THE CONTINUING EDUCATION OF HEALTH EDUCATION OFFICERS

James Kilty and Jane Randell

A revised version: of a paper given at the

Xth INTERNATIONAL CONFERENCE ON HEALTH EDUCATION
LONDON, September 2 - 7 1979

Xth INTERNATIONAL CONFERENCE ON HEALTH EDUCATION
LONDON, September 2 - 7 1979

THE CONTINUING EDUCATION OF HEALTH EDUCATION OFFICERS

James Kilty and Jane Randell

Abstract

This paper reports on the research project into the education and training needs of Health Education Officers (HEOs) carried out at the University of Surrey with the support of a grant from Health Education Council. The project, now in its final stages, set out to ascertain the educational and training needs of HEOs, the priorities which might be met in the context of a short course, and test the extent to which these needs had been met in practice. The paper reports on the methods of determining needs; the actual needs identified; the issues dealt with in designing appropriate courses to meet these needs; the participative model and action research strategy adopted; and on the successes achieved and problems posed in this process.

The paper sets the continuing education model adopted in this research, within the range of training options available and under discussion within the various groups involved, and evaluates it in terms of how the process was continued by the Regional groups of HEOs themselves. This peer directed learning process is presented as a major successful outcome of the project. The results are offered to illuminate local and national decisions about the provision of training for HEOs.

Whilst many of the details presented here are specific to health education and HEOs, the model and its application are believed to be transferable to similar professional and occupational groups who desire to improve and expand professional effectiveness and are willing to work together experientially and collaboratively.

James Kilty is a Lecturer in Adult Education at the University of Surrey, Guildford, UK

Jane Randell is Assistant Director (Training) at the Health Education Council, London

Background

History

The system that supports health education services and provision in England and Wales and Northern Ireland is centred on Health Education Officers (HEOs) working in health education units with Area Health Authorities (AHAs). The service has developed slowly and spasmodically over a period of more than twenty years with the Cohen Report (1964)[1] creating an identifiable point of acceleration relating to staff appointments and service provision and to the expansion and development of training. The reorganisation of the National Health Service (NHS) in 1974 took health education from the health departments of local authorities and centred all but a minority of administration within AHAs; this reorganisation enabled specialist health education units to be set up within the NHS for the first time[2].

Recruitment and Training

HEOs, in the main, come to health education from other professional groups, usually, but not exclusively, from nursing, education, environmental health, nutrition and administration and will hold the professional qualifications of that group. They are expected to undertake further relevant training for their new occupation. This is, most usually, the Diploma in Health Education, a one-year advanced diploma validated by the Council for National Academic Awards.

In 1978. the HEO group. in England and Wales comprised 342. Approximately 40% of these had completed the Diploma in Health Education. Not all HEOs are able to attend this training; other training opportunities for HEOs are few.

Socialisation into the HEO role takes place over several years; the Diploma in Health Education is a part of this process which includes local induction programmes, peer interactions and field experience with colleagues. This may include HEOs meeting regionally both to develop coordinated health education activities within an NHS Region and to undertake self-generated training and development work.

Role

The primary function of Health Education Units is with the provision, organisation, administration, innovation and stimulation of health education. This is carried out in collaboration with the many health and education workers, both statutory and voluntary, who have health education responsibility and makes use of appropriate local and national research and evaluation[3].
(Note: Research relevant to health education is carried out both locally and nationally. Health Education Council carries reference copies of research and evaluation reports relating to campaigns undertaken by them and of research projects funded by them. AHAs have initiated projects that are to do specifically with their own needs[4].)

The HEOs initiate, coordinate, support and administer the developments in health education and advise and train others in health education. They seek to encourage and maximise the growth and development of health education within the community served by the AHA and help health educators to develop and apply their skills as a part of this process. They will also, at times, collaborate with those who have responsibility for training health educators (e.g., nurse tutors, teacher trainers, medical educators, environmental health lecturers).
(Note: Health educators are professionally trained persons who have a recognised health education role within their professional role; they will carry out health education in the course of their professional duties.)

While the job description for an HEO is broadly and clearly defined[5], interpretation can vary considerably between HEOs themselves and those they work with and through. An emerging discipline needs to confirm role and function through a process of development. During that time there will be periods in which some degree of misunderstanding between the discipline and those it works with and through will be inevitable; there will be those within the discipline who find the change and development temporarily unacceptable and who will reject the progress accepted by the majority[6]. That this is true for the HEO occupational group has been discussed elsewhere[7].

Role interpretation, by the HEO, is necessarily dependent on their previous qualifications and mode of practice. Socialisation into the new role is aided by training, by peer example, and by the support of senior colleagues. When, as is often the case, health education itself is poorly defined and understood by both the health and education service with which the HEO works, socialisation into the HEO role may be inhibited and delayed[8]. This delay in development may be compounded when, as is often true, the health education unit and staff are isolated from colleagues, physically and numerically. This tends to lead HEOs to keep more closely to their previous professional role, to act as health educators and to relate only to former colleague groups.

The Project

The Health Education Council (HEC) has among its functions,

> "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."

It was to improve and extend the training provision that this research project was developed and mounted.

In their contacts with HEOs, the officers of HEC had been made aware of the need for additional relevant training provision. HEC thus agreed to sponsor a project which had as its main aims to identify more clearly what the educational needs are, develop programmes to meet these needs and assess their effectiveness.

The project was commissioned to design and implement three trial courses of six days' duration in different centres in England in the period 1978-1979.

The length proposed for the courses was considered optimum to provide a reasonable basis for experimental verification of the determined needs and methods of meeting these needs, and without placing undue demands on the service. The end result was expected to be the provision of information to guide the future development of training and some tried and tested practical training activities for HEOs, which might take modular form.

Research Strategy

Course Design

The target population for the trial courses was chosen to be all HEOs, regardless of experience or rank, on the assumption that such a course would be based firmly on a notion of continuing education aimed at the professional development of its members; on shared experience and peer learning; on problem-solving approaches linked substantially to the short and long-term concerns of members and on the assumption that small group work could cater for differing needs of different individuals linked to the chosen themes.

In order to develop appropriate structure in content and methods of the courses, a model was adopted with the following elements[9]:

1. identification of needs and selection of priorities appropriate to a series of study days
2. identification of study centres, resource personnel, sequence and timing of relevant activities
3. trial of each course in turn in each of three centres, with careful observation through attendance at the courses[10]
4. evaluation of the extent identified and emergent needs had been met, changes had taken place in course members and course activities had been appropriate to participants' needs[11].

The identification of needs was carried out in two ways: firstly, an identification of needs generally applicable throughout the profession and, secondly, consultation with course members about their own specific needs and interest within the broader framework. The former involved extensive consultation with HEOs and with professional colleagues with concern about and influence over the work of the HEO, both directly and indirectly (e.g., Area Medical Officers, Divisional Nursing Officers, teachers, doctors). These consultations involved interviews of persons attending nationally organised conferences and individuals selected from the above groups in their work setting and questionnaires. The latter involved consultation with Area HEOs in the Regional Health Authority in which the course was taking place and questionnaires to participants. In the case of the second and third courses, as will be described below, all participants were involved together in a face-to-face procedure designed to inaugurate the course and identify priorities for learning.

Research Team - System Interface

In work of this kind, both the immediate viability and credibility and the long-term effectiveness of the project depends on the excellence of the research team - system interface. Structural links across this interface have been established in several ways: through the network of consultation and interview; through regular reporting to the HEO profession; through the research steering committee and through the adoption of an action research strategy.

Reporting has been through direct personal letters to AHEOs, the Guild of HEOs, the Association of AHEOs, AMOs and articles in Guild News, the Journal of the Guild of HEOs. This is to ensure an adequate flow of information to members of the profession and to ensure informal channels of communication about needs and concerns, about project matters and about the project itself.

The Steering Committee was set up to provide a more formal interface structure[12] and contains members of different groups having influence and concern in the project and its outcomes, chosen to be representative of the most important of these. They include, in addition to the authors:

an AHEO
an AMO
a DNO
an HEC Senior Officer
an LEA Educational Adviser
a DHSS Official :
a Diploma in Health Education Course Director

They were invited 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[13].

Action Research

The action research strategy adopted took as its hypothesis that a continuing education model would be most effective if it continued after the project. This meant that it should be set up in such a way as to maximise the probability of this happening. Therefore, the project explored methods of facilitating the development of the course from within. This objective as well as other considerations implied the provision of courses based on the Regional Health Authorities. Whilst all pilot courses involved consultation with AHEOs and their line managers (the AMOs), the second and third pilot courses involved meetings with Regional Groups of AHEOs to establish the principles of the course and a study day for all participants to launch the course. This inaugural meeting was designed on a humanistic basis to help participants meet as persons and identify and rank order their perceived needs in a peer group. The framework for the study day was general, though participants had prior information about needs previously identified about which some were sceptical. With difference of emphasis only, these needs were confirmed and added to as a result. Thus the overall strategy has been devolution of responsibility to HEOs for the design and development of their own training, starting from a consultative model through a cooperative design model, to a model in which support and encouragement were provided to the group to continue on a peer-directed basis[14].

Course Development

The Three Pilot Courses

A course was developed and tested in three dissimilar NHS Regions with the full cooperation both of the HEOs and their managers. A preliminary peer group exercise at the beginning of two courses defined the fields in which HEOs identified both personal and group educational needs.

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

a) The developmental model. Each training day has several recurring and linked themes. Participants can experiment in real life with new strategies and skills, report on their experiences, receive comment and support from the group and thus refine their ideas and approaches. One of the trial courses used this model.
b) The thematic model. Each training day is 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.

Each course developed in response to the particular felt needs of the participants. The timetable of each course was open to negotiated amendment, and the trainers were available for consultation. Constraints experienced were, in the main, to do with matching the needs of the group to the locally available resources and with providing training for a group with a variety of expertise and experience. Participants were encouraged to link the training experience, and the knowledge and insight thus gained, to pertinent parts of professional practice; to use both materials and techniques experientially and then reflect the experience gained back to the group for comment and support; and to develop tools specific to certain areas of identified difficulty and either individually or collaboratively experiment with them.

Inaugural Study Day

The study-day design involved the following elements in sequence:

i. pre-course information outlining the history and preliminary findings of the project, with a1l practical matters decided in collaboration with or by AHEOs
ii. paired introductions, to (a) exchange personal data informally and (b) review recent job successes
iii. review in fours
iv. pairs of same grade in different Areas share problems and concerns and make a private list, adding undisclosed items
v. amalgamate data in small groups of four to six, starting from the general, nonpersonal, to the personal, with more specific questions to guide the formulation of these, e.g., “What roles are you expected to play which you find difficult”? and encouragement to disclose as yet hidden concerns
vi. the groups make a preliminary indication of strength of need
vii. results posted on flip charts; a composite list being formed
viii. same rank groups add their impressions of the educational need of the other groups
ix. AHA groups privately rank the list of needs as a self assessment;
x. followed by discussion in these groups.
xi. discussion in same AHA groupings, with revised self assessment
xii. gathering of data in same rank groups
xiii. plenary discussion to limit priorities .
xiv. follow-up and report of a summary of the day together with a full statement of perceived needs.

This day was designed to deal with classic problems of such professional groupwork (discussed later in the paper) by engaging participants in quality interpersonal processes. It was also designed on the principle that the most important felt needs must be dealt with first so that (a) a sense of achievement is speedily achieved and (b) other, unperceived needs will surface more readily in the future.

Course Elements

While each of the three HEO groups identified broadly similar areas of need, the strength of that need varied from group to group. Additionally, within the constraints of time and trainer expertise, certain needs could not be met.

The elements that were studied were: interpersonal communication, role identification/clarification, management skills, priority determination, project development, audit, research and evaluation. Styles of presentation of ostensibly similar material varied from didactic to interactive exploration.

Three of the elements of the courses will now be explored in some detail:

1) *Interpersonal communication* - The HEO role demands that he/she be able to communicate effectively with a wide range of people at different management levels and in different professions or voluntary groups. Examples include technical and clerical staff, senior administrators, consultants, head teachers, general practitioners' receptionists, trade unionists, occupational health nurses, health visitors and members of the public - to name only a few. This communication takes place through a variety of channels, informal and formal. Examples include face-to-face conversation which might be informative, advisory or persuasive; telephone calls; irregular or

ongoing work with committees, presenting arguments and lobbying; teaching small and large groups.

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 in these identified difficult relationships. Examples of matters dealt with in this way have included effectiveness in committees; opening up communications with an obstructive manager; handling staff who try to work outside the team.

A group exercise on committee procedure enabled participants, some of whom had a negative view of this aspect of their work, to explore the source of their difficulties, experiment in the group with alternative strategies, apply these when the opportunity occurred and eventually bring their experiences back to the group. In addition the various training activities that comprised the course were a model for training activities carried out by HEOs. Participants, having observed the model in action, could apply it and come back to the trainers for further discussion and support.

2) *Role identification* - The HEO role is an amalgam of many functions which have their historic roots in the health educator role but which in development passed through a period in which the HEO was predominantly a resource officer. It emerged in the late 1970s as an advisor, innovator, coordinator, manager and trainer for health education within an AHA.

While the HEO may be able to define his role with clarity, the associated professional and lay groups with which he works often lack that clarity. This places constraints on professional development and often confuses and retards the emergence of a mature role. Additionally, role confusion in role partners can produce ‘blocks’ to carrying out health education activities in such a way that neither partner in the interaction is satisfied. An exercise in which potential role relationships were listed, role models constructed and role blocks identified, enabled participants to explore not only a less ambiguous HEO role but also the ways in which the conflicts engendered could be dissipated. A useful outcome from this activity in one course was a small enquiry which confirmed the hypothesis ‘that medical 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 health education. The final successful outcome was intended to enable them to communicate more effectively and work more constructively with this specific occupational group so as to increase health education activity in important centres.

3) *Strategies for determining and achieving priorities for health education*. Area and Senior HEOs forward health education activity by determining those areas of action that are of priority by presenting a case with supporting evidence to the appropriate authority and by ensuring the evidence is brought in the correct form, at the optimum time and with significant individuals adequately informed and briefed. While these skills are often part of management training, not all HEOs (even at a senior level) necessarily have these. The exercise presented a model for priority management which was discussed and then further explored in small groups, which worked out the strategies necessary to take the model through to completion, and presented their responses for critical, constructive and supportive examination and analysis in the whole group.

Interim Project Outcomes

Possible Outcomes

The continuing education project should be viewed from two perspectives: firstly, the short-term or immediate changes which have been reported by course participants and others; secondly, the long-term outcomes, some of which are still clarifying and are being reported to us. These will be detailed more fully in a monograph which will describe the project as a whole.

Outcomes can be the achievement of service objectives and the benefits that the continuing education provision may bring to it, the achievement of individual personal objectives, and additional unanticipated personal development. These sorts of outcomes often overlapped. There are also undesirable outcomes, to which the project has been alert[15].

Data-gathering Methods

Data has been gathered in three ways:

- by questionnaire at the completion of each course
- by interview of a sample of the group, including managers (AHEOs), within the first three months following the course and again at about nine months
- by observation during the course.

This data includes achievements identified by the course members, observed by the evaluator, and reported by their managers. It also includes personal reactions to course proceedings.

Outcomes

Collated, a provisional. assessment of the data shows the following:

a) The continuing education programme acted as a catalyst for one HEO group in a way that no other prior activity experienced by them had done. As the group under survey was Regional and expected to cooperate and collaborate, their mutual support was enhanced, as were inter-Area activities and the mutual facilitation of skills development.
b) Work on role supported members in questioning the existing role models and descriptions, in challenging inappropriate role elements and in exploring more appropriate roles, so aided growth and development through enhanced understanding of the HEO role.
c) Blocked or inhibited communications between HEO and peer, colleague, manager and critic were freed because of insights gained and new strategies identified, practised and acquired.
d) Awareness of creative approaches to resolve role conflicts was heightened and the group was used to explore and improve techniques.
e) One course group accepted the importance of continuing education in their professional development and took corporate responsibility to continue this provision in bi-monthly meetings. In part they sought to meet needs already identified but unfulfilled and in part to meet needs that were being newly identified. Responsibility for creating the framework for the first trial period of six months was invested in three members of the group; each of the Health Education units agreed to take responsibility for a one-day programme Another group has this possibility under review.
f) Individuals, having been alerted to personal training needs, expressed the intention of exploring ways by which they could meet those needs.

Individually, reported outcomes attributable to specific parts or aspects of the course in which they participated were:

a) the ability to understand more completely the roles of senior colleagues
b) acquiring a greater tolerance for the difficulties of others
c) a developing self awareness which increased confidence to disclose a current inability to understand a certain task
d) being better able to identify and understand training needs
e) an increasing confidence in peer group interaction and ability to participate without 'losing face'
f) being able to identify particular support networks
g) an expanding understanding of the HEO role relationships and blocks: an increased perception of how to overcome those blocks
h) increased confidence in mounting training days for colleagues.

The Range of Possibilities in Continuing Education

Other Continuing Education Provision

Many professional groups, through a variety of services, are able to fulfil some if not all of their in-service education and training needs; management courses within the NHS are one example[16]. Other opportunities may be to do with extending and enhancing knowledge, acquiring and practising new skills and developing more sophisticated techniques appropriate to their particular discipiine[17].

Continuing education as a self-directed and team-directed activity may be carried out informally and intuitively in daily work. Thus engagement in new activities and private evaluation of each activity or set of activities and personal development goals and action plans which result from individual reflection can be regarded as the primary mode of continuing education for every person[18].

Similarly, informal conversation amongst peers, carried out ad hoc, or in staff meetings and case conferences, and teamwork reviews, carried out more systematically, complement and enhance this process and, with appropriate learning procedures, can help individuals meet their own personal development needs. In addition, humane appraisal procedures can help individuals identify their own needs and associated educational resources within the multifaceted systems available to practitioners operating in the different sectors of education.

Other continuing education tools include using conference and workshop reports as channels of dissemination about innovation and evaluation both as self-directed learning resources and as catalysts for groups to consider new initiatives.

HEOs can make use of opportunities in several areas on an interdisciplinary basis (management courses; with school teachers on education for personal relationship; with health workers on interpersonal skills; with managers on policy determination and so on) and as an HEO group at seminars or colloquia provided specifically for them[19]. In some Regions the HEO group meet regularly and each meeting has a training component which is initiated by the group and may be facilitated by themselves or by an invited specialist.

HEO Generated Provision

At the same time as this was running, other self-actuated Regional HEO groups were running individual training programmes; they have reported their experiences to the project and a brief account of their activities is included below.

1) In collaboration with the Regional Education and Training Officer and using the experience of the HEO groups, three-day residential workshops are organised. The content is designed to meet the felt needs of the group and may be to do with updating information and knowledge, acquisition or improvement of skills or exploration of new or different techniques. The structure is most usually modular without any overt continuity other than the central core which is to do with the development of health education.
2) The AHEO group of a Region have constructed a 'checklist' of topics which the whole HEO group believed were important. All HEOs were invited to use this list to indicate the needs they saw as important (the list contained within it many of the matters identified during the pilot coursework of this research project). From the collated results of this exercise, priorities were determined and a subgroup invited to organise training days.
3) Again using the Regional HEO meeting as starting point, priorities were determined and a 'deal' negotiated with the Regional Education and Training Officer. This enabled the group to use external educational resources to provide an intensive course on one pre-determined priority matter.

Comment on These Three Regional Initiatives in Relation to the Pilot Continuing Education Research Project

While the outcomes as perceived by the participants naturally vary according to the nature of the training and the needs of the individual, it is possible to make some preliminary and tentative comment. On the whole this is subjective and a result of informal interaction between the evaluator and some participants; in due course these observations will be more carefully examined to provide a more informed basis for future developments.

A major problem for any facilitator in all learning groups is to create an environment of such trust that people are willing to share their vulnerability by taking increasing risks in disclosing areas of weakness and learning need. Only by honest and frank discussion of issues of individual concern can significant learning take place. This problem is compounded in groups with members from the same organisation who have mutual expectations and hidden aspirations of each other. It is increased greatly when members of the different hierarchical ranks work together[20]. This demands a greater level of skill in all members and in those who attempt to help work through and lower their defences against significant disclosure and discussion[21]. Such defences lead such groups to guard against disclosing that which is sensitive or threatening, to collude and deny or deride the existence of "problems". and to have members making considerably unequal contributions, tod mention only three.

It is thus our impression that, in the three cases mentioned, the sense of group cohesion, corporateness and commitment in joint responsibility and of support from peers was not so vividly developed as in project courses and, in any case, not so well developed as to help participants as a whole experience significant gains. The introductory exercise designed for this project seemed to have been surprisingly effective, not only to participants but also to ourselves.

Conclusions

In making training available to a group as varied as are HEOs, in a service which is only slowly coming to accept the potential of health education and in which finance and other supportive resources are severely limited, a number of problems and constraints became apparent. The discussion is presented with a view to illuminating the issue of improving the provision of continuing education, whether it be by educational courses or in the context of daily working life.

The 'purse' out of which all continuing education provision must be made is neither limitless or without restriction. Competition for resources is often fierce and well established claimants command a high priority. Appreciation of the contribution that investment in continuing education makes to the Health Service is often imperfect. While the professional group may be convinced of their need and the Service benefits that would accrue, managers may not. Credibility is essential. Negotiation, using skills acquired in life experience and management training, is often necessary. The present absence of either a statutory training body or a strong professional association capable of carrying the supporting arguments to an effective level inhibits development. A successful pilot course can go some way towards helping in the argument but, in the area of interaction and interpersonal and communication skills, evidence is increasingly emerging from diverse professional groups of substantial needs. This project has been able to provide significant evidence of need, by methods which help managers to respond and move towards accepting training of this nature as important to the development of professional skill both for this group and for many others. More sophisticated and politically sensitive methods of establishing needs and negotiating provision need to be explored and tested[22].

In the light of our work, we draw the following conclusions and offer recommendations to develop the continuing education and training of HEOs:

1) HEOs form a vulnerably small group with a role in the development of education for health. They need ongoing support and continuing education to help them fulfil this role. They and their AHEOs welcomed our initiatives, explorations, negotiations and eventual support through our experimental programme.
2) Resources need to be made available on a modest scale to enable HEO staff meeting in Regional groups to use those meetings for a primary educational function as well as to initiate and sustain the first few meetings of this kind, using facilitators external to the group. Subsequently, occasional use of such resources will be helpful to sustain the impetus for growth.
3) Specific needs have been determined, including some common to other professional groups, such as communication skills training.[22]
4) Training methods to meet these needs have been tried and tested and have been documented in modular form[23], They are capable of extension and adaptation to suit initial training schemes.
5) The training module for the inaugural day enabled two groups of HEOs to develop a degree of openness and trust, empathy and the support required to identify collaboratively significant particular and general needs to be met during the course.
6) In addition to the development of knowledge, attitudes and skills in the directions envisaged, an important and significant unexpected outcome of the project and its design was a heightened identity of HEOs as a Regional group and enhancement of communication and support within one group.
7) The project explored the conditions necessary to optimise the possibility that HEOs continue the course process as a voluntary, cooperative effort after project completion. Two groups have taken responsibility for setting up a peer learning programme to follow the course and of keeping us informed of their developments. The inaugural study day, facilitated

externally, and the groups' chosen local resources were remarkable helpful in achieving this end, which was an explicit aspiration of the project and considered by us to be a major success. We do not know how successful this will be in the longer term.

8) The course design and diversity of teaching methods used in the courses have provided a useful model for HEOs to apply creatively in their own in-service training ventures for health educators. We cannot fully assess the contribution such application has made to the development of such training, nor the extent to which HEOs will continue to draw on these models in their designs for continuing their own education.

Dissemination

9) HEOs as a professional group have been kept thoroughly informed of these initiatives and have been supportive of the research throughout[24]. A paper was presented at the Xth International Conference on Health Education summarising the work of the project[25].
10) Evidence from the project was sought by and given to the National Staff Committee Working Party examining the training needs of the HEOs and related matters[26].
11) HEC has agreed to publish the full results of this work in the HEC Monograph Series[23] This will provide a training tool for future use.
12) We recommend that further support be given to aid in the dissemination process in new Regions: one Regional group has now been given assistance to follow this lead. We believe that others will quickly follow.
13) We recommend further exploration of the validity of the model developed. and of appropriate modifications to suit the need of Regions who do not respond in a similar way in the near future
14) We recommend monitoring the continuation programmes to determine the need for further Support to maintain them and particularly to determine the optimum frequency for the injection of ideas and skills from persons external to these groups to provide Stability in their development[27].

References

(1) Health Education: Report of a Joint Committee on the Central and Scottish Health Service Councils HMSO 1964 (Cohen Report)

(2) DHSS Reorganisation of National Health Service and of Local Government Operation and Development of Services HRC (74) 27 DHSS March 1974

(3) Graham H The First Months of Motherhood University of York 1979
Baric L Primary Socialisation and Smoking *University of Manchester Monograph Series No 1* HEC 1979

(4) England P Health Education Campaign Against the Head Louse *Health Education Journal* Vol 36 No 2 pp 42-45
Quigley C R Ricketts in Bradford Institute of Education Leeds 1972-73 (unpublished dissertation)

(5) Job description for an HEO: As yet there is no nationally agreed HEO job description. The summary that follows is drawn from a consultative document prepared by a group of the National Staff Committee of the NHS which is currently discussing the training provision for HEOs.
Key tasks

a) Advisory - to provide advice and guidance to health educators, liaise and guide representatives of local authorities, voluntary organisations and other agencies on health education matters.
b) Education and Training - to be actively involved in the health education content of basic and post basic education of health professions; to assist with specialist courses and conferences and to be involved with training programmes for trainee HEOs
c) Planning - to participate in and contribute to the development of strategic and operational plans for the health education Services and to health care and other planning teams where there is a health education input
d) Exhibitions, etc - to participate in the organisation and administration of exhibitions, displays and relevant health education support materials
e) Research and Evaluation - to participate in the identification and evaluation of health education activities.

(6) Wilensky H L The Professionalisation of Everyone? *Am J Soc*. pp 137-158 1964
Vollmer HM & Mills DL (eds) *Professionalisation* Prentice-Hall 1966

(7) Tones BK The Role of the Health Education Officer: A study of emergent professionalism University of Bradford 1975 (unpublished Masters thesis)

(8) Baric L Professional Socialisation *Institute of Health Education Newsletter* July/August 1978

(9) For a theoretical and practical amplification of a model proposing these stages of curriculum development, see Stufflebeam D L et al *Educational Evaluation & Decision-making* Peacock, California 1971
For an application, see:
Kilty J M Vocational Training: A Framework for Evaluation British Postgraduate Medical Federation 1977

(10) Parlett M & Hamilton D Evaluation as Illumination - a new approach to the study of innovatory programs *Occasional Paper 9* Centre for Research in the Educational Sciences Edinburgh 1972

(11) Scriven M The Methodology of Evaluation In '*Perspectives of Curriculum Evaluation*' Tyler R W, Gagné RM & Scriven M (eds) *AERA Monograph No 1* Rand McNally 1967

(12) Kilty J M Curriculum Planning and Decision-making in Two Innovatory Courses in Higher Education University of Surrey 1975 (unpublished PhD thesis)

(13) Kilty J M & Potter F W The Midwife Teacher's Diploma (Research Project Report to The Royal College of Midwives) *RCM* 1975

(14) See for example:
Rowan J A Dialectical Paradigm for Research April 1976 (unpublished)
Heron J Behaviour Analysis in Education and Training University of Surrey 1977
Heron J Experience & Method University of Surrey 1971
Reason P & Rowan J (eds) Human Inquiry Wiley 1980

(15) Stake R E The Countenance of Educational Evaluation *Teacher's College Record* 68 pp 523-540 1967

(16) See for example:
South West Thames Regional Health Authority. *Training*. 1979-80

(17) See for example:
British Postgraduate Medical Federation. Annual Reports and Programme of Educational Courses & Workshops (1980)

(18) Tough A Major Learning Efforts: *Recent Research & Future Directions* Ontario Institute for Studies in Education Toronto 1977

Rogers C *Freedom. to Learn* Merill 1969

(19) Health Education Council *Annual Report* 1978/9

(20) Heron J Experiential Training Techniques University of Surrey 1973

(21) Heron J Dimensions of Facilitator Style University of Surrey 1977

(22) Garner N & Kilty J M A Community Staff Training Project, an investigation of the continuing education needs of community health care staff S W Thames RHA 1975

(23) Kilty J & Randell J A Monograph on this work is in preparation publication expected in 1981

(24) Kilty J & Randell J In-Service Training for HEOs *Guild News* Spring 1978
Kilty J & Randell J Continuing Education of HEOs A Progress Report *Guild News* Spring 1979

(25) Kilty J & Randell J The Continuing Education of Health Education Officers Paper presented at the Xth International Conference on Health Education September 1979

(26) Kirby R W (chmn) The Recruitment, Training and Development of Health Education Officers. Report of a Working Party DHSS January 1980

(27) HEC agreed to recommendations (12) – (14) by sponsoring a continuation project under the joint supervision of the authors, to start when a suitable dissemination officer can be appointed within the HEO group.

Acknowledgements

We are indebted to so many people for consistent support, helpful advice and timely information given in a spirit of deeply felt concern and hope. Ian Sutherland in particular and other members of the Research Team, AHEOs, HEOs, many individuals consulted, colleagues at HEC and the University have given freely in such a way as to make possible the success of this work. We are indebted to the HEC for financial support for our exploration. We are also indebted to Kay Thomas for typing this work and the service she gave to the project.