RESEARCH REPORT

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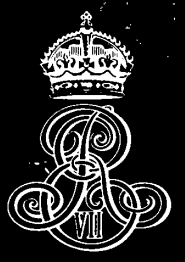
SWIMMING UPSTREAM

TRENDS AND PROSPECTS IN EDUCATION FOR HEALTH

MARGARET WHITEHEAD



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MARGARET WHITEHEAD

CONTENTS

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This report builds on and extends a review of the effectiveness of educational initiatives which I prepared in 1986 for Bobbie Jacobson and the Health Education Council as background information for the book entitled The Nation's Health (Smith and Jacobson, 1988). Special thanks are due to the former Health Education Council for funding that earlier phase of background research and to Bobbie Jacobson for advice and encouragement throughout.

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Margaret Whitehead
August 1989

SUMMARY

The need to give health education much more serious attention, and to get it *right*, has become more pressing in recent years. The advent of AIDS has brought with it the recognition that education may be the main, perhaps the only, defence we have against the disease. The newly-emerging environmental hazards re-emphasise the critical need for people in this country to be informed about known hazards and how best their health can be protected. General prospects for reducing death rates and relieving the effects of chronic disease also point to a prominent role for education for health in the coming years.

However, decisions on education for health currently take place against a background of conflicting policy and practice. To clarify some of the main issues, this review sets out:

- to identify trends in policy and practice in Britain in recent years;
- to summarise the evidence on effectiveness of some of the most significant developments;
- to comment on the policy implications of these developments;
- to highlight recommendations for action.

Different *methods* of education for health are discussed within the context of the *setting* in which they have to operate, so that policy constraints and options can be considered. The main settings covered are schools, mass media, health services, deprived neighbourhoods and formal professional training institutions, together with community wide programmes which cover several of these settings. Detailed case studies and examples are given in places to illustrate evaluation points or policy questions.

The main points to emerge from the review are set out below.

1. In all the settings, there is evidence of growing interest in education for health, with increased activity on many fronts during the 1980's. For instance the percentage of secondary schools with a designated health education co-ordinator increased from virtually nil in 1975 to 50 per cent by 1983. In the mass media there was a growth in spending on advertising on health issues from £1.6 million in 1979 to £11.4 million in 1988, mirrored by feverish activity by television and radio programme-makers. There was also an expansion of specialist services concerned with health education in health and local authorities and a mushrooming of lay self-help groups and projects concerned with health.

2. Despite this increase in activity, the total amount of effort and resources put into education for health is still insignificant in relation to the size of the task and in relation to resources allocated to other policies of arguably lower priority. There is much rhetoric about how important health education is, particularly for children and young people in relation to a growing list of social problems concerned with substance abuse, sexual activity and violence. But there is very little substance behind the rhetoric. The issue has been and still is of low-status and low priority in many organisations, with consequent underfunding, under-resourcing and haphazard implementation. The fact that the national health education bodies have only been allocated approximately £1 in every £1,000 of NHS expenditure is one indicator of the continuing low-status accorded to health education in this country.

3. There are large variations in the quality of educational efforts, but significant advances have been made in recent years. Effective methods have been developed over the decade in each setting to achieve specific goals. No longer are sweeping generalisations justified about the 'ineffectiveness of health education'. For example, in schools, programmes have been developed which influence smoking and dental health behaviour, which encourage aspects of personal and social development or which influence school policy towards the introduction of comprehensive health education programmes. In health service settings, randomised controlled trials have demonstrated the effectiveness of personal one-to-one education by doctors, nurses and health visitors. Training initiatives have shown that it is possible to improve the communication and health teaching skills of health professionals to meet the information needs of patients. In local neighbourhoods, community development techniques have been used successfully to help deprived communities find a voice and participate in policy decisions about their local services and about their own priorities. Some of these initiatives have been of the highest quality. Indeed some, particularly in the school and professional training fields, have been outstanding on an international scale, and are amongst the most advanced and sophisticated to be found anywhere. Examples are given of some of the key initiatives.

4. Despite the potential that some of these methods have demonstrated, this knowledge is not being applied on a wide scale. There have been instances of agencies 're-inventing the wheel' in different parts of the country, using strategies which have long been shown to be ineffective or even counter-productive. Nowhere is this more apparent than in the field of mass media public education. For example, there is concern that the Department of Health's mass media illegal drugs campaign helped to set an *inappropriate* agenda in the country. It perpetuated the unhelpful stereotype of the heroin addict, used scare tactics known to be ineffective, if not counter-productive for such a sensitive task, and diverted attention and resources away from other legal drug problems, which had a higher claim for national priority.

5. The lack of knowledge and understanding of previous successes and failures of educational efforts has also led to unrealistic expectations of what each method can achieve. In schools, for instance, there is evidence that single lesson lectures are still commonly employed with the aim of influencing complex social problems like illegal drug use, sexual activity in relation to AIDS, smoking and drinking habits and so on, even though any long-term behaviour change is highly unlikely with such a method.

6. The balance of activity on different health issues has been very uneven, with inadequate coverage of certain important areas. For example, the majority of policies and initiatives in all sectors have been concerned with individual lifestyles, aimed at reducing

conventional risk factors by changing the behaviour of members of the general public. On the whole there has been (a) a neglect of education concerned with social and environmental influences on health and (b) a relative neglect of education directed at local and national policy-makers as opposed to the general public.

7. Several administrative and political obstacles were identified which have blocked progress in education for health. These included the low-status, low priority nature of health education already mentioned, leading to underfunding and under-resourcing; work overload of professionals geared to crisis intervention and treatment; and the lack of coordination and advisory systems to support the coherent development of health education throughout the country. A further obstacle has been the lack of recognition that educational policy is only one facet of health promotion policy which should encompass additional legal, fiscal and social measures.

8. When considering prospects for the future, specific priorities for action in each setting have been identified in the body of the report. Overall there are four requirements common to all sectors.

Firstly, the low-status, under-resourcing issue needs to be addressed. If health education really is a high national priority, then resources have to be allocated accordingly and political commitment has to be firm and obvious.

Secondly, new channels of communication need to be created between researchers and developers of health education programmes on the one hand and policy-makers and practitioners on the other hand. Attention needs to be given to dissemination of the findings from educational development work. In addition, the planning of research and service development needs to be synchronised more closely.

Thirdly, the balance of activity on individual, social and environmental factors needs to be reassessed; there has been too much emphasis on individual lifestyle so far.

Coupled with this proposed change in emphasis is a requirement to pay more attention to the education of local and national policy-makers. They need to be alerted to the effect of their decisions on the safety of the environment and on the opportunities open to the general public to choose a healthier way of life.

Fourthly, and above all, there is a need for a coherent and comprehensive national policy for *health promotion*. This would co-ordinate action across the different government departments with an influence on health issues and also link various local and national levels of organisation. Plans for *health education* would then form an integral part of this broader policy.

1 INTRODUCTION

Remarkable developments have been taking place in education for health, which began in the mid-1970s and accelerated in pace from the mid-1980s onwards.

Some, but not all, the developments could be seen as positive: others may well prove to be counter-productive in the end. A critical stage has now been reached when key decisions are due to be made about future policy, against a background of conflicting present-day policy and practice. In many ways education for health appears to be at a crossroads with difficult choices ahead.

With this in mind this report sets out:

- to identify trends in policy and practice in education for health in Britain in recent years;
- to summarise the evidence on effectiveness of some of the most significant developments in school, community and professional education;
- to comment on the policy implications of these developments;
- to highlight recommendations for action.

However, before going any further it is useful to look at why health education is so important at the present time. The terms and approaches used in this report also need to be defined and these are set out in Box 1.

BOX 1 · DEFINING TERMS

Adopting the World Health Organisation's working definition:

Health is seen as 'the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs and, on the other hand, to change or cope with the environment. Health is therefore seen as a *resource for everyday life*, not the objective of living; it is a positive concept, encompassing social and personal resources as well as physical capacities' (World Health Organisation, 1984).

As the influences on health are many and varied, so *education for health* encompasses a broad spectrum of activities not only concerned with personal lifestyle but also concerned with the social and environmental factors which affect health. As such it is not only focused on the general public, but also on the professions in contact with the public or the local and national policy-makers who can influence the state of the environment and the opportunities for improving health available to the public.

Education for health is seen as just one component of the overall process of *health promotion* which encompasses actions to protect or enhance health, including legal, fiscal, educational and social measures. It is, however, a crucial component, because education for health is often needed to lay the foundations before the other components can come into play. For example, education of policy makers on the life-saving benefits of compulsory car seat belts preceded the legislation.

'Education for health' and 'health education' are used interchangably here.

Why is it so important?

In the past health education has commonly been viewed as a peripheral concern, an unexciting optional extra to the main task of improving health through the treatment of disease. Against this background its importance may not be immediately obvious. Yet all the recent public health analyses of trends in health and disease highlight the need to give health education much more serious attention.

There are, of course, ethical reasons why education concerning health and hazards should be considered a right for all members of the public, but here two examples from a public health perspective are given. Consider the scope for reducing the toll of premature deaths in this country. While the dominance of infectious disease as a cause of death has been declining over the century, other diseases have gained in prominence. The leading causes of death are now heart disease, strokes and cancers in middle and old age and accidents in children and younger adults. Together these account for well over 400,000 deaths per year — over 70 per cent for the total. In addition growing threats to public health are posed by alcohol-related problems and AIDS (Smith and Jacobson, 1988). These are the health problems commonly identified for priority action, but there are no 'miracle cures' on the horizon for any of them. Most do not have one simple cause which could be tackled by medical science. On the contrary, the determinants of these health problems are multiple in nature and rooted in a mix of personal and community behaviour, social and environmental conditions which interact in ways which are not fully understood. However, some of them can be seen to hold potential for prevention. That is why most strategies aimed at tackling these modern epidemics put the emphasis firmly on prevention with education for health of the public and policy-makers as a central element in those strategies (Smith and Jacobson, 1988; World Health Organisation, 1985). Indeed, as far as AIDS is concerned, it has been stressed repeatedly that public education is the only defence we have against the disease at the present time (House of Commons, 1986). If this is accepted, then the importance of getting health education right becomes even more pressing.

Concentrating solely on reducing death rates neglects important aspects of the quality of life experienced by people in this country. Changes in the pattern and nature of illness and the age structure of the population also indicate an expanding role for education for health. The major killer diseases listed above are chronic and degenerative in nature, often leading to years of illness before death; this is in contrast to the short episodes of acute illness which characterised the infectious diseases of the past. There are also several conditions which have become major sources of suffering and ill-health even though some do not register highly in the death statistics. These include mental illness, chronic bronchitis, diseases of the circulation, rheumatism and arthritis (Allsop, 1984; Cox *et al.*, 1987). At the beginning of the century roughly 5 per cent of the population was aged 65 and over; the proportion has now risen to 18 per cent with further rises in the number of the very elderly

predicted. These demographic changes have profound implications across the whole spectrum of public policy, not least because multiple chronic conditions are more common in old age. On the positive side, most older people say they feel healthy and want to lead an active life for as long as possible (Smith and Jacobson, 1988).

The increased impact of chronic disease has led to calls for a completely new approach to education for health: one which takes an advisory and supportive role to help people improve their quality of life and maintain their independence whatever their state of health or disability (Kickbush, 1981).

Methods and format

Two main methods were used in compiling this report. Firstly, a review of the literature and of known work was carried out. Secondly, lengthy personal and telephone discussions were held with the people listed in the acknowledgements, all of whom have long experience in the field of education for health in England, Wales or Scotland. Their insight and advice proved especially valuable in identifying common obstacles and dilemmas in education for health and in pin-pointing events or initiatives which had been instrumental in bringing about progress, accounts of which would not necessarily appear in the published literature. Their recommendations for action were also sought and recorded.

Following a brief note at the end of this introduction on how educational initiatives are evaluated, the report goes on to review developments in education for health in the United Kingdom. It cannot hope to give a fully comprehensive review of all the initiatives which have taken place in the last decade or so. Only certain policy settings have therefore been chosen. These are the ones, like school and health service settings, in which most development work has been done. Others, such as workplace and post-school youth settings which are only in the early stages of investigation (in this country at least) have been omitted. It is useful to think in terms of policy *settings* in order to consider the effectiveness of different *methods* of education for health in the context of the administrative and political framework in which they have to operate. Effective methods may fail to be implemented without plans which take account of the policy structure of the particular setting.

Section 2 therefore looks at the education of young people in the school setting, perhaps the most extensively investigated area so far. It comments on trends, effective methods, teaching dilemmas, policy constraints on implementation and priorities for action.

Section 3 deals with some key community settings. After a brief comment on trends it is subdivided to illustrate widely differing approaches: techniques used within the mass media, personal and small group methods in health care settings, and the community development techniques in local neighbourhood settings.

Section 4 discusses professional development of doctors, nurses and teachers under the many constraints of formal training settings.

Section 5 briefly considers the broad community-wide context, in which major initiatives attempt to incorporate the range of methods and settings discussed above under one unifying umbrella.

Finally, Section 6 draws together conclusions listing those issues common to all settings. It also notes what has been learnt about the process of health education over the decade and the critical gaps in knowledge and the obstacles still to be overcome if further progress is to be made in the future.

Judging performance

One trend identified by several commentators has been the increasing pressure from policy-makers and funding bodies to measure and justify the performance of educational initiatives. Yet this has often been coupled with a lack of understanding of the special problems of evaluation in the community and of the methods appropriate for the different tasks. In this climate there is a real danger that decisions about future funding and policy will be based on misconceptions.

For this reason it is worth examining some of the issues here. It will also give a basis for judging the developments outlined in the following sections and help pin-point the gaps in research discussed later. The whole issue of measuring effectiveness and efficiency in education for health is explored in depth in a forthcoming review (Tones *et al.*, 1989).

Many of the prevalent ideas about evaluation have been influenced by the methodology of medical and physical sciences, typified by the randomised controlled trial. For example, in drug trials patients would be randomly allocated to either a control group receiving a placebo or an experimental group receiving the drug under test. After a time the effects of the drug would be evaluated by comparing the control and experimental groups. To reduce bias from the evaluator, double blind assessment is often used, in which the person assessing the outcome does not know which patients were in the control group and which received the drug.

While the method is well-suited to highly regulated situations, the scope for its use in assessing educational initiatives is very limited indeed. In most cases, the technique is inappropriate for three main reasons. Firstly, in the community people cannot be *randomly allocated* into control and test groups and manipulated to suit the convenience of the researcher. To get round this, control and test *areas* are sometimes chosen for study, which contain populations with similar characteristics in terms of age, sex, social class and so on. Even so, the movement of people in and out of the experimental areas and other important variables cannot be regulated.

Secondly, even when a well-matched control area can be found there is no way of insulating the population from *external influences*. Test areas may well receive powerful educational inputs other than the one under test and so too may the control area. Some external influences can work in the opposite direction to that of the experiment and may mask any positive effects the educational programme may have had.

Thirdly, an attempt to mould the conditions in the community to fit an experimental design can render the results meaningless if it changes crucial features of the object under study by taking it *out of its social context*. Findings would be of very limited value if they could not be duplicated in other real-life settings.

These are not the only difficulties with which to contend. There are great problems in measuring some of the desired changes. It may be relatively easy to measure the level of knowledge but what about measuring levels of self-esteem, or well-being, progress in personal or professional development, sexual activity, degree of loneliness and social support? Many forms of behaviour change are not amenable to assessment. Successful sex education, for example, may lead to the use of preventive services many years in the future. Measuring attitudes and opinions may seem relatively straightforward but different answers can be obtained by making minor alterations to questionnaires – for example, by varying the wording of a question slightly or changing the order of the questions. If people are not allowed to answer 'don't know' to questions, opinions on a subject can appear polarised when there is no real debate about the issue (Davies, 1986; Davies and Baker, 1987; Schuman and Presser, 1981).

The process of evaluation can have an effect on the situation under study and this has to be borne in mind when making comparisons. It is not unknown, for instance, for an initial enquiry about a health policy to trigger off a review of policy in an organisation. When the evaluator returns to the control group later there has been a policy shift without any explicit educational input.

There are also several pitfalls concerned with setting of objectives for later measurement. Some goals of educational initiatives have been unrealistic; almost impossible to achieve by the methods employed. For example, a one-off lesson on a topic can hardly be expected to have more than a transient effect – perhaps only on knowledge. Yet initiatives have been dismissed as failures for not bringing about quite dramatic changes in behaviour.

On the other hand, there is always the danger of pre-setting too narrow and rigid objectives at the beginning of a project, with corresponding narrow evaluation. This was the trap that many school-based studies fell into in the 1960s. Some projects in schools were judged solely on their effects on pupils. They ignored unforeseen effects on parents, teachers or general school policy. This issue arises especially in the evaluation of community development projects, in which initiatives can be judged as successes or failures depending on whether they are assessed at the level of the individual, the family or the community (Hunt, 1987).

The above list of problems is not meant to discourage attempts to evaluate educational initiatives. But it does mean that the more common statistical and epidemiological approaches are not adequate on their own. They need to be supplemented by more complex designs adapted from social and educational research. Sometimes several complementary methods need to be used at the same time. Increasingly, educational projects are using a combination of approaches including: *formative evaluation* – to monitor progress and feedback information to help in the development and refinement of the programme as it progresses; *process evaluation* – to describe exactly what happened at each stage in the project so that successful elements can be distinguished from the unproductive ones; *summative evaluation* – to assess the final outcome, but employing a variety of quantitative and qualitative measures to try to understand not just *what* people did, but *why* they acted as they did.

Examples of different approaches to evaluation can be noted in the initiatives described in the following sections.

[illegible] the results [illegible] the object [illegible]

The [illegible]

[illegible]

[illegible] direction [illegible]

2 SCHOOL: THE UNIVERSAL REMEDY?

Health, personal and social education through the school system has figured prominently in many policy recommendations emanating from official commissions and working parties over recent years. It has been put forward in response to a growing list of perceived problems ranging from drugs, AIDS and coronary heart disease to unemployment, violence in marriage and child abuse – not just in this country but internationally.

Amid all the clamour for action it is important to question what can reasonably be expected of school programmes, the trends and the prospects for the future.

THE TRENDS

Six clear trends can be discerned which, taken together, indicate that substantial progress has been made in putting health education onto the agenda in schools. There are still major obstacles to its further progress though and also potential conflicts looming. The positive trends include:

1. A general broadening of the concept of health employed in many schools. In the 1960s and early 1970s a narrow view of health was prevalent, particularly in secondary schools, linked mainly to hygiene and sex education (Brierley, 1983; Scottish Education Department, 1974). However, by the 1980s attitudes had changed. As one HMI noted:

> *'A fair proportion of schools had a broad concept of health education which was positive: associated with self-esteem, mental health and relationships. There is more about education for health, not simply for its own sake, but to enable people to get on with other things'* (Brierley, 1983).

This last point is very much in line with the WHO concept of health as a *resource for life*, rather than a goal in itself.

Further support for this view is found in the evidence of a growing trend for health education to be arranged as one part of a wider personal and social education programme (Jones, 1986). Indeed in a survey in 1981-83, the staff of 70 per cent of schools thought that health education should be part of such a broadly based programme (Williams and Roberts, 1985).

Specific studies of the nature of sex education have also suggested that secondary schools have increasingly adopted a wider concept of what it encompasses, comparing the results from a 1974 study (Farrell, 1978) with a similar one carried out in 1985 in which 16-year olds reported on the topics covered in their schools (Allen, 1987). All the topics showed increases from 1974 to 1985, with notable gains in the coverage of personal relationships, family and parenthood.

The 1985 study also noticed widespread evidence of sex education being intergrated into the school curriculum as a whole rather than treated as an isolated subject through one-off lessons.

2. A dramatic increase in the number of schools in which health education appears in the formal curriculum. In the mid-1970s a survey by Her Majesty's Inspectorate (HMI) considered that only 11 per cent of secondary schools in England were making good provision for pupils' personal development through the curriculum. In a large number of other schools, courses were included in the options systems and were largely designed for the less able pupils (Department of Education and Science, 1979). Similar conclusions were drawn from a survey in Scotland (Scottish Education Department, 1979).

By the mid-1980s, 90 per cent of schools made planned provision in this area (Department of Education and Science, 1988). A marked increase, specifically in health education, had been noted by the inspectorate, from 66 per cent of schools in 1982-83 to 92 per cent in 1985-86. A survey in Wales in 1986 found 78 per cent of schools with a planned health education programme, either as a separate course or as part of personal and social education (Nutbeam *et al.*, 1987).

What was less encouraging was that provision was still not consistent for all pupils throughout each year of schooling, with many pupils either receiving disjointed or overlapping programmes, or even missing out on health education altogether. Lack of clear arrangements to coordinate the work of several departments was seen as a particular defect of many English schools (Department of Education and Science, 1988). In Wales, only 30 per cent of schools offered a planned programme in each year of secondary schools although 62 per cent offered it in at least two years (Nutbeam *et al.*, 1987).

3. A trend towards more systematic coordination of health education programmes. In the mid-1970s school coordinators for health education were almost non-existent (Reid, 1985), but by 1981-83 18 per cent of primary schools and nearly half the secondary schools had a person designated as responsible for health education, usually at senior level (Williams and Roberts, 1985). Recognising the complex nature of organising health education across the curriculum and the need for a senior person to have oversight of the arrangements was a significant development.

4. A shift in teaching methods to involve more active learning. There has been a noticable move away from methods which rely mainly on information giving towards ones which help pupils to explore feelings and practice skills and involve more active learning methods such as role-play and small group discussion. These have now spread to other educational settings which can be seen, for example, in methods used in the General Certificate of Secondary Education courses and in Technical and Vocational Education.

5. An upsurge in curriculum development projects in health education. The first national project was funded in 1973 and since then many more have followed involving systematic formative evaluation in their development. These provided models of how health education could be introduced into the curriculum and how different themes could be inter-linked, incorporating sound educational

principles. Some of them started to provide evidence of effectiveness which further boosted the introduction of the subject.

6. Increased emphasis on the importance of health education in Department of Education and Science and Her Majesty's Inspectorate reports. There has been a marked progression of emphasis in official reports, changing from rather bland statements of support for health education to the recognition in 1981 that it should be seen as an *essential* part of the curriculum for every pupil (Department of Education and Science, 1981). Health education was also included in formal school inspections by HMI from about that time onwards.

Tones has traced the change in concept of health emerging from successive Department of Education and Science reports. For instance, the medicalised approach of the 1968 handbook, laying great stress on *rules* and *training* for health, gave way by 1978 to a greater emphasis on personal and social factors, including the fostering of self-esteem and decision-making skills (Tones, 1988).

One year later an HMI report was making strong comments on the lack of provision for personal development in the formal curriculum and recommending improvements (Department of Education and Science, 1979). This report was especially influential in encouraging the subsequent trend towards greater personal and social education in the curriculum.

This sixth trend had to be weighed against conflicting messages on national policy, discussed more fully in later pages.

To sum up, gains on the health education front in schools have been impressive, bearing in mind the normal time-scale for curriculum change (15 years would be typical). However, despite this progress it has to be remembered that health education is still a low-status activity in British schools, mainly because it is a non-examination subject. Many schools still do not offer a comprehensive programme for all pupils throughout their school careers and, in many, lack of coordination of the subject across departments is apparent. In other words, the gains are significant but the subject is still in a fragile state.

SOME SUCCESSES

Much has been learnt in the past 20 years about the process and methods required for more effective health education in schools. Experience from numerous interventions has led to a general consensus on three key principles.

- That attention needs to be given to how children make decisions about health. In this context, education would mean not simply giving information but helping children to clarify their own ideas, values and attitudes and giving them the chance to practice making choices about health through active learning methods.
- That learning in general and health behaviour in particular are closely tied up with self-concept and self-esteem and methods need to be directed at enhancing self-esteem.
- That health education needs more than single lessons on isolated topics. Certain key themes need to be revisited from time to time in ways which are matched to the child's stage of maturity; this is termed a 'spiral curriculum'.

In 1985 an American evaluation study on a vast scale (involving 30,000 children in over 1,000 schools), confirmed the importance of these principles (Connell *et al.*, 1985). It showed that:

- knowledge gains could be achieved in relatively few hours, but effects on attitudes and reported behaviour required a sizeable commitment of classroom hours (30 hours or more);
- a programme conducted over two years was more influential than a one-year programme;
- inservice training and preparation of teachers greatly enhanced implementation and effectiveness;
- the involvement of parents was influential;
- the commitment of the school (by providing adequate time and materials) enhanced implementation and effectiveness;
- a balanced 'comprehensive' health education programme was important.

Major initiatives in recent years have paid attention to these principles, although they may have been directed at different goals. The aims overlap to a certain extent but some have concentrated mainly on organisational changes and developed strategies to enhance the organisation and delivery of health education programmes in schools and to promote participation by the school sector in general.

Others have been concerned more with educational goals. For example, *'the need to encourage personal growth and skill-enhancement leading to the development of responsible, autonomous and assertive young people, capable of making rational and well-informed decision about their health'* (Reid and Massey, 1986).

Only some have been directed explicitly at influencing conventional risk factors in terms of improving health-related knowledge, attitudes and behaviour. Several initiatives can be pin-pointed in these three categories which could be considered landmarks in influencing the positive trends already noted.

Putting Health Education on the Agenda

Firstly, on the organisational front, The Schools Council Health Education Projects (SCHEP), developed for the age ranges 5-13 and 13-18, have been identified by many as instrumental in putting health education on the agenda in schools. These were national projects jointly funded by the Health Education Council and the Schools Council (a joint Department of Education and Science/local authority body). The first of these, the 5-13 project, was developed over three years with formative evaluation in 70 schools in nine different areas of the country. A continual process of modification took place until the materials were acceptable in the classroom and were

suitable for and enjoyed by the children in these age groups (Schools Council, 1977). By 1984 the 5-13 material was in substantial use in 25 per cent of primary schools. Summative evaluation of the project's effect on children's behaviour found no effect on smoking and nutrition-related behaviour but did detect small gains in self-concept even under difficult conditions (Murray *et al.*, 1984). In relation to policy, observers claimed that the project laid the groundwork for the funding of many of the subsequent projects and helped to secure the cooperation of the educational establishment for further development work in schools because it was based on sound educational principles. In this respect it could be considered a successful pump-priming exercise to help put health education on the agenda.

In a similar way the SCHEP 13-18 project was developed from 1977 to 1980 following a survey of schools which found that even in those with a good record of health education, teachers had difficulties in organising the subject across the curriculum and with the methodology required. This project addressed itself to the problem of how health education could be organised in a secondary school and how the components could be effectively coordinated. Training workshops for school coordinators were a vital element of the project. By 1982 the project was in use in 15 per cent of secondary schools and by 1986 was used in nearly half the Welsh secondary schools. It has been claimed that this influenced school policy on the appointment of coordinators and on their training; it helped to establish the role and credibility of the coordinator in most regions of the country (Williams, 1986a). As noted earlier, by 1983 50 per cent of all secondary schools had designated coordinators, mostly of high status. Fifty per cent of local education authorities took part in the training for the 13-18 project which involved 6-day intensive courses for coordinators; some authorities, like the Inner London Education Authority, took part in the initial training and then devised on-going schemes of their own to train their staff.

The SCHEP projects also promoted cooperation between health authorities and education authorities. For example, nine out of ten local education authority inservice training courses for the SCHEP projects received substantial support from local health education officers and opened the way for further joint work.

In Scotland the SCHEP 13-18 project did not have the same impact because it coincided with the major reorganisation of the secondary school curriculum following the Munn and Dunning reports (Scottish Education Department, 1977 a and b). However, what is now recognised as a major impetus to health education in the *Scottish system* came about as a result of another training initiative which was initially focused narrowly on drugs. In November 1985, the Scottish Education Department (SED) issued a circular to schools stressing the importance of drug education and (crucially) providing central funding for inservice training of teachers on this topic for 1985/86. A national programme of inservice training emerged from this initiative, with guidelines prepared by a planning group chaired by HM Chief Inspector of Schools. There was input from several educational bodies, including the Scottish Health Education Group (SHEG), whose training courses, each lasting 6 days, were set up around the country and were designed to allow consideration of the wider issues of legal as well as illegal drugs, and the management issues common to health education in general including school policy on health education, coordination, processes involved and curriculum organisation. Of the 430 secondary schools in Scotland, nearly every school sent a senior member of staff to attend one of these courses. In effect this meant that within two years virtually all secondary schools had a senior member of staff who was aware of the basic issues and was in a position to operate as an effective coordinator of drug and health education. These drug education courses were offered at a time of industrial action in Scottish schools but, fortuitously, the courses were supported by the teachers' professional bodies and therefore had a high profile at that time. Since then health education has been designated by the Scottish Education Department as a priority area for inservice training.

In England and Wales similar central funding for drug education was used in a different way. Advisers on drug education were appointed in most of the 104 local education authorities. A survey of authorities found that most drug education coordinators believed drug education should be carried out in the context of a broader programme of health, personal and social education and the role of these advisers broadened accordingly (Turner, 1989).

A new generation of curriculum development initiatives has been funded in the 1980s to carry on the work started by the SCHEP projects of the 1970s. For example, the HEA Primary Schools Project has been addressing the problem of lack of coordination in the primary schools following surveys which showed the current piecemeal and fragmented approach, even in schools where individual teachers were doing excellent work in their own classes. The School Governors Health Education Project aimed at raising awareness of health education issues among school governing bodies, which took on new responsibilities under the 1986 Education Act. This project developed training courses for governors to enable them to consider and formulate appropriate school policies on health.

Promoting Personal and Social Development

In the second category, several initiatives were aimed primarily at fostering personal and social development. The best of these were concerned with *empowering people* to take charge of themselves and their own lives. Specific techniques for encouraging such social skills have been evolving since the early 1970s, notably following the Developmental Group Work scheme of Button (1974), and the Active Tutorial Work programme of Baldwin and Wells (1979 onwards) which grew out of Button's work. The latest HEA project, Health Skills, extends this approach to a whole-school setting.

While some of the objectives of such programmes are not at present amenable to assessment, Box 2 illustrates the evaluation of some of the more

accessible features of developmental group work – for example, changes in self-confidence in a group setting, improvements in listening skills and general acceptability of the method for teachers and pupils. The research technique acknowledges that to be able to assess such changes, the evaluator must get to know the children over a period of time to observe their interaction with other children and with adults.

BOX 2 · ASSESSING DEVELOPMENTAL GROUP WORK

A study by Thacker in 1985 illustrates the use of *participant observation techniques* to assess the effect of a programme of developmental group work to encourage personal and social development.

In such programmes the group is not used merely as a forum for discussion. Students use the group setting to build up confidence and learn how to trust and help one another. Activities are carefully guided so that even the shyest member is helped to have a say without fear of ridicule. As a result, the method used is more important than the subject under discussion.

In the 1985 study, a programme of developmental group work in Devon was assessed by paired teams of teachers and educational psychologists, involving 200 children in four schools. Eight teachers were matched up with eight educational psychologists and trained in the appropriate methods. Then each pair team-taught a programme for six, one and a half hour sessions. Then the psychologist slipped into the observer role for a further five sessions, while the teacher continued with the programme.

Both teachers and psychologists kept notes and information sheets and the psychologist also interviewed participating children and compared feedback from all the different sources. The reactions of both teachers and pupils were assessed.

The evaluation concluded that 'without exception the teachers were enthusiastic about developmental group work'. Colleagues of the project teachers noticed a positive change in style – calmer, less forceful, more child-centred. 'In several instances children spontaneously reported that they got on better with the teacher in group work sessions'.

The project made an impact on nearly all the participating children, some more so than others. Observers noted that there was a general improvement in listening skills and children became more considerate and sensitive to one another's needs. The cohesiveness of the classes tended to develop as pupils became more confident. As one child put it: 'I'm not as shy as I used to be'.

The research technique had the advantage of being able to make a start at assessing changes in such factors as 'listening skills', 'self-confidence' and 'consideration for others', which are difficult, if not impossible, to assess by more quantitative methods. (Thacker, 1985)

An evaluation of Active Tutorial Work in 1982 by Bristol University found that the response to the project was overwhelmingly positive and noted an improvement in self-confidence of pupils, again through participant observation techniques (Bolam and Medlock, 1985). The way the project was disseminated and the training given to teachers by the project directors was judged to be highly effective:

> *'The National Directors have proved to be outstandingly successful and effective as disseminators and trainers. The Active Tutorial Work books and work of the National Directors are very familiar to and highly valued by the majority of local education authorities in England and Wales. . . . the strategy and methods are also exceptionally effective and are among the most sophisticated anywhere'* (Bolam and Medlock, 1985).

The dissemination and training phase of the project lasted from 1980-86 and, by the end of that period, 70 of the 104 local educational authorities in England and Wales had been involved in training. Forty four per cent of authorities went on to set up training teams of their own. A 1986 survey of Welsh secondary schools found that Active Tutorial Work was in use in 38 per cent of Welsh schools (Nutbeam *et al.*, 1987).

Group work of this nature is not without its problems. The approach needs trained teachers who feel confident in the methods and sufficient tutorial time set aside during the school day to allow for proper use of the techniques. In some schools without appropriate arrangements the programmes may be used in ineffectual, even counter-productive, ways and may lead to resentment among teachers and pupils.

Influencing Health Related Behaviour

In the third category, some projects have been more overtly concerned with influencing health-related behaviour and, with the application of improved techniques, some have shown that they can be effective. Reid and Massey, in a review of school programmes aimed at this particular goal, noted a complete transformation in the international literature – from little if any evidence of effectiveness of traditional school programmes in changing health factors before 1980 to abundant data by 1985 that well planned programmes can promote healthy behaviours in pupils (Reid and Massey, 1986). Most progress has been made in the fields of smoking control, dental health and, in a more general sense, on teenage pregnancy and exercise.

In Britain, the first school health education project to show a direct influence on children's *smoking behaviour* was the My Body project (Health Education Council, 1983). This was developed in Sheffield and Derbyshire schools and then disseminated nationally through the HEC. It was a programme for 10-12 year olds, taking approximately 40 hours to complete and focusing on body mechanisms, especially breathing and the effects of smoking. A study in Sheffield and Derbyshire with control and experimental groups reported significant increases, compared with controls, in boys' knowledge of the effects of smoking and a change in their attitude to smoking after they had participated in the project (Murray *et al.*, 1982). In a later study, the longer-term effects of the programme were assessed, comparing children in experimental and control groups two years after participation in the project.

It found that pupils in the control group ran twice the risk of experimenting with smoking than those in the project group. This held true for both boys and girls (Gillies and Wilcox, 1984). Effects of the project on parents' smoking habits have also been reported. Fifteen per cent of smoking households reported cutting down or stopping smoking because of their child's comments following the project (Wilcox and Gillies, 1978). A larger-scale study to test this effect found a much smaller but still positive influence on parental smoking. In addition, parents connected with the project children were more favourably inclined towards health education programmes in schools in general than the control group's parents (Wilcox *et al.*, 1981).

In relation to adolescents, several programmes have made notable achievements in deterring the onset of smoking by addressing the social pressures that teenagers often face and by highlighting the immediate rather than long-term effects of smoking. American studies have found that teenagers can be helped to develop and practice skills to resist these social pressures (for example Evans *et al.*, 1981; Arkin *et al.*, 1981; Perry *et al.*, 1980). These methods have now been adapted for use in British schools for example, in the Smoking and Me project (Health Education Authority, 1988a), and in a Scottish experiment (Ledwith and Osman, 1985),and these findings are now being actively disseminated to teachers.

In the field of *dental health education* the HEC Natural Nashers project is an example of a programme which has been carefully developed and researched. This was a scheme for 13-14 year-olds, taking three double lessons to complete. Originally developed in Cambridge schools, it has now been tested with control and experimental groups in schools all around the country and found to achieve gains in knowledge and favourable changes in attitude towards oral hygiene. Reduction in plaque scores has also been noted. The effects spread out to encompass parents, who gained information from children involved in the project (Craft *et al.*, 1984; Arnold and Doyle, 1984; Craft, Croucher and Blinkhorn, 1984). Cooperation between district health authorities and education authorities was also encouraged by this project. By 1985 almost 50 per cent of district health authorities had agreed to take part in the dissemination of the project, with district dental officers drawing together advisory groups from the two authorities to coordinate local efforts (Health Education Council, 1985).

While this programme is a good illustration of a thorough evaluation, it also illustrates the considerable costs involved in terms of time and resources to assess what amounted to a fairly modest intervention.

Impressive results in promoting participation in *exercise* have been achieved by the Linwood project in Scotland, which have implications for broader aspects of mental and social health. From 1983 a daily programme of physical education was undertaken in 16 classes of 10 and 11 year-olds in five primary schools in Linwood. Five hundred children were involved in total. The project consisted of 40 minutes a day, encouraging participation in a broad programme of individual, cooperative and competitive activities. In addition all opportunities were maximised to link the physical education to the classroom curriculum. Control groups, selected from matched schools, experienced 'normal' physical education twice a week. The children experiencing daily physical education showed a greater improvement in all physical fitness tests over the control group. Attendance at school also improved for the experimental group and a marked improvement in attitude to school, self-confidence and self-esteem was noted in some children who had not performed well in normal classroom activities. Furthermore, when their academic performance was measured, children in the experimental groups not only maintained their performance in reading comprehension scores but improved on some scores including, for example, computation skills, relative to controls (Pollatschek, 1985; Pollatschek, Renfrew and Queen, 1986). Outside school an increase in the use of community facilities by the experimental group children was noted. For example, there was an escalation of interest and enrolment by these children in courses run at the local sports centre and most parents also reported that their children were more physically active outside school (Pollatschek, 1988). The project's findings have influenced local education authority policy, with plans to extend the scheme into secondary schools in the district in 1989.

Evidence of the effectiveness of school health education in *reducing unintended teenage pregnancies* was presented in 1985. A major study by the Guttmacher Institute compared national policies and various statistics in 37 developed countries and made additional in-depth policy analyses of five of these countries. In particular, the study investigated the reasons for the high teenage pregnancy rates in the USA compared with the relatively low rates in Canada and certain European countries, including England and Wales.

Some of the common myths about the causes of high teenage pregnancy rates were exposed in the process. For instance, the study concluded that the high rates found in the USA were *not* due to higher sexual activity rates in American teenagers – the rates were about the same in all five countries studied in depth. Nor was it accounted for by higher abortion rates in countries with low birth rates. In fact the USA had the highest rate of abortion as well as the highest rate of teenage births. Neither did the high rate of pregnancy correlate with higher rates of deprivation or the free availability of welfare benefits (For example, Sweden with the most comprehensive welfare benefit system had the lowest rate of teenage pregnancy.) Most importantly for this discussion the high USA pregnancy rates were not caused by the provision of school sex education. On the contrary, it was the more widespread availability of sex education coupled with reasonable access to contraceptive advice and services in countries like England and Wales which were key factors helping to keep pregnancy rates lower than in the USA (Jones, *et al.*, 1985).

This conclusion is in agreement with previous studies which could find no evidence that the provision of sex education encouraged early sexual experimentation (for a review see Reid, 1982). Of course sex education should not be justified solely in

terms of reducing teenage pregnancy rates. It is more often justified on educational grounds, as a crucial part of young peoples' preparation for current relationships and adult life.

TEACHING DILEMMAS

Not all initiatives aimed at specific health topics have met with the same success. Education on some sensitive areas has posed certain dilemmas for the school system. *Drug education* is one prominent example. Box 3 describes the classic experiment of De Haes and Schuurman in the Netherlands in the mid-1970s to test out different approaches to school drug education – scare tactics, a factual approach and a personal relationship approach allowing pupils to talk about their own problems (De Haes and Schuurman, 1975).

An assessment after two weeks showed knowledge gains; one after six months recorded no long-term gains. It also highlighted the need to consider carefully the *negative* results as well as the positive. For example, there was an increase in wrong answers in the knowledge tests as well as an increase in the correct answers indicating a false sense of confidence in their drug knowledge by some pupils.

Since then there have been many other experiments on drug education, predominantly in the United States. Numerous reviews of the literature have been undertaken all reaching the same general conclusion: that the methods aimed specifically at preventing drug abuse have at best been ineffective and at worst been counter-productive (Swadi and Zeitlin, 1987; Berberian *et al.*, 1976; Randall and Wong, 1976; Kinder *et al.*, 1980; Schaps, 1981). The one positive finding to come out of the research is the potential in some personal and life-skills approaches for enhancing self-esteem and helping to resist peer-group pressure. Nevertheless the pressure continues for schools to 'do' drug education as though it can do nothing but good. Calls for education on *solvent abuse* and *oral tobacco* have raised similar concerns, especially if it serves to bring previously unknown behaviour to the attention of pupils and even demonstrates the techniques involved.

The conclusion they drew, which shaped subsequent local and national policy, was that *'substance orientated drug education programmes, either purely factual or using scare tactics, had a stimulating effect on drug experimentation'*. They recommended that this type of drug education programme should not be encouraged. Instead teacher training was recommended to promote the personal relationship approach, which showed some promise in fostering personal and social development. This study also illustrated that the 'success' of health education projects may depend upon the timing of the evaluation.

Similarly, little or no success has been achieved with methods aimed specifically at reducing *alcohol*

BOX 3· A TEACHING DILEMMA: DRUGS EDUCATION

No programme has yet had a beneficial long-term effect on preventing drug abuse, and some have been counterproductive. A classic experiment was carried out in the Netherlands in the mid-1970s to test different methods of approaching school drugs education. It highlighted several salient points which are still very relevant today (De Haes and Schuurman, 1975).

The study involved 1035 pupils from 50 classes in 20 schools all aged between 14-16.

Group 1 – controls – received no drug education.
Group 2 – 'Warning approach' – received drug education employing scare tactics.
Group 3 – 'Information approach' – received factual information only on drugs.
Group 4 – 'person oriented approach' – received a discussion-based programme concentrating on pupils lives and their own problems.

Results

a) Did pupils *stop* using drugs as a result of any of the approaches? No, the number of users (nearly all cannabis users) remained stable at between 3-4 per cent.

b) Did any of the approaches reduce the number of pupils starting to use drugs? No, but the warning and information approach appeared to increase experimentation (see Table 1).

TABLE 1

GROUP	Percentage of non-users who started to try drugs after exposure to the programme.
1 Control	3.6 per cent
2 Warning	7.3 per cent
3 Info.	4.6 per cent
4 Personal	2.6 per cent

c) Did any of the approaches increase knowledge about drugs? Yes, but only in the short term. Both the 'warning' and 'information' groups gave a greater number of correct answers after two weeks, but this returned to the original level after six months. Furthermore, the same pattern emerged for *wrong* answers – an initial increase in wrong answers in Group 2 and 3 and a decrease after six months. After these programmes pupils who had originally answered 'don't know' *thought* they knew the right answers but this was false confidence in some cases.

d) Did the programmes change attitudes? Complex results were obtained on this point, generally attitudes changed in line with the original purpose of each programme. Group 4 – the 'personal' approach had positive effects on teacher-pupil relationships.

consumption (Bagnall and Plant, 1988). Most of the ineffectual methods have had one thing in common: they have tended to concentrate on the substance abused rather than the problems of the person or the social context in which abuse takes place.

The latest calls for education about "AIDS" raises different dilemmas, for example, how to educate about AIDS without creating a generation of children who are afraid of sex and equate it with death – a worry recently expressed by the International Planned Parenthood Federation (British Medical Journal, 1988).

These dilemmas also serve to highlight the impracticality of schools tackling more topics one after another in response to each new crisis in society. Further dilemmas for teachers and policy-makers can be seen in some of the wider policy conflicts considered below.

POLICY CONFLICTS

New policy pressures are currently threatening some of the promising beginnings. Table 2 summarises six major areas of conflict. The first has already been mentioned: the fundamental conflict between an approach which tackles a series of separate health problems and one which attempts to place health in a planned educational framework. The approach chosen will affect what is taught, how it is taught and where it appears in the curriculum.

Policies on the second issue are in a state of flux. Since 1979 there has been strong support from HMI for personal and social education to be part of the curriculum, and since 1981 for health education to be considered an 'essential' component. However, when the proposals for a National Curriculum were published in 1987, health education was not specified as one of the 'core' subjects. It was given a single paragraph, equating it mainly with biology:

> *'In addition there are a number of subjects or themes such as health education and use of information technology, which can be taught through other subjects. For example, biology can contribute to learning about health education, and the health theme will give an added dimension to teaching about biology. It is proposed that such subjects or themes should be taught through the foundation subjects, so that they can be accomodated within the curriculum but without crowding out the essential subjects'* (Department of Education and Science, 1987a).

Personal and social education received no official recognition whatsoever. Many organisations put in strong objections to this state of affairs; under this pressure a working party was set up as a subcommittee of the National Curriculum Council to consider the issue. This made recommendations to the Council in July 1989, and advice to schools is due in the autumn.

But why was there such concern? Apart from the fact that the document seemed to have a very narrow view of what education for health was about (returning the subject to the stage it was 20 years ago) there were more pragmatic concerns. Firstly there were fears that any subject not given a specified allocation in the National Curriculum would be dropped by many schools hard-pressed to meet their statutory demands — a task which has been likened to fitting a quart into a pint pot. Secondly, there was the additional disadvantage of education for health being a non-examination subject when the emphasis in the National Curriculum proposals was on academic subjects and frequent testing. The realities of school life would mean that any non-examination subject would be accorded low status and receive low priority for timetabling and resources. All these factors would work against the advances made in recent years.

The third conflict surrounds the issue of sex education which now, more than ever, appears to be a 'hot potato' in policy terms. In 1986, two apparently contradictory policy stands were taken by the DES. The HMI report, *Health Education from 5 to 16*, showed a firm commitment to sex education in every school and stated:

> *'the importance of sexual relationships in all our lives is such that sex education is a crucial part of preparing children for their lives now and in the future as adults and parents'* (Department of Education and Science, 1986a).

But in the same year the Education (No 2) Act gave governors of individual schools the power to decide whether there should be any sex education at all in their schools and if so what form it should take (Department of Education and Science, 1986b). Furthermore, no specific provision was made for sex education in the National Curriculum proposals. A 1987 DES circular did recommend that whatever the overall policy on sex education adopted by a governing body, the governors should at least give attention to forms of sexual behaviour which carry a risk of infection with HIV and about ways in which risks may be avoided or lessened (Department of Education and Science, 1987b).

These latter developments seem to imply a lack of the former commitment to sex education and seem to suggest that it would be acceptable (if indeed possible) to teach about AIDS in isolation, without covering any of the more positive aspects of normal growth and development and sexual relationships.

Fourthly, official reports have been encouraging more exploration of and sensitivity to pupils' own feelings about themselves and about personal relationships. It was stressed that they should be acquainted with a range of sexual values prevalent in society. HMIs have advised that discussion on sensitive issues, such as contraception, abortion and homosexuality, should not be avoided: *'the discussion of these issues should be objective and attempt to explore all sides of the argument honestly'* (Department of Education and Science, 1986a). Contraception has been a topic in the syllabi of several examination boards since at least 1981.

On the other hand, in 1986 and 1987 restrictions were placed on how 'objective' and 'honest' teachers could be in exploring all sides of the argument. For example, the DES advised teachers that specific advice to girls under 16 on contraception without parental consent could constitute a criminal offence

(Department of Education and Science, 1987b). By 1988, contraception had been removed from all examination syllabi. Discussion of homosexuality was restricted and *'moral considerations and the value of family life'* were to be promoted (Department of Education and Science, 1986b). Whose morality was to be promoted was not made clear. Nor was it clear how teachers were to adhere to these restrictions while at the same time being sensitive to the feelings of individual pupils, an increasing number of whom would not have traditional family backgrounds.

There is also dispute about the timing of sex education, with national agencies such as the Health Education Authority and the Family Planning Association advising an early introduction to sex education, including a discussion of contraception and AIDS, to prepare pupils before they become sexually active — that is, by the time the pupils are 12-14 years of age. However the DES advised that AIDS education should be left until the later years of secondary education.

This particular area of conflict came to a head in 1988 over the publication of a joint HEA/AIDS pack for *teachers* (not pupils). This was intended for use in a flexible way so that teachers could match the style and content of the education to the level of maturity of their pupils. The teaching pack, prepared by the HEA, did not meet with the approval of the DES because it advocated AIDS education for 12-13-year olds, because some of the group work it suggested was too open-ended and because the moral messages in it were not strong enough. As a result, 10,000 copies of the pack were subsequently shredded. Revised copies are, however, available and proving popular.

The cumulative effect of the various contradictory policies on sexual matters has been to produce a climate of doubt and uncertainty for schools. The whole area is now a minefield for teachers worried about what can and cannot be discussed within the bounds of the law.

Given these uncertainties, there must be a temptation to avoid any problems by not covering any of these issues at all. However, there are encouraging signs that many agencies are continuing to take seriously their responsibilities concerning sex education. Most local education authorities are now drawing up policies and guidelines on sex education to assist schools within their districts, and bodies like the Family Planning Association have been flooded with requests from schools for training in relation to the new responsibilities of governors on sex education policy. The FPA book on the subject has become a bestseller for the Association.

The fifth issue concerns inservice training for teachers. There are currently many changes being introduced into the school system over a short period of time, all requiring curriculum development and inservice training. These include course development work and assessment for GCSE, for the Technical and Vocational Education Initiative (now called TVE), for the Certificate of Pre-Vocational Education, for the National Curriculum changes, for records of achievement and the introduction of 'balanced science' courses. These are currently taking up much of the time and energy of practising teachers and some schools are reaching saturation point with regards to inservice training. For the sake of their pupils they cannot afford to take teachers away from their classroom duties for yet more training. But many of the health education initiatives developed in schools have relied for their success on the commitment of teachers in trial schools and on adequate inservice training. In

TABLE 2 · POLICY CONFLICTS IN THE SCHOOL SYSTEM

1a. Policies encouraging broadly based health education programmes encompassing *positive* concepts of mental and social health.	1b. 1985 onwards, direct government pressure for 'crisis' education in schools on separate health problems – preventive medicine model.
2a. DES and other policies encouraging development of health education and personal and social education as *essential* parts of the curriculum.	2b. No place for these in the National Curriculum.
3a. Broadening of concept of sex education and growing practice of incorporating it into wider health and personal education programme. Recongnised as 'crucial'.	3b. Individual school governors given responsibility to decide if *any* sex education to be included in the curriculum and, if so, what and how.
4a. HMI encourage more exploration of sensitive issues about homosexuality, contraception and abortion. Contraception in examination syllabi.	4b. Teachers advised not to give contraceptive advice to girls under 16. Contraception removed from exam syllabi in 1988. Restictions on discussion of homosexuality, moral codes, family life.
5a. Inservice training for health education encouraged.	5b. Teachers overloaded with training for other innovations.
6a. Schools increase health education input in formal curriculum.	6b. Messages conveyed by school environment and ethos contradict health messages received through curriculum.

the present climate there is a danger that the uptake of this training will slump and the cause of education for health will be set back considerably.

The sixth area of conflict is concerned with the concept of the health promoting school. Many schools are still not arranged in ways which would promote the health and well-being of pupils and staff. While there has been an increase in the time given to health matters in the formal curriculum, messages about health conveyed in these lessons are not being reinforced and are more often contradicted by the school ethos and policies.

For example, schools rarely have coherent policies on non-smoking which apply to pupils and teachers (Newcombe, 1985; Charlton, 1985). There is an uncoordinated approach to nutrition, with high fat, high salt, high sugar foods on sale in school tuckshops and canteens, even in schools carefully following National Advisory Council on Nutrition Education guidelines in lessons. Also, schools sometimes do not enlist the support of parents and the wider community to reinforce school health education despite mounting evidence of the influence of a variety of social factors on the adoption of a healthy lifestyle.

PRIORITIES FOR ACTION

The previous pages have detailed some of the most promising trends in education for health in schools, but have also identified certain dilemmas and conflicts of policy. Further progress in the school sector will hinge on resolving some of the more immediate policy conflicts, and then finding ways of promoting further developments in this field on a long-term basis. This requires action at national, regional and local levels.

Central government

Some of the most pressing problems can only be resolved by central government actions. Three immediate and three longer-term issues have been identified as priorities.

A place in the whole curriculum for all pupils

The survival of health education and personal and social education in the school curriculum depends on the quality of advice issued by the National Curriculum Council. The consensus view among health educators is that although schools with a strong commitment to education for health may continue to find room for work in this area many others, with less commitment, will drastically reduce or drop the subject altogether. Recommended policy includes firm advice from the NCC to all schools:

- that personal, social and health education are essential components of the whole curriculum for all pupils;
- that a specified percentage of the curriculum should be given to work in these areas, with access to every pupil;
- that the proper developmental process should be taken into consideration with a planned spiral curriculum throughout the child's school career.

At the time of writing, such amendments are being considered and the outcome is awaited with great interest because this more than anything else will influence future trends in the school sector.

Coherent sex education policy

At present there is no coherent policy covering sex education at a national level. Instead there is much confusion at a time when more demands than ever are being made on the school system in this area. An immediate task is for central government to address the confusion and provide a firm lead on the issues, with a national policy which would:

- emphasise the status of the subject by incorporating it into the National Curriculum as an essential part of a wider programme of personal and social education;
- provide unambiguous guidance to school governing bodies and local education authorities on their responsibilities for sex education, emphasising the unacceptability of providing piecemeal programmes on AIDS education without a broader introduction to sex education;
- provide clear and consistent guidance to schools and teachers on the hitherto ambiguous statements about *'moral considerations and the value of family life'* and the legal pitfalls concerning issues of homosexuality and contraception.

Monitoring

Careful monitoring of the situation in schools needs to take place concerning the effects of the National Curriculum and other major interventions in the Education Reform Act on education for health. This monitoring needs to start now, before the reforms get under way, and any adverse effects on the provision of education for health can then be picked up quickly and corrected.

Inservice Training

Inservice training for teachers has been the key to successful implementation of school policies on education for health in the curriculum. Central funding for key courses (in Scotland, for example) has proved highly effective in stimulating change.

Now the possible overload in the system needs to be tackled and central funding for further health education training may ease the situation considerably.

Long-term planning

In the longer term there needs to be a move away from 'crisis management' in education for health at all levels. At central government level this means limiting the pressure put on the school system by various government departments for instant progress on topical problems.

A long-term plan is needed for the ordered development of education for health in schools, with an understanding of the concept of the health promoting school illustrated in Table 3. In planning, notice should be taken of the evidence on effectiveness of different methods and approaches.

Part of a wider strategy

There needs to be recognition at central government level that schools are only one component of a wider strategy to promote the health of young people. Policies of different departments need to be coordinated across the board so that, for example, government actions concerning young people and the mass media are consistent with the thrust of education for health in schools. This is a point to which the paper returns later in the discussion on community education.

National health education agencies

The national agencies with responsibility for promotion of education for health have played central roles in the past and have equally important roles in the future. These include the four main health service agencies – the Scottish Health Education Group (SHEG), the Health Education Authority in England, the Health Promotion Authority for Wales and the equivalent arrangements in Northern Ireland. They also include key agencies from the voluntary sector, such as the Family Planning Association, the Brook Advisory Centre and Action on Smoking and Health. Four areas have been singled out in this context:

Curriculum development and dissemination

By continuing to fund carefully selected curriculum development projects and their dissemination in schools, the national health education agencies can have a major influence on future policy. For the ten years before its demise, the former Health Education

TABLE 3 · THE HEALTH PROMOTING SCHOOL MODEL: 10 KEY POINTS FOR SCHOOL MANAGEMENT

MOVING FROM TRADITIONAL SCHOOL HEALTH EDUCATION TOWARDS THE HEALTH PROMOTING SCHOOL

	Traditional health education	The health promoting school
1.	considers health education only in limited classroom terms;	takes a wider view including all aspects of the life of the school and its relationship with the community – for example, developing the school as a caring community;
2.	emphasises personal hygiene and physical health to the exclusion of wider aspects of health;	is based on a model of health which includes the interaction of the physical, mental and social aspects;
3.	concentrates on health instructions and acquisition of facts;	focuses on active pupil participation with a wide range of methods developing pupil skills;
4.	lacks a coherent, coordinated approach which takes account of other influences on pupils;	recognises the wider range of influences on pupil's health and attempts to take account of pupils pre-existing beliefs, values and attitudes;
5.	tends to respond to series of perceived problems or crises on a one-off basis;	recognises many underlying skills and processes are common to all health issues and that these should be pre-planned as part of the curriculum;
6.	takes limited account of psychological factors in relation to health behaviour;	views the development of a positive self-image and individuals taking increasing control of their lives as central to promotion of good health;
7.	recognises the importance of the school and its environment only to a limited extent;	recognises importance of the physical environment of the school in terms of aesthetics and also direct psychological effects on pupils and staff;
8.	does not actively consider the health and well-being of staff in the school;	views health promotion in the school as relevant to staff well-being; recognises the exemplar role of staff;
9.	does not actively involve parents in development of a health education programme;	considers parental support and cooperation as central to the health promoting school;
10.	views the role of school health services purely in terms of health screening and disease prevention.	takes a wider view of the school health services which includes screening and disease prevention but also attempts to actively integrate services within the health education curriculum and helps pupils to become more aware as consumers of health services.

Source: Scottish Health Education Group/Scottish Consultative Council on the Curriculum (1989) SHEG Copyright reserved.

Council spent 20-30 per cent of its budget on national curriculum development in health education, and indeed was recognised as the major funder of such projects in schools. As such it was a key catalyst for change in the system. Several commentators believe that the promotional work in schools was the HEC's most significant achievement.

Now that all four national agencies are part of the NHS, it is important that work in schools is still counted as a priority. There is some concern that it may be more difficult for a health service agency to secure funding for school-based developments and the necessary long-term commitments, including the funding of substantial dissemination phases, may not be forthcoming.

Priorities would include:

- recognition of the importance of continued funding of curriculum development in schools;
- recognition of the long-term nature of the support required and the need for a dissemination phase to be built into each project at the beginning, together with adequate funding for these developments.

Training and staff development

In order for the curriculum development material to be used successfully, teachers require regular and structured inservice training as well as staff development programmes for themselves. As Reid and Massey point out, teachers may not view changes in health-related behaviour as acceptable goals for education. They may also experience conflicts concerning their own health behaviour, or be under a great deal of stress, all of which needs to be resolved before they can consider education for health with their pupils (Reid and Massey, 1986).

There is a requirement for the national agencies to promote:

- inservice training for teachers and associated policy makers;
- personal development for staff;
- more dissemination of information on the most effective methods and strategies in education for health.

Policy analysis

There are many possible inputs for the national agencies in the development of the health promoting school model outlined in Table 3. In particular, school and local education authority policy analyses are required to find out what is happening on the policy front, and what changes are taking place.

The Welsh Health Promotion Authority, through the Heartbeat Wales project, has been carrying out regular surveys of school policy to find out what curriculum development is taking place in Welsh schools, how health education is organised, what policies there are in the school environment, and the extent of family and community links (Nutbeam *et al.*, 1987).

This kind of analysis needs to be extended to other parts of the UK on a regular basis. The national health education agencies are well placed to carry them out, and to give support and guidance on policy change.

Specialist national bodies, such as the Family Planning Association, also have a key role in helping policy formulation in their fields (Massey, 1988).

Evaluation and research

There have been several recent calls for more evaluation of health education initiatives in Britain (Williams, 1986a; Tones *et al.*, 1989) and the national agencies are in an excellent position to coordinate this effort. The suggestions coming forward from the literature include:

- helping teachers to evaluate and assess the gains they make with their pupils in terms of knowledge, attitudes, behaviour and decision-making skills;
- short-term and longitudinal studies of the effects of health education on pupils, teachers and schools in general;
- more process evaluation to identify which components of particular initiatives were the critical ones in bringing about significant policy change/attitude change and so on.

There is also a major role for the agencies in disseminating research findings on the positive and negative effects of health education programmes so that subsequent programmes do not keep on 'reinventing the wheel'. The need is for two-way dissemination – to central government on the one hand and to practitioners in the field on the other.

Local education and health authorities/ schools

Local education authorities already give major support to health education in schools, through the provision of advice and inservice training for staff. District health authorities through the enthusiastic work of many health education officers also provide much needed support advice and training. In some areas even closer cooperation has been achieved: for example, in Devon a joint health and local education authority appointment has been made of a secondary school adviser for health education. Exeter Health Authority provides the salary and expenses; Devon Education Authority provides access to schools, resources and funding for inservice training or workshops organised by the adviser. This kind of 'pump-priming' has meant that training for teachers in active learning methods has been introduced and support given to schools on how to coordinate health education across the curriculum (Lear and Plant, 1986).

Priorities for future action would include:

- further joint initiatives and closer links in general between local education and health authorities, including the promotion of home-school links via health visitors and primary care teams;
- continued provision of inservice training for teachers, for LEA staff and for school governors;
- the formulation of LEA policy on education for health and guidelines to help schools within the authority;
- monitoring by the LEA of school health education policy changes;

- the formulation of district health authority policy which promotes liaison between health education departments and the education service. In this respect it has been suggested that health education departments charge for support and training services, but this is thought to be a retrograde step and one to be avoided. If charges discouraged schools and advisers from seeking help, then the strategy would also reduce the opportunities open to health education departments to influence and guide schools' policy;
- the expansion of the role of school health services to actively promote the health of children, in addition to their present screening and preventive work;
- the appointment by every school of health education coordinators at a senior management level and the assessment by schools of their health promoting role.

3 OUT IN THE COMMUNITY: PLENTY OF RHETORIC BUT WHAT ABOUT THE SUBSTANCE?

There has certainly been an increase in numerical terms in activity concerned with education for health in the community at large. But as far as *quality* is concerned there has been very mixed progress. Policy, particularly in the mass media field has been pulling in different directions in recent years, and some of the biggest conflicts relate to this area. This section looks at attempts to reach out to the general population through three main methods, with a consideration of the different contexts in which they take place: initiatives within the mass media; the personal and small group methods in health care settings; and community development techniques in local neighbourhood settings. This is followed by a discussion of options for the future. First of all, though, some general trends should be considered.

TRENDS IN THE COMMUNITY

In this context five clear trends can be discerned over the decade:

1. Increased mass media health advertising
There has been a distinct increase in the use of mass media advertising on health issues, especially since 1985. The total amount spent in health advertising by all official sources has increased from £1.6 million in 1979/80 to £11.4 million in 1988/89 (House of Commons, 1989a).

Greater use has also been made of other public relations strategies, including an increase in sports sponsorship in health education as a response to the growth in the commercial sector activities (Hastings *et al.*, 1988a).

Related to the first trend, 1985 was a turning point in government policy on health advertising. Dating from 1985 and the heroin campaigns, the Department of Health began to take much more direct control over health education, dictating which topics should be chosen as priorities and the methods and approaches to be employed. This led in some cases to direct government campaigns through the Central Office of Information rather than ones planned and controlled by the national health education bodies. The marked increase in funding for mass media work stems from that date. It should, however, be viewed in perspective: £11 million is still very modest in media campaign terms bearing in mind that it covered a wide range of complex health issues from coronary heart disease and smoking to drugs and AIDS. In comparison, commercial organisations only concerned with single topics spend that amount and more in a matter of weeks. The alcohol industry, for example, spends around £200 million a year promoting its products. The government itself has allocated considerably more than £11 million to short bursts of mass media activity on non-health issues: for example £40 million on marketing costs for the sell-off of British Gas in Autumn 1986 and £23 million for similar promotional activities concerned with the British Petroleum sell-off in November 1987 (National Audit Office, 1987).

2. Increased editorial coverage
There has been a parallel increase in attention given to health topics by the mass media in general measured by coverage in the press and the proliferation of television and radio documentary series on health-related issues. For instance, a content anaylsis of seven UK newspapers in 1981 found 1,397 articles on health over a period of just two months (Kristiansen and Harding, 1988). A 1985 study of Scottish and UK newspapers found 1,197 health related articles in the month of July alone (Currie, 1987).

On television, the 1980s saw the beginnings of several series on all four channels of a direct educational nature, backed up with health education booklets for viewers. For example, the 1982 six-part series on BBC TV, on 'So You Want to Stop Smoking', the 1983 Radio 4 series, Action Makes the Heart Grow Stronger, Food for Thought and the ten-part TV series Play it Safe in 1984, all had thousands of requests for the back-up materials provided. Perhaps the peak of media interest was achieved at the end of February 1987, when there was a week of television and radio coverage on AIDS devised by the television authorities. Fourteen programme titles were shown on television (some single items, some three or four-part items), and by agreement among the television companies no AIDS programmes were shown at overlapping times (Wober, 1988). This type of cooperation and the resultant blanket coverage was unprecedented on British television in relation to any issue, not just health.

Health issues have also been deliberately written into the scripts of soap operas – a new departure for the broadcast media in the 1980s. Examples include Central Television's Crossroads (attitudes to mental handicap), Grange Hill (drug misuse) and Radio Scotland's daily serial Kilbrek (various issues including inequalities in health). The combined effect of all this mass media activity is considered in the pages which follow.

3. Expanding community health movement
Far removed from the national mass media scene are the activities taking place at the 'grass-roots' in local communities, but here too there has been a dramatic growth in interest in health issues. A database set up to provide an information network recorded 10,000 community health groups in 1984 (Klein, 1984), mostly very small self-help and other supportive activities. Only a handful of these initiatives were sufficiently well-established in the early 1980s to employ paid community workers, whereas now there are approximately 40 independent community health projects around the country with paid workers, all based on community development principles (National Community Health Resource, 1987). There is also a growing number of health and local authority initiatives in this field.

4. Growth of adult education courses on health
Growth in the provision of health related courses for adults is another noticeable trend in the community.

For example, the number of basic ten-week Look After Yourself courses had grown from less than 200 in 1981 to over 3,000 by 1986, involving around 100,000 people in a variety of settings from adult education and health centres to workplaces. In particular the Look After Yourself courses in the workplace have shown a dramatic increase from nil in the 1970s to 1,500 courses per year in 400 companies by 1986 (Crew, 1986; Daines *et al.*, 1986).

Open University community education courses have expanded in the health field since the mid-1970s. For example, a ten-year development programme starting in 1976 produced ten health-related courses each averaging 40-50 hours of study as well as other learning material designed to appeal to the lay-person. Over a quarter of a million people participated in the courses or associated activities generated by them. This included over 83,000 students registered formally for the courses of whom 30,000 were disadvantaged and therefore sponsored under a HEC/SHEG scheme. As a result of the success of these developments, health and parentcraft eduaction have a prominent place in the Open University's plans for the future (Open University, 1986).

5. Expansion of statutory services
Specialist statutory services concerned with health education have grown up in response to the increased need for action at the local level. For example, health authorities employed approximately 200 health education officers ten years ago; now there are 1,000 in post (French and Hayton, 1989). There has also been a reawakening of interest in the role local authorities can play in public health policies. Increasing numbers have been establishing health units, often closely linked to environmental health departments, and several have taken on the principles of the WHO Healthy Cities project. Most recently there has been a growth in specialist services in health and local authorities concerned with drug abuse and AIDS in the community, some of which have encompassed prevention and health education (Hogg, 1988; Health Education Authority, 1987). Whether this response is adequate for the scale of the work required at local level is discussed in greater detail later.

MASS MEDIA: PLAYING WITH FIRE?

Developments in the mass media over the past decade have been rapid but not always coordinated or even capable of being brought under control. There has been a complex set of factors at work including:

- official health advertising by government and national health education bodies;
- commercial advertising and sponsorship promoting products potentially damaging to health;
- editorial coverage of health matters on television, radio and press intended to be informative or educational;
- editorial coverage of health matters mainly for their sensational or entertainment value;
- the deliberate introduction of health themes into drama and fiction for educational purposes;
- the unintended promotion of unhealthy lifestyles through similar drama and 'soap-opera' channels.

All these factors have interacted in often unpredictable ways and, to complicate matters, even some of the initiatives intended to promote health have had negative side effects.

This is the background against which the planning of education for health has had to operate in the 1980s. Furthermore, fundamental problems have arisen concerning the strategies and approaches to be used in planned mass media activities, as discussed below.

Mass media dilemmas for health educators

What has happened in relation to the mass media over the decade has to be understood in the light of the dilemmas faced by health educators in this field. First there is the question of what can reasonably be expected of these channels of communication. Over the years certain useful lessons have been learnt from research and direct experience about using mass media for education concerning health (Pasick and Wallack, 1989). In brief, raising awareness and transferring simple information is relatively easy to achieve (given adequate resources), conveying complex ideas and changing attitudes is extremely difficult, and changing anything other than simple one-off behaviour is exceptional. The more subtle findings have been summarised recently by Tones and colleagues as follows:

> *Mass media will not normally be able to achieve certain health goals:*
>
> *i) it will not convey complex messages and create understanding of often complicated issues related to health and disease;*
>
> *ii) it will nto readily teach complex motor or social interaction skills — such as the capacity to deal assertively with interpersonal pressures;*
>
> *iii) it will not produce attitude change in resistants, nor will it provide the support necessary for motivated individuals who wish to change their behaviour in adverse physical and social circumstances.*
>
> *On the other hand mass media will deliver simple messages and, where people are already motivated, this may trigger often dramatic changes in behaviour . . . this means that mass media can be stunningly successful in its agenda-setting function'.* (Tones *et al.*, 1989).

Agenda-setting in this context means raising awareness of an issue and getting people to talk about it. Unfortunately, by the same token, an *inappropriate* agenda can be set and this is where health educators risk playing with fire.

Clearly mass media strategies have their place, but they also have their limitations. Yet certain sections of society, including some politicians and policy-makers, have called for mass media campaigns to address some of the most difficult health education tasks outlined in

i-iii above concerning, for example, the prevention of drug abuse and halting the spread of AIDS, where changes in deep seated attitudes or behaviour may be called for and skills required to resist a variety of social pressures. The first policy dilemma in such circumstances is whether to use mass media at all, and if so how much emphasis to put on such work compared to other options, given the pressure to be seen to be doing something about an issue.

Secondly, a whole series of dilemmas has arisen concerning the strategies to be used in mass media work, in particular in the use of fear and highly negative, authoritarian images. Politicians, journalists and the public in successive surveys have called for hard-hitting, frightening images to be used in drugs and AIDS education. Yet the health education literature has shown repeatedly that the use of fear is a double-edged sword. In very specific circumstances fear has motivated people to change their behaviour (for example, in situations where the solution to the problem is simple and involves a one-off action, like buying a smoke detector). For more complex problems where there is no easy remedy and the behaviour to be changed is deep seated and habitual, any change induced by fear tends to be short-lived. Furthermore, if people are frightened too much or are put into a state of undue anxiety, they tend to respond in a defensive way. For example they may:

- misinterpret or distort the message to make it less threatening;
- shut the message out completely, avoiding it rather than dealing with the problem;
- or, when unavoidable, rationalise and then dismiss it by saying, for example, "it won't happen to me".

There is also the danger of panic inducing prejudice and discrimination against high-risk groups who may be portrayed as the cause of the problem. Such reactions defeat the whole purpose of the education (Leathar, 1981; Bandy and President, 1983; Tripp and Davenport, 1989).

Also, using highly negative 'don't do this, don't do that' messages, even without the use of fear, has been found to be counter-productive, evoking similar defensive reactions.

Clear illustrations of these defensive reactions to fear appeals and other negative images have been found during the work of the Advertising Research Unit, Strathclyde University in ten years of testing health education materials (Hastings and Leathar, 1986). One classic example concerned an anti-smoking press advertisement set in a graveyard. It was seen by all the non-smokers as intended but misinterpreted by smokers in a variety of ingenious ways, some even taking it to be promoting cigarettes (Leathar, 1981). Even with changes so that smokers could not misinterpret the meaning it was never entirely satisfactory from the target audience's point of view because the message was still too threatening for the smokers to accept. Interestingly this particular advertisement went on to receive wide aclaim from the advertising industry and won a Designers and Art Directors Award. (It also had the effect of annoying the tobacco industry which tried to have it banned).

An added problem of using high-profile scare tactics has been in relation to young people. If the techniques serve to bring rare or novel behaviours to their attention and in so doing glamourise them, then curiosity may be stimulated and more may be pushed in the direction of the habit. This effect has already been noted in relation to school drugs education programmes on page 16 and has also caused concern in connection with solvent abuse and oral tobacco.

This tension between what is known about the potential for education through the mass media and what is demanded of these channels have grown in recent years, leading to confused policy-making in this field.

Nowhere are the contradictions more apparent than in the field of drugs and AIDS education: the only really major mass media campaigns in terms of resources to have been undertaken in the last decade. Because these particular subjects make good news stories and lend themselves to sensationalism, the risk of the media setting an inappropriate agenda is very high. To illustrate some of the conflicts and constraints encountered in education for health in the mass media setting, these two topics are used as detailed case studies below, followed by an example concerning tobacco which illustrates action on media policy.

Case Study 1: Illegal drugs and the mass media

The subject of drugs and young people has been gaining in prominence in the mass media since the mid-1980s. For example, articles on drug misuse in the press in 1985 amounted to 12 per cent of all health-related articles, compared to 5 per cent in 1981 (Currie, 1987). Many of the press stories were of a sensational nature, running the risk of glamorising drug use to the young and perpetuating myths about heroin and hard drugs which were unhelpful from a health education point of view. Pearson has detailed four false impressions about the use of heroin which mass media stories tend to reinforce:

a) the idea of the typical 'pusher' being an evil stranger, when usually the first offers of drugs come from friends;
b) the idea that heroin is only a burden leading to enslavement, thus failing to tackle the attractions of the drug and the need for positive alternatives;
c) the myth that coming off heroin is always a very painful experience, when it can be relatively easy;
d) the myth that heroin is instantly addictive. This would be unhelpful if it led to a 'self-fulfilling prophecy', or if it discredited all health education advice among people who had discovered that this idea was false (Pearson *et al.*, 1985).

In 1984, the government's own Advisory Council on the Misuse of Drugs became concerned about the inappropriate presentation of information about drugs in the media and recommended that work should be undertaken at policy level with programme-makers to avoid these unhelpful media images.

The Advisory Council also warned against the damage that ill-chosen drug education programmes could do by inadvertently encouraging abuse:

> *'Drug education should not concentrate solely on factual information about drug misuse, even less present such information in a way that is intended to shock or scare – national campaigns aimed specifically at reducing the incidence of drug misuse should not be attempted'* (Home Office, 1984).

At the same time research in different parts of the country illustrated the highly scattered and localised nature of heroin misuse, local differences in style of use and great variation in service response. Therefore, even from a practical point of view, researchers advised that it would be difficult for a nationally devised campaign to respond to these wide variations (Pearson *et al.*, 1985).

However, against prevailing advice and the refusal of the HEC to take any part in it the Department of Health and Social Security chose to launch a national campaign through the Central Office of Information specifically against heroin abuse in May 1985 in England and Wales. It employed the popular stereotype of the heroin addict, showing the progressive physical decline. This was based on concept tests among young people and parents which showed that they thought frightening images were a good idea for putting other young people off drugs (Irving, 1985a and b).

The £2 million campaign featured television, cinema and radio commercials as well as advertising in youth press and posters and was certainly widely noticed. The campaign was monitored just as it began and at intervals afterwards and was found to have acheived high levels of awareness among young people, ranging from 80-94 per cent depending on the measure used (Research Bureau Ltd, 1986). An increase in the number of people having anti-heroin attitudes and beliefs was also claimed, with 93 per cent saying they would not try heroin or cocaine after the campaign compared to 83 per cent at the start.

The interpretation of findings on attitude change have been questioned, because the samples at stage 2 and 3 of the evaluation seemed to be much more cautious than the stage 1 sample in many aspects of life, not just in relation to heroin; this suggests that there might have been a sampling defect (Tones, 1986; Marsh, 1986). Whether there was a chance variation in the sampling or not, the evaluation was not able to answer the key question of whether the campaign was helping or hindering efforts to reduce drug misuse. (Having a negative attitude to heroin does not predict subsequent behaviour on drugs.)

However, by 1986 qualitative research, commissioned by the DHSS to test materials for the second stage of the campaign was raising these kinds of questions. Like the original concept test in 1985, this study found consistent calls from young people for the more unpleasant aspect of heroin addiction to be advertised, but the deeper attitudes and responses from the young people most at risk of drug abuse led the researchers to question the whole basis of the campaign. The researchers advised the government:

> *'. . . the campaign appears to us to be fundamentaly misconceived. The response suggests overwhelmingly that mass media advertising (particularly government sponsored) can have little role in the prevention of heroin addiction'* (Market Research Services, 1986).

Three possible side effects of the campaign – drawing individuals to heroin, reducing their sense of danger of other drugs, effects of advertising on drug addicts – were also raised and it was recommended that they should be researched in some depth.

The advice was not heeded because the campaign went ahead in 1986 and 1987 at a cost of £2 million annually using increasingly 'shocking' imagery of needles going into arms, and so on. The 1987 campaign linked drug injecting with AIDS, the message being that becoming involved with drugs could be the start of a process of decline which could ultimately lead to injecting and the risk of AIDS (Home Office, 1988). The proposed material underwent an independent concept test in Scotland. Again the young people liked the advertisements because they showed shocking scenes. A common reaction was: 'the advertisement will get *them* scared and stop *them* from sharing needles'. However, on further discussion it became apparent that all the respondents were strongly against drugs and found the idea of injecting repulsive. The scenes in the advertisements were therefore so remote from their own lives that they did not even consider that the advertising was trying to get a message across to them, personally. They certainly did not feel that a shock approach would work in relation to any of the risky behaviour they themselves engaged in – whether in terms of sex, smoking or soft drugs. The research concluded:

> *'In short, it is apparent that "shock" approaches work for "others" but not for "me"'* (Eadie and Hastings, 1987).

The material had two further drawbacks. Firstly, the linking of the drugs and AIDS messages was confusing. Secondly, it became clear that some of the respondents were learning new facts from the advertising about how to abuse drugs. For example, few knew that heroin could be smoked before seeing these advertisements. Others were intrigued with the techniques and the equipment needed for injecting heroin, the whole process being depicted in great detail in the campaign material. These advertisements were finally shown in England and Wales, but only one (linked to the AIDS campaign) was shown in Scotland. During 1986 and 1987 the regular tracking surveys and other qualitative studies continued to show high levels of awareness of the campaign and highly negative attitudes to drugs among young people (Research Bureau Ltd., 1988; Irving, 1988).

The DHSS drugs campaign did not cross the border into *Scotland* until March 1988. A completely different approach was taken until then. In 1984 the Scottish Health Education Group (SHEG) was instructed by the Scottish Home and Health Department to mount a high-profile drugs campaign. The Group was concerned about possible exacerbation of the drug problem and about drug education assuming top

priority above SHEG's chosen, long-term planned programmes.

Nevertheless, SHEG devised a strategy based on three principles: the campaign should do no harm; it should be about drugs in general rather than heroin-specific; and it should be built into a broader base of SHEG's positive health programme, Be All You Can Be and was to be only one component of a broad educational strategy including inservice training, research and support for local services.

The mass media material devised for the campaign under the banner Choose Life not Drugs was therefore concentrated on young people's self-esteem, on suggesting alternatives to drugs and highlighting refusing skills. Scare tactics were deliberately avoided; instead an up-beat pop video style was chosen in various stages of the campaign which ran from 1985 to 1988. Qualitative research at the concept, pre-testing and post-testing stages was undertaken by the Advertising Research Unit throughout the development of the materials to help spot communication difficulties and match the information more closely to the needs of the audience. As in England and Wales, a communication and awareness monitor found high awareness of the advertising (Macaskill *et al.*, 1989).

An interesting concept test in 1987 showed the SHEG and DHSS advertising material to Scottish teenagers. Although the Scottish flavour of the SHEG material was well liked and appreciated, the respondents in general felt that the material was not taking the drugs problem seriously enough. It did not show the physical decline and drug-addict stereotype that the respondents had come to expect whereas the DHSS material did (Eadie and Hastings, 1987). On the other hand the DHSS material suffered from the defects mentioned on page 26.

From March 1988 the Scottish campaign merged with the Department of Health (DoH) campaign because of pressure for more to be done on injecting and AIDS. The DoH campaign had changed from a heroin-specific one to a more general anti-drugs campaign, but still continued with highly negative imagery through the anti-injecting/AIDS advertisements, which covered the whole of the UK. It had also begun to overlap with the AIDS education campaign from 1987 (see Table 4, page 29) both converging on the anti-injecting/AIDS theme.

It can be seen from Table 4 that conflicting images were presented to the public during this time based on *two fundamentally antagonistic strategies for education*. For example, in 1987 young people in Scotland were receiving positive imagery about alternatives to drugs, based on supportive educational strategies, while at the same time receiving the negative imagery on drug-injecting from the UK AIDS campaign which was based on fear tactics. In 1988 the UK population as a whole was experiencing the postitive imagery on AIDS from the HEA (stressing the benefits of safer sex, for example) while receiving negative messages on AIDS/drug injecting from the DoH campaign. In the end the two very different approaches were thoroughly mixed and the effects of this combination difficult to assess.

In parallel with the government's official drugs campaign run by the Central Office of Information the mass media had bursts of activity on the subject. In September 1985, for instance, the children's television series Grange Hill introduced drugs into the storyline, a BBC representative explaining, 'We want to warn kids before the (drug) pushers reach them at the school gates' (Shaw, 1986) (note the myth of pushers at school gates, page 25). Nine million school children (40 per cent of total) watched the series so this, coupled with other activities going on at the time, ensured that most children had the issue brought to their attention. The cast of Grange Hill even went on to make a hit single on the theme of 'Just Say No'.

Reaction to this state of affairs was polarised. The BBC producer responsible for the Grange Hill initiative considered that this had been 'one of the great all-time successes of positive health promotion' (Shaw, 1986). Drug researchers, on the other hand, expressed their exasperation that an issue which was a problem for a tiny minority of the population had been promoted to 100 per cent of the population. As one researcher put it, an issue that had been of little relevance to the vast majority of young people had been foisted on them and they had been forced into the position of having to make decisions in areas where previously no decisions were necessary (Davies, 1986).

All this time, as background noise, massive advertising campaigns were promoting the attractions of legal drugs, in the form of alcohol and tobacco. The combined advertising budgets for these two products were running at approximately £300 million a year, and a further £30 million was being spent on sports sponsorship. Much of the advertising was seen and appreciated by many children and adolescents (Barton and Godfrey, 1988; Aitken *et al.*, 1986; 1988; Ledwith, 1984). Soap operas were also portraying unrealistically high levels of smoking as part of everyday life (Piepe *et al.*, 1986).

Considered as a whole, the issue of drugs – legal and illegal – in the mass media has been riddled with contradictions, and whether the overall effect has been beneficial or counter-productive is open to debate.

Case Study 2: AIDS comes on the scene

Press interest in AIDS grew from 1983 onwards, but much of this initial coverage concentrated on gay men, which stirred up and reinforced prejudice (Naylor, 1985) and also gave misleading information which aroused high levels of fear (Miller *et al.*, 1985). A content analysis of the articles on AIDS in July 1985 found that while most of the coverage in the 'quality' newspapers served an educational purpose, the tabloid press coverage was less educational with less potentially useful information for readers on how to protect themselves from the virus. *'The popular press paid more attention to symptoms which were so unspecific as to be at best useless, and at worst worrying'* (Currie, 1987).

The DHSS launched a low-key media campaign on the issue in March 1986, mainly in the press. Some of these early newspaper advertisements were criticised for being so difficult to read that only 24 per cent of the

population would be able to understand them (Sherr, 1987). It seemed to have little impact and the results of a postal questionnaire before and after the campaign indicated a decrease in the level of public knowledge about AIDS (Mills *et al.*, 1986). A Scottish survey in July 1986 found that 75 per cent of adults found the whole idea of AIDS very frightening (Hastings *et al.*, 1988b).

In October 1986, two powerful television documentaries on the subject were screened on the same night, one on Central TV and one on BBC, both emphasising the heterosexual spread of HIV. These, with the attendant press coverage, fuelled widespread alarm. For example, the number of people requesting anti-body testing for HIV increased dramatically; one hospital in London reported a 300 per cent increase in requests from the end of September to mid-November with a sharp rise starting at the end of October. Most were at minimal risk of exposure and showed disproportionate anxiety (Sonnex *et al.*, 1987). The rise in requests for tests continued, reaching a peak for England and Wales as a whole in March 1987, when the Public Health Laboratory Service was analysing 20,000 tests a month and was barely able to cope (Wellings, 1988a). This anxiety was reflected in the findings of a concept test with young people in October and November 1986. Teenagers had absorbed facts from the media but also fiction, with sensational stories of AIDS victims compounding the confusion and increasing fear (Reflexions Market Research, 1986).

Following the increased media activity and public disquiet, the government decided to set up a special Cabinet committee on AIDS and plan a national mass media campaign. Into this atmosphere of growing alarm a high-profile television campaign was launched by the DHSS in December 1986 using doom-laden images of ice-bergs and tombstones with the slogan 'Don't Die of Ignorance'. This alerted people to a leaflet drop to every household which took place in January 1987.

A market research tracking survey, which sampled the population between March 1986 and February 1987, showed that 82 per cent of the adult population had proven recall of the advertising (that is, could describe it), which was an exceptionally high figure for this type of advertising. Eighty-one per cent had seen the leaflet distributed to households, 48 per cent of whom claimed to have read it all the way through. There had been substantial knowledge gains in the year up to February 1987, attributable to the media effort as a whole. For instance, knowledge that HIV could be caught via homosexual sex was high throughout the period, but there were large gains in the proportions knowing that it could be transferred in other ways – for example, via heterosexual sex, injections, and passed on to an unborn baby by its mother. Knowledge also increased on how it could not be passed on – for example, via kissing, toilet seats, and so on. Most adults by February 1987 also knew that using a condom was a way of reducing the risk. There were also large increases in the proportions believing promiscuous people and those who had casual sex were at high risk (Central Office of Information/Department of Health and Social Security, 1987).

In addition, the monitor showed some areas of confusion – for example, substantial numbers still believed that HIV could be caught via blood transfusions and blood donations. There was little improvement in sympathy for minority groups who developed AIDS, and an increase in feelings that AIDS sufferers 'only have themselves to blame'. A Scottish survey of July 1986, repeated in July 1987, found similar shifts in knowledge. It was noticeable that nearly everyone (96 per cent) appeared to know that drug misusers can spread HIV by sharing needles (Hastings *et al.*, 1988b), a finding confirmed by several other surveys around the UK (Gallup, 1987).

However, this kind of dipstick market research survey could only give a superficial indication of what was going on in the thoughts of the general public. Deeper insights have been gained through qualitative studies, which have uncovered misunderstandings in communication, contradictions in knowledge and attitudes, and obstacles to behaviour change. They also serve as a reminder of the enormity of the task facing AIDS educators. For example, they showed that warnings about promiscuity and AIDS went over the heads of teenagers because none saw themselves as promiscuous or 'sleeping around' (Reflexions Market Research, 1986; 1987). Young people overlooked messages in a leaflet aimed at them on the heterosexual spread of HIV, because the information was presented together with messages about drug-injecting and homosexual transmission, from which they dissociated themselves (Hastings *et al.*, 1987). Studies in Scotland showed that young people who knew that correct use of condoms reduced the risk of HIV still did not know what 'correct use' involved. People who knew correctly that HIV could not be caught by certain social contacts were still cautious of those contacts in their own lives. The Scottish research concluded that with high levels of anxiety already abounding, *'fear-inducing appeals should be discontinued and replaced by material that attempts to resolve peoples' concerns about AIDS'* (Hastings and Scott, 1987).

Basically that advice was acted upon by the HEA when it took over the mass media AIDS programme from the DoH in October 1987. But in the months before then the DoH launched the second stage of the AIDS campaign and the third stage of the drugs campaign both on the theme of anti-drug injection and AIDS which continued to portray negative, frightening images of drug injecting.

The decision to target the general population through the mass media with this message could be questioned on three counts:

a) the fear appeal would do nothing to reduce the evident anxiety in the population;

b) it was providing no new information as there had been a high level of awareness of the link between injecting and AIDS among the general population since 1986;

c) as most people dissociate themselves personally from the idea of injecting drugs, concentrating on this aspect in the mass media could encourage them to distance themselves from the AIDS issue and thus take no action on it.

When the Health Education Authority took over the AIDS campaign in October 1987 a policy decision was taken to avoid scare tactics. Instead, the strategy concentrated on clearing up misconceptions and offering practical advice on reducing risk. However, the HEA's attempts to reduce the use of fear may have been counterbalanced by the simultaneous campaign being run by the DoH on drug-injecting and AIDS, which was based on an antagonistic strategy (see Table 4).

Furthermore, attempts to give practical advice have sometimes been thwarted by different sections of the media. For example, even in 1989, after two years widespread coverage of the issue of AIDS, a national tabloid newspaper refused to take a press advertisement by a national health education agency because it discussed the use of condoms for safer sex.

To sum-up on drugs and AIDS

It has been argued that the mass media setting was not the best choice for national illegal drug education efforts. There is concern that the DoH mass media drugs campaign has helped to set an *inappropriate* agenda in the country. For instance, the campaign perpetuated the unhelpful stereotype of the heroin addict, it used scare tactics known to be ineffective if not counter-productive for such a sensitive task, and diverted attention and resources away from other legal drug problems, such as alcohol, tobacco and prescribed medicines which deserved a higher claim for national action. (Smith and Jacobson, 1988).

Although the campaign was only one small part of the patchwork of activity on drugs going on in the media, it reinforced rather than countered the sensationalism already in evidence in the media, focusing as it did on drugs and young people. However, there have been some positive side-effects, like the funding of intensive training of senior teachers in Scotland (page 13) and the appointment of drugs advisers in local education authorities in England and Wales. Both initiatives have taken a broader view on health education rather than concentrating on drugs alone.

Alternative strategies have been put forward by various agencies which acknowledge the importance of controlling availability of drugs by *legal* measures. The most useful educational role would be supportive: for example, by providing counselling at local level for drug abusers to help them overcome their habit (this would also help limit the availability of drugs to young people); by educating the press and programme makers to reduce distortion in the media; and by providing training for a variety of professionals (Smith and Jacobson, 1988; Home Office, 1984; Pearson, 1985; Davies, 1986).

TABLE 4 · MASS MEDIA CAMPAIGNS ON DRUG AND AIDS: OPPOSING STRATEGIES

DATE	Drug campaigns England and Wales	Drug campaigns Scotland	AIDS campaigns England and Wales	AIDS campaigns Scotland
1985	**Stage 1 DHSS** Heroin-specific: 'Heroin Screws You Up'	**Stage 1 SHEG** Promotion of healthy alternatives to drugs: 'Choose Life not Drugs'		
	NEGATIVE imagery	POSITIVE imagery		
1986	**Stage 2 DHSS** Heroin-specific, physical decline and social stigmatising.	**Stage 2 SHEG** Healthy alternatives	**Stage 1 DHSS** 'Frightening, if obscure' images of icebergs and tombstones.	**Stage 1 DHSS**
	NEGATIVE imagery	POSITIVE imagery	NEGATIVE imagery	
1987 Sept	**Stage 3 DHSS** General drugs and anti-injecting/AIDS	**Stage 3 SHEG** Refusing Skills	**Stage 2 DHSS** AIDS anti-injecting Drugs	**Stage 2 DHSS**
	NEGATIVE imagery	POSITIVE imagery	NEGATIVE imagery	
1988 March	**Stage 4 DoH** Anti-injecting/AIDS	**Stage 4 DoH** Anti-injecting/AIDS	**Stage 3 HEA** promoting ways of reducing risk	**Stage 3 HEA**
	NEGATIVE	NEGATIVE	POSITIVE imagery	

The coverage of Aids in the mass media is a somewhat different case because it has a high claim for national priority and some mass media work could be justified. Nevertheless, it was unfortunate that the government campaign started by using fear to attract the public's attention when misinformation and anxiety levels were already running very high. Some sections of the press, in particular, were feeding on the frightening aspects of the disease and its link with sexual activity in a way almost guaranteed to cause panic and prejudice.

The HEA now seems to be moving in a more logical and research-based direction, showing by the type of studies that it has commissioned that it is aware of possible side-effects and pitfalls and is attempting to monitor them. It has also been acknowledged that in the long-term, when it comes to attempting to influence people's sexual behaviour, *'government health agencies and officials are not the most effective role models for most people'* (Wellings, 1988b). Media personalities including soap-opera characters are though to have more credibility, but careful education of the media would be necessary for this approach to be feasible. A more comprehensive strategy on sexuality and health promotion has been outlined in The Nation's Health (Smith and Jacobson, 1988).

Smoking control: influencing mass media policy

Not all attempts to work with mass media have been fraught with such difficulties, especially when directed at less emotive subjects and used as *one component in a broad, long-term community eduaction programme* (Pasick and Wallack, 1989). Smoking control is one area in which some useful lessons have been learnt, spanning the 25 years since the hazards to health were first publicised by the Royal College of Physicians (Flay, 1987). Early efforts used fear appeals and authoritarian messages and the relative ineffectiveness of such approaches was identified (Tripp and Davenport, 1989; Leathar, 1981). More recent efforts have concentrated on more supportive education – concerned with helping smokers to give up, for example. In the last decadé there have also been some concerted attempts to influence policy relating to the mass media by tackling several of the factors listed on page 24 which work against health educational processes. The goodwill of media personel has also been successfully enlisted. The 1984 initiative spearheaded by the BMA was a notable example. In that year, the BMA, and many other organisations, such as ASH, HEC and the British Heart Foundation, launched a powerful campaign specifically against the multi-national tobacco companies and their promotional activities. The aim was to influence government policy to ban all tobacco advertising, sponsorship and promotion (British Medical Association, 1986). Strategies included parliamentary lobbying for legislation, the publication and promotion of reports exposing cigarette advertising tactics in women's magazines (Jacobson and Amos, 1985), identifying major investors in tobacco companies (Gilbert, 1985) and publishing studies on the effects of advertising and sports sponsorship on children (Ledwith, 1984). Action by doctors all over the country was encouraged by providing them with black-edged postcards to send to the MP of each patient who died from a smoking-induced disease. As these started to filter through to the House of Commons, they provoked awareness and also irritation in some quarters.

In 1985 as part of the on-going activities on this front, the HEC and BMA launched a publication called *The Big Kill*. In this, figures for smoking-related deaths and related NHS costs were detailed in 14 volumes – each volume devoted to a specific region in England, Wales and Northern Ireland. Copies of the relevant volume were sent to every MP, every local authority and every health authority and the media were alerted. It was timed to coincide with a review of the voluntary agreement between the government and the tobacco industry. Within 48 hours of publication it was quoted in nearly every national and local daily paper, generating thousands of column centimetres of coverage. Reports suggested that it triggered off numerous local responses: for example, a clampdown on sales of cigarettes to children; district health authority action, particularly in Barnsley which was cited as the country's mortality blackspot; calls for action on tobacco sponsorship; and an increase in non-smoking areas and policies in buildings (Roberts, 1986a). Several women's magazines changed their policy on cigarette advertising as a result of the Jacobson and Amos report.

During the same period the flouting of the voluntary agreement between the industry and government was carefully documented for BBC and ITV broadcasts (Roberts, 1986b), and presented to television companies and government agencies by the HEC. By Spring 1986 there were signs that the BBC at least was responding – by stricter control of camera shots in snooker matches, for example (Times, 1986). What all this activity did *not* do was to bring about a complete ban on tobacco advertising and sponsorship, though there was a tightening of the rules in the voluntary agreement and a high level of anti-smoking coverage in the media throughout, which influenced local smoking control policy.

ACTION AT THE 'GRASS-ROOTS': THE PERSONAL APPROACH

A very different method for consideration is the personal approach which takes place independently or in conjunction with mass media work.

Evidence on the effectiveness of one-to-one and small group education has continued to accumulate over the decade. So far most of these studies have concentrated on changing separate health behaviours and have thus been researched most extensively in relation to health service workers in frequent contact with the general public. Such health care settings, considered in greater detail here, offer great opportunities for education but also present major obstacles which require more open debate if they are to be resolved.

Opportunities and success

The opportunity for health education presents itself in many everyday encounters between the public and

GPs, nurses, pharmacists and allied professions (Fowler, 1985; Syred, 1981; Lyne, 1985). There is ample evidence that patients want more information and do not mind opportunistic health education from, for example, general practitioners (Sullivan, 1988; Wallace and Haines, 1984).

In addition, patient education has been one area in which it has sometimes been possible to construct randomised controlled trials to test educational interventions, with some promising results. For example, in relation to *general practice*, GPs who offered patients who smoked advice on stopping, gave them a leaflet and warned that they would be followed up, achieved a 5.1 per cent smoking cessation rate with their patients after one year, compared to 0.3 per cent for controls who were only asked if they smoked or not (Russell *et al.*, 1979). It was calculated from this that if all GPs adopted this procedure, the exercise would produce half a million ex-smokers per year.

In a large-scale controlled trial of three different anti-smoking interventions by Oxfordshire GPs, 17 per cent of a group receiving verbal and written anti-smoking advice, plus a demonstration of exhaled carbon monoxide, claimed to have stopped smoking after one year. This compared with 11 per cent in a control group, 15 per cent in the group receiving advice alone, and 13 per cent in a group receiving advice from a GP plus the offer of further help from a health visitor (Jamrozik *et al.*, 1984). The carbon monoxide demonstration was found to be particularly valuable in influencing patients from lower socioeconomic groups.

A district-wide study in inner London found that brief intervention by GPs with support and back-up from a local smoker's clinic could, when sustained on a continuous basis, reach sufficient smokers to reduce smoking prevalence in the practice populations (Russell *et al.*, 1988).

Evidence concerning GPs and alcohol education is also encouraging (Babor *et al.*, 1986). A randomised controlled trial to determine the effectiveness of advice from GPs (who had received special training) to heavy drinkers found that alcohol consumption was reduced significantly in the experimental group compared with controls. The study concluded that, if the results were applied to the whole of the UK, education by GPs could each year help to reduce to moderate levels the alcohol consumption of 250,000 men and 67,000 women who currently drink to excess (Wallace *et al.*, 1988). Smaller scale experiments by GPs to influence exercise habits also show some promise (Campbell *et al.*, 1985).

There are indications that *nurses* may make even more effective health educators in certain circumstances. A study of hospital and community nurses' attempts to help their patients to give up smoking found that 17 per cent of the experimental group who were followed up after a year had successfully given up smoking; this compared with 8.3 per cent of the controls. The nurses had taken part in a two-day training programme to introduce them to the principles of a health promotion approach in nursing. This study tape-recorded the conversations between nurse and patient and was able to pinpoint strengths and weaknesses in the communication process (Macleod-Clark *et al.*, 1987a).

In relation to hospital nurses, a study in Edinburgh assessed the effectiveness of brief intervention with problem drinkers identified as having a current alcohol problem (though they had come to the hospital for other reasons). An intervention group had a 30-60 minute counselling session from a nurse in the presence of the patient's spouse if possible. They were then given a booklet on how to reduce drinking. After one year control and experimental groups were assessed by a different nurse who did not know which patients belonged to the control and which to the experimental group. Thirty-five per cent of the experimental group were assessed as having alcohol problems compared with 62 per cent of the control group (Chick *et al.*, 1986).

Several studies with *health visitors* in people's own homes have revealed interesting results. A long-term study in Sheffield to reduce unexpected infant deaths indicated that extra health visitor sessions with infants scored at 'high risk' were associated with 18 per cent of the observed reduction in preventable deaths (Carpenter *et al.*, 1983).

In a Newcastle study the effects of health visiting and of mass media were investigated. Two groups of families in a deprived area of the city were encouraged to watch the BBC TV series *Play It Safe* on preventing accidents to children. One of the groups also received a visit from a health visitor who gave the parents a *Play It Safe* booklet, assessed the hazards in the house and gave specific advice on how to reduce the hazards. Sixty per cent of the group of parents who had a visit took steps to improve the safety of their homes, whereas only 9 per cent of the parents without a personal visit took any action (Colver *et al.*, 1982). In Edinburgh a controlled study found that counselling by health visitors in eight weekly visits was valuable in managing postnatal depression (Holden *et al.*, 1989).

The Child Development Programme in Bristol has grown into the largest parent support programme in the UK, and is one of the few health service studies aimed at boosting the confidence of parents and empowering them to develop their skills rather than being directed at one aspect of physical health. In the programme, a health visitor spends an hour each month with parents, mostly in deprived areas, fostering parenting skills and awareness of preventive health in relation to nutrition and language stimulation. Results have shown 90 per cent immunisation rates in the deprived areas where the programme has been running compared with as little as 50 per cent in other deprived areas. Improvements in the quality of children's diets, in language and social behaviour, and significant height differences, have been found in the programme children compared with controls. Furthermore, the rate at which infants were admitted to hospital was reduced and an extremely low level of child abuse was found in programme families – well below half the national average and far below current levels in disadvantaged areas. Twenty health authorities have been collaborating in this scheme and more than 10,000 families become involved in the programme each year (Barker and Anderson, 1988).

Last, but not least, is an example of an educational achievement through the joint work of several agencies

and individuals. On the issue of AIDS and sexual behaviour, the combined educational efforts of voluntary bodies such as the Terrance Higgins Trust and Body Positive, gay newspapers and staff of sexually transmitted disease clinics, are thought to have been the main influences helping to bring about a shift in the sexual lifestyle of gay men in Britain (Carne *et al.*, 1987). There is evidence from surveys of a reported reduction in sexual partners, a possible increase in condom use, and a decline in the prevalence of anal sex among gay men. A corresponding decline in rectal gonorrhoea rates in gay men (an indirect indicator of sexual behaviour) reinforces the view that a shift in behaviour has indeed taken place (Carne *et al.*, 1987) and the shift started before mass media or government interventions. It is considered remarkable because it involved a change in long-standing behaviour and this change needed to be sustained over a long period of time. Part of the success of the educational effort has been attributed to three factors:

a) gay men were highly motivated to take action, having seen the suffering caused by AIDS at close hand;

b) the advice was seen as highly relevant to their own lives;

c) detailed practical advice was offered which was closely tailored to the needs of the people involved.

Obstacles in the health care sector

Initiatives such as those above, encouraging though they are, are not commonplace in health care settings for a number of reasons.

The first obstacle is almost certainly inadequacies in pre-service and inservice training for the various professions. Training is often treatment-oriented and little effort has been put into developing communication skills or health teaching as outlined in the next section. The importance of communication between health workers and patients has not been widely appreciated, even though a series of studies in the early 1980s was influential in bringing this issue more to the fore. They showed, for instance, that only limited information was offered by GPs in consultations, lifestyle issues were rarely discussed and advice on how to prevent illness recurring was seldom given (Boulton and Williams, 1983). Even when explanations were given they were not detailed enough to allow patients to make an informed decision on the topic, and half the consultations in the sample led to patients who 'misunderstood' what the doctor said or who were not committed to the advice given. The patients in the study were far from passive. They had the capacity to 'fill-in' and 'make sense' of even the most brief or obscure explanations, by drawing on their lay knowledge and experience, but the resulting 'understanding' was not always what the doctor had intended (Tuckett, 1985). Until professionals become more aware of patients' need for information and the possibility of communication breakdown, the motivation to improve skills will be lacking.

The second obstacle is the work overload of many health workers and the way it is arranged. They are often involved in 'crisis' treatment and have little time for 'less urgent' preventive or health promotion activities. The financial crisis in the health service has compounded the problem, with educational activities ripe for cost cutting exercises. Anything other than tending for patients' immediate physical needs has been continually eroded, especially if these activities are difficult to translate into performance indicators. Even health visitors, who were intended to be the main preventive health workers within the health service, are spending more and more of their time coping with child abuse crises with less time available for more long-term preventive work (Sharma and Sunderland, 1988). The way health visitors are being forced into 'policing' roles and away from their original remit is a matter of grave concern to the profession. Other reasons cited by health workers for not undertaking more educational work include not seeing it as their role, lack of confidence in educational skills, and lack of support from managers who may give the impression that it is not a legitimate activity for their staff (Popay *et al.*, 1986; Macleod-Clark *et al.*, 1985). Voluntary agencies also find themselves struggling to cope with the upsurge in demand on certain health issues, a notable example being the AIDS-related charities. The Terrence Higgins Trust is said to be *'all but overwhelmed with the weight of demands on its services'* (Watney, 1987).

The third obstacle concerns the infrastructure for supporting educational efforts at a local level which is inadequate for the sheer size of the task. For example, it is often overlooked that whatever interest is stimulated by campaigns at national level has to be translated into action at local level. But health promotion work in general in health authorities is only allocated in the order of 0.1 per cent of the total revenue budget (National Audit Office, 1989). *Health education departments* bear the immediate brunt of the work stemming from national initiatives. It was noted on page 24 that there had been an increase in the number of health education officers, from 200 to 1000, over the decade, although some of these were on temporary contracts for specific projects (Society of Health Education Officers, 1988). This increase may seem impressive until translated into district terms. Nearly all districts have a health education department or equivalent, but for the majority of districts this consists of between one and three officers with a non-staff budget of under £10,000. Very few would have a budget in excess of £25,000 (French, 1989).

With this level of staffing and budget the departments have to cover a whole district, responding to local queries generated by national campaigns such as Look After Yourself, National No Smoking Day and waves of activity on national priorities such as immunisation, drugs and AIDS. They have to mount campaigns based on local priorities set by their own district. They have to provide training and support for a variety of health and education service staff, as well as attempting to influence local policy-makers to develop healthy public policy. A department of one or two people cannot hope to cover this volume and diversity of work. The network of departments around the country provides a valuable infrastructure but at the moment it is understaffed and under-resourced.

The same applies to *public health doctors*, who have

an important educational and advisory role to play in shaping the health promotion policies in the area. But there has been serious under-staffing for this specialty for many years in most districts with a few districts not employing any specialists at all (Harvey and Judge, 1988). The seriousness of this situation for public health in general and disease control in particular is at last being recognised, for example, in the report by the Acheson committee.

LAY PARTICIPATION: THE CHALLENGE OF COMMUNITY DEVELOPMENT

Very few of the initiatives mentioned so far have faced the challenge of encouraging lay participation. Almost all have involved central policy-makers or professionals deciding on priorities and designing education for the public on those priorities.

Yet WHO principles concerning education for health call for a shift away from the medical orientation towards education which recognises and encourages lay skills, boosts confidence and encourages lay participation in decisions which affect health (Kickbush, 1981).

The increasing number of community health projects has already been noted, and among these is an important set of initiatives, now numbering about 40, which have set out to address this issue using a community development approach (Sommerville, 1984; National Community Health Resource, 1987). Such an approach involves finding out what the concerns and priorities of a local community are and working with people in that community to help them acquire skills to take action on their chosen priorities.

Many have grown up in response to inequalities in health, with the knowledge that traditional health education has failed to engage in dialogue with people living in disadvantaged conditions.

All the projects are based on certain common characteristics, *the primary one being the encouragement of communities to set their own agendas*. In addition they aim for:

'a positive view of health,
a collective approach to the social cause of ill-health,
better access for people to health information and resources,
increased self-confidence amongst people,
better relationships between clients and health professionals,
greater public influence on health policies and allocation of resources'
(Community Projects Foundation, 1988)

The Granton project below illustrates how the community development approach is put into practice, but also illustrates some of the tensions that the approach brings to the surface.

Granton Community Health Project

Following an influential report on health education in areas of multiple deprivation (Scottish Health Education Coordinating Committee, 1984), a pilot project was funded in Granton by SHEG and the Scottish Home and Health Department, to raise awareness of health issues in a deprived area and *'to find ways of creating channels whereby people in the community could communicate their health needs and concerns'* (Jones, 1989). The project was staffed by a community development worker and health visitor and later a research worker was added. Lothian Region and Health Board have now taken over the permanent funding of the project.

Establishing contact

Establishing contact with people in a community and building up trust is a slow and sensitive process in all of these initiatives. The community development worker in Granton started by getting to know and documenting all the local resources provided by statutory and voluntary agencies in the area as well as the community-based groups. A small survey of local residents and professionals was then carried out to provide information on concepts of health, health needs and so on, and this highlighted interesting differences in the views of residents and professionals.

To encourage local people to give their opinions and become involved further a larger survey was planned with suggestions from the residents. Eighteen local people were trained and paid as interviewers. The survey served two purposes. It helped in the gradual building up of a picture of health needs in the area, but it was also part of a process of education for the interviewers themselves. Following the survey they were found to have improved self-image and a raised awareness of conditions in the area. Their desire to discuss some of the issues in greater depth led to the setting up of a group which then drew in more residents by personal contact. Several groups were initiated in the same way as people came up with problems and issues they wanted to address. These groups were gradually taken over and run by local residents as they gained confidence.

Activities

Several groups were formed for varying lengths of time. Some remained small but others had far reaching effects. For example, the *Women's health discussion group* started by looking at topics such as stress, childbirth and talking to doctors. The group then focused on the problem of *damp housing* on the estate and eventually prepared a tape-slide presentation showing the problem and how it affected their lives. This was shown at a seminar at Edinburgh University, and stimulated a research project to investigate the effects of damp housing and health (This was an important piece of research in itself, showing the link between damp, mouldy housing and specific aspects of children's health (Martin *et al.*, 1987)). The process of putting forward their concerns helped group-members gain confidence and also demonstrated that residents from a deprived area could stimulate academic research on their own chosen priorities.

A major concern of local women was found to be their dependence on tranquillisers and antidepressants. A group was therefore set up to support people who wanted to withdraw from

tranquillisers. As members gained confidence they became more skillful in helping new recruits. All the regular members of the group eventually came off drugs, but continued to share their expertise with both self-help and professional groups. The tranquillisers support group is now run by volunteers and is represented on the Scottish Drugs Forum. Members successfully applied for funding to write a booklet on the issue. They then turned their attention to how mental health problems in the community could be prevented and admissions to psychiatric hospital averted. Following the offer of a house, rent-free, for two days per week they set up a Stress Centre, which operates on an informal, drop-in basis. Two of the original members of the group are employed by Lothian Health Board to staff the centre (Hunt, 1989).

Throughout the project, groups have been formed related to the needs of older people in the community – for example, a swim club, a fruit and vegetable cooperative and so on. Pilton Elderly Forum grew out of these initiatives. This brings together pensioners and local professionals every six weeks to discuss matters of mutual interest. The Forum was able to respond to the Scottish Office when it was seeking comments on joint planning for the elderly. Through the Forum a working-day conference was organised for 50 local pensioners, who made recommendations on improvements to services for elderly people in the area. Although nothing has come directly from the submission to the Scottish Office, the information gathered was used to secure Urban Aid funding. This provides for four new community workers to address the pensioners concerns – the provision of a minibus and driver to ease transport problems, the appointment of an information worker on pensioners issues, and a coordinator to organise a voluntary visiting scheme for frail elderly people returning home from hospital. The steering group for these service developments is drawn from older people in the community.

Users of the local health clinic have met together and, through their survey of 100 local women, have been able to show health professionals where improvements could be made to the service to make it more responsive to local needs.

The evaluation carried out by the University of Aberdeen concluded that the project had been successful in attaining most of its objectives – it had opened up channels of communication between professionals and residents, it had developed ways of fostering the skills of some of the residents in dealing with health issues and had shown how some of these issues could be tackled by lay people in new ways (Drummond, 1989; Hunt, 1989).

Facing the implications of community development

The Granton Community Health Project and other initiatives around the country using the community development approach all tend to come up against similar problems when the implications of the approach have not been fully understood. Five areas of tension have surfaced:

1. Different priorities

The priorities chosen by the community are not always the same as the priorities of the funding body. For example, in a deprived area a health authority would tend to identify for priority treatment problems of low birth weight babies, high levels of coronary heart disease risk factors (for example, smoking, heavy drinking, lack of exercise) and poor uptake of preventive services, especially immunisation, antenatal and child health services. In general these are concerned with separate *physical* health problems. However, it is clear from the Granton project, and many others, that community priorities often centre on *social* and *mental* health. For example, residents have expressed concern about stress, social isolation, poor housing, transport difficulties, lack of childcare provision, difficulty in buying fresh foods, social security benefits and lack of communication and information on health services. Furthermore, health topics are rarely separated from all the other worries of everyday life.

Conflict arises when the funding body has not understood that the community may not choose the same priorities. In such cases, community development workers may feel unable to work on some of the issues, unless a clear line of responsibility to the community has been established.

2. A threat to local health workers

If local residents gain confidence through the community development techniques, they may start to voice their concern about gaps or defects in local services and this can be very threatening to some local health workers. It may seem a direct criticism of the way they organise their services and even the treatment they give.

The thought of sharing policy-making with lay people may also be alien to them and to higher levels of management in authorities. All this can lead to conflict and misunderstanding if sufficient educational groundwork is not done as a preliminary to setting up the projects.

3. Instant results

Funding bodies may expect almost instant results to prove that the project is a legitimate health service activity (Stewart-Brown and Prothero, 1988). But the work may take *years* to set up and get running smoothly, including the painstaking process of building links with local residents and professionals. Timescales imposed on projects may therefore be totally inadequate.

4. The easy option

In some cases a community development project may be seized upon because it is seen as a cheap and easy option for dealing with inequalities in health in a particular area. There may be unrealistic expectations of the project in terms of the impact it can have on such complex problems, some of which will not be within the power of the local communities to solve. It may also be used to divert interest away from what can only be addressed by social policy.

5. Evaluation conflicts

Outside agencies may expect to see results in terms of 'outcome'– for example, improved immunisation rates and uptake of preventive services, and decline in child hospitalisation rates. However, community development initiatives can rarely be evaluated in such terms because the objectives are concerned mostly with increasing self-confidence, promoting better relationships between lay and professional people, increasing public influence and so on (see page 33). This requires an entirely different approach to evaluation (Hunt, 1987). Similar conflicts may arise between evaluators drafted in from outside and the community development workers involved who want the findings to be of benefit to the community, not just to an external body.

All these tensions can manifest themselves right up from local to national level. In this respect it is encouraging to note that the HEA has set up a new division to stimulate community development in a more planned way, in line with WHO principles. The Authority is in a position to provide much needed support for health and local authorities in building up an infrastructure, and can help with dissemination of local good practice and with evaluation. It remains to be seen how far the HEA will be able to progress with the development of such a strategy while keeping within government policy. Doubts have recently been expressed in the media about whether ministers will allow the HEA to operate effectively in this field.

FINDING A WAY FORWARD

A start can be made on addressing some of the more immediate problems raised in this section though some of the more fundamental questions require a longer-term perspective.

Policy options in the mass media

The many contradictions apparent in mass media policy need urgent attention. Options to deal with problems in drugs and AIDS mass media work have already been mentioned on page 29. Six action areas have potential for making improvements on a more general level:

1. Analysing the overall picture

A much broader view of policy is needed, one which takes account of the complex set of factors at work (see page 24). Detailed analysis is therefore required of the 'background noise' – the forces working for and against the proposed intervention – before a strategy is developed. This would help to avoid situations where, for instance, scare tactics used in education reinforce the public anxiety induced by other sections of the media.

2. Controlling anti-health forces

Although it is not possible to influence all the counter-productive effects of the media, some of the more blatant factors working against the promotion of health can be more tightly controlled. *Effective* restrictions on advertising of alcohol and a ban on the promotion of tobacco products and sports sponsorship, for instance, are long overdue and would help to influence the climate of opinion on these issues (Smith and Jacobson, 1988). Much could be learnt from successful experiments in other countries, for example, in the USA where the 'knock for knock' policy operated in the 1970s. This required that for every three tobacco advertisements on television the tobacco industry funded one health education advertisement. This eventually led to the voluntary withdrawal of all tobacco advertisements on television.

3. Working with programme makers

Closer working relationships can be built up between health educators and the press and broadcast media. Experiments in the USA in developing a method called 'cooperative consultation' have shown how successful this can be (DeFoe and Breed, 1986). This is necessary not only to help correct misinformation and distortions, but also to find new, creative ways of raising health issues through these influential channels. The process of *education of the media* should be seen as a legitimate activity for health educators, deserving higher priority. It is encouraging to note that in 1989 SHEG created a new post which had this role as a central part of the remit. Also, professionals need to be educated on how to use the media effectively themselves.

4. Questioning the use of the mass media

Before a campaign of education through the mass media is initiated there needs to be much closer inspection of effectiveness and resources. This would include careful attention to research evidence to assess whether this was the right channel for the desired goal, and what weight should be given to work through other channels. There have been examples in the recent past of negligible time allowed between the generation of the idea for a campaign and the briefing of the advertising agency, precluding any assessment of research findings or policy alternatives on the specific issue.

More careful assessment is also needed to judge whether the available resources match those required for effective use of the mass media. In the past mass media campaigns have been doomed to failure from the start because the minimum level of funding was not available to achieve adequate levels of audience awareness (Flay, 1987; Fynn, 1981). In such cases considerable amounts of money may have been wasted and could perhaps have been used to greater effect elsewhere. The setting of more realistic objectives for mass media education is essential.

5. Local back-up

If a central mass media initiative expects cooperation and reinforcement from locally based campaigns, then part of the budget should be set aside to help local events. In relation to Look After Your Heart, the National Audit Office noted that many district health authorities had failed to respond to the national campaign, even though instructed to do so (National Audit Office, 1989). The question of whether the resources were there for an appropriate local response was not raised, though it was certainly relevant.

6. Monitoring effects

Much closer attention could be paid to researching the effects of education through the mass media. This means matching the material more closely to the audience by extensive use of qualitative techniques and monitoring the negative effects of a campaign, as well as looking for the positive effects. It also requires an overview of what is happening in other sectors, so that messages conveyed through the mass media are consistent with those in other areas (schools, for example).

Options for health services

As discussed on page 32, one of the most glaring problems for health education policy in relation to health services has been the lack of resources allocated to local work, in terms of both time and people. Without these resources to carry policies through, national pronouncements on the importance of health education are little more than rhetoric. There are five key areas where improvemnts could be made:

1. Professional development

Services are required which offer personal one-to-one education, providing the support and encouragement needed on so many issues relating to health. The need for such supportive services has already been noted in relation to the increased impact of chronic disease. Part of the solution to lack of such services lies with improvements in pre-service and inservice training of professionals along the lines discussed in the next section. This would aim to encourage them to recognise their educational role and provide them with the skills required to carry them out.

2. Provision of facilitators

More widespread provision of 'facilitators' would also help health service staff, especially in primary care teams, to set up administrative structures and information systems to make it easier to carry out preventive and educational tasks in day-to-day routines.

3. Education of managers

Improvements also depend on the attitudes of policy-makers and managers. If they do not recognise the value of the educational role adopted by their staff, then time will not be allotted for this activity. Awareness-raising programmes with this group are therefore urgently needed to encourage them to see education for health as an essential component of the work of their departments.

4. Strengthened infrastructure

An important requirement is for people to act as advisers, catalysts and coordinators for educational initiatives at local level. Health education officers help to fill this role valiantly at the moment, but are woefully under-staffed and under-resourced. Proposals have been put forward which would improve the situation -- for example, by providing each district with a minimum core of staff with numbers reflecting the size of the district population and the wide range of tasks to be undertaken. The tasks are just as numerous in small districts as in larger ones. It has also been suggested that the budget for such departments be calculated to match the priorities which have been set for the district, rather than on some arbitrary percentage of the total district budget as is currently the case.

The strengthening of Public Health Departments also needs to be given greater priority. Some recommendations from the Acheson report, reflecting the serious decline of this specialty, come into force in autumn 1989. From then every district health authority will be required to employ a director of public health and have access to a consultant in communicable disease control. This is a start, although the minimum arrangements are still far from adequate.

5. Increased funding

None of the above developments can take place without increased funding and a firmer commitment to education for health at every level.

Facilitating community development

The problems faced by community development initiatives have been documented on pages 34-35. Some have found the problems insurmountable; others have survived long enough to work out solutions to at least some of the problems and have gone on to develop guidelines. (Youd and Jayne, 1986; Jones, 1989; Mansfield Community Health Forum, 1986; Ginnerty *et al.*, 1989). These include:

- education of policy-makers at every level to increase understanding of the approach and it implication for their service;
- careful preparatory work with local professionals and residents before projects start so that tensions are anticipated and worked through;
- the need for a firm management structure for such projects, with clear lines of accountablity, including responsibility to the community;
- the development of an infrastructure in each region, to support community development workers;
- the promotion of evaluation techniques which are tailored to the needs of the approach;
- long-term funding which recognises the length of time needed to undertake work of this nature.

This section has discussed health education in the community, by various methods and in various settings. Some have shown great promise. But it is clear from many of the obstacles encountered that more attention should be directed at professionals and policy-makers. So far nearly all the effort has been focused on influencing lay health behaviour, with the relative neglect of other strategies. The role of professionals and policy-makers in education for health should now be addressed as a matter of priority.

4 HEALTH IN PROFESSIONAL EDUCATION: MORE THAN AN OPTIONAL EXTRA?

Many of the developments discussed so far have brought into sharp focus the importance of educating professionals:

- to prepare them for their role in health teaching;
- to raise their awareness of how their policy decisions help or hinder provision of education for health by their staff;
- to alert them to the wider social issues of making healthy choices easier for the public, and the environment safer.

But how well prepared are they for their role in education for health? The evidence on trends in *initial education* (pre-service), indicates that modest advances have been made, in some professions more than others. For example, nurse education appears to be more advanced than medical education in this respect. But progress is very slow and there is still a long way to go before education for health is generally seen as more than an optional extra.

Inservice training for some professions (for example, teaching) has made considerable progress but is less well-developed elsewhere. Particular concern has been expressed about training and education for an ageing society. A survey of initial and continuing education for GPs, community nurses, social workers and home helps showed that the key area of health education and old-age was being neglected (Phillipson and Strang, 1986). Most courses reinforced the traditional negative stereotypes of ageing. Paid carers were therefore not being encouraged or trained to help older people retain independence and learn positive skills for maintaining health.

Training for health education officers is in a state of crisis at the present time. Specialist diploma and masters courses have been developed over the past 15 years in colleges and universities around the country, with financial help from the HEA and SHEG to support the secondment of students. However, due to technical reasons, funding for training has recently been withdrawn by the HEA and no formal arrangements have yet been made to replace the funds from another source. Trials are taking place in one region to see if a scheme for health education officers can be devised on a regional basis. Until an alternative is found and funding secured prospects for training these key workers are bleak.

Overall training for professionals would seem to be a most under-developed area, although certain outstanding initiatives have shown what is possible. This section looks at education and training for three professions: nursing, medicine and teaching. These examples represent only a few of the professions with a potential role in education for health but arguably they should be the ones at the forefront of any training on this issue.

NURSE EDUCATION: TRENDS AND INNOVATIONS

Education for health is now firmly on the agenda in discussions on the new nursing curricula. That in itself has been a major achievement over the decade, even if there may still be more rhetoric than action at present.

In the mid to late 1970s the role of the nurse in health education was generally given very little attention by colleges of nursing. If present at all, health education was implicit in the curriculum rather than explicit, though there were, of course, exceptions. A survey of schools of nursing in 1980 found that definitions of health education were still rather negative and there was little evidence of coordinated programmes, or opportunities for nurses to develop their practical education skills. The personal health education needs of nurses appeared to be neglected (Health Education Council, 1980).

Since then the structure of nurse education has been put in the 'melting pot' starting with the reorganisation of the regulating body for the profession. In 1983, Parliament laid down new rules for the education and training of the profession and the duty to equip nurses for health teaching was made perfectly clear:

> *'[the nurse] will receive an education which will prepare her to give advice on the promotion of health and the prevention of disease'* (Department of Health and Social Security, 1983).

Four national boards have been set up to administer training for the four countries of the UK. Each board has produced a new syllabus for basic nurse education based on the rules laid down in the 1983 Act. Some, like the National Board for Scotland, have issued separate guidelines on health education in anticipation of the new syllabus (General Nursing Council, 1980).

As a result, there has been a vast amount of curriculum development activity going on in the colleges of nursing to interpret the Act and to meet the requirements of the new syllabus. Proposals for further major structural changes in nursing including working in neighbourhood teams (Cumberlege, 1986) and altering the way student nurses are trained (United Kingdom Central Council, 1986) have all added to the general opening up of the debate on training requirements and the curriculum.

As far as *post-qualification training* is concerned, the health education content is often quite high, especially in health visitor, district nurse and midwifery training. However, community and hospital nurses have expressed their need for training in educational and communication skills in which they lack confidence (Scottish Health Education Group, 1983; Macleod-Clark *et al.*, 1985).

It is impossible to say what will come out of all these changes as far as education for health is concerned, although the combination of events offers a unique opportunity to influence the new courses at the planning stage.

Some have already seized on the opportunity and a number of innovations have emerged over the decade. For example, in 1977 SHEG funded a *nursing lecturship in health education* in the Department of Nursing Studies, University of Edinburgh. It was the first such lectureship in a nursing department in Europe and the remit was to innovate. At that time little explicit health promotion work was evident in the curriculum. Within the first two years, a 15-hour group-work course in self-appraisal was developed for first year students and courses for third years were devised on patient education and on community health education. The *self-appraisal in health* course was based on the premise that before nurses can educate about health they have to examine their own feelings, values and practices concerned with health. This course gave them an opportunity to start discovering, in a small group setting, how their ideas about health would affect other people. The Edinburgh course spread to other colleges (Schröck, 1981) and in 1982 a manual for nurse teachers was published on the subject, giving working examples from around Scotland (Hardy, 1982).

In 1979 an MSc *option in health education* was developed and introduced into the same department, and the lecturer also helped to stimulate and then coordinate the Basic Curriculum Project. This sprang from the guidelines on health education issued by the General Nursing Council for Scotland in 1980. The following year SHEG ran two workshop-based courses to help nurse teachers interpret and implement the guidelines and the Basic Curriculum Project, supported by the professional bodies, grew out of these workshops, as the need for a more thorough examination of the place of health education in the curriculum became apparent. The aims of the project were: to identify health education teaching opportunities in the basic nursing curriculum and to develop and test methods for clinical and classroom settings. Three out of the 20 Colleges of Nursing and Midwifery each convened health curriculum development groups to develop and test new approaches. Further colleges participated in pre-testing. By spring 1986, the project had produced three different sets of curriculum plans, sets of teaching materials and a series of recommendations for national dissemination (Scottish Health Education Group, 1986).

In England the HEC (now HEA) funded a similar lectureship in the Department of Nursing Studies at King's College, London. From this a training course on communication skills has emerged, initially concentrating on how nurses could *help patients to stop smoking* (Macleod-Clark *et al.*, 1987a). This highlighted the skills and support needed for nurses to take up an effective health education role, not just concerning smoking. The success of this project has led to an expanded initiative on communication skills to include doctors, physiotherapists and occupational therapists (Macleod-Clark, *et al.*, 1987b).

Since 1981 the HEC/HEA has also been funding the Communication in Nurse Education project. The aim was to devise an experimental programme on communication skills, introduce it into selected nurse training programmes and evaluate the effects against a control group. An improvement in skills in the experimental group has been demonstrated compared with controls (Faulkner, 1986). A survey of schools of nursing in connection with this project showed that tutors also needed more help in teaching communication skills (Faulkner *et al.*, 1985). Therefore a second phase of the project began in January 1985, in which an input on communication was introduced into two tutor training courses; this is in the process of being evaluated.

In connection with *health visiting*, pioneering work has been carried out by Vari Drennan to investigate how health visitors can work in different ways – for example, with groups and communities instead of concentrating on individuals (Drennan, 1986; 1988). This has considerably opened up discussion on health visitor training and practice.

MEDICAL EDUCATION: SLOW PROGRESS BUT A FOOT IN THE DOOR

What inroads has education for health made into the undergraduate medical curriculum? A few tentative steps have been taken, but there is a widespread view that British medical schools have made much less progress in this respect than other disciplines, notably nursing, and are falling behind many of their counterparts in Western Europe and the United States (Weare, 1988).

It is useful to consider what is expected of medical education in the context of health promotion. In 1981 the Director General of WHO suggested we should be looking at medical schools and asking such questions as:

> *'Do graduates think and behave in terms of 'health' rather than 'disease'? That is to say, do they apply techniques of prevention and health promotion and not only those of cure and rehabilitation? Do graduates think and behave in terms of the family and community rather than in terms of the individual sick patient? Do graduates think in terms of membership of a health team?'* (Mahler, 1981).

On such criteria, UK medical schools in general do not fare very well. For example, surveys of medical education in Europe in 1983 found an almost total lack of attention to health and its maintenance in the curriculum of UK and many other European medical schools and 'scarcely any place' in the curriculum for teaching about prevention and healthy lifestyles. (Walton, 1983; 1985).

A 1986 survey of the coordinators of all 50 undergraduate courses at Southampton Medical School confirmed this impression (Weare, 1986). It found that very little explicit education was going on in the field of health promotion, although there was some evidence of it, particularly in sociology, psychology and community medicine. It was usually mentioned in the early (low status) theoretical courses, rather than the later clinical attachments, thus giving doctors little opportunity to develop their practical skills. The same very basic messages about health promotion were repeated time and again with the danger of making the

subject seem worthy but boring. Most coordinators defined health promotion primarily as preventing disease through telling patients what they should do to avoid it – a model which many found negative, authoritarian, repetitive, unproven and 'not a task for doctors, especially hospital doctors'.

However, the picture is not all gloom. The medical curriculum has changed over the past 15 years or so to make room for psychology and sociology, and there is also some (though not widespread) coverage of doctor/patient communication skills (Baric and Friedman, 1985), which has increased from an almost non-existent base in the mid-1970s (Wakeford, 1983). It is also significant that there is now a department of general practice in almost every medical school in the UK; 30 years ago there was only one in the whole country (Lambert, 1988). These developments show that changes can be initiated, albeit very slowly, and they help to pave the way towards a more social orientation of medical education.

Several initiatives around the country have been showing what strategies are effective in *introducing health education and promotion into the medical curriculum*. For example, the 1986 Southampton survey of medical coordinators proved to be a valuable strategy for raising awareness of health promotion throughout the medical school and of identifying coordinators who were particularly keen to develop health promotion teaching. The HEC-funded lecturer who carried out the survey was then able to start by working with the community medicine department to make improvements to a course on Man, Medicine and Society. This covered 20 hours over the first five weeks of the first year, and was originally based on optional lectures where attendance was of the order of 30 per cent. Improvements made to the course included a variety of inputs each followed by workshops for groups of 14 students, using active learning methods. Attendance rose to 95 per cent using more participatory approaches. The success of this led to further opportunities in other courses (Weare, 1988).

During the 1980s the Scottish Health Education Group has funded lectureships in all three departments of community medicine in the medical schools in Scotland and this strategy has proved effective in stimulating developments in each department. For example, a four day module on health promotion, based on the WHO Health for All principles, has been developed as part of the training for all medical students at Edinburgh University. The module forms the final part of a new four-week course on community medicine for fourth and fifth year students. It has two very significant features:

1. All 180 students each year take the module, but they are split up into groups of 15 so that they can experience small-group active learning methods. Previously, teaching consisted of half a day of lectures to 60 students at a time.

2. Assessment of the health promotion module is part of the community medicine assessment which in turn forms part of the students' fifth and final professional examinations. Students therefore have to pass this in order to qualify as a medical practitioner (Amos, 1989). Evaluation of the module shows that it is rated very highly by the students and this is reflected in the questions students choose to answer in the final examination.

Interest in some studies has centred around the effects of *communication skills training*. A controlled experiment in Cambridge in 1978 evaluated the effects of such training on a group of first-year medical students randomly assigned to either control or experimental groups. The test group received three 60-90 minutes tutorial sessions in groups of two or three using video-tapes of their own early patient contacts. Controls met with the teacher in a more conventional routine learning basic skills of history taking and physical examination. A highly significant improvement was recorded for the test group, in which *every* student's score improved. No overall change took place with the control group (Wakeford, 1983).

An assessment of the longer-term benefits of communication skills training in Manchester, five years after training, found that both control and experimental groups had improved since qualifying, but those with feedback training had maintained their superiority in the skills associated with accurate diagnosis. Both groups still had problems covering psychosocial problems in physically ill patients and tended to use 'closed questions'. Those trained conventionally were clinically inadequate in both these aspects, and in clarifying their patients' statements (Maguire *et al.*, 1986a). This showed the value of skill training in improving accurate diagnosis. However in a related study both sets of doctors were equally bad at *giving information* and reporting results of the tests to their patients (Maguire *et al.*, 1986b). A training course tackling information-giving skills in particular is currently being developed and evaluated at Cambridge University Clinical School (Morris, 1988).

In an innovative project in St Mary's Medical School, London, an HEC-funded lecturer has been exploring the implications of the principles of *community development* for undergraduate medical education. For example, this has involved reorganising community medicine project work so that seven to nine students work on the same project, instead of singly or in pairs. For two weeks of the four week rotation, groups of students work together on a locally-based project on an aspect of health promotion policy. A key aspect is that the policies are evaluated from the point of view of local residents, and the inner city population of the district, as well as the policy-makers and service providers. The students' work is now extending to encompass policy issues that local community organisations have identified as important – for example, the impact of homeless families living in hotels on the local health and social services (Farrant, 1988; Joffe and Farrant, 1989).

Some departments in medical schools are obviously receptive to change with the correct stimulus, but the percolation of ideas to other departments is a very slow process.

TRAINING FOR TEACHERS

Unlike their medical and nursing counterparts, tutors in colleges of education in successive surveys have been found to have a broad concept of health education, not restricted to preventing disease, and generally consistent with the WHO definition (Head *et al.*, 1975; Williams and Roberts, 1985). However, over the years the subject has had mixed fortunes in securing a place in the curriculum and there has been great variation in the length of courses provided and in their compulsory or optional status.

A national survey in 1982 looked at what was happening in the universities, colleges of education and polytechnics offering initial teacher education in England and Wales. This found that 63 per cent of institutions had some health education input, but only 25 per cent included it as a compulsory course. The length of the 'core' course varied from 1-50 hours with an average of 1.5 hours in universities (Williams and Roberts, 1985). There was a rapid improvement from 1982 to 1985. For example, the proportion of institutions with a compulsory 'core' course increased from 25 per cent to 43 per cent over that time, and the average length of course also increased – from 1.5 hours to 4 hours in universities, for example (Williams, 1986b).

There are signs of a willingness to accept a health education role which is perhaps not so evident in medical and nursing students. For example, a survey of students in teacher education institutions found that over 80 per cent said they would welcome the opportunity to take part in teaching related to health education, although less than half felt that they had a good enough grasp of the subject to teach it (Williams and Roberts, 1985).

The rapid improvement in coverage of health education in colleges between 1982 and 1985, has been attributed in part to the Initial Teacher Education Project carried out by the University of Southampton Department of Education and funded by the HEC. This project was set up in 1981 to find out what was happening in initial teacher-training and to develop appropriate materials and strategies for re-establishing health education as a viable part of professional preparation for teachers. The above surveys of schools, training establishments, tutors and students were carried out in 1982 and work started with colleges all over the country, drawing them into the development process. The completed materials and curriculum guides from this project were recently published.

Any progress made over the past few years in this field has to be viewed as rather precarious because the whole structure of initial teacher education is under review at the present time. Some of the proposals being put forward might change the situation completely. For example, the 'licenced teacher' scheme has implications for the amount of time students would spend in college.

Whatever developments occur in pre-service training it is thought that inservice training is likely to have the most impact on education for health in schools in the future. This is because, with falling rolls and contraction of the education service, *'the teachers of the next generation of children are already in the schools'* (Young, 1985). There have been encouraging signs in this field, with many of the initiatives introduced into schools over the decade having extensive in-service training components (for example, see pages 12 and 16). The techniques used in some of the training courses are considered to be among the most sophisticated encountered anywhere and are also highly effective (see page 14). In addition, the large American study quoted earlier showed the influence of inservice training for teachers on the subsequent success of school health education programmes (Connell *et al.*, 1985).

The problem is that inservice training does not always take place before health education programmes are introduced into schools and some are implemented in a haphazard way. In such cases there is a risk of programmes being delegated to staff who have not been motivated or prepared for such a task. The added complication of teachers currently being overwhelmed with other inservice training commitments has already been discussed (page 18), and no easy answer is available for this.

5 COMMUNITY-WIDE PROGRAMMES

On a scale larger than anything discussed so far, there have been attempts throughout the 1970s and 1980s to set up community-wide programmes, which combine several of the methods already discussed in a variety of settings. Evidence of the effectiveness of such initiatives in influencing coronary heart disease factors has come mainly from Finland and from the USA. Currently this strategy is being developed in Wales in a major initiative, which builds on successful components of earlier studies. Consideration of the Welsh project and comparison with the one set up in England two years ago illustrate the strategy and some of the difficulties.

Heartbeat Wales

Heartbeat Wales was set up in 1985 as a national demonstration project to test the feasibility and effectiveness of a major health promotion exercise in the field of cardiovascular disease prevention on a regional basis (Parish, 1987; Nutbeam and Catford, 1987; Smail and Parish, 1989).

Originally it was funded by the HEC and Welsh Office, but has now been taken over by the Health Promotion Authority for Wales. Table 5 lists the main activities of the project, and from this it can be seen that it does not rely on a single approach, but uses complementary strategies at both individual and community level to try to bring about change. The Table illustrates five key points about the approach taken in the project.

1. It does not concentrate solely on changing the behaviour of the general public but seeks to bring about *structual changes* which support healthy choices – for example, restrictions on smoking in public places, better food labelling, increasing availability of 'healthy' foods in shops and canteens, and changing work practices of health and education professionals. This involved collaboration with a wide range of opinion-leaders and policy-makers.

2. The mass media are used to create a climate of opinion conducive to the development of the wider programme. About one-sixth of the budget was used for this purpose but *none* of it was spent on buying advertising time or space. Instead, links were developed with media and materials produced to support media programme-makers in a close working relationship.

3. Approximately £250,000 (one third of the budget) was spent annually on supporting local community initiatives which is where the crucial face-to-face education takes place. Many of these were experiments in different ways of supporting people who wished to change aspects of their lifestyle.

4. Research and evaluation were used throughout the project, but in a very creative way. Not only did the various surveys and in-depth studies measure changes, but they were also used to stimulate action by opinion-leaders, to generate much of the media coverage, and to influence policy-makers. In this last respect, considerable effort was put into processing results quickly and disseminating the findings widely to policy-makers around Wales.

5. High levels of awareness and participation in the programme were achieved by these methods. For example by 1988, 70 per cent of the population was aware of the programme and a large proportion approved of it.

The evaluation plan for this project is extensive, covering four main tasks: describing what the programme consisted of and what happened at each stage; measuring any change in a wide range of individual and structural indicators; looking at the *process* by which change was achieved (why and how it occured); assessing the project's policy relevance – for example, are any of the strategies repeatable elsewhere, and what are the costs involved in different components of the programme? (Nutbeam and Catford, 1987).

Outcomes, such as changes in risk factors, will not be known for some years, but already the evaluation has shown promising results in other respects. For example, the Heartbeat Awards have proved a successful ploy for motivating catering establishments to make improvements and the idea has now spread to England, as have the changes originally introduced into supermarkets in Wales. The initiative has also stimulated policy changes in education and health authorities. It has shown the importance of engaging the interest of a range of agencies outside the health services, of supporting local activities and of continual research and evaluation for planning purposes.

Comparisons

Early in 1989 the National Audit Office contrasted the approach taken in Wales with that taken on coronary heart disease in England under the DoH/HEA banner of Look After Your Heart which began in 1987. The English initiative was based much more heavily on mass media advertising with fewer resources committed to community initiatives compared with the Welsh programme (0.5p per head compared to 10p per head in Wales). It gained much lower awareness among the population and ran into other problems (National Audit Office, 1989). One reason noted by the National Audit Office for the difficulties in England was the under-staffing of the Look After Your Heart programme. Heartbeat Wales had a staff of 25 to organise a programme for a population of 2.8 million in one region containing nine district health authorities. Look After Your Heart had a staff of three for a population of 47 million living in 14 regions containing 191 district health authorities. Direct comparisons on staffing cannot easily be made because Look After Your Heart contracted out some of the research work, whereas Heartbeat Wales saw research as an integral part of the education strategy and carried out much of it in-house. However, the logistical problem of three people liaising with 191 districts, as well as making the necessary contacts outside the health service is obvious.

Following the comments of the National Audit Office the staffing level for the English project is being increased somewhat. But it still illustrates a more general point about the lack of human resources available for education for health – a point which has

TABLE 5 · HEARTBEAT WALES PROGRAMME INITIATIVES

with **Mass media**

Co-produced 49 different TV programmes in Wales.

Press coverage measured in miles – mostly generated by research findings. Regular newspaper insert in regional press; circulation 300,000, readership of one million.

National exhibitions at county shows/eisteddfod.

with **Health authorities**

Promoted setting up of multidisciplinary CHD planning groups.
Development in every district of smoking, food and health policy.
Financial support of local initiatives in each district.
Promotion with ambulance services of schemes to teach cardiopulmonary resuscitation to the public, led to 'save a life' scheme.
Encouraging coordinated policy for blood pressure screening and control and exercise.
Mobile fitness testing stations supplied to health authorities.

with **Primary health services**

Support for primary care facilitators and county nutritionists, experimenting with different models.
Collaboration with Open University to develop distance learning course on cardiovascular disease for primary care team. Uptake of course now more extensive in Wales than elsewhere.
Initiatives with nurses, dentists and pharmacists.
Repeat surveys of all GPs in Wales, all 600 health visitors, all practice nurses.

with **District and borough councils**

Planned survey of local authority chief officers and local politicians.
Heartbeat Awards developed with environmental health officers given to catering establishments which meet certain 'health' criteria – for example, healthy menus, non-smoking.

Work with trading standards officers to enforce laws strongly on illegal sales of cigarettes to minors.

with **Lay opinion leaders**

Developing a network of Look After Yourself adult education courses, tailored to specific needs of community groups.
Funding lay support projects.
Joint events and Look After Yourself courses with community organisations – for example, Women's Institutes, Young Farmers Associations.

with **Agriculture and food industry**

Meat and Livestock Commission projects – promoting lean-meat, developing new fat-grading system for carcases in abbatoirs, training butchers on leaner cuts.
Work with Tesco supermarket chain to modify own-brand products – for example, reduced fat, salt, sugar; to introduce new range of products; to introduce new food labelling scheme and in-store nutrition education.
With Unigate Dairy – to develop doorstep delivery scheme for skimmed and semi-skimmed milk.

with **Schools and young people**

Regular surveys of young people, teachers, headteachers and local education authorities on health education policy and practice.
Work with county school meals service to promote healthy eating.
Curriculum development on nutrition and exercise modules.

Promotion of *tester* modules on smoking – every education authority now has a food and health policy as a result.

in the **Workplace**

Promoting workplace smoking policies with health and local authorities, trade unions, British Institute of Managers.

Developing an annual award for most health-promoting employer with CBI.

Providing mobile screening service to factories.

in **Research**

Policy and practice surveys of key change agents as mentioned above.

Repeat community surveys of risk factors, and so on.

Process evaluation of components of project.

recurred in other sections. It also raises the question of whether it is realistic to manage such an initiative at a national level, or whether regions would be better focuses for activity.

Perhaps the most important difference between the two initiatives is that the Welsh one is based on wider health promotion policy. It has attempted to tackle structural factors, such as the availability and quality of food in the shops, as well as educating the public. The English initiative, on the other hand, has so far relied more on educational strategies, with little or no emphasis on influencing other policies which would make the recommended lifestyle changes easier to undertake. The objectives of the initiative will be more difficult to achieve without action on supporting policies.

Community-wide operations also highlight more general concerns. Many of the tasks which the national health education bodies have been called on to undertake have been on a community-wide scale; they have spanned several different settings and a growing list of topics. Yet throughout the decade the funding for such bodies has been at the approximate level of £1 in every £1,000 of NHS expenditure (House of Commons, 1989b). Even by 1988/89 the budget of the HEA, for example, stood at £10 million for AIDS education plus £12 million to cover everything else. Considering what is involved, this level of funding would be judged by many to be insufficient for the task in hand and indicates a general lack of national commitment to education for health, which needs to be reassessed.

6 CONCLUSIONS: DRAWING THE THREADS TOGETHER

This report has looked at education for health in terms of the various methods which have been employed in a range of major settings. Now, surveying the scene as a whole, some of the common threads can be drawn together.

The first point which should be acknowledged is the tremendous amount of work which has been accomplished over recent years. There are examples of high quality initiatives in each setting and of people finding ways of exploiting every opportunity offered. Indeed some, particularly in the school and professional training fields, have been outstanding on an international scale and are among the most advanced and sophisticated to be found anywhere. Having said that, the over-riding impression in the work reviewed is one of health educators attempting to swim upstream, against the current of forces which have operated to damage health or undermine educational efforts – hence the title of the report. This is apparent both when looking at trends in the past and when considering prospects for the future.

What does and does not work?

It is also apparent that while the volume of research and experience concerning education for health has continued to grow over the past 10-15 years, this body of knowledge has not always been applied. There are still many areas where knowledge is missing and initiatives proceed by trial and error. But for specific purposes certain 'ingredients for success' have been identified and, equally important, strategies which have proven to be ineffective have been exposed.

For example, in connection with *schools* (see page 12), the active learning methods employed in a spiral curriculum have achieved objectives which methods based on one-off lectures had failed to reach. Greater insight into some of the structural policies which enhance the effectivenesss of school health education programmes has also been gained: the importance of inservice training, of adequate preparation of teachers before introduction of programmes, the encouragement of parental involvement, the commitment of the school in terms of timetabling, resources and the provision of a balanced programme with a senior coordinator. Pages 12-16 give examples of initiatives which have put these principles into practice. Yet the knowledge is still not being used to best advantage on a wide scale. As one survey in Wales put it:

> *'The evidence suggests that the one-off talk by a guest speaker may still be alive and well in Wales, despite the fact that such approaches have long been identified as ineffective in either improving knowledge or changing behaviour'* (Nutbeam *et al.*, 1987).

In *mass media* work there is a wealth of data to draw upon from the field of advertising and communications research as well as from health education studies. At a very basic level, experiments have shown how to improve the readability of a communication, to increase the likelihood of its being read and understood by the intended audience. Despite that knowledge there are still situations from time to time, such as the one concerning AIDS on page 27, where government press advertisements are issued in a form which the majority of the general public would have difficulty reading and comprehending.

It has become clear that certain tactics run a high risk of being counter-productive — for example, scare tactics or an over-authoritarian approach which appears to be telling people how to lead their own lives (as discussed on page 25). Even so, there are recent instances of advertising agents, who would not dream of using these approaches in other areas of their work, applying these strategies to complex health issues – for example, the drug misuse campaigns detailed on pages 25-27. In addition there are now well-researched processes for refining mass media programmes from the important first step of assessing the appropriateness of mass media for the task in hand, through the formative stages of matching the material with the target audience, to the mechanics of ensuring adequate exposure, selecting the best mix of channels and so on. By no means all mass media programmes over the decade have employed this cycle of research and development.

Similarly, over the decade much has been discovered about the personal one-to-one encounters between lay people and professionals: the desire for information by the majority of patients; the one-sided nature of communication in many consultations; the misunderstandings and sometimes breakdown in communications that occur; the low compliance rate for medication. Studies have shown that patients can be helped to remember the salient facts about their illness and treatment with a consequent improvement in correct drug use. Methods have been found for improving the communication skills of doctors and nurses to better meet the information needs of their patients. Effective methods have been devised to reduce patient's anxiety, with a consequent reduction in the experience of pain, and also to motivate patients to change behaviour in connection, for example, with smoking and alcohol (see pages 30-32). Nevertheless surveys of patients repeatedly show that in many cases their information and education needs are not being met.

On the professional training front some strategies have proved very useful in improving the coverage of health education in the curriculum. For example the funding of lectureships in key departments, the setting up of demonstration courses and the concerted efforts to have health education accepted in the formal examination procedure have all paid off, as the projects described on pages 37-40 have shown.

Even in one of the most difficult areas of all – addressing inequalities in health – some of the approaches through community development show promise for opening up a dialogue with people in disadvantaged areas, developing services better tailored to their needs (see pages 33-34).

Most important of all is the realisation that education rarely works without being linked to complementary social and public policy. Education for health stands most chance of success when backed-up by fiscal, legal and other regulatory measures.

Progress on the issue of seatbelt wearing and tobacco has illustrated this point well.

In the light of all the available evidence, the big question is *why* is this knowledge not being put to better use?

Obstacles to progress

Part of the answer to the above question lies in the administrative and political obstacles which stand in the way of implementing effective methods. Some of these obstacles differ from setting to setting and these are discussed in detail under the relevant headings in the body of the report, together with recommendations for action. Box 4 summarises the salient features of each setting.

However, several obstacles can be discerned which are common to all the settings. Firstly, some of the problems stem from failures in communication between researchers and developers of health education programmes on the one hand and policy-makers and practitioners in the field on the other hand. Consequently there have been cases of people 'reinventing the wheel' in different parts of the country and also signs of a lack of understanding at all levels of complexity of the process of health education, with over-simplistic solutions adopted as a result. New channels of communication between researchers and policy-makers need to be created and phases of research and planning synchronised more closely. In addition, more systemmatic education of policy-makers needs to be initiated and all new health education developments would benefit from having dissemination phases built into them from the beginning with funding and time allocated to inform those who would be able to make most use of the results. WHO has been formulating further specific recommendations on this key issue (Nutbeam, 1987b).

A second, much more fundamental, obstacle is the 'high rhetoric – low-status' position surrounding education for health in this country. For all the pronouncements on the importance of health education, and the need to give it priority, in reality it is accorded low-status in most sectors. There is much more rhetoric than resources put into the activity. This can be seen in relation to the school sector, where nationally it has not secured an adequate place in the National Curriculum, and locally where it shares the fate and status of many other non-examination subjects, vying for a place in the timetable. Similarly, in professional education settings, it has struggled for recognition as a crucial matter of concern in initial

BOX 4 · STRUCTURAL OBSTACLES TO PROGRESS

Schools setting

lack of commitment in national curriculum;
curriculum overload;
inservice training overload;
low-status, non-exam subject;
cross-curricular nature of the subject;
lack of coordination across subjects and years;
political pressure to respond to 'crisis' issues on one-off basis;
lack of complementary school environment policy – for example, school meals policy.

Mass media

cost;
media-imposed restrictions on information content – for example, use of condoms for safer sex;
counter-productive activities of the media – for example, sensationalism and unrestricted promotion of damaging products;
inequalities in health information in the press;
political attractivenesss of the mass media for instant, high-profile solutions;
inadequate liaison channels between national and local services;
inadequate channels of communication between programme-makers, press and health educators.

Health care settings

lack of 'grass-roots' workers in health education field;
lack of adequate funding for educational purposes;
work overload of professionals on crisis management cases;
low priority with managers;
lack of specific training and motivation of professionals;
communication gap between professionals and lay-public.

Local community settings

failure of funding body to recognise priorities of communities;
perception of threat by local health workers;
insufficient time allocated for setting up projects and evaluating effects;
unrealistic expectations of projects.

Professional training settings

major curriculum shake-ups;
curriculum overload;
non-examination, low-status nature of health education;
curative orientation, especially medical schools.

teacher, nurse and medical education, and even now has only a tentative foothold, despite encouraging statements from professional bodies. The same applies to education in the community where provision is totally inadequate for the volume of work required in, for example, health authorities, where health education departments are generally of low-status, are understaffed and under-resourced, and health promotion work in general is allocated roughly 0.1 per cent of the total revenue budget. Furthermore, it is the educational work of nurses and other health workers which may be seen as a dispensable luxury when managers are looking for efficiency savings.

Government spending priorities reinforce the low-status view. Health education appears to be low on the list judging by the proportion of total NHS expenditure allocated to the national health education bodies and also judging by the amounts allocated to *health* information campaigns compared to other information campaigns undertaken in recent years. If this state of affairs is not recognised, there is a danger of the rhetoric leading to a false sense of security: 'we're already doing all we can about education for health'.

Many other problems have stemmed from this basic lack of status. For example, because of this perception organisations have not given priority to education for health in terms of funding, in terms of time allocated to carry out the tasks and in terms of human resources deployed. Inadequacies have therefore developed on all these fronts. This obstacle will only be overcome by firm political commitment at a national level. If health education and health promotion in general are really national priorities then this has to be reflected in concrete resources and plans to match the rhetoric.

The third common obstacle is the lack of a mechanism for coordinating policy at different levels within settings and across different settings. Because resources are finite, decisions taken in one sector have implications for resources and approaches taken in another. Policy in all sectors is interlinked, whether by conscious design or not. At a national level, lack of coordination has led to antagonistic strategies on some topics and other issues being neglected. Some coordination has begun to take place at cabinet level with the interdepartmental committees on drugs and AIDS, but this is nowhere near enough. There is an urgent need for a national health promotion policy which coordinates action coherently (Beardshaw, 1987; Smith and Jacobson, 1988), with *health education* as part of this broader policy.

Filling the gaps

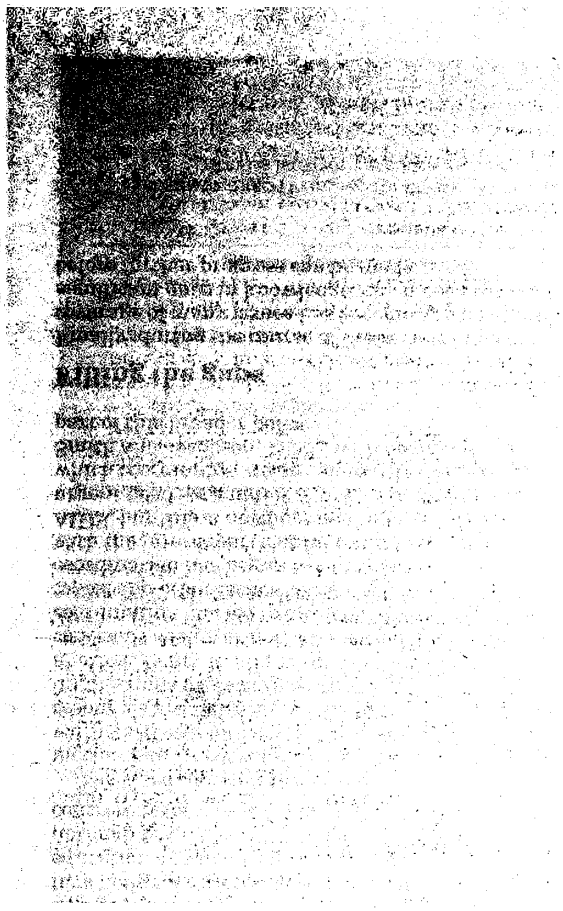
Finally, during the course of the review inadequate coverage of many issues has become apparent, as have significant gaps in knowledge which need to be filled before further progress can be made.

For instance, it is noticeable that the majority of policies and initiatives in all sectors have been concerned with individual lifestyles, aimed at reducing conventional risk factors by changing the behaviour of members of the general public. There have been exceptions to this, but on the whole there has been neglect of education concerned with social and environmental influences on health and a relative neglect of education directed at local and national policymakers as opposed to the general public. So, for example, in the mass media campaigns the emphasis has been on educating the public about separate health behaviours, such as the risk factors for coronary heart disease, drugs and AIDS. The carefully controlled trials of education by doctors and nurses have been predominantly concerned with helping individual patients to stop smoking or change their drinking behaviour, without reference to the social context. Even in schools, where initiatives have not been so concerned with preventing disease, the emphasis has been on personal and social development, rather than on the health of communities. Only now is there a move to think in terms of the health promoting school. It also means that much research on changing health behaviours has been limited to a narrow selection of possible behaviours (McQueen, 1989) and most of these have been linked to physical rather than mental or social health. The balance of activity on individual, social and environmental factors needs to be reassessed, together with more attention given to the educational needs of policymakers.

Even within the field of lifestyle education there are many unanswered questions. We need to know much more about what motivates people to change complex behaviour. This has become more urgent with respect to sexual activity with the advent of AIDS. Too little is known about the constraints there are on people who wish to change behaviour and about how a change in one behaviour affects behaviour concerning other issues.

Apart from the major community development initiatives, hardly any attempts have been made to encourage lay participation in health decisions or to take into consideration the unequal impact of health education across the social class spectrum.

There are large gaps in knowledge of how to influence institutions and policy-makers to adopt effective methods of education for health. In particular, there is very little published on why good initiatives failed to be taken up, even though such analyses are invaluable for future planning (for example, Goodman and Steckler, 1987). In this respect much more process evaluation needs to be built into educational initiatives so that successful and unsuccessful components can be identified. How to implement known effective methods in different settings is one of the many challenges in education for health in the coming years.



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