicated in the pilot course assessment, was the degree to which participants perceived themselves as inhibited by the presence of their colleagues. There was a fear of either appearing ignorant to those much more senior than oneself or, sadly, of being unable to contribute openly in case, despite one's seniority, one was found wanting by those who, while younger and more junior, were seen to be 'brighter'.

The central theme of this course was an examination of the role and function of the HEO; a chart was developed (figure 18) showing the many role relationships experienced by the HEO; (this has been discussed in chapter 2). The nature of these relationships was explored, and blocked, difficult or ambiguous relationships examined; problem solving and role play was used to illuminate the nature of the relationships and strategies for improving them. For instance ... 'how shall I, the HEO, cope with field work health educators (nurse, health visitor, environmental health officer) whose managers perceive my presence as initiator and facilitator of health education activity as a threat rather than a matter for creative collaboration': and '... how do I communicate my belief in and adherence to a reasoned programme of health education activities in line with agreed priorities, in the face of managers, health educators and others who are determined to cast me in the role of the provider of audio visual aids only'.
Role and function of the HEO: role relationships

Figure 18.
A useful outcome from this activity in this course was a small enquiry which confirmed the hypothesis 'that GP receptionists are ignorant as to the function of health education'. This led to an exercise in which strategies were sought to explore and overcome this block, to increase the awareness of receptionists about health education so as eventually to improve their understanding of it. The eventual outcome of the exercises enabled participants to confront the problems they perceived between themselves, the service they represented and the receptionists; it further enabled them to achieve a more constructive working relationship and a better take up of health education in this area.

A significant meeting place with those with whom one has role relationships can be in committee; much discussion and decision on policy and practice takes place in committee and HEOs, no less than anyone else, have their share of committee meetings to attend. The skills of communication necessary to achieving a rewarding experience at a committee meeting are complex and an understanding of them, with an opportunity to practise in role play, was enlightening. The role play was used to identify critical and difficult interactions within the procedure of the committee; these interactions were then explored so enabling the participants to experiment with responses, challenges, creative questions and diversions which they could use to extend their repertoire. The participants thus had opportunity to gain insight into committee procedure and tactics, experiment in the 'safety' of a simulated committee, carry their newly acquired expertise into their work place and into subsequent committees and, report back on their experiences to this group who would offer support.

The model of learning for this pilot course was thus developmental; that is each of the training days contained themes which were recurring and linked; the committee work theme shows one aspect of this method in which
participants could experiment in real life with newly acquired strategies and skills, could report back on their experiences, receive comment and support from the group, refine their ideas and approaches and seek to improve their ongoing practice by so doing.

An equally important aspect was about the accepted trainer role of the HEO and the opportunity that participating in experiential training affords in reviewing and extending their own trainer skills. To this end a variety of training activities were used - discussion, role play, problem solving, brain storming - so that they could be explored and incorporated. The course therefore was to do with content (HEO role clarification, communication skills) and with method. Content was overt and method was, initially, covert.

To enable participants to examine critically and constantly part of their whole professional role, it is helpful to use audit. In this process the group collaboratively determine all the components of their work (figure I9); this can include the responsibilities they carry, the content which they must understand and use, the relationships they have, the management structure which they work in and the constraints that the system and the profession lay upon them. Sharing together all these factors they individually or collectively decide on one area of functioning which they will examine, in detail, on the job, by means of an agreed, and possibly collaboratively constructed, 'tool'. It is usual to allocate certain days of the week or parts of the day to this scrutiny: at the end of the examination period the completed tools are analysed personally and areas of difficulty, conflict, stress, malfunctioning are shared within the group. For example, within this group the element to be audited was 'use of time' and this was carried out on an agreed number of days during a set period of time. The subsequent analyses and 'sharing' enabled participants to identify unconstructive patterns of working and together seek solutions which could subsequently be tested.
anti-smoking education
+ anti-smoking advisory clinic
giving advice
group work
face-to-face work
exhibition running
planning-in-service training
liaison with hospitals
++ selection of priorities
writing of health education materials
writing reports
attending meetings
++ use of time
facilitating obesity clinics
++ getting professional staff to undertake health education
teaching
negotiating with senior staff - management
reading reports
++ running the centre
seeing visitors
assistance with projects
+ evaluating
+ making time to talk to colleagues
+ policy making
self development
assessing the value of resources
assessing the resource provision
+ office management
liaison with voluntary groups
being a committee member
interviewing staff
budgeting
forward planning
answering the telephone

Figure 19.
The components of a health education officer's job
The framework which I used in the evaluation was based on Stake's (1967) matrix which enables data to be gathered together in an ordered fashion; the sources of the data are likely to be different (from managers, from participants in the educational process, from the source of the educational intervention) as are the ways of collecting it. The matrix enables systematic gathering and recording to take place during the educational process and takes account of three important bodies of information: antecedents, transactions and outcomes. Stake postulates that an antecedent is '... any condition prior to teaching and learning which may relate to outcomes'; they can be about the complex status of the student prior to the instruction, his status, knowledge base, previous experience, intention to co-operate and so on; they also can be to do with the setting in which the learning is offered, the intentions of the organizers and trainers and the social/economic/political climate which holds at that time. Transactions are '... the countless encounters of students with teachers, student with student, author with reader, ... the succession of engagements which comprise the process of education'; outcomes are '... the abilities, achievements, attitudes and aspirations of students resulting from an educational experience ...' (Stake 1967).

Stake further suggests that superimposed on that framework of antecedents, transactions, and outcomes is a second framework which he labels intents, observations, standards and judgements. These put together provide Stake's model for the collation of evaluation data: in setting out this model Stake is seeking to provide a framework with which to collect a wealth and detail of data which might not normally be collected and is suggesting that true evaluation cannot properly take place unless considerable detail is examined.
<table>
<thead>
<tr>
<th>Intents</th>
<th>Observations</th>
<th>Standards</th>
<th>Judgements</th>
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<tr>
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<td>Antecedents</td>
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**Description Matrix**  **Judgement Matrix**

_Evaluation Matrix: after Stake (1967)_

Figure 20
In the context of the first Pilot course the evaluator used this tool and was able to show, both to steering group and project director, some of the constraints that inhibited the development of learning within members of the group. This experience was made available to those developing the second and third Pilot course.

<table>
<thead>
<tr>
<th>INTENT</th>
<th>OBSERVATION</th>
<th>STANDARDS</th>
<th>JUDGEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The group identified 'division of time' as an area for peer group audit.</td>
<td>One group member absent at discussion about this 2/52 ago and is therefore uninformed. One very positive member absent.</td>
<td>All but one had contributed to the material used; there was an apparent high level of understanding. But, perhaps because on unfamiliar ground some students were apprehensive.</td>
<td>The preparation for audit 2/52 ago was lively and committed; they seemed to feel that this could be important.</td>
</tr>
<tr>
<td>By brainstorming and discussion, identify the criteria by which audit will take place.</td>
<td>The group worked constructively; brainstorming is lively and pertinent. Resulting list synthesised into categories and then further refined.</td>
<td>The concept and execution of audit is new to all students.</td>
<td>One student (not present at preparatory work 2/52 ago) initially unconvinced. One out of patience with the process; the remainder involved and contributing.</td>
</tr>
<tr>
<td>An instrument which can be used for audit on 'division of time'.</td>
<td>The construction of an instrument which will be used over a 2/52 period by all members.</td>
<td>The members will be expected to understand the tool they have constructed and carry out the audit as informally agreed among themselves.</td>
<td>Comment by one student 'I've had my eyes opened. I've got to go away and think'. The audit led students to be self-critical though they did not achieve objectivity. Were they ready for this or should there have been more 'warming up'?</td>
</tr>
</tbody>
</table>

An example of the use of Stake's matrix

Figure 2I.

The objectives of the session were:

1) To prepare a peer group audit on division of time.
2) To carry out a trial audit to ensure that the instrument works.
3) To agree to do the audit for two weeks.
5.8.2 The Second Pilot Course

This course was developed first with the help of Area Health Education Officers of the Region who accepted it and committed themselves and the HEOs in their units to the activities; second with the whole HEO group as participants in a needs identification exercise (5.4) in which the training needs were discussed and agreed, and thirdly, with the trainers who used the experience of the first course, the evidence from the HEO group, the experience of a representative HEO group and the knowledge of the research workers to construct the course. The approach was thematic though some elements were carried over to following sessions.

Work on role enabled participants to produce a role chart similar to that produced by the first Pilot course and shown at figure 18. This exercise, while lowering barriers and liberating concepts, also provided a reservoir of information on role which could be referred back to in subsequent discussion; this was particularly so in the element on relationships which, as on the first course, enabled participants to explore actual and potential blocked relationships.

Communication skills are developed experientially during life and professional training and subsequently, through trial and error, in personal experience in the job. A course, however, provides a powerful opportunity to work with colleagues to increase personal effectiveness through discussion and experiment in the context of peer support and mutual understanding. This enables 'difficult' relationships to be identified and analysed, tactics to be constructed and used and outcomes to be examined critically. The presence of peer and trainer support, the facility to 'try out' strategies in role play and the opportunity to take the experiences to real-life encounters in the knowledge that support and advice continue to be available, enable participants to seek and achieve improvement to these identified and
difficult relationships. Those dealt with included effectiveness in committees; opening up communications with an obstructive manager and handling staff who try to work outside the team.

This can be illustrated in one example for the work on relationships, where the trainer asked small groups to brainstorm about difficulties they had with relationships; in many instances the difficulty was to do with a blocked role relationship that had been explored in the previous session. After showing the nature of the difficulties in relationships the groups used role play to play it out 'as it is': after each role play the remaining participants explored the interactions, identified the blocks, supportively suggested alternative strategies and actions. For some participants this period of constructive discussion was sufficiently illuminating, for others the scene was replayed to enable the changed interaction to be 'tried out'. Further 'trying out' was, in some instances undertaken in real life and was the subject of discussion at a later session.

In the needs determination exercise management skills of several kinds had been identified as a priority. It's realisation in this course was within an examination of, and an exercise in, policy making. Participants explored, under the guidance of a lecturer, the constituent elements of policy making, the power and politics inherent in this activity, and the strategies and skills that might be useful. In small groups they then undertook an exercise which incorporated these elements and which enabled them to explore strategies, snags and pitfalls. In this exercise the groups were so constructed to include a mix of seniority and of place of work. This was designed to and seen to achieve a spread of knowledge, and a growth or appreciation of the value of consulting colleagues, of seeking peer support, of being open to others and able to accept each other in a consultancy role. It allowed, and gave opportunity to, even the more junior participants, and ensured, as was disclosed in post course
interviews that the notion of peer support within the regional framework was a reality. The peer learning included sharing of experience in policy making in which the more experienced could contribute to the development of those less so. A critical, constructive examination of each policy was facilitated and the strategies to argue it through the administrative framework were explored. It will be argued elsewhere that this element, which is part of management training, should more appropriately be situated in a management course where it can be dealt with in greater detail and possibly more appropriately; within this framework, whatever the instructive value of the management aspect of the exercise, the benefit to the participants was perceived to be in the way it facilitated improved relationships both within and across area teams.

This course concluded with a participant evaluation of the intentions and outcomes and with the group accepting the importance of continuing education in their professional development; they took corporate responsibility to continue this provision on a bi-monthly basis and sought, in part, to meet the needs already identified but unfulfilled and, in part, to identify new needs. Responsibility for creating the first trial period was invested in three members of the group and each of the health education units agreed to be responsible in turn for taking responsibility for one day's programme. Here a group, initially motivated by an external facilitator, adopted the continuing education model and also adopted the organizational and educational responsibility inherent in running it.
5.8.3 Pilot Course Three

The steering group and research team moved into the development of the third pilot project encouraged that the mode and method of the second course had justified the choices made and encouraged also to devolve further the development of the third course onto the participant group. The formula was similar to that of the second course; a needs determination exercise was held after the AHEOs had agreed that their units should participate and also after the trainer establishment had been nominated by them and the HEO group had found the nomination acceptable.

The programme was developed and consultation between trainer/facilitators and HEOs was organised; this never materialised and 'briefing' of that nature was in the form of job descriptions for those who would attend and information supplied by the research worker. The presentation of material was, as in the second pilot course, thematic with one or more topic being covered during a day. Role play, CCTV and small group interaction were used to explore role conflicts and role barriers and to examine the dynamics of group interaction and of the communication process.

Structured activities (in pairs and being video recorded) to explore particular aspects of human communication and interactions were used to increase participants' awareness of both the spoken communication and of body language and other non-verbal communication. Exercises such as this tended on the whole in this course to be centred on everyday life activities rather than on health education officer activity. There is a very real difficulty, identified by the participants in all the courses, for those trainers/facilitators who have only a superficial knowledge of both the health service and the health education service to make the training
activity 'real' to the participants. It should be possible to achieve transfer of skills from the general to the particular but participants did not find it as rewarding or as illuminating as they had hoped.

Similarly, exercises, not dissimilar from the other courses, to do with management and project design were perceived as less relevant. The reasons for this will be explored later. This group, after a post hoc meeting decided to continue the study days, on a regular basis and carrying the responsibility themselves.

5.8.4 Summary

Three pilot courses were developed in three dissimilar regions. An action research model was developed and within the second and third courses participants play an active and significant part in determining the content of the course. In the second course only, the participants were also active in negotiating for the style by which the course would be developed and the content allocated. Each course ran for a series of six days and the last two courses are continuing on a self supported basis. Each of the courses had a post course assessment instrument administered; evaluation and an examination of the outcomes will be explored in subsequent chapters.
5.9 Data Summary

5.9.1 This section summarises data already present in the thesis which was original at the time of the completion of the research in 1981; as far as is known data from this field has not been presented by any other author in any published, or unpublished form such as a dissertation for Diploma or MSc. in (Health) Education other than that which is cited here. The data is very varied and is of considerable potential value as illumination for HEOs, their managers and trainers. In presenting some of the data, quotes from conversations and interviews with participants are used as illustrative and representative statements of evidence. These are presented in square brackets [...].

Data already located in the text will be reviewed briefly first in two forms.

i. Training provision in existence at the start of the project in 1977 was presented in the main at 4.2.5 and with previous brief comment at 2.6. This information will not be repeated; in summary, a range of opportunities was available; their take-up and use was fragmented and no coherent identification of needs was being undertaken either by the HEOs or their managers.

ii. The training provision made available within the project Pilot Courses is presented at 5.8. In summary that comprised work in and around:

* role exploring and clarifying identifying and models overcoming blocks. (Pilot 1, 2, 3)

* role exploration of range; problem solving, relationship role play. (Pilot I)
"reservoir of information to which later activities referred. (Pilot 2)

"exploration of conflicts and barriers addressed by problem solving strategies. (Pilot 3)

* trainer derived from examples of experiential methods used during the course. (Pilot 2)

* committee exploration and experimentation in safe environment. (Pilot 1)

* interpersonal facilitating learning in respect of blocked relationships. (Pilot 1, 2, 3)

* skills of managing illuminating specifically the parameters of policy-making using practical examples from participant's workplace and experience. (Pilot 2, 3)

* peer examining aspects of role and using this to stimulate self directed improvement (Pilot 1)

Threaded throughout Pilot Courses 2 and 3, and as an emerging and recurring theme were

* peer support learning that practical and emotional support is available within the Region; appreciating how they can strengthen and support each other. (Pilot 2)

* taking responsibility for own development using the structure provided by the pilot course to continue the inservice training. (Pilot 2, 3)
The detail of each of these modules is not set out here; the purpose is primarily to concentrate on the process. Those who carried out the training, who put the content into the modules, developed them within the training criteria which were usual for them as educators, and usual also for the house-style of the institution and discipline within which they worked.

5.9.2. The data on HEO qualification and recruitment (Chap.2) was original at the time the writer gathered it. This has more recently been explored independently by Rawson and Grigg (interim reports 1984, 1985.) within data emerging from the South Bank Health Education Project; additionally the HEC Initial Training Project (Steel, 1985) has reviewed the data. Reports from both of these HEC projects are currently unpublished.

5.9.3. The protocol for the needs identification exercise is described in 5.4 and the way in which it was administered is described at 5.5. It was applied to two pilot courses comprising thirty three participants. Data was gathered from 22 respondents.

5.9.3.1. The exercise was developed as a research tool and, since it was instrumental in meeting its purpose on three occasions and was used later with appropriate modification, it is offered here as part of the data of the project. It is a specific product, enabling the action research process, and is transferable.

5.9.3.2. In each instance the exercise provided participants with a view of the training needs ranked in order of importance to them, which they had negotiated and which they agreed: sixteen reported that the exercise had identified new training needs for them. This evidence, together with facilitator initiated meetings with the trainers, was the
basis for the course construct. In each case the courses differed and they are described in more detail at 5.8.

5.9.3.3. All but one responded positively to the tasks and exercises they undertook as part of the needs identification exercise; they reported that it had been helpful to them showing methods of working and relating that they had not previously experienced.

['...a means of bringing potentially disparate people to a group together.]

5.9.3.4. The lists of needs elicited by the exercise in the two instances for this project (discussed fully in 5.3) were very similar. In a subsequent third exercise (post-project) a similarly weighted and comparable list was developed.

5.9.3.5. This outcome, while confirming that the expressed needs of HEOs from different areas or from differing units are broadly similar, also identified another difficulty to do with the interpretation of the material collected. Concepts central to HEO practice (such as definitions of health education) are not necessarily universally agreed; interpretation varied, and disagreement, despite discussion, was not resolved.

5.9.3.6. Identification of need provided a shared experience which bonded the group together and, after the first experience, made supportive links between the groups involved; this was a positive and good experience. They could look to each other for support in a way they could not when they were working in separate units, through the realisation that others had similar, even identical needs.

5.9.3.7. Interpretation of the need into activity had the potential to increase the group identity though there was also a potential for failure if participant and trainer perception of outcomes could not be reconciled.
5.9.3.8. Twelve respondents had a sufficiently positive experience (and these are indicators only) for elements of the needs identification exercise to be added to and used in their own educational work.

["...have used greatly in our own training sessions'"

["...used part and can report positively on its power as a learning tool'"]

and sometimes with their peer group.

One respondent took the whole of the structure of the exercise and translated it into an appropriate structure for the training work that was her responsibility.

["...I used the ideas that I got from the needs identification exercise on the next training course for midwives that I ran and it worked well."

Within the whole participating HBO group a small number used it widely and a larger number used small parts within their overall practice.

5.9.3.9. Many HEOs stated that the experience of this to them, new and unfamiliar structure within their own learning, was sufficiently powerful to make them understand the centrality of participation and collaboration in decision making in education and training over-all.

5.9.3.10. In each case a different course structure was negotiated.

5.9.3.11. The emerging course structure changed the understanding of the group and individuals about their own learning needs. Fifteen reported that it contributed to their skills as an HBO.
'...When we started this I didn't believe that interpersonal skills were important; this exercise has shown me that they are and that the group sees it that way too.'

5.9.3.12. An aspiration at this stage was that the trainers for the courses would be briefed through some representative form of communication and using the HEO group who had participated in the needs identification exercise. This was only partially successful; one Pilot group undemocratically selected a few senior managers [AHEOs] to meet and brief the trainers; another accepted the responsibility but never achieved the meeting.

5.9.4. Project data and what it demonstrated
Results, whether long or short term, positive or negative, can be related to the achievement of service objectives and to the effect of the continuing education approach of the project; results can be related to the achievements of individual and personal objectives which may well spill over into the service objectives. Results can be observed by those providing the training especially with an experiential and collaborative approach; they may be experienced by the evaluator in improvements which may be made available to others or be personal. In accepting a person centred view it is difficult, especially in the arena of interpersonal and communication skills, to separate the various kinds of results each from the other. Finally, it must be recognised that participants may not find all the results acceptable.

Data was gathered as follows

* during preliminary meetings with the potential groups.
* during the needs identification exercise
* by observation of the participants during each course
by questionnaire at the end of each course

* by interviewing a sample of
  a) participants
  b) their managers
  within three months of the course and at nine months.

This data is mostly about short term results for each of the three interventions; it includes student and manager identified achievements; in the longer term it will be about outcomes that can be only partially recognised currently.

As the data comes primarily from in-depth interviews and from on-course observation, a considerable amount is anecdotal; because presenting the text in this way would be lengthy, what follows is a summary of the main areas of data, illuminated with illustrative statements or observations; these have been selected to be typical or to show extreme variation.

5.9.4.1. Negative feelings expressed by participants were relatively few; they were sometimes about the presentation of the material and the facilitation of learning

['..it needs one person in charge to enable one to develop insightful trains of thought.']

and sometimes about the discrepancy between the felt needs of the individual as opposed to the needs which had been selected to meet those of the group. For instance, one participant linked her own perception of her capabilities (skilled especially in interpersonal work), with her view of the nature of the work relationships between the HEO participants during the exercise

['..there is a lot of holding back and superficiality (in the group) and I don't think the course changed anything.']

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The later interview with her manager showed a different view; this participant had benefited and he could see the evidence in her work; when pressed to identify what this was, the improvement centred around the way the HEO 'managed' her work. There is an interesting polarisation here though, as the manager [CAHEO] was and is, in the opinion of this researcher, a traditionalist and, as a result of the course, was one of the participants who gained a considerable amount of insight into the value of interpersonal skill. Another, in the first pilot course, and looking for personal promotion, represented her disappointment at not finding

'[...more indepth learning for HEOs about the new trends in health education.]

5.9.4.2. Managers often identified improvement in 'people management' as part of their gain

'[...has altered my understanding of the needs of junior colleagues and I am making myself more accessible and am more willing to advise and support.]

An informal check showed that colleagues agreed on the improvement but saw his style as paternal rather than participative.

Another (recently promoted to a senior post) reported

'[...am using the skills in my new manager role ....feel I understand my staff better.]

Improved understanding of the dynamics of colleague interactions were reported repeatedly

'[...and won't make decisions without consulting now; we used to and staff didn't always like it.']
5.9.4.3. Responses showed that participants did not restrict their understanding of the changed way of working ('consulting' for instance) to their working colleagues; the majority of responses contained data about consulting more openly with clients, using participative methods to determine agendas for training and using the techniques incorporated in the courses in their own work.

["...and XX's teaching methods made me think about the way I do it ....am now using the methods he does."]

5.9.4.4. The experience of working together in a group was generally reported as useful; individual participants were able to identify professional and personal support from the larger group which was not always available to them in their own management structure.

["...now aware of capabilities of others in the Region and can organise my requests accordingly"].

This view was repeatedly replicated and showed the range of skills and attributes held by HEOs which are potentially available for mutual help and support; this was both for potential in-service training and for main-stream work.

5.9.4.5. The work on role was almost universally appreciated and there were a range of responses that illustrated the perceived beneficial effect.

["...took the tension out of what I thought would be a tricky session"].

["...removed the hierarchical boundaries and we were all able to work together"].

It enabled participants to explore and examine the existing role models within which they worked; to question their
appropriateness and start exploring more appropriate alternatives.

The HEO works within a framework of multiple lateral and hierarchical relationships. Blocked, inhibited or ineptly handled communications between HEO and peer, colleague, manager and critic were identified, causes explored, new patterns of interaction practised (initially in role play but subsequently with the specific individual) and the blockage diminished or removed; this was because of and attributed to newly acquired insight and coping strategies.

Many HEOs experienced conflict between their self perception of their role and that held by other professionals; group work explored the nature of these conflicts, made participants aware of creative approaches designed to resolve conflict, and gave safe opportunity for exploring and improving techniques, handling conflicts and improving relationships.

5.9.4.6. The exercises revealed very little perception by the HEOs of their own needs as trainers; two only of the respondents showed any understanding of this area of need; one manager who acknowledged that too often carrying out the training role had been done without explicit consultation; and one, more junior person, who was confident about her own interpersonal skills and her ability to use them effectively.

5.9.4.7. A range of other outcomes were reported; that they were reported in the context of the interviews shows that participants believe that they are attributable to the learning they had participated in irrespective of other experience.

* ability to understand more completely the roles of senior colleagues; this linked in part to the work on role and to the professional support networks that grew out of the learning experience.
['...value of inter-area approach where each learns from others especially across hierarchies'.]

* dealing better with 'blocked' role relationships and understanding better how to avoid the blocks.

['...I've realised what else I could do (with the problem)'.]

* acquiring a greater tolerance of others difficulties and thus being more supportive of colleagues and personally experiencing more self-support.

['...more aware of loneliness of HEO and need for moral support'.]

* developing self-awareness which brings increased confidence and assertiveness (for instance in disclosing personal inability to understand communications).

* being more skilled at identifying and understanding training needs, and in translating that into training events for colleagues and others

['...confirmed my belief in the complexity of the HEO'.]

* increasing confidence in peer group interaction which leads to reduced hierarchical boundaries.

['...other participants views/ideas gave me further insight into problems'.]

* identifying relevant support networks.

5.9.5. The continuing education programme was able to cover only partially the needs identified by the groups. At the
conclusion of the project two groups went on to develop their own programme

["...HEOs don't believe they can do it (organise own training) on their own."]

["...trust each other now to organise our own work together."]

and to assume responsibility for it. This preceded the emergence of the HEC appointed officer referred to in the next section [5.9.6]. Where individuals identified personal and particular training needs

["...I know now that I need more on 'executive' management."]

they are seeking help and resources either through the NHS training network or through a range of other possibilities

["...am now registered for an M.Phil. (reported at 9 month interview)."]

5.9.6. A proposal was submitted to HEC to fund a 3 year dissemination phase of this project, with a full time person appointed to the task. The primary objective was to apply the working strategy produced, systematically, Region by Region, fine tuning it as necessary, in the light of field testing. This proposal was accepted.

Thus a new project officer took forward the design, refined, developed and modified it in response to the needs of the HEO groups; this project has presented its findings independently. Relevant details are presented in chapter 7.

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5.10 The role of the evaluator.

The final aspect of this outcome phase is to do with the effect on the evaluator. The role of the evaluator was an extended one and, in some ways, a complex one. I was employed by HEC, the sponsoring organisation, and one that is linked to field health education in many ways; the links are not always harmonious.

I have been an HEO and was known to at least some of the participants, at the time of the pilot work, in that role rather better than in the current HEC one. I was not only the evaluator but also the course organiser and the facilitator for the needs exercise. In these last two roles I could be perceived as having considerable power to develop the activity in the way I wanted, whether consciously or not. I found it difficult at times to maintain the semi-participative stance that had been agreed.

Not only did my own inclination encourage me to join in the discussion, to prompt a slow interaction, to contribute from personal experience, but also the participants tried to use me as a reference point. This could take several forms; canvassing for support of a particular view; seeking direction; putting me in the role of teacher or authority figure.

On the other hand the evaluation role allowed me insights into the HEO relationships and functioning. This is valuable for all the work that I do with this group.

In a wider context, the skills used and improved with this group are being used across the whole range of my work and can be seen reflected in the development of projects and initiatives with other health service groups.
CHAPTER 6 CONCLUSIONS

6.1 Introduction

6.2 What did the research team set out to do

6.3 How well did this action succeed

6.4 Observations

6.5 The learning opportunities.

This chapter explores the process and outcomes of this project and seeks to assess their relationship and significance. It looks at certain parts in detail and in particular focuses on participants, facilitator, trainers and institutions. As a whole the chapter seeks to illuminate the experiential work and identify key relationships.
6.1. Introduction
The problem that this project was asked to address was identified in the first instance, by the participants in the intervention, the HEOs. They asked for 'more training' (1.1) and they 'handed Health Education Council this problem and asked them to provide some solutions.

6.1.1. The first response from HEC, as an organisation, was to accede to the request and then seek to delegate the responsibility to those who were (later) identified as the research team; they were to produce a course and some solutions to the problem.

6.1.2. A research model (described in chapter 2) was created and a method of achieving in-service training sought; this determined, for the participants on the first course, the course content; this was derived from extensive pre-course consultation but it could not be defined as being more than consultative. The second and third courses were experiential and they grew out of the experience of the first course, the interests of the research team, and the interests of the steering group.

6.1.3. The original problem was handed back to the HEO group who were asked, through the outcomes of the experiential work in the second and third pilot courses to take responsibility for their own in-service development in this matter.
6.1.4. The context in which HEOs work, was perceived to be both patriarchal and hierarchical; their managers made minimum enquiries only about the proposed training and were satisfied with modest consultation and information. The experiment went ahead and little interest was shown in what followed. The HEOs stated opinion in one Region was that training would not be allowed. They colluded with this impression and called the course events 'meetings' so disguising their purpose and thus preventing identification of the activity as training. This subversive strategy was defended because of the perceived resistance of management within the NHS to all but statutorily required training. Later, with the establishment of the continuing education project, and as NHS Regional Training Officers became more involved, so the provision gained visibility and acceptance and HEOs had confidence to claim this for themselves.

6.2. What did the research team set out to do

6.2.1. Superficially the research team responded to the need as presented to the HEC. In depth, and experientially, the team sought to negotiate a change in the way in which HEOs construed and accessed continuing education for themselves.

6.2.2. They were actively committed to recruiting HEOs into a participative model and involving them fully in the process. They sought to release to them the power to take responsibility for making decisions about their own training and sought also to pass on to them the final responsibility for this from the project.

6.2.3. The research team tested a range of models and sought to find one that was both acceptable to the participants and capable of providing a usable outcome.
6.2.4. Evidence was sought to evaluate the effectiveness of the training models chosen with particular attention being paid to the process and to the quality and appropriateness of the outcome.

6.2.5. Lastly the team sought to pass on the developed model to the target group and to support them, the HEOs, as they attempted to accept responsibility for continuing its use themselves.

6.3. How well did this action succeed.

6.3.1. At the beginning those who funded the project and released the research officer assumed that a traditional model of research would be used. At the time the project was initiated this was how much HEC research was commissioned. They assumed that a training solution would be sought and found.

6.3.2. The actual project construction located finally in an action research model and this was communicated to HEC in project reports; there was no adverse comment. This is explored more fully in Chapter 7.

6.3.3. It was hypothesised that the NHS would support training of this kind because HEC was piloting it for them in its normal, accepted, innovative role. This was not proved at that time nor is it evident that it is happening more recently. The training 'culture' of the NHS is not well developed except to meet statutory qualifications. In this the UK are behind some of the EEC countries and behind N. America.

6.3.4. A course which could meet some major learning needs was provided in such a way that a transferable development
process was also produced; this represented a significant addition to the training of the group and contributed to HEOs gaining ownership of it to the extent it became a Regional course, continued by them.

The needs identified were met through the course to some significant extent with clearly identified pay-off to members. Thus a training solution was viable, although to a relatively limited extent in view of the need to address each issue. The continuation process became the criterion of success, taking into account the depth of need and the importance perceived of the continuing education model (vs the training model assumed from HEC). Only partial ownership was achieved and this was less successful than envisaged.

6.3.5. Later, when the Continuing Education project (5.9.5) officer was in post HEOs exhibited a tendency to shift away from the participative, experiential towards more traditional, organisation centred work (Keeley Robinson 1984).

6.3.6. Emerging into the training culture is a move toward experiential work; towards participation and towards manager and institution support for this. Thus, as this is occurring so the HEO training is ineluctably being drawn in as well.

6.4. Observations

6.4.1. Training was provided for three groups in three distinct and separate parts of England. It was important to attempt to demonstrate applicability in differing locations and with possibly diverse HEO groups. Evidence from this project, and supported by the Continuing Education project
shows little difference between the regional groups in the way they handle this type of training.

6.4.2. The two different models for a course were identified and used. The participants in the first Pilot course, with their course content defined for them, experienced and appreciated the variety of learning opportunities and styles made available to them. The second and third courses had very clear ownership of the training activity using the participative model.

6.4.3. Thus, meeting their 'felt' needs with experiential training provision was on the one hand a means to bridge the variety and the range of needs; and on the other hand was a considerable risk because of the demonstrated fragility of the HEO networks and relationships (5.9.3.3.; 5.9.4.1.).

6.4.4. Each group membership was drawn, as are all HEO groups, from a range of previous professional and occupational disciplines; the considerable variety in both experience and acquired skills and their location in a hierarchical system influenced the training activities. Ownership was only partial. In the first course the development was individual, and in the second and third courses it emerged both through group identity, and through interactive work. In the process a regional identity was heightened, interpersonal relationships improved, consultative styles of management adopted and improved, and peer support developed.

6.4.5. During the life of the project the choices made by the research team were demonstrated as acceptable, liberating and enabling (5.9.4.4.; 5.9.3.6.; 5.9.3.9). Evidence from the continuation phase of the project shows a regression to a more traditional approach; regional groups are now less participative in making decisions for
training, are allowing managers to initiate and decide and are choosing more didactic methods (Keeley Robinson 1984). There was frequently a tendency to concentrate on information centred work and to fail to use the equally important process and skills side. A recent example (Howe 1985) shows a consistent attempt being made to jettison all but the information section of the 'Drinking Choices' learning package for instance.

6.4.6. The models, enthusiastically accepted within the context of the experiment, have not survived intact. In part I suggest this is because the hand-over was too rapid and outside and in advance of the ability of the group to themselves change their behaviour; it was perhaps in advance also of the training culture in which they are located. To be an innovator requires confidence and security; the HEO group is not yet firmly located in a secure health education structure within the NHS: to expect them to confront the training structure of the NHS from this position was unrealistic.

6.4.7. The needs identification exercise did it's job where previous attempts by HEOs to identify their own needs had not succeeded. It produced a weighted list which was immediately reflected back to the participants for two purposes: to illuminate their knowledge of self and group and to provide, after discussion and synthesis, a framework and reference that could be used to negotiate the content of the training course.

6.4.8. The majority of the data on this initiating exercise was positive (5.9.3.9.); individuals reported good outcomes and the data shows that it was instrumental in identifying the agenda for two of the pilot courses. The evidence shows a powerful tool, liberating participants from their usual mode of working.

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It transferred to other Regions (though not always in its entirety) and showed consistency in application and outcome in those Regions. Its validity was accepted though the research team are aware of a possible personal bias towards interpersonal work (chapter 7).

The excitement of facilitating this, of seeing initially tentative and sceptical people (5.9.3.3.) reaching out to the emerging-data, identifying with it and using it to achieve change in the delivery of training provision is powerful for all who are involved. Later evaluation could question beyond this euphoria and look for the negative experiences and for the transient outcomes (chapter 7).

6.4.9. Facilitator observation the 22 responding participants, identified little unease with the process and considerable apparent commitment to the intention of the subsequent exercise. The most usual reason for failing to respond to the enquiry instruments was excessive workload, change of job (this group appear more mobile than other occupational groups with a similar status in the NHS) and inability to attend more than a very few of the pilot course training days, again given as due to workload.

6.4.10. Viewed from one perspective the satisfactory experience of the needs identification exercise and the training that followed from it, was pivotal in helping the regional HEO groups to move forward into other areas of work; for useful outcomes, this positive experience was a foundation on which learning could be successfully built; there are now established HEO training networks in all NHS regions but one; there are other supportive HEO network groups (on race, on ageing, on occupational health) which could reasonably owe something of their genesis to the outcomes of this project. Latterly this kind of growth can be identified in the developing institutional realisation that participative and collaborative ways of working are
helpful. More recent HEC projects for HEOs and for others, have made considerable use of the methods and strategies used in this project.

6.4.11. The experience of learning together in a group, with barriers reduced, with supportive networks of colleagues emerging, could and perhaps did, produce a 'Hawthorne' effect; this phenomenon is well documented. However, support remained good, networks continue to exist and to grow.

6.4.12. The strategies used within the needs identification exercise were found to be useful (5.9.3.8.) and continued in use in participants' own work.

6.4.12.1. This exercise (often carried out over two days (Heron 1974)) was contained within one day for service reasons. That it succeeded on one day shows that it tapped into participants' needs in a number of ways:

* it provided a setting that allowed needs to be expressed with confidence

* it provided opportunity to affirm and accept themselves as having the ability to determine the pattern of their training. This is counter to the usual 'expert' approach.

* it gave them strength, because of the support available, to accept new ways of learning

* it allowed them to use the experience here gained to translate it into their own interactive work.

All of this was cited frequently by respondents in describing what was good from the courses.
From this it might be concluded that the needs identification exercise was the most important part of the activity. Certainly some participants would have preferred a longer time with it to allow greater attention to be paid to their interpretation;

["..I was getting really interested and then we had to stop."]

They would have liked the exercises to be the basis for learning rather than a deductive tool. Notwithstanding, combined with the consultative work and followed by work within the courses participants were provided with a model of collaborative and participative enquiry. This has been amply described in section 5.4 and will not be repeated here.

6.4.13. The data from the courses themselves, the interviews with participants, and the observation of the effect of the courses, all suggest to the research officer that, while the needs identification exercise gained great visibility because of novelty, and provided important learning experience, the core material of each course provided a valuable and necessary component. Later use of the exercise, while acknowledging that it could better be used as originally constructed, was mediated by service needs and was shortened. Expediency is not the best leader but it is very often the most pressing one.

6.5. The learning opportunities

6.5.1. The needs identification exercise became a learning tool in its own right and had greater importance than the research team had anticipated. It succeeded in the task for which it was created and identified areas of training need in a positive way which the participants accepted as being
founded in their world and their statements about their world. It could not sensibly be short-circuited.

6.5.2. The courses on all three occasions sought to provide inputs that were relevant and the reported and subsequent evaluation shows that this was valued and seen to be appropriate.

6.5.3. The effectiveness of the courses was influenced by five factors

* the skills of available trainers

* the ability of the trainers to translate need into action

* the time required to achieve change

* the mix of experience and insight in the group

* the quality of support available to participants as they attempt to grow and change.

6.5.4. Dealing with ROLE; this emerging occupational group have a poorly defined role interface with others; there is poor appreciation of what 'health education' is about and what HEOs do. There are equally varied experiences and definitions (5.9.) among themselves. Their ability to gain from the experience of role work done with them is crucially affected by the quality of learning that is available to them. In two instances this was of high quality, demonstrating participative and experiential work openly and supportively, and creating a facilitating, experiential learning environment.
6.5.4.1. In all three courses little change was achieved in reaching agreement on the fundamental components of HEO role despite the self-awareness and growth of understanding that was reported. It was perhaps unrealistic to expect, in the time scale available to each course, a significant shift. This group and their trainers are now more aware of this need and with other skills available to them are more able to work on this.

6.5.4.2. It is critically important that learners are led and facilitated by teachers who have skills appropriate to the learning objectives; in turn this places a responsibility on both the teachers and the system that supports them, for their own learning and practice to be frequently and creatively updated and enhanced. Experiential learning is emerging chrysalis like from a more structured system. The infra-structure to support this is also emerging but not demonstrably at the same pace. The shortfall is evident in the uneven availability of experienced teachers in this area of work.

6.5.4.3. In one instance the work was more about learning skills for situations and gave little emphasis to the true interpersonal and facilitating skills. Later HEC projects (Working With Groups; Drinking Choices) have expanded this area; the wide dissemination of both of these has enabled many HEOs, and others, to enhance their skills.

6.5.5. **Interpersonal skills work** is integral to health workers' practice; it is often poorly represented in their training. It was experienced as liberating and empowering by many of the participants. It grew from within the needs identification exercise when the first experience of working together in groups began the enhancement of (as perceived by the RO) a hitherto weak group identity; later course work reinforced this;
6.5.6. Peer support is essential for those working in a minority discipline and in a service that focuses more on curative work. HEOs are seeking to influence this focus and in a sometimes hostile setting peer support is important.

6.5.6.1. The strength of the project was its ability to raise awareness sufficiently for participants to be able to recognise the need and find additional sources of help. The courses demonstrated the strategies and liberated some of the participants sufficiently for them to continue their use. This emerges in responses which show continuing use of the networks created in the context of Regional work both during the pilots and afterwards. The Continuing Education project and other HEC projects have now a range of supporting networks throughout the NHS regions (regional trainers group; HEO groups on racism, ageing, occupational health and so on.) which also attempt to provide some support.

6.5.7. Managing skills were and are clear deficit areas for the majority of HEOs. In the experience of the research officer every piece of work on training has identified this. Within these courses a safe environment was created so that some specific areas (committee work; policy making) could be explored; these were however more as examples than as definitive studies. It was realised that within the constraints of time and expertise, little more could be attempted. However, out of the work of this project grew an HEC 'managing' course which is now the responsibility, with an HEO steering group, of the National Health Service Training Authority. Again the project acted as an instigator.
6.5.8. The need for **Skills for training** were not openly identified though the research team recognised this from the evidence of the needs identification exercise. In their own observation of the HEOs it was seen as a 'blind spot' and opportunity was made when possible to work with participants in this area. Most usually work of this sort was implicit, ie, through the process introduced, rather than explicit, as content explored systematically.

6.5.8.1. Much HEO work is in providing health education training for others; course material (on communication; on role; on managing) as well as the needs identification exercise all had potential to improve trainer skills. Later HEC projects have developed a range of skills learning material which are now widely available to HEOs, and used by them.

6.5.9. **Peer Review Audit** was a strategy used in only one course; it was powerful for that group and generated extensive examination of individual role and function. It was not repeated because the specific training skill was not then widely available.

6.5.10. Taking responsibility for **organising their own learning** was an integral part of course two and three. It was perceived by the research team to have a number of learning components

*to encourage them to conduct negotiation with the educational institution*

*to provide the HEO group with primary control of how learning was handled (the research team saw themselves as having a secondary role in this)*

*to enable identified trainers from the institution to become familiar with the HEO field.*
6.5.10.1. The research officer observed much tentative behaviour among participants, coupled with undisclosed anxiety about carrying out those parts of the project that had been negotiated as their responsibility. As a project officer having a non-directive and facilitative role a range of interventions could have been initiated.

*to make clear the research team view on lack of progress and seek to improve the situation

*to act autocratically and take over the tasks that had been agreed as their portion of responsibility.

*to retrace the steps of the project until the difficulty was resolved.

6.5.10.2. The research team had negotiated with the HEO group for them to take responsibility for themselves. No attempt was made to change this though the communication between course members and institution in course three failed to materialise. There were very pragmatic reasons for not getting involved.

*the timetable of supervisor and R.O. were heavily loaded

*the HEO group were not flying any distress signals

6.5.10.3. The links negotiated for each part of the project require careful and thorough preparation and development. The difficulties encountered by an emerging discipline are compounded when the style and method of proposed training and courses does not clearly and easily fit in with the majority of work done by either the institution or the trainers. This was a weak part of the project with clear evidence that the research team had failed to appreciate the limited expertise of the HEO group
when undertaking negotiations for educational and experiential work.

6.5.10.4. Currently two options for organising training are available

*national provision made available locally and conforming to tightly drawn criteria

*local provision only after local trainers have been identified who can meet the agreed criteria for this type of training

The first option was not viable for this project; it is however used widely (by the FPA for instance) and, until local resources become available and are reliable, may be the best option.

The research team learnt, in attempting to use the second option, that either extensive in-service training would need to be provided or the type of provision for participants would have to be mediated by the skills that were available.

6.5.10.5. Although this project was not flexible enough to allow us to change the form of training the experience gained has provided essential information on which to base existing and future work. This will be explored more fully in Chapter 7.

6.6. Each of the subject areas (role, IPS, peer support, managing) were congruent with needs identified and expressed by the participants. Within the limitations of the teachers and institutions they were appropriately presented and learning was facilitated. Because a range of needs were selected each element could be a 'taster' only.
6.7. The participants were on the whole, happy with this and a proportion were led towards other training and towards personal practice change which is itself identified as coming from the stimulus of this work.

6.8. However imperfectly, the completion of the project achieved in some part, the objectives of HEC, the expressed needs of the HEOs and a growth in knowledge and skills in the research officer. This last, in project terms was serendipitous; it is however the ROs' belief that the learning that stemmed from this project has illuminated much of the professional development work that has followed.
CHAPTER 7 DISCUSSION

7.1 Introduction

7.2 Review of Research

7.2.1 Evaluation Research

7.2.2 Action Research

7.2.3 Grounded Theory

7.3 Current Training Provision

7.4 Longer term Effects.

The final chapter seeks to place the data in a broader context; the activity that informed the research is linked with more recent developments.
CHAPTER 7

DISCUSSION

7.1. Introduction
This project took place within a discrete period of time and with a clearly identified group of occupational health workers, emerging and aspiring towards professionalism, but lacking clearly defined role, status and power. Although the project work was contained within the negotiated and agreed time allocation, the subsequent data gathering and the eventual completion of the written thesis over a longer timespan, has enabled the research worker to take a more panoramic view of the impact of the project on both the worker group (as opposed to the participants alone) and on the service in which they work.

7.1.1. The discussion will cover:

*the ability of the research models and methods to reflect coherently the activities undertaken and provide qualitative data

*the effect of the intervention on the participants.

*the effect of the intervention on significant others

*the effect of lack of health education status on participants and the wider group of health education officers
7.2. Review of Research

7.2.1. As Evaluation Research
The Stufflebeam model worked well to produce the first curriculum. Each stage of the model was applied in turn; each stage itself contained several mini research cycles; these were analysis, data gathering, reflection and reality testing. The model originators suggest that these stages merge eventually but that they are initially distinct. The recycling stage of this model was applied to another group of HEQs elsewhere in the country; thus it was never fully separate from the subsequent planning stage of the next cycle and it was never a matter of refining an existing curriculum. The needs identification exercise was necessarily repeated from the beginning. The 'technology' for this was developed for the second curriculum and applied in the third course (and subsequently under the influence of the researcher was used by others (6.4.8)). The sets of needs identified in each case were shown to be highly congruent with each other (5.3).

7.2.1.1. That the needs identification exercise introduced bias towards the interpersonal dimension of learning needs was proposed by a steering committee member. This bias, demonstrating restoration from a position where most courses are biased against interpersonal work and towards the technical, was consistent with the value position of the original curriculum provided. Evidence is recorded to show that technical work was also identified (3.5). Each course, in its own way, responded to this dimension with modest experiential training. A blind area of need was shown to be in the domain of training competencies and is, of its nature, serious.

7.2.1.2. The role of the evaluator was guided by Stufflebeam (1977), Parlett and Hamilton (1972), and particularly by Stake (1967). The 'anti-sepsis' that is part of Stufflebeam's model was replaced by interaction. There was close involvement with implementation and responsiveness to the
existing participant scenario. This illuminated specific emerging issues (becoming more aware of the importance of personal role model for instance) and allowed opportunities to be used. Within this, while attempting to distance the facilitator perspective there was also opportunity, (on the whole welcomed by the participants), to use knowledge and skills supportively. This role was extended in the second and third stage major cycle as the action and research models became feasible.

7.2.1.3. The model was not centralised though this style is used widely in many national schemes and by HEC; the participating groups were regionally based and the training provision inevitably ensured that each course was unique. The identification of need (to be translated into course content), and the course structure were however very broadly similar and enough alike to make valid comparisons. The delivery of the course material, the discussion it engendered, the practice that it changed, were specific to the centre in which the learning was acquired though also having many similarities. This model allowed full use to be made of local resources, it attempted to place the responsibility in the hands of the participants and it sought to increase their self-realisation and empowerment.

7.2.1.4. A tension between the range of course provision likely in response to externally agreed guidelines and the expectations of the recipients or their sponsoring organisations, exists. Energy is best directed towards enhancing the resources and skills base of these teachers thus enriching learning overall while acknowledging that in working with emerging disciplines, it is likely that there will always be some discrepancy.

7.2.1.5. Rowan (1981), in exploring research styles diagramatically shows the range of relationships that can exist between researcher and researched. In his models a full circle represents the stages through which the researcher
proceeds. Contact with the researched is represented by a line

![Diagram](https://example.com/diagram.png)

**Basic Research: a model after Rowan (1981)**

In this pure and basic research there is a meeting at only one point; there is one encounter and here it is role to role rather than person to person. There is alienation and the dotted line is used to indicates this.

7.2.2 As Action Research

7.2.2.1. In researching the question "is there a procedure which can be replicated to produce an appropriate curriculum under other conditions elsewhere and at a later date?" the opportunity was created and grasped to have a much more participative first stage (planning) process.

7.2.2.2. This process was marked by issues related to institutional politics, solved in each case in a different way. The degree of participation was extended and limits, to the degree acceptable to each group, were found. These limits were that the group delegated the course to an existing educational body and in particular they delegated their practical decision, other than needs and goals to those bodies. Thus the researcher acted as a broker, innovator, go-between and facilitator during the critical first stages; these stages had not hitherto been carried by the groups beyond the occasional study days in safe topics. The

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facilitation not only led to a first course in each case but also the work was empowered to the degree that two Regions out of the three were able, more or less competently, to continue to provide training sessions for themselves in a peer directed and self structured way.

7.2.2.3. When the continuation phase started it was assumed that there would be a greater momentum. This did not occur and was believed in part to be because of the restrictions imposed by the 1982 restructuring of the NHS.

7.2.2.4. In the second and subsequent courses there was member participation in the development of the process and delegation of the design to outside institutions.

Because there were differing degrees of contact by the participants and because these were as well at different times, a more accurate diagram, based on Rowan's model might be.

The first course

Subsequent courses showing alienation
Alienation (dotted line) occurred when participants were so distanced from, or had been absent from, initial work that they failed to make the relevant connections (5.8.3.).

7.2.3. As Grounded Theory

7.2.3.1. A modest claim is made in this thesis that it has contributed to understanding about how continuing education can be set up for HEOs. It has provided answers to the question "can the procedures developed in this research become part of a wider developmental process under the direction of its members?". Putting this differently, "can the research project, within it's limited resources, assist the professional sub-group to become more fully reflective practitioners?" [Schon 1983]

7.2.3.2. The research intervention confirmed that such stimulus was necessary, that a supportive intervention from the centre could help groups synergise and could overcome their fears of continuing education among peers. The blind spot of the research, the need of the HEO group acting in the trainer role to develop appropriate forms of continuing education for others, became implicitly an area of development. After the research of this thesis was formally completed this became more visible and explicit as the same style of intervention was repeated throughout the country suitably adapted and developed. The group is now in a more established position in the education and training network of the NHS. Help was needed for the maturation process, and was provided. As a result they took more control over the delegation of training provision.
Two initiatives illuminate this

* The development and establishment of the Initial Training Project [1985] which requires managers to take active training responsibility for trainees.
The formation of multi-regional support groups to the Certificate in Health Education; the HEOs act as a resource to the courses for specialist contribution and support.
- as facilitators within the group
- as link persons with the employers
- as trainers to enhance manager understanding.

7.3. Current Training Provision

7.3.1. In all but three NHS regions regional training groups [RTG] have been set up for HEOs as an outcome of the continuing education project (Keeley-Robinson 1984) and as a result more coherent and clearer pattern of regional training is emerging (2.6; 4.2.5; 5.9.); they have both formal and informal terms of reference. In four of these an education officer from the Regional Health Authority is now a member of the group.

7.3.2. The RTGs are responsible for identifying and enabling training in their region; their presence indicates an acceptance of the responsibility and a commitment to ensure adequate function. The RTGs are becoming more independent, are maintaining their impetus, have an accepted authority with their peers and are implementing local regional training plans.

7.3.3. This activity is set against an increasing pressure from their employers to give priority to service commitments, and to be seen to be working in the area in which they are employed [and not off somewhere else working on "training"]; the increase in workload consequent upon changing DHSS/DHA priorities give managers little incentive to release trained staff either to plan peer training or to participate in such training.
7.3.4. The picture is not wholly negative. In three Regions the HEO group has negotiated both time and financial support from Region; this indicates that DHA managers must recognise and accept the validity of the training provision. There is a welcome move by HEOs to cease calling all training events 'meetings' and thus deflect anticipated critical comment.

7.3.5. The needs identification exercise, a key element of the pilot training courses, continued to be used after the project finished. Evidence from the continuing education project shows other less rigorous methods being used as this pilot project distanced itself from their memory and experience. This change was usually at the request of the group as it planned the training and a range of reasons were advanced:

- too time consuming
- identifying other methods to take its place
- believing that the evidence had already been gathered and was available and thus it was not necessary to repeat the exercise.

This is interesting; the needs identification exercise certainly demonstrated to the project very clearly what and in which rank-order were the training needs of this occupational group.

7.3.6. But this exercise had at least two functions in the pilot courses; overtly it identified training needs; but it is claimed that far more importantly it acted as a catalyst for the group; it illuminated their inter-relationships, it demonstrated the commonality of their problems and it provided a satisfying comfort that problems and perplexities were shared and not one person's burden. This experiential learning was an important part of the total process, and was, as the evidence post course shows, recognised as such.
7.3.7. Whether it succeeded in achieving self determination (Friere 1976) is doubtful. There was at least partial decay from the original intentions and aspirations.

Why then did it lapse?

7.3.7. I would suggest two possible reasons; these have emerged from the thinking that has been done around the project and from post-project work.

7.3.7.1. The exercise was presented and used as a preliminary activity and as a prelude to the real work of the course. Thus, while it was important within the pilot work, and when the project sanctioned spending time on it, it became less imperative and more difficult once it moved beyond this stage.

7.3.7.2. The project did not attempt to develop the exercise in a way that would have perhaps authenticated it. This might have been possible if time and space had been available to offer one experimental course with the exercise spread over two days (thus giving ample time for the outcomes to be explored and internalised). The course that followed would derive from this work but would be more clearly linked by the participants with their contribution.

7.3.7.3. This pattern was used later, and in another sphere of HEC's work, in other courses (Drinking Choices for instance). However that process had immediate access to nationally available and suitably qualified trainers. It did not rely, as this project did, on recruiting from local and available resources (with the inevitable and consequent problems), whoever was available. It may be that, until appropriately trained facilitators are universally available, the most efficient way will be to provide such training nationally. More recent, and other innovations in health education have followed this latter pattern.
7.3.7.4. The responsibility for initiating courses using the evidence was handed over to the HEO group (6.4.6.) and was less successful than had been anticipated. The participative and experiential model in use was new to this group; the project had their adaption of it built in and this with their agreement. The research team expected that this would require some support but did not anticipate the difficulties the group experienced. In later HEC projects more support over a longer time has been available for groups like this. It is difficult, with only modest experience to try to outline a model for this. The important matters are close collaboration and a fine balance between protecting/guiding and encouraging independence.

7.4. The longer term effects of the project are difficult to assign with either accuracy or complete confidence. The range of influences on the training culture generally, on health service training particularly, and on the HEO culture specifically are vast.

7.4.1. It can be shown that there are now a network of Regional training groups and that they have taken, either in partnership or solo, the responsibility for their own in-service training.

7.4.2. The aims of the project were reached but additionally, the project, by it's facilitative methods promoted empowerment, participation, experiential work styles, and decentralised activity.

7.4.3. The project published (Kilty and Randell, 1978, 1979a, 1979b, 1980) a range of articles. Dissemination was assured through the continuing education project (Keeley Robinson) and additional activities (72.3.2) show that the skills and knowledge are being transferred to their trainer role.
7.4.4. To that can be added the increased activity and involvement of the Society of Health Education Officers both in taking over the running of their annual four day training seminar (facilitated by Regional groups in rotation) and the active formation of a training section within the Society; this last is responsible for providing policy papers on education and training to the DHSS and HEC among others, and it's role in this matter is recognised and accepted.

7.4.5. Course development, in some cases inhibited by poorly focused learning provision was identified as a problem. This is predominately in two arenas

* that of interactive and experiential learning

* that of health education appreciation.

Subsequent professional development project and curriculum work at HEC was made aware of this. A range of current projects are developing participative training materials, are supporting networking and taking health education into adjacent courses. This is effective on two levels. It ensures that health education has a more prominent place in a diversity of courses and it reaches and influences the teachers of those courses so giving them opportunity to restructure the learning they provide. I would suggest that, in a modest way the contribution the research of this project has made (3.2.) combined with other advances in education and in health education, within colleges and courses, is, over time proving to be useful and supportive.

7.4.6. Many of the areas of need identified within the pilot work are now incorporated into readily available training.

* "Working with Groups" which originally provided HEOs with skills as they themselves started to run training activities is now part, not only of their training, but is taught by them to key health educators and is
incorporated into the training of other professions.

* "Learning to Manage" which followed the identification work in this project, took two years to establish; by 1986 it has emerged as a responsibility of the NHS.TA.

* The Initial Training Project developed at Leeds Polytechnic and in direct response to need, provides primarily for new recruits as they become familiar with health education and the primary prevention service.

7.4.5. It is not possible to assign fully precise weightings to the degree of influence that this project has had. Other development can be linked which will have been influential (growth of co-counselling, increase of participative and group work) and altogether they have exerted and influenced in a similar vein and with a similar paradigm. Consistency in process, content, and general direction was discernable.

7.4.6. Additionally it is not possible to say how much is the work of this project team and how much has been the influence, and expertise of others. New paradigm research, of which this is an example, uses people's capacity for self awareness so that they can accept the power to change their world. It uses much closer relationships than that which is usual between researcher and researched, it exposes realities and fixed patterns and has as its outcome knowledge and power (Reason and Rowan).

What is important is that this emerging discipline has increased the range and scope of its learning. It has begun to help itself, and is contributing successfully to others. Many trainers and institutions will have been involved and will continue to be.
Go in search of your people
Love them, learn from them
Plan with them, serve them
Begin with what they have
Build on what they know
But of the best leaders when their
task is completed, their work done
The people will remark
'We have done it ourselves'. Old Chinese Proverb.
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