An investigation into NHS Health Promotion Specialists' ethical dilemmas about their work

A thesis submitted for the degree of Doctor of Philosophy

by

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PREAMBLE

After completing a degree in Psychology and Behaviour in Organisations, and then a Diploma in Personnel Management, I obtained a job working in a South London district's Health Education Unit running 'quit smoking groups' and training health personnel to do the same. After a year or so of debate, the Health Education Unit became a Health Promotion Unit because nationally others were doing the same, and the staff became Advisors after having been Officers. The Health Promotion Unit (HPU) was given new signs, and we were given new badges and business cards, but the essential philosophy of the HPU did not seem to change at all. I subsequently worked there for eight years as smoking and alcohol Senior Health Promotion Advisor. During that time, I completed the 2 year 'day release' Health Education Diploma course, and was then allowed to continue on 'block release' to undertake the MSc. in Health Promotion. I became interested in the philosophy behind Health Promotion and subsequently in the ethical dilemmas myself and my colleagues were experiencing with their work.

My friends, and sometimes my colleagues, and the public often remarked on what exactly it was that I did at work. My mother in law told me I had a 'funny job', bossing people around. I was introduced at meetings and conferences as being an expert in smoking issues, yet I had never smoked. Health 'experts' I'd met as a patient, I often found intrusive, so I wondered how my 'expertise' was viewed. I felt the 'expert' name tag added to my professional status and credibility, but that I was not really an expert at all.

During the mid 1990's, massive amounts of money were being injected into Health Promotion Units for HIV/AIDS awareness, which caused great debate amongst colleagues with substantially smaller budgets. The department got a new manager who had previously been a nurse, who seemed to make everyone's life unbearable, and many of my colleagues left. The Health Promotion Unit was absorbed into the Public Health Department and we were asked to begin evaluating and doing cost effectiveness studies into our work and to 'justify' our existence. We wondered what to do with the cost analyses we were conducting, and what to do with our research findings. We mostly ended up doing nothing at all, just filing these important findings.

I also began wondering what I was doing at work.

I became disillusioned with having to justify to others and myself what I was doing all day as an NHS "Health Promotion Specialist". I was struggling with a number of ethical dilemmas, including my credibility, whether I told the truth, people's autonomy, my perceived power, inequalities in health, ways of working, and the impact of NHS changes and bureacracy.

So, after 8 years doing a job I loved, and felt I did well, I left.

CONTENTS

	Page
Thanks	2
Preamble	3
Research aim	9
Research questions	9
Supervisor	9
CHAPTER 1: Health, Health Education and Health Promotion	10
Defining health	
Defining health education and health promotion	
Health Education	
Health Promotion	
The relationship between Health Education and Health Promotion	
An overview of 20th century Health Education and Health Promotion: 1960's to 2000	
Health promotion training	
Health promotion as a profession	
Society of Health Education and Promotion Specialists	
Health promotion as a service	
Staff	
Length of service	
Qualifications	
Public opinion and expectations	
Health promotion theory; theoretical framework	
Models of health education	
Clarifying health promotion aims	
CHAPTER 2: Philosophy and Ethics	40
philosophy	
ethics	
moral judgements	
good	
bad	
truth	
autonomy	
equity	

justice
duty
power
expertise
credibility
role models
rights

CHAPTER 3: Health Promotion and Ethics 53

Ethical enquiry in Health Promotion
receiving messages
selling health
persuasion
sponsorship
leaflets
harm minimisation/ just say no
health education and young people
targeting programmes
government policy
evaluation

CHAPTER 4: Professions within Health Promotion, and the implications for ethical dilemmas 71

Medical ethics
Health Promotion and nurses
Health Promotion and teachers
Health Promotion Specialists and ethics

CHAPTER 5: The preliminary research

Preliminary studies 79

preliminary interviews 80
Design
Findings
Discussion
Health Promotion Service team focus group 85
Design
Findings

Discussion
patient questionnaire 89
Design
Findings
Discussion
regional Health Promotion staff questionnaire 94
Design
Findings
Discussion
final interviews 106
Design
Findings
Discussion

CHAPTER 6: Main study 111

National Health Promotion Advisor questionnaire
Design

CHAPTER 7: Results 117

Statistical findings for the following questions:

district
job title
years in job
years in current Health Promotion Unit
worked in any other Health Promotion Unit
age
sex
main area of work
contracted hours
hours worked
member of SHEPS
Health Promotion qualifications
other academic or professional qualifications
prior jobs
'model' of working
good points
bad points
dilemmas

future for Health Promotion

CHAPTER 8: Results- associations between variables 166

regions and ethical dilemmas
job and ethical dilemmas
job and health promotion qualification
age and job
age and health promotion qualifications
age and highest qualifications
sex and job
sex and HIV/ sexual health workers
sex and qualifications
sex and health promotion qualifications
previous work and ethical dilemmas
Ex-teachers
Ethical dilemmas of ex-teachers
Ex- teachers
Ethical dilemmas of ex- teachers
Ex-social workers/ youth workers/ counsellors (caring professions)
Ethical dilemmas of ex-social workers/ youth workers/ counsellors (caring professions)
SHEPS
SHEPS and job
SHEPS and sex
SHEPS and age group
SHEPS and Health Promotion qualifications
SHEPS and model of working
SHEPS and good points about job
SHEPS and bad points about work
SHEPS and ethical dilemmas
SHEPS and offer to be followed up
SHEPS and future for Health Promotion
relationship between bad points and ethical dilemmas

CHAPTER 9: Discussion of findings 206

the respondents 206
ethical dilemmas 209

CHAPTER 10: Discussion of relationships between variables 229

Discussion of Methodology 244

CHAPTER 11: Conclusions and Recommendations 246

Research questions and answers summarised 246

References 253

Appendices 272

Pilot study raw data
Questionnaire
Variable lists
Raw data for questions
district
age
qualifications
Crosstabulations:
job and ethical dilemma
health promotion qualification and ethical dilemma
bad points about work and ethical dilemmas
Profile of 36 respondents
36 verbatim questionnaires
Profile of managers
Profile of dietitians
Profile of HIV/ sexual health workers
Profile of SHEPS members
Profile of ex-teachers
Profile of ex-nurses
Profile of ex-social workers

Research aim

- to investigate and analyse the ethical dilemmas of United Kingdom NHS Health Promotion Specialists.

Research questions

- what ethical dilemmas do Health Promotion workers report about their work?
- does regarding Health Promotion as a profession detract from its intended impact?
- does the educational background of people who work in Health Promotion feature as a factor in determining their dilemmas?
- does the work experience, (for example, ex-nurses, ex-teachers, ex-social workers) of people who work in Health Promotion feature as a factor in determining their dilemmas?
- does membership of the professional body, SHEPS, correspond with particular ethical concerns?
- are recent structural changes to the NHS perceived by staff as detrimental to the standard and efficacy of Health Promotion?
- do Health Promotion workers perceive the concern about their ethical dilemmas about Health Promotion as posing a barrier to the practice of Health Promotion?
- do those Health Promoters who have ethical dilemmas about their work leave the job?
- can specific variables which influence ethical dilemmas be identified?

Supervisors

Professor Theodore MacDonald

CHAPTER 1: Health, Health Education and Health Promotion

Summary: *defining health; defining Health Education and Health Promotion;* the *relationship between Health Education and Health Promotion; an overview of 20th century Health Education and Health Promotion: 1960's to 2000; Health Promotion training; Health Promotion as a profession; Society of Health Education and Promotion Specialists; health promotion as a service: Staff, Length of service, Qualifications; public opinion and expectations; Health Promotion theory; theoretical framework; models of Health Education; clarifying Health Promotion aims.*

Defining Health

At first, the meaning of the word 'health' may seem straightforward, and probably most people would know what they mean when they commonly use the word, but any deeper philosophical reflection makes an 'academic' definition very complex. Few will agree how such a broad and value laden concept can ever be circumscribed. Indeed, Seedhouse (1986) devoted a whole book to a search for the definition, explaining that

> *"...health is one of a number of words which are constantly in use which are so rich in meaning that they cannot be explained fully without invoking controversy. This poses a challenge for us to try to understand more clearly what we mean when we use such words."* (Seedhouse, 1986: xii)

Gallie (1956) suggested that 'health' will remain an 'essentially contested concept' and that people will never be able to define it. The word 'health' means substantially different things to different people. It could be argued that looking at the word health in a variety of ways is a 'post-modern' approach, which questions notions of scientific dominance, objectivity and progress, and concludes that there can only be 'truth claims' rather than final answers.

There are a number of theories of health, each with a different philosophy and outlook, including that health is:

- the absence of ill-health
- an ideal state
- the physical and mental fitness to do socialised daily tasks
- a commodity
- a personal strength or ability, either physical, metaphysical or intellectual
- the ability to achieve one's potential

- physical, social, and mental wellbeing

Some of these theories overlap, others are not readily compatible. In the past, health was always traditionally associated with not being ill, and therefore the medics were the 'experts'. Access to their information was somewhat privileged, and the non-medic would be subservient to the medic. Farrell, (1986: ii) surveyed the residents of Bath Health District and found that the respondents defined being healthy differently to medical definitions, for example, as *"...having a clean environment, a job, and suitable housing, as well as taking exercise and eating a healthy diet."* The non-medic therefore seems to have a broader definition of health as involving much wider issues, such as housing, transpost, culture, religion, and money.

It would then follow on that definitions of health will reflect on definitions of Health Education and Health Promotion. In addition, a more medically orientated definition of health will therefore have direct implications for the running, funding and targeting of a Health Promotion Unit. Following recent NHS changes, many Health Promotion Units have direct responsibility to the Public Health Department, whereas other units would be directly responsible to less medical departments. Can a less medically orientated Health Promotion Unit 'sit well' in a National Health Service funded function?

Defining Health Education and Health Promotion

Many authors have defined Health Education and Health Promotion. It has become a rather long debate; maybe even become a cliché. The search for the perfect (or even a reasonable) definition will have repercussions on Health Education/ Promotion philosophy and practice, because which other profession does not actually know or cannot agree about what it does?

> *"If we were secure in our definition of health, then it might be easier to describe the potential role of health educationalists or health promoters."* Campbell, in Doxiadis, 1987:23.

Some Health Promotion Advisors might see the search for a good definition as their search for a 'Holy Grail'. Is the search for a definition illusory? Sutherland, 1987, states that looking for definitions of nouns is an 'unhelpful exercise', because it limits thinking, becomes abstract, and then impossible, and that usually context defines terms. However, looking at other people's definitions can help mould one's own definition, and many authors have defined health Education and Health Promotion.

Health Education

It is not really known whether the term 'education' is derived from the Latin *'educere'*, 'to bring forth', or *'educare'*, 'to nourish or rear'. Both imply some form of instruction, training, schooling, or set example, by another person or process. There is also the implication that the process is a valuable activity, and that the result is maturity, development knowledge and experience.

Health 'education' can therefore be seen as a beneficial process for the recipient, by another interested party. Health Education is seen as representing *"...consciously constructed opportunities for learning which are designed to facilitate changes in behaviour towards a pre-determined goal."* (Nutbeam, 1986:114). Katz and Peberdy, 1997, define Health Education as *"... a form of communication which aims to give people the knowledge and skills needed to make choices about their health."*

Leo Baric, 1996 states that Health Education has undergone a number of changes, namely starting with the 'simple transmission of knowledge' about health threats and prevention and management of diseases, to an ecological approach taking into consideration the external as well as personal factors affecting health. He is suggesting that Health Education is a process centred around individuals and therefore around autonomy in decision making. People are therefore considered in charge of their own health. To Baric, Health Education is

> *"...concerned with the raising of individual competence and knowledge about health and illness, about the body and its functions, about prevention and coping, with raising competence and knowledge to use the health care system and to understand its function, and with raising awareness about social, political, and environmental factors that influence health."* Baric, 1996:11

Rose (1992:116) defines the aims of Health Education as *"...to inform, to challenge, to encourage independent judgement, and (arguably) (sic) to persuade."* It is interesting that 'encouraging independent judgement' and 'persuading' seem compatible to Rose.

Strehlow (1983) concludes that there is no 'satisfactory' definition of Health Education- each health professional has to arrive at their own definition. Ewles and Simnett (1990) agree, and suggest that instead of looking for one all-encompassing definition, it is useful to think of Health Education in a framework of prevention in three modes- primary (aimed at healthy people), secondary (aimed at people with an improvable condition), and tertiary (aimed at people with permanent disabilities or handicaps). Tones et al (1991) differentiate between three types of Health Education definition, namely preventive (persuade the individual to take responsible decisions),

radical-political (raise individuals' awareness to trigger political action), and self-empowerment (foster informed choice).

Health Promotion

Health Promotion as a term was coined by Lalonde, the Minister of Health and Social Welfare in Canada, in 1983. He put forward the notion that conditions should be created so that people's sense of self-esteem and social effectiveness could in turn influence the adoption of attitude and lifestyle so that there was a promotion of health, rather than prevention of illness. The WHO defined Health Promotion as *"...the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health."* (WHO, 1986). Thus Health Promotion is seen as a powerful process tool.

Nutbeam, 1986:114 suggests that Health Promotion is *"...the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health"*. This adds a national perspective, but still rests with the community or even the individual. However, Tones et al, 1991:4 state it is a *"...concern to build a system conducive to health through the development of policy at local and national levels"*, which implies a national process quite out of the hands of the individual and into the hands of national decision making bodies. Bunton and Macdonald, 1992:7 state it is *"...a strategy for promoting, in some positive way, the health of whole populations"*. Baric, 1996:11, states that it has come to represent *"a unifying concept for those who recognise the need for change in the ways and conditions of living, in order to promote health"*. Yeo, 1993 states that it is a 'reform movement' advocating a shift of priorities and resources in alignment with a broader way of thinking about health but has a multiplicity of meanings according to one's concept of health; and O'Neil, 1989, concluded that the term Health Promotion means whatever someone wants it to mean. De Leeuw E., 1989, states that Health Promotion is a new and powerful concept. However, French, 2000:1, concludes that Health Promotion is *"...a poorly articulated and understood concept. This leads to confusion in policy development, planing and evaluation."* He argues that Health Promotion covers Health Education and Public Health.

Relationship between Health Education and Health Promotion

It has been suggested that the differences between Health Education and Health Promotion are 'contentious and confused', (Tones, 1986; Tones et al, 1991), indeed, *'more of a shift of title than a true shift of paradigms'* (Rawson, 1992:204) and probably have more of a 'symbiotic' relationship (Tones et al, 1991). Baric, 1996 states that the main difference is not so much the aims, but in the levels on which the

activities are carried out. Baric suggests that, in effect, it could be argued that a distinction could be made between those who are concerned with the influence of external factors, and those concerned with dealing personal factors within the individual, and therefore these could be labeled as political interests. Baric asks whether it is better to alter the environment to satisfy individual needs, or adjust individuals to fit in the existing environment?

MacDonald, 1994, suggests that Health Promotion *"...consists of strategies of health education, health protection, health advocacy and preventive health with different levels of action from the biological to the global."* Tones, in Wilson-Barnett and Macleod Clark, 1993:3 suggests that *"Health Promotion = Health Education X Healthy Public Policy."* Yeo, 1993, states that Health Promotion as a new term has both political and practical implications.

Sutherland, 1987, states that Health Education and Health Promotion are 'plainly different' terms, because otherwise, why would the second term have been developed when the first one was already in existence? He suggests that the term Health Promotion was devised because the term Health Education was an 'unsatisfactory' term, and that the word 'promotion' implies a word which conjures up 'active and dynamic' and some form of advancement, rather than alternative 'education' which implies 'passive', and some relationship with knowledge and personal development. In addition, education and promotion have different purposes and values. However, Ewles and Simnett, 1990, suggest that Health Promotion is an 'umbrella term', incorporating Health Education. Timmreck *et al*, 1988:24, states that *"The Health Education and health Promotion movement is a theoretical jungle."* Jones, 1997:76 adds that *"...the terrain has been dauntingly large, imprecisely defined and constantly evolving."*

Do Health Education/ Promotion practitioners see practical differences in the philosophy/ terminology/ practicalities of the day to day 'doing' of Health Education versus Health Promotion. Health Education and Health Promotion are also alternately differentiated from or included with disease prevention, health protection, preventive health services and health development. In addition, how do we define Health Education and Promotion to 'new' health promoters?

French, 2000:9 sums it up well,

> *"If a better understanding of Public Health, Health Promotion and Health Education is to be developed these concepts need to be explored and deconstructed. Within the play of words used to elucidate these concepts numerous possible interpretations, classifications and forms of synthesis are possible."*

An overview of 20th century Health Education and Health Promotion

Health Promotion seems to have had a long past but a short history. People will have always been involved with advising about health, but it has only been within this century that people have been employed in a professional capacity as health promotion advisors. Prior to the 1900's, the main concern in Public Health was general sanitation, individuals' responsibility to avoid disease and be hygienic themselves, and reducing infant mortality rates.

Some key points about the recent history of Health Education/ Promotion are described next. This summary is not meant to be exhaustive, but rather to point out some of the events that shaped Health Education/ Promotion. Few historical accounts of the development of Health Education/ Promotion in the UK exist (Sutherland, 1979, 1987; Macdonald and Bunton, 1992; French, 2000).

1920's to 1960's

The Central Council for Health Education (CCHE) (1927- 1969) were given the following as their tasks: the promotion of health education, through provision of better and cheaper posters and leaflets and exhibits for exhibitions, production of a readable monthly bulletin, production and assessment of films, advice on methods, provision of a panel of lecturers who could 'really lecture and hold an audience', and co-operation with the Ministry of Health and other departments, whenever national publicity was needed. From the late 1940's to the 1960's, health policy decision makers in the developed world were trying to bring modern medical care to all its citizens. Parker, 1995, concluded that there was no published debates about theory/ practice in Health Education because its purpose was to give information out to and educate, the public. Health Education Officers were involved in giving talks and designing 'handout' type leaflets when giving talks to groups of people, often seen as lists of 'tips' for cooking, keeping clean, or bringing up a baby. In 1959, the Department of Health instigated an enquiry, led by Lord Cohen, into the work of Health Education Officers (HEO's), and it was subsequently published in 1964 (HMSO).

1960's

Health Departments started employing more Health Education Officers in the early 1960's. The Cohen report, 1964 recommended that a central body be set up to co-ordinate and develop Health Education work, and train Health Education Officers. The Health Education Council (HEC) was subsequently founded in 1968, and the Central Council for Health Education was disbanded in 1969. Most of the new recruits to Health Education were from nursing or teaching (Ewles, 1997).

1970's

By 1971, in the UK, there were 91 Health Education Officers (Sutherland, 1987) Whilst there was much national and international impetus for Health Promotion, there has been a relatively obscure career route into Health Promotion. Portsmouth University started a Certificate in Health Education course in 1971. The Master of Medical Sciences degree started at Nottingham University in October, 1972, but the course folded in 1979, when the lecturer retired. By 1974, there were about 150 Health Education Officers (Sutherland, 1987) .South Bank Polytechnic started the first CNAA diploma course in September, 1974. Leeds Polytechnic started a new Health Education course under the management of Keith Tones, who was then an educational psychologist, which would add a new dimension of the relationship between Health Education and psychology to the course.

Thus there were very few Health Education academic courses in the 1970's and into the 1980's. Sutherland stated that...

> *"...health education had little or no academic standing...health educators for the most part saw themselves as public health workers under the thumb of doctors, dispensing posters, leaflets, and flannel graphs. Academics of no kind were interested in that sort of thing."* (Sutherland, 1986:50)

The early 1970's saw the development of environmental activism (Scheffer, 1991). In 1970, the first Clean Air Act was introduced in the USA. Health activists were advocating a restraint on general consumption, a return to a simpler way of life, and pressures were made on improving workplace conditions, and health and safety.

The term 'Health Promotion' was coined by Marc Lalonde, the then Minister of Supply and Services in Canada, in 1973, in the French, 'la promotion de la sante', (MacDonald, 1994). In 1974, he produced "A New Perspective on the Health of Canadians", in which the 'health field' concept was first discussed. Lalonde described the factors affecting ill-health, namely, inadequacies in health care provision, lifestyle

and behavioural factors, environmental factors and genetic and physical factors. Some argue that this document marked a turning point in Health Promotion's history (eg. Macdonald and Bunton, 1995; MacDonald, 1998; French, 2000). Three subsequent UK Government reports focused on lifestyle change, namely: *'reducing The Risk in Pregnancy and Childbirth'*, *'Eating For Health'*, and *'Occupational Health: The Way Ahead'*. As the health promotion movement gathered pace in the 1970's, attention was drawn to the scope for public policy (Jones and Sidell, 1997). At the Alma Ata conference of 1978, principles of Primary Health Care were developed and an emphasis made upon community participation, intersectoral co-operation and the positive promotion of health. (The central Alma Ata Primary Health Care values were subsequently elaborated by the 200 delegates from 38 nations at the WHO in 1984, which were transcribed into the Ottawa Charter, in 1986.)

The NHS was re-organised in 1974, and subsequently Health Education Officers were starting to be employed by the NHS rather than the local Councils. They were paid on the NHS Admin. Clerical scale (not the Professional scale). In 1976, the Department of Health published *'Prevention and Health: Everybody's Business'* which seemed to be suggesting that lifestyles and therefore individuals themselves were to blame for ill-health, and subsequently, *'Priorities in Health and Social services: The Way Forward'* was published in 1977. In 1977 the Association of Area Health Education Officers (managers) was set up, and by 1978, 40 people out of 79 (about half) had joined (Geddes, 1993).

In 1979, "A Case For Refocusing Upstream: The Political Economy of Illness" was published in Jaco's "Patients, Physicians, and Illness". The author, McKinlay, suggested that resources and activities in the health field were '...superficial tinkering' (p.1), led only to short term good, and were therefore ultimately futile. He 'begged' health educators to 'reorientate' their thinking, analyse the social roles of groups in health options, and to realise that there was a 'conspiracy of manufacturers of illness'. If we didn't address these issues, health educators were *'...doomed to frustration, repeated failure, and perhaps ultimately to a sicker society.'* (p.11). Health Educators had started wondering if there was any point in what they were doing. In America, the Surgeon General produced the report *Healthy People*, in 1979, and in 1980, the national report *1990 Objectives For The Nation In Health Promotion/ Disease Prevention* was produced.

1980's

The term Health Promotion was more widely used after 1980 (Sutherland, 1987; Rawson, 1992), and Health Education Units with Health Education 'Officers' became Health Promotion Units with Health Promotion 'Advisors' or Health Promotion

'Specialists'. However, it appeared to writers (eg. Caraher, 1988; Rawson and Grigg, 1988) that the name change was motivated more by 'political expediency' than by any fundamental change in belief. The costs of changing departmental names on all documents, resources and signposts was probably huge. Strik, 1993, however, argued that many Health Education Units changed because they felt the term to better describe their work which was incorporating policy development and organisational change.

The Feminist Health Education Officers Group was formed in 1980. Members of this group wrote about the politics of Health Education and health information, and subsequently the 'Radical Health Promotion' group formed. Bremnar, 1994, suggested that the number of Health Promotion Advisors was around 2,000 during the early 1980s.

In 1981, the WHO regional Office for Europe, Copenhagen, identified 38 targets to achieve *Health For All 2000* (WHO, 1985). These included twelve 'general health' targets, stating specific figures for reduction of illnesses and increases in other areas, five 'lifestyle' targets, eight 'environmental' targets, six 'appropriate care' targets, one 'research' target, and six 'health development support' targets. The main themes covered by the 38 targets included equity in health, emphasis on promotion of health, full use of community participation, to employ a multisectoral approach, to fully use the primary health care system, and to strengthen international co-operation. The WHO stated that the pre-requisites for health were freedom from war, equal opportunities, satisfaction of basic needs, and political will and public support. The WHO targets shifted the emphasis from medical causes to include personal and environmental factors. A new concept of 'lifestyles' arose, and this became the central theme behind the report published by the WHO, entitled *"Lifestyles and Their Impact on Health."* (WHO, 1982).

UK Area Health Authorities were disbanded in 1982, and were replaced by District Health Authorities. The U.K. Society of Health Education Officers was formed in 1982 by a merger of the Association of Area Health Education Officers, the Guild of Health Education Officers and the Voluntary Register of HEOs. This society was re-named in 1985 to the Society of Health Education and Health Promotion Officers (SHEPS), because of the growing trend for Health Education Officers to be called Health Promotion Officers/ Advisors. The *'Black Report'* was produced in 1986, a document and book which detailed what the authors felt was the causal link between poverty and ill-health.

The Health Education Council (HEC) was 'reconstituted' in November 1986, and the new Health Education Authority (HEA) was formed. The HEA was to assume the responsibilities of the HEC and to take on the responsibility for public health education

about AIDS. The HEA was to be a new Health Authority, and thus be part of the NHS, directly accountable to the NHS management board, and to the Secretary of State. Because of re-organisations, some authors (e.g. Moran, 1986) felt that Health Promotion's place should be back within Local Authorities, and therefore away from the medical domain. The numbers of 'new' Health Promotion Advisors increased because they were employed to carry out AIDS awareness. Recruits were coming into Health Promotion from 'new' professions such as social work and counselling, whereas Health Education had previously been dominated by ex-teachers and ex-nurses. This would probably have a huge impact on Health Promotion as a profession.

The first International Conference on Health Promotion was held in Canada in 1986. The *Ottawa Charter for Health Promotion* was published in 1986, building on the WHO 1985 'Targets For Health for All 2000'. It was a statement of principles of a new public health movement. It called for the reorientation of the health services and a strengthening of community action as the way to empower people and widen access and equity. It set forward ideological perspectives and an ethical and moral view of humanity. The Charter argued that health should be viewed holistically and as a positive state, that inequalities are at the root of ill-health, that a healthy nation needs an empowered community not just equitable distribution of resources, that health services need to be re-oriented and not left to medical practitioners, and that health is not just individual responsibility, it is governed by physical, social, cultural and economic environments. The second International Conference on Health Promotion was hosted by Australia in Adelaide, in 1988. In America, in the late 1980's, the *Healthy People 2,000 - National Health Promotion And Disease Prevention Objectives* was produced.

The Society of Health Education and Promotion Specialists (SHEPS) launched a voluntary registration scheme in 1989, which was launched to set up a professional register in order to establish a benchmark of professional good practice: 700 specialists registered. This would have implications for SHEPS membership becoming a 'closed shop'.

The Welsh Health Planning Forum produced a *Strategic Intent and Direction for the NHS in Wales* in 1989, which laid out the strategic intent to *"...take the people of Wales into the 21st century with a level of health on course to compare with the best in Europe."* The strategic direction was to be 'health gain focused', by adding years to life through a reduction in premature deaths and life to years through improvement in well-being for both patients and the population at large. It was felt to be 'people centred', in that the NHS *"...should value people as individuals and manage its services to this end."* The document attempted to be 'resource effective', stating that the NHS in Wales should strive to achieve the most cost effective balance in its use of available resources. The document detailed protocols for eleven health areas, which

were: cardiovascular diseases, respiratory diseases, physical disability and discomfort, cancers, maternal and child health, healthy living, healthy environments, mental health, mental handicap, injuries, pain, discomfort and palliative care. It was also stated that all organisations and bodies in Wales, and the general public, should unite and work together, emphasising 'participation in planning' and introducing the notion of 'community participation'. Measurable objectives and targets were also detailed, with 'health goals' for cardiovascular diseases, cancers, injuries, maternal and child health, respiratory diseases, sexual health, mental distress and illness, dental and oral health, physical disability and discomfort; 'healthy lifestyles', which included smoking, alcohol and drugs, nutrition, physical exercise, stress and violent behaviour; 'health skills', which included goals for knowledge, attitudes, self-confidence, coping and relationships, parenting, safety and first aid, self-help and mutual support; and 'healthy environments', which included families, communities, work and the workplace, natural environments, and housing and habitats. The National Audit Office,1996, stated that the Welsh strategy with its specific targets was useful for translating theoretical analysis into local policy and practice. Jones and Sidell, 1997:137 called this strategy paper 'pioneering'. It will be interesting to see whether respondents to this research from Wales are having different ethical dilemmas to other respondents.

During the 1980's, there was a major shift in UK policy focus, from expanding access to care, to containing its costs because of the huge demands by consumers. Inefficiencies and inadequate management within the medical care systems, and inappropriate and ineffective care were being identified. 'Whistleblowing' became a new word. By the late 1980's, controlling the rate of growth in health care costs to a constant proportion of national income was being stabilised (Marmor, 1986.) This is despite the fact that many documents about inequalities in health and determinants of health, most notably the Lalonde report had been produced.

> *"(Disputes) ...feature regularly in the medical world's claim that more must be spent if the people are to rightly enjoy the fruits of modern medical science. Yet these conflicts show little or no awareness of the issues and evidence ...the debates are carried on in almost complete isolation from the growing understanding that the determinants of health are much broader than the medical care system itself...Despite nearly two decades of repeated intellectual efforts to redirect health policy away from curative medicine to more fundamental interventions, the task remains largely undone. "*
> Marmor et al, in Evans et al, 1994:217.

It will be interesting to see whether respondents to this research will raise issues about inequalities in health as ethical dilemmas.

1990s.

In 1990, the NHS review *'Working for Patients'* was produced, which detailed changes in the function of regional, district and Family Health Service Authorities because they would be focussing on health 'needs assessment' using epidemiology. However, nationally there was no training offered in acquiring these new skills. In addition, in 1990, the NHS and Community Care Act introduced dramatic changes into the health sector in the UK, and a purchaser-provider split was created. Writers spoke of a 'quasi-market' with a new ethos of competition, eg. Ranade, 1994. The NHS became an 'industry' and patients became health 'consumers'. Subsequently, many Health Authorities merged, as did their Health Promotion Departments, and GPs were allowed to become fund-holders. All these factors had varying effects on Health Promotion Units, some of whom went through the changes smoothly, others not so. Jones and Sidell, 1997: 147 argued that Health Promotion Specialists *"...faced an initial fragmentation of their work and a consequent lessening of their influence."* Some HPU's were moved into purchasing and others into provider roles. If they were moved into provider units, their relationships with public health medicine were dissipated (Ewles, 1996), but, on the positive side, health promotion became written into contracts (although that doesn't necessarily guarantee finances, nor action.). Jones and Sidell, 1997: 148 state that the *"...notions of* (NHS) *markets and competition sit uneasily with* (Health Promotion notions of) *collaboration, principles of equity and empowerment."* However, the NHS restructuring emphasised health promotion as an aim of health authorities, and focused on the importance of effectiveness, quality and evaluation. French, 2000: 24 concluded that *"This focus on the effectiveness and efficiency of health service delivery had, it could be argued, drawn public health doctors' attention away from wider issues related to what makes people ill in the first place."* It will be interesting to see whether respondents to this research will raise issues about a return to medical targets determining Health Promotion's focus as ethical dilemmas.

The Principles of Practice Standing Committee of the Society of Health Education and Promotion Specialists (SHEPS) identified four basic duties for Health Promoters: the duty to care, the duty to be fair, the duty to respect personal and group rights and the duty to avoid harm (SHEPS, 1993). These identified duties were expanded upon into 11 points, which then formed SHEPS first Code of Professional Conduct, which was produced in 1990. This may well have been a turning point for ethical enquiry in Health Promotion. The (typed and photocopied, not professionally printed) Code of Professional Conduct stated that...

By taking out membership of SHEPS, and/ or by appearing on the Register of Health Education and Health Promotion specialists, it is agreed that practitioners within either or both categories have a duty to:

- *not harm people and/ or colleagues by willful deception or by knowingly misinforming on health matters*
- *not harm people and/ or colleagues by involving them in health education/ promotion activities nor provide materials, resources or experiences which are damaging or inappropriate*
- *not knowingly participate in health education/ promotion activities for which the practitioner is not adequately trained or competent*
- *not discriminate by any act or omission against anyone on the basis of sex, age, race, class, religion, sexual orientation, disability or health status*
- *not exploit any individual, group or employer with the primary purpose of personal gain or satisfaction*
- *not provide staff, services or resources solely on the basis of convenience or privilege*
- *not be involved in the provision of services designed solely to meet the demands of income generation or other subsidiary goals at the expense of meeting demonstrable health needs*
- *not willfully withold available services or information needed by people to make health choices*
- *not breach confidentiality nor invade personal privacy*
- *not compromise professional credibility by engaging in inappropriate collaboration with commercial enterprises or other organisations whose objectives are incompatible with health promotion principles and practice*
- *not take any deliberate unjustifiable professional action which may bring the Society, the Register or any of their respective members into disrepute; this does not preclude health professional criticism*

It will be interesting to see whether respondents to this research describe or discuss any of the above Code of Conduct points, or refer to it in the answers about their ethical dilemmas.

In March, 1991, the Government published a national policy statement on Health Education in Scotland, which identified priority areas for improving the health of the people in Scotland, set a number of national targets for improving health, and provided a framework for the new Health Education Board for Scotland, which was established on April 1, 1991. The priority areas included coronary heart disease, smoking, alcohol misuse, drug misuse, cancer, HIV/AIDS, accidents, and dental and oral health. In 1992, the Scottish Office produced *Scotland's Health: a Challenge to Us All* which

had disease reduction, such as CHD, as its main focus. Emphasis was also placed on smoking issues and dental and oral health, as these were two problem areas for Scotland with higher smoking levels and teeth problems than the rest of the UK, and Europe. Behaviour change was the main focus for this document. However, it did point out that 'health varies according to socio-economic standing and wealth', but that the relationship was 'complex'. The document also looked at environmental influences on health. The Health Services were seen to be leaders in health work, over other statutory and voluntary bodies. It will be interesting to see whether respondents to this research from Scotland are having different ethical dilemmas to other respondents, and whether their approach will be behaviour change.

A new Public Health Association was formed in 1991, the Public Health Alliance. The Government produced the white paper *The Health of the Nation* in July 1992. *'The Health of the Nation'* 's 5 main targets addressed expected reductions in rates of coronary heart disease, stroke, cancer, mental illness, HIV/AIDS and sexual health, and accidents, which are all very 'medical model approach' and the emphasis was placed on the NHS 'delivering' the strategy. It was the first time a national strategy for health in England had been attempted, and was a response to the WHO Health For All strategy, which the previous government had been reluctant to develop (eg. Jacobson et al, 1991; Scott-Samuel, 1991; Parish, 1995). Ewles, 1996, stated that the positive side of the Health Of The Nation put Public Health and health promotion policy on the national agenda, alongside treatment and care services. However, Jones and Sidell, 1997:139, suggest that the Health Of The Nation strategy *"...reads like an attempt to steer a delicate path between political liberalism and WHO-style interventionism."* Because of the medical focus of the HON, health promoters who had previously been working on broad areas had to focus more narrowly, eg. breast and cervical cancer awareness rather than 'women's health'. An ethical dilemma is that the strategy stresses the responsibility of individuals to look after themselves, rather than addressing issues of personal circumstance, such as poverty, housing, economics, etc.

A series of re-organisations took place within the British Health Education Authority, based in London, in April 1993. This was in response to the publication of *The Health of the Nation*, and the subsequent development of the Health Education Authority 's own strategy for 1993-98 (HEA, 1993). The new Health Education Authority determined its main strategic priorities as follows: to work more closely with the NHS; to base work more closely on identified needs; to link national initiatives to local needs; to identify and promote good practice in health promotion. Thus, there should be more liaison between local HPU's and the Health Education Authority, and the organisational structure was reorganised. It will be interesting to see whether the demand for needs assessment research impacts on the ethical dilemmas responses to this research.

In 1993, Atkinson, in an unpublished survey found that nationally, the number of staff in Health Promotion departments averaged 8 people. 86% had between 1 and 12 members of staff and 47% had between 5 and 8 members. The numbers ranged from 1 to 55 members of staff. Organisations other than the Health Authority had designated Health Promotion posts; these included the FHSA in 67% of districts, the District Council in 56.5%, the Education Authority in 51% and other organisations in 13%. In 1993, a SHEPS survey found that since the NHS reforms, many Health Promotion Specialists felt that their general managers did not understand their role, that they felt undervalued, that their resources and budgets were poor, and that Health Promotion was being viewed in a narrow, medical way. It will be interesting to see if these issues are raised by the respondents involved in this research. SHEPS also established a formal recognition scheme for postgraduate health education/ promotion courses. In 1993, there were 27 'recognised' MSC or Diploma courses at 19 different institutions. Some Health Promotion Units allow staff to attend Health Promotion training courses, and some Health Promotion Units pay for the courses- however, there is no uniformity. Thus, some Health Promotion Units will have people who have formally undertaken academic Health Promotion courses, but there are no practical training courses as such.

Another unpublished survey -Health Promotion Training and Education Needs of Specialist Staff Within South West Thames Regional Health Authority, SWTRHA, July 1993, commissioned by the Jocelyn Chamberlain Unit, (revealed that of 67 respondents, length of service in post averaged 1.5 years for Health Promotion Officers, 2.44 years (Senior Health Promotion Officers), 1.7 years (Deputy Health Promotion Managers), and 5 years (Health Promotion Managers). It was also revealed that average (mean) ages were 34 years (Health Promotion Officers), 40 years (Senior Health Promotion Officers), 46.5 years (Deputy Health Promotion Managers) and 49 years (Health Promotion Managers). There was great disparity of qualifications with only 1 Health Promotion Manager having a degree, compared to 6 Health Promotion Officers and 8 Senior Health Promotion Officers (1:14). The figures were similar for teaching qualifications (1:8), and management qualifications (1:4). However, 6 HPMs had a nursing qualification compared to 3 at other levels (6:3), and 5 had a Diploma in Health Education as well as 5 Senior Health Promotion Officers and Health Promotion Officers (5:5). These statistics reveal that, of those managers who responded in South West Thames Regional Health Authority, only one has a degree and most have nursing backgrounds. It will be interesting to see whether the same is true in this research.

Dark, 1993 (unpublished survey) found that, of those who responded, no Health Promotion staff in position in 1993 in South West Thames had been in post before 1987. The longest length of service was thus 6 years. Some units had the longest length of service, including the Manager, as 3 years. However, the 'support staff', such as secretary, driver, graphics/resource staff, generally had longer length of service. The

Health Promotion staff turnover is thus incredibly high, which will have an effect upon the history and practice handed down to new staff, and any ethical dilemmas.

A study of Health Promotion Units in the reorganised NHS, undertaken by SHEPS in 1994 found that 81% of respondents felt that morale had been badly affected by the NHS changes. Anxieties included the feeling that inappropriate models of competition affected their work, that resources were inadequate and that Health Promotion was being viewed very narrowly and in a medical model of health (SHEPS, 1995).

In 1995, Northern Ireland produced a *Regional Strategy for Health and Personal Social Services for Northern Ireland*, which had four key themes: promoting health and social welfare, targeting health and social need, improving care in the community and improving acute care. Seventeen selected regional targets were produced, according to topics, e.g. circulatory diseases, stroke, high blood pressure, smoking, nutrition, cancers, mental health, accident and trauma, HIV/AIDS, and maternal and child health. The targets were set for eight years hence, and emphasised the health and personal social services, and advocated community development. The strategy also called for research into causes of ill-health through inequalities. It has been suggested that the N.I. strategy was the *'most comprehensive of the UK strategies'*, (Jones and Sidell, 1997:138), because of its emphasis on well-being, informed choice and the need for social support.

A progress report on the HON was published in 1995, and many of the targets had been met (eg. HEA, 1996; National Audit Office, 1996; Jones and Sidell, 1997). However, 3 areas had seemingly not been positively affected, namely: smoking among school children, drinking by women, and obesity in both sexes. The DoH report called for effectiveness studies and more evidence based research, which also set the scene for Health Promoters to provide evidence for their work's effectiveness. It will be interesting to see whether the respondents to this research describe ethical dilemmas bout effectiveness.

The third International Conference on Health Promotion was hosted by Sundsvall in 1995, and the fourth by Jakarta in 1997, with the emphasis being on empowerment. Becker, 1986 suggested that empowerment was replacing 'lifestyle' Health Promotion because that was becoming ethically and practically questionable. The WHO, 1986 described empowerment as 'rhetorically useful and politically attractive'. The Jakarta Declaration, 1997, placed Health Promotion within 'health development', but did not define it, rather, identified the five aims of: promoting social responsibility for health, increasing investments for health development, consolidating and expanding partnerships for health, increasing community capacity and empowering the individual, and securing an infrastructure for Health Promotion. The Health Promotion Resolution

adopted by the World Health Assembly in May 1998 identified the following 6 aims: promoting social responsibility for health, increasing community capacity and empowering the individual, increasing investments for health development, securing an infrastructure for health promotion, strengthening the evidence base for health promotion, and reorienting health systems and health services.

At the Fifth Global Conference on Health Promotion (5GCHP), in Mexico City, an event which focused on how health promotion, by addressing the social determinants of health, helps to improve the lives of economically and socially disadvantaged populations, the Director-General of the WHO, Dr. Gro Harlem Brundtland, introduced the conference by succinctly describing,

> *"Last Wednesday, I was at a mass meeting in Bangkok. Standing on a platform I looked out over a sea of blue caps and white T-shirts. Wave upon wave of slogans against tobacco. Ten thousand health volunteers from villages all over Thailand had marched or bicycled to the city to mark the World No Tobacco Day. Health was being promoted on a giant scale. From local level to regional, from regional level to national, people were mobilised. The speeches, though, weren't just about telling people not to smoke. They were not about local, or even national issues. They were about levels of taxation, about world-wide bans on advertising and the Framework Convention on Tobacco Control. These global responses support a growing national movement in Thailand...What happened that Wednesday morning brought out the essence of health promotion. Promoting health is about enabling people to keep their minds and bodies in optimal condition for as long as possible. That means that people know how to keep healthy. It means that they live under conditions where healthy lifestyles are feasible. It means that they have the power to make healthy choices. Yes, health promotion is about making decisions - within the household, within society, and within the nation state. Its about making decisions within international institutions - whether they are concerned with development, trade, health or finance...we know how to benefit from the increasing inter-dependence in our world. Yes, globalization frightens some people and causes uncertainty to many more. But it also presents us all with genuine opportunities. New opportunities for global solidarity continue to emerge. There is great convergence - of values, of ideas and of action. At the same time the search for equity and justice in health now involves more people in effective local-level action than ever before, reflecting our cultural and linguistic diversity...health is no longer a concern only of health professionals. A much wider constituency is engaged...When the World Health Organization set out to improve health 50 years ago, there were hopes that antibiotics, vaccines and biomedical technology would provide the tools to achieve health for all. However,*

decades of health development have clearly shown that technologies are not enough to guarantee people's health. A range of civil, cultural, economic, political and social conditions have to be addressed as well. Many of the major determinants of better health lie outside the health system. Knowledge. Made available to people. Clean environments. Access to basic services. Fair societies. Fulfilled human rights. Good government. Enabling people to make decisions relevant to their lives, and to act on them."

This Fifth Conference took forward the priorities for health promotion in the 21st Century which were: to demonstrate how health promotion strategies add value to the effectiveness of health and development policies, programmes and projects, particularly those that aim to improve the health and quality of life of people living in adverse circumstances. Its specific objectives were to: show how health promotion makes a difference to health and quality of life, especially for people living in adverse circumstances; place health high on the development agenda of international, national and local agencies; stimulate partnerships for health between different sectors and at all levels of society. French, 2000: 69, states that, to the WHO, Health Promotion has thus become *"...the new social goal...(and) is nothing short of a new world economic order."*

In April 1996, in the UK the District Health Authorities and FHSA's formally merged and Regional Health Authorities were disbanded. The term 'New Public Health' was emerging. Some Health Promotion Units were being subsumed by Public Health Departments, rather than being accountable to them. Some Health Promotion Advisors/ Specialists now call themselves Public Health Specialists. A change in name/ philosophy/ both? This will emerge. French, 2000:1 argues that *"Recent NHS reforms appear to have grown out of the twin desires to contain escalating costs and to increase the efficiency of the delivery of health care services."* and he concluded that *"A key feature of the Conservative Government's NHS reforms... was the introduction of the internal market which divided the NHS into purchaser and provider functions...These management reforms triggered the first managerial rifts between Public Health Doctors and HEOs."* (2000:37). However, Robinson, 1987, felt that the reforms could be seen in a more positive light, with Health Promotion Specialists having more freedom to develop non-individualistic based interventions and strategies, and to take more control of strategy development.

SHEPS carried out a survey of U.K. Health Promotion Units in October, 1996, which was responded to by 139 units, which was a 62% response rate. 79% of the English responding units had more than ten staff, 15% had six to ten, and 6% had less than 5 staff. The figures were similar in Scotland, but in Wales and Northern Ireland, the average unit had less than five staff. The questionnaire also asked about specialist

Health Promotion posts in Local Authorities, Education Authorities, and in other local organisations. It seems that many (average of over one third), Local Authorities did have specialist Health Promotion posts, fewer in the local Education authorities (average of less than one third), and less than a quarter of other local organisations. Thus there are many Health Promotion specialists who are difficult to identify through an NHS route.

The 1997 Health Promotion Unit mailing list from the national Health Education Authority listed 232 Units. There was generally one unit per district Health Authority, and in some instances two or three per district, and in some instances there was one unit covering a few Health Authority districts. This suggests that there will be different ethical and practical constraints because of the differing work ethics of the organisations. It does not seem possible to find out exactly how many people are currently working as N.H.S. Health Promotion Specialists. French, 2000:37 reported that, in 1998, there were 29 'recognised' MSC course, and that *"Entrants were increasingly better academically qualified and were drawn from an increasingly diverse range of feeder professions."*

2000

The Health Education Authority (HEA) closed on March 31, 2000. It was replaced by a new organisation, the Health Development Agency (HDA) on April 3, 2000. Some of the HEA's work was transferred to other agencies and some to the HDA. The HDA was set up by government to play a central part in implementing the public health strategy. The HDA's role will be to raise standards in public health and its main functions will be research and evidence, standard setting and capacity development. The Health Development Agency (HDA) is a special health authority that aims to improve the health of people in England - in particular, to reduce inequalities in health between those who are well off and those on low incomes or reliant on state benefits. Unlike the HEA, the HDA will not run campaigns nor carry out direct public health education. Public education is still seen as important, but does not fit with the more specialised remit of the HDA. It will have a staff of approximately 120 and an estimated annual budget of £10 million. Some of the HEA's public education work has transferred to a new unit, Health Promotion England (HPE).

Health Promotion England was established in April 2000 to develop and deliver public education campaigns and health promotion programmes including a range of published resources on drugs and alcohol misuse, immunisation, sexual health, older people, and children and families. Working in partnership with national and local organisations, both statutory and voluntary, Health Promotion England provides support to health professionals, particularly those who are tackling health inequalities at local and community level. HPE is part of the NHS, and it works under contract to the

Department of Health and other government departments and is managed through Lambeth, Southwark and Lewisham Health Authority.

Health Promotion as a Profession

Is Health Promotion a profession, or is it just a job? Health Promotion is 'everybody's business', yet Health Promotion Specialists are striving towards declaring itself a profession, in the same way perhaps, as Psychologists have been trying to declare Psychology a profession. It could be argued that Health Promotion has a somewhat 'closed shop' Society membership, with related practical experience and academic qualifications a prerequisite for job applications.

Health Promotion Specialists can join the professional body, the Society of Health Education and Promotion Specialists (SHEPS), with its fourteen local Society of Health Education and Promotion Specialists branches, or the Institute of Health Education. The Society of Health Education and Promotion Specialists, which was founded in 1982, has a Code of Professional Conduct which those who join are supposed to adhere to. There are four basic duties: the duty to care, the duty to be fair, the duty to respect personal and group rights, and the duty to avoid harm (SHEPS, 1998), which are developed into a further eleven. There are also thirteen Health Promotion Principles of Practice, which form a Code Of Conduct. The membership in 1998 stood at six hundred people, which had grown from four hundred at the end of 1997, but is currently (2001) around 500 members.

Millerson (1964) defined 21 characteristics associated with professionals including: defining skills and knowledge, training, membership of a society of specialists, a culture/ code of ethics and an exclusivity. Millerson would thus probably not class Health Promotion as a profession. Freidson (1983) argues that Health Promotion can never be a profession like medicine is, because being a professional means having 'legitimate organised autonomy', evaluation by others is illegitimate, and that being professional also means having an air of mystery, power and class.

Goud (1969) states that professionals have a code of conduct, concrete problems to solve, society believes in them, that the professional has the last word, that there is an element of sacrifice and piousness (such as doctor's bemoaned long hours) and that there is real (or imagined) threat of reward or punishment. Health Promotion specialists would thus not fall into the categories of having the last word, nor sacrifice, nor society believing in them. They do have a code of conduct produced by SHEPS, and have a threat of reward and punishment; but having concrete problems to solve is debatable.

Barber, 1963, suggests that there are four essential attributes to being a profession: a high degree of generalised and systematic knowledge; primary orientation to the community interest rather than to individual self-interest; a high degree of self-control through codes of ethics internalised in the process of work socialisation and through voluntary associations organised and operated by the work specialists themselves; and a system of rewards and thus ends in themselves, not means to some end of individual self interest. It could perhaps be argued that Health Promotion specialists have three of the four essential attributes, but not the internalised code of ethics, although there is a SHEPS written one which members may well adhere to.

Baric, 1996, argues that if Health Education and Health Promotion 'agents' have a professional status, eg. doctor, nurse, teacher, then they will be able to approach clients directly since their professional status implies that they are responsible for the diagnosis of needs as well as for the outcomes. Those who do not have a professional status, he argues, will only be able to approach people indirectly, because they can not take on the professional responsibility for the individual outcomes. However, this seems to be a narrow definition, because the health educators/ promoters would not be introducing themselves to their clients as an ex-nurse, ex-doctor, ex-teacher. Some professions who could incorporate Health Education/ Promotion into their daily tasks at work, might even argue that Health Education/ Promotion was not part of their job, eg. nurses, who could argue that they are there to help cure the sick, and not do Health Education/ Promotion. It is only very recently, that nurses are required to incorporate Health Promotion into their work. So to judge those Health Educators/ Promoters as those with an established profession seems narrow.

Jackson, 1970, suggests that the following are the major issues: degree of substantive theory and technique in the practising of professional activities; the degree of monopoly over claimed professional activities; the degree of external recognition; and the degree of organisation of the profession. Health Promotion specialists do not really fall into any of these categories. Indeed, Adams (1992) stated that as Health Promotion is an 'emergent' discipline, it can not yet be a profession. It is trying to professionalise by qualifications, pay, the register, the society and the staff aiming to 'be professional', but Adams would argue that it does not meet any standard criteria. Adams suggests that because Health Promoters define health needs, they mistake privilege with power and therefore with being professional.

Ewles, in Scriven and Orme, 1996 states that to call Health Promotion a profession is 'arguable' because specialised training is not a statutory obligation and there are no requirements for a license to practice as a pre-requisite of employment, as nurses or dietitians, for example, are required to. Ewles wonders whether Health Promotion

Does considering Health Promotion to be a profession impact on the ethical dilemmas its workers have?The question of whether Health Promotion is a profession may be aided by ascertaining whether Health Promotion is a science. It could be suggested that Health Promotion is not a science because it's subject matter is too broad, or that it is common sense, or that it can be reduced to medicine. However, Health Promotion does try to find order in people's behaviour, thoughts, needs and motives, Health Promoters do try to communicate their research findings to others in order to make this order collective and public and Health Promoters do submit their theories to experimental test. For scientific research to be progressive, the scientific community in a particular research area must agree on certain basic issues: its members must agree on the goals of their science, on the basic characteristics of the real world relevant to their subject, on what counts as a valid explanation of phenomena and on permissible research methods and mathematical techniques (Leahey, 1980).

There are a number of academic courses nationally for Health promoters to undertake. However, there are no practical training course, this would be 'on the job' mentoring. Here are a small selection of the academic courses currently available.

Current course content of a sample of Health Promotion qualifications

MSc. courses

The MSc. course (part-time/ full-time) at **Bristol UWE** (2000/2001) involves studying the following modules:

Year 1-

- *Understanding Public Health*
- *Partnership working*
- *Evidence based Public Health*
- *Epidemiology*

Year 2-

- *Research methodology*
- *Public Health Policy*
- *Health Promotion theory and practice*
- *Health Promotion professional practice*

Year 3-

- *interprofessional research*
- *dissertation*

Diploma courses:

The Diploma course (part-time/ full-time) at Bristol UWE (2000/2001) involves studying the following modules:

Year 1-

- *Understanding Public Health*
- *Partnership working*
- *Evidence based Public Health*
- *Epidemiology*

Year 2-

- *Research methodology*
- *Public Health Policy*
- *Health Promotion theory and practice*
- *Health Promotion professional practice*

Certificate courses:

The Certificate course (part-time, distance learning) at Bristol UWE (2000/2001) involves studying the following modules:

modules-

- *the scope of Health Promotion*
- *differences between people*
- *contemporary issues in health and Health Promotion*
- *Health Education in practice*
- *communication and management of change*
- *social policy and administration*

workshops
8 one day workshops during the year

The **Open University** Promoting Health certificate (1 year part-time distance learning) course involves studying the following modules:

modules:
- *exploring Health Promotion*
- *communicating and educating for health*
- *investigating health information*
- *evaluating Health Promotion*

5 assignments:
- *critical evaluation of case study*
- *academic essay re. evaluation*
- *project proposal*
- *project write-up and evaluation*
- *reflective practitioner portfolio*

2 one day workshops:
- *communication skills*
- *policy in practice- negotiation skills*

Ethical issues and values thus form only a small part of these courses. However, different tutors will have different emphases on these issues. Students would have the opportunity to explore these issues in tutorials or seminars where appropriate, or through carrying out field research.

Health Promotion Theory

It could be argued that Health promotion theory is disjointed, and taken from other many other disciplines, namely psychology and sociology.

> *"The abundant models of behaviour used in health promotion research and practice tend to be descriptive explanations rather than analytic interpretations, limited to that which is currently observable, and not supported by cogent theoretical, intellectual or ideological frameworks."*
> Lupton, 1994:111.

It has been suggested that health promotion theory has developed in an *ad hoc* manner (Tones, 1990; Caplan and Holland, 1990; Rawson, 1992; Macdonald and Bunton,

1992). Research findings in Health Promotion are not traditionally disseminated, in part due to the relative recency (1982) of the founding of the professional body, the Society of Health Promotion Specialists (SHEPS), and there only being two recently founded UK orientated dedicated professional Journals, Health Promotion International and The Health Education Journal.

Crosswaite and Curtice, 1994, stated that lack of dissemination is also due to factors such as the access to other research findings, diversity of the audience, career structures, institutional barriers, ownership issues, publishing mystique, secrecy and lack of trust. Thus, the *"... multidisciplinary context contributes towards widening the communication gap between researcher and research user"*, Crosswaite and Curtice, 1994:289. Basch et al, 1986 suggest that Health Promotion dissemination is more closely aligned to a '*diffusion*' than a dissemination. In addition, there are the views of the 'stakeholders' to take into consideration, who include policy makers, professionals, academics, and the researchers, (Eakin and Maclean, 1992). French, 2000, concluded that many of the theoretical positions are 'directly contradictory' and adopt an adversarial stance towards other positions.

Theoretical framework

Descriptive models take on the appearance of a theory, but that Health Promotion essentially lacks any structure of theoretical constructs, and that the only analysis currently is reflexive (Caplan, 1993; French, 2000).Caplan, 1993, states that *"The net result of all this confusion is a failure to spell out more precisely what it is one means by health education/promotion, and more importantly, what one is doing when one claims to be practising health education/ promotion."*

French, (2000:104-5) explains that

> *"While apparently seeking to clarify and systematise the theoretical understanding, this* (descriptive) *material also serves the interests of professionals and academics in this field by maintaining a position exclusiveness in that this work has generated a specialist language and conceptual models. This in turn helps to legitimise divisions and hierarchies within the field and may serve to exclude or at least impede non specialists from taking an active part in the debate. The confusion or contestedness about the nature of health promotion serves to legitimise professionals working in the field in that it indicates the need for expert interpretation. Through a failure to come to conclusions, specialists do maintain the rights and power to act as interpreters of what is legitimate public health/ health promotion/ education."*

Caplan states that Health Promotion relies very heavily on medical evidence or data, and causal links, but that health promotion in particular, as a social science, actually reveals that people 'subjectively' experience their health, not objectively or mechanistically, and that causality is less linear and more complex than medical evidence would suggest. He suggests that the philosophical positions of the social construction of experience are in direct contrast to the objective psycho-social type of behaviour, and these two are therefore in a horizontally opposing positions. Caplan goes on to state that there are two other directly opposite poles, which can be represented vertically, namely radical change and social regulation. The radical change viewpoint states that Western society is essentially unstable and has a basic tendency towards change, with basic conflicts such as that between capital and labour, sexism, work ethics, racism, discrimination, etc. Radical change theorists therefore want to address social inequalities. Social regulation theorists argue that society is essentially stable, with consensus, social institutions, and rules, and therefore health promotion should address the family, and other integrated institutions.

Caplan felt that if all models of health promotion were studied along his four dimensions, then it would become possible to construct a comprehensive account of health promotion theory. However, French and Adams, 1986, have argued that current thinking within health promotion means that it is unlikely that a definitive map of health promotion would be possible.

Lindsey and Hartrick, 1996, stated that Health Promotion is gaining widespread recognition throughout the world as the most efficacious practice in achieving health for all. In Canada, the philosophy of health promotion is driving both federal and provincial health initiatives. Lindsey and Hartrick, 1996, suggest that such a philosophy is derived from a human science paradigm and is in direct opposition to the natural science paradigm from which the biomedical approach to health care emerged. There now exists a tension between these contrasting paradigms as health care shifts to embrace a health-promotion perspective. this will be especially problematic for nurses trying to incorporate Health Promotion in their work

Models of Health Education

Health Education and Promotion have an abundance of 'models'. Do Health Promotion Advisors have a preferred approach to working, or do they alternate between different ones? Should there be a preferred style? Is there a 'correct' style? Models can be 'iconic' (descriptive representations) or 'analogic' (metaphorical representations). Models are 'tools', abstract concepts, which define a chosen part of reality as a system of inter-related parts, such as objects, social positions, actions, etc. Theories, on the other hand, define the relationships between parts of a model. Leo

Baric, 1996, argued that the main shortcomings of Health Education is that it has an abundance of models but lacks theories about the relationship between the parts of these models, as well as sufficient theoretical and empirical information about the link between the problems and solutions. However, models are by their nature 'reductionist', and therefore limited to some extent.

A well known and often quoted British model is that put forward by Ewles and Simnett (1990) who identified five ways of working: medical, behaviour change, educational, client directed and social change. The aim of the medical approach is freedom from medically-defined disease and disability, such as infectious diseases, cancer and heart disease. The health promoter is seen as an academic, credible, educated expert, who can predict future illness from current risk behaviours. The recipient of the message must be obedient and subservient. Those advocating the behaviour change approach aim to change people's attitudes and behaviour, so that they adopt a 'healthy' lifestyle. They too are seen as an expert, but less medically orientated, although still advocating 'good' over 'bad' behaviours. They suggest giving up certain behaviours, and adopting new ones, eg. stop smoking and take up swimming. The educational approach aims to give knowledge and ensure understanding of health issues, whereby well informed decisions can be made and acted upon. They are also seen as an expert, but a friendly and helpful one. they are advocating certain behaviours in a concerned, 'know what's best for you', paternalistic/ maternalistic way. You'll be sorry if you don't, and I told you so. Alternatively, the client directed approach focuses on working with clients in order that they can identify what they want to know about and make their own decisions and choices according to their own interests and values. This suggests that the client is well informed and committed enough to initiate contact with the health promoter. The aim of the social change approach is to change the environment to facilitate the choice of healthier lifestyles. The health promoter is seen as a useful facilitator in processes of change with decision makers. rather than direct quit smoking messages to smokers, the social change health promoter would target increasing tobacco taxes, or targeting shops who sell cigarettes to the under 16's.

There are many other models of Health Education/ Promotion, all of which have different perspectives. They include: Draper (1980) who put forward 3 approaches: education about human health, resources for health care, and the whole environment; Thompson (1987) who put forward 4 approaches: medical, educational, community development, and socio-political; French and Adams who put forward 3 approaches: education about human health, available resources for health care, and the whole environment; Beattie (1993) who put forward 4 approaches: power, individual, clients, and focus (social structure). Green and Raeburn (1988) identify two main approaches: individual and system. They suggest that Health Education/ Promotion models either

focus on the individual, whereby the aim of intervention is to health educate or encourage self-help so that the individual can make lifestyle changes, or is a 'systems' approach, whereby the aim is to focus on social, economic, institutional, cultural, legislative, industrial and physical environments. Tones, 1990, differentiated between value orientated models, namely 'preventive' models, 'radical-political' models, and 'self-empowerment' models. Baric, 1996, suggested that there are theoretically orientated models, namely cognitive, psychological, psycho-social, sociological, descriptive, social marketing, at-risk, and ecological models.

A more recently developed model has been put forward by the Canadian, Collins, 1995. This model was influenced by the model of Health and the Community Ecosystem of Hancock, 1993, which attempted to show the interactions between community, environment and the economy as they relate to health. Collins' model proposes two levels of activity at which health interventions could occur, namely the individual and the community, but the model puts forward the computing notion of 'nesting' whereby one factor is nested within another, thus making the two factors linked, inter-dependent, and reciprocally interacting. Collins suggests that the individual component of the model comprises psychosocial environment, micro- physical environment, race/ class/ gender environment, behavioural environment, and work environment, whereas the community component involves political and social climate, macro-physical environment, degree of social justice and equity in the community, and the extent of community control and cohesiveness. Collins, 1995:322, felt that her model attempts *"...to provide a fluid representation of both individually and societally relevant determinants of health ..."* and an attempt to keep the user aware of *".. the multiple 'levels' of health determinants and their implications for health promotion practice and policy development. "* She reminds the reader that the model is a simple representation of a situation that is temporally and spatially varying, and warns that models of health have the potential to become 'dangerous political tools'. Collins therefore sets a more sinister overtone to the concept of reducing health promotion to a model, because the model is emeshed in political practicality.

Clarifying Health Promotion aims

A reflection on the values inherent in health promotion is necessary, and follows next.

> *"Health Promotion work, if successful, will affect the lives of other people and it would be irresponsible (not to)... understand the values and ethics implicit in the work...A key question is: should it aim to change individual behaviour and lifestyles, or to change the socio-economic and physical environment?"* (Ewles and Simnett, 1995:34)

How many Health Promoters realise and fully understand the implications that their work has on the lives of people who take on their messages? As one smoker who attended my quit smoking classes said to me, ***"You haven't stopped me smoking, but at least I feel guilty about every cigarette now."*** This obviously wasn't the intended outcome. But maybe it was? If that smoker felt guilty long enough, maybe he'd stop, and surely that was my underlying aim. I had conspired against him, and I began to feel guilty myself. How many others had I influenced? I was pleased with behaviour change statistics, because they were something tangible, but how many people had I made miserable by increasing their knowledge about health risks?

CHAPTER 2: Philosophy and Ethics

Summary: *philosophy; ethics; classification of various kinds of ethical theories; moral judgements; good; bad; truth; autonomy; justice; duty; power; rights.*

Philosophy is the system or study of the basic truths and principles of the universe, life, morals and of human understanding of these. Russell, 1993, suggests that philosophy is a product of religious and ethical questioning mixed with science, *"something intermediate between theology and science"* (1961:13). Maybe philosophy is not about finding answers, but a critical contemplation of the issues.

> *"There are sound reasons why we should all exercise our philosophical abilities... we should all practice clarification... we owe it to ourselves... not to take anything at face value until we have thought it through personally. Where our work affects other people, as is the case with work for health, it is vital to recognise that not everyone has the same values and priorities."* Seedhouse, 1988:12.

Russell (1993:784), however, warned that *"It gradually became clear that a great part of philosophy can be reduced to something that may be called 'syntax'."* Thus, it was being suggested that philosophical debate is purely a linguistic investigation, with philosophers merely debating over the meaning of words, and not their true, deeper meaning or context. But it may be the case that too long or deep a pondering brings about distortions.

'Ethics' involves 'moral enquiry, and 'morality' can be defined as a system of rules for distinguishing right from wrong, and good from bad. Ethics can be seen as a 'critical', questioning discipline, without being judgmental. The critical questioner wants to explore uncertainties. Ethics can be of both theoretical and practical value. 'Normative' ethics aims to establish what the standards ought to be. 'Metaethics' aims to determine the meanings of normative terms, such as right, good, ought, justice, and obligation, and determine any interconnections, and whether any of these concepts are basic. It also aims to analyse the nature of moral judgements and to determine whether they can be justified and are true or false, and are facts or cultural or religious values.

Ethics involves studying what is natural and can be investigated, and also what people think or feel they know, intuition, subjectivity (whereby each individual believes himself to be the final arbiter of the moral standard), relativism (whereby moral standards which vary with the insight of the individual or situation), and scepticism.

The objectivist theories appeal to standards or moral codes which are said to exist independently of individual preferences.

classification of various kinds of ethical theories

Within normative ethics, are two major classifications of theories, which are consequentialist (teleological), or nonconsequentialist (deontological). Consequentialist theories maintain that the morality of an action is determined solely by its results or its consequences, and is therefore only made wrong by bad consequences. Deontological theories claim that the morality of an action depends on its intrinsic nature, or on its motives, or on its being in accordance with some rule or principle, and either not at all or only partly on its consequences. Teleological theories therefore rely heavily on value and subsequent evaluations. Hedonism takes the point that pleasure must be the end result. Utilitarianism takes the view that the 'greatest happiness of the greatest number' is the test of right or wrong. However, self-realisationists or perfectionists take the view that the greatest good is perfection of the self. Theological or divine command theorists state that the will of God determines whether an action is right or wrong. Religious moralists would claim that there can be no morality without religion, because without God there can be no reason to be moral. Others suggest that if an action is morally right, then it can be taken as a universal law, and take on board legal and political aspects.

Duncan (1992) stated that the aim of ethics is to 'clarify and clear away confusion' through systematic and critical analysis of the assumptions most people make all the time, but that recognising ethics' limitations can add to its value. Questions are raised within ethical enquiry but there seem to be few answers. However, clarification of the issues can lead to justification for decisions.

As MacIntyre, (1993:97) puts it...

> *"If I do not abstract sufficiently, I shall always be in danger of making myself the victim of what is taken for granted in a particular situation. I shall be in danger of presenting what is merely the outlook of one social group or part of the conceptual framework for men as such."*

Campbell, 1987, suggested, however, that ethics can be distinguished from morality.

> *"Ethics uses codes, beliefs, opinions, decisions, guidelines as the raw material for its analysis, seeking norms by which to judge the coherence and the adequacy of these constituents of the morals of groups and individuals. Thus ethics is a critical discipline, at one stage removed from the day-to-day*

choices of morality. But (ideally at least) the critical reflection which it offers should improve the quality of the decisions made."
Campbell, in Doxiadis 1987:16.

Moral judgements

Hume and his contemporaries were concerned with the possible, or impossible, objectivity of moral judgements.

> *"Moore believed that other moral judgements, for instance those about right action, were related to the basic intuitions of goodness, right action being action that produced the greatest possible amount of good...Moore insisted that these judgements were objective, and he explained that they were made by intuition... An intuitionist is one who believes that in the end we must 'see' that certain things are good, or right, or obligatory."* Foot, 1974:2.

However, Ross suggests that we cannot always be objective about morality, and that *"every ethical system admits intuition at some point."* Indeed, Downie and Calman, 1987, suggested that we cannot be taught how to make moral decisions, that there is no special skill in acting justly, and that it would be difficult to teach or learn morality. Thus, they argued, morality is always subjective, and, therefore, personal and professional moral knowledge are impossible to separate, because moral knowledge is intertwined with *beliefs* and *attitudes*. Thus there would be little room for an objective factual nature to morality.

Stevenson, 1972, agreed, suggesting that morality is full of emotive meaning, and Hare, 1972, states that emotive meanings to morality become prescriptive. Foot 1974:6. argues that in order *"...to be descriptive, a word must be non-evaluative."*

> *"If, whenever I judge an action to be right, I am merely judging that I myself have a particular feeling towards it, then it plainly follows that, provided I really have the feeling in question, my feeling is true, and therefore the action in question really is right. And what is true of me, in this respect, will also be true of any other man."* G. E. Moore, Ethics, 1912:91.

(i.e. if two people believe something, it is true for each person, even if the two things are opposing beliefs.)

Morality can change over time, situations, and personal opinion. Moore, 1912:97 stated that *"An action...(which a man) formerly regarded with...disapproval, he may now regard with... approval, and vice versa."* Morality changes due to individual

interpretations, and internal contradictions (e.g. always tell the truth- apart from white lies). Morality can be subdivided into moral knowledge, conduct and feeling.

At one point, in ancient history, homosexuality was not considered out of the norm, but more recently, homosexuality has been considered as in the minority, and has been held abhorrent by the majority, even a mental illness until the 1960's, and illegal under a certain age, recently reduced to 18 years from 21 years of age, between consenting adults. Other health issues in debate over their morality may more recently include, for example: surrogacy, immunisation, euthanasia, sex change operations, cloning, and giving information to the public about BSE or 'foot and mouth' disease.

Morality is also heavily influenced by culture and custom eg. some cultures feel it is immoral not to circumcise their children, girls as well as boys. Culture poses a large problem for ethical enquiry because ethics tempts one to say that one practice is more ethical than an other, and hence that one culture is superior in its beliefs to another. *"...the common moral consciousness is in part made up of superstitious elements, of morally bad elements, and of logically confused elements."* Smart, J.J.C., in Foot, 1974:173.

Religion can also play a large part in the morality of health issues, for example, sex education, sex before marriage, fidelity, eating certain animals, cooking methods, contraceptive use. Neither moral relations, nor the moral law, can operate 'in vacuo'. William James, 1891, as described in Singer, 1994, stated that moral relations' only habitat can be a mind which feels them. Thus in an insentient world, morality would not exist because it would only contain physical and chemical facts; there would be no 'spectating'.

Campbell, in Doxiadis 1987:18, is concerned as to who are then the 'expert' judges of 'moral' quality? He argues that setting oneself up as an expert in an area of morality leads to elitism, stating, *"Each time a group sets itself up as those who possess the necessary 'krisis' in morality... a body of professional experts... there comes a narrowing of the perception of the good to the limited vision of a fallible few."*

Campbell, 1987, suggests that morality can lead to hypocrisy and prejudice, because of the assumption that there must be people who consider themselves as moral experts. Socrates said that the only thing he knew was that he didn't know everything. It is therefore important to distinguish between fact and value. Can ethics therefore be applied to 'human sciences' because it is inevitably value laden. Foot, 1974:84 explains, *"One man may say that a thing is good because of some fact about it, and another may refuse to take that fact as any evidence at all, for nothing is laid down in the meaning of 'good' which connects it with one piece of 'evidence' rather than another."*

Values should be debated across *disciplines*. This may be particularly true of health issues, which covers many disciplines, for example medicine, protection, law, academia, nursing.

> *"Thus philosophy is primarily (though not exclusively) analytical, and as a result it is a parasite upon the other disciplines... For moral choice entails commitment to some set of values in a situation which is by definition one of uncertainty and dilemma."* (Campbell in Doxiadis,1987:20)

Good

Health Promoters assume that being healthy is good, and that we should all be trying to achieve good health. Why is health good? It can be assumed that being not healthy or unhealthy is therefore bad. As Aristotle, in Nicomachean Ethics observed, *"Every craft and every enquiry, and similarly every action and project, seems to aim at some good; hence the good has been well defined as that at which everything aims."* Hare suggests that the word 'good' has an action-guiding function. But, Foot, 1974, points out that why should the thought that something is a bad action deter anyone from doing it? Indeed, utilitarianism puts forward the notion that *"...actions are made right or wrong by their good or bad consequences."* Foot, 1974:13.

Newman, 1986:7 states that *"We have become idolatrous of health...those who don't have it are viewed as inferior or even repulsive and don't belong with the responsible majority...(it) is as if death were the antithesis of health..."* The view that health is the absence of disease has pervaded early thinking about Health Promotion. Perhaps those who don't have health or undertake having unhealthy lifestyles, could perhaps even be punished for it. Kurtz, 1987, argued that health has become a new religion, and health promoters are 'puritanical priests' who can offer punishments for the bad, and rewards for the good.

Seedhouse, 1995, argues that 'well-being' is frequently said to be the ultimate goal of health promotion, but health promotion authorities do not offer a clear definition of "well-being", and that instead, health promoters either assume a causal relationship between their activities and the increase of "well-being" or claim privileged knowledge of "well-being" and its means of production, or both. Seedhouse goes on to state that the use of "well-being" in health promotion acts to obscure the analysis of health promotion philosophy and practice. He concluded that either the term "well-being" should be given clear and substantial content, or it should preferably be discarded by health promoters.

There are two sorts of adjectives- attributive eg, a red book, and predicative eg. this book is red. Geach, in Foot, 1974: 64 states that *"...'good' and 'bad' are always attributive, not predicative, adjectives."* and that *"...normally, and other things being equal, a man who wants an A will choose a good A, and will not choose a bad A- or rather will choose an A that he thinks good and will not choose an A that he thinks is bad."* Geach, in Foot, 1974: 69.

Truth

Health Promoters give other people information in a variety of forms, so how much truth is in the information? Do Health Promoters check on the truth of their information? Katz and Peberdy, 1997:192, state that *"Reliable health information is essential for health promoters as the basis for planning and carrying out interventions and campaigns."* They also state that health promoters need to be able to substantiate their arguments with indisputable facts. Is it that there is any 'reliable' health evidence? Health Promotion information comes from a massive range of sources, eg. medical research, social and psychological science research, biological, agricultural and environmental sciences, and major national agencies, all involving different research tools and researchers, some Government funded. There may be biases or 'slants' to their findings.

Downie and Calman, 1987, state that health professionals interpret the information they are given, and they then pass this information on to clients. However, it is the unquestioning nature of this 'regurgitation' of information, and usually out of context from the original source, that is worrying. Campbell (1991:24) warns that...*"For Health Education to be genuinely educational its independence and total commitment to factual accuracy must be beyond question. This is perhaps a rather naive hope for health education..."*

Truth must objective, it is how people interpret or understand the truth that becomes subjective. Singer, 1994: 139, stated that the *"...objectivity of truth lies in the recognition of facts as true by all who understand them fully. ...to the verdict of a perfect intellect ... all would submit. "* Huxley, 1994, suggests that the word 'truth' can be used in three senses, namely, as a synonym for 'fact', knowledge about reality, and the representation by verbal symbols. MacIntyre, 1993:96, suggests that *"...human society presupposes language; language presupposes rule following; and such rule following presupposes a norm of truth telling."*

Maybe there is no truth, as such, only 'essence'. Huxley, 1994, quotes a parable whereby a young boy who has been sent away to get a good education, returns home, and his father asks him to pick a fruit, and break it, then break one of the seeds he

found in the fruit. When the son was asked what he could see, he replied nothing, but the father revealed that he was in fact blind to the essence of the fruit. Something far too small to see within the seeds of the fruit of the tree, was what in fact made up the essence or context of the tree.

It has been suggested that the truth will differ according to the theories we hold (Pratt, 1978). Kuhn (1962) suggests that truth is relative to 'paradigms', and that there are no 'theory-independent', 'neutral' facts against which to measure the correctness of any given framework. This implies that notions of 'true' or 'untrue' are without sense: this theory is entitled the 'Theory of Relativity of Truths'. You can therefore compare facts within a theory, but you can't compare different theories.

Ewles and Simnett (1990) ask at what point does a Health Educator decide that the evidence is sufficiently convincing that he/ she should begin to educate the public with a new message? Some facts, such as suggested risks associated with the contraceptive pill, seem to keep changing. Is the truth, or current research findings changing? Downie and Calman, 1987:10 pointed out that *"In future, new answers and facts will inevitably come to light which may change our whole concept of a particular disease or illness."*

How does telling the truth impact on Health Promotion? The Health Promoter could make a decision about the truth of the evidence they impart, but do they? In addition, following the lifestyle advocated by Health Promotion does not necessarily lead to a guarantee of future good health, so where was it that the truth lay? Latour, 1987, suggested that social scientists puts forward negotiated facts or truths, based on current knowledge claims.

"Science's contribution to control lies...in the predictive capacity of its general laws." (Pratt, 1978:74). They enable one to know what will happen under specified conditions, so that what is not wanted can be avoided by ensuring that the necessary conditions do not arise. 'Positivism' therefore places emphasis on the predictive aspect of scientific theorising, (for example, if you smoke, you will get lung cancer.) The important implication of 'positivism' is that a theory can predict and the question of truth becomes irrelevant (Friedman, 1968). So, for example, with regard to smoking, the fact that smoking does not lead to cancer in every case, questions the truth about a causal relationship. Friedman would argue that this actually is of no importance, what is important is that it can generally be predicted that smoking will lead to a smoking related illness. The inference is that Health Promoters need not worry about the truth of the message, only the predictive nature of that message.

However, could making the truth 'seem' true be seen as something more sinister? Flaysakier (1991) suggests that there are 'boundaries of truth' whereby the truth is

stretched, and prevaricated. It has been suggested that the public don't need to know the whole truth, especially with regards to such issues as immunisation, AIDS and screening: if the public were given the truth about these issues it would confuse them, it is enough to encourage them to listen to the advice of the health experts and be 'herded' into health care.

So, do Health Educators know the truth about their messages and does the public want to know the truth anyway? Perhaps the message is true if people believe it to be true. Sir George Godber states that Health Education's *"...effectiveness did not rest upon scientific evidence but upon the opinion held by ordinary people about its worth."* (Quoted in Sutherland, 1987:46). Downie and Telfer, 1980, state that it is the duty of the caring worker to tell the truth to his clients about their situation, because it connects with respect for the clients' capacity for self-determination. Also, questions are raised about the truth of the 'situation' the client is in, the efectiveness of the treatment, and their imminence of danger. Medical decision making thus involves decisions about deception and truth, although these issues cover avoidance of distress. Beck, 1992, states that the public use as current information as is available to them, and then assess the risk involved in undertaking certain kinds of behaviour. Wildavsky, 1995 suggests that Health Promoters should investigate how the public look at risk perception and risk consequences, rather than whether they judge 'the truth'.

Tones (1977) suggests that the knowledge base of Health Education constantly changes and that there are, therefore, limited areas in which recommendations can be made on a factual basis. Cribb, 1997, agrees, stating that the knowledge claims which underpin Health Promotion are fallible and contestable. Seedhouse (1988) suggests that truthfulness is a central principle of conduct, because it has implications on autonomy and respect for others. Ahmed, 1995:239 argues that *"...information can influence health care delivery either by revealing performance failings, or by demonstrating how known problems might be solved."* The suggestion is therefore that people make changes if information is given. Current NHS thinking is that practitioners must subscribe to 'evidence-based practice', which may be raising similar doubts and dilemmas. it will be interesting to see if this emerges in this research.

Autonomy

Health Education and Promotion gives people health messages in a variety of ways and the receiver of the information has to decide what to do with this: however, it could be argued that some people are not able to make decisions about the validity of health information, or are not in a position to adapt or change even if they wanted to, or have the freedom to listen to or ignore the information if they want to. Health Promotion relies heavily on one group giving information to another group, so can it ever be said that the receivers are ever truly autonomous, even if they have autonomously decided what to do with the information or empowerment. Thus the reality of the existence of autonomy when so many external factors intervene, is the basis for questioning the morality of intervention. Similarly, in medicine, one group is providing and the others receiving services.

Kant (1949) argued that autonomy is freedom of the will and that it is the supreme principle of moral action. Harris (1985) describes autonomy as *"Critical self-determination in which the agent strives to make decisions which are as little marred by defects in reason, information or control, as she can make them."* The emphasis there is that individuals are able to make their own decisions. However, this notion may be seen as naive (Townsend and Davidson, 1990; Doxiadis, 1991; Naidoo, 1992) and that *"Autonomy is possible only when we are able to act consistently and in a reasonably well-informed manner."* (Doxiadis, 1991:17). Rumbold (1993:199) supports this, arguing that *"...autonomy is the ability to decide an act on the basis of reason... following that if the patient is able to exert any autonomy, then they must be given the necessary information in order to do so."* Thus people can have autonomy only if they are given correct and factual information to make decisions upon. However, 'truth' is a contentious concept and means different things to different people. (See later section).

Lindlay (1986) and Downie (1991) argue that individuals have to strive for both 'personal' and 'political' autonomy, in that people sometimes make free choice decisions, but cannot act upon them because of a variety of reasons, maybe due to constraints, such as relationships, imprisonment, economic or Political reasons. Lindlay also identifies 'cognitive' and 'conative' hazards to autonomy, whereby cognitive hazards stem from the failure to use one's reason actively to establish the reliability of the beliefs upon which decisions are made. Conative hazards stem from an irrational tendency to act inconsistently with one's expressed preferences in life.

Ewles, in Scriven and Orme, 1996:71, argue that *"...health promotion can be seen as unwelcome 'nannying', coming from do-gooding spoilsports with negative messages, wasting public money because people don't respond anyway, and curbing freedom of*

the individual." Naidoo (1992) suggests that the Government uses the notion of all individuals having free will, in order to rationalise that people choose unhealthy lifestyles and that they have only themselves to blame, supported by the claims, for example, in Government documents that *"Much of the responsibility for ensuring his own good health lies with the individual."* (DHSS, 1976:95).

Thus the question of the reality of autonomy, and if it exists, are we able to exert it, has not been solved. Pratt (1978) argues that humans are still dependent on their environment and concludes that we have developed but not conquered autonomy, and that the capacity to learn is the result of the stage achieved so far. Lerner, 1990:19, states that we cannot comprehend autonomy, so maybe should not be searching for it..

> *"Our society places a great emphasis on developing the 'I'. Words like 'autonomy', 'independence', 'separateness', 'authenticity', and 'selfhood' are popular if not universal goals. Yet there is much misunderstanding about what these words actually mean, who defines them, and how we can evaluate and improve where we stand on the 'selfhood' scale."*

Indeed, Lerner suggests that we are not living in a vacuum, free from the influence of the family or culture but that we are constantly influencing and being influenced by mostly unconscious or covert communications, which are often outside the awareness of the sender and receiver. She goes on to suggest that some groups of people are more defined than others because society, mainly men, have carved out definitions for moulds, and the 'self' is even harder to find for these people. In addition, Lerner, 1990:19 goes on to state *"What freedom is in each time and place is defined by the specific limitations of that time and place and by the characteristic goals of that time and place."*

Thus, if the individual is autonomous, has free will, and is able to choose, he/ she may choose 'unhealthy' options. The Health Education Unit of WHO, as quoted in Beattie, 1993; suggest that *'the essence of health promotion is choice'* and that people must therefore be free to refuse. If people are free to choose and therefore free to choose unhealthy options, then 'paternalistic and utilitarian use of coercion' may be adopted on the grounds that people must be looked after 'for their own good' and for the good of society (Tones, 1986). Katz and Peberdy, 1997, state that if all outcomes are as good for health as each other, then there is little point in promoting health, so the main aim of Health Promotion is to 'guide' people *"...to what you see as the 'right' decision for their health."* (Katz and Peberdy, 1997:103).

Indeed, as K. Weare, 1992:81 points out something that may often be forgotten,

> *"Education is concerned with the autonomy of the individual and with the creation of a free society, not with persuading people to adopt desirable attitudes and behaviours. The notion of people being free to choose, even if the choice is unhealthy, has to be respected."*

This must surely pose a dilemma for the Health Promoter, who wants people to become healthier, not make unhealthy choice decisions.

> *"Individualism is the dominant ideology underlying modern health education... Individualism is here defined as the ideology which views individual free choice as both an accurate account of the status quo, and as a desirable goal for which to aim. The role of health professionals and government is therefore limited to ensuring that the public get access to knowledge: the effective transmission of a message."* Naidoo, 1986:17.

Justice

Justice can be seen as 'fairness' or 'retribution'/ 'punishment'. The notion of justice in Health Promotion as retribution or punishment is not really relevant. However, justice with regards to fairness does have a place. Seedhouse (1988:109) suggests that there are three versions of justice as fairness *"...to each according to his rights, to each according to what he deserves, and to each according to his need"*. However, entrenched within the idealistic notion of justice is the reality of injustice because of inequalities. With regard to 'each according to what he deserves' then there is the worrying notion that some people, for example perhaps- smokers, have brought any illness upon themselves. Rawls (1993) states that justice entitles people to liberty and equality. Both of these concepts have a place within Health Promotion. However, liberty and equality are bound by political and social structures.

Yeo (1993) states that it is the notion of 'distributive justice' within Health Promotion that needs to be addressed, so that guiding principles and values for allocating societal resources can be clarified. A guiding goal or value would be to reduce inequity in health status across populations. However, Yeo sees this as desirable but naive and perhaps impossible.

Foot, 1974:96 points out that,

> *"...prudence, courage and temperance are qualities which benefit the man who has them, justice seems rather to benefit others, and to work to the disadvantage of the just man himself. Justice as it is treated here, as one of the cardinal virtues, covers all those things owed to other people..."*

Duty

The ideas of duties, rights, and responsibilities are often discussed interchangeably. The notions seem to overlap, and have implications for each other. A duty implies a moral imperative, and, once defined, becomes binding. The ethical enquiry into duty is termed 'deontology'. If a duty is ethical, it is assumed that all outcomes will be good, because central features of deontology are integrity and honesty. Parents, nurses, doctors, teachers have duties, so, do Health Promoters, and if so, what are they?

The Society of Health Education and Promotion Specialists (SHEPS) has identified four basic duties for Health Promoters: the duty to care, the duty to be fair, the duty to respect personal and group rights and the duty to avoid harm (SHEPS, 1993). These identified duties are subdivided into 11 and then form a Code Of Conduct. But unless one joins the SHEPS, one would not know about these duties or the Code Of Conduct, which obviously has implications for the duties of those who are not members of SHEPS. However, it could be suggested that one is bound by the duties of the job description, but each district's job descriptions vary.

There are two types of professional codes: codes of ethics and codes of conduct (Rumbold, 1993). A code of conduct is concerned with how members should behave, which the SHEPS has defined, whereas a code of ethics is concerned with what the profession believes itself to be - a statement of belief.

> *"What duty-based ethics do is place a limit on the means while not necessarily disagreeing with the goodness of the end...The duty remains a binding duty even if in acting in accordance with it will do nothing to achieve the goal, or even detract from its achievement."* (Rumbold, 1993:60).

It has been suggested that *"If society is going to flourish, then its members must be healthy"* (Downie et al, 1992:146), which implies that each of us has the duty to be as healthy as we can and maybe the implication that there are people who have a duty to make us healthy. Do we really have a duty to be healthy? (Darwin (1958) suggests that we do, that life is 'the survival of the fittest'.) Seedhouse (1988:17) warns against the 'disastrous confusion' between seeing being healthy as being good and therefore seeing being unhealthy as being bad.

Do Health Promoters have a duty to Health Educate/ Promote? The SHEPS defined duties are philosophical concepts, not day to day duties. Duties often give rise to 'rights'. Thus if we assume that we have the right to health care, we therefore have the right to health information and Health Education. If people have the right to health

information, then there must be a duty to provide it. But who has this duty- the Government, nurses and doctors, or Health Promotion Advisors?

Are Health Promoters morally obliged to be beneficent, or is it a duty? Beneficence is seen as a moral injunction always to do good (Rumbold, 1993.) It is sometimes developed into a 'beneficent paternalism', whereby a health professional 'knows what is best' for the patient/ client: *"...since the doctor has a moral obligation to do good, then to determine on behalf of the patient what will be done to them is morally justified."* (Rumbold, 1993:192.) However, justifying intervention on the grounds of beneficence may be bypassing autonomy and assuming that interventions are right.

CHAPTER 3: Health Promotion and Ethics

Ethical enquiry in Health Promotion; receiving messages; selling health; persuasion; sponsorship; leaflets; harm minimisation/ just say no; health education and young people; targeting programmes; government policy; evaluation; Health Promotion and nurses; Health Promotion and teachers.

Ethical enquiry in Health Promotion

There are a number of ethical, moral and philosophical issues which are pertinent to health, education, and medicine. Beauchamp and Childress (1983) suggested that there are four prima facie principles of medical ethics: respect for autonomy, beneficence, non maleficence, and justice. These have a place within Health Education/ Promotion ethical enquiry.

However, unlike medicine, which could be said to have a definable outcome, Health Promotion does not. It can be seen as a process as well as a specialist activity. Cribb points out, in Jones and Sidell, 1997:236, *"At the 'process' end of the spectrum all clarity and specificity is lost and instead there is almost total indeterminacy. It is far from clear who should and should not take responsibility for health promotion."* Thus, specialist activities, such as the national No Smoking Day campaign or producing a leaflet, or running quit smoking groups are entirely different from the processes such as cycle paths being implemented, changes in housing policy, or contraceptives being available in schools. Some of the Health Promotion processes will involve Health Promotion Specialists, but will often involve many other agencies, some not even directly related to a Health Promotion service. It could then be argued that those Health Promotion outcomes are on a continuum or a spectrum, rather than be a clearly defined activity.

Whether Health Promotion can be divided up into processes and activities, becomes an academic debate, because most of the ethical enquiry into Health Promotion has been carried out with regard to medical scenarios. The literature review revealed that most ethical issues pertinent to Health Promotion were looked at in isolation, as issues *per se*. 'Surprisingly little' work has been done on the ethics of Health Education or Health Promotion (Seedhouse, 1988; Doxiadis, 1991; Yeo, 1993; Roberts et al, 1993). Seedhouse (1988) suggested that this is because 'health work' is so varied, that the workers are too busy, and that ethics has 'pompous jargon' which few people understand. Rawson and Grigg (1988) suggested that little work has been done because it is assumed that, by its very nature, Health Education is pursuing worthy goals and that it has been assumed that moral or ethical enquiry is therefore not

necessary. Rawson, 1994:203, suggests that Health Promotion theory is like *"...a teetering structure built on unsound philosophical grounds". It* is only recently that Health Promoters have been asked to evaluate their work, and therefore have analysed or debated the worth of their work. Yeo (1993) states that health interventions touch upon 'dearly prized values' and therefore ethical debate is essential.

McLeroy *et al*, 1993, described how, in America, the interest in ethical issues with regard to health promotion only began in the early 1980's. A number of reasons for this interest were given, including a number of reports, an interest in school health policies, interest from commercial food companies introducing 'healthier' foods, and the newly acquired prestigious status of health promoters.

> *"Accompanying this improvement in the status of health education as a profession and opportunities for practice outside more traditional settings has been an increase in concern about ethical issues."*
> McLeroy *et al*, 1993.

In America, the Society for Public Health Education (SOPHE) revised its 1976 code of ethics in 1983, due to the widespread changes in the practice of Health Education. In 1984, SOPHE and the Advancement of Health Education (AAHE) appointed a joint committee to develop a profession-wide code of ethics. In 1987, the American *Health Education Quarterly* theme was ethical dilemmas in health promotion. In addition, in 1987, the Society for Public Health Education mid-year conference in New York City was devoted to ethical issues.

In the book *Ethical Dilemmas in Health Promotion,* edited by Doxiadis, 1987, each contributing author was concerned with ethics from a different focus. Although the book title suggests that it concerns itself with Health Promotion, most of the chapters are, in fact, medically based concerns. Campbell is concerned with *definitions*, Karhausen is concerned with the relationship between ethics and *medical ethics*, Blaney with *intervention ethics*, Knox with *personal and public health*, Beauchamp with *paternalism*, Pinet with *legislation*, Eisenberg with *social policy*, Bungener with *health economics*, Pochin with *occupational risk*, Dupuis with *reproductive medicine*, Manciaux and Sand with *child health*, Riis with *screening*, Strasser, Jeanneret, and Raymond with *prevention trials*, Martin with *organisation of ethical control*, Rayner with *mass communication media.* In his later book, entitled *Ethics In Health Education*, 1991, the chapters were about specific topics in Health Education/ Promotion rather than about the philosophy of the ethics of Health Promotion *per se.* The contributing authors included Downie who wrote *an introduction to the topic of Ethics in Health Education*, Campbell wrote about *Indoctrination and Autonomy*, Gillon wrote about *The ambiguity of the medical role*, Gorovitz wrote about *Health*

Care Advertising, Pattison and Player wrote about *The political tensions in Health Education*, Harlem wrote about *the role of organised medicine*, Flaysakier wrote about *the journalist as health educator*, Doxiadis and Garanis wrote about *the ethics of health education for children*, Downie and Fyfe wrote about *Health Education in schools*, Tountas wrote about *self care*, Eisenberg wrote about *the AIDS epidemic*, Riis wrote about *nutrition*, Atkinson wrote about *mental health*. Thus the philosophy of the ethics of Health Promotion has not been addressed in the UK yet. It is hoped that this research will go some way towards addressing the gap.

Cribb, in Jones and Sidell, 1997, argues that Health Promotion ethics can be viewed merely as another 'sub-domain' of health care ethics. He suggests that the ethical issues are similar but more problematic for a number of reasons, namely: interventions are initiated by the professional rather than the clients who do not invite intervention as patients would normally do, that Health Promotion is aimed at abstract national or local audiences rather than specific individuals, the aims/ 'ends' are abstract not concrete, that the interventions are mixed in with social, economic and cultural processes, and finally, that Health Promotion does not rely on facts nor evidence.

Some occupational groups have formal codes of ethics, because of the intrinsic questioning within that profession, for example, lawyers, scientists, engineers, physicians, journalists, medics. The formal code of ethics sets forth principles of conduct deemed appropriate to the special objects and responsibilities of that profession. The SHEPS Code of Conduct does not fully cover ethical issues in the same way as could be said of that governing medics.

A practical tool is provided by Seedhouse, 1988, who devised an 'ethical grid', which he suggests provides a practical framework to be applied in day-to-day work. He suggested that practitioners ask themselves about the central conditions in working for health(eg. autonomy and respect), key principles in working for health (eg. doing good and avoiding harm), consequences of ways of working for health (eg. increase of good to the individual and to society), and the external considerations in working for health (eg. legal implications, risks, evidence, justifications of intervention).

Ethical issues in practice

Communication

Health Promoters are perhaps in a difficult position because they are rarely/ if ever in a 'consultation' position with their client group. Doctors would meet clients in a consultation situation, and the conversation is probably one with an unspoken recognition of different roles and the doctor has the 'power'. The patient consults the

doctor, who has medical expertise and advice to give. The patient may be subservient or articulate. Many writers (eg. Byrne and Long; Pendleton; Heath) have studied the doctor-patient relationship, and the 'games' both play. Metcalfe, 1989, also describes the imbalance in both arousal and power between both parties. This situation has been recognised and is being addressed by doctors and nurses receiving 'communication skills' training as part of their curriculum. However, what about the communication between Health Promoter and client group? People will not see the Health Promoter as being 'in the same league' as doctors or nurses, yet may have consulted the Health Promoter for advice. For example, a member of the public going to a display stall regarding quitting smoking will be having a different conversation than with their doctor. The doctor will have case notes and some sort of history with the patient, but the Health Promoter and the public will be strangers. Robinson (1992) studied the doctor -patient relationship and states that... *"Evidence suggests that many patients lie towards the passive end of the continuum, and relatively few towards the active end..."* She concludes that patients need to feel free to present spontaneously and that information, instructions and advice needs to be presented in a way which encourages both doctor and patient to become aware of misunderstandings and problems. However, the doctor and patient each have agendas and negotiations to conduct, and some sort of mutually agreeable ending, which the Health Promoter will not have to go through, especially since they may never see each other again.

receiving messages

Health Education/ Promotion messages are received by the public. Psychologists have studied humans as 'message recipients' - a piece of information given is not necessarily the same as that heard. People 'translate' the information so that it makes sense in their context. Most of the research that has been done into the public's understanding of health messages has been the doctor-patient interaction, and therefore more needs to be done into the receiving of Health Education/ Promotion information. For example, what does the public understand having read a particular leaflet, seen a certain poster, watched a factual documentary, seen a funny health related cartoon, etc? Watt (1986), however, states that one is wrong if one assumes that the public are passive recipients...*"Health educators tend to operate from the assumption that people's health knowledge is extremely limited."* (Rodmell and Watt, 1986:154). It has been found that it is not that patients are passive, but that doctors think that patients do not understand what is said to them (Friedson, 1970; Zola, 1973; Illich, 1975; Stimson and Webb, 1975; Meredith, 1993.)

Health Promoters also need to find out if or when the recipients of their health messages are rational, critical and if there are 'moments of decision'. It may be that people consciously, or subconsciously weigh up the 'pros and cons' for themselves. Do

people really take a calculated look at their lifestyle and life expectancy? *"Few people, if any, seek to maximise their health and life expectancy per se."* (Bunton et al, 1992:116.) It has been suggested that we should not just be giving the public messages, but skills with which to make decisions about information, such as confidence, assertiveness and self respect (Pearce, 1993).

It also needs to be born in mind that the public receive 'silent' messages from many other sources- role models, parents, friends, pop stars, religion, soap operas, Government policy. These may well conflict with Health Promotion messages. However, on occasions, the conflicting messages may be utilised by 'sharp' Health Promotion media specialists, for example, in the late 1980's, Brian Harvey of the pop band 'East 17' was a well known ecstasy taker, who had to publicly state that he had previously taken ecstasy, but had changed his ways, and also, more recently, Daniella Westbrook, of television soap Eastenders' fame, has been photographed with no bridge to her nose because of taking cocaine, and she too has taken part in many interviews describing how she regrets taking cocaine now because of the effects it has had on her previous good looks and the impact the notoriety has had on her young son.

power

There are many definitions of power, but most authors define *types* of power. French and Raven (1959) identified 5 types of power: reward, coercion, legitimate, referent and expert. Do Health Promoters have power? It would seem that they have available all of French and Raven's types. Reward power is available by Health Promoters offering success and praise to people and the promise of a longer/ more healthy life. Coercion is often used by various persuasion techniques, including 'cutting down' described as 'foot in the door'(try this small thing and then this big thing after), and 'slap in the face techniques'(try this large thing when really a small thing is required). Legitimate power is probably used most by medical Health Promoters, such as doctors, nurses, health visitors, etc. The Health Promoter is seen as legitimately having power. However, the Health Promotion Specialist is perhaps seen by the public as not having this 'legitimate power'. Referent power is used by Health Promotion campaigners who utilise celebrities and successful people in their campaigns. Expert power is utilised by the assumption that Health Promoters are professional, and have been trained and are therefore experts.

Habermas, 1984, described society's 'master-slave' relationships, which Health Promotion Specialists and the public could be included in. Morrow and Brown, 1994:149, point out that

> *"A fundamental assumption of critical theory is that every form of social order entails some forms of domination and that the critical emancipatory*

interest underlies the struggles to change those relations of domination-subordination...power relations engender forms of distorted communication that result in self-deceptions on the part of agents with respect to their interests, needs and perceptions of social reality."

In addition, Health Promoters could be seen as having the power to empower, and they are thus 'sharing' their power. Katz and Peberdy, 1997:103 state that *"Power sharing is a crucial factor in health promotion...The objective is not to ensure compliance...but to enable people to think for themselves about health dilemmas and choices..."* Stewart and Shamdasani (1992) suggest that it is the perception of power and not the actual possession of power that influences the behaviour of individuals. If the end objective is to ensure compliance, then the Health Promoter could be seen as being in a position of power, whereas if the end objective is to give accessible information, then the word power does not have such negative connotations.

Health Promoters need to be aware of a number of powerful social influences they may have upon people, including: making people feel guilty, being role models, inhibiting/ disinhibiting others, being credible and initiating obedience (Baron and Byrne, 1991). In addition, there are obviously many other social influences on people's health behaviour, but Health Promoters need to be aware of the influences they have in particular.

expertise

What is it that Health Promoters are experts in? They are often ex-teachers or ex-nurses, and are therefore experts in another field. Kemm and Close, 1995, argue that if health promoters' information influences other people's decisions, then health promoters must accept some responsibility for giving that information.

Caplan, 1993, argues that the educational and self-empowerment notions of models are presented as a radical antidote to the mechanical objectivism of the medical view based on disease prevention and or individual behaviour change. However, they all still require an expert to provide the public with the information, so they can make their informed decisions. Keeley Robinson, 1984 states that this objectivist tendency is 'hidden' within the self-empowerment framing of the model, and using such terms as 'self-esteem' and 'informed healthy choices'.

In Scriven and Orme, 1996, Ewles argues that a distinction can be made between health promotion 'generalists' and 'specialists'. 'Generalists' could include parents, voluntary workers, teachers, youth workers, etc. i.e. people whose life/ work may generally include health promoting activities, whereas 'specialists' are those who are

paid in their work capacity as experts, planning, implementing and evaluating a wide range of activities. She therefore considers Health Promotion Specialists to be experts, but points out in the same chapter that the numbers within the professional body, SHEPS, is small at 1,000 people in 1993 (SHEPS, 1993b), and 326 in 2000. This massive reduction in numbers was not addressed.

credibility

Do Health Promoters have credibility? Do different Health Promoters vary in their credibility? The Oxford Dictionary defines 'credible' as 'believable'. Should Health Promoters be believable, or believed? Certain professions such as doctors and the police, are seen as credible. For some members of the public Health Promotion will be seen as a profession, therefore credible, therefore telling the truth.

> *"It may appear that the persuasive aspects of preventive medicine are doomed to be either ineffective (because too careful not to interfere with the autonomy of others) or counter-productive (because effective by methods which remove the autonomy of others)."*
> Campbell in Doxiadis, 1987:23.

role models

Can one be a fat dietitian or a drug smoking nurse, or an alcoholic doctor? Does the health promoter have to be credible, or is showing empathy important? It may be that the fact that the health promoter previously smoked may be helpful for a person trying to quit.

persuasion

It has been suggested that any form of information giving, including traditional Health Education can be seen as trying to persuade someone of one's point of view (Hogg, 1991). Yeo, 1993 suggested that Health Promotion interventions can be plotted along a continuum ranging from voluntary to non-voluntary or coercive. Faden (1987) identified persuasion, manipulation and coercion within Health Education and Promotion. Seedhouse (1988) identified six types of intervention- those which are requested, those desired, those not requested and not desired, those enforced by law, those interventions which should be done but are not, and those situations where non-intervention is decided upon. Wikler (1983) distinguished between education, incentives (such as subsidies and taxes) and regulative measures. Cribb, 1997 argues that there are various forms of social influence, eg. peer pressure, social pressure,

advertising, incentives, professional persuasion, taxation, etc, and that they are all 'morally ambiguous'.

More 'sinister' labels have also been applied to Health Promotion techniques, such as indoctrination- an unquestioning adherence (Hare, 1972; Snook, 1972), propaganda and fascism. Indeed, (even) the HEA has been seen as epitomising

> *"...a modern, sophisticated form of propaganda...in which there is... selective presentation of scientific evidence to support an official position ... a conspiracy of silence on deprivation as a factor in social inequalities in health: a conspicuous avoidance of education and a favouring of education for individual change; and a concentration on health messages that foreshorten and oversimplify complex and difficult issues."* (Farrant and Russell, 1986:8)

However, Hare (1972) states that education can not be seen as persuasion.

> *"The educator is waiting and hoping all the time for those whom he is educating to start thinking...The indoctrinator, on the other hand, is watching for signs of trouble, and ready to intervene to suppress it when it appears."* (Hare, 1972, 1991:18.)

The No Smoking Day fact pack (HEA, 1993) has a section on 'what to say to awkward people', which Hare would thus categorise as 'indoctrination', because one is anticipating what to say to (awkward?) people who ask questions. Are education and indoctrination any different from each other? Downie (1992:144) suggests that Health Promoters have *"...the belief that there are better and worse ways of living one's life."* , therefore they would feel the imperative do show people the 'better' way. Baelz, 1979 points out that changing people's attitudes is incompatible with respecting the individual's freedom of choice, especially if the methods of change are manipulative.

Campbell (1991:18) asks

> *"Then how are we to understand 'health education' - as genuine education or as indoctrination, as an enhancement of autonomy or as merely the substitution of one heteronomy for another, the paternalistic beneficence of the 'health expert'?"*

Thus it could be argued that people aren't educated merely for their sake, but for the gratification of the 'smug' educator, who doesn't necessarily want to care for people but wants everyone to be good.

Perhaps the purpose of ethical enquiry is to clarify the *level* of persuasion and any imposition on privacy, freedom, responsibility and the common good (Yeo, 1993). Rothschild, 2000, argues that 'marketing' is felt by many to be an unethical way to manage public health behaviours, and that 'social marketing' within the context of a contemporary democratic society can be ethical education. Cribb, 1997, points out that consent or agreement is unlikely to have been given because Health Promotion targets the mass not the individual.

Selling Health

There seem to be two main areas for debate within the notion of 'selling' health. Firstly the notion of selling health at all, and secondly, the notion of the advertising and persuasion involved in selling. The new era of business-like competition in the NHS, and the emergent Trusts has repercussions on Health Promotion.

It might be suggested that Health Promotion sells itself with similar techniques as any other salesperson. Maybe some of the claims of Health Promotion are exaggerated, prevaricated or just plain altered. Downie (1991) suggests that Health Education *"...respects the autonomy of its recipients, whereas health promotion bypasses autonomy and sells health like a commodity."*

Health Promotion is now incorporating marketing, evaluation, and customer satisfaction surveys. Much of the language of health promotion is imbued with the language of marketing, eg. 'campaigning', targeting', 'strategies', and evaluation'. within this market ideology, the consumer is given an illusion of choice, but is actually only in the range of current options. The services or products for the human body can be itemised and utilised or not, especially with the advocating of self examination tests, or using one's initiative. For example, someone could feel for lumps in the body, or self diagnose a cough being linked to smoking. Companies can therefore market their products to a consuming society. This can also be seen to now be true of national health services.

Gorovitz (1991) warns us of the morality of health care advertising, and asks if it is 'communication or confusion'?

> *"The significance of advertising in communication regarding health care will certainly continue to grow and we will all face conflicts...our commitment to freedom of expression, our desire to protect the public against deception, and our sense of the mission of health care as a fundamental non- commercial commitment of any decent modern society."* (Gorovitz, 1991:46).

Gorovitz described an imaginary situation, whereby hospitals would advertise their success rates, for example 'only 2% death rate here', or add comedy to the advertisement- 'fed up of your kids? Get your snip here, and a weekend away too', or publish testimonials from 'satisfied' clients. Private 'alternative' health care practitioners, such as hypnotherapists, provide success rates, so should health care services and Health Promotion do the same? Some HEA campaigns do juggle figures about lives 'saved', in particular, the No Smoking Day campaign annually publish research revealing that X thousands of people don't die each year because of the annual No Smoking Day.

Research shows that people, especially the young, are influenced by the glamorous, successful, popular images in adverts. The No Smoking Day committee, amongst others, employ P.R. companies to 'sell' health messages for them. Is there anything wrong with trying to 'compete' with successful advertising campaigns? Or does the public just want the truth about prospective washing powder, anti-ageing cream, their chances of being infected with HIV? However, Watt argues that *"...glossy posters of glossy families do not help us to tackle our health problems"* (Rodmell and Watt, 1986:154). Campbell reminds us, however, that *"All education contains some element of persuasion, even if it is no more than that of persuading people to pay attention to the issues being discussed..."* (Campbell, 1991:22.)

Because the public are being given information about illnesses, products available, services, treatments, cures, it could be suggested that people are feeling 'empowered' to choose what is right for them, but actually they are choosing from what has been decided to be given by decision makers they will never meet. Marketing 'standardises' needs and choices, whereas true empowerment would respect diversity.

Ewles states in Scriven and Orme, 1996:72, that *"The NHS reforms are underpinned by a belief that market forces and competition will lead to more efficient, effective health services. But this poses a fundamental problem for specialist health promotion work. Health promotion practice is deeply rooted in an ethos of collaboration...The strains imposed by competition and conflicts of interest are often very uncomfortable indeed."*

Blair, 1995, argues that social marketing provides a theoretical basis to increase awareness of preventable health conditions and to increase participation in wellness programs. Social marketing is from a more general use of the word 'marketing' because social marketing utilises 'non-tangible' products such as ideas, attitudes, and lifestyle changes. But, Baum and Sanders,1995 argue that the increasing dominance of market economics and the promotion of economic growth at all costs is reinforcing inequities in health experience globally and within countries, and that individualism, the

philosophical accompaniment of market economics, has reinforced a behavioural and lifestyle focus and undermined a collective approach to Health Promotion.

Leaflets

The predecessor to the HEA and the current HDA, the Central Council for Health Education (CCHE) (1927- 1969) had the promotion of health education, through provision of better and cheaper posters and leaflets and exhibits for exhibitions, as their main task. Health Promotion has thus inherited a history of producing, and being expected to produce, leaflets. This perceived link between Health Promoters and leaflets interested Murphy and Smith, 1992, who interviewed Health Promotion Advisors, and found that

> *"...the overall feeling towards leaflets is perhaps summed up by a 'can't live with them, can't live without them' attitude. It was felt that there is too much emphasis and activity centred on them in health promotion, but also that there is nothing really to replace them."*
> Murphy and Smith, 1992.

They asked whether health education leaflets were *'crutches, confetti, or useful tools'*?

Recently, Health Promotion has been using sponsorship of leaflets, often because of lack of funds. A leaflet can look quite different when it has been professionally published, compared to typed and photocopied, and money for this 'professional' look can be supplied by sponsors. However,

> *"Sponsorship affects not only the content, but also credibility...It is likely that sponsorship gives professional legitimacy to a product... But it is equally likely that some of the HEC's credibility as an impartial adviser on health could be jeopardised by such an association with a commercial company."* (Naidoo, 1986.)

Player (Pattison and Player, 1991) asks us to bear in mind that the independence and credibility of the HEA may be compromised by the wrong kind of commercial sponsorship. Player proposes a number of issues for Health Educators to beware of, for example association with the tobacco industry, alcohol companies (unless promoting safe and sensible drinking), specific branded drugs, dietary supplements, infant feeding formula, food companies (unless promoting consumption of less fat), more fibre, less salt and the product is reasonably priced and freely available.

It seems that Health Promoters try to avoid sponsorship by pharmaceutical companies, yet are more easily persuaded by bread, meat and baby milk companies. Hospitals have favoured brands of baby milk, which parents are perhaps likely to use for their child for at least a year, but this kind of subtle persuasion seems to go by unnoticed.

Gorovitz (1991) warns us of the morality of health care advertising, and asks if it is 'communication or confusion'?

> *"The significance of advertising in communication regarding health care will certainly continue to grow and we will all face conflicts...our commitment to freedom of expression, our desire to protect the public against deception, and our sense of the mission of health care as a fundamental non- commercial commitment of any decent modern society."* (Gorovitz, 1991:46).

Murphy and Smith's research, 1992, revealed that Health Promoters used leaflets without reservation because they were free, although they were more concerned about commercially produced leaflets. *"They used commercial leaflets to meet demand, but only after reviewing their content, to see if it was ethical, unbiased and correct."* Health Promoters may feel uneasy about some sponsors, for example a nicotine patch company sponsoring a quit smoking leaflet, but how many would reject using the leaflet which may have some really useful information in it because of a logo which some readers may associate with a particular company.

Harm minimisation/ Just say no

A more recent addition to the variety of ways of working is the 'harm minimisation' approach. 'Harm minimisation' aims to stop or reduce use/ sharing of contaminated injecting equipment, to stop or reduce drug use, to stop or reduce unsafe sex, to encourage health consciousness, to encourage a more stable way of life and to establish and retain contact with clients. Harm minimisation strategies would include education about: hazards of drug misuse, safer sex, education about and provision of sterilising equipment, provision of condoms, dangers of overdose, First Aid, immunisation, H.I.V. testing and counseling and substitute drug prescription.

The harm minimisation philosophy already exists in alcohol education and also smoking education to some extent, with the concepts of 'sensible drinking' and cutting down cigarette consumption to stop or stay on a reduced level, or switching brands or tar levels. The harm minimisation approach seems to be gaining momentum and increasing respect in the drug education field, with the reasoning that many drug users don't want to stop, so they should be shown how to take drugs more safely. However, *"A fine line*

often needs to be drawn between appropriate acknowledgement and tacit encouragement." (Heller et al, 1987:5) Seedhouse (1988) states that it is better to urge harm minimisation than adopt a 'do no harm' approach, as it is more realistic. Harm minimisation necessitates involving the people at risk, because it is they who have to make the changes and 'partnerships' are essential.

Health Education and young people

If it is believed that Health Education should start with the very young, then it might be suggested that this is nearer to indoctrination than might first be thought. The Government's "Choice and Diversity: A new framework for schools" stresses the importance of "...a strong moral dimension and how the general atmosphere and ethos of a school is also an important factor in a good education."(Home Office, 1993.) This implies that there is a predetermined set of morals. However, *"Schools that only provide facts are missing the point. They should be developing in young people the assertiveness skills that permit them to say yes or no..."* (Pearce, 1993:12.)

If one agrees that Health Education has a place in schools for example, then debate as to the suitability of some topics may arise. Should children be educated for example about smoking, drinking alcohol, taking drugs, contraception, gay sex? It has been suggested that education on these topics will encourage early dabbling/ experimentation, others would say 'so what' and others would say that the children will experiment with these things anyway.

Government Policy

In some health issues, the Government intervenes, such as seat belt legislation. This seemed to be welcomed into legislation. *"Legislation worked where health education failed. Overnight the proportion of people wearing seat belts rose from 45% to 90%."* (Hogg, 1991:21) The Government is often called to intervene and impose rules and restrictions, but there is more debate and hostility, most notably with regards to smoking...

> *"Smoking ...is not some mysterious virus or elusive mental condition requiring research and lacking a cure, but give or take a measure of addiction, a simple habit that in principle could be eliminated overnight...This places much responsibility on Governments, to take the necessary legislative and administrative action."*
> (Pollock, 1993:8.)

Government intervention could ban something altogether, also ban/ restrict advertising, impose age restrictions on purchase, enforce heavy taxes, etc. Others suggest that these kind of interventions are 'fascist'. It could be argued that products should be initially vetted and then the public allowed to buy it if they wish, allowing for 'autonomy', such as the voluntary advertising agreement between the Government and the tobacco industry. It has been suggested, however, that the voluntary agreement is 'contradictory', because *"...the advertising agreement stipulates that smoking may not be associated with sporting success whilst the sports sponsorship agreement is about precisely that."* (No Smoking Day Fact Pack, HEA, 1993.) It is also interesting to note that a Health Minister has been reported as stating that there is nothing wrong with surgeons withholding treatment from smokers who refuse to give up smoking (Hendry and Ironside, Daily Express, 1993). To some extent, smoking restrictions are welcomed because the majority don't smoke.

Others (Farrant and Russell, 1986; Rodmell and Watt, 1986; Townsend at al, 1991) suggest that the Government actually have more sinister motives for not intervening in various health issues...

> *"On the one hand we have a junior minister at the DHSS exhorting members of the working class to improve their dietary habits as a means of rectifying inequalities in health recorded for the northern region. On the other hand, ministers and officials are spending their time trying to suppress the information which shows that those inequalities exist..."* (Draper, 1991:124.)

If evidence of the link between unemployment and ill- health becomes substantiated, then this becomes a damning indictment of the Government's social and economic policies.

Targeting programmes

Health Promotion programmes often 'target' specific groups, in particular minority ethnic groups. However, some authors (eg. Parmar, 1981; Pearson, 1986; Rose, 1992) feel that targeting ethnic groups is actually just a well disguised form of racism, inherent within a culture-blaming ideology. Targeting could be seen as a 'side step' from a medical model approach, because the health professional decides who is most at risk and then tries to help these 'poor unfortunates'. Ethnic minorities are seen to have biological differences and predispositions to such illnesses as stroke (Afro- Caribbeans), and CHD (Asians) (eg. Giacosa and Hill, 1991; HEA, 1991; Poulter et al, 1993). Rose (1992) suggests that in order to categorise whole populations or communities requires *"...carefully standardised measurements to be undertaken on large samples in*

multiple places, and they require investigators to publish their data on whole distributions." (Rose, 1992:58).

However, is targeting amplifying differences rather than helping?

> *"There is a prevailing ethos amongst health professionals that different, alien diets cause health problems amongst black and ethnic minorities because 'their foods' are not available here and because their diets are somehow inherently unhealthy."* (Pearson, 1986:51.)

The Health Education messages seem to stress a deficient culture, ignorance, an unwillingness to change and refusal to use health services on the behalf of the recipient of the messages. However, it seems that it is an impossible situation because...

> *"To emphasise difference within racist ideology is to reinforce and emphasise notions of alieness, whilst within an anti-racist perspective, recognition of difference is a prerequisite for a positive and sensitive awareness, a welcome departure from ethnocentrism."* (Pearson, 1986:44.)

Also Rose suggests that, by implication, populations or communities labelled as 'predisposed' in some illness are seen as 'not normal', and are therefore 'deviant' (Rose, 1992:61.) Rose concludes that society, once it has labelled people, can then categorise them, distance itself from them, or deny them the responsibility for their problems and he warns that *"A targeted approach may assist but it cannot be sufficient."* (Rose, 1992:95). Golding, 1995, states that *"Every country which seeks to provide medical care for its citizens has the problem of deciding what it will and what it will not provide."*
Identifying which patients should and should not be treated, eg premature babies, senile people is a major ethical dilemma.

Should the emphasis be on the 'individual' or the 'group' in health care? The doctor is obliged to help the individual patient. Problems arise when the health of whole populations is used, eg. education, advertising, prophylactic measures (immunisation, screening), legislation.

> *"It is in the public health aspect of preventive medicine that the controversial ethical issues arise. Indeed the problem is that this is largely unknown territory for ethics as a whole."* Campbell, 1987:20.

Richards, Potvin and Mansi, 1998 commented that Canadian Health Promoters do not seem to have a problem with targeting individuals and individual change, because they also perceived a high need for targeting environmental issues.

Sponsorship

Recently, we have seen the advent of Health Promotion being associated with sponsorship, often because of lack of funds. A leaflet can look quite different when it has been professionally published, compared to typed and photocopied, and money for this 'professional' look can be supplied by sponsors. However,

> *"Sponsorship affects not only the content, but also credibility... It is likely that sponsorship gives professional legitimacy to a product... But it is equally likely that some of the HEC's credibility as an impartial adviser on health could be jeopardised by such an association with a commercial company."* (Naidoo, 1986.)

Player (Pattison and Player, 1991) asks us to bear in mind that the independence and credibility of the HEA may be compromised by the wrong kind of commercial sponsorship. Player proposes a number of issues for Health Educators to beware of, for example association with the tobacco industry, alcohol companies (unless promoting safe and sensible drinking), specific branded drugs, dietary supplements, infant feeding formula, food companies (unless promoting consumption of less fat), more fibre, less salt and the product is reasonably priced and freely available.

It seems that Health Promoters try to avoid sponsorship by pharmaceutical companies, yet are more easily persuaded by bread, meat and baby milk companies. Hospitals have favoured brands of baby milk, which parents are more likely to keep their child on for at least a year, but this kind of subtle persuasion seems to go by unnoticed.

Evaluation

Increasing in importance is the necessity to demonstrate the effectiveness and cost effectiveness of programmes (HEA, 1993; SHEPS, 1993, French, 2000.) Health Education and Health Promotion have always seemed to have question marks hanging over them with regard to effectiveness and efficiency.

But as Haycox, 1994:5 succinctly points out

> *"...the impact of health promotion is far less easy to capture as it focuses upon the prevention of ill health that would otherwise have occurred. Thus by definition, health promotion leads to hypothetical*

health gains arising to individuals and groups who remain perfectly healthy- but would not have been so in the absence of the intervention."

There are a number of types of evaluation: 'process' which involves measuring the activities of a programme, programme quality and who it is reaching; 'impact' which measures the immediate effect of the programme, and whether it has met its objectives; 'outcome' which measures the long-term effect of the programme and whether it has met its goals; and 'evaluability' assessment which refers to the review of the state of a programme at a particular point in time. Others see evaluation as of little importance. For example, Downie, 1991:210, stated that *"...health education is worthwhile regardless of its impact on costs, health is a value in its own right."*

The Committee on Health Promotion, and the SHEPS (1993) has developed a proposed framework for levels of evaluation and indicators for the promotion of health. However, evaluating health interventions is notoriously difficult (RCP, 1991; Clayton, 1993). Health Promotion can be measured a little more easily than Health Education, it seems. Health Promotion activity can be identified, to some extent, by specific results, and evidence can be taken from, for example, epidemiology, demography, clinical practice, psychological testing, up-take figures, contact figures. However, Health Education cannot be measured as effectively by 'external outcomes', because the educator's interest lies in the development of the individual's personality, skills, understanding, or knowledge, which are difficult to measure.

Epidemiology is concerned with the statistical exploration of the incidence of particular diseases and ill-health in populations and population groups. Epidemiology attempts to explain disease causation, and if the cause is identifiable, it may then be possible to combat the disease in other ways, eg. immunisation programmes. Epidemiological surveys can also, therefore, to some extent, test the effectiveness of programmes; and health promotion programmes could then be used to improve the acceptance rate of such programmes among the public, should this be required. Epidemiology can also identify pattern changes over time, and look at ascending or declining figures for illnesses. If a problem is on the increase, then appropriate responses can be planned. Epidemiology can also be used in evaluation of health promotion programmes, and therefore, in decision making.

However, although statistics may seem to be representing true pictures, it is often the way the statistics are described that may lead to distortions, or even abuses, of their implications, rather than uses. In addition, some health statistics may be quoted as causes, rather than correlations.

Ewles, in Scriven and Orme, 1996:71 state that

> *"A health service culture of looking for quantitative measures has developed...but health promotion does not sit easily with this approach. There is no neat unit of measurement...which...means that there is no clear way of monitoring how much health promotion activity is underway...Commissioners want to know what has been achieved with their investment; in other words, the outcomes rather than the details of processes."*

However, Ahmed, 1995:239 sees evaluation more positively, stating that *"...information can influence health care delivery either by revealing performance failings, or by demonstrating how known problems might be solved."*

CHAPTER 4: Professions within Health Promotion, and the implications for ethical dilemmas

Health Promotion and ex-nurses; Health Promotion and ex-teachers; Health Promotion staff as NHS employees

Professions within Health Promotion

ex-nurses

By observation, many people working in Health Promotion are ex-nurses. Thus, it would be useful to consider how nurses feel about Health Promotion, and why so many nurses change career into Health Promotion, and then subsequently how they consider ethical issues within Health Promotion.

Medical ethics has been widely addressed, and would form part of doctors and nurses' training. Issues of medical ethics include, for example: **consent and refusal,** including pressures on consent, refusal of treatment; **confidentiality and medical records,** including privacy, disclosure, access to records, computerised records, pre-employment reports and testing, doctors with business interests, media doctors; **relations between doctors,** including professional standards, etiquette, 'whistle blowing', reporting of misconduct, fund-raising, fundholding, advertising; **inter-professional relations,** including nurses, midwives, health visitors, complementary therapists, social workers, carers, pharmacists, pharmaceutical industry; **rationing and allocation of health care resources,** including auditing, quality, costs, patient demand, decision taking, decision making selection criteria, core treatments, prioritising, right to treatment. Some of these issues would overlap with Health Promotion ethics, such as, for example, consent and refusal, professional standards, etiquette, 'whistle blowing', reporting of misconduct, general practice, fund-raising, fundholding, advertising, inter-professional relations, rationing and allocation of resources. However, the settings of hospital and Health Promotion Unit are very different, even though colleagues and client groups will be very similar.

Traditionally, nurses educate patients about disease management and give structured information to patients about their condition or the procedures they will be undertaking. The emphasis has been on reducing anxiety and improving recovery by compliance and standardised approaches. However, recently, different approaches have been encouraged, such as individualised, patient centred approaches, incorporating self-efficacy beliefs (van Ryn and Heaney; Norton, 1998).

Latter, (in Scriven and Orme, 2001:77-78), argues that

> *"Values central to health promotion- collaboration, public participation and empowerment- do not sit easily with the tradition of hospital healthcare. The latter has been founded on a medical model approach to care, characterised by an orientation towards cure, treatment in the medical environment, a tendency to dismiss the patient's perspective and an expectation of the patient role as one that involves passivity, trust and a willingness to wait for medical help."*

Latter's observational and interview research, 1994, found that the reality of nurses carrying out health education 'falls short of the potential' and is minimally integrated. Latter called for greater involvement of nurses in health education and promotion activities, stating that

> *"Nurses need to recognise and develop their potential role in the broader arena of health promotion in addition to their more traditional role as health educators. Creating environments that are supportive of health, encouraging community participation in health matters and helping to build healthy policies may all form part of the potential for health promotion in hospital nursing practice."* Latter, (in Scriven and Orme, 2001:79)

Latter's interviews with 132 ward sisters, revealed that only two had formal liaisons with the local Health Promotion Unit and with the hospital catering manager (re. nutrition policy). Latter explained that the unique potential for Health Promotion by nurses includes close contact with patients, detailed and holistic understanding of physical, social and psychological needs, whether patient needs are met by current provision of services; nurses also have specialist medical knowledge, support of healthy hospital policies, and collaborate with a wide range of professionals. However, the current reality was that nurses had a *"...lack of recognition of the broader policy or structural aspect of health promotion."* Latter, (in Scriven and Orme, 2001:83). But can it be a practical reality that busy nurses caring for patients have the time to undertake Health Promotion?

Smith et al, 1999, found that in their evaluation, which involved documentary analysis, observation and interviews with teachers, students and nurses in four educational institutions, that the interpretation and implementation of a philosophy of health in nursing in the UK has been variable. Trained hospital nurses in particular continued to view nursing as primarily concerned with disease treatment. Health was operationalised as both health education and health promotion ranging from individualised information giving and disease prevention to more participatory forms based on equity and empowerment. Participants' responses to the introduction of health in the curriculum

were categorised in one of four ways: pessimism, partisanship, fanschen (to turn over) or marketisation. Their response depended on whether they viewed health as the central nursing philosophy rather than disease or care.

Health Promotion is primarily an activity based in the health and social fields, and not as such a medical service, but *"...health professionals have a massive role in nurturing and enabling health promotion."* (Baric, 1986:39). However, how can nurses truly fulfil their role of caring for the sick, if they are being asked to concern themselves with empowering patients? A stage further from empowering patients must be raising awareness of any inadequacies in the provision of health care services. Wilson-Barnett and Macleod Clark, 1993:9, also point out that

> *"The reality is that health promotion is fundamentally political and although it might not be a sensible career move for individuals to become political activists, professional bodies must surely lobby for healthy public policy in accordance with the principles of the Ottawa Charter."*

Thomas and Wainwright, 1996, state that it is widely held that nurses have a key role to play in health promotion and that this is particularly the case for nurses working in primary health care. This assumption is reinforced by policy documents from the World Health Organization, the Department of Health and statutory bodies such as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. They suggest that the approach of many nurses to health promotion has tended on the one hand to be somewhat naive and on the other to be authoritarian and didactic; and they point out that there has been little discussion in the nursing literature of the ethical aspects of health promotion. However, recent developments in nurse education, such as Project 2000 and the consequent changes to preregistration programmes, have resulted in increased attention to both ethics and health promotion within the curriculum.

Clark and Maben,1998, investigated the perceptions of Project 2000 educated nurses about Health Promotion. The new approach to pre-registration nursing education in the UK (Project 2000) has an overt health focus as well as a specific remit to prepare nurses for a role as promoters of health. Their findings indicate that students are confused about the terms health education and health promotion, although most feel there is a distinction between the two. Students' descriptions emphasise individualistic approaches, and lifestyle and behaviour changes. Many recognize that health promotion should have a broader application and demonstrated a sophisticated grasp of the philosophy underpinning the promotion of health through their general perceptions of nursing. Clark and Maben suggested that this understanding is not labelled health education or health promotion, but is embedded in their articulation of concepts such as holism, patient-centred care and enhancing independence. They concluded that, paradoxically, both students and Project 2000 qualified nurses (diplomates) illustrated a

clear grasp of the more complex issues surrounding the concept of health promotion, while remaining confused by the terminology and its relation to practice.

At a similar time of publication, Robinson and Hill, 1998, argued that there was a dominance of an 'individualistic' philosophy of nursing, and that nurses' own perceptions of their role and the hospital/ community divide are all obstacles to health promotion being well integrated into nursing practice. Robinson and Hill state that these obstacles need to be overcome in order for the new health promoting nurse to emerge in practice.

Wilson-Barnett and Macleod Clark, 1993, conclude that there is a need to emphasise the need for critical thinking on how health promotion might be implemented within the hospital setting. Lindsey and Hartrick, 1996, argue that the nursing process is based in the natural science paradigm and on a biomedical approach to health care, and that in order for nurses to embrace health promotion fully, they must move away from the philosophy of the natural sciences and adopt a human science perspective. However, they point out that such a shift requires a radical transformation in nursing practice as nurses move away from the "top-down" approach of the nursing process and adopt a "bottom-up" approach to health-promoting nursing practice. Tones, 1993, pointed out that the nurse who empowers patients should also be empowering him/ herself. Hospitals should be providing assertion training and communication skills for staff. Pearson, 1988, asserted that only autonomous nurses could aid autonomy for patients.

But is bringing Health Promotion to nursing practical? Health Promotion in nursing must be fraught with dilemmas. Then those nurses bring their nursing ethical dilemmas to their new job in Health Promotion.

ex-teachers

Teachers may be in a difficult position to resolve their ethical dilemmas about Health Education/ Promotion. The school will have rules and regulations about the children, and also statutory obligations. However, how would a teacher reconcile, for example, knowing a fifteen year old in his/ her class were smoking, and therefore buying cigarettes illegally, yet his/ her colleagues smoke, or perhaps drink alcohol during their lunch break for colleagues' birthdays. How are the teachers deciding what to do, at present, in the pilot schools giving out the 'morning after' pill to their teenagers? Teachers must surely be in a difficult position morally, and ethically. However, in addition, there are Health Promotion Specialists employed by the NHS who have their brief as school based Health Promotion, yet have none of the obligations or duties of school teachers paid by the school.

Balog, 1999, looked at what he called a 'symbiotic' relationship contained within school-based condom availability programs in which health educators are confronted with the union of health and moral concerns. He suggests that health educators are obligated to address and resolve these ethical issues, such as whether a health educator's responsibility to promote health and prevent disease should morally obligate health educators to implement condom availability programmes for teenagers. Balog argues that the ethical principles of autonomy, justice, beneficence, and nonmaleficence justify the existence of school-based condom availability programmes, and that these principles should form the fundamental ethical foundation for health education programmes. Balog concluded that there is a need to increase the presence of moral deliberations and models in the health education professional literature.

Health Promotion staff as NHS employees

It would be interesting to know whether Health Promoters enjoy their work, and feel some satisfaction from their work. It could be seen as vocational work, perhaps even missionary-type, saving people. If people are dissatisfied with their work, is it because of any inherent ethical dilemmas about the nature of their work, or is it more to do with dissatisfaction with the workplace? Work has changed over the years from being necessary for one to make and grow things for use or bartering, to the modern, work being a means-to-an-end position Western society is in today. Many people apparently do not like their job, they are doing it for their pay. Blauner, 1960, for example found that 84% of the unskilled steel workers and 79% of the unskilled car workers he researched would not choose that job again. However, 91% of the mathematicians and 83% of the lawyers would choose that job again. Research has consistently found that repetitive, time pressuring, automatic, or low status work can be dis-spiriting and alienating for people. Hackman and Oldham, 1980, put forward five characteristics that motivate work performance, namely: skill variety, task identity (completing a satisfying and recognisable whole), task significance (impact on others), autonomy, feedback (information on success). It could be argued that Health Promoters would score highly on the first four, but the lack of feedback about success is missing. Most of Health Promotion work has little feedback, because most of the work is about safeguarding the future. For example, when running a quit smoking campaign, one can assume that predictable, hypothetical numbers of people have stopped smoking, and therefore not risked future illnesses, but these are all speculations and hypothetical. working hard for the sake of it has been termed a 'protestant work ethic', whereby people feel guilty if they are not contributing to society by working very hard, and perhaps being rewarded in the next life for doing thankless tasks at work.

Many people are motivated by money, but people in such jobs as the clergy, research workers, volunteers, health service workers, teachers, nurses, are often not getting high

pay, and must be motivated by something else, namely the 'good' work they are doing. Argyle and Henderson, 1985 suggested that people go to work for the friendship as well as other reasons, suggesting that colleagues are important when deciding if one likes work. Many rules for roles are in practice, and many sub-groups develop. Health Promotion Advisors are often on the same level of the NHS hierarchy, and in what might be termed a (metaphorically) 'flat' institution, whereby many people are on the same level below the manager, and decisions are made through meetings and committees. This would be different to the traditional 'tall/ pyramid shaped' workplace of factory work. Much research has also been done into the communication channels and problems of different organisations. Although Health Promotion is within the NHS, many decisions are reached by people in meetings and committees and in a democratic way. However, many NHS decisions are just as often 'delivered' to people from the autocratic bureacracy, as *'fait accompli'*, such as large mergers, lines of accountability, departmental moves. budgets, etc.

Much of the research into job satisfaction has traditionally been done with manual workers, whose 'output' can be measured. Psychologists especially have carried out research with factory workers. These would include classics like the Hawthorne studies, Tavistock Institute, Taylor's 'scientific management', Ford's assembly line, etc. Work as varied and diverse in nature such as Health Promotion would not easily fit into the categories provided by psychologists. However, there are some classic theories about the nature of work, and because Health Promoters invariably work for large bureaucracies like the NHS, and have line managers, and accountability, have to evaluate the effectiveness of their work (justify themselves), and get pre-determined pay (salary), maybe Health Promoters do fit into the categories. Here is a brief summary of the research into work, morale and satisfaction.

job satisfaction theories

Maslow theorised that humans go through a hierarchy of needs, and that usually one would have to pass through the fulfillment of one stage before moving on to the next. He categorised basic physiological needs such as food, water, warmth, shelter as primary needs, which if all were achieved a person would go on to trying to fulfill the next stage of safety needs, then belonging and love needs, then esteem needs and finally self-actualisation needs. He had his critics, but it is probably obvious that the general idea of his theory seems apparent, ie a hungry person will search for food above a good book. Aldefer re-categorised Maslow's 5 stages into 3 broadly similar

ones. Intrinsic theorists such as McGregor and Lokert argue that modern humans strive more for the higher needs because all the basic ones are usually fulfilled in western society.

Katz, 1978, researched whether the length of time someone had been in a job influenced the satisfaction they got from it. He found that initially people placed importance on the significance of their work and feedback on performance, more so than satisfaction with the job as a whole. However, later, variety, autonomy and a completeable task became more important. After five years, Katz then found that these factors became less important than contractual factors such as pay, benefits, colleagues and compatibility with the supervisor. He concluded that even self-actualisation became boring if one stays in the same job too long.

This research questionnaire specifically asked about job satisfaction, and what people liked and did not like about their work. The hypothesis under test is that having ethical dilemmas is associated with poor job satisfaction.

Are Health Promotion Specialists considering ethical issues in their work?

Skrabanek, 1990, argues that preventive medicine exists in an 'ethical vacuum', free from constraints put upon other disciplines. Campbell, in Wilson-Barnett and Macleod Clark, 1993: 20, argues that *"One must concede that health promotion is an easy target for criticism, because (for the most part) it is so public that we all have views about it- indeed it must be so for it to succeed."* De Leeuw E., 1989, argues that the notion of Health Promotion may be received with considerable scepticism by some professionals in the field as well as by actors in the policy making spheres. He attributed this scepticism, as well as barriers to include notions of health promotion in day-to-day work, to a lack of knowledge of essential concepts in the health promotion context. Hunt, 1992, asserts that Health Promotion ignores the most scientific evidence about the causes of ill health. Balog, 1999, states that the pursuit of healthy lifestyles often links scientific interests about reducing mortality and morbidity with philosophical interests about promoting morality. Seedhouse, 1997, argued that Health Promoters have failed to debate the purpose of Health Promotion and, therefore, 'foster the illusion' that all forms of Health Promotion are equally valid.

Cribb, in Jones and Sidell, 1997:240, argues that *"...it would be no exaggeration to say that health promotion is inherently contentious, and that ethical dilemmas are the norm rather than the exception."* He also points out that Health Promotion is associated with positive factors such as empowerment, equity, participation, respect, etc., but is also criticised for its social control, and moralising about health and lifestyle.

Duncan's PhD research, 1999:256, identified four themes which encompass the difficulties faced by practitioners when using theory to inform practice, namely: diverse perceptions about the nature of priorities, needs and values; competing views about what is justifiable activity; lack of shared understanding about the nature of key concepts such as health and empowerment; lack of agreement about what constitutes acceptable knowledge, especially of effectiveness. But, Welle, 1995, found that Health Promotion practitioners tended to alter their philosophical stance according to the setting in which they were working, and he concluded that Health Promotion practitioners are 'action people' and not philosophers. French, 2000, asks whether this 'context specific' philosophy that Welles found, shows (positively) flexibility, or (negatively) a lack of a grounded core theory. Jolly, 1998, concluded that Health Promotion specialists in the UK perceived philosophising about Health Promotion as being of academic interest and not of real practical concern. Brunton, Nettleton and Burrows, 1995, concluded that, rather than Health Promoters having little concern about philosophical or ethical issues, it is that their perceptions, activities and knowledge base haven't been researched because of an overemphasis being on research with recipients of the Health Promoters' work.

If Health Promoters do not share a purpose, nor a methodology, nor a regulatory method, then how can they share or conceive of the same ethical dilemmas and any solutions?

But who provides reasoned answers? It is being argued that Health Promoters do not usually consider ethical issues in their work, and when they do, they leave the job or report poor job satisfaction.

CHAPTER 5: THE PRELIMINARY STUDIES

Summary

The objective of this research study was to explore the ethical issues surrounding Health Promotion. Although these issues were initially of interest to investigate with peer colleagues, a number of other groups were of as much interest too, namely those making decisions about Health Promotion as an NHS service, and the public, to whom the work was aimed at.

Firstly, 8 people were **interviewed** whose work had an impact on Health Promotion as a service, to find out their ethical dilemmas about Health Promotion in general. A small **focus group** was facilitated, which consisted of members of an NHS District Health Promotion Service team, who discussed their ethical dilemmas about their work. A **questionnaire** was distributed in a G.P.'s surgery, to find out what a small sample of the public thought about Health Education and Promotion. A **questionnaire** for Health Promotion department staff was designed and distributed to the 13 NHS Health Promotion departments in the South West Thames region. 5 Health Promotion Specialists (colleagues) who responded to a request to follow up their questionnaires were subsequently **interviewed** to expand on the issues they had raised. Thus a variety of research methods were used to consolidate the decision to distribute a UK national questionnaire. Thus, both qualitative and quantitative methods were used to provide a number of facets to the enquiry. The preliminary study findings contributed to the formulation of the plan for the main phase of the PhD research.

This can be summarised further:
preliminary studies:

- preliminary interviews with 8 decision makers
- Health Promotion Service team focus group
- patient questionnaire
- 15questionnaires to 13 S. West Thames NHS Health Promotion departments
- final interviews with 5 colleagues

final stage:

- **main phase of PhD research**
  15 questionnaires to every UK NHS Health Promotion department

- **Preliminary interviews**

aim

The purpose of the interviews was to find out what issues, and in particular what ethical issues people in related work disciplines felt were important to Health Promotion. The interviews were conducted for two main purposes: to assist in the design of the self-administered questionnaire, and to provide qualitative material on interviewees views.

design and methodology

The 8 interviews were informal (issues raised in conversational style) and non-directive (minimal control/ direction by interviewer). An interview is *"...a two person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information, and focused by him on content specified by research objectives of systematic description, prediction, or explanation."* (Cannell and Kahn, 1968.) Using qualitative methods in the initial phase of research are useful especially in areas where little past research can guide the enquiry. There are many advantages with using interviews as a research tool, including: direct information transfer, extensive personalisation of information, interview adaptability and the possibility of tape-recording (Tuckman, 1971; Kitwood, 1977; Bell, 1987; Cohen and Manion, 1991). However, there are disadvantages, including: interviewer bias, interviewee nerves, ambiguity, magnitude of information, coding errors, selection of interviewees, stereotyping of interviewees, time consuming, limited availability of interviewees (Rice, 1931; Cicourel, 1964; Bell, 1987; Cohen and Manion, 1991).

The interviewees consisted of the following, and were from different Health Authorities: Chief Executive, Director of Public Health, District Information Officer, Deputy Head of Information Service of a national charity, General Practitioner/ GP trainer, Chair Health Authority Ethics Committee, Consultant in Public Health (Health Promotion), Chair Community Relations Council. Each interview lasted between forty minutes and one hour. The interviews followed the same format and were conducted in the interviewee's offices. There were 8 questions on the schedule (see Appendix), including biographical questions opinions about Health Promotion as a service, and their ethical dilemmas about Health Promotion. Interesting points the interviewee raised were expanded upon. The interviews were not tape-recorded because it might make the interviewees nervous, as (confidential) opinions on Health Promotion as a service were being sought, and they were decision makers who may have felt 'territorial' about their answers. Each participant was assured before, during and after the interview that their comments would be anonymous and confidential. The

participants were asked if notes could be taken, so the following are brief summaries of what was said.

Findings *(brief summaries)*

Interviewee 1

The Chief Executive of the Health Authority has been with the NHS for about 20 years. He has a keen interest in Health Promotion, and favours a dictatorial approach to some issues, especially smoking. He would like to see smoking banned, if this were possible. He admits that some health issues do not lend themselves to legislation. He feels that the issues facing Health Promotion at present are rationing, and budgeting for programmes, due to cut backs. He feels that Health Promotion's future lies in finding credibility, acquiring an 'expert' role, and ensuring accuracy.
His ethical dilemmas about Health Promotion included: debate about autonomy of, for example, smokers, and the autonomy of the rest of the public; allocation of budgets; truth of imparted information; credibility of 'experts'.

Interviewee 2

The Director of Public Health has been in the Health Service since 1974. He suggests that Health Promotion is a Public Health 'tool'. He feels that Health Promotion has an active role, should not be about imparting information, but about empowerment. He is committed to Lifestyles Surveys, for the professionals to have accurate information available to them.
His ethical dilemmas about Health Promotion included: medical versus social model of imparting information; accuracy of information; and evaluation of Health Promotion interventions.

Interviewee 3

The District Information Officer has been in the NHS for 8 years, and has had no contact with the Health Promotion Unit. He has previously worked as Systems Manager and Patient Services Officer. His degree is in Politics and Economics. He deals in many aspects of patient information data. During the interview he stated that it would be beneficial for Health Promotion and the Information Department to liaise. He therefore felt that he had no ethical dilemmas about Health Promotion because he hadn't thought it through enough.

Interviewee 4

The Deputy Head of Information of a national smoking education charity had been in her current job for 8 years. The organisation is 60% funded by a grant from the Department of Health, and 40% from donations/ sales, and there were 12 staff. They produced fortnightly bulletins about smoking 'news' and the information was taken from newspaper articles. It was assumed that if a news feature is in enough 'credible' newspapers it must be true. Medical experts on the Management Committee check the accuracy of medical statements. The public is discouraged from visiting the premises because of the limited space.
She had no ethical dilemmas about Health Promotion, because she felt her work was in health education, that is, imparting information to the public, who then have the autonomy whether to take that information on board.

Interviewee 5

This General Practitioner had been practising since 1976. He had previously been in pathology, and orthopaedic surgery. He had been involved in many innovative projects, including early computerisation of medical notes and details, and buying a surgery car for needy people to be transported to the surgery if they have no transport. He is a great believer in following ideas through. He has Health Promotion literature in prominent places throughout his surgery and waiting room. He feels that the way forward for Health Promotion is for the aligned professions to share information, network, and build Healthy Alliances: he feels there is too much secrecy and withholding of information in the Health Service. He suggests that the patients should be given every piece of information available, and then they can sift through this and make their own decisions: he believes in autonomy, and free choice.
He had no ethical dilemmas about Health Promotion as he felt that it was his duty to educate the public; he was, however, concerned about social inequalities and their impact on health.

Interviewee 6

The Chair of the Health Authority Ethics Committee had been in this position for only a few months. The Ethics Committee meetings were held quarterly, and they were considering charging for applications. The Ethics Committee was extremely hard to locate, they do not advertise their function, and seemed to be something of a 'closed shop'. It was assumed that 'suitable' applicants would know how to find them. Researchers who have an application accepted, are requested to send details of their findings, but this was not followed up. A list of research topics was included in their Annual Report. The Chair had no contact with Health Promotion before our meeting.

He therefore felt that he had no ethical dilemmas about Health Promotion because he hadn't thought it through enough.

Interviewee 7

This interviewee was a Consultant in Public Health (Health Promotion), and had been in that position for under a year. She had special responsibility for the Health of The Nation, and saw Health Promotion's way forward is in addressing the issues it raises. She was a firm believer in evaluating Health Promotion, and felt that Health Promotion would survive only if it can prove that it is effective.
Her ethical dilemmas about Health Promotion included: proving Health Promotion was effective from evaluation reports.

Interviewee 8

The Chair of the Community Relations Council had been in his position for 3 years. His service had an Advocacy role, and dealt with complaints from the public about the Health Service. The Regional Health Authority statutorily fund the service. There were 2 paid staff, and 24 voluntary members. He felt the need for Health Promotion to provide clear and consistent information, although he questioned whether health information was always clear cut. He felt that Health Promotion's role is 'empowerment'. He felt that the Government's role outweighed any work Health Promotion could do, although he questioned the ethics of this.
His ethical dilemmas about Health Promotion included: truth and accuracy of information; the role of the Government; autonomy and empowerment.

Discussion

Some of the key issues those interviewed raised were: finding **credibility**, acquiring an **'expert'** role, ensuring **accuracy**; **autonomy** of individuals versus public; allocation of budgets (interviewee 1); Health Promotion is a Public Health **'tool'**, **medical** versus **social** model; **empowerment**, Lifestyles Surveys, **accurate information**; **evaluation** (interviewee 2); more **liaison** (interviewee 3); **credibility**, **accuracy** of information (interviewee 4); **sharing** information, **networking**, Healthy Alliances, **autonomy**, **free choice** (interviewee 5); **educated** people will seek out information, **no ethical dilemmas** (interviewee 6); **evaluation** and **effectiveness** (interviewee 7); **truth and accuracy** of information; **empowerment**; the role of the **Government**; **autonomy** (interviewee 8).

It became apparent that people outside the Health Promotion Unit had very little idea about Health Promotion as a practical service, and some ideas about Health Promotion

as a philosophy. As the people who were interviewed were directly affecting Health Promotion, it was interesting but rather disconcerting to see the wide range of opinions on the role and future of the service. It was disappointing to discover that few knew anything about Health Promotion at all, even where their local HPU was based. Some had concepts of Health Promotion philosophy, but not the Health Promotion Unit *per se*. A small number did have definite opinions on the Health Promotion Unit, and the philosophy of Health Promotion. However, these opinions were divided between those who felt Health Promotion should follow the medical line of The Health Of The Nation, and those who felt that Health Promotion was about sharing, and building networks. Those who had a medical or purely educational orientation towards Health Promotion did not have ethical dilemmas about its work or role.

There were a number of design faults, including: notes were taken so the information elicited was somewhat fragmented, interviewer 'nerves', omissions in notes, reliance upon memory. However, the length of the interviews and the vociferousness of the interviewees made for rich data.

Summary of the key points made by the decision makers about ethical dilemmas:

professional issues
credibility
expertise
autonomy
'approach'
medical versus social model
empowerment
liaison
sharing information
networking
Healthy Alliances
truth and accuracy of information
accurate information
Lifestyles Surveys
evaluation
none

It would be interesting to see how the answers given about ethical dilemmas given by people who were decision makers compared to people who worked within Health Promotion and knew the nature of the research focus.

It would be useful to discuss these issues with people who actually did work in a Health Promotion Unit, so a focus group was the next stage.

- Focus group

aim

to discuss ethical dilemmas in some depth with a team of Health Promotion Specialists

design and methodology

A focus group was facilitated which consisted of staff from the District Health Promotion Service department that the author worked in, who discussed ethical dilemmas in Health Education/ Promotion. A 'focus group' is another name for a group interview or a group discussion, where the focus is on a particular topic of interest. The group facilitator keeps the session on track, while allowing people to talk freely and spontaneously. A range of opinions should evolve, and the researcher is then provided with qualitative data which can provide a basis upon which to develop a questionnaire for a quantitative survey. Focus groups are suggested to be effective in providing information about why people think or feel the way they do (Krueger, 1988; Hawe et al, 1992). The focus group research tool has emerged because of disadvantages which arise with face to face interviews and questionnaires, because it allows for more participant interaction, flexibility, allows for discussion and a sharing of ideas. There are no rights or wrongs for participants to feel nervous about because the emphasis is on discussion. However, focus groups rely on people being forthcoming with ideas and opinions. Krueger (1988) suggests that focus groups work best when the participants are more similar than dissimilar. Differing status or educational level may inhibit participants. Prior relationships need to be taken into account, because they can also inhibit response. Ideal participant numbers fall between 4 and 12 (Krueger, 1988; Hawe, 1992).

Each member of a Health Promotion Unit were approached to see if they would be willing to participate in a Focus Group. The format of such a meeting were explained and all the staff agreed to participate. A small committee room in the same building was booked and sent a short letter to the participants detailing the date, time and venue for the Focus Group. It was arranged that the Focus Group would limit itself to 2 hours duration. Notes were taken, rather than a tape recording, as some participants had expressed grave concerns about that, and, practically, a tape recorder might not pick up 8 voices. Each participant was assured before, during and after the interview that their comments would be anonymous and confidential, and kept within the confines of the group.

On the day of the focus group, one person dropped out because she was too busy, one because he felt nervous, one because she had taken the day off, and one because there was a new secretary starting and she had to show her how to use the computers that morning. Four people were still available to participate so it was decided to go ahead with the focus group, because the four people would still have a valid contribution to make. In addition, the venue was changed because the original venue was the office of one of the participants who had dropped out! There was a small committee room available nearby, so this alteration did not prove too difficult to rearrange. In hindsight, organising a focus group in one of the participant's office was not ideal because that person may alter their plans.

The four participants consisted of three females and one male, of whom two were Health Promotion Advisors and two were dietitians, one person was the manager, the age range was 26 to 37, the length of service was between a few months and 2 yrs., and NHS experience was between a few months to over 10 years.

Findings ***(brief summary)***
(see Appendices for transcript)

At the beginning of the Focus Group, it was reiterated to the participants that the group were going to look at the concept of ethical issues in Health Education/ Promotion. One of the participants stated that she had looked 'ethics' up in the dictionary that morning and gave us her dictionary definition. It was stated that only one and a quarter hours were available to use for the focus group, due to the venue change. The participants were asked to brainstorm the concept of 'Ethics In Health Promotion' to set the scene. There seemed to be hesitation at the beginning, but the group eventually put forward a number of issues, which were:

free will
health promoters as role models
health education versus promotion
teaching vs. education
prevention
environment
hygiene
unrealistic targets
clients versus patients
targeting groups
social and economic factors
interventions
body image
materials
money
choice
group dynamics
what is health
research
'models'
hierarchy of needs
styles of work
correctness
'duff' information

resources
ethnic minority groups
scientific basis of information
management of health promotion staff
should we do health promotion at all?
HIV/AIDS
work environment
dictatorship
topics

The participants were then asked to suggest the three ethical issues that were important to them as a Health Promoter and then the group could discuss three that emerged. The group decided that the three issues to be discussed would be: **definitions of health, education and promotion; targeting; and social and economic factors.**

The group was facilitated by the author, who offered little direction, only refocusing the group to the point in issue on occasions. The group suggested a time constraint of 15 minutes per topic. The participants all seemed hesitant at first, and clarified with each other what was required in a focus group setting. Each discussion had to be cut short due to time constraints, but the first topic took over 20 minutes. There was a variety of definitions of Health, Education, and Promotion given, and explanations to support a stand taken. One person felt that health was to do with not being ill, another felt it was to do with enjoying yourself, one felt that health was on a continuum, one felt that health was about achieving your potential. The discussion went off at a tangent and had to be refocused. They then went on to define education. This immediately went into a definition of what Health Promotion was. One participant tried to reiterate her definition of education, and another participant gave her distinction of the difference between Health Education and Health Promotion. The role of the Government and Health Promoters as role models was discussed. This seemed to then remind the group that the next topic was targeting.

The discussion about targeting started off looking at the ethics of targeting groups labelled as 'high risk'. The participants suggested that targeting was possible due to statistical evidence, from research, needs assessment and a gut feeling. It was suggested by one participant that maybe targeting was 'scapegoating', but the others dismissed this and carried on discussing ethnic minorities and young people. When it was suggested to one participant that she be the focus of targeting, she seemed to feel intimidated and seemed to change her opinion on the validity of targeting. The group then turned to focussing on whether targeting was social control, pyramid selling, or trying to maximise change. When the group was asked to finish that topic, all four participants tried to summarise their view. Each seemed to want to finish on a standpoint.

The group gave differing ideas about what the social and economic factors involved in health were. One participant suggested that it was to do with money, another that it was

to do with pollution and people should all cycle to work, another felt it was to do with reducing CHD incidence, another felt it was to do with saving the Government money. It was felt that the accuracy of statistics was doubtful. The group also discussed unemployment, a recent local Health Promotion campaign and the role of advertising.

Discussion

The participants were reluctant first to be forthcoming, but eventually the 'brainstorm' session gave rise to 33 different ethical issues. Three were identified as being the most important, and these were discussed by the group. The 3 key issues those in the focus group raised were **definitions of health, education and promotion; targeting; and social and economic factors.** It is questionable whether these were ethical dilemmas at all, although they obviously impinge on ethics. Defining health, and health education/ promotion is important but not an ethical dilemma *per se*. It becomes an ethical dilemma if one cannot carry out one's work, because one does not know what one is doing, or if it is difficult to describe one's work. This would have implications for credibility issues. Targeting is an issue when the debate about identifying certain groups as being 'high risk' or being 'susceptible' to factors is included. There are also ethical issues about causal links between certain factors and ill-health, (eg. targeting Afro-Caribbeans with CHD messages), and about labelling certain groups as therefore being 'deviant' from the norm (eg. targeting single parents with anti-smoking materials). When the group looked at social and economic factors they pointed out certain factors rather than discussed the ethical issues, for example, money is not an ethical issue until it is linked, for example, with spending power, and access to information. It appeared that the group were mentioning issues that were 'interesting' rather than debating the ethical issues they had raised. This may have been revealing that the members were not used to discussing ethical dilemmas without it sounding as if they were issues that they had not thought through fully and come to some conclusion about.

When the discussion wandered off the topic in question, no one in the group was holding it together, so the group were reminded about the topic at hand, which added some 'artificiality' to the discussions. However, most of the time, people were making comments, rather than discussing the issues. There was reminiscing, and describing examples. There was what could be termed 'game playing'. The discussion seemed to even get quite hostile on occasions. There was a great deal of hesitation on the behalf of three of the participants. One of the participants was the new manager, who the department had been finding it difficult to get along with. It seemed that the participants were keen to get their point of view across and there seemed to be little notice taken of others' opinions. Very little in-depth debate was had because each person seemed to want the others to listen to them, and accept their point.

There were a number of design faults, which included: notes being taken which may have produced researcher bias/ selectivity; negative group dynamics which did not become evident until the discussions started; 4 participants may be too few for an effective focus group discussion; the group discussion kept going off at a tangent; people were trying to keep to time limits, which may have made the discussion somewhat artificial. There were four participants, although it was originally intended to be eight. Interestingly, at the end of the focus group participants felt that it had been a very worthwhile exercise and suggested that a future meeting be arranged to discuss the issues further. It was agreed to distribute the notes from the discussions.

The focus group was not found by the researcher to be a useful investigation arena in this circumstance as the group dynamics were too overpowering. Anonymous questionnaires were concluded to be a better research tool for the sensitive nature of the topic at hand, namely ethical dilemmas.

Summary of the key points made by the Health Promotion Service team focus group about ethical dilemmas:

definitions of health, education and promotion
targeting
social and economic factors

It was felt to be useful to find out what the public thought about Health Promotion, so a patient questionnaire was the next stage.

- **Patient questionnaire**

aim

to find out what the public thought of Health Education/ Promotion, and who they felt was a credible source of advice and information to do such work

design and methodology

A local General Practitioner suggested that his surgery could be used to distribute a questionnaire to the public. questions were designed, and a flow chart written to give direction. 11 questions were subsequently included in the questionnaire. The questionnaires had no allocated space for name or address, so it was assumed that those filling the questionnaires in would realise that their comments would be

anonymous and confidential. The questionnaire was distributed to a number of colleagues, who made comments, and the questionnaire amended accordingly.

The questions were as follows:

1. About how long ago did you last visit the doctor?
This question was asked so that the respondent would feel that the questionnaire was somehow 'personal' to them, and would help with identifying people who visited the doctor quite often and may feel 'ill' compared to someone who rarely/ occasionally visited the doctor, and may consider themselves 'healthy' but with a current illness
2. Who do you think is best to talk to you about your health?
It would be interesting to see if people relied on the 'experts', the doctor/ nurse or informal networks such as friends or family, or even mention Health Promotion Advisors
3. What does the word 'health' mean to you?
This would give people the opportunity to explain their attitude towards the very general word 'health'
4. What is health education?
This question gave people to identify their definition of health education
5. What is health promotion?
This gave people the opportunity to state whether they felt that the 2 concepts were the same/ different/ similar
6. What do you think Health Education/ Promotion Advisors do?
It would be interesting to see the public's perception of a rather misunderstood profession
7. What do you feel are the major health issues of today?
It would be interesting to see whether they would focus on global issues, their personal reason for visiting the doctor, or the major media issues of AIDS
8. Which poster/ leaflet do you find interesting?
This question was to see whether people described posters in the surgery or perhaps a billboard or magazine one that they had noticed
9. Please state your age
This question was included to see the range of ages of respondents
10. Please state your sex.
This question was included to see the distribution of the sexes of respondents
11. Please state your occupation/ last job
This question was included to see the range of jobs of respondents

I made 100 photocopies of the questionnaire, and took them to the surgery. I used a typing paper box, which was covered in white paper, and I printed a notice: 'Questionnaires to be returned in here please.' I left some Health Promotion pens (with

the HP Service phone number on it), and newsletters on the 'Reading Table'. The receptionists were asked to give each patient a questionnaire, and ask them to put the completed questionnaire in the box on the way out. If they had the time they were asked to remind patients on the way out to put their questionnaire in the box. The questionnaire was distributed for two days.

Findings (brief summaries)

Patient information

A total of 37 questionnaires were returned to the designated box. The number of responses to individual questions ranged from 57% to 97%. The age range was 17 to 79. The respondents included 25 females and 11 males (one did not state their sex).

1. About how long ago did you last visit the doctor?

There was a wide range of answers, from 1 day to 3 years. The average (mean and mode) was 6 months.

2. Who do you think is best to talk to you about your health?

The majority of patients (33 people/ 92%) stated that the Doctor was the best person to talk to them about their health. The nurse was also suggested by 12 people (36%).

3. What does the word 'health' mean to you?

There were a variety of answers which broadly fell into 4 main categories. These were 'well-being' (9/ 26%), 'ideal state' (9/ 26%), 'being physically fit' (6/ 17%), 'feeling well' (5/ 14%).

4. What is health education?

95% of respondents answered this question. The main responses to this question were 'giving people information' (8/ 23%), 'teaching how to look after yourself' (7/ 20%), 'teaching about better lifestyles' (6/ 17%), 'understanding how to be healthy' (4/ 11%). Some specific health education topics were mentioned. The main one was diet/ food, mentioned by 5 patients.

5. What is health promotion?

The main answers were 'raising awareness' (7/ 27%), 'promoting health' (7/ 27%), same as health education (5/ 19%), leaflets/ poster/ adverts (4/ 15%).

6. What do you think Health Education/ Promotion Advisors do?

Respondents felt that Health Educators/ Promoters 'raise awareness of issues' (8/ 33%), 'inform the public' (5/ 21%), 'teach people about health' (4/ 17%), organise campaigns (3/ 13%).

7. What do you feel are the major health issues of today?

Many people answered this question. The main health problems were felt to be: Cancer (14/ 41%), HIV/ AIDS (13/ 38%), heart problems/ disease (10/ 29%), smoking (8/ 24%), bad diet/ overweight (6/ 18%), pollution (5/ 14%).

8. Which poster/ leaflet do you find interesting?

Few people (57%) responded to this question. 5 (24%) people stated that they were all useful, 3 (14%) stated 'diet', and some said 'none'.

9. Please state your age

The range of answers was 17 to 79. The mean age was 38, with the mode being 23(3 respondents), and the median 33. The largest age group was 21-30 (11/ 31%).

10. Please state your sex.

25 respondents were females (69%), and 11 were males (31%). (1 no answer).

11. Please state your occupation/ last job

There was a wide range of answers from all social classes. The most common response was admin./ clerical.

Discussion

The questionnaire provided interesting reading and a small insight into how a small sample of 37 members of the public viewed Health Promotion. The majority of the respondents had very clear and precise views on what health is, what Health Education/ Promotion are and what they felt the main health issues were. It was interesting that the focus group professionals' definitions (not being ill, enjoying

yourself, health being on a continuum, achieving one's potential) were broadly the same as the public's (well-being, ideal state, being physically fit, feeling well).

Few respondents felt that Health Education/ Promotion was to do with leaflets/ posters. Many respondents felt that Health Promotion was an active process- involved in 'selling' health, persuading and campaigning. Two thirds of the respondents felt they knew what Health Education/ Promotion Advisors do. These answers could be categorised in the Ewles and Simnett (1990) 'models' of Health Promotion. 'Raising awareness' and 'teach about health' fall into the 'educational' model, 'inform the public about health' falls into 'medical' model, 'campaign work' falls into 'social change'. The responses about what Health Promoters do all seemed positive, such as raise awareness of issues, inform the public, teach people about health, organise campaigns. There was no mention of interference, or propaganda, etc. The respondents identified 14 different health issues, but the main issues were: cancer, HIV/ AIDS, heart disease, smoking, poor diet and pollution, (which broadly cover the Health Of The Nation topics). Many respondents identified 2 main areas for concern, only a few suggested more than 2. Alcohol and drugs were mentioned by very few respondents.

Few had noticed the surgery posters or leaflets and only about half of the respondents identified 'useful' posters or leaflets in the surgery. Of those who identified any as being useful, a quarter stated that they all were. The main topic area which was identified as being the most useful was 'healthy eating' posters/ leaflets. It may be that people only notice leaflets or posters pertinent to them at the time, or maybe 'useful' was a leading adjective. The healthy eating posters displayed had recently been devised by a colleague at great expense with a professional photographer, and did 'stand out' among the photocopied and often typed notices/ posters in the surgery, which looked quite 'amateur' in comparison.

Many people had last visited the doctor within the last 6 months. There was a massive age range, from 17 to 79. The average (mean) age was 38, with the mode being 23 (3 respondents) and the most common age group was 21 to 30. This may reflect the ages of those who tend to visit the doctor, or the age of those who tend to or like filling in questionnaires. Two thirds of the questionnaires were returned by females, and a third by males. One respondent did not state their sex. The predominance of female respondents may reflect the sex of those who visit the doctor, or the sex of those who fill in questionnaires. There were great variations in occupation/ last job, although a large number were from admin./ clerical. The occupations showed a spread across all the social classes.

There were a number of design faults, which included: the questionnaire was only distributed for 2 days, which may not have been very representative; open questions

were difficult to categorise; it is not known how many questionnaires were not filled in, only how many were filled in. It was not known whether the questionnaires were filled in by people at particular times or whether special clinics/ clubs were running on those days. People had no incentive to fill in the questionnaire, and did not really know directly to whom the questionnaire would be going to.

It was felt that it would be useful to find out more about Health Promotion staff's ethical dilemmas, so a Health Promotion staff questionnaire was the next stage.

- **Self completion Health Promotion staff questionnaires**

aim

to investigate Health Promotion staff's ethical dilemmas

design and methodology

Questions which would elicit answers about moral and ethical concerns about Health Education/ Promotion were devised. The points were written as a flow chart, and rearranged in a suitable sequence. Factual questions were formulated about job, length of service, seniority and age, and some similar questions as those asked of the public in the patient questionnaire for comparison.

The postal questionnaire is "...the best form of survey in carrying out an educational enquiry." (Cohen and Manion, 1991:109.) Bell, 1987:58 stated that *"You will only reach the stage of designing a questionnaire after you have done all the preliminary work on planning, consulting and deciding exactly what you need to find out."* When designing the questionnaire, presentation and lay out were considered, instructions were included for filling it in, details of where the questionnaire had to be returned to and a covering letter explaining why the questionnaire has been devised were included. There are advantages to using the questionnaire as a research tool. It can be representative because the questionnaire can be sent to a large number of people, sources of error are limited, there is fair reliability, it is inexpensive and should not be too time consuming (Oppenheim, 1966; Bell, 1987; Cohen and Manion, 1991.) However, there are disadvantages, such as investigator pre judgement of variables, few opportunities for respondent personalisation, generally poor rates of return, few opportunities for probing or explanation of answers and lack of opportunity for distinguishing cause and effect relationships (Oppenheim, 1966; Bell, 1987; Cohen and Manion, 1991, Daly et al, 1992). Response rates are generally between 40% and 75% (Hoinville and Jowell, 1978).

The questionnaire was given to a number of colleagues to read. They needed clarification on a number of points. The questionnaire was altered and colleagues were subsequently asked to read the amended version. Some minor alterations were still needed, which were changed, and the final questionnaire was produced (see overleaf). 16 questions were formulated, 2 of which were subdivided (Q's 9 and 14), making 18 questions in total. The first questions asked about factual details about job title, length of service, age and hours worked per week, membership of SHEPS, for demographic purposes; and then opinions about their way of working, good and bad points about their job, their ethical dilemmas and what they thought was the future of Health Promotion as a service. Each participant was assured on the questionnaire that their comments would be anonymous and confidential.

A list with the addresses and phone numbers of the 13 Health Promotion Units in South West Thames was obtained. Each of the 13 HPUs was telephoned, and an explanation of the research interest and job of the author was given. It was asked how many staff there were in total, not just Health Promotion Advisors, in the department, so that responses from all members of staff in the HPU's could be obtained. The number of staff was noted, and it was asked who the questionnaires should be sent to. The appropriate number of questionnaires was put in one envelope for each HPU along with one covering letter, and the questionnaires were photocopied in a different colour for each HPU, and a note made of the colour coding. Each questionnaire was individually marked by a reference number (1-13) according to which of the 13 Health Promotion Units it was sent to. The total number of questionnaires sent out was 140. The questionnaire was pre-coded, self completion, and postal. Near to the reply-by date, each HPU was subsequently telephoned, to ask the office manager to remind any non-respondents to reply if they wanted to.

Questions were asked about the following points:

1. job title
to analyse number of respondents in each job, and to look at correlations between job and other answers
2. length of time in this job
to analyse length of time in post, and to look at correlations between length of service and other answers
3. length of time working in current Health Promotion Unit
to analyse length of time in NHS, and to look at correlations between length of service and other answers
4. work in any other Health Promotion Unit(s)
to analyse whether people moved from one Health Promotion Unit to another and to look at correlations between having worked in more than one HPU and other answers

5. age
to analyse age distribution, and to look at correlations between age/ age groups and other answers
6. main area of work
to analyse different topics of work and responsibilities, and to look at correlations between type of work and other answers
7. contracted hours
to analyse work patterns, and to look at correlations between part/ full time staff and other answers
8. average hours
to analyse extra hours worked per week, and to look at correlations between part/ full time staff and other answers
9. member of the Society Of Health Education and Promotion Specialists (SHEPS)
to analyse numbers who are a member of the professional body, and to look at correlations between SHEPS membership/ not and other answers
if yes, how long
to analyse length of membership/ loyalty to the professional body, and to look at correlations between SHEPS membership/ not and other answers
if no, why not
to analyse why people don't join the professional body, and to look at correlations between SHEPS membership and other answers
10. Health Promotion qualifications
to analyse which specifically Health Promotion academic qualifications have been undertaken and to what level, and to look at correlations between Health Promotion qualifications and other answers
11. other academic or professional qualifications
to analyse which other academic/ professional/ practical qualifications have been undertaken and to what level, and to look at correlations between Health Promotion qualifications and other answers
12. previous jobs
to analyse which previous work employees were in and to look at correlations between work background and other answers
13. 'model' of working
to analyse which preferred way of working employees had, and to look at correlations between ways of working and other answers
14. good and bad points about present job
to analyse which good and bad points respondents identified, and to look at correlations between advantages and disadvantages of working in Health Promotion and other answers
15. ethical dilemmas

to analyse what were the main ethical dilemmas and to look at correlations between ethical dilemmas and other answers

16. the future for Health Promotion

to analyse what respondents felt was the future of Health Promotion and to look at correlations between ethical dilemmas and other answers

Findings *(brief summaries)*

(see appendices for fuller raw data, charts and graphs)

The response rate was **46%**; 65 people responded out of 140. In addition, 7 questionnaires were returned after the closing date, but these are not included in the data, because the analyses had already begun. This would have been a response rate of **51%**. The results were collated, summarised and tabulated. A number of colleagues were asked to classify open-ended question comments into the summary categories, and the coding was similar enough to continue with the same categorisation. There was high inter-rater reliability.

district

Each HPU had been telephoned and asked for the total number of staff, so the totals for each HPU are different. The responses from each district were as follows: Merton and Sutton (9/10; 90%), Croydon (9/11; 82%), Wandsworth (2/15; 13%), Richmond Twickenham and Roehampton (3/8; 38%), Kingston and Esher (2/5; 40%), East Surrey (6/11; 55%), Mid Surrey (10/15; 67%), Worthing (8/12; 67%), N.W. Surrey (3/20; 15%), Chichester (1/8; 13%), W. Surrey and N. E. Hants (4/8; 50%), Mid Downs (6/10; 60%), S.W. Surrey (2/7; 29%). The replies were not evenly distributed amongst districts, but were across levels. One Health Promotion Unit returned only 2 out of 15 (13%), and yet another returned 9 out of 10 (90%).

job title

The responses were from: Manager 4 (6%); Deputy Manager 3 (5%); Senior HPA 16 (25%); HPA 9 (14%); Trainee HPA 1 (2%); Office Manager 2 (3%); Secretary 5 (8%); Resources Manager 4 (6%); Resources Assistant 4 (6%); Dietitian 6 (9%); Counsellor 3 (5%); Acting manager 2 (3%); Graphics Officer 2 (3%); Public Health Specialist 2 (3%); District HIV co-ord. 1 (2%); Mental Health Facilitator 1 (2%). In summary, 54% of responses came from Health Promotion staff, 26% from Support staff and 20% from Associated staff.

length of service

9 (14%) respondents had 0 to 1 year's experience in the NHS. 21 (32%) respondents had over 10 years service in the NHS. 3 categories had similar lengths of service: 1 to 2 years, 3 to 4 years, and 5 to 6 years (12% to 18%). Few staff had 7 to 8, and 9 to 10 years of service (both 5%). 17 (26%) respondents had only been in their current HPU for less than one year. There was quite an even spread across 3 categories, 1 to 2 years, 3 to 4 years, and 5 to 6 years (18% to 25%). Few staff had been in the current HPU for 7 to 8 years (5%) and none for 9 to 10 years. 4 (6%) respondents had been in their current HPU for over 10 years. If people stated that they had been in the NHS and their current HPU for the same amount of time, one can assume that this is their first Health Promotion job. 8 (12%) people stated that they had been in the NHS and their current HPU for 5 to 6 years, 8 (12%) people for 3 to 4 years, 5 (8%) people for 1 to 2 years, and 12 (18%) people for 0 to 1 year. Thus a total of 33 (51%) people were in their first HPU. In addition, 4 (6%) people stated that they had been in the NHS for over 10 years, and in their current HPU for over 10 years, but it cannot be assumed that they have been in the same HPU. Thus between 51% and 57% of staff were working in their first HPU.

hours per week

The majority of respondents- 46 people (71%) worked full time. Only 16 (25%) worked part time, and 3 (5%) worked for 2/3 of a week.

age

Peoples' ages varied considerably, but with quite an even spread across the 9 age groups. There were 15 people (23%) in the 34-39 age group, and 14 (22%) in the 40-45 age group. 9 (14%)people were ages 22 to 27, and 46 to 51, and 10 (15%) in the 28 to 33 age group. There were less people (3/ 5%) in the 52-57 age group and 4 (6%) in the 58-63 age group. However, there were no people in the youngest age group and only 1 in the oldest age group. Thus 45% of the staff are between 34 and 45.

age and job

The age bands were evenly distributed. However, 45% of staff are between 34 and 45 years. The age range of Health Promotion managers was 40 to 63, Resources managers was 46 to 63, and Office managers was 40 to 51. The deputy and acting managers were slightly younger, age range 34 to 51. The age range of HPAs was 22 to 51, with the most common age group being 22 to 27. The age range of SHPAs was 22 to 57, with the most common age range being 28 to 39. Seniority reflected age.

main area of work

29 people (45%) stated that they worked on a topic basis, 11 (17%) on a locality basis, and 9 (14%) in management, and only 1 (2%) in research. Respondents added other areas- settings, sec/ admin. counselling. these accounted for 22 responses. Some people ticked 2 or more areas, so figures add up to over 100%.

current work

The major areas of work were smoking (26/ 40%), diet (22/ 34%), alcohol (21/ 32%), HIV/AIDS (21/ 32%), exercise (20/ 31%), CHD (19/ 29%). However, subsequent analysis including only SHPA, HPA, and THPA (26 in total) revealed that staff were involved in the following: smoking-18 (69%), alcohol-15 (58%), exercise- 14 (54%), HIV/AIDS -13 (50%), sexual health -12 (46%), CHD- 11 (42%), Diet- 11 (42%). Thus there was quite a spread among health topics, it wasn't only people working within one or two particular topics that responded.

membership of SHEPS

The majority of respondents did not belong to the SHEPS; however, when only HP staff (35) were analysed, it was revealed that 19 (54%) were members, and 15 (43%) were not, and 1 (2%) used to be. Three quarters of staff (46/ 71%) did not belong to the Society of Health Education and Promotion Specialists (SHEPS). However, when this was analysed further it was revealed that 19 of the 35 Health Promotion staff (54%) were members of SHEPS.

qualifications

The majority of respondents did not have a Health Promotion qualification. However, when only HP staff (35) were analysed it was revealed that 34% had the Diploma, 20% had the Certificate and 17% the MSc. 9% were currently studying, and 6 (%) planned to. Thus 60% have a HP qualification, and 26% were in the process of getting a qualification, totalling 86%. 14% did not have a HP qualification. Some respondents mentioned that they had qualifications other than HP ones. It may be that those who were currently studying were too busy to return the questionnaire, as only 9% indicated that they were currently studying. Thus only 2/3 of staff are qualified, although some respondents indicated that they have a certificate, diploma, or MSc in a related discipline.

previous work

The responses to previous work history included admin/clerical 25%, teaching 22%, nursing 22%, management 12%, and counselling 12%. Nobody stated that this was their first job. Thus all of the respondents had chosen or been in other careers before Health Promotion.

'model' of (approach to) working

There were 6 categories suggested, and the opportunity to define one's own. Three of the categories suggested were stated to be the preferred style. These were behaviour change 48%, client directed 46%, and educational 42%. The other categories were social change 20%, harm minimisation 11%, medical 6%. 6% ticked 'not applicable'. Most respondents indicated that they covered 2 or more models, and a number indicated that they would alternate between all the models of working. This reveals that there was no predominant style of working, indeed, people adapted as they went along.

good and bad points about job

The highest individual score for **'good' points** was **variety (38%),** colleagues (32%), freedom (26%), flexibility (18%), self-direction (15%), interesting (15%), clients (15%). The highest score for **bad points** was **NHS reforms/ politics (17/ 26%),** insufficient funding (25%), workload (22%), unsure of direction (15%), insufficient resources (14%). Some people used different terms for similar issues, so the good and bad points were categorised. It was revealed that the good points were variety and flexibility issues (80%), autonomy issues (60%), colleagues generally (58%), and clients generally (54%). The bad points were insufficient money/ resources/ staff (54%), self doubts (52%), and workload (42%).

ethical dilemmas

41 people (63%) responded to this question, including **28%** who stated that they had **no ethical dilemmas**, and **9%** who **did not know.**
These are some representative verbatim examples of the dilemmas described:
"The idea of knowing what's best but not wishing to 'interfere' with personal freedoms."
"Smoking might be some people's only crutch in their life."
"Dilemma of how message is put across rather than context of messages."
"A lot of what we are asked to do is to satisfy government agendas, not real health needs."
"There's too much talk and too little implementation."

"I question the attitude of the Government with regards to smoking, housing."
"It is predominantly a 'middle class device' reaching and being accepted by those in least need- inverse care law."
"The inequalities of access to health and the ability for people to make desired changes due to their circumstances."
"I worry that the money available to HIV/AIDS is disproportionate to that available for other health topics."
"Because I have to prioritise due to lack of resources, I know there are areas of need not being met."
"Inequalities in health are increasing due to uncertain funding."
"Charging for some services excludes those less well off."
"I would like to see more information given to the general public."
"The role of health promotion seems to be unclearly defined and perceived both from within the Health world and from outside."
"There is a lack of standards re HPA skills and training etc."
"I am concerned that much of health education/ promotion is about behaviour change ... should the profession still see this as its role."
"Health education and promotion are going round in circles."
"There seems to be little involvement in mental health issues."
"There seems to be a good deal of overlapping of work which leads to endless meetings where people defend their own domain."
"We hold the knowledge and therefore the power and we choose which information to share."
"How do we decide which groups have most needs? Should we be thinking along these lines at all?"

There was a wide range of ethical dilemmas listed, which were categorised into summaries. The main areas were: **inequalities in health 34%,** the **way** we work (28%), the **truth and accuracy** of information imparted (15%), and the **professional status and credibility** of Health Promotion (15%).

Future of Health Promotion

The main areas identified were: Health of the Nation (9%); all health workers (9%); should be a national direction (6%); agency work (6%); marketing role (5%); forward (5%); community development (5%); outreach work (3%). There was a large diversity of response to the notion of where Health Promotion is going. Many people felt that it would become something less for specialists and more for an approach adopted by all health professionals. Others felt that Health Promotion Specialists needed to get their act together, take a firm stand, join forces in SHEPS, and become

more professional. Many felt that the focus on Health of The Nation would quickly mould Health Promotion into a medical model approach.

Discussion

The questionnaires were sent to 140 people in the 13 Health Promotion Units in South West Thames. 65 (46%) people replied by the closing date. The replies were not evenly distributed amongst districts, but were across levels. Each Health Promotion Unit was telephoned to see if they had received the questionnaires, and they all had, so there is no apparent explanation why one Health Promotion Unit returned 2 questionnaires out of 20, and yet another returned 9 out of 11. It was assumed that people who knew the author would be more likely to return questionnaires, but that did not appear to be the case.

One can assume that there was one manager, one deputy, at least one HPA/ SHPA, a resources person, and a secretary in each district. One district had 5 staff in total and another had 20: the average was 11 (10.77), which supports earlier regional aforementioned surveys (eg. Atkinson, 1993; Dark, 1993; Kumar, 1993). The respondents consisted of 6 managers/ acting managers (46% of 13), 3 deputies (23%), 5 secretaries (38%) and 8 resources staff (62%). There was an average response of about half across staff levels.

The lengths of NHS service at first seemed to be quite evenly distributed. However, closer analysis reveals that most staff have either been in the NHS for a long time or a very short time. This must have implications for style of working, attitudes, age distribution and consistency of service. With regards to length of service within the current HPU, relatively few had been in the same Unit for over 6 years. In addition, a quarter of staff had been in their current job for less than a year. It was very interesting to compare length of service in the NHS compared to current HPU. This revealed that half had remained in their first HPU. In addition 4 people (6%) had worked in their current HPU for over 10 years, but it is not necessarily their first. This was not initially evident when comparing NHS service with current HPU. Thus many staff had remained loyal to their first Health Promotion job.

The age bands were evenly distributed. However, 45% of staff were between 34 and 45 years. The age range of Health Promotion managers was 40 to 63, Resources managers was 46 to 63, and Office managers was 40 to 51. The deputy and acting managers were slightly younger, age range 34 to 51. The age range of HPAs was 22 to 51, with the most common age group being 22 to 27. The age range of SHPAs was 22 to 57, with the most common age range being 28 to 39. This supports other studies' findings (Atkinson, 1993; Dark, 1993; Kumar, 1993), that seniority reflects age. Three

quarters of staff (46/ 71%) did not belong to the Society of Health Education and Promotion Specialists (SHEPS). However, when this was analysed further it was revealed that 19 of the 35 Health Promotion staff (54%) were members of SHEPS. Thus just over half of the respondents were members of their job's professional body. The region had a SHEPS local group which met at least quarterly, and which rotated its meeting place at the different member districts. It had a strong membership, but people were beginning to complain that they weren't allowed time to attend meetings since they had been taken over by their Public Health Department. Many support and associated staff were not members because they did not think they were allowed to join. This has implications for knowledge about, and adherence to the SHEPS Code of Conduct. The regional SHEPS meetings had historically been the place to catch up on local news of new initiatives. They had not traditionally been the place to have debates or discuss ethical dilemmas because the time for the meeting was short.

21 people (60% of HP staff) had a Health Education/ Promotion qualification. It may be that those who are currently studying were too busy to return the questionnaire, as only 3 (9%) indicated that they were currently studying. Thus only about 2/3 of HP Specialists were qualified, although some respondents voluntarily indicated that they had a certificate, diploma, or MSc in a related discipline. It was as if they felt that a nursing qualification or a having a teaching qualification amounted to the same thing as having a Health Promotion qualification. The ethical dilemma here is how much opportunity staff had to look at the relationship between theory and practice, and to discuss the philosophical base of Health Promotion. Respondents' main work histories were clerical, nursing, and teaching. No-one stated that their current job was their first one. Thus all of the respondents had chosen or been in other careers before Health Promotion. The ethical issues here revolve around people's loyalty or dedication to Health Promotion. Is it a stop-gap job, rather than a job someone saw as more of a 'vocation'.

Three different approaches were stated to be the preferred style of working. These were 'client directed', 'behaviour change' and 'educational'. Most respondents indicated that they tried to incorporate at least 2 ways of working, and a number indicated that they would alternate between all the ways of working. This reveals that there is no predominant style of working, indeed, people adapt as they go along. Thus in some instances, the Health Promoter would be a facilitator for a group, in others they would take the lead, and in others they would adopt a paternalistic stance.

There was a great diversity of good and bad points in people's work. In the main, however, people liked the freedom, flexibility, and the people - both colleagues and clients. Thus they liked the autonomy of their work, and the people contact. They disliked the NHS reforms and politics, the bureacracy and paperwork, felt their

workload was too great, and that their service's funding, their pay and their conditions were insufficient. People also expressed great self doubts about their direction, felt undervalued, and were worried about justifying their work. I did not suggest good or bad points in this question, it was left open. This resulted in an overwhelming variety in answers.

41 people stated that they did have ethical dilemmas about Health Promotion. 18 had no ethical dilemmas, and 6 did not know. The 2 main concerns were inequalities in health and access to health information, and the way Health Promoters work, both mentioned by a third of respondents. Thus the main emphasis of the respondents' ethical dilemmas was the client group or the public, and also the way Health Promoters work. The emphasis from Health Education to Health Promotion was a major recent issue at the time, alongside the emerging interest in social inequalities and their impact on health issues generally. Yet the absorption of many Health Promotion Units into Public Health departments meant that Health Promoters were having to change their work to fit in with Health of The Nation topics, and to produce cost effectiveness reports for the Director of Public Health . The 3 main issues identified by the focus group, namely: definitions of health/ education/ promotion, targeting, and social/ economic factors, were thus broadly similar to the issues raised by the questionnaire respondents.

There was a large diversity of response to the notion of where Health Promotion was going. Many people felt that it would become something less for specialists and more for an approach adopted by all health professionals. Others felt that Health Promotion Specialists needed to get their act together, take a firm stand, join forces in SHEPS, and become more professional. Many felt that the focus on Health of The Nation would quickly mould Health Promotion into a medical model approach. There did not't seem to be any consensus, which perhaps reflected how Health Promotion was becoming fragmented and splintered.

The questionnaire answers were really interesting to analyse, and strengthened the decision to conduct a national survey into the ethical dilemmas of Health Promotion staff. The responses were grouped and conclusions drawn, and correlations inferred. (Subsequently the computer statistics package, SPSS, was used to code and categorise the large amounts of data obtained by the final phase of the research.) Many people also added points along the margins, or on extra pieces of paper and gave 'suggestions' about correlational/ causal links between points they had made. These links would be useful to look out for in the national questionnaire. It was interesting to see that some people had pointed out their justifications for the reasons behind including the question as well as their justification for their answers. For example, some people stated that there were not allowed to have time off for further study such as the Diploma/ MSc in

Health Promotion, and commented that if they were allowed day release/ study time, then they would have been able to work through ethical dilemmas with a peer group, and be less annoyed about the bad points of their job, and more positive about their future within Health Promotion. In another, instance, people pointed out the links between the subsuming of Health Promotion within the Public Health Department, and what they felt were a whole new set of resultant ethical dilemmas about cost-effectiveness and evaluation studies. The respondents were thus pointing out the links between various questions and answers.

There were a number of design faults, which included: sex was omitted from the questionnaire; some open ended questions yielded many responses; telephoning HPUs to ask non-respondents to reply may not have been useful because the questionnaires were filled in anonymously; lack of allocated space may have impinged upon answers.

Summary of the key points raised by respondents to the regional questionnaire about ethical dilemmas:

inequalities in health
inequalities
social issues
ways of working:
targeting
contact with the general public
professional issues:
autonomy
direction and vision
power
communication skills
NHS issues:
being part of a conspiracy
budget
lack of involvement with certain topics
agendas
none

It was decided to discuss the issues arising from the questionnaires with a group of peer colleagues, so interviews with 5 colleagues was the next stage.

- **Health Promotion Advisor interviews**

aim

to interview a small sample of questionnaire respondents to expand on questions asked in the questionnaire they had completed, and be tape recorded

Design and methodology

5 Health Promotion staff (colleagues) were asked if they would be willing to be interviewed. They were all willing to be interviewed. The date, time and venue was arranged by telephone, and sent a confirmatory letter to each. Each participant was interviewed separately in their office. A Dictaphone was used to record the interviews, because there was no access to a larger machine. A colleague, a friend and a child were used as a 'trial run'. It seemed that the interviewer and the interviewee were best placed near each other, with the Dictaphone between them. The interviews lasted between 15 and 30 minutes because that was the length of the tape. A set of pre designed questions were asked (see below) and the interviewees were asked to comment or add anything at the end of the interview.

- *Could you define health for me?*
- *How would you define Health Education?*
- *How would you define Health Promotion?*
- *Do you have any ethical dilemmas about Health Promotion?*
- *Where do you see Health Promotion going?*
- *What do you like about your job?*
- *What do you dislike about your job?*
- *Do you have any comments about the questionnaire or interview?*

Findings (brief summaries)

Interviewee 1

This interviewee was a DHPM aged 58. She has been in the NHS for 19 years, and had within the last year (at the time) returned to the NHS in the same job, in a different district. She is seen as a very well respected person in this region, and has a wealth of practical experience and knowledge about Health Education/ Promotion. Her ethical dilemmas centred mainly on inequalities in health, but she had discovered over the years that worrying about these issues solved nothing, and she had resigned herself to 'just getting on with things' rather than becoming cynical. The DHPM felt that Health

Promotion was becoming more medically orientated, especially since The Health of The Nation, and that the profession would therefore become absorbed by the FHSA. She felt that Health Promotion was being steered away from its caring direction and more towards strategies and documents. She wanted to see 'outreach' and 'hands on' work being done rather than the 'top down' approach of Health of The Nation.

Interviewee 2

This interviewee was a SHPA aged 31. She had been in post for 5 years, but had been Acting Manager for about 6 months. However, she enjoyed the practical side of Health Promotion work, and wanted to remain as a SHPA. She finished the Diploma in Health Education/ Promotion about one year ago. This SHPA enjoys meeting clients, and doing some good by her job, but her ethical dilemmas were the bureacracy, paperwork and meetings associated with the management of the Health Promotion Service, which detracted from the work needed to be done. Ideally, this interviewee would like to see a client directed approach to Health Promotion.

Interviewee 3

This interviewee was a SHPA aged 28, who had been in post for 2 months. His degree was Law, and his work history included Probation and most recently in the Youth Service. He felt that "Health Promotion is about me trying to work with client groups", and not about picking a topic to go armed into the Youth Service with. His ethical dilemmas included being worried about the concept of duties..."What's my duties to them, what's my duties to myself where does my duty lie?" He was having doubts about the whole philosophy of Health Promotion, because he felt he might be seen as setting himself up as a 'paragon of virtue' and as knowing all the answers. He saw his future in 'outreach' type Health Education, and wanted to work on a one to one basis although he realised that this was not really possible.

Interviewee 4

This interviewee was a SHPA, aged 26. He had been in post for 6 months, and had the Diploma in Health Education. His work brief was workplace Health Promotion. He felt that Health Promotion was being run by ex-nurses, and wanted Health Promotion to take a more business like approach with costings, evaluation, marketing and money management. He had no ethical dilemmas about Health Promotion, he was being paid to do his job.

Interviewee 5

This interviewee was aged 63, and had been in Health Education for 25 years. She was the Resources manager. She had seen Health Promotion go through many changes over the years. She said she yearned for the days when Health Education was delivered directly to the public, via ante-natal talks, in particular. The main topics then were personal hygiene, cooking tips, and anti smoking. Her ethical dilemmas were mainly the emerging academic side of Health Promotion, and the total lack of direct contact with the people she wanted to serve.

Summary of the key points raised by interviewees about ethical dilemmas:

inequalities in health
inequalities in health
NHS issues
bureacracy
'approach'
The Health of The Nation medical focus
more 'outreach' and 'hands on' work
more client directed approach
professional issues
duties
philosophy of Health Promotion
being a role model
the emerging academic side of Health Promotion
theory vs. practice
lack of direct contact with the public
none
none

Discussion

The aim of the interviews was for the author to more deeply analyse answers to the questions that had been asked on the questionnaires. It appeared that the 5 people interviewed were all becoming cynical. This was leading to them either adopting a 'just get on with it then'/ defeatist attitude, or a need for reform/ revolution outlook. Everyone was committed to Health Promotion as a concept, and each portrayed themselves as a genuinely caring individual. The cynicism was arising due to lack of prestige/ credibility/ self doubt/ co-ordination of the profession. It appeared that these individuals had very deep worries about Health Promotion. It was interesting that at each interview, when the participants had finished answering all the questions on the

schedule, they added a few more thoughts to the concept of ethics, but by then the Dictaphone had been put away and the comments were given as 'asides'.

There were a number of design faults, which included: finding an unobtrusive tape-recorder was difficult, the Dictaphone tape was 15 minutes per side, which I felt made the interviews shorter than they might have been; keeping to the question schedule was difficult, because people made interesting comments that were useful to expand on; the dictaphone for a somewhat artificial positioning. It could also be argued that had colleagues who had a similar outlook to the author were chosen to discuss the ethical dilemmas brought up in the questionnaires with and that the discussions were somewhat biased.

Subsequent to the preliminary studies, a list of the main points brought out by the 5 preliminary studies was drawn up.

In summary, some of the key issues raised by the five preliminary studies were:-

- definitions of health, education, and promotion
- accuracy of information
- inequalities in health/ social and economic factors
- access to health information
- empowerment
- credibility
- expertise
- liaison
- sharing/ networking
- autonomy
- evaluation
- effectiveness
- targeting

In order to get a true 'snapshot' of the ethical dilemmas of Health Promoters, it was decided to go ahead with the national survey.

Final phase of PhD

The initial interviews with the decision makers revealed that they had no worrying ethical dilemmas about Health Promotion, indeed, it was seen as a useful 'tool' in educating an autonomous public. However, the decision makers did not know the research interest of the author, ie. ethical dilemmas about Health Promotion, and may

not have had the chance to think through their answers to the question about ethical dilemmas. The public who answered the questionnaire seemed to know what Health Promotion work involved, and were able to describe and discuss health issues they felt important. Some staff within the District Health Promotion team were having ethical dilemmas about their perceived definitions, credibility, work (NHS) issues, and the medical vs. social focus of their work, and similarly for those who responded to the regional questionnaire, but, indeed, some had no ethical dilemmas. However, half of those who had arranged to participate in the focus group did not do so, and in the regional questionnaire 54% of people didn't return their questionnaires and 28% of those who did had no ethical dilemmas, and 9% did not know if they did. It may therefore be that the people who had been chosen to speak to were similarly concerned about the same issues as the researcher, and were therefore a biased sample. It was felt that a questionnaire filled in anonymously would be best and that a UK-wide survey was needed, so the following account is of the final phase of the research.

It would be interesting to see if the issues raised by people in the preliminary studies would resemble those from the last phase, the national research.

CHAPTER 6: Main study

HEALTH PROMOTION STAFF QUESTIONNAIRES

aim

to survey nationally the perceived ethical dilemmas of NHS Health Promotion staff, and to investigate relationships between variables

research design

The Health Education Authority was approached in 1997 for an up to date United Kingdom National Health Service (NHS) Health Promotion Unit mailing list. In due course, they sent a mailing list with 232 Health Promotion Units (HPU) on it.

1 covering letter and 15 questionnaires and envelopes were sent to each HPU as it was felt that 15 would be enough. The covering letter and a short paragraph at the beginning of the questionnaire explained the purpose of the study, the work background of the researcher, the intended purpose of the research, and a guarantee of anonymity of responses. The covering letter was addressed to the office manager, and it was politely asked that if any more than 15 were needed could additional ones be photocopied if not too inconvenient. A total of 3,480 were posted. All 3,480 questionnaires were individually marked by a reference number according to which of the 232 Health Promotion Units they were sent to. The questionnaires were 'staggered' during mailing, because of sheer volume and funding for photocopying, envelopes and postage costs. The mailout took 6 months to complete. Because of the possibility of regional variations in response, a random sample was not used, but a census survey was. Because the SPSS computer statistics package was to be used, it was felt that a large number of responses could be analysed.

Questionnaire design

17 questions were formulated (see overleaf), 2 of which were subdivided, making 19 questions in total. Sex was originally omitted from the pilot study, so this question was included in the main study.

Questions were asked about the following points:

1. job title
to analyse number of respondents in each job, and to look at correlations between job and other answers
2. length of time in this job
to analyse length of time in post, and to look at correlations between length of service and other answers
3. length of time working in current Health Promotion Unit
to analyse length of time in NHS, and to look at correlations between length of service and other answers
4. work in any other Health Promotion Unit(s)
to analyse whether people moved from one Health Promotion Unit to another and to look at correlations between having worked in more than one HPU and other answers
5. age
to analyse age distribution, and to look at correlations between age/ age groups and other answers
6. sex
to analyse distribution of the sexes, and to look at correlations between sex and other answers
7. main area of work
to analyse different topics of work and responsibilities, and to look at correlations between type of work and other answers
8. contracted hours
to analyse work patterns, and to look at correlations between part/ full time staff and other answers
8. average hours
to analyse extra hours worked per week, and to look at correlations between part/ full time staff and other answers; respondents may add points about the voluntary nature of extra work, or whether it was used later as 'time off in lieu'
9. member of the Society Of Health Education and Promotion Specialists (SHEPS)
to analyse numbers who are a member of the professional body, and to look at correlations between SHEPS membership/ not and other answers; in addition, it may add impact to understanding whether membership of a professional body helps people to work through ethical dilemmas with like-minded people, or whether membership gives rise to more/ different ethical dilemmas
10. if yes, how long
to analyse length of membership/ loyalty to the professional body, and to look at correlations between SHEPS membership/ not and other answers

11. if no, why not
to analyse why people don't join the professional body, and to look at correlations between SHEPS membership and other answers
12. Health Promotion qualifications
to analyse which specifically Health Promotion academic qualifications have been undertaken and to what level, and to look at correlations between Health Promotion qualifications and other answers
13. other academic or professional qualifications
to analyse which other academic/ professional/ practical qualifications have been undertaken and to what level, and to look at correlations between Health Promotion qualifications and other answers
14. previous jobs
to analyse which previous work employees were in and to look at correlations between work background and other answers
15. 'model' of working
to analyse which preferred way of working employees had, and to look at correlations between ways of working and other answers
16/17. good and bad points about present job
to analyse which good and bad points respondents identified, and to look at correlations between advantages and disadvantages of working in Health Promotion and other answers
18. ethical dilemmas
to analyse what were the main ethical dilemmas and to look at correlations between ethical dilemmas and other answers; this section was to be the focus of the entire research and therefore each other question would be analysed in relationship to this issue; to analyse whether individuals had different ethical dilemmas or whether patterns/ trends emerged
19. the future for Health Promotion
to analyse what respondents felt was the future of Health Promotion and to look at correlations between ethical dilemmas and other answers

Participants

774 self-selecting respondents; of whom 21% were male, and 79% were female.

Materials

(see questionnaire overleaf)

Health Promotion questionnaire

Dear colleague,
The purpose of this questionnaire is to provide me with some quantitative and qualitative data for my PhD. in Health Promotion. I am interested primarily in what sort of people work within a Health Promotion Service, whether people enjoy their work, and whether they have any ethical dilemmas about parts of their work.
Most of the questions here are hopefully brief enough for you to be able to fill in the questionnaire quite quickly, however, if anyone filling in this questionnaire would like to discuss any of the issues addressed here further, I would really welcome a discussion with you. Please feel free to contact me on 0181.789.3712.
There are no rights or wrongs, I would just like your opinions. Obviously, all replies are confidential because they are anonymous.
Thank you for your time and help. Best wishes, Penny Walters.

~ ~ ooOOoo ~ ~

Please answer all the questions, if you can,
and feel free to add any comments on the page as you go along.

What is your job title? .....

How long have you worked in this position? .....

How long have you worked in your current Health Promotion Unit? .....

Have you worked in any other Health Promotion Unit(s)? .....

What is your age? ..... or age group.....
Are you male or female? .....

What is your main area of work? .....
.....

How many hours are you scheduled to work per week? .....
How many hours do you tend to put in?.....

Are you a member of the Society Of Health Education and Promotion Specialists (SHEPS)?
Yes **No**
If yes, how long for?.....
If no, is there a reason why not?.....

Do you have any Health Promotion qualifications?.....
If so, please tick any of the following: Certificate Diploma MSc

Do you have any other academic or professional qualifications?
If so, please list them.....

Have you worked in any other jobs prior to your present Health Promotion position? If so, what jobs did these include; most recent first.....

Do you have a particular 'model' of working, eg. medical, behaviour change, educational, social change, client directed, harm minimisation, or 'not applicable'?

.....

.....

.....

What do you feel are the good and bad points about your present job?

good 1..... 2..... 3 .....

bad 1..... 2..... 3 .....

Do you have any general areas that present you with problems or dilemmas in your work? (eg. credibility, training opportunities, professionalism, effectiveness of campaigns, budgets, targeting, inequalities in health, changes in NHS, conspiracy issues, etc.)

If yes, please describe

.....

.....

.....

.....

.....

.....

.....

.....

Are there any particular ethical dilemmas that you face/ have faced in your work? (eg. disagree with No Smoking Day, but agree with smoking policies at work, job description is changing, a campaign was criticised or not well received, etc.)

.....

.....

.....

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.....

.....

What do you feel is the future for Health Promotion?

.....

.....

.....

Please feel free to make any comments about this questionnaire here

.....

.....

Many thanks for filling in this questionnaire. Don't forget to post it back! Please could you return it in the attached envelope by 1998

If the envelope is not attached, the address is:

Penny Walters, MSc., 18, Smithwood Close, Wimbledon Park, London. SW19 6JL

~ ~ ooOOoo ~

The **Health Promotion questionnaire** was subsequently categorised into the following questions and reference numbers for coding:

	district and region
1	job title
2	years in job
3	years in current Health Promotion Unit
4	worked in any other Health Promotion Unit
5	age
6	sex
7	main area of work
8	contracted hours
9	hours worked
10	member of SHEPS
10a	how long
10b	why not
11	Health Promotion qualifications
12	other academic or professional qualifications
13	prior jobs
14	'approach' of working
15	good points
16	bad points
17	ethical dilemmas
18	future for Health Promotion

These questions were coded according to volunteered answers, and were coded on the **SPSS package** as such. Each variable was given an identification number, and these variable lists are in the Appendices.

The responses were analysed in full as they were given and also recategorised in a summary. Thus, for example, the question regarding job title yielded 31 responses, so the answers were coded as such, and then subsequently analysed in summary of job types, in 5 categories, and then reanalysed according to 2 categories, ie. health promoter or support staff. Thus there are 3 levels of analysis for that question, and similarly for other questions. (These details are given alongside each question's results).

CHAPTER 7: Results of national survey into the perceived ethical dilemmas of NHS Health Promotion staff

Returns

774 questionnaires were returned out of 3,480 posted

at least one response from 151 out of 232 units (65%)
81 units did not respond

774 questionnaires out of 151 responding units (151x15= 2265 posted questionnaires) returned = 774/2265 = **34% response rate**

774 self-selecting respondents; of whom 21% were male, and 79% were female; ages ranged from 18 to 62 years of age

The statistics were transferred to an SPSS computer package

Each answer to each question was coded and tabulated. In addition, each question's answers were summarised and re-categorised. In some instances, a 'brutal' yes/ no categorisation was used, so a third level of summary was obtained.

Each question's answers has been correlated with each of the other questions. Thus there are a number of what's termed 'crosstabulations'.

Qualitative findings

Finally, a selection of 36 verbatim questionnaire responses was transcribed to form a 'snapshot' of the qualitative data. (See later section). These questionnaires were the 36 people who had offered to be followed up to discuss their responses.

In addition, a selection of 4 "typical" questionnaires from 5 groups of respondents were transcribed as 'profiles' for interest, namely the managers, and also dietitians who by the nature of their job are working within the medical model, yet work within the team of Health Promoters, ex-teachers, and ex-nurses, who made up a large proportion of the respondents; and ex-social/ youth workers, who seem to be a new profession to be entering Health Promotion.

WHO RESPONDED TO THE QUESTIONNAIRE BY DISTRICT

15 questionnaires were sent to each of the HPUs on the HEA mailing list.

By the final closing date, 774 people had responded, which represented staff from 151 Health Promotion Units. The response rate from those Units which responded was 774/2265 = **34% response rate.**

There were varying response rates, including some with only 1 respondent, and others with 13 respondents. The mean number of questionnaires received from responding HPU's was 5.

25 units sent between 2 and 14 spare copies back, as asked (totalling 215 questionnaires); 2 sent rejection letters back, (totalling 30 questionnaires), 1 HPU was told by the manager not to respond to the questionnaire (totalling 15 questionnaires) and some did not respond at all. These returns totalled 260 questionnaires.

Thus the 2265 questionnaires sent minus the blank ones sent back gave possible responses from 2005 people, giving a response rate of **38.6%.**

No reminders were sent because of the cost implications.

Health Promotion Units with more than one address

HPUs 1, 2, and 3 had the same name but 3 different addresses, and HPU 1 sent 1 reply, HPU 2 sent 12 replies and HPU 3 sent none. It may have been the case that there was a low response rate from HPUs 1 and 3, or it may have been that there was only a 'skeleton' staff at the 2 other addresses, ie. HPUs 1 and 3, or that these were old addresses and did not really exist any more. Similarly, for HPUs 4 and 6, the same name but 2 very different response rates of 8 replies and 1 reply. This was the case for a further **27 districts** which had between 2 and 4 HPUs but at different addresses.

Health Promotion Units with no address

9 HPUs were listed, but not with an address. 1 HPU's questionnaires were returned by the postal service as not existing. Because of the time and accuracy implications, an analysis was not made into these figures because some HPU's sent back unused questionnaires, and some wrote on a compliment slip, for example, that too many had been sent, but did not indicate how many were in the department, nor how many were not filled in rather than not distributed. For example, HPU 321 were sent 15

questionnaires, but someone returned 9 stating there were only 6 people in the HPU, but only 5 questionnaires were returned from that HPU, so 1 person did not fill a questionnaire in.

Largest response rates

The largest response was13 questionnaires from HPU 2 (Tees) and HPU 245 (Argyll), and 12 questionnaires from each of HPUs 8 (N. Durham), 12 (Gateshead), and 28 (Huddersfield). These are all districts in the **North East of England and Scotland.** However, some HPUs may have only had 5 people in it, but did not state this on their return, and it appeared that the others were not filled by staff, rather than they had fewer people in that department.

- **regions**

The districts were subsequently re-categorised into the **15 regions** they came under in 1997.

Numbers of respondents from each region

	regions	
	Count	%
N.East	77	9.9%
N.West	99	12.8%
Yorks./Humberside	54	7.0%
E.Anglia	18	2.3%
E.Mids	46	5.9%
London	95	12.3%
Midlands	34	4.4%
W.Mids	49	6.3%
SEThames	39	5.0%
SWThames	37	4.8%
S.West	70	9.0%
Wales	58	7.5%
Scotland	70	9.0%
Channel Islands	5	.6%
Ireland	23	3.0%

(In the above table, percentages are of the whole group of 774 people.)

The largest response was from 99 people in the districts in the N. West region (12.8%), and then London (12.3%), then N.East (9.9%). The lowest response was from 5 people in the Channel Isles (0.6%), and from Ireland (3.0%) and E. Anglia (2.3%). However, there were more districts in some regions, so the figures are not an accurate representation.

Q.1. WHO RESPONDED TO THE QUESTIONNAIRE BY JOB TITLE

The questionnaire asked people for their **job title**, and there were **32 different** types of job title given.

The jobs of those who responded were, in descending order:

Label	Frequency	Percent
sec. /admin.	80	10.3
HIV/sexual health HP	74	9.6
HPA (general)	61	7.9
director/manager	55	7.1
youth/schools HP/ teacher	54	7.0
resources	54	7.0
PHC/primary health co-ordinator	49	6.3
CHD/cancer HPA	38	4.9
SHPA (general)	32	4.1
smoking /project co-ordinator	27	3.5
dietitian/healthy eating	26	3.4
workplace/industry HPA	25	3.2
locality manager	22	2.8
drugs HP/substance misuse	19	2.5
community development	16	2.1
deputy manager	15	1.9
mental health	14	1.8
exercise/physical activity	13	1.7
accident prevention	12	1.6
HP youth worker/drama	11	1.4
graphic designer	10	1.3
gay men project	10	1.3
HP researcher	10	1.3
HP trainer	9	1.2
campaigns/ bus HPA	9	1.2
office manager	6	.8
HP assistant	6	.8
dental HP	6	.8
HON co-ordinator	4	.5
black/Asian health	4	.5
trainee HPA	2	.3
Snr. public health	1	.1
Total	774	**100%**

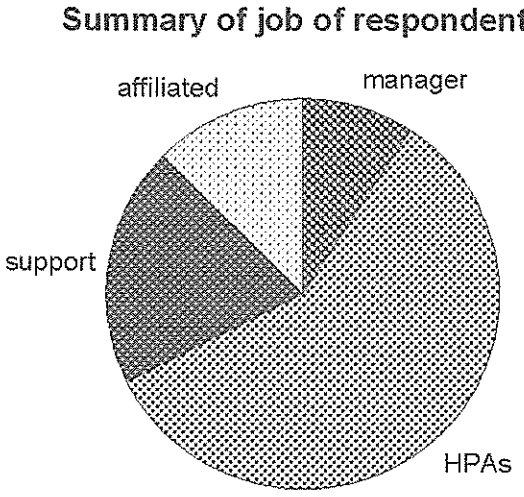
Q.1. WHO RESPONDED TO THE QUESTIONNAIRE BY JOB TITLE

There were too many different job titles given to make sense of the analyses. The job titles were therefore **summarised into 6 groups:**

manager/ deputy manager/ director	70	9%
SHPAs	188	24.3%
HPAs	63	8.1%
community development/ outreach/ project managers	201	26%
support staff/ resources staff	156	20.2%
medical HP/ dietitian/ dental HP	96	12.4%

This can be further summarised into 4 groups:

manager/deputy / director	70	9%
Health Promoters (SHPAs/HPAs/community development)	452	58.4%
support staff/ resources staff	156	20.2%
affiliated professionals (medical / dietitian/ dental)	96	12.4%



Q.2. WHO RESPONDED TO THE QUESTIONNAIRE BY NUMBER OF YEARS IN CURRENT POST

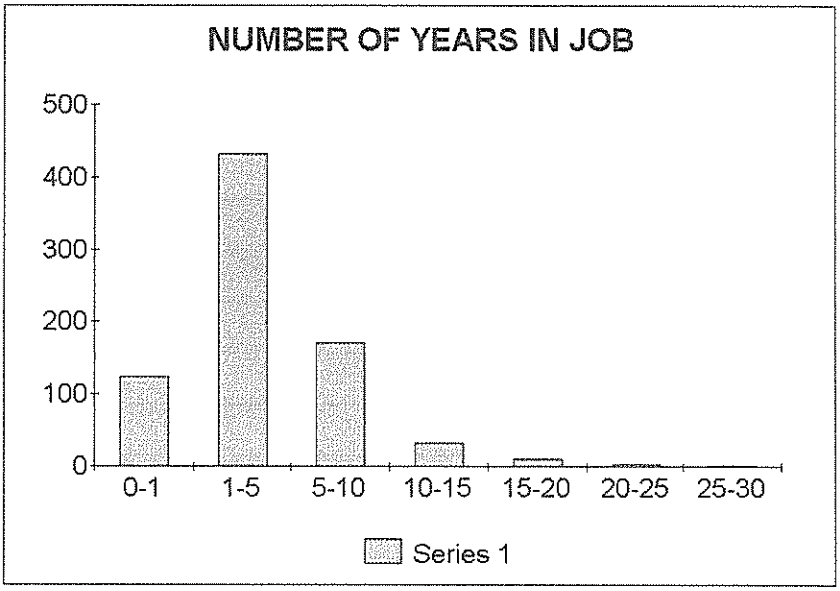
(see appendices for raw data)

Summary of number of years in post:

Years	Total	%
0-0.9	123	15.9
1-4.9	432	55.9
5-9.9	171	22.1
10-14.9	32	4.1
15-19.9	11	1.4
20-24.9	3	0.4
25-29.9	1	0.1
missing	1	
total	773	

Bar chart of number of years in post

- frequency -



- years in post -

- **number of years in post**

The picture emerged that very few people had been in that job for more than 10 years. The majority (**432 people/ 55.9%**) had been in post for between **1 and 4.9 years**, and **171 people/ 22.1%** had been in post for 5-9.9 years. A massive **15.9%/ 123 people** had been in post for **less than 0.9 years**. However, there was loyalty shown by length of service by **32 people/ 4.1%** who had been in post for **10-14.9 years, 11people/ 1.4%** who had been in post for **15-19.9 years, 3 people/ 0.4%** who had been in post for **20-24.9 years; and 1 person/ 0.1%** who had been in post for **25-29.9 years**. Only 1 answer was missing.

- **number of people in post for less than 2 years**

WK2YRS

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
>2 years	1	338	43.7	43.7	43.7
2 years +	2	435	56.2	56.3	100.0
	.	1	.1	Missing	
	Total	774	100.0	100.0	

Valid cases 773 Missing cases 1

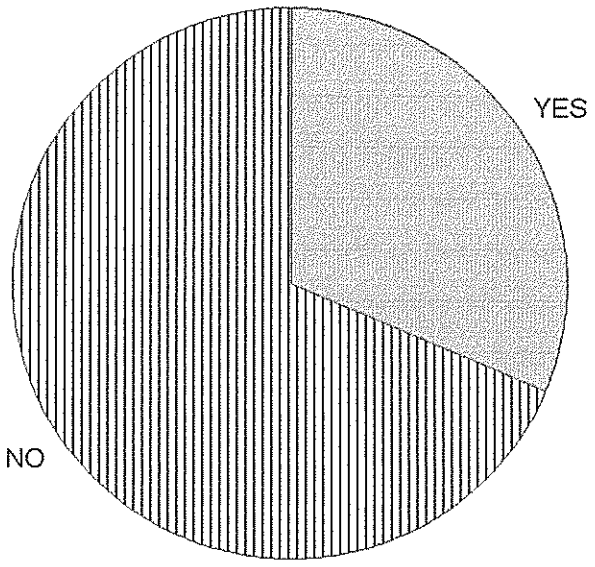
Just under half of the respondents had been in post for less than 2 years.

Q.4. WHO RESPONDED TO THE QUESTIONNAIRE BY WHETHER THEY HAD WORKED IN ANOTHER HEALTH PROMOTION UNIT

Value	Frequency	Percent
yes	241	31.1
no	530	68.5
Missing	3	.4
	---	---
Total	774	100.0

Valid cases 771 Missing cases 3

Pie chart showing work in other HPUs



One third of respondents had worked in another Health Promotion Unit, but two thirds had not.

Q.5 WHO RESPONDED TO THE QUESTIONNAIRE BY AGE

(see appendices for raw data)

summary

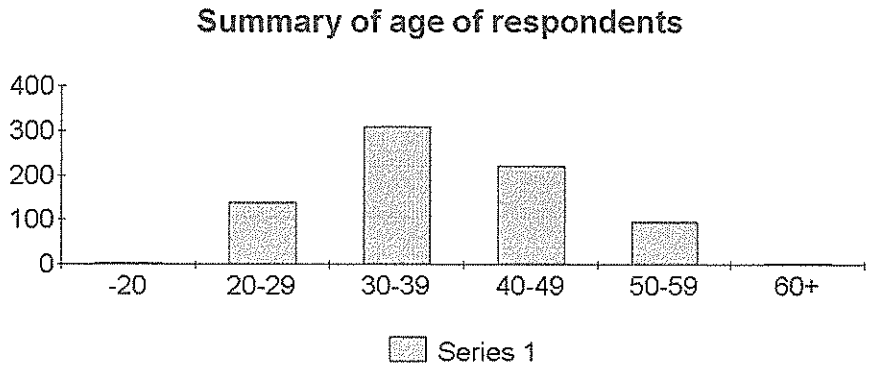
Value	Frequency	Percent
-20	2	0.3
20-29	139	18.1
30-39	309	40.2
40-49	221	28.8
50-59	95	12.4
60+	2	0.3

768 valid cases
6 (.8%) Missing

Mean	38.027	Std Dev	8.807
Variance	77.562	Range	44.000
Minimum	18	Maximum	62

mode: 52 people were aged **36 years**

Bar chart showing the distribution of the ages
- frequency -



- age in years -

This represents a **normal distribution curve** for age.

- age

The ages of the respondents ranged from 18 to 62, a range of 44 years, which is the whole spread of ages allowed to work. Some people did not want to state their exact age, and instead put an age group, eg. age 50 to 60, so the middle figure was given for these respondents, ie. aged 55. The mean age was **38 years**, with the majority being in the age group **30-39 years**. The single largest groups of respondents (modes) were **36 years (52 people /6.7%)** and **35 (5.0%)**. Only a few individuals were aged 18, 19, 21, 22, and at the other end, 60 and 62 years. 6 people didn't want to state their age. Five other common (4% or 4.1%) ages were aged 26, 30, 32, 40 and 45 years.

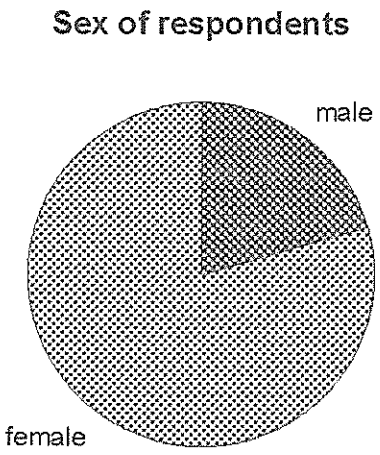
age groupings

Age groupings revealed that only 29 people (3.7%) were under age 25 years, 256 people (33.1%) were 25-34 years, **286 people (37%) were 35-44 years**, 164 people (21%) were aged 45-54 years, and 33 people (4.3%) were 55-64 years. Thus, Health Promoters are generally a **middle aged** workforce. There may be some link between age and job/ seniority.

Q.6 WHO RESPONDED TO THE QUESTIONNAIRE BY SEX

sex	frequency	percentage
male	160	20.7
female	614	79.3
	---	---
Total	774	100.0

Pie chart showing the sex of the respondents



sex

The majority (79%) of respondents were female, with only 1 in 5 (21%) being male. These findings suggest that either the majority of respondents to this questionnaire were female, or that the majority of Health Promotion Specialists are female.

sex and age groups

	sex			
	male		female	
-20			2	.3%
20-29	24	15.1%	116	18.9%
30-39	70	44.0%	242	39.5%
40-49	54	34.0%	167	27.2%
50-59	11	6.9%	84	13.7%
60+			2	.3%

The females were the youngest and oldest to respond, with 2 females being under 20, and 2 females being over 60, but no males were in these age groups. The pattern of responses from males and females according to age was very similar, but the females ages were more spread out. Both sexes were predominantly in their thirties.

Q.8. WHO RESPONDED TO THE QUESTIONNAIRE BY CONTRACTED HOURS PER WEEK

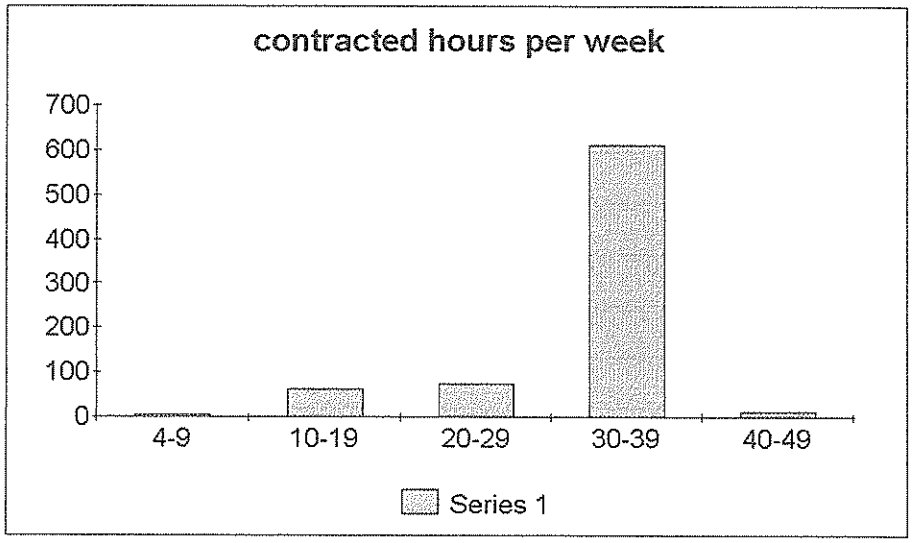
Summary:

hours	frequency	percentage
4-9	4	0.5
10-19	62	8.1
20-29	75	9.8
30-39	611	80
40-49	12	1.6

Valid cases 764
Missing cases 10

Mean	33.548	Median	37.000	Mode	37.000
Sum	25764.500				

Bar chart showing number of contracted hours per week
- frequency -



- hours per week -

The majority of respondents were contracted to work a 37 hour week, with only a small percentage contracted to work part-time. Two thirds worked between 20 and 40 hours per week.

Q.9. WHO RESPONDED TO THE QUESTIONNAIRE BY WORKED HOURS PER WEEK

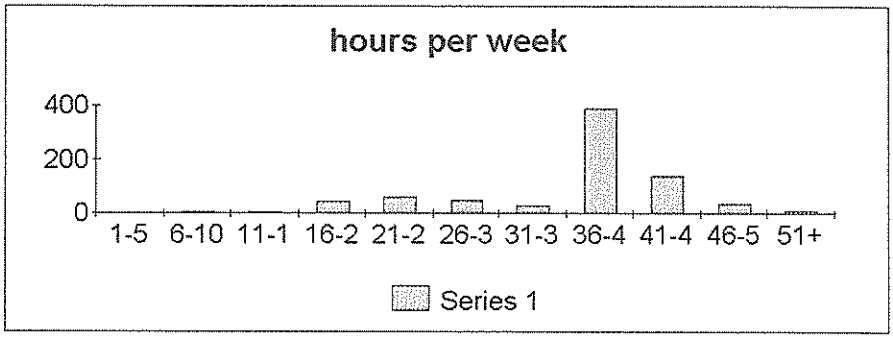
Summary

hours per week	frequency	percentage
1-5	1	0.1
6-10	3	0.4
11-15	5	0.7
16-20	44	5.8
21-25	57	7.5
26-30	47	6.2
31-35	26	3.4
36-40	390	51.4
41-45	139	18.3
46-50	37	4.8
51+	9	1.2
Valid cases	758	
Missing cases	**16**	**2.1%**

Mean	36.546	Std Dev	8.174
Variance	66.822	Range	66.000
Minimum	4	Maximum	70

mode hours: 37hrs, 40 hrs, 45hrs

Bar chart showing number of contracted hours per week
-frequency -



- hours per week -

The majority of respondents work **longer** than their contracted hours. A **quarter** work **over 40 hours** per week.

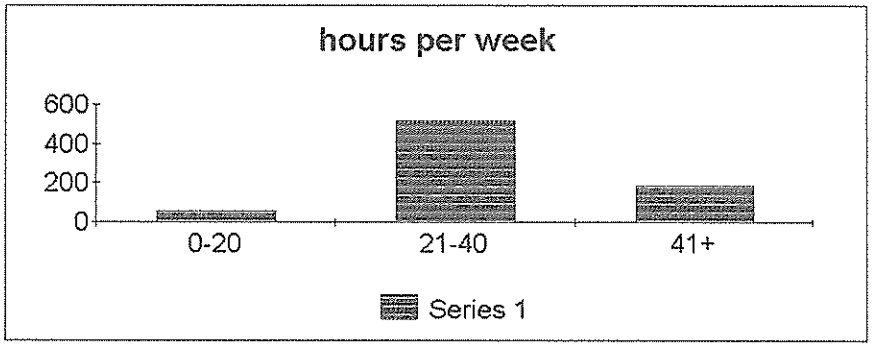
The average contracted hours were 37 hours. However, most actually worked many more hours than contracted. The range of contracted hours were 4 hours to 45 hours, with the range of actual hours worked being from 4 hours to 70 hours. 16 people didn't respond to the question.

1 person worked less than 5 hours per week, 3 people worked between 6 and 10 hours, 5 people worked between 11 and 15 hours, 44 people worked between16 and 20 hours, 57 people worked between 21 and 25 hours, 47 people worked between 26 and 30 hours, 26 people worked between 31 and 35 hours, 390 people worked between 36 and 40 hours, 139 people worked between 41 and 45 hours, 37 people worked between 46 and 50 hours, and 9 worked between 51 and 70 hours.

further summary:

hours per week	**frequency**	**%**
0-20	53	7
21-40	520	69
41+	185	24

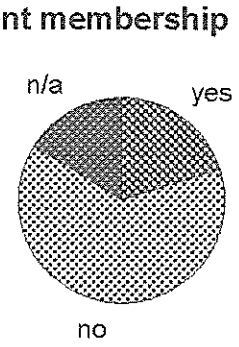
Bar chart showing distribution of hours worked per week
- frequency -



- hours per week -

Q 10 WHO RESPONDED TO THE QUESTIONNAIRE BY MEMBERSHIP OF SHEPS

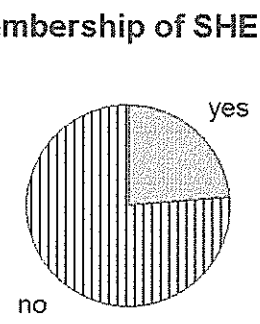
Value	Frequency	Percent
yes	154	19.9
no	495	64.0
n/a	125	16.1
Total	774	100.0



The majority of respondents were not members of SHEPS.

Discarding 'not applicables', the figures for membership are as follows:

Label	Frequency	Percent
yes	154	23.8
no	495	76.3
total	649	



SHEPS and reasons for non-membership

Some representative quotes from non-members who gave a reason for not being a member are as follows...

I am not a member of SHEPS because:

"Closed shop policy." ref 28, 37 yo. f. HPA
"Didn't know they existed." ref 70, 21 yo. m. HPA
"Local branch is totally shambolic." ref 74, 47 yo. m. HPA
"I was for 8 years, but nothing seems to be achieved." ref 75, 36 yo. f. manager
"I let my membership lapse. I felt there was little SHEPS offered and yet still feel we need a national organisation. " ref 82, 33yo. f. HPA
"I haven't been convinced of the value of joining." ref 85, 26 yo. f. HPA
"I don't feel they have much clout." ref 87, 33 yo. f. HPA
"Just the effort of finding out who has the forms and finding the time in a very busy programme to sort it out, plus the cost, not that I know how much it is." ref.140, 36 yo. f. Heart Health Facilitator
"Member of Unison, don't want to pay 2 lots of subscriptions out" ref.146, 31yo f. generic HPA.
"I do not agree on their position paper for physical activity, and I have commented on it." ref 282, 35 yo. f. HPA
"They appear to spend too much time forever creating position papers which seem rather toothless." ref 283, 49 yo. f. HPA
"It has not been a pre-requisite of my work position, but may soon be required." Ref. 378, 36 yo. f. community dietitian
"Has little clout." Ref. 414, 31 yo. f. HPA - sexual health.
"Have felt they have little to offer me, or I them." Ref.436, 47 yo m., SHPO - substance misuse
"I am not convinced it is the way to go." Ref. 497, 36 yo. f. localities programme manager
"Dubious value of membership." Ref. 630, 35 yo. m. HPA (drug education).
"Was once a member but felt let down by its inability to improve the salary structure for HPOs/ SHPOs in general." Ref.705, 45 yo. m. SHPA- health information

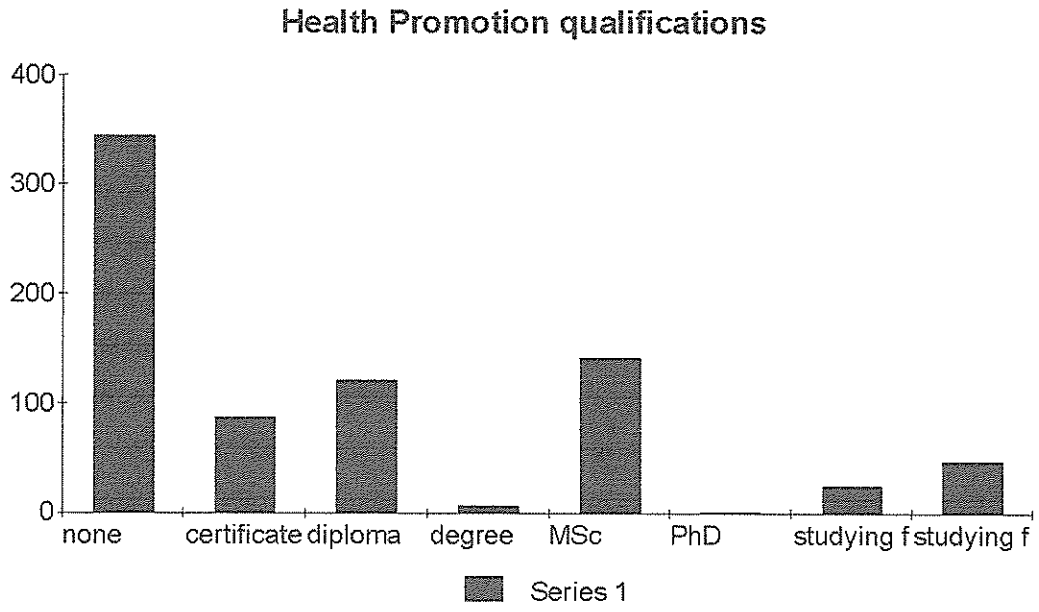
Q.11 WHO RESPONDED TO THE QUESTIONNAIRE BY HEALTH PROMOTION QUALIFICATIONS

in descending order

label	Frequency	Percent
none	344	44.4
MSc	142	18.3
certificate	87	11.2
diploma	121	15.6
studying for MSc	47	6.1
studying for diploma	25	3.2
degree	6	.6
PhD	1	.1
Missing	1	.1
Total	**774**	**100.0**

Valid cases 773 Missing cases 1

Bar chart showing distribution of Health Promotion qualifications



Nearly half of the respondents had no HP qualification, and nearly one fifth had the MSc.

44.4% of respondents had no health promotion qualifications. Those who stated that they had health promotion qualifications included 11.2% who had the certificate; 15.6% had the diploma; 0.6% had the degree; 18.3% had the MSc., and 0.1% had a PhD.

Some respondents specifically stated that they were studying for a qualification, even though the question was not worded to include this category of respondents. Thus, the people who stated that they were studying for a qualification added this point in. Therefore, these figures may be distorted, as some who were near completion of a course, may have included themselves in that category. However, 3.2% stated that they were studying for diploma and 6.1% were studying for the MSc.

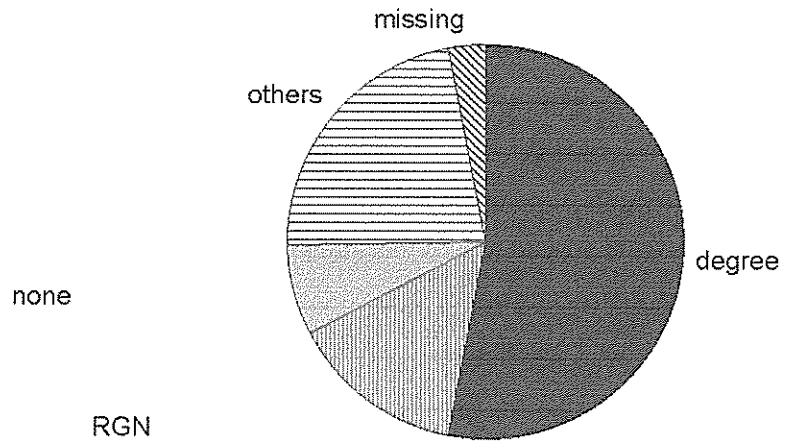
Q.12 WHO RESPONDED TO THE QUESTIONNAIRE BY OTHER QUALIFICATIONS

(see appendices for raw data)

Summary:

	frequency	%
degree	410	53.0
RGN	110	14.2
none	59	7.6
others	172	22.2
total	751	
missing	23	3.0

Pie chart showing distribution of qualifications



Just over half of the respondents had a first degree, a further fifth had other qualifications, and one seventh had nursing qualifications.

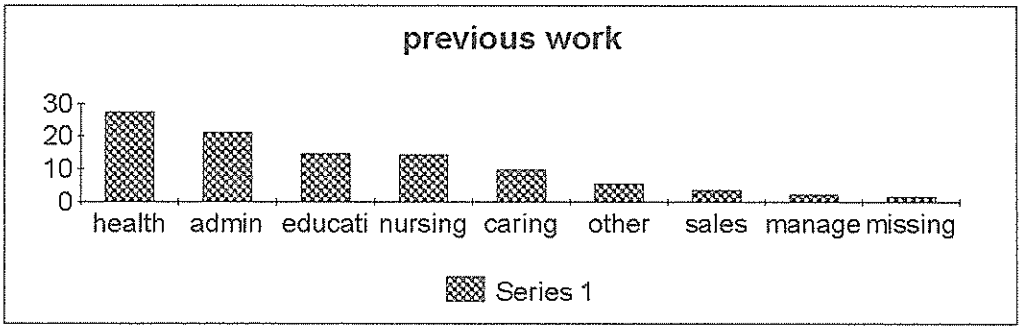
Q. 13 WHO RESPONDED TO THE QUESTIONNAIRE BY PREVIOUS WORK

A total of 20 different jobs were given as being the last job before working in Health Promotion. These were categorised into 8 groups. 761 people answered this question, and 13 did not. ***(see appendices for raw data)***

summary:

health	211	27.3%
admin/clerical/library	163	21.1%
education/training	113	14.6%
nursing	111	14.3%
caring	75	9.7%
other	42	5.5%
sales	28	3.6%
management	18	2.3%
missing	13	1.7%

Bar chart showing distribution of previous work
- frequency -



- previous work -

Prior to working in Health Promotion, just over a quarter of respondents came from health related jobs, a fifth from admin/clerical, one seventh from education and one seventh from nursing.

The question about work history was supposed to initiate one or two responses to the question. However, some people listed all the jobs they had ever had, so the most recent was used for analysis.

Q.14 WHO RESPONDED TO THE QUESTIONNAIRE BY APPROACH

in descending order

Label	Frequency	Percent
varies	286	37.0
n/a	176	22.7
behaviour change	52	6.7
all	44	5.7
client directed	40	5.2
social change	38	4.9
educational	36	4.7
community development	32	4.1
no	23	3.0
Ottawa Charter	11	1.4
harm minimisation	5	.6
medical	2	.3
Missing	29	3.7
	---	---
Total	774	100.0

Valid cases 745 Missing cases 29

Nearly two fifths of respondents felt their approach varied, and one fifth felt the question was not applicable. The remaining answers were quite evenly spread among 10 other answers.
Because so many people (72.1%) stated all, n/a, no, missing, this question has not be pursued further.

Q.15 WHO RESPONDED TO THE QUESTIONNAIRE BY GOOD POINTS

720 people responded to this question, and 54 did not.17 different 'good points' about work were given.

Label	Frequency	Percent
variety	155	20.0
autonomy	114	14.7
colleagues/manager/staff	84	10.9
flexibility/flexitime	57	7.4
clients/public	54	7.0
interesting/enjoyable	52	6.7
useful/worthwhile/important	37	4.8
teamwork/interagency work	37	4.8
prevention/make changes	34	4.4
rewarding/challenging	31	4.0
opportunities/training	15	1.9
environment/location	15	1.9
pay/hours	12	1.6
action/progressive	10	1.3
creativity	6	.8
don't know	4	.5
none	3	.4
Missing	54	7.0
Total	774	**100.0**

The space allocated for the answers to this question was small, so that meant that all answers were one word only. 720 people answered this question, and 54 people omitted it. The largest responses for good points about the job were for: variety **(20%)**; autonomy **(14.7%)** and colleagues/ manager/ staff **(10.9%)**. The next main groups were: flexibility/ flexitime **(7.4%)**; clients/public **(7.0%)**; and that the job was interesting/ enjoyable **(6.7%)**.

Because people used so many different terms for similar concepts, the responses were re-categorised into 7 groups. (see over).

Similar good points were grouped together.

Summary:

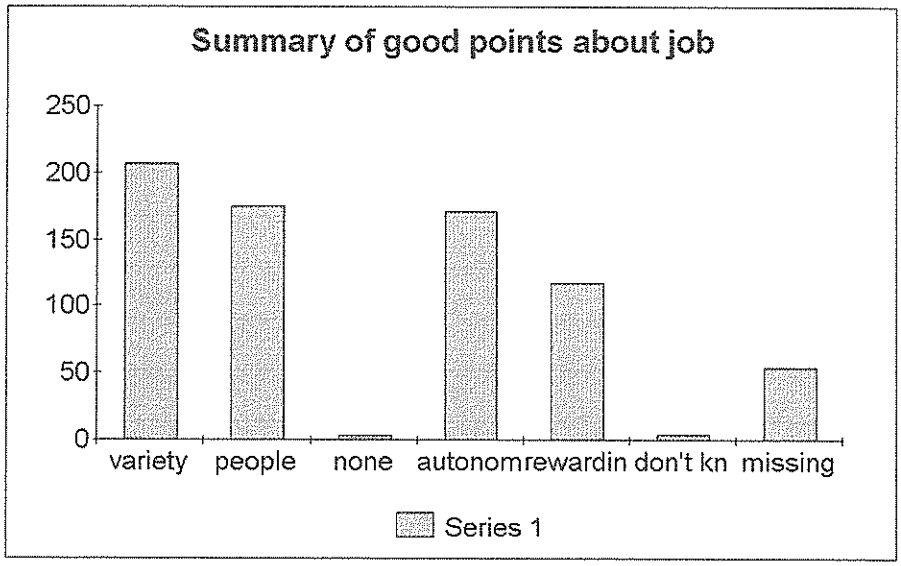
variety	**207**	**45.1%**
variety	155	20.0
interesting/enjoyable	52	6.7
people	**175**	**24.3%**
colleagues/manager/staff	84	10.9
teamwork/interagency work	37	4.8
clients/public	54	7.0
autonomy	**171**	**23.8%**
autonomy	114	14.7
flexibility/flexitime	57	7.4
rewarding	**118**	**16.4%**
useful/worthwhile/important	37	4.8
prevention/make changes	34	4.4
rewarding/challenging	31	4.0
action/progressive	10	1.3
creativity	6	.8
physical factors	**42**	**5.8%**
environment/location	15	1.9
pay/hours	12	1.6
opportunities/training	15	1.9
don't know	**4**	**.6**
none	**3**	**.4**

valid cases 720

Missing	**54**	**7.0% of total**

variety	207	45.1%
people	175	24.3%
autonomy	171	23.8%
rewarding	118	16.4%
physical factors	42	5.8%
don't know	4	.6
none	3	.4
valid cases	720	

Bar chart showing good points about job
- frequency -



- good points -

good points grouped

When grouped, the good points revealed that variety was the most important for nearly one half of respondents (207 people/ 45.1%), nearly a quarter listed people and nearly a quarter listed autonomy.

Q.16. WHO RESPONDED TO THE QUESTIONNAIRE BY BAD POINTS

708 people responded to this question, 66 did not. 25 different 'bad points' were mentioned.

	BADPTS	
	Count	%
pay/temp.contract/hours	60	8.5%
Bureacracy	190	26.8%
no training/direction	41	5.8%
no career path/promotion prospects/short contract	13	1.8%
budget/funding	44	6.2%
colleagues/staff/ "politics"	22	3.1%
effectiveness/waste of time/evaluation	17	2.4%
no status/power/poor image/fragmentation/ isolation	34	4.8%
pressure/stress/workload	116	16.4%
not valued/misunderstood/ not supported	37	5.2%
meetings	2	.3%
practicalities/ resources/conditions	24	3.4%
remit too big	14	2.0%
workplace/travelling	13	1.8%
don't know	4	.6%
medical/disease focused	12	1.7%
need to be motivated/low morale/boring	25	3.5%
inequalities in health	4	.6%
purchaser conflicts/constraints	19	2.7%
none	7	1.0%
understaffed	3	.4%
training others/ no contact-public	3	.4%
working with under 16's/homophobia	4	.6%

The main bad points about the job were **bureacracy (26.8%)** and **pressure (16.4%)**. The rest varied between 0.3% and 8.5%.

Some quotes from the questionnaires about the bad points are as follows:

bureacracy (190 people/ 26.8%)

"Some communication problems, eg. missing news because I'm a part-timer." Ref. 378, 36 yo. f. community dietitian
"Alliance working- another bloody group." ref.140, 36 yo. f. Heart Health Facilitator

pressure/ stress/ workload (116 people/ 16.4%)

"There's too much to do" ref 305, 45 yo m, HPU 90, schools sex education
"Too much to do, as I have both operational and managerial responsibilities" ref 313, 29 yo f. SHPA primary care
"We don't have enough hours to do our work" ref. 389, 38yo f. community dietitian

pay (60 people/ 8.5%)

"Poor pay in relation to those with whom I liaise at senior levels in partnership organisations." Ref.705, 45 yo. m. SHPA- health information.
"Poorly paid by European standards." Ref. 774, f. Director of Nursing research & development.

not valued/ misunderstood (37 people/ 5.2%)

"The profession is not respected by those outside health promotion." ref 213, 28yo f, HPU 60, SHPA cancer awareness
"having to sell myself" ref. 388, 52 yo f. SHPA, sexual health
"Some clients expect us to deliver leaflets, etc., and do not understand our role, or do not want to understand." ref. 478, 47 yo. f. Assistant HP manager

no status/ power (34 people/ 4.8%)

"No respect for specialist knowledge" ref 382, 30 yo f. SHPA, primary care
"Lack of authority." Ref. 497, 36 yo. f. localities programme manager
"lack of credibility of hp in many people's eyes." Ref. 630, 35 yo. m. HPA (drug education).

colleagues (22 people/ 3.1%)

"There is no manager in post due to bungling by Public Health" ref 283
"Managing the staff is very difficult" ref 238, 32 yo m. manager
"Lack of managerial commitment and back-up" ref 382, 30 yo f. SHPA, primary care
"Insufficient staff." Ref. 611, 47 yo. f. resources manager

purchaser conflicts (19 people/ 2.7%)

"Too many bosses because of joint commissioning." Ref. 548, 36yo. f. manager

effectiveness/ waste of time (17 people/ 2.4%)

"I feel as if I'm getting nowhere" ref 313, 29 yo f. SHPA primary care
"Am I effective?" ref. 388, 52 yo f. SHPA, sexual health

no career path/ promotion prospects (13 people/ 1.8%)

"There is no career structure and no opportunities for pay." ref 213, 28yo f, HPU 60, SHPA cancer awareness
"Poor career structure." Ref. 708, 33 yo. m. HPA- young people.

workplace (13 people/ 1.8%)

"Poor and cramped working conditions in the department, eg. rising damp and falling plaster" ref 283

medical/ disease focused (12 people/ 1.7%)

"Disempowered by those who only function in medical model." Ref. 435, 47 yo. f. HPA, workplace
"Health Board management." Ref. 708, 33 yo. m. HPA- young people.

inequalities in health (4 people/ 0.6%)

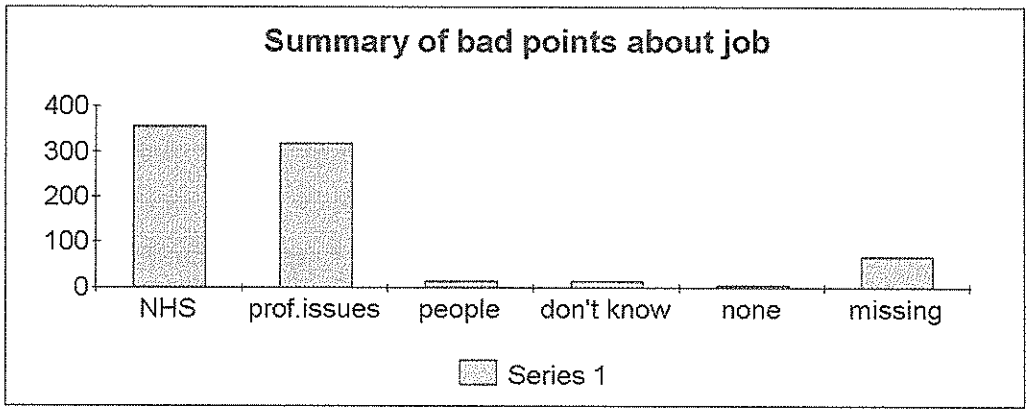
"root causes are ignored, treating symptoms not condition" ref. 258, 23yo m. HPA, substance misuse.

The 25 different 'bad points' mentioned were **categorised into 5 groups** for analysis:

- **NHS issues** (pay, contracts, hours, bureacracy, budget, funding, pressure, stress, workload, meetings, practicalities, resources, conditions, remit too big, medical focus, purchaser/ provider constraints.)
- **professional issues** (no training, no direction, no career path/ promotion prospects/ short contracts, effectiveness, no status, poor image. fragmentation, isolation, not valued, misunderstood, not supported, need to be motivated, low morale, boring, inequalities in health, training others, no contact with public, working with under 16's, homophobia.)
- **people** (colleagues, public)
- **don't know**
- **none**

	bad points summary	
	Count	%
NHS	355	50.4%
prof.issue	318	45.2%
people	13	1.8%
don't know	14	2.0%
none	4	.6%

Over half of respondents cited NHS issues, and nearly half cited professional issues as their bad point about work.



Q.16. WHO RESPONDED TO THE QUESTIONNAIRE BY ETHICAL DILEMMAS

in descending order

Label	Frequency	Percent (of respondents)
budget allocations	103	13.3
NHS/ bureacracy/ changes	97	12.5
credibility/ low status	80	10.3
none	50	6.5
misunderstood/ undervalued	48	6.2
campaigns/ short term	44	5.7
inequalities in health	41	5.3
told what to do/ hidden agendas	40	5.2
medical model/ NHS/ GPs	37	4.8
'politics'	30	3.9
effectiveness/ or not	28	3.6
lack of skills/ communication	25	3.2
evaluation/ evidence	21	2.7
job description changes	16	2.1
condoms to under age	12	1.6
targeting	11	1.4
theory vs. practice	7	.9
being a role model	6	.8
victim blaming	5	.6
time	4	.5
too many to list	2	.3
breadth of role/ pressure	2	.3
policies	1	.1
Missing	64	8.3
	---	---
Total	774	100.0

Valid cases 710 Missing cases 64

Q.17. SUMMARY OF WHO RESPONDED TO THE QUESTIONNAIRE BY ETHICAL DILEMMAS

The 23 different ethical dilemmas mentioned were categorised into 5 groups for analysis:

Label	Frequency	Percent
NHS issues		**41.9%**
budget allocations	103	13.3
NHS/bureacracy/changes	97	12.5
told what to do/hidden agendas	40	5.2
medical model/NHS/GPs	37	4.8
'politics'	30	3.9
job description changes	16	2.1
policies	1	.1
professional issues		**28.3%**
credibility/low status	80	10.3
misunderstood/undervalued	48	6.2
effectiveness/or not	28	3.6
lack of skills/communication	25	3.2
evaluation/evidence	21	2.7
theory vs. practice	7	.9
being a role model	6	.8
victim blaming	5	.6
type of work carried out		**8.8%**
campaigns/short term	44	5.7
condoms to under age	12	1.6
targeting	11	1.4
time	4	.5
too many to list	2	.3
breadth of role/pressure	2	.3
none		**6.5%**
none	50	6.5
inequalities in health		**5.3%**
inequalities in health	41	5.3
Missing	64	**8.3%**
	---	---
Total	774	100.0

Valid cases 710 Missing cases 64

Some people wrote one word to describe their ethical dilemma, some expanded upon comments. A representative selection of quotes are transcribed next.

Ethical dilemmas quoted

A brief summary of the person's job, sex and age comes after the quote, (along with their reference number).

- **budget allocations** (103 people/ 13.3%)

This was the **most frequent** listed ethical dilemma. Some quotes about budget allocations are as follows:
"Lack of finance limits what we can offer." ref. 34, 47yro f. CHD SHPA
"The money given is not sufficient to run such a service." Ref. 35, 36yro m. gay men's project worker
"The lack of resources for development of policy and services remains very problematic. Money can be obtained for research but not for implementing good practice unless it can be withdrawn from other services. This is very difficult when all services are cut to the bone." Ref 180, 41 yo. f., SHPA- children and young people.
"Disinvestment" ref 238, 32 yo m. manager
"Limited staffing budget prevents expansion of a very popular service." ref 308, 50yo f., bus/campaigns co-ordinator
"lack of resources, money, computer access, support staff time." ref 359, 38yo f. SHPA, schools
"In the past, nutrition health promotion money has been diverted into clinical work as its easier to justify numbers seen when there are waiting lists" ref. 389, 38yo f. community dietitian
"Lack of funding means everyone is trying to get sponsorship and apply for bids of money, both at local and county level, by all sorts of agencies for different projects." Ref. 477, 38yo. f. HPO - localities
"Budgets allocated to 'high profile' projects which do little more than raise awareness but which can be counted and a certificate hung on the wall." Ref. 435, 47 yo. f. HPA, workplace
"Suggestion that McDonalds might sponsor Smokebusters. Should dept. stock literature from commercial companies? Should BUPA sponsor Health Weeks?" Ref. 640, 36 yo. f. HPA-youth programmes
"We are extremely under-resourced which greatly limits our capabilities with groups like teachers (no money to pay for locum cover for training courses) and in many other areas." Ref. 729, 50yo. f. Deputy Manager

The budget issues concerned budget allocation, diverting budgets, budgets for campaigns, budgets for HIV/ AIDS.

- **NHS/ bureacracy/ changes/ cuts** (97 people/ 12.5%)

This was the **second most frequent** listed ethical dilemma. Some quotes about NHS/ bureacracy/ changes/ cuts are as follows:
"Health Promotion is not a priority for many providers (Trusts) of Health Promotion Depts. One year funding and job contracts do not allow for long term planning at local level or recognises that behaviour change can be a slow process." Ref. 12, 33 yo. f. HPO-Primary Health Care Support
"changes in the NHS which incorporate the free market, individualism, choice and competition fly in the face of ideals which we are striving to work towards" ref. 58, 39yo m., HPA Primary care.
"Bureacracy, locally and on a national level, proclude logical options and slow things down- it can be frustrating" ref 213, 28yo f, SHPA cancer awareness
"The 1993 and 1996 changes in the NHS locally have left this HP dept. in limbo-staff feel isolated." ref 284, 58yro f. resources manager
"Practising idiotic health promotion within the pseudo market of the NHS. Competing with acute services for funding, deciding about commissioning of services, being made to be a medically dominated commissioning team." ref.293, 48yo f. SHPA, locality work
"Currently the amalgamation of 2 HP Units are due to take place, therefore the changes are yet again proving to be an anxious time. The framework and structure of HP in which we currently work depends on the outcome and managerial lead upon the decision of the merge." ref 303, 27yo f., CHD HPA
"NHS changes have confused the general public." ref 308, 50yo f., bus/campaigns co-ordinator
"With a newly restructured service, we have less time and a bigger geographical area to cover, how do we deliver effective hp in such circumstances?" ref 359, 38yo f. SHPA, schools
"There is constant change in the NHS and HP within the structure." Ref. 435, 47 yo. f. HPA, workplace
"We've just been re-organised totally, so this brings new challenges, but problems too, with new ways of working and new colleagues etc." Ref. 477, 38yo. f. HPO - localities
"Changes in NHS re primary health care development." Ref.491, 38yo. f. HPA- oral health
"Constant battle to carve out a unique role for HP, particularly important to safeguard the Unit I work in from being cut financially or disbanded. Are we best

placed as purchasers of health promotion or providers?" Ref. 630, 35 yo. m. HPA (drug education).
"Too much bureacracy, no direct links to HEA." Ref 765, 44 yo. m. Manager

The NHS issues concerned bureacracy, lack of consultation, and constant change.

- **credibility** (80 people/ 10.3%)

This was the **third most frequent** listed ethical dilemmas. Some quotes about credibility are as follows:
"credibility is a major problem we face particularly within our provider trust, medics would rather use the finance to treat patients!!" ref. 58, 39yo m, HPA Primary care
"I'm responsible for development of work with black communities. I'm a white worker and got off to a bad start with some black workers not accepting me in this role. Ref. 62, 34 yo. f. Health Promotion Officer - H.I.V. and Sexual Health
"Credibility with other health professionals tends to be low, HPAs are often seen as 'the people who provide leaflets and organise exhibitions'." ref 213, 28yo f, SHPA cancer awareness
"We are not seen as professionals in the same sense as doctors or nurses."
"Credibility- some primary care workers do not view health promotion as a worthwhile thing to be involved in. Often people in hp do not have an agreed shared understanding of what they do." ref 313, 29 yo f. SHPA primary care
"Credibility- something you have to work at to obtain and continue to build upon." ref. 345, 29yo f SHPA Primary Care
"Credibility with health professionals." ref 377, 27 yo. m. HPA - sexual health.
"Not given any credibility for our expertise, knowledg and practice, especially amongst other professionals who see health promotion as part of their job and can't see why we are necessary!!" ref 382, 30 yo f. SHPA, primary care
"Lack of credibility in doctor's eyes." Ref. 436, 47 yo m., SHPO - substance misuse.
"Credibility and recognition re role of HP in society." Ref.491, 38yo. f. HPA- oral health
"Credibility. Constant battle to carve out a unique role for HP, particularly important to safeguard the Unit I work in from being cut financially or disbanded. Are we best placed as purchasers of health promotion or providers? There is a role confusion in HP in general at present." Ref. 630, 35 yo. m. HPA (drug education).
"Credibility- primarily my own perceptions, not necessarily from anywhere else." Ref. 646, 24 yo. f. HPA-youth and schools
"I feel a credibility problem in not having a professional qualification. However, I am addressing this year when at last I can undertake an MSc." Ref. 729, 50yo. f. Deputy Manager

"Credibility: I work in a hospital setting and there is a degree of territorial attitude from some medical staff. Many people won't start to listen because they think they have all the knowledge/ info." Ref. 751, 55 yo. f. Health Promotion Officer for Older People.

The credibility issues concerned credibility with medical colleagues, the public, credibility and qualifications, and perceived credibility of oneself.

- **none** (50 people /6.5%)

Most people just wrote 'none' but some expanded on this. Some quotes about having no ethical dilemmas are as follows:
"Because the SHEPS Code of Principles and Practice guide me in this area." Ref 14, 41yo m, manager
"I am a jack of all trades and master of none, but I have no ethical dilemmas with my work." Ref. 656, 42 yo. f. HPA (generic)
"None. If I don't agree with something I say no." Ref. 764, 47 yo. m. SHEO

- **misunderstood/ undervalued** (48 people/ 6.2%)

Some quotes about being misunderstood/ undervalued are as follows:
"The constraints of expectations of those around, ie posters and leaflets expected by some when more innovative and effective ways of working are available." ref. 258, 23yo m. HPA, substance misuse
"HA managers have no idea of the expertise of HP staff, their knowledge of local needs or what their current work is." ref 284, 58yro f. resources manager
"The submissive role played to medics by colleagues within the HA. We need to value ourselves for others to value us!" ref 285, 35yo f. physical activity HPA
"Lack of understanding of the value of long term community development work" ref.293, 48yo f. SHPA, locality work
"No-one shouting our corner, consistently being put down by managers of other associated professions" ref 382, 30 yo f. SHPA, primary care
"Medical/ clinical staff couldn't give a toss about HP, fundamentally they don't understand the concepts." Ref. 414, 31 yo. f. HPA - sexual health.
"Not clear the organisation I work for actually understands/ supports what we are trying to achieve." Ref. 497, 36 yo. f. localities programme manager
"Other professionals- they think we have a bottomless pit of money for them. Don't appreciate that we are not just the 'leaflets department'." Ref. 646, 24 yo. f. HPA-youth and schools

"Inability of colleagues to see that IT has a relevance and future impact on how we work/ communicate within health promotion." Ref.705, 45 yo. m. SHPA- health information.

The issues regarding being misunderstood and undervalued were often with regard to medical colleagues and managers.

- **campaigns** (44 people/ 5.7%)

Some quotes about campaigns are as follows:
"The opportunity to be more radical with our campaigns is discouraged." Ref. 12, 33 yo. f. HPO-Primary Health Care Support
"I am ambivalent about No Smoking Day, but there is a great deal of pressure from professionals for us as a HPU to support it." ref.140, 36 yo. f. Heart Health Facilitator
" How effective are one-off events? ref.146, 31yo f. HPA.
"Campaign materials are not pertinent to the general population." ref 308, 50yo f., bus/campaigns co-ordinator
"World AIDS Day over-funded and dull, but colleagues don't agree." ref 377, 27 yo. m. HPA - sexual health.
"Monitoring the 'effectiveness' of a campaign" ref. 389, 38yo f. community dietitian
"World AIDS Day keeps coming around with its good intentions, bit I'm Bored of it, and the impact it makes with us is small." Ref. 414, 31 yo. f. HPA - sexual health.
"We want to get away from the high profile of National No Smoking Day, and continue on smoking policies and Heartbeat Awards for restaurants etc." Ref. 477, 38yo. f. HPO - localities
"We have felt in the past tensions over giving resources to No Smoking Day to maintain a profile with the Health Authority while not believing that the campaign has any effect any more. Fortunately, this situation has changed." Ref. 729, 50yo. f. Deputy Manager

The issues regarding campaigns centered around their effectiveness, and the perceived need for their continuance.

- **inequalities in health** (41 people/ 5.3%)

Some quotes about inequalities in health are as follows:
"Concerned that Health Promotion is increasing inequalities in health through missing the deprived, disadvantaged sections of our society." Ref. 12, 33 yo. f. HPO-Primary Health Care Support

"The main challenge remains inequalities in health and poverty." Ref 180, 41 yo. f., SHPA- children and young people.
"I sometimes wonder if health promotion is widening inequalities in health, maybe our salaries should be given to unemployed people instead." ref 213, 28yo f, SHPA cancer awareness
"Too often H. promoters raise an issue- this opens a can of worms - which again cause alarm and concern with people who are already stressed/ smoking/ alcoholic, etc." ref. 345, 29yo f SHPA Primary Care
"The difficulties of working with people on low income. Should we be looking at social change, inequalities in health?" ref. 389, 38yo f. community dietitian
"Lip service paid to inequalities in health and health for all." Ref. 414, 31 yo. f. HPA - sexual health.
"everyone sticks with the do-able issues so whilst poverty and health is talked about, nothing really meaningful is done." ref 442, 48 yo f, Publicity and Marketing officer

The issues regarding inequalities in health seemed to surround the hypocrisy people felt when perhaps Health Promotion as a service was not altering and perhaps even adding to the situation.

- **told what to do/hidden agendas** (40 people/ 5.2%)

Some quotes about being told what to do/hidden agendas are as follows:
"Sometimes when something is designed specifically for one brief, it is often the case that a person with no knowledge of communication design can make major inappropriate changes." Ref 13, 37 yo. f. Senior graphic designer
"I am constantly faced by ethical dilemmas in that what schools think are priorities and ways of addressing sex education are not necessarily mine. It is very important to address homosexuality but many schools are frightened." ref 305, 45 yo m., schools sex education
"Political appointees in management with no insight into what the dept. is trying to do. Shift in emphasis imposed on depts. from community empowerment and positive health philosophy to disease management and 'thou shalt not...'. The conflict between the ethics which I believe in and what I am ordered to do- not by HP manager, but by Board management/ director of Public Health. Our health needs assessment documents are just ignored." Ref. 708, 33 yo. m. HPA- young people.

- **medical model/ NHS/ working with GPs** (37 people/ 4.8%)

Some quotes about working in the medical model are as follows:

"Working to the Health of the Nation targets which are too medically orientated." Ref. 12, 33 yo. f. HPO- Primary Health Care Support
"We have to keep GPs happy, even if this means providing services that may not be effective." HPU 8, 38yro, f. SHPO
"Difficult to access GPs and cope with their attitudes to Health Promotion which can be mis-informed." Ref. 477, 38yo. f. HPO - localities
"Evidence based approach working against HP because the evidence is so medical. HP as you know is social, mental, physical, etc. Primary care led is just another way of saying there is no money for HP." Ref 765, 44 yo. m. Manager

The issues surrounding working with medics and in the medical model came up in many other stated ethical dilemmas, such as credibility and being misunderstood, but also specifically as an ethical dilemma *per se* as being a difficult and perhaps inappropriate group to be having to work with.

- **'politics'** (30 people /3.9%)

Some quotes about 'politics' are as follows:
"District Council trying to raise its own laudos and political expediency by staging 'naff' campaigns to be seen, but which I know are a total waste of money." ref.140, 36 yo. f. Heart Health Facilitator
"The role of HPAs tends to attract 'touchy-feely' personalities" ref 213, 28yo f, SHPA cancer awareness
"Tackling the disagreements which exist between vociferous care managers and catering managers." Ref. 378, 36 yo. f. community dietitian
"Political problems, treading on other people's toes!" ref. 388, 52 yo f. SHPA, sexual health
"everyone is watching their back, lack of motivation and enthusiasm" ref 442, 48 yo f., Publicity and Marketing officer
"Individual colleagues can be very destructive, while the general ethos is support/ share/ co-operate. Do you 'tell' or just allow them to dominate/ manipulate?" Ref. 751, 55 yo. f. Health Promotion Officer for Older People
"Because of the track record, I have to meet the health board requirements by a 'softly-softly' approach." Ref 765, 44 yo. m. Manager

- **effectiveness** (28 people/ 3.6%)

Some quotes about effectiveness are as follows:
"Participating in activities, planned by others, when you know a full needs assessment has not been completed, and therefore the activity will be ineffective." Ref. 12, 33 yo. f. HPO- Primary Health Care Support

"Some of the campaigns, particularly mailouts and exhibitions are not effective and especially not cost effective yet. Due to their high profile, ease of implementation and routine, we continue to undetake them" ref 213, 28yo f, HPU 60, SHPA cancer awareness
"Effectiveness of training/ campaigns- long term implications." Ref. 646, 24 yo. f. HPA-youth and schools

- **lack of skills** (25 people/ 3.2%)

Some quotes about lack of skills are as follows:
"Professionalism/ skills - are we the right people to do this job, expertise needed in this area, also a changing environment- changing skills." ref. 345, 29yo f SHPA Primary Care
"Lack of support for professional development" ref 359, 38yo f. SHPA, schools
"Training opportunities. Present role does not enable me to undertake MSc. as I would wish, as it must be covered full-time, but agreement may be reached regarding Diploma." Ref. 611, 47 yo. f. resources manager

- **evaluation** (21 people/ 2.7%)

Some quotes about evaluation are as follows:
"We need to be really sure of the arguments around evaluation and outcomes of our work, if we are to attract decent funding and appease Purchasers." ref.140, 36 yo. f. Heart Health Facilitator
"Accountability in areas that are difficult to evaluate." ref 238, 32 yo m. manager
"Conflict between having to satisfy the 'number counters', and carrying out effective meaningful work which might not produce 'real' evidence for a long time after." Ref. 435, 47 yo. f. HPA, workplace
"How to undertake effective evaluation." Ref. 640, 36 yo. f. HPA-youth programmes

- **job description changes** (insecurities) (16 people/ 2.1%)

Some quotes about job descriptions changing are as follows:

"My job description has totally changed 3 times in the last 2 years, from accidents to men's health to cancers, and not through choice." ref 213, 28yo f, SHPA cancer awareness
"Uncertainty about the role- continual assessment of HP roles- continually on the 'hot spot' continually scrutinised by GPs, even colleagues in this organisation." ref. 345, 29yo f SHPA Primary Care

"Job description moving away from face to face work into strategic purchasing from less qualified or able disciplines." Ref.436, 47 yo m., SHPO - substance misuse

The comments about the job description changing were very specific, and may have been well placed in the NHS issues category, but most of the NHS issues dilemmas were to do with NHS changes, and this group seemed to be focussing on uncertainty and disruption rather than change.

- **targeting** (11 people/ 1.4%)

Some quotes about targeting are as follows:
"I would like to see more of our HIV prevention budget spent on targeting gay and bisexual men." ref. 17, 50yo. m. outreach project manager
"Ethical issues when collecting data via questionnaires etc., especially in areas of socio-economic deprivation, etc. Also projects in these special areas and making sure of sensitive press coverage." Ref. 477, 38yo. f. HPO - localities
"Imposition of middle class, white values on vulnerable groups. Often delivered by white, m-c females without reference to the potentially damaging effects that might ensue." Ref. 497, 36 yo. f. localities programme manager
"Targeting is a problem as there has been no previous direction to health promotion. This is the first year that this district has had a specification that has been produced for the service. This means that health promotion has been diverse, but also unmanaged, changing the culture and encouraging targeted and evaluated work." Ref. 548, 36yo. f. manager
"Targeting older men, 50+, effectiveness of campaigns, because each one to be well done could take so much time." Ref. 751, 55 yo. f. Health Promotion Officer for Older People.

- **theory vs. practice** (7 people/ 0.9%)

Some quotes about theory vs. practice are as follows:
"Believing in community development as an approach, but not being able to operate it." ref.140, 36 yo. f. Heart Health Facilitator
"The conflict between good basic health information and a sense of value and morality" ref. 388, 52 yo f. SHPA, sexual health
"In house development: we work hard at team development with other agencies but rarely our own, this makes me very angry and confused." Ref.491, 38yo. f. HPA-oral health

- **being a role model** (6 people/ 0.8%)

Some quotes about being a role model are as follows:
"Having to be the perfect role model for healthy living." Ref. 12, 33 yo. f. HPO-Primary Health Care Support
"I often wonder whether as a HPO I should be a better role model than I am. Often when training on issues such as heart health, physical activity or weight control, I get to feel guilty and will embark on a fitness spree for a couple of weeks!!" Ref. 177, 32 yo. f. HPA - cancers
"I agree with environmental policies to limit traffic, yet I need my car for work, and the bus project would not exist if it did not move from one site to another." ref 308, 50yo f., bus/campaigns co-ordinator
"I don't drink but I am not anti-alcohol. I feel that members of the NHS workforce and general population, however, do think we should be role models of fit and healthy specimens. I do not believe this needs to be so, but I would still have some credibility difficulties leading sessions on exercise and healthy eating!" Ref. 630, 35 yo. m. HPA (drug education)

- **victim blaming** (5 people/ 0.6%)

Some quotes about victim blaming are as follows:
"Constantly aware of judgmental attitudes of others, and more alarmingly of professional's attitudes to specific groups of people." HPU8 58yro. f. HIV/Sexual health co-ordinator
"I personally am not entirely happy with the local emphasis on breastfeeding. I agree it should be promoted effectively but it should not stop our dept. stocking information from formula manufacturers who are following EC directives in their literature. There are women who cannot breastfeed and the current campaign makes them 'outcasts'. ref. 284, 58yo f. resources manager
"The approaches that are being used by health promoters- do we have the right to determine how health professional work, eg., behaviour change approach- could become victim blaming, rather than looking at external factors." ref. 345, 29yo f. SHPA Primary Care

- **policies** (1 person (0.1%))

The quote about policies is as follows:

"I believe in using children for test purchasing cigarettes, the local council has an opposing policy." Ref.436, 47 yo m., SHPO - substance misuse

Summary:

The quotes are to provide some insight to the ethical dilemmas people described. It could be argued that more depth could have been obtained from the responses by, for example, interviews. However, the respondents were able to write as briefly or a fully as they wanted to. Someone stating 'credibility' as their ethical dilemma got the point over as well as someone who expanded on the point further with an anecdotal example.

What is probably needed as a result of this research is for people to be able to raise and then debate and discuss their ethical dilemmas, rather than merely state them. (See Discussion section).

Q.18. WHO RESPONDED TO THE QUESTIONNAIRE BY FUTURE OF HEALTH PROMOTION

Value	Frequency	Percent
don't know	118	15.2
new Government-positive	108	14.0
to be more professional	82	10.6
positive	79	10.2
bleak/poor	59	7.6
PHC/ NHS/medical model	48	6.2
community development	45	5.8
policy/strategy/in all jobs	34	4.4
Local Authority/Environmental H.	28	3.6
Public Health	23	3.0
to be more effective	20	2.6
get/need larger budget	17	2.2
health agencies/projects	16	2.1
social model/ Ottawa Charter	10	1.3
Provider/Commissioning	6	.8
trainers	6	.8
targeting	4	.5
Purchaser	4	.5
computer/IT/internet	3	.4
Missing	64	8.3
Total	774	**100.0**

Valid cases 710

The responses were grouped and summarised as follows:

positive	**187**	**24.2**
positive	79	10.2
new Government-positive	108	14.0
to be more professional	**128**	**16.6**
to be more professional	82	10.6
to be more effective	20	2.6
get/need larger budget	17	2.2
trainers	6	.8
computer/IT/internet	3	.4
social model	**137**	**17.7**
community development	45	5.8
policy/strategy/in all jobs	34	4.4
Local Authority/Environmental H.	28	3.6
health agencies/projects	16	2.1
social model/ Ottawa Charter	10	1.3
targeting	4	.5
don't know	**118**	**15.2**
medical model	**81**	**10.5**
PHC/ NHS/medical model	48	6.2
Public Health	23	3.0
Provider/Commissioning	6	.8
Purchaser	4	.5
Missing	64	8.3
negative	**59**	**7.6**
bleak/poor	59	7.6

<u>Summary:</u>

positive	**187**	**24.2**
to be more professional	**128**	**16.6**
social model	**137**	**17.7**
don't know	**118**	**15.2**
medical model	**81**	**10.5**
Missing	64	8.3
negative	**59**	**7.6**

Some quotes about suggestions as to the future of Health Promotion are as follows:

don't know (118 people/ 15.2%)

These mostly stated 'don't know', but some people expanded on that:

"Very uncertain. Since the election of Labour, there has been a lot of noise about the rising significance attached to public health but we'll have to wait and see." ref 213, 28yo f., SHPA cancer awareness
"It's in the balance, but unless there is a total change in perceptions and the value of HP, it is a soft target and soft money, it will disappear, unless they become more income generating." Ref. 414, 31 yo. f. HPA - sexual health.

- **positive** (187 people/ 24.2%)

"Promising in terms of continuing interest from general public." Ref. 378, 36 yo. f. community dietitian
"It should be enhanced by the new government's commitment." Ref.436, 47 yo m., SHPO - substance misuse
"With the new government and Tessa Jowell's comments on the Green paper looking at the health inequalities review, it reinforces many of the approaches and principles of our new way of working with public health strategy. Hopefully there will be a brighter future for health promotion." Ref. 477, 38yo. f. HPO - localities
"Promising. More and more people are undertaking further study to gain knowledge." Ref. 611, 47 yo. f. resources manager
"Depending on the substance of New Labour's public health drive, it could be promising. However, this strategic framework may take a while to filter down to local level." Ref. 630, 35 yo. m. HPA (drug education)
"Good." Ref. 764, 47 yo. m. SHEO
"The future is bright. we work closely with DOH, Education, Employment, training, voluntary sector etc." Ref 765, 44 yo. m. Manager

- **to be more professional** (82 people/ 10.6%)

"HP specialists have to embrace change and develop wider skills such as marketing, project management etc. The Diplomas and MSc in health promotion have to change to be more relevant to the skills requirements of the practice setting." ref 238, 32 yo m. manager

"We must concentrate on being positive and effective, so that we are considered an important and necessary part of health promotion." ref 313, 29 yo f. SHPA primary care
"It should be of paramount importance and far better co-ordinated" ref. 388, 52 yo f. SHPA, sexual health
"We need to continue to promote the importance of our role." Ref.491, 38yo. f. HPA- oral health
"The future looks rosy when certain powers that be really see the value of it. It all depends on whether we can continue to prove our worth, both to local professionals and communities and also to national Government." Ref. 646, 24 yo. f. HPA-youth and schools

- **bleak/ poor** (59 people/ 7.6%)

"In this HA, I foresee the dept. being cut back to nothing as the lack of resources currently means we are ineffective and therefore a likely target for cuts" ref 359, 38yo f. SHPA, schools
"Feel that it is going to become a job of the past or if we do continue to offer a service it will be further fragmented and very much in the style of the 80's service." ref 382, 30 yo f. SHPA, primary care
"I feel the future for dietitians in our area will be more difficult in future as numbers seem to be shrinking, and funding seems less secure." ref. 389, 38yo f. community dietitian
"Grim." Ref. 708, 33 yo. m. HPA- young people.

- **community development** (45 people/ 5.8%)

"To be organised into localities to have a representation from health promotion and locality commissioning teams to begin to influence purchasing, to move towards 'health for all' philosophy in localities and to take a holistic perspective which is shared by other organisations" ref.293, 48yo f. SHPA, locality work
"I believe the most effective health promotion work will be done by enthusiasts and volunteers. The real, time intensive health promotion will be done by the passionate wellness crusaders who communicate with and work for health for all of us." Ref. 435, 47 yo. f. HPA, workplace
"Multi-agency working towards tackling the fundamental determinants of health." Ref. 497, 36 yo. f. localities programme manager
"Locality based working with a generic remit is the way forward, but needs to have reasonable funding." Ref. 656, 42 yo. f. HPA (generic)

"To move from the 'nanny state' approach to a more participative and innovative interpretation of health." Ref. 774, f. Director of Nursing research & development

- **Local Authority** (28/ 3.6%)

"To grow up and shake off persistent pre-occupation with health education and realise that public policy is in need of expert health input. Maybe move to Local Authority." ref. 258, 23yo m. HPA, substance misuse.
"Close partnership with Local authority, possibly managed through LA. Should be instrumental in changing organisational policy and facilitating new direction." Ref. 548, 36yo. f. manager

- **Public Health** (23/ 3.0%)

"HPO's might be employed by other bodies, such as by Public Health Depts." Ref. 640, 36 yo. f. HPA-youth programmes

- **agency** (16/ 2.1%)

"It will become the dominant theoretical and practice issue for a new kind of health focused agency." Ref 14, 41yro m, manager

- I.T. (3/ 0.4%)

"Health information from central/ regional locations sent to homes and workplaces via the Internet, or on Internet linked TVs with on-screen interaction between the client and the 'expert'." Ref.705, 45 yo. m. SHPA- health information.

Q.19. WHO RESPONDED TO THE QUESTIONNAIRE BY OFFERING TO BE FOLLOWED UP

36 people (5% of the total respondents) offered to be followed up after their questionnaires were received. Due to time constraints, they were not re-questioned, but their questionnaires were transcribed verbatim to give a **'snapshot'** of the respondents.

Label	Frequency	Percent
yes	36	4.7
n/a	738	95.3
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Total	774	100.0

see *Appendices* for statistical profiles and verbatim questionnaires from this group of 36 people.

CHAPTER 8: RESULTS- associations between variables

This section details the findings from the associations between the variables, Chapter 12 discusses these findings.

The variables to be detailed are:

- regions and ethical dilemmas
- job and ethical dilemmas
- job and health promotion qualification
- age and job
- age and health promotion qualifications
- age and highest qualifications
- sex and job
- sex and specific jobs: managers; HIV/ sexual health workers
- sex and qualifications
- sex and health promotion qualifications
- previous work and ethical dilemmas: ex-teachers, ex-nurse, ex-social workers
- SHEPS
- SHEPS and sex
- SHEPS and age group
- SHEPS and Health Promotion qualifications
- SHEPS and model of working
- SHEPS and good points about work
- SHEPS and bad points about work
- SHEPS and ethical dilemmas
- SHEPS and offer to be followed up
- SHEPS and future of Health Promotion
- relationship between bad points and ethical dilemmas

- **regions and ethical dilemmas**

N. East

77 people responded from 11 districts. This region's main ethical dilemmas were NHS **(18.5%), budget (15.3%), misunderstood (11.3%), credibility (9.9%), totalling 55%.** The other responses covered a broad spectrum.

N. West

99 people responded from 21 districts. This region made up the **largest** reponse, **12.8%** of the whole sample's respondents. This region's main ethical dilemmas were: **budget (21.3%), NHS (10.6%), none (10.6%), credibility (8.5%), totalling 51%.** The other responses covered a broad spectrum.

Yorks/ Humberside

54 people responded from 9 districts. This region's main ethical dilemmas were: **working in the medical model (16.7%) credibility (11.9%), misunderstood (11.9%), budget (9.5%), totalling 50%.** The other responses covered a broad spectrum.

E. Anglia

18 people responded from 4 districts. This region's main ethical dilemmas were: NHS **(22.2%), budget (22.2%), working in medical model (11.1%), none (11.1%) totalling 66.6%.** The other responses covered a small spectrum.

E. Mids.

46 people responded from 6 districts. This region's main ethical dilemmas were: NHS **(19.6%), misunderstood (13%), campaigns/ inequalities in health/ being told what to do (all 8.7% each). The first 4 totalled 50%.** The other responses covered a broad spectrum.

Midlands

34 people responded from 5 districts. This region's main ethical dilemmas were: NHS **(23.3%), budget (23.3%), credibility (16.7%), inequlaities/ medical model/ told what to do (all 6.7% each),** the first 4 totalling **70%.** The other responses covered a

smaller spectrum. For the respondents in the Midlands, having ethical dilemmas about NHS **bureacracy/ changes** formed the single largest percentage for a region out of all the regions.

W. Mids

49 people responded from 8 districts. This region's main ethical dilemmas were: **budget (19.1%), NHS (12.8%), credibility (10.6%), campaigns(10.6%), totalling 53.1%.** The other responses covered a broad spectrum.

S. W. Thames

There were 15 districts on the mailing list for this region, 12 in reality as 3 HPUs had different addresses for the same HPU, and 37 people responded from 7 districts. This region's main ethical dilemmas were: NHS **bureacracy/ changes (22.2%), budget (11.1%), being told what to do (11.1%),** and **campaigns (8.3%),** totalling 52.7%. The other responses covered a broad spectrum of responses.

S. E. Thames

39 people responded from 7 districts. This region's main ethical dilemmas were: **credibility (18.9%), NHS bureacracy/ changes (13.5%), budget (13.5%), none (13.5%)** totalling 59.4%. The other responses covered a broad spectrum of responses.

London

95 people responded from 15 districts. This region represented the second largest response (12.3%). This region's main ethical dilemmas were: **budget (18.4%), NHS (11.5%), credibility (9.2%), being told what to do (8%), totalling 47.1%.** The other responses covered a broad spectrum of responses.

S. West

70 people responded from 19 districts. This region's main ethical dilemmas were: **credibility (20%), NHS bureacracy/ changes (12.3%), evaluation (10.8%) and inequalities (9.2%),** totalling 52.3%. For the respondents in the S. West, having ethical dilemmas about **credibility** formed the single largest percentage for a region out of all the regions.

Wales

There were 16 districts on the mailing list for this region, 2 HPUs were from the same district, so there were 15 districts in reality, and 58 people responded from 13 districts. This region's 4 main ethical dilemmas were: **budget (16.7%), credibility (12.5%), NHS bureacracy/ changes (12.5%),** and **campaigns (10.4%)**, totalling **52.1%.**

Scotland

There were 13 districts on the mailing list for Scotland, and 70 people responded from 9 districts. The 4 main ethical dilemmas were: **credibility (13.4%), NHS bureacracy/ changes (10.4%), budget (10.4%); misunderstood (9%)**, totalling **43.2%.**

Channel Islands

There was only 2 districts on the mailing list for the Channel Islands, and 4 people responded. There were no main ethical dilemmas because only 4 people responded, and each one gave a different answer, namely: **targeting, campaigns, credibility and lack of skills.**

Ireland

There were 5 districts on the mailing list for this region (country), and 23 people responded from all 5 districts. However, the range of number of responses was from one person in one HPU to 10 people in another. The 4 main ethical dilemmas were: **misunderstood/ undervalued (16.7%) and 'politics' (16.7%),** and **budget (11.1%) and 'none' (11.1%)**, totalling **55.6%.**

Summary:

Some regions had **far less** HPUs than others, which must have distorted the findings. The **first** 4 ethical dilemmas covered about **50%** of the total reponses for each region, other than **The Midlands** which had **70%** of its responses concentrated on the first four, and **E.Anglia** which had **66%** of its responses concentrated on the first four. **The Midlands** had an unusually figure for **NHS issues** (23.3%), and also **budget** (23.3%). The **S.West** and **SEThames** had unusually high figures for **credibility** (S.West - 20%; SEThames-18.9%), and **Yorks/ Humberside** had unusually high figures for **working in the medical model (16.7%).** (See Discussion section for further debate).

Summary of ethical dilemmas (professional or other) by region

	regions			
	N.East		N.West	
	Count	%	Count	%
others	46	70.8%	64	76.2%
prof.dil	19	29.2%	20	23.8%

	regions			
	Yorks./Humberside		E.Anglia	
	Count	%	Count	%
others	25	62.5%	13	81.3%
prof.dil	15	37.5%	3	18.8%

	regions			
	E.Mids		London	
	Count	%	Count	%
others	31	72.1%	58	70.7%
prof.dil	12	27.9%	24	29.3%

	regions			
	Midlands		W.Mids	
	Count	%	Count	%
others	24	82.8%	31	68.9%
prof.dil	5	17.2%	14	31.1%

	regions			
	SEThames		SWThames	
	Count	%	Count	%
others	19	59.4%	27	79.4%
prof.dil	13	40.6%	7	20.6%

	regions			
	S.West		Wales	
	Count	%	Count	%
others	40	63.5%	32	71.1%
prof.dil	23	36.5%	13	28.9%

	regions			
	Scotland		Channel Islands	
	Count	%	Count	%
others	40	64.5%	3	75.0%
prof.dil	22	35.5%	1	25.0%

	regions	
	Ireland	
	Count	%
others	12	75.0%
prof.dil	4	25.0%

- **job and ethical dilemmas**

does job (seniority) have an impact on stated ethical dilemma?
All the jobs were 'collapsed' into 3 main categories, namely: **Health Promoters** include all Health Promotion Specialists, managers and project workers; **sec/ admin** include resources staff; **'others'** includes medically oriented staff, dietitians, Public Health Specialists.

Correlation between job(summary) and ethical dilemma (summary)

	health promotion jobs			
	health promoters		sec/admin	
Ethical dilemma (summary	Count	%	Count	%
none	24	4.2%	23	20.5%
inequalities	38	6.7%	2	1.8%
work (type of..)	67	11.8%	8	7.1%
NHS issues	259	45.4%	49	43.8%
professional issues	182	31.9%	30	26.8%

	health promotion jobs	
	others	
Ethical dilemma-summary	Count	%
none	3	10.7%
inequalities	1	3.6%
work (type of..)		
NHS issues	16	57.1%
professional issues	8	28.6%

More sec/ admin staff have no ethical dilemmas than Health Promotion Specialists or other staff, Health Promotion Specialists have more ethical dilemmas about professional issues and type of work they are involved in than sec/ admin or other staff, and other staff have more dilemmas about NHS issues than Health Promotion Specialists or sec/ admin.

- **job and health promotion qualification**

is there a relationship between health promotion qualification and seniority?

	HPQUAL			
	none	certificate	diploma	degree
manager	12	6	20	1
Health Promoter	202	50	89	5
support staff	114	22	6	
affiliated staff	16	9	6	

	HPQUAL			
	MSc	PhD	studying for diploma	studying for MSc
	job summary	job summary	job summary	job summary
	Count	Count	Count	Count
manager	27		1	3
Health Promoter	111	1	22	41
support staff	3		2	2
affiliated staff	1			1

Of the **70 managers** who responded to both questions, 30 managers (42.9%) had/ were studying for the **MSc**, but 12 managers (17.1%) had no Health Promotion qualifications, 6 had the certificate and 21 had/ were studying for the Diploma.

Of the **521 Health Promoters** who answered both questions, 202 people (38.8%) had **no** Health Promotion qualifications, 152 (29.1%) had/ were studying for the MSc., 111 (21.3%) had/ were studying for the Diploma.

- age and job

Cross correlations between age and job revealed that the mean age of managers was 42 years, of SHPAs was 38.7 years and of HPAs was 36.8 years. The youngest mean age group was trainee HPAs at 28.5 years, HP researchers at 31.8 years, exercise HPAs at 32.5 years, black/ Asian responsibility HPAs at 33.3 years, mental health responsibility HPAs at 33.4 years, and gay men project workers at 33.7 years. The oldest mean age groups were Senior Public Health Consultants at 50 years, and dental HPAs at 46 years and office managers at 43.8 years. Thus there seems to be a link between seniority and age, although some respondents did not fall into the norm and were somewhat older/ younger than their counterparts. However, the average HPA was 2 years younger than the average SHPA, and the average SHPA was 3 to 4 years younger than the manager. The NHS pays annual increments, up to a 'ceiling' whereby promotion is sought or given, and thus HPAs will often ask for promotion after a particular amount of time, whereas to be promoted from SHPA to deputy manager, or manager would involve a manager vacating their post, and the SHPA being interviewed. However, the data seemed to suggest that it took 2 years to be promoted from HPA to SHPA, and 6 years to go from HPA to manager. This could be seen as quite a quick career route, from junior to senior.

age and health promotion qualifications (767 people answered both questions)

The largest group in the 29 under 25s was 'no health promotion qualification' (21 people/ 72%). The largest group for the 255 25-34 year olds was 'no health promotion qualification' (113 people/ 43.1%), but the second largest group was diploma/ degree (41 people/ 16.1%). The largest group for the 286 35-44 year olds was 'no health promotion qualification' (120 people/ 42%), but the second largest group was MSc (51 people/ 17.9%) and also degree/ diploma (50 people/ 17.5%). The largest group for the 164 45-54 year olds was 'no health promotion qualification' (69 people/ 42%), but 30 people had the degree/ diploma (18.3 %). The largest group for the 33 55-64 year olds was 'no health promotion qualification' (18 people/ 54.5%) but 6 people (18.2%) had the MSc.

age and highest qualifications (745 people answered both questions)

The largest group for highest qualification was14 out of the 27 under age 25's had a degree. Of the 247 25-34 year olds the largest group was degree (131 people/ 44.5%). Of the 280 35-44 year olds, 119 people(42.5%) had a degree. Of the 159 45-54 year olds, 34 people (21.4%) had a degree. Of the 32 55-64 year olds, 9 people (28.2%) had a degree as their highest qualification. Thus it appeared that the majority of the Health Promotion staff had a degree as their highest qualification, regardless of age.

is there a relationship between gender and other variables?

- **sex and job**

(males were 1 in 5 of the whole sample)

	JOB			
	director/ manager	SHPA	HPA	HP assistant
sex				
male	20	8	14	
female	35	24	47	6

	JOB			
	resources	HP trainer	sec/admin	dietitian/ healthy eating HPO
sex				
male	9		2	1
female	45	9	78	25

	JOB			
	trainee HPA	accident prevention	PHC/primary health care/NHS liaison	CHD/cancer
sex				
male	1	1	10	3
female	1	11	39	35

	JOB			
	graphic designer	gay men project	youth/ schools HP/ teacher	HIV/sexual health HP/ outreach-prostitutes
sex				
male	5	9	15	25
female	5	1	39	49

sex and job (continued)

	JOB			
	HP youth worker/ drama	community development	office manager	locality manager
sex				
male	1	3		1
female	10	13	6	21

	JOB			
	campaigns/ bus HPA/media	HP researcher	smoking /project co-ordinator	exercise/ physical activity co-ordinator
sex				
male	1	4	6	2
female	8	6	21	11

	JOB			
	deputy manager	Snr. public health	drugs HP/ substance misuse	mental health
sex				
male	1		8	4
female	14	1	11	10

	JOB			
	workplace/ industry HP	HON co-ordinator	dental HP	black/Asian health
sex				
male	5			1
female	20	4	6	3

males were over-represented in the jobs of manager, HIV workers, graphic designers, gay men projects, PHC, and under represented in dietetics, locality work, drug educators, dentistry.

- **sex and specific jobs**

Managers

	MANAGERS			
	manager		others	
	Count	%	Count	%
male	20	36.4%	140	19.5%
female	35	63.6%	579	80.5%

There was a higher percentage of male managers than other jobs. Despite the fact that the majority (80%) of the workforce are female, as with many professions, there is an over-representation of males as managers. It will subsequently be seen that many people's dissatisfaction at work was centred around their manager (and staff). It may therefore be that the female workers are resentful about their male managers.

HIV/ sexual health workers

	HIVOTHER			
	others		HIV/ sexual health worker	
	Count	%	Count	%
male	136	19.3%	25	33.8%
female	568	80.7%	49	66.2%

There was a higher percentage of male HIV/ sexual health workers than other jobs. HIV/ sexual health workers were a new job to the Health Promotion workforce, and there was an over-representation of males. A predominance of one sex in such a heavily emotional job may have implications for that job.

- **sex and qualifications**

is there a relationship between gender and highest qualification?

	sex			
	male		female	
MA/MSc	20	12.7%	31	5.2%
degree	73	46.2%	237	39.8%
diploma	14	8.9%	30	5.0%
certificate	3	1.9%	6	1.0%
none	4	2.5%	57	9.6%
PhD	5	3.2%	6	1.0%
BEd	2	1.3%	7	1.2%
MBA	1	.6%	2	.3%
C&G			5	.8%
RGN	17	10.8%	93	15.6%
RSA/Secretarial/IT/music			34	5.7%
BTec	2	1.3%	1	.2%
CertEd/PGCE	8	5.1%	18	3.0%
state registered radiographer			1	.2%
C&G 7307			1	.2%
O'Level/GCSEs	3	1.9%	15	2.5%
RNMH			1	.2%
dental quals			8	1.3%
management/health service m'm	3	1.9%	9	1.5%
counselling certificate	1	.6%	1	.2%
SRdietitian			24	4.0%
LAY tutor			3	.5%
CQSW/youth work	2	1.3%	6	1.0%

More males had a degree and an MSC. than females, and more females had an RGN or secretarial qualification. Many females had no qualifications.

	QUALS			
	MA/MSc		degree	
male	20	39.2%	73	23.5%
female	31	60.8%	237	76.5%

	QUALS			
	diploma		certificate	
male	14	31.8%	3	33.3%
female	30	68.2%	6	66.7%

	QUALS			
	none		PhD	
male	4	6.6%	5	45.5%
female	57	93.4%	6	54.5%

	QUALS			
	BEd		MBA	
male	2	22.2%	1	33.3%
female	7	77.8%	2	66.7%

	QUALS			
	C&G		RGN	
male			17	15.5%
female	5	100.0%	93	84.5%

	QUALS			
	RSA/Secretarial/IT/ music		BTec	
male			2	66.7%
female	34	100.0%	1	33.3%

	QUALS			
	CertEd/PGCE		state registered radiographer	
	sex		sex	
	Count	%	Count	%
male	8	30.8%		
female	18	69.2%	1	100.0%

	QUALS			
	C&G 7307		O'Level/GCSEs	
male			3	16.7%
female	1	100.0%	15	83.3%

	QUALS			
	RNMH		dental quals	
male				
female	1	100.0%	8	100.0%

	QUALS			
	management/health service m'm		counselling certificate	
male	3	25.0%	1	50.0%
female	9	75.0%	1	50.0%

	QUALS			
	SRdietitian		LAY tutor	
male				
female	24	100.0%	3	100.0%

	QUALS	
	CQSW/youth work	
male	2	25.0%
female	6	75.0%

- **sex and health promotion qualifications**

is there a relationship between sex and health promotion qualifications?

	sex			
	male		female	
	Count	%	Count	%
none	70	43.5%	277	45.0%
certificate	13	8.1%	75	12.2%
diploma	32	19.9%	89	14.4%
degree			6	1.0%
MSc	30	18.6%	112	18.2%
PhD	1	.6%		
studying for diploma	7	4.3%	18	2.9%
studying for MSc	8	5.0%	39	6.3%

it appears that males and females have similar health promotion qualifications

	HPQUAL			
	none		certificate	
male	70	20.2%	13	14.8%
female	277	79.8%	75	85.2%

	HPQUAL			
	diploma		degree	
male	32	26.4%		
female	89	73.6%	6	100.0%

	HPQUAL			
	MSc		PhD	
male	30	21.1%	1	100.0%
female	112	78.9%		

	HPQUAL			
	studying for diploma		studying for MSc	
male	7	28.0%	8	17.0%
female	18	72.0%	39	83.0%

- **previous work**

Most respondents (**80.1%**) had been in other types of work, with only **11.5%** having been in the health field, and **8%** in the health promotion field previously. The respondents came from the following backgrounds: **15.5%** from **admin/ clerical/ library**; **14.6%** from **education** (teaching/ lecturing)/ training; **14.3% from nursing**. Discounting 'support staff', who had admin./ clerical backgrounds, and made up **15.5%** of job responses, this implies that many (**29.8%**) health promotion respondents came from either education or nursing backgrounds. **75 people (9.9%)** were from **social work/ youth work/ counselling** backgrounds. There was a huge variety of **other previous jobs**, namely, in descending order: dietetics/ dental; research/ computers; sales/ marketing/ journalism; none/student; management; fitness/ exercise/ leisure; environmental health; shop work/ factory; graphic design; self employed; hairdresser/waitress; army.

3 professions are profiled next, namely:
ex-teachers
ex-nurses
ex-social workers

Raw data for these groups can be found in the Appendices

- **Ex-teachers**

761 people answered both the 'current job' and 'previous work' questions. **113 respondents (14.6%) were ex-teachers**, and made up the **second largest group** after Admin/clerical. They were currently more likely to be a **manager** -16.8% (19 people out of 113) compared to 7.7% (50 people/ 648) of the rest of the sample, and were in a variety of different topics and settings. They were somewhat **older**, in the 40-49 age group compared to the average age group of 30-39. 761 people answered both the 'current job' and 'sex' questions. 29 (25.7%) of the 113 ex-teachers were **male** compared to a lower figure of 19.8% of the rest of the sample (128 males out of the 648).

Some quotes from the ex-teachers' ethical dilemmas are:

"I feel disempowered by those who only function in the medical model. Budgets allocated to 'high profile' projects which do little more than raise awareness but which can be counted and a certificate hung on the wall. There is constant change in the NHS and HP within the structure. Conflict between having to satisfy the 'number counters', and carrying out effective meaningful work which might not produce 'real'

evidence for a long time after." Ref. 435, 47 yo. f. HPA- workplace. Previously a ***teacher.***
"Budget restriction- this is my second merge in H.A. changes, too much change hindering the job. Spending money on campaign promotions but not on people, ie. HIV issues. Knowing one target group need information, but how to do so without offending." Ref. 476, 41 yo. f. HPO - sexual health. Previously a ***teacher in a high school.***

"Inability of colleagues to see that I.T. has a relevance and future impact on how we work/ communicate within health promotion. Efficiency savings year-on-year and their impact on work. Having to base majority of energies on Board health targets that are very medically oriented and illness focused. Lack of understanding about 'process' outcomes by general management." Ref.705, 45 yo. m. SHPA- health information. Previously a ***geography teacher***.

"Targeting older men, 50+, effectiveness of campaigns, because each one to be well done could take so much time. Credibility: I work in a hospital setting and there is a degree of territorial attitude from some medical staff. Many people won't start to listen because they think they have all the knowledge/ info. Individual colleagues can be very destructive, while the general ethos is support/ share/ co-operate. Do you 'tell' or just allow them to dominate/ manipulate?" Ref. 751, 55 yo. f. Health Promotion Officer for Older People. Previously a ***teacher.***

Ex-teachers and ethical dilemmas

111 of the 113 ex-teachers answered both the 'previous work' and 'ethical dilemmas' questions. Their main ethical dilemmas were: **NHS issues** (18 people/ 16.2% of this group), **budget** (13 people/ 14.4% of this group), and **credibility** (12 people/ 10.8% of this group), which is the **same order** and similar percentages as the rest of the 589 people who answered both questions.

As can be seen, <u>no pattern</u> of ethical dilemmas seemed to have emerged from the group termed 'ex-teachers'.

- **Ex-nurses**

761 people answered both the 'current job' and 'previous work' questions. **141 ex-nurses** answered both, and were a predominantly **female group**, with only 17 (12.1%) being male, compared to 140 (21.6% males) of the rest of the sample. The ex-nurses were in the **same average age group** of 30-39 years as the rest of the sample.

Some quotes from the ex-nurses' ethical dilemmas are:
"Coming from a professional background of psychiatric nursing, I recognise the importance that cigarettes play in the lives of people in mental distress. I feel it is cruel to enforce no smoking policies in hospitals and recognise people's need to smoke. Of course, this goes against the grain and in my role as HPO I have to toe the line so to speak, even though I don't agree. I think we need to move away from traditional medical settings and get into more collaborative working with many organisations." Ref. 177, 32 yo. f. HPA - cancers. Previously an ***RMN.***

"Health Promotion is still very poorly understood outside of the profession and its status (and hence expectations) are low outside of the health sector. The main challenge remains inequalities in health and poverty. Even with a change in government, this agenda needs resourcing and legitimising for effective action to take place. The lack of resources for development of policy and services remains very problematic. Money can be obtained for research but not for implementing good practice unless it can be withdrawn from other services. This is very difficult when all services are cut to the bone." Ref 180, 41 yo. f., SHPA- children and young people. Previously a ***midwife and occupational health nurse.***

"Lack of credibility in doctor's eyes. Internal politics and budgeting between NHS trusts. Lack of strategic thinking at local and national level. Much of what we do is ineffective in the lower socio-economic groupings and there is too much doing for the sake of being seen to do rather than evidence based work." Ref. 436, 47 yo m., SHPO - substance misuse. Previously an ***RGN.***

"A coherent framework for career advancement is missing in Health Promotion. Credibility. Constant battle to carve out a unique role for HP, particularly important to safeguard the Unit I work in from being cut financially or disbanded. Are we best placed as purchasers of health promotion or providers? There is a role confusion in Hp in general at present. I have no particular dilemmas with my role in drug and alcohol education. I do drink but I am not anti-alcohol. I feel that members of the NHS workforce and general population, however, do think we should be role models of fit and healthy specimens. I do not believe this needs to be so, but I would still have some credibility difficulties leading sessions on exercise and healthy eating!" Ref. 630, 35 yo. m. HPA (drug education). Previously an ***RGM, RMN, drugs counsellor.***

"I am a jack of all trades and master of none, but I have no ethical dilemmas with my work." Ref. 656, 42 yo. f. HPA (generic) Previously a ***midwife, SCM.***

"Changes in Scotland post- Shields report entirely damaging. Political appointees in management with no insight into what the dept. is trying to do. Shift in emphasis imposed on depts. from community empowerment and positive health philosophy to disease management and 'thou shalt not... '. The conflict between the ethics which I believe in and what I am ordered to do- not by HP manager, but by Board management/ director of Public Health. Our health needs assessment documents are just ignored." Ref. 708, 33 yo. m. HPA- young people. Previously a ***psychiatric nurse, RMN.***

"Poor management of health care practitioners. Lack of resources (low GNP contribution to .... Health Service.) Confidentiality." Ref. 774, f. Director of Nursing research & development. Previously an *RGN, RPN.*

Ex-nurses and ethical dilemmas

106 of the 141 ex-nurses answered both 'previous job' and 'ethical dilemma' questions. The ex-nurses' main ethical dilemmas were: **NHS issues** -20 people (18.9% of ex-nurses), **budget** -15 people (14.1%), and **misunderstood/ undervalued** -11 people (10.4 %). These responses were **similar** to the whole of the sample, whose ethical dilemmas were (in order) **budget allocations** (103 people/ 13.3%), **NHS/ bureacracy/ changes** (97 people/ 12.5%), and **credibility/ low status** (80 people/ 10.3%).

Thus the ex-nurses' ethical dilemmas still focused on how the NHS and the budgets were impacting on health.

- **Ex-social workers/ youth workers/ counsellors (caring professions)**

761 people answered both the 'current job' and 'previous work' questions. **75 people (9.9%) were from social work/ youth work/ counselling backgrounds**. There were 54 females (72%) and 21 males (28%), which is a greater proportion of males compared to the rest of the whole sample (80% female: 20% male), and greater than the proportion of male: female in ex-teachers. The vast majority of this group had been in post for less than five years. 27% were male, whereas 20% of the rest of the respondents were male. 50% of the ex-social workers were in their thirties, compared to 39% of the rest of the respondents, and 26.3% were in their twenties, whereas 17% of the rest of the group were.Nearly a third (28.9%) of the ex-social workers were currently working in the HIV/ sexual health field, 7.9% were general HPAs (compared to 7.8% of others), 6.6% worked in the drugs/ substance misuse field, (compared to 2% of others), none worked in secretarial/ admin jobs nor were managers.

ethical dilemmas summarised of ex-social workers

The ex-social workers' ethical dilemmas were **credibility (15.5%), inequalities in health (14.1%), budget (12.7%),** and NHS issues appearing much further down their list, mentioned first by only 7%. Thus ex-social workers were having **very different** ethical dilemmas to their colleagues.

Some quotes from the ex-social workers' ethical dilemmas are:

" How effective are one-off events? Relationship between Public Health and department not that good! Poor communication. Not having enough budget for specific projects we want to develop. Have to do Health Fayres for Trust's AGM, totally disagree with them! The exercise bike- I hate it." ref.146, 31yo f. HPA. Previously a ***hospital social worker.***

"Credibility with health professionals. World AIDS Day over-funded and dull, but colleagues don't agree." ref 377, 27 yo. m. HPA - sexual health. Previously a ***youth worker.***

"HPU placed with purchaser- little chance to do provider work. Lip service paid to inequalities in health and health for all. Medical/ clinical staff couldn't give a toss about HP, fundamentally they don't understand the concepts. World AIDS Day keeps coming around with its good intentions, but I'm Bored of it, and the impact it makes with us is small." Ref. 414, 31 yo. f. HPA - sexual health. Previously a ***youth worker.***

Summary:

The ex-teachers' main ethical dilemmas were: NHS issues (16.2% of this group), budget (14.4%), and credibility (10.8%), which is the same order and similar percentages to the general pattern of firstly NHS, budget and then credibility. But no pattern of ethical dilemmas seemed to have emerged to distinguish 'ex-teachers'from the rest of the sample. The ex-nurses' main ethical dilemmas were: NHS issues (18.9% of ex-nurses), budget (14.1%), and misunderstood/ undervalued (10.4 %). This group's ethical dilemmas were similar to the general pattern of firstly NHS, budget and then credibility. But no pattern of ethical dilemmas seemed to have emerged 'ex-nurses' from the rest of the sample. The ex-social workers' ethical dilemmas were credibility (15.5%), inequalities in health (14.1%), budget (12.7%). Thus ex-social workers were having very different ethical dilemmas to their colleagues. Thus, ex-social workers could be identified as a group but ex-nurses and ex-teachers were broadly similar as groups to the whole sample.

- **membership of SHEPS**

	SHEPS	
	Count	%
yes	154	19.8%
no	499	64.1%
n/a	125	16.1%

154 (19.8%) of respondents were **members** of SHEPS, but the majority (64%) of respondents (495 people) **did not** belong to SHEPS, and 125 people (16.1%) stated the question was not applicable. These were mostly admin/ clerical staff. When these respondents were discounted, this left 649 applicable respondents, changing the figures to154 SHEPS members out of 649 health promoter respondents, or **23.7 % being a member of SHEPS**, and **76.3% not being members.**

As 154 respondents were members of SHEPS, and the national figures for membership were about 500 when the research was conducted, then about one third of SHEPS members responded.

SHEPS and job

	SHEPS			
	yes		no	
	Count	%	Count	%
director/manager	28	18.2%	26	5.2%
SHPA	7	4.5%	25	5.0%
HPA	15	9.7%	46	9.2%
HP assistant			4	.8%
resources	4	2.6%	15	3.0%
HP trainer	1	.6%	8	1.6%
sec/admin			18	3.6%
dietitian/healthy eating HPO	2	1.3%	11	2.2%
trainee HPA			2	.4%
accident prevention	4	2.6%	8	1.6%
PHC/primary health care/NHS liaison	15	9.7%	34	6.8%
CHD/cancer	12	7.8%	26	5.2%
graphic designer			3	.6%
gay men project			10	2.0%
youth/schools HP/ teacher	18	11.7%	36	7.2%
HIV/sexual health HP/outreach-prostitutes	8	5.2%	66	13.2%
HP youth worker/drama	2	1.3%	9	1.8%
community development	2	1.3%	14	2.8%
office manager	2	1.3%	1	.2%
locality manager	4	2.6%	18	3.6%
campaigns/bus HPA/media			9	1.8%
HP researcher			10	2.0%
smoking /project co-ordinator	5	3.2%	21	4.2%
exercise/physical activity co-ordinator	1	.6%	12	2.4%
deputy manager	9	5.8%	6	1.2%
Snr. public health drugs HP/substance misuse	2	1.3%	17	3.4%
mental health	4	2.6%	10	2.0%
workplace/industry HP	6	3.9%	19	3.8%
HON co-ordinator	1	.6%	3	.6%
dental HP	2	1.3%	4	.8%
black/Asian health			8	1.6%

(continued)

	SHEPS	
	n/a	
	Count	%
director/manager	1	.8%
SHPA		
HPA		
HP assistant	2	1.6%
resources	35	28.0%
HP trainer		
sec/admin	62	49.6%
dietitian/healthy eating HPO	13	10.4%
trainee HPA		
accident prevention		
PHC/primary health care/NHS liaison		
CHD/cancer		
graphic designer	7	5.6%
gay men project		
youth/schools HP/ teacher		
HIV/sexual health HP/outreach-prostitutes		
HP youth worker/drama		
community development		
office manager	3	2.4%
locality manager		
campaigns/bus HPA/media		
HP researcher		
smoking /project co-ordinator	1	.8%
exercise/physical activity co-ordinator		
deputy manager		
Snr. public health	1	.8%
drugs HP/substance misuse		
mental health		
workplace/industry HP		
HON co-ordinator		
dental HP		
black/Asian health		

SHEPS and sex

	sex	
	male	female
SHEPS		
yes	26	128
no	125	370
n/a	9	116

Of the 154 people who were members of SHEPS, 26 respondents (16.9%) were male, and **128 (83.1%) were female.** 125 males and 370 females were not, and 9 males and 116 females felt the question not applicable. The SHEPS males constituted 16.9% of SHEPS respondents, whereas the males for the whole sample constituted 21%. Thus SHEPS is even more predominantly female than the female predominated profession as a whole.

SHEPS and age group

	SHEPS	
	n/a	
	agegrp	
	Count	%
-20	1	.8%
20-29	24	19.4%
30-39	37	29.8%
40-49	34	27.4%
50-59	28	22.6%
60+		

SHEPS and Health Promotion qualifications

	HPQUAL			
	none	certificate	diploma	degree
SHEPS				
yes	29	14	30	1
no	220	50	88	5
n/a	95	23	3	

	HPQUAL			
	MSc	PhD	studying for diploma	studying for MSc
SHEPS				
yes	59		9	12
no	83	1	14	34
n/a			2	1

773 people answered both the membership of SHEPS question and the HP qualification questions. Of the 154 SHEPS members, **59 respondents (38%) had the MSc.**, 30 (19%) had the Diploma. Of the 495 non members of SHEPS, 83 respondents (16.8%) had the MSc. and 88 (17.7%) had the Diploma. 12 people studying for the MSc were SHEPS members, but 34 people were not members, and a similar picture for those studying for the Diploma with 9 people being members of SHEPS and 14 not. Those 274 people who had **no** HP qualification consisted of 29 members of SHEPS (11%), 220 non members, and 25 n/a's.

SHEPS and model of working

	MODEL			
	medical	behaviour change	educational	social change
SHEPS				
yes	1	9	4	13
no	1	39	28	24
n/a		4	4	1

	MODEL			
	client directed	harm minimisation	all	varies
SHEPS				
yes	3	1	10	76
no	32	4	31	196
n/a	5		3	14

	MODEL			
	Ottawa Charter	community development	no	n/a
SHEPS				
yes	4	11	5	14
no	7	21	12	79
n/a			6	83

Of the 154 SHEPS members, the single largest model was: varies (76 respondents/ 49%), social change (13 people/ 8%), community development (11 people/ 7%), and all (10 people/ 6%). Of those who stated they were not members, varies was the largest category (196 respondents/ 40%), followed by behaviour change (39 people/ 8%), client directed (32 people/ 6%), and all (31 people/ 6%). Thus it is interesting that SHEPS members are concerned about **policy** and **empowerment**, whereas their non member colleagues are concerned about behaviour change.

SHEPS and good points about job

	SHEPS			
	yes		no	
autonomy	43	29.3%	67	14.3%
clients/public	6	4.1%	32	6.8%
variety	31	21.1%	98	20.9%
interesting/enjoyable	8	5.4%	32	6.8%
useful/worthwhile/ important	9	6.1%	22	4.7%
colleagues/manager/staff	10	6.8%	63	13.4%
environment/location	1	.7%	7	1.5%
none	1	.7%	2	.4%
prevention/make changes	10	6.8%	22	4.7%
opportunities/training	3	2.0%	10	2.1%
teamwork/interagency work	9	6.1%	22	4.7%
action/progressive	2	1.4%	8	1.7%
creativity	3	2.0%	3	.6%
rewarding/challenging/ good at job	3	2.0%	27	5.8%
flexibility/flexitime/ stress free	6	4.1%	45	9.6%
don't know			4	.9%
pay/hours	2	1.4%	5	1.1%

	SHEPS	
	n/a	
autonomy	4	3.8%
clients/public	16	15.4%
variety	26	25.0%
interesting/enjoyable	12	11.5%
useful/worthwhile/ important	6	5.8%
colleagues/manager/staff	11	10.6%
environment/location	7	6.7%
none		
prevention/make changes	2	1.9%
opportunities/training	2	1.9%
teamwork/interagency work	6	5.8%
action/progressive		
creativity		
rewarding/challenging/ good at job	1	1.0%
flexibility/flexitime/ stress free	6	5.8%
don't know		
pay/hours	5	4.8%

The main good points about their work for SHEPS members were: **autonomy** (43 people/ 29.3%), **variety** (31 people/ 21.1%), **colleagues** (10 people/ 6.8%), and **making change** (10 people/ 6.8%). This was somewhat **different** to the non-members' good points of **variety** (98 people/ 20.9%), **autonomy** (67 people/ 14.3%), **colleagues** (63 people/ 13.4%), flexibility (45 people/ 9.6%). The three main good points for SHEPS members made up % of the total, whereas the non-members first three good points made up % of the total, and the remaining good points were more evenly spread. Although the good points of autonomy and colleagues were mentioned by both, they were substantially different percentages, ie. autonomy was important for nearly a third (29%) of the SHEPS members, but only 14% of the non-members, and colleagues. Flexibility was a good point for 9.6% of non-members, but only to 4.1% of members. In addition, colleagues were important to 13% of non-members, but only to 7% of members However, variety was important to 21% of both members and non-members.

SHEPS and bad points about work

	SHEPS			
	yes		no	
pay/temp.contract/hours	16	11.1%	40	8.7%
Bureacracy	37	25.7%	126	27.3%
no training/direction	9	6.3%	27	5.8%
no career path/promotion prospects/short contract	1	.7%	8	1.7%
budget/funding	10	6.9%	28	6.1%
colleagues/staff/ "politics"	7	4.9%	15	3.2%
effectiveness/waste of time/evaluation	2	1.4%	14	3.0%
no status/power/poor image/fragmentation/ isolation	7	4.9%	22	4.8%
pressure/stress/workload	23	16.0%	67	14.5%
not valued/misunderstood/ not supported	7	4.9%	23	5.0%
meetings			2	.4%
practicalities/ resources/conditions	7	4.9%	10	2.2%
remit too big	1	.7%	12	2.6%
workplace/travelling	3	2.1%	8	1.7%
don't know			4	.9%
medical/disease focused	3	2.1%	9	1.9%
need to be motivated/low morale/boring	3	2.1%	19	4.1%
inequalities in health			3	.6%
purchaser conflicts/constraints	5	3.5%	14	3.0%
none	2	1.4%	4	.9%
understaffed			2	.4%
training others/ no contact-public			2	.4%
working with under 16's/homophobia	1	.7%	3	.6%

(continued)

	SHEPS	
	n/a	
pay/temp.contract/hours	4	3.8%
Bureacracy	27	25.7%
no training/direction	5	4.8%
no career path/promotion prospects/short contract	4	3.8%
budget/funding	8	7.6%
colleagues/staff/ "politics"		
effectiveness/waste of time/evaluation	1	1.0%
no status/power/poor image/fragmentation/ isolation	5	4.8%
pressure/stress/workload	26	24.8%
not valued/misunderstood/ not supported	7	6.7%
meetings		
practicalities/ resources/conditions	8	7.6%
remit too big	1	1.0%
workplace/travelling	2	1.9%
don't know		
medical/disease focused		
need to be motivated/low morale/boring	3	2.9%
inequalities in health	1	1.0%
purchaser conflicts/constraints		
none	1	1.0%
understaffed	1	1.0%
training others/ no contact-public	1	1.0%
working with under 16's/homophobia		

The 154 SHEPS respondents were most concerned about bureacracy (24%), pressure (15%), pay (10%). The non-SHEPS respondents were most concerned about bureacracy (26%), pressure (14%), pay(8%). Thus the SHEPS and non-SHEPS respondents were overall describing the **same bad points about work.**

SHEPS and ethical dilemmas

	SHEPS			
	yes		no	
none	6	3.9%	25	5.4%
inequalities in health/root causes	12	7.9%	28	6.0%
campaigns/short term proj./sponsorship/ media coverage	11	7.2%	32	6.9%
targeting	2	1.3%	9	1.9%
budget allocations/ understaffed/ resourcing/income gen.	20	13.2%	70	15.0%
victim blaming			5	1.1%
credibility/low status	19	12.5%	53	11.4%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	6	3.9%	20	4.3%
job description changes/no career development	2	1.3%	7	1.5%
policies effectiveness/or not	8	5.3%	19	4.1%
NHS/bureacracy/changes/ cuts/arguments	20	13.2%	60	12.9%
lack of skills/communication probs	2	1.3%	20	4.3%
medical model/NHS/GP interference/P&P/HON	15	9.9%	22	4.7%
misunderstood/ undervalued	9	5.9%	30	6.4%
condoms to under age/harm minimisation/ sexuality	4	2.6%	7	1.5%
too many to list			2	.4%
being a role model			5	1.1%
theory vs. practice	1	.7%	6	1.3%
evaluation/evidence needed	6	3.9%	13	2.8%
told what to do/hidden agendas/interagency work/conspiracy	9	5.9%	28	6.0%
time			3	.6%
breadth of role/pressure			2	.4%

	SHEPS	
	n/a	
none	20	21.1%
inequalities in health/root causes	1	1.1%
campaigns/short term proj./sponsorship/ media coverage	3	3.2%
targeting		
budget allocations/ understaffed/ resourcing/income gen.	13	13.7%
victim blaming		
credibility/low status	8	8.4%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	4	4.2%
job description changes/no career development	7	7.4%
policies	1	1.1%
effectiveness/or not	1	1.1%
NHS/bureacracy/changes/ cuts/arguments	17	17.9%
lack of skills/communication probs	3	3.2%
medical model/NHS/GP interference/P&P/HON		
misunderstood/ undervalued	9	9.5%
condoms to under age/harm minimisation/ sexuality	1	1.1%
too many to list		
being a role model	1	1.1%
theory vs. practice		
evaluation/evidence needed	2	2.1%
told what to do/hidden agendas/interagency work/conspiracy	3	3.2%
time	1	1.1%
breadth of role/pressure		

ethical dilemmas

The 154 SHEPS respondents were most concerned about **budget** allocation (20 people/ 13%), NHS bureacracy/ changes (20 people/ 13%), and **credibility** (19 people/ 12%). The 495 non-SHEPS respondents were most concerned about **budget** allocation (70 people/ 14%), NHS bureacracy/ changes (60 people/ 12%), and **credibility** (53 people/ 11%). Thus the SHEPS and non-SHEPS respondents were overall describing having the **same ethical dilemmas** and in the **same proportions.**

SHEPS and dilemmas summarised

Count	SHEPS yes 0	no 1	n/a 2	Row Total
DILSUM .00 none	6	24	20	50 7.0
1.00 inequalities in	12	28	1	41 5.8
2.00 type of work	17	53	5	75 10.6
3.00 NHS issues	72	207	45	324 45.6
4.00 professional iss	45	151	24	220 31.0
Column Total	152 21.4	463 65.2	95 13.4	710 100.0

SHEPS and offer to be followed up

	FOLLOWUP
	yes
SHEPS	
yes	9
no	25
n/a	2

36 people offered to be followed up after the questionnaire, and 9 (25%) of those were SHEPS members, 25 (69%) were not, and 2 (6%) felt SHEPS membership was not applicable. Thus the people who offered to help after the questionnaire were in the same proportion for non-SHEPS members, but less SHEPS not applicables offered, and more SHEPS members offered than was their proportion of the whole group.

SHEPS and future for Health Promotion

	SHEPS			
	yes		no	
Purchaser	2	1.3%	2	.4%
new Government-positive	32	21.2%	64	13.5%
don't know	21	13.9%	77	16.3%
Local Authority/ Environmental Health	9	6.0%	16	3.4%
Public Health	7	4.6%	16	3.4%
policy/strategy/in all jobs	8	5.3%	23	4.9%
to be more professional	17	11.3%	57	12.1%
positive	14	9.3%	53	11.2%
community development/ empowerment/locality	7	4.6%	35	7.4%
bleak/poor	14	9.3%	35	7.4%
PHC/ NHS/medical model	7	4.6%	38	8.0%
trainers	1	.7%	5	1.1%
get/need larger budget	1	.7%	12	2.5%
health agencies/projects	4	2.6%	10	2.1%
Provider/Commissioning	1	.7%	5	1.1%
social model/ Ottawa Charter	3	2.0%	7	1.5%
effectiveness;to be seen as effective/evidence based	3	2.0%	13	2.7%
computer/IT/internet			2	.4%
targeting			3	.6%

(continued)

	SHEPS	
	n/a	
Purchaser		
new Government-positive	12	13.3%
don't know	21	23.3%
Local Authority/ Environmental Health	3	3.3%
Public Health policy/strategy/in all jobs	3	3.3%
to be more professional	8	8.9%
positive	14	15.6%
community development/ empowerment/locality	3	3.3%
bleak/poor	10	11.1%
PHC/ NHS/medical model trainers	4	4.4%
get/need larger budget	4	4.4%
health agencies/projects	2	2.2%
Provider/Commissioning social model/ Ottawa Charter effectiveness;to be seen as effective/evidence based	4	4.4%
computer/IT/internet	1	1.1%
targeting	1	1.1%

- **relationship between bad points and ethical dilemmas**

(see appendices for raw data)

673 people answered both the bad points and ethical dilemmas questions. (106 people/ 13.6% were missing.)
some bad points and some ethical dilemmas were listed by many (more than 10) people:

- **bureacracy**

33 people stated that **bureacracy** was their **bad point** about work and also stated that **bureacracy** was their **ethical dilemma**. (This represents 5% of the 673 people who answered both questions.)
21 people stated that **bureacracy** was their **bad point** about work and that **credibility** was their **ethical dilemma**.
21 people stated that **bureacracy** was their **bad point** about work and that **budget allocation** was their **ethical dilemma**.
14 people stated that **bureacracy** was their **bad point** about work and that **being misunderstood** was their **ethical dilemma**.
13 people stated that **bureacracy** was their **bad point** about work and that they had **no ethical dilemmas**.

Thus those whose bad point about work was bureacracy had ethical dilemmas about bureacracy, credibility, budget allocations, being misunderstood and none.

- **pressure/ stress**

18 people stated that **pressure/ stress** was their bad point about work and that **budget allocations** was their **ethical dilemma**.
15 people stated that **pressure/ stress** was their bad point about work and that **NHS issues** was their **ethical dilemma**.

Thus those whose bad point about work was pressure/ stress had ethical dilemmas about budget allocations and NHS issues.

- **budget allocations**

12 people stated that **budget allocations** were their bad point about work and also that it was their **ethical dilemma**.

- **pay**

13 people stated that pay was their bad point about work and that budget allocations was their ethical dilemma.
When the bad points and the ethical dilemmas are both grouped the following picture emerges:

Table showing the relationship between bad points summarised and ethical dilemmas summarised

dilemmas summary

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
none	.00	51	6.5	7.2	7.2
inequalities in heal	1.00	41	5.3	5.8	12.9
type of work	2.00	77	9.9	10.8	23.7
NHS issues	3.00	324	41.6	45.4	69.1
professional issues	4.00	220	28.2	30.9	100.0
	.	66	8.5	Missing	
	Total	779	100.0	100.0	

Valid cases 713 Missing cases 66

bad points summary

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
NHS	1.00	355	45.6	50.4	50.4
prof.issue	2.00	318	40.8	45.2	95.6
people	3.00	13	1.7	1.8	97.4
don't know	4.00	14	1.8	2.0	99.4
none	5.00	4	.5	.6	100.0
	.	75	9.6	Missing	
	Total	779	100.0	100.0	

Valid cases 704 Missing cases 75

NHS issues are the main bad point for 45.6% of respondents, and an ethical dilemma for 41.6%. In addition, professional issues are a bad point for 40.8% of respondents and an ethical dilemma for 28.2%.

The next table shows if there is a relationship between bad points about the job and ethical dilemmas.

dilemmas summary by bad points summary

DILSUM	Count	BADPTSUM NHS 1.00	prof.issue 2.00	people 3.00	don't know 4.00	none 5.00	Row Total
.00 none		21	21	2			44 6.6
1.00 inequalities in		17	16		2	2	37 5.6
2.00 type of work		36	26	2	1	1	66 9.9
3.00 NHS issues		155	140	3	5	1	304 45.6
4.00 professional iss		109	96	5	5		215 32.3
	Column Total	338 50.8	299 44.9	12 1.8	13 2.0	4 .6	666 100.0

Number of Missing Observations: 113

666 people responded to both questions about bad points about the job and ethical dilemmas, 113 were missing. **There is obviously a relationship between bad points and ethical dilemmas emerging. 500 people (75% of the 666 people) described NHS issues or professional issues as either an ethical dilemma or a bad point about work.**

155 people who listed NHS issues as a bad point also listed it as an ethical dilemma, and 96 people's bad point being a **professional issue** was also an ethical dilemma. But also, 140 people whose bad point about work was a professional issue had an ethical dilemma about NHS issues, and similarly, 109 people whose bad point about work were NHS issues had a professional issue as their ethical dilemma.

The following will be discussed: the respondents and each of the ethical dilemmas in detail.
(The next chapter will discuss the relationship between the variables, and the relationship between specific variables and ethical dilemmas.)

The respondents

- **job**

People were asked 'what is your job' (Q.1) and also 'what is your main area of work' (Q.7). Most people put the same answer for both questions, so the answers to questions 1 and 7 were subsequently combined. For example, in Q1 a respondent would put down HPA (generic), and in Q7, they would state 'work in all health topics', or in Q1 state 'dietitian' and in Q7, state' healthy eating advisor'. However, some people gave a job title that seemed to slightly differ from the work content that they described, so the job title given was the one noted. For example, someone might state that their work was CHD advisor, but only discuss smoking issues on their questionnaire. As previously described in the Results section, the largest response was from 80 secretarial /admin. staff, (10.3% of the responses), 74 HIV/ sexual health Promotion advisors (9.6%), 61 (general) Health Promotion Advisors (7.9%) and 55 directors/ managers, (7.1%).

The four main groups of respondents are discussed individually:

- **secretarial /admin. staff**

The largest response was from **80 secretarial /admin. staff,** who constituted **10.3%** of the responses. It may have been that these people were the ones who opened the questionnaires initially. Some respondents put a comment on their returned questionnaire that 'it was nice for support staff to be asked to respond'. It was a problem that a number of support staff only filled in page 1's factual rather than page 2's opinion based questions, which has distorted the 'no response' section of the questions, eg. ethical dilemmas, or good/ bad points about their job. Support staff particularly mentioned on the questionnaire that their responses must remain confidential, and some stated that they hadn't filled in the opinion based section because of worries about who would be reading the responses. It is disheartening to see that so many secretarial /admin. staff were nervous about filling in an anonymous questionnaire in case their manager read it.

- **HIV/ sexual health promotion advisors**

The **second** largest group of respondents was **74 HIV/ sexual health** Promotion advisors (**9.6%**). This group of respondents often filled in additional comments, eg. along the margin of the questionnaire and gave 'full' answers. It may be that this group of respondents felt strongly about their work or client groups, due to the sensitive nature of their work. In addition, it will be revealed later that the budget allocated to this group was a cause for concern to many of their colleagues in other areas of Health Promotion, so perhaps this group of workers felt 'different' or pressurised.

- **(general) Health Promotion advisors**

The **third** largest group of respondents was **61 (general) Health Promotion advisors** (**7.9%**). Many respondents were Health Promotion advisors, but specified their topic area or locality, for example some respondents stated 'SHPA', some stated SHPA (smoking issues), some stated SHPA (CHD). It was difficult to re-categorise people eg. a respondent who stated they were the drugs prevention advisor may have been a SHPA or a HPA. Respondents were thus categorised according to the respondent's own labelling of themselves. (However, when all Health Promotion Advisors and Senior Health Promotion Advisors were grouped according to 'rank' rather than topic or speciality, this group actually constituted **67%** of the respondents.)

- **directors/ managers**

The **fourth** largest group was **55 directors/ managers**, who constituted **7.1%** of the response rate. It was encouraging for the author to see that so many directors/ managers responded to this national survey, compared to the fewer numbers who responded to the regional pilot survey. Managers may often be too busy to respond to questionnaires, but the design of this one was intentionally brief in format, so that people could fill the questionnaire in relatively quickly. Although the majority of the 774 respondents were female ( ), the 55 managers had a greater proportion of men (36.4% male, 63.6% female). Managers' previous work tended to be health (27.8% compared to 10.5% of the other respondents), Health Education/ Promotion (18.5% compared to 7.4% of the rest of respondents), teaching/ education (22.2% compared to 14.3% of the rest of respondents), and they only came from 10 different work backgrounds, compared to 19 for the rest of respondents.

other jobs

There were responses from a large variety of other jobs, (see Results section for complete list), including resources staff, CHD/ cancer educators, smoking project

co-ordinators, dietitian/ healthy eating advisors, workplace/ industry HPA, locality manager, drugs HP/ substance misuse, mental health worker, exercise/ physical activity advisor, accident prevention advisor, youth worker/ drama co-ordinator, graphic designer, gay men project, researcher, trainer, campaigns/ bus HPA, dental HPA, black/ Asian health. Some of these jobs were quite new, because of the new (at the time) Health of The Nation priorities, eg. Accident Prevention, CHD/ cancer educators, and some could be seen as quite innovative, an they were in smaller numbers too, eg. drama co-ordinators, black/ Asian health. Thus although some responses from HPUs were only from the manager, or only from HPAs, the overall picture that emerged was that people responded from all ranks and all topic areas. Thus, the job titles were summarised into 6 groups, namely manager (9%), SHPAs (24.3%), HPAs (8.1%), support/ resources staff (20.2%), medical workers (12.4%), and community development/ outreach/ project managers (26%). This could be summarised as three-quarters were health promoters, one fifth were sec/admin., and a small number of 'others'. The respondent figures represent the 'make-up' of the 'standard' Health Promotion Unit, rather than only represent those who tend to fill in questionnaires. It became obvious that Health Promotion Units were employing a wide range of workers whose main job focus, ie. Health Promotion was being used as a perhaps too all encompassing 'umbrella' term.

Now that the respondents have been described and discussed, the next section focuses on the main focus of the research, namely the ethical dilemmas these respondents were reporting:

ethical dilemmas

As previously described in the Method section, the questionnaire asked people to offer suggestions for main ethical dilemma, and **23 different ones** were cited. These were noted as they were given and then 'labelled' under headings. **660 people** (85%) listed/ described their ethical dilemmas. To recap from the Results section, the 3 **most frequent** ethical dilemmas listed were: **budget** (103 people/ 13.3%), **NHS/ bureacracy/ changes** (97 people/ 12.5%), and **credibility/ low status** (80 people/ 10.3%). These are quite similar figures for each, with the remaining ethical dilemmas being of a much lower percentage of the whole group. In addition, 64 people (8.3%) **did not answer** the question and 50 people (6.5%) stated that they had **no ethical dilemmas**. The ethical dilemmas listed were then quite evenly spread with between 4.8% and 6.2% for the following: **misunderstood/ undervalued, campaigns/ short term effectiveness, inequalities in health, being told what to do/ hidden agendas, working in the medical model/ NHS/ with GPs**. The following ethical dilemmas listed were then quite evenly spread with between 0.1% and 3.9% of the respondents listing the following as their main concern: **'politics', being effective/ or not, lack of**

skills/ communication, evaluation/ evidence, job description changes, condoms to under age, targeting, theory vs. practice, being a role model, victim blaming, time, too many to list, breadth of role/ pressure, policies.

Thus, it appears at first, that the respondents were all having different ethical dilemmas. However, when they were grouped under similar issues, a trend appeared. **NHS issues** were listed first by 324 people (41.9%), **professional issues** by 219 people (28.3%), **type of work carried out** by 75 people (9.7%), **inequalities in health** by 41 people (5.3%), and 114 people had no ethical dilemmas or did not answer the question. (see later section for discussion of these issues).

It was interesting to read the ethical dilemmas people described. Some just wrote a few key words, others wrote at great length. Transcriptions of some representative ethical dilemmas were given in the Results section.

Each ethical dilemma is next discussed individually:

- **budget**

budget was the **most frequent** listed ethical dilemma and was the main issue for 103 people/ 13.3% of respondents. The research was conducted at the time of the height of the HIV/AIDS media scares, and many/ most HPUs had massive 'injections' of cash for awareness raising of this topic. During the same year, Labour had won the General Election and were promising radical reforms for the Health Services, but the 'medical model' Health of The Nation had recently been implemented and created many changes in the way HPUs worked and who they were newly responsible to.

Many people just stated that budget was an ethical dilemma but did not explain the issue, as if it were obvious that budget issues were self explanatory dilemmas to some extent, eg. Ref 359, a 38 year old female SHPA (schools) simply wrote *"lack of resources, money, computer access, support staff time"*, and Ref 238, 32 year old male manager bluntly writing *"Disinvestment"* as his ethical dilemma. Many respondents wrote about the money allocated to Health Promotion as being too small to run the service, eg. Ref. 35, a 36 year old male gay men's project worker stated that *"The money given is not sufficient to run such a service."*, echoed by Ref 308, a 50 year old female bus/ campaigns co-ordinator who stated that *"Limited staffing budget prevents expansion of a very popular service."*, and Ref. 34, a 47 year old female SHPA (CHD) stated that *"Lack of finance limits what we can offer."*

People were also complaining about the way that money was manipulated or 'moved around' perhaps from its intended audience, eg. Ref. 389, a 38 year old female

community dietitian who stated that *"In the past, nutrition health promotion money has been diverted into clinical work as its easier to justify numbers seen when there are waiting lists"* and Ref. 477, (38yo. f. HPO - localities) suggested that people were having to 'fight' for money and compete, stating *"Lack of funding means everyone is trying to get sponsorship and apply for bids of money, both at local and county level, by all sorts of agencies for different projects."* People felt that there was some 'underhandedness' in the way money was being moved around and relocated, which would relate to fairness being an ethical issue.

People were also feeling guilty about having to 'fight' for the money available, and this was leading to ethical dilemmas for people, for example, Ref. 180, a 41 year old female SHPA (children and young people) explained that *"The lack of resources for development of policy and services remains very problematic. Money can be obtained for research but not for implementing good practice unless it can be withdrawn from other services. This is very difficult when all services are cut to the bone."* It also appeared that people felt that there was some injustice in the way money was being allocated, which would relate to fairness and equity being ethical issues.

In addition, people were becoming resentful about the money issues, and this is where the ethical dilemmas were arising, for example, Ref. 435, a 47 year old female HPA (workplace) explained that her dilemma arose when *"Budgets allocated to 'high profile' projects which do little more than raise awareness but which can be counted and a certificate hung on the wall."* Some respondents were sounding as they had 'given up' with budget issues, for example, Ref. 729, a 50 year old female Deputy Manager sounded disillusioned when she stated that *"We are extremely under-resourced which greatly limits our capabilities with groups like teachers (no money to pay for locum cover for training courses) and in many other areas."* Thus the resentment about money was becoming an ethical issue.

It was a surprising finding to the author that budget was the main ethical dilemma for respondents, as money did not seem to be an ethical dilemma as such. However, it was the allocation of budget that appeared to be the issue. People were also concerned at the apparent ease of other departments' (eg. Public Health) ability to remove or allocate money to particular projects, when the NHS was making cost cutting and cost effectiveness such primary concerns. the massive amounts of money allocated to the HIV/ AIDS Health Promotion also seemed to be a major issue for respondents. People seemed concerned at the apparent ease of allocation of funds to what many seemed to be considering a passing scare. Thus, although the main issue at hand was 'budget' for many people, it was in fact, other issues surrounding the allocation of the budget that were in fact the ethical dilemmas, for example, resentment at allocation, the equity of distribution and the hypocrisy or even deceit in some allocations.

- **NHS/ bureacracy/ changes/ cuts**

This was the **second most frequent** listed ethical dilemma, and was the main issue for 97 people/ 12.5% of respondents. Some people simply stated that NHS changes were altering or disrupting normal working services, eg. Ref 303, 27 year old female HPA (CHD) stated that *"Currently the amalgamation of 2 HP Units are due to take place, therefore the changes are yet again proving to be an anxious time. The framework and structure of HP in which we currently work depends on the outcome and managerial lead upon the decision of the merge."* and Ref. 12, 33 year old female HPO (Primary Health Care Support) pointed out that *"Health Promotion is not a priority for many providers (Trusts) of Health Promotion Depts. One year funding and job contracts do not allow for long term planning at local level or recognises that behaviour change can be a slow process."* The short term contracts and short term project funding were leading to uncertainty for people, both on a daily practical level and with longer term planning. People on one year contracts would probably need about six months to set up and establish contacts prior to actually establishing their position, in just enough time to start looking out for adverts for a new job. Similarly, people who had set up the ground work for new or innovative projects would have just done all the ground work and raised local community expectations before having to potentially wind down the service.

Some people were simply stating that NHS changes were ethical dilemmas, but not explaining why, as if it were obvious by their seriousness/ gravity. These simply stated answers were similar in brevity to budget dilemmas, (as previously discussed), for example, *"There is constant change in the NHS and HP within the structure."* Ref. 435, 47 year old female HPA (workplace) echoed by Ref 765, a 44 year old male manager whose dilemma was *"Too much bureacracy, no direct links to HEA."* Ref 308, a 50 year old female bus/campaigns co-ordinator stated that *"NHS changes have confused the general public."* and Ref.491, a 38 year old female HPA (oral health)'s dilemma was *"Changes in NHS re primary health care development."*. Some people sounded as though they were becoming used to the changes and the disruption it brought, for example, Ref. 477, 38 year old female HPO (localities) explained *"We've just been re-organised totally, so this brings new challenges, but problems too, with new ways of working and new colleagues etc."* Organisational psychologists would probably agree that the management of change is a hefty task. However, the NHS decision makers deliver change as a *fait accompli*.

Others sounded as if the changes were 'grinding' them down, and making them feel disillusioned, for example, Ref 213, 28 year old female SHPA (cancer awareness) simply stated that *"Bureacracy, locally and on a national level, proclude logical*

options and slow things down- it can be frustrating" and Ref 284, a 58 year old female resources manager pointed out that *"The 1993 and 1996 changes in the NHS locally have left this HP dept. in limbo -staff feel isolated."* Ref 359, a 38 year old female SHPA (schools) asked, *"With a newly restructured service, we have less time and a bigger geographical area to cover, how do we deliver effective hp in such circumstances?"*, and Ref. 630, 35 year old male HPA (drug education) stated that it was a *"Constant battle to carve out a unique role for HP, particularly important to safeguard the Unit I work in from being cut financially or disbanded."*

In addition, many of the responses about NHS changes often sounded quite or really angry, for example, Ref. 58, a 39 year old male HPA (Primary care) sounded cross when explaining that *"changes in the NHS which incorporate the free market, individualism, choice and competition fly in the face of ideals which we are striving to work towards"* and Ref. 293, 48 year old female SHPA, (locality work) sounded very cross when describing her dilemma with *"Practising idiotic health promotion within the pseudo market of the NHS. Competing with acute services for funding, deciding about commissioning of services, being made to be a medically dominated commissioning team."*

Ewles would probably not be surprised to see the above comments about the NHS changes being ethical dilemmas, and states in Scriven and Orme, 1996:69 that

> *"These* (NHS) *changes were profoundly unsettling, and continue to be so for many specialist health promotion services. Experience and observation suggests that the relationship of health promotion specialists across the purchaser-provider divide is varied: from the ideal of a relationship based on mutual respect, trust and collaboration, to one characterised by animosity, suspicion and power struggles... The move into NHS trusts was traumatic for some departments, which experienced a different style and management accountability...Mergers upset established allegiances, networks and ways of working...The impact of these changes, often taking years to agree and settle, should not be underestimated. Such issues sap energy and channel resources into sheer survival, rather than into the development of services for the benefit of the population."*

Baum and Sanders, 1995, suggested that 'managerialism', manifesting in a 'goals and targets' approach to health promotion, market economics and 'individualism' have come to dominate and constrict the implementation of Health Promotion through HFA 2000, detracting from social and environmental imperatives and community action in addressing these. SHEPS, 1995, found that anxieties included the feeling that inappropriate models of competition affected Health Promoters' work, that resources were inadequate, and that Health Promotion was being viewed very narrowly and in a

medical model of health. Scriven and Orne, 1996:1 stated that, *"Uncertainties surrounding future organisational structures and available funding for health promotion often mitigate against the formation of collaborative interagency partnerships."* It was pointed out by Vickeridge, 1995:79 that *"...the NHS re-organisation has been driven by a mechanistic managerialism ...following a narrowly physical, rather than ethical criteria..."*

- **credibility**

credibility was the **third most frequently** listed ethical dilemma, an issue raised by 80 people/ 10.3% of respondents. These responses had a different tone to the previous two, which were very NHS based responses. The credibility dilemmas were to do with how people were being judged, often negatively, by others. Other negative feelings about oneself are listed separately, and come under the heading, for example, lack of skills (see later sections). Typical responses were from, for example, who described that *"Credibility- something you have to work at to obtain and continue to build upon."* ref. 345, 29 year old female SHPA (Primary Care).
Some pointed out who the credibility problems were with, and it was usually medical professionals, for example, Ref 213, a 28 year old female SHPA (cancer awareness) explained that *"Credibility with other health professionals tends to be low, HPAs are often seen as 'the people who provide leaflets and organise exhibitions'."* supported by Ref. 436, a 47 year old male SHPO (substance misuse) who felt a *"Lack of credibility in doctor's eyes."*, echoed by Ref 377, a 27 year old male HPA (sexual health) who felt a lack of *"Credibility with health professionals."*, and Ref 313, a 29 year old female SHPA (primary care) who explained that credibility was a dilemma because *"Credibility- some primary care workers do not view health promotion as a worthwhile thing to be involved in. Often people in h.p. do not have an agreed shared understanding of what they do."* Ref. 751, a 55 year old female HPO (older people), explained that *"Credibility: I work in a hospital setting and there is a degree of territorial attitude from some medical staff. Many people won't start to listen because they think they have all the knowledge/ info."*, similarly described by Ref. 58, a 39 year old male HPA (Primary care), who explained that *"credibility is a major problem we face particularly within our provider trust, medics would rather use the finance to treat patients!!"* Others felt that it was the lack of credibility to the public, not the medics. Ref. 491, a 38 year old female HPA (oral health)'s dilemma was the *"Credibility and recognition re role of HP in society."*

Some sounded angry about having to fight for credibility, for example, Ref 382, a 30 year old female SHPA (primary care) described *"Not given any credibility for our expertise, knowledge and practice, especially amongst other professionals who see*

health promotion as part of their job and can't see why we are necessary!!" Ref. 630, a 35 year old male HPA (drug education) described a number of credibility issues with line management and roles, *"Credibility. Constant battle to carve out a unique role for HP, particularly important to safeguard the Unit I work in from being cut financially or disbanded. Are we best placed as purchasers of health promotion or providers? There is a role confusion in HP in general at present."*

Some pointed out that the feeling of lack of credibility may not be wholly justified, just a feeling within, for example, Ref. 646, a 24 year old female HPA (youth and schools) pointed out that *"Credibility- primarily my own perceptions, not necessarily from anywhere else."* It may be that feeling that one was lacking in credibility may be related to previous professional work or academic qualifications. Some were undertaking academic courses to add to their credibility, for example, Ref. 729, a 50 year old female Deputy Manager who stated that *"I feel a credibility problem in not having a professional qualification. However, I am addressing this year when at last I can undertake an MSc."* It sounded, though, as if some-one had previously stopped her from undertaking the course. (In the next chapter), discussion will be made of the relationship between professional qualifications and perceived credibility. However, interestingly, those who were ex-nurses did not describe credibility as an ethical dilemma (see next chapter for more discussion).

French, 2000 would perhaps explain this feeling of a lack of credibility by his finding that professionals in Health Promotion feel insecure because they are not seen as justifiable professionals and they therefore maintain a position of exclusiveness, including generating a specialist language and conceptual models, which he felt helped to legitimise divisions and hierarchies. However, adopting such a professional 'front' may lead to people feeling guilty about being 'fraudulant' and therefore lead to doubts about credibility. Goud (1969) states that professionals have a code of conduct, concrete problems to solve, and society believes in them; he would probably therefore not be surprised to see that so many respondents to this research had dilemmas about credibility.

- **misunderstood/ undervalued**

A similar dilemma to credibility issues, were the explanations given by 48 people (6.2%) that they felt **misunderstood/ undervalued**. This was summed up well by Ref 284, a 58 year old female resources manager who explained that *"HA managers have no idea of the expertise of HP staff, their knowledge of local needs or what their current work is."* and by Ref. 497, a 36 year old female localities programme manager who suggested that it was *"Not clear the organisation I work for actually understands/ supports what we are trying to achieve."* A similar point was made by

Ref. 293, a 48 year old female SHPA (locality work) who felt there was a *"Lack of understanding of the value of long term community development work."* Ref. 258, 23yo m. HPA, substance misuse felt that they understood their work and the issues surrounding it better than others, by describing *"The constraints of expectations of those around, ie posters and leaflets expected by some when more innovative and effective ways of working are available"*, a similar point raised by Ref.705,45 year old male SHPA (health information) who described the *"Inability of colleagues to see that IT has a relevance and future impact on how we work/ communicate within health promotion."* It will be interesting to see the impact that the Internet will have on Health Promotion. Ref 285, a 35 year old female HPA (physical activity), felt that being misunderstood or undervalued was more to do with Health Promotion staff putting themselves in a subservient role, describing her dilemma as *"The submissive role played to medics by colleagues within the HA. We need to value ourselves for others to value us!"* Ref 13, a 37 year old female Senior graphic designer described professional interference and the impact of top-down changes, *"Sometimes when something is designed specifically for one brief, it is often the case that a person with no knowledge of communication design can make major inappropriate changes."* Ref. 414, a 31 year old female HPA (sexual health) described how *"Medical/ clinical staff couldn't give a toss about HP, fundamentally they don't understand the concepts."* Thus people were describing Health Promotion as a service being apparently easily moved around and manipulated.

Others described the link between budget allocation and being misunderstood or undervalued, for example, Ref 382, a 30 year old female SHPA (primary care) felt that there was *"No-one shouting our corner, consistently being put down by managers of other associated professions."* This was similarly described by Ref. 646, a 24 year old female HPA (youth and schools), whose dilemma was *"Other professionals- they think we have a bottomless pit of money for them. Don't appreciate that we are not just the 'leaflets department'."* However, in the past, being a leaflets distribution base was often what the Health Education Unit was.

Thus, some people's ethical dilemmas about being 'misunderstood or undervalued' were, on the face of it, the same, but their explanations and therefore, their reasoning were vastly different. For example, someone who feels undervalued/ misunderstood because their wages are lower than other professionals is likely to be different from someone whose dilemma of being undervalued/ misunderstood because of their budget allocation, and is again different to someone whose dilemma of being undervalued/ misunderstood was because they were not allowed to undertake the MSc course. Yet each started their explanation with 'I feel undervalued/ misunderstood." This is where the labelling became difficult and in some instances, pointless. However, a future study could investigate the reasoning behind what was, on the face of it, the same label.

- **campaigns**

44 people/ 5.7% were having ethical dilemmas about **campaigns**. Ref. 12, a 33 year old female HPO (Primary Health Care Support) wanted to do campaigns, but her ethical dilemma was that *"The opportunity to be more radical with our campaigns is discouraged."* Some people were concerned about having to do them at all, for example, Ref.146, a 31year old female HPA asked *" How effective are one-off events?"* Others described how colleagues/ managers believed in them, or the public seemed to want them, but they didn't, for example, Ref.140, a 36 year old female Heart Health Facilitator stated that *"I am ambivalent about No Smoking Day, but there is a great deal of pressure from professionals for us as a HPU to support it."*, similarly explained by Ref 377, a 27 year old male HPA (sexual health) who stated that *"World AIDS Day over-funded and dull, but colleagues don't agree."* Ref. 414, a 31 year old female HPA (sexual health) explained that *"World AIDS Day keeps coming around with its good intentions, bit I'm Bored of it, and the impact it makes with us is small."* These two issues of the need for one-off days, and their effectiveness tied in with the comment made by Ref. 389, a 38 year old female community dietitian, whose dilemma was *"Monitoring the 'effectiveness' of a campaign"* .

Feeling that one-off days had no effect had been resolved by some HPUs by not partaking in them any more, but they seemed to be feeling somewhat guilty about this, as it was still an ethical dilemma for Ref. 729, a 50 year old female Deputy Manager, who stated that *"We have felt in the past tensions over giving resources to No Smoking Day to maintain a profile with the Health Authority while not believing that the campaign has any effect any more. Fortunately, this situation has changed."* Others felt that other work was more useful, Ref. 477, 38yo. f. HPO (localities) explained that *"We want to get away from the high profile of National No Smoking Day, and continue on smoking policies and Heartbeat Awards for restaurants etc."* Ref 308, a 50 year old female bus/campaigns co-ordinator was concerned about the targeting of materials, explaining *"Campaign materials are not pertinent to the general population."*

It was interesting that respondents from Wales were more concerned about campaigns than the rest of the UK, featuring as the fourth main ethical dilemma (10.4% of respondents from Wales), after budget, credibility, NHS bureacracy/ changes (regional variations will be discussed in more detail in the next chapter).

Thus, some respondents were concerned about having to do campaigns at all because of the lack of proven effectiveness of one-off awareness raising events, whereas others felt that they were expected to do campaigns by the public and by the decision makers,

because it raised the profile of the HPU, and seemed to make it apparent to others exactly what HPUs do.

- **inequalities in health**

At first it was surprising to the author that only 5.3% (41 people) of the respondents had ethical dilemmas about **inequalities in health**. However, it could perhaps be argued that rather than worrying about inequalities in health, the staff were aiming to combat it with their work. A difficult theory to test is that those who were sufficiently disillusioned with worrying about inequalities in health may well leave the job, and find work they found more useful elsewhere.

Ref 180, a 41 year old female SHPA (children and young people) stated very simply ~~by~~ that *"The main challenge remains inequalities in health and poverty."* Ref 442, a 48 year old female Publicity and Marketing officer's dilemma was that *"everyone sticks with the do-able issues so whilst poverty and health is talked about, nothing really meaningful is done."* A dilemma for some respondents was that Health Promotion was not doing enough to reduce inequalities in health, and may even be adding to the problem, as explained by Ref. 12, a 33 year old female HPO (Primary Health Care Support) who stated that she was *"Concerned that Health Promotion is increasing inequalities in health through missing the deprived, disadvantaged sections of our society."*, similarly described by Ref 213, a 28 year old female SHPA (cancer awareness), *"I sometimes wonder if health promotion is widening inequalities in health, maybe our salaries should be given to unemployed people instead."* Ref. 414, a 31 year old female HPA (sexual health) cynically worried about the *"Lip service paid to inequalities in health and health for all."*

Ref. 389, a 38 year old female community dietitian's dilemma was" The *difficulties of working with people on low income. Should we be looking at social change, inequalities in health?"* Ref. 345, a 29 year old female SHPA (Primary Care) felt concerned that *"Too often H. promoters raise an issue- this opens a can of worms - which again cause alarm and concern with people who are already stressed/ smoking/ alcoholic, etc."*

- **medical model/ NHS/ working with GPs**

37 people/ 4.8% of respondents' ethical dilemma was about working in the **medical model/ NHS/ working with GPs**, for example, Ref. 12, a 33 year old female HPO (Primary Health Care Support) explained that *"Working to the Health of the Nation targets which are too medically orientated."* and Ref 765, a 44 year old male Manager was concerned that *"Evidence based approach working against HP because the*

evidence is so medical. HP as you know is social, mental, physical, etc. Primary care led is just another way of saying there is no money for HP." Respondents seemed concerned that having taken Health Promotion away from a medical model based philosophy to a social based model, it was being returned to the medical model again. Government targets which were medically oriented, such as the *Health of The Nation* and GPs being paid to run Health Promotion clinics meant an increase in medical model practice. In addition, this meant more liaison with GPs.

Many respondents were concerned about their increased contact with what they felt were a difficult group of colleagues, namely GPs. For example, Ref. 477, a 38 year old female HPO (localities) explained that it was *"Difficult to access GPs and cope with their attitudes to Health Promotion which can be mis-informed."*, similarly explained by HPU 8, a 38 year old female SHPO who remarked that *"We have to keep GPs happy, even if this means providing services that may not be effective."* Although both professions could be seen to be undertaking similar work, Public Health Specialists have a greater focus on disease prevention and treatment and a greater concern for evidence that interventions are effective.

French, 2000 pointed out that there is friction (competition) arising between Health Promotion Specialists and Public Health Specialists resulting in occupational tensions arising, and in turn, organisational tensions. Thus Health Promotion Specialists are not only having to work with GPs on occasions, but more recently with Public Health Specialists on a daily basis, or the HPU may have even been subsumed into the Public Health Department and the two groups are having to work together. Anecdotal evidence suggests that many Health Promotion Specialists are undertaking Public Health courses because their department has been taken over by Public Health, and they perhaps feel that HPU will not exist as they were previously known. Ref. 708, a 33 year old male HPA (young people) summed it up with, *"Political appointees in management with no insight into what the dept. is trying to do. Shift in emphasis imposed on depts. from community empowerment and positive health philosophy to disease management and 'thou shalt not...'. The conflict between the ethics which I believe in and what I am ordered to do- not by HP manager, but by Board management/ director of Public Health. Our health needs assessment documents are just ignored."* Thus it is interesting that Health Promotion seems to be gradually getting subsumed into Public Health departments and into working with a group who the respondents to this questionnaire were so dissatisfied with.

- **'politics'** (30 people /3.9%)

People, and having to 'play games' with people at work can be part of a 'normal' work life, because of the compromising and negotiating that needs to take place when people

are brought together into an 'artificial' team through the interview process. People have to 'bond' and help each other for an effective team to develop. Health Promotion works probably relies very heavily on collaboration, teamwork and 'comraderie' in order for effective networking to take place. However, the 'people politics' became the main ethical dilemma for 30 respondents. Ref. 388, a 52 year old female SHPA (sexual health) described *"Political problems, treading on other people's toes!"* and Ref. 378, a 36 year old female community dietitian described having to keep groups of decision makers happy, *"Tackling the disagreements which exist between vociferous care managers and catering managers."* Ref 765, a 44 year old male Manager had to 'play games' with decision makers, *"Because of the track record, I have to meet the health board requirements by a 'softly-softly' approach."* Ref 442, a 48 year old female Publicity and Marketing officer complained that *"everyone is watching their back, lack of motivation and enthusiasm."*

Ref.140, a 36 year old female Heart Health Facilitator felt that the people politics was spilling over into large groups such as the Council, stating, *"District Council trying to raise its own laudos and political expediency by staging 'naff' campaigns to be seen, but which I know are a total waste of money."*

- **effectiveness** (28 people/ 3.6%)

The word 'effective' is an interesting one because it implies that something has to change, in order for something to be effective. In this case, it would be people having to change, or the Health Promoter having made some change. This was described by Ref. 646, a 24 year old female HPA (youth and schools) who questioned the *"Effectiveness of training/ campaigns- long term implications."*, and Ref 213, a 28 year old female SHPA (cancer awareness), *"Some of the campaigns, particularly mailouts and exhibitions are not effective and especially not cost effective yet. Due to their high profile, ease of implementation and routine, we continue to undetake them."*

If describing 'effectiveness' as the main ethical dilemma meant that the Health Promoter wanted people to change, and a desirable outcome is to be had, then probably those Health Promoters would advocate a 'behaviour change' way of working. However, closer analysis revealed that the majority of those whose ethical dilemma was 'effectiveness' stated that their way of working varied. Only 2 respondents stated that their preferred way of working was 'behaviour change', but three stated it was 'social change' and a further three described their preferred way of working as 'client directed'. So perhaps the term being effective is not about the Health Promoter being effective, but the outcome of their work, having some effect. This would explain the comment by Ref. 12, a 33 year old female HPO (Primary Health

Care Support) who felt that there were ways of increasing effectiveness, and was concerned about *"Participating in activities, planned by others, when you know a full needs assessment has not been completed, and therefore the activity will be ineffective."* She was perhaps trying to explain that effectiveness can only be brought about by changing society rather than changing individuals.

The 1995 DoH progress report on the HON called for effectiveness studies and more evidence based research, which also set the scene for Health Promoters to provide evidence for their work's effectiveness. It will therefore interesting to see that the respondents to this research describe ethical dilemmas about effectiveness, especially as most will not have had training in statistical methods.

- **lack of skills** (25 people/ 3.2%)

Many people came to Health Promotion from other types of work, as stated in the Results section, and discussed later. In summary, prior to working in Health Promotion, just over a quarter of respondents came from health related jobs, a fifth from admin/ clerical, one seventh from education and one seventh from nursing. Thus many people were trained and experienced in other jobs. 344 respondents (44.4%) did not have a Health Promotion qualification, (see Results section) and 432 people (55.9%) had only been in post for between 1 and 4.9 years. Thus it is not surprising that people had ethical dilemmas about their lack of skills. It is perhaps surprising that this did not feature for more respondents. However, maybe many of the skills were transferable. The concern about lack of skills was summed up well by Ref. 345, a 29 year old female SHPA (Primary Care) whose dilemma was, *"Professionalism/ skills - are we the right people to do this job, expertise needed in this area, also a changing environment- changing skills."*

Many respondents whose dilemma was lack of skills were concerned that they were not able to rectify the situation, for example, Ref. 611, a 47 year old female resources manager's dilemma was *"Training opportunities. Present role does not enable me to undertake MSc. as I would wish, as it must be covered full-time, but agreement may be reached regarding Diploma."* echoed by Ref. 359, a 38 year old female SHPA (schools) who simply stated that her dilemma was *"Lack of support for professional development."* SHEPS in the Multi Disciplinary Public Health briefing and discussion paper, May 2000:13, stated that there should be *"...ongoing induction and accreditation programmes for all Health Promotion Specialists..."* and that all branches should be *"...encouraged to work with their local universities to develop an acredited initial induction programme, and post-basic professional capacity building mechanisms."* This would alleviate the problem for many new staff, however, not all HPUs are near Universities, and they should not necessarily have to be relied upon to

provide the academic or practical course that the profession should be providing. During the 1980's the HEA did provide a common framework of induction training packs and regular courses, but this seems to have now stopped. There also appears to be an increasing trend for Health Promotion staff to undertake Public Health courses (French, 2000).

- **evaluation** (21 people/ 2.7%)

Health Promotion is now subject to scrutiny for effectiveness, and for justifying budgets, but Health Promoters in this research were finding it difficult having to justify themselves and their work. As Haycox, 1994, pointed out, the impact of health promotion is very difficult to quantify, and especially when the figures are often focussing on hypothetical health gains, as described by Ref. 435, a 47 year old female HPA (workplace) who described her dilemma as the *"Conflict between having to satisfy the 'number counters', and carrying out effective meaningful work which might not produce 'real' evidence for a long time after."*, similarly described by Ref. 238, a 32 year old male manager whose dilemma was *"Accountability in areas that are difficult to evaluate."*

Ewles, in Scriven and Orme, 1996 described the health service culture of looking for quantitative measures which has developed, which health promotion does not 'sit easily' with. Ref.140, a 36 year old female Heart Health Facilitator stated that *"We need to be really sure of the arguments around evaluation and outcomes of our work, if we are to attract decent funding and appease Purchasers."* But Ahmed, 1995, felt that Health Promotion should be evaluated because information can influence health care delivery either by revealing performance failings, or by demonstrating how known problems might be solved. Being told to evaluate by others was a dilemma, especially when people hadn't been trained in evaluation tools and methods (for example, 'process', 'impact', or 'outcome'), as explained by Ref. 640, a 36 year old female HPA (youth programmes) *"How to undertake effective evaluation."*

- **job description changes** (insecurities) (16 people/ 2.1%)

Some quotes about job descriptions changing are as follows:

"My job description has totally changed 3 times in the last 2 years, from accidents to men's health to cancers, and not through choice." ref 213, 28yo f, SHPA cancer awareness

"Uncertainty about the role- continual assessment of HP roles- continually on the 'hot spot' continually scrutinised by GPs, even colleagues in this organisation." ref. 345, 29yo f SHPA Primary Care

"Job description moving away from face to face work into strategic purchasing from less qualified or able disciplines." Ref.436, 47 yo m., SHPO - substance misuse

- **targeting** (11 people/ 1.4%)

Ref. 548, a 36 year old female manager explained the new 'culture' of targeting well, when she described *"Targeting is a problem as there has been no previous direction to health promotion. This is the first year that this district has had a specification that has been produced for the service. This means that health promotion has been diverse, but also unmanaged, changing the culture and encouraging targeted and evaluated work."* Much of the targeting has been aimed at particular classes or races, and difficulties arise. Some blaming that class or race for its problems, or merely pointing out the differences? Ref. 497, a 36 year old female localities programme manager felt that there was some 'paternalism' involved in targeting, when she described her ethical dilemma being the *"Imposition of middle class, white values on vulnerable groups. Often delivered by white, m-c females without reference to the potentially damaging effects that might ensue."* These comments would support what, for example, Parmar, 1981; Pearson, 1986; Rose, 1992, feel is a "well disguised form of racism, inherent within a culture-blaming ideology." Although, for example, statistically, ethnic minorities in the U.K. are more predisposed to such illnesses as stroke (Afro-Caribbeans), and CHD (Asians), this could be seen as supporting the argument that different races have biological differences, and Pearson, 1986, suggested that there is a need to distinguish between recognition of differences, as opposed to emphasising notions of alieness. Targeting must therefore be a sensitive issue for Health Promoters, because, as Rose, 1992, suggested, by implication, populations or communities labelled as 'predisposed' in some illness are seen as 'not normal', and are therefore 'deviant' and society, once it has labelled people, can then categorise them, or deny them the responsibility for their problems, especially when, Pearson, 1986, pointed out it is because ethnic diets cause health problems because 'their foods' are not available here and because their diets are somehow inherently unhealthy."

The consequences of targeting were described by Ref. 477, a 38 year old female HPO (localities) who was concerned about the ethical issues involved in identifying who to target, describing her concerns as *"Ethical issues when collecting data via questionnaires etc., especially in areas of socio-economic deprivation, etc. Also projects in these special areas and making sure of sensitive press coverage."*

Ref. 17, a 50 year old male outreach project manager, was concerned about the budgets attached to targeting, explaining *"I would like to see more of our HIV prevention budget spent on targeting gay and bisexual men."* and Ref. 751, a 55 year old female Health Promotion Officer (older people) wanted to be effective in the

targeting, and was concerned about *"Targeting older men, 50+, effectiveness of campaigns, because each one to be well done could take so much time."*

- **theory vs. practice** (7 people/ 0.9%)

Only 7 people (0.9%) described **theory vs. practice issues** as being their main ethical dilemma, a typical quote from Ref.140, a 36 year old female Heart Health Facilitator, *"Believing in community development as an approach, but not being able to operate it."* French, in his PhD research, 2000, described how the thirty four people he interviewed found that analysing values and looking at theoretical perspectives were not a 'top of the mind' issue and that *"...theory was indeed important and that a perceived failure to root practice in theory was seen as a significant weakness and a block to further progress."*. He subsequently coined the term *'intuitive rightness'* (2,000:152) to describe how Health Promotion Specialists 'retreat from theory' and feel unwilling to explain or justify their work. He described how the lack of an active dialogue with colleagues was evident form the data and also in the request of several participants for copies of colleagues' transcripts (with their permission) to enable them to gain a better insight into their own beliefs.

"The conflict between good basic health information and a sense of value and morality" ref. 388, 52 yo f. SHPA, sexual health
"In house development: we work hard at team development with other agencies but rarely our own, this makes me very angry and confused." Ref.491, 38yo. f. HPA-oral health

- **being a role model** (6 people/ 0.8%)

It was interesting that only 6 people (0.8% of the respondents) listed being a role model as their main ethical dilemma. A good summing up of the worry about being a role model came from Ref. 630, a 35 year old male HPA (drug education) *"I don't drink but I am not anti-alcohol. I feel that members of the NHS workforce and general population, however, do think we should be role models of fit and healthy specimens. I do not believe this needs to be so, but I would still have some credibility difficulties leading sessions on exercise and healthy eating!"* , echoed by Ref. 12, a 33 year old female HPO (Primary Health Care Support) describing her main ethical dilemma as" Having *to be the perfect role model for healthy living."* Ref. 177, a 32 year old female HPA (cancers) described feeling guilty about not being a better role model, and often embarking on new fitness regimes to be a good role model. Some described the hypocrisy they felt at not always 'practicing what they preached', for example, Ref 308, a 50 year old female campaigns co-ordinator, who felt guilty about driving to work, when advocating taking up cycling to others. For some, being a role model was

impossible, for example, Ref. 62, a 34 year old female Health Promotion Officer (H.I.V. and Sexual Health) *"I'm responsible for development of work with black communities. I'm a white worker and got off to a bad start with some black workers not accepting me in this role."*

- **victim blaming** (5 people/ 0.6%)

Only 5 people (0.6%) stated that **victim blaming** was their main ethical dilemma. Some quotes about victim blaming are as follows:
"Constantly aware of judgmental attitudes of others, and more alarmingly of professional's attitudes to specific groups of people." HPU8 58yro. f. HIV/Sexual health co-ordinator
"I personally am not entirely happy with the local emphasis on breastfeeding. I agree it should be promoted effectively but it should not stop our dept. stocking information from formula manufacturers who are following EC directives in their literature. There are women who cannot breastfeed and the current campaign makes them 'outcasts'. ref. 284, 58yo f. resources manager
"The approaches that are being used by health promoters- do we have the right to determine how health professional work, eg., behaviour change approach- could become victim blaming, rather than looking at external factors." ref. 345, 29yo f. SHPA Primary Care

- **policies** (1 person (0.1%))

The quote about policies is as follows:

"I believe in using children for test purchasing cigarettes, the local council has an opposing policy." Ref.436, 47 yo m., SHPO - substance misuse

- **sponsorship**

"Suggestion that McDonalds might sponsor Smokebusters. Should dept. stock literature from commercial companies? Should BUPA sponsor Health Weeks?" Ref. 640, 36 yo. f. HPA-youth programmes

"I am constantly faced by ethical dilemmas in that what schools think are priorities and ways of addressing sex education are not necessarily mine. It is very important to address homosexuality but many schools are frightened." ref 305, 45 yo m., schools sex education

- **colleagues**

Some quotes about colleagues are as follows:

"The role of HPAs tends to attract 'touchy-feely' personalities" ref 213, 28yo f, SHPA cancer awareness
"Individual colleagues can be very destructive, while the general ethos is support/ share/ co-operate. Do you 'tell' or just allow them to dominate/ manipulate?" Ref. 751, 55 yo. f. Health Promotion Officer for Older People

no ethical dilemmas

50 people (6.5%) stated that they had **no ethical dilemmas** and 64 people (8.3%) **did not answer** the question. There was problem with coding the 'no answer' people because it could be argued that 'no answer' meant 'no ethical dilemma'. The 2 figures for **no dilemma** and **no answer** are (a very large) **114 people (14.3%)**, which is a **higher** figure than for the 3 main listed dilemmas of budget allocations (13.3%, NHS/ bureacracy/ changes (12.5%), and credibility/ low status (10.3%). 4.2% of health promoters (24 people) had **no ethical dilemmas**, and 10.7% of 'others' (3 people) having none, whereas, a much larger 20.5% of sec/admin.(23 people) had none. As previously mentioned, a problem arose when looking at the 'no ethical dilemmas' answers in conjunction with the 'no answer/ missing' group of people. Some people with no ethical dilemmas may well have missed out the question rather than written in the word 'none'. They were coded separately, because 'none' and 'no answer' are different, but they may well have not been. Thus the 64 people who omitted ('missing') this question have distorted the picture somewhat, especially as many admin/ secretarial staff stated on their questionnaire "I don't know if this section is for me, so I've left it out." It is an ethical issue that admin/ secretarial staff feel that their opinions are not considered worthwhile enough to include on an anonymous questionnaire.

"Because the SHEPS Code of Principles and Practice guide me in this area." Ref 14, 41yo m, manager
"I am a jack of all trades and master of none, but I have no ethical dilemmas with my work." Ref. 656, 42 yo. f. HPA (generic)
"None. If I don't agree with something I say no." Ref. 764, 47 yo. m. SHEO

- **Ethical dilemmas- grouped**

The 3 main ethical dilemmas (as discussed in previous section), namely: budget (103 people/ 13.3%), NHS/ bureacracy/ changes (97 people/ 12.5%), and credibility/ low

status (80 people/ 10.3%) are to do with very different themes, budget and NHS changes are to do with NHS/ organisational issues, whereas credibility/ status are to do with professional issues. This re-grouping led to the emergence of the finding that NHS issues were listed first by 324 people (41.9%), professional issues by 219 people (28.3%), type of work carried out by 75 people (9.7%), inequalities in health by 41 people (5.3%), and 114 people (14.7%) had no ethical dilemmas or did not answer the question.

organisational (NHS) issues

Organisational (NHS) issues, as a group, were the major ethical dilemmas for respondents 324 people (41.9% of respondents). These issues involved dilemmas about: budget allocations, NHS/ bureacracy/ changes, told what to do/ hidden agendas, medical model/ NHS/ GPs, 'politics', job description changes, policies. As previously discussed, budget was the most frequent listed ethical dilemma (103 people/ 13.3%) and 97 people (12.5%) stated that NHS bureacracy/ changes were their main ethical dilemma. It could perhaps be argued that organisational issues are not really ethical dilemmas as such, but give rise to ethical dilemmas. The conspiratorial or bureaucratic nature of these NHS changes/ reforms, also gave rise to 40 people (5.2%) listing being told what to do/ hidden agendas as their main ethical dilemmas. People complained about the 'fait accompli' deliverance of many of their departmental changes, and especially complained about being answerable to the Director of Public Health. This was in addition to 37 people (4.8%)'s main ethical dilemma being concerned with having to work to the 'medical model' and in particular working with GPs. 30 people (3.9%) described NHS/ office 'politics' as being their main dilemma. 16 people (2.1%) were concerned that their job description kept changing without their consultation. 1 person (0.1%) was concerned about policies.

Some strong terms were used by the respondents to this research about organisational issues, as can be seen from the previously quoted dilemmas:
money not sufficient
limits what we can offer
all services are cut to the bone
Disinvestment
lack of resources
health promotion money has been diverted into clinical work
everyone is trying to get sponsorship
money only allocated to high profile projects
extremely under-resourced
greatly limits our capabilities
do not allow for long term planning

fly in the face of ideals
frustrating
in limbo
feel isolated
pseudo market
anxious time
confusion
how do we deliver effective hp in such circumstances
constant change
re-organised totally
constant battle

No-one wrote positively about the NHS changes or restructuring, all comments were negative. Some people re-iterated their comments from the section about 'bad points' about their work, into the ethical dilemmas section of the questionnaire. It may be that some people were a little muddled about the term 'ethical dilemma' as so many of the ethical dilemmas were in fact gripes about working for the NHS. However, the comments about 'professional issues' being ethical dilemmas were a bit clearer to see as 'ethical dilemmas'. (next section).

professional issues

219 people (28.3% of the 774 total) had dilemmas which concerned **'professional' issues**, (namely credibility/ low status, misunderstood/ undervalued, effectiveness/ or not, lack of skills/ communication, evaluation/ evidence, theory vs. practice, being a role model, victim blaming), and 441 people (60%) had 'other' dilemmas, and 114 people did not answer the ethical dilemmas question, (so the figures are continually distorted.) Ignoring the 'missing' people, 33.2% of the dilemmas were 'professional' issues, and 66.8% were 'others'.

The third single main ethical dilemma was **80** people (10.3% of respondents) reporting lack of **credibility/ low status**. This was third to budget and NHS changes/ bureacracy (described previously). If it could be argued that budget allocation and NHS issues are organisational issues which give rise to ethical dilemmas, then lack of credibility/ low status was the main ethical dilemma for respondents. In addition, 48 people (6.2%) felt **misunderstood/ undervalued**. This was misunderstood/ undervalued by medical colleagues, not by the public. Some people also had **doubts about themselves** though, including 28 people (3.6%) who were concerned about their **effectiveness**, and 25 people (3.2%) who felt they **lacked skills**, especially **communication skills**. This self doubting totalled **6.8%**.

Some **strong terms** were used by the respondents for these professional issues, as can be seen from snippets from the previously quoted dilemmas:

are we the right people to do this job?
expertise needed
don't understand the concepts
not having/ able to undertake a professional qualification
not being able to operate community development
conflict between information and value and morality
makes me very angry and confused
credibility is a major problem
HPAs are often seen as the people who provide leaflets and organise exhibitions
are not seen as professionals
other professionals can't see why we are necessary
constant battle to carve out a unique role for HP
role confusion in HP
people won't start to listen

These findings support the position of Caplan, 1993, who argued that Health Promoters are in the difficult position of giving information to the public (education and self-empowerment), but the public need an expert to explain the medical view based on disease prevention and/ or individual behaviour change, so they can make their informed decisions. Keeley Robinson, 1984, stated that giving information to a supposedly autonomous public is 'hidden' within a self-empowerment model which uses such misleading terms as 'self-esteem' and 'informed healthy choices'. Ewles, in Scriven and Orme, 1996, pointed out that although Health Promotion Specialists could be considered experts, but 'generalists' such as parents, voluntary workers, teachers, youth workers are often carrying out the same work. Kemm and Close, 1995, argued that if health promoters' information influences other people's decisions, then health promoters must accept some responsibility for giving that information. But, Health Promoters are often experts in another field such as teaching or nursing.

These findings also seem to support the findings of the 1993 SHEPS survey which found that since the NHS reforms, many Health Promotion Specialists felt that their general managers did not understand their role, that they felt undervalued, that their resources and budgets were poor, and that Health Promotion was being viewed in a narrow, medical way. Thus the situation had continued through to 1998 in a similar vein to the opinions expressed in 1993.

CHAPTER 10: Discussion of relationships between variables

This section discusses the findings from the associations between the variables, Chapter 10 detailed the Results.

The variables to be discussed are:

- regions and ethical dilemmas
- job and ethical dilemmas
- job and health promotion qualification
- age and job
- age and health promotion qualifications
- age and highest qualifications
- sex and job
- sex and specific jobs: managers; HIV/ sexual health workers
- sex and qualifications
- sex and health promotion qualifications
- previous work and ethical dilemmas: ex-teachers, ex-nurse, ex-social workers
- SHEPS
- SHEPS and sex
- SHEPS and age group
- SHEPS and Health Promotion qualifications
- SHEPS and model of working
- SHEPS and good points about work
- SHEPS and bad points about work
- SHEPS and ethical dilemmas
- SHEPS and offer to be followed up
- SHEPS and future of Health Promotion
- relationship between bad points and ethical dilemmas

- **location and ethical dilemmas**

regions

Because so many reported ethical dilemmas were concerning NHS issues, it may be that the NHS as an **employer** is a major factor in determining the incidence of ethical dilemmas. As such, looking at **regional variations in response** has been given considerable space here.

At the time of the research, there were 15 NHS regions. It was therefore possible to recode the District Health authorities into regions. However, some regions were geographically large, eg. S. West, which covers Devon, Cornwall, etc., and London, which is considerably smaller on the map. However, London is an internationally renowned city, and the capital, yet the S. West region is rural. In addition, Wales, Scotland, N. Ireland and the Channel Islands were all labelled regions, when, in fact, they are countries. Thus, to some extent, the labelling of such is nonsensical, but it serves its purpose of pinpointing physical areas. Some regions had more District Health Authorities than others, and therefore more Health Promotion Units, which must have distorted the findings. If it is difficult to find out how many people work in each Health Promotion Unit, it will have repercussions on finding out how many people work in the region too. However, one can estimate, and utilise the numbers who did respond.

The **first 4** ethical dilemmas generally covered about **50%** of the total reponses for each region, showing that the first four were more of a dilemma than the other responses. However, **The Midlands** had **70%** of its responses concentrated on the first four, and also had an unusually figure for **NHS issues** (23.3%), and **budget** (23.3%), and **E.Anglia** which had **66%** of its responses concentrated on the first four.

The following regions **differed from the norm** in some respect, and have therefore been discussed in more detail.

S. W. Thames

This region's main ethical dilemmas were: **NHS bureacracy/ changes (22.2%), budget (11.1%), being told what to do (11.1%),** and **campaigns (8.3%)**, totalling **52.7%**. This region seemed to have a **lower response rate** than other regions, with only **37** people responding from 7 of 12 districts. **That was the region that the author worked in** and this region formed the preliminary study research: it may have been that the respondents did not want to reply to the second such questionnaire in one year. The preliminary study was coded somewhat differently to the main study, but the preliminary study findings from the S.W.Thames region the year before revealed that the main dilemmas were: inequalities in health 34%, the way we work (28%), the truth and accuracy of information imparted (15%), and the professional status and credibility of Health Promotion (15%). Thus NHS issues and budget feature far more strongly in the main than the preliminary study, presumably as a result of numerous NHs chnages that had happened in that region that year, and the massive amounts of money that were being given to HIV/ AIDS work and staff.

Districts in the S.W.Thames region had undergone a number of changes and mergers during the previous year to the research, and a number of Health Education Units had

become Health Promotion Units, and some HPUs had been absorbed into the Public Health Departments, and some became purchasers, some providers, and some had a dual role. There had thus been massive changes to the organisations themselves. Merton and Sutton Health Promotion Unit had been merged with the nearby Wandsworth, which had only been separated from them a few years previously. The changes were all delivered as 'fait accompli', and sometimes information was given a long time after the decisions had been made. Because of the mergers, many people were being interviewed for senior jobs, for example the manager of one of the two merging HPUs was to be the manager over the other manager. Many people resigned or moved to other jobs in other Health Promotion Units. Although physically nearby, Merton and Sutton had a very different population to Wandsworth in terms of ethnicity, problems, councils, and even class make-up. Major problems were developing with friction between colleagues, and many 'team-building' days caused even more resentment. It was thus not surprising that this region's respondents main ethical dilemmas were **NHS bureacracy/ changes** and formed the second largest percentage (22.2%) for a dilemma out of all the dilemmas in all the regions, apart from NHS issues in Anglia and the Midlands. However, a low response rate from this region meant that each individual respondent had a higher impact on the percentages, and the picture may be somewhat distorted as a result.

Wales

58 people responded from 14 of the 16 districts. This region's 4 main ethical dilemmas were: **budget (16.7%), credibility (12.5%), NHS bureacracy/ changes (12.5%),** and **campaigns (10.4%)**, totalling **52.1%.** This region had the same first three ethical dilemmas as the national picture that has emerged of budget, NHS bureacracy/ changes, and credibility, but dilemmas about campaigns features. It would be interesting to find out why respondents from Wales were concerned about campaigns. However, in 1989, the Welsh Health Planning Forum produced a *Strategic Intent and Direction for the NHS in Wales* , which laid out the 'health gain focused' strategic intent to *"...take the people of Wales into the 21st century with a level of health on course to compare with the best in Europe."* The strategy aimed to add years to life through a reduction in premature deaths and life to years through improvement in well-being for both patients and the population at large. The strategy was 'people centred', but also emphasised cost effectiveness and 'participation in planning', and introduced the notion of 'community participation', and measurable objectives and targets were also incorporated. Because of this 'culture' of analysing cost- effectiveness and facilitating community participation, it may well be that campaigns and one-off events are not seen in Wales to be an effective way of working. The physical geographical spread of Wales as a 'region' is much larger than any other region, apart from scotland, and some areas are rural and others are inner cities, so it may not be

useful to group Wales as a region It was also interesting that there were only 2 HPUs in north Wales, one in central Wales and one in the west, and that 12 of the districts were from a very small area in the south eastern corner of Wales.

Scotland

70 people responded from 10 of the 13 districts. Respondents from Scotland represented 9% of the total, the fifth largest response from the 15 regions. As with Wales, the physical geographical spread of Scotland as a 'region' is much larger than any other region, and some areas are rural and others are inner cities, so it may not be useful to group Scotland as a region. However, the 4 main ethical dilemmas described by respondents from Scotland were: **credibility (13.4%), NHS bureacracy/ changes (10.4%), budget (10.4%); misunderstood (9%)**, totalling **43.2%**. The total for the main four ethical dilemmas is lower than for other regions, so they had a more varied rather than unanimous response to ethical dilemmas. The main three national ethical dilemmas of budget, NHS bureacracy/ changes, and credibility were the same, but in a different order, credibility being the main ethical dilemma. The S. West region also put credibility as the main ethical dilemma, but had campaigns as a fourth dilemma, whereas the respondents from Scotland had 'being misunderstood' as their fourth, which is another 'professional' dilemma rather than an organisational one to do with the NHS. These two 'professional' ethical dilemmas accounted for **22.4%** of the region's ethical dilemmas, compared to 20.8% for organisational issues. This is a different pattern to other regions. It would be interesting to investigate why Scotland had more 'professional' ethical dilemmas than other regions, apart from S.E.Thames.

In March, 1991, the Government published a national policy statement on Health Education in Scotland, which identified priority areas for improving the health of the people in Scotland, set a number of national targets for improving health, and provided a framework for the new Health Education Board for Scotland, which was established on April 1, 1991. In 1992, the Scottish Office produced *Scotland's Health: a Challenge to Us All* which had disease reduction, such as CHD, as its main focus. Emphasis was also placed on smoking issues and dental and oral health, as these were two problem areas for Scotland with higher smoking levels and teeth problems than the rest of the UK, and Europe. Behaviour change was the main focus for this document. It may be that the Health Promotion Specialists in Scotland feel that the figures for poor health do not reflect the work they were doing, which would, in turn, give rise to different ethical dilemmas to their colleagues outside of Scotland.

Ireland

23 people responded from all 5 districts. Respondents from Ireland only represented 3% of the total. The 4 main ethical dilemmas were: **misunderstood/ undervalued (16.7%) and 'politics' (16.7%),** and **budget (11.1%) and 'none' (11.1%),** totalling **55.6%.** This is therefore a very **different** picture to the standard national one that has emerged of budget, NHS bureacracy/ changes, credibility . The total figure of 55.6% is larger than all the other regions' total for the first four, implying that these four were obviously important. In addition, this region is the only one whose 'no ethical dilemmas' group featured so strongly. This region was also different in that respondents had less of a 'spread' of ethical dilemmas, listing only 12 of the 23 different ethical dilemmas put forward nationally. Health Promotion Units in Ireland have fewer staff than in Britain, and staff therefore have much broader remits. In addition, the 1995 N.I. *Regional Strategy for Health and Personal Social Services for Northern Ireland,* which had four key themes: promoting health and social welfare, targeting health and social need, improving care in the community and improving acute care, also had seventeen regional health targets but the targets also emphasised the importance of fostering well-being, informed choice and the need for social support, and advocated community development, as well as targeting the usual health and personal social services. Thus the philosophy and work of the Ireland Health Promotion teams may well be different to the UK ones.

- **job and ethical dilemmas**

managers and ethical dilemmas

55 people (7% of the total) were the manager/ director, and their main ethical dilemma was NHS changes (22.2%), compared to 13% of the rest of respondents, followed by budget which was a similar figure to other respondents, and thirdly, working with the medical model/ interference by medical staff (GPs) was listed first by 11.1% of managers, compared to 4.7% of other respondents. The national picture that emerged for dilemmas for the whole group of respondents was firstly budget, then NHS changes, then credibility, so the picture that emerged for managers was **similar** to the group as a whole. The managers' main ethical dilemmas were actually very **management based** rather than profession based. Thus the ethical dilemmas raised by these Health Promotion managers may not have been very different from any group of managers describing work dilemmas.

The main ethical dilemma for managers was NHS changes, which would mean managers having to re-define their department's work and workers and justify their existence in the new NHS competitive market. Budget being an ethical issue for

managers probably implied having to fight for the budget allocation per se, rather than, Health Promoters, for example, having ethical dilemmas about budget allocations being given to specific topics or audiences. However, credibility did feature as the fourth issue for managers (9.3%), a little less compared to 11.4% for the rest of the respondents. One can assume that having the title of manager lent some credibility to the managers, whereas for the other Health Promoters their job title did not immediately give credibility.

Differences for the managers as a group was that only 1.9% stated they had no ethical dilemmas, compared to 7.5% of the rest of respondents. It would appear at first, then, that managers were having more ethical dilemmas than their subordinates. However, many of the managers' ethical dilemmas were, in fact, management issues, rather than what might traditionally be termed *ethical* dilemmas. Only 3.7% of managers were concerned about campaigns compared to 6.4% of the rest of the respondents. It could perhaps be argued that campaigns would raise the profile of the department, which would be a good point to managers, whereas workers were more concerned about the long term effects of one-day events. Evaluation was more of an issue for managers (7.4%) compared to others (2.6%). Evaluation often implies having to justify the work being done, which can be threatening for many people, and probably especially for managers who have to justify the work of the whole department, not just themselves. However, being told what to do was only an issue for 1.9% of managers, compared to 5.9% of the others. Thus the managers were having ethical dilemmas about being accountable to someone when justifying effectiveness of the department but not themselves.

HIV/ AIDS/ sexual health workers

74 people were HIV/ AIDS/ sexual health workers (9.6% of total and the second largest group after secretarial/ admin.). These workers presented a somewhat different 'profile' to other groups, for example, they were more likely to be male than those in other jobs, were predominantly aged 30-39 years, were more likely to have no Health Promotion qualifications, more likely to have the Diploma, less likely to have the MSc., more likely to have the qualified social worker certificate, or be an RGN. Thus they had received their academic training elsewhere, a fact borne out by the fact that their previous work history differed too, for example, many having previously worked in youth work, social work or refuges. The three main ethical dilemmas were NHS issues, budget and credibility which are the same issues as the rest of the respondents but in a slightly different order but very similar percentages for budget and credibility.

It is interesting and perhaps to be expected to some extent, that these Health Promoters did not have different ethical dilemmas than the other respondents. For example, a

person who has to go out in the evenings and liaise with prostitutes and 'cruising' gay men, for example, is doing very different work, and using different tactics to someone who is visiting a school or a having a meeting with a company representative who produces leaflets. Some of these Health Promoters would probably have more knowledge about some of the social injustices that had brought their client group to where they were in life, perhaps with stories of sexual and physical abuse, homelessness, etc. In addition, discussing sexual issues with certain groups, such as teenagers, does warrant a different approach, and therefore different ethical dilemmas than with perhaps a group of mothers and toddlers. It could perhaps also be argued that sexual health, sexual issues and sexuality are person issues, and therefore inherently difficult to discuss with others, and this may then in turn have implications for associated ethical dilemmas. None of the HIV workers had no ethical dilemmas whereas 7.8% of the rest of the respondents had no ethical dilemmas. Thus all of the HIV worker respondents were having ethical dilemmas about their work.

dietitians and ethical dilemmas

26 people were dietitians, almost all of whom were female, only one person was male, (a completely different picture to the whole sample of 1 in 5 being male). Their pattern of ethical dilemmas differed from the rest of the sample, in that their main dilemmas was budget (26%), then evaluation (13%), and 'none' (13%). Dietitians are in the difficult position of being able to tell people about right and 'wrong' (or at least not so good) foods, but are working in HPUs whose philosophy veers more towards a social model of health. evaluation would be a difficult issue for dietitians because their work often has an impact on, for example, grossly obese people, but not such a 'quick' effect for anorexic, bulimic, or slightly overweight people. How would they evaluate their effectiveness with giving advice to, for example, a diabetic, whose attitude rather than anything tangible would change. Having no ethical dilemmas may feature higher for this group because they are actually in the position of asking people directly to change their behaviour.

- **ethical dilemmas and previous work**

ex-nurses

It is interesting that nearly 20% of the ex-nurses' main concerns were about NHS issues. It may be that they left the NHS to work in Health Promotion but were being faced with the same problems as their previous job. It may also be that they had a greater insight into NHS issues, than other respondents, who had not worked in that organisational 'culture' before. However, Robinson and Hill, 1998, suggest that health promotion being well integrated into nursing practice has proved difficult, and that the

new health promoting nurse has yet to emerge in practice. It is also interesting that the ex-nurses did not have the same credibility issues as the rest of the group, rather their concerns were about being undervalued/ misunderstood, so being an ex-nurse lent some credibility to them as Health Promotion Specialists.

ex-social workers

76 people used to be social workers or youth workers, but they were somewhat different to the rest of the group because there were more males, the average age groups were younger, and many were currently working in the HIV/ sexual health field, or drugs/ substance misuse field, and none worked in secretarial/ admin jobs nor were managers. This group's ethical dilemmas were somewhat different from the general pattern of firstly NHS, budget and then credibility. This group's main ethical dilemmas were firstly credibility, inequalities in health, and then budget, and very few people were concerned about NHS issues, which the rest of the averaged sample put first. This group may be concerned about credibility within their department because the predominance of Health Promotion Specialists are either ex-teachers or ex-nurses. It may also be that they feel they lack credibility with client groups, because people will often ask how does one get into Health Promotion work, and may be surprised to hear that this group's background was social work/ youth work. Inequalities in health would probably be an issue for this group who may well have seen the relationship of poverty, deprivation, class or culture affecting social/ youth work issues such as crime, substance misuse, violence, unwanted pregnancy.

French, 2000:106, points out that *"...what appears at first to be a diverse range of opinion is in fact a reflection of distinct theoretical and practical approaches to health promotion adopted by professionals who come to the field of study with very different views. It may be the case that there exists some form of theory that binds together what appears to be disparate positions together."* (underlining added).

- **job summary and ethical dilemmas summary**

Job title and main ethical dilemma were **both grouped** into smaller categories, i.e. 3 jobs (health promoters, secretarial/ admin., or 'others') and 4 dilemmas (none, inequalities in health, NHS issues, professional issues).

It was found that the figures for **professional issues** were very similar, with 31.9% of health promoters (182 people), 26.8% of sec/admin (30 people), and 28.6% of 'others' (8 people) having this as their major concern. For concern about **NHS issues** 45.4% of health promoters (259 people), and 43.8% of sec/admin (49 people) had this as their main ethical dilemma, whereas a larger figure emerged for 'others' with 57.1% of

'others' (16 people) having this as their major concern. **Inequalities in health** was the major ethical dilemma for 6.7% of health promoters (38 people), 1.8% of sec/admin. (2 people), and 3.6% of 'others' (1 person). These figures were similar and small.

- **sex and ethical dilemmas**

The majority (79%) of respondents were female, with only 1 in 5 (21%) being male. Either the majority of respondents to this questionnaire were female, or the majority of Health Promotion Specialists are female. Observation and anecdotal evidence would suggest that Health Promotion is predominantly female. The main ethical dilemmas for males were **budget allocation** (22 males/ 14.7%), followed by **NHS bureacracy/ change** (18 males/ 12%), **credibility** (14 males/ 9.3%), with a remarkably **similar** picture emerging for the females, whose main ethical dilemmas were **budget allocation** (81 females/ 14.5%), **NHS bureacracy/ change** (79 females/ 14.1%), **credibility** (66 females/ 11.8%). The three issues were in the same order but the second and third dilemmas had slightly higher percentages for the females than the males. The other categories were all very similar too, within a couple of percent, with the only two exceptions of **inequalities in health** being listed by 4 males (2.7%) but 37 females (6.6%), and **medical model** (12 males/ 8% compared to 25 females/ 4.5%).

It may be that there was a triangulation between sex, previous work and ethical dilemmas, because there were greater percentages of males who were ex-teachers and ex-caring professions than there were for ex-nurses. For example, male ex-teachers were having different ethical dilemmas to their female counterparts.

It would be interesting in a subsequent study to investigate the relationship between sex, previous work and ethical dilemmas.

- **age and ethical dilemma**

The younger respondents were concerned about being a role model (mean age 33 years), theory vs. practice (mean age 34.9 years), being told what to do/ hidden agendas (mean age 35.8 years), while the older age groups were concerned about targeting (mean age 46.5 years), NHS bureacracy/ change (42.4 years), time (40.8 years), breadth of role/ pressure (40.5 years). When grouped, the under 25 age group were concerned about budget issues, and credibility, and interestingly,17.4% had no ethical dilemmas. The 25-34 age group were mainly concerned about budget, and credibility, the 35-44 age group were mainly concerned about budget and NHS issues, the 45-54 age group were mainly concerned about NHS issues, and budget, and the 55-64 age group were mainly concerned about NHS issues, campaigning, targeting and budget. There may be some triangular relationship between age, job and length of

service because those older respondents who had been in the job a long time had seen various stages that the NHS and Health Education then Health Promotion as a service, had been through over the years.

It would be interesting in a subsequent study to investigate the relationship between age, job and length of service.

- **SHEPS and ethical dilemmas**

SHEPS respondents

The pilot questionnaire distributed (1997) to one region the year prior to this research (1997/8) revealed that 35% (19 of the 35 Health Promotion staff) were members of SHEPS. One year later, the national response rate to this questionnaire was a lower figure of 24%. Either the South West Thames region had a higher membership rate, or the figures were dwindling within the year. **28 managers (52%) were** and 26 managers were not members of SHEPS, with many more Senior Health Promotion Advisors and Health Promotion Advisors **not** being members, namely, 7 SHPAs were and 25 (78%) were not, and 15 HPAs were and 46 (75%) were not. Thus, one quarter of HPAs were members, but only one fifth of SHPAs were. Perhaps HPAs gave up their membership during their careers, or the HPAs were more likely to have SHEPS membership discussed with them when they joined the HPU. Managers were the most likely to be members, but still only half were.

Interestingly, many of the other people in less 'specialist' health promotion jobs were members, eg. 15 PHC staff were compared to 34 who weren't, 2 dental advisors were and 4 were not. However, dietitians were less likely to be members of SHEPS: 2 were members, 13 were not, and 11 stated they were a 'not applicable' group, some said they had been told they could <u>not</u> join, but did not state whether it was by managers or the SHEPS membership secretary. There did not seem to be any continuity to this because some dietitians, for example, were members, and some complained that they had not been allowed to join. Battel-Kirk, the current (2000/2001) UK chair of SHEPS, argued that *"It is proving ever more difficult to function as a small organisation...Recognition of SHEPS as a valuable source of professional development and as a means of gaining useful experience in policy development has lessened amongst employers, particularly in England. Many members, at all levels, are attending meetings and undertaking SHEPS work entirely in their own time."* (SHEPS Newsletter, Oct/ Nov. 2000, page 1). She was therefore suggesting that the dwindling numbers were due to people not being allowed time off work to attend meetings, as was more usual in the past. She also stated that *"We are experiencing a period of uncertainty. While membership of SHEPS has been maintained at more or less our usual level, our members, and potential members, are working under different titles and within what is now termed 'multidisciplinary public health'."*

(SHEPS Newsletter, Oct/ Nov. 2000, page 1). This seems to suggest that people are not joining SHEPS because their job titles are changing. However, it is interesting to see why the questionnaire respondents stated that they weren't members.

SHEPS and reasons for non-membership

There was the opportunity for respondents to put on the questionnaire why they weren't a member of SHEPS. The quotes were fascinating to read, and some have been transcribed (in the Results section). However, two rather representative comments are as follows: *"They appear to spend too much time forever creating position papers which seem rather toothless."* ref 283, 49 yo. f. HPA; *"Have felt they have little to offer me, or I them."* Ref.436, 47 yo m., SHPO (substance misuse). Respondents stated that they were not a member of SHEPS because it was too disorganised at a local level, and that nothing ever seemed to be achieved, especially because it had little impact on other professional bodies, that SHEPS is ineffectual, it lacks direction, and is 'elitist'. People also complained about not having heard of it, or how to go about joining, and others complained that there was a 'closed shop' policy when they did find out about it. There seemed to be no guarantee that new staff were told about the organisation. Many people had been a member, but let their membership lapse due to discontent with the organisation. Some were unhappy about being a member of trade unions too, and having to pay out a number of subscriptions. The complaints about SHEPS were from all levels of staff.

Some people were not a member because their 'new' line managers, the Department of Public Health were not allowing people time off for meetings, because SHEPS attendance was not considered important enough, and the respondent had come to see that as 'true', and therefore stopped attending. Very few mentioned not being allowed time off to attend meetings, as Battel-Kirk, 2000, suggested, but more to a general dissatisfaction with the running, the lack of effectiveness, and the impact of SHEPS. On the other hand, some respondents, such as resources people, or dietitians, wanted to be members, but had been told they were not allowed. People were not given the opportunity to say why they were a member, but were given the opportunity to say for how long. The responses varied from a few weeks to since the organisation started (eg. Ref. 14).

SHEPS and Health Promotion qualifications

Of the 154 SHEPS members, **59 respondents (38%) had the MSc.**, 30 (19%) had the Diploma. Of the 495 non members of SHEPS, 83 respondents (16.8%) had the MSc. and 88 (17.7%) had the Diploma. 12 people studying for the MSc were SHEPS members, but 34 people were not members, and a similar picture for those studying for

the Diploma with 9 people being members of SHEPS and 14 not. Those 274 people who had no HP qualification consisted of 29 members of SHEPS (11%), 220 non members, and 25 n/a's. Thus it seems as though the members of SHEPS have more Health Promotion qualifications than non-members of SHEPS, and at a higher level, and also, conversely, that very few SHEPS members have no qualification. It may be that those studying the Diploma and MSc courses are encouraged, or feel more inspired, to join the professional body, or it may be that having joined SHEPS, the member decides to further their HP qualifications. *It would take another study to investigate the relationship between these two issues.*

SHEPS and ethical dilemmas

Of some concern was that only one respondent mentioned the **SHEPS Code of Professional Conduct**, which was produced in 1990. The document stated that by taking out membership of SHEPS, and/ or by appearing on the Register of Health Education and Health Promotion specialists, it was agreed that practitioners within either or both categories have a duty to: not harm people and/ or colleagues by willful deception or by knowingly misinforming on health matters; not harm people and/ or colleagues by involving them in health education/ promotion activities nor provide materials, resources or experiences which are damaging or inappropriate; not knowingly participate in health education/ promotion activities for which the practitioner is not adequately trained or competent; not discriminate by any act or omission against anyone on the basis of sex, age, race, class, religion, sexual orientation, disability or health status; not exploit any individual, group or employer with the primary purpose of personal gain or satisfaction; not provide staff, services or resources solely on the basis of convenience or privilege; not be involved in the provision of services designed solely to meet the demands of income generation or other subsidiary goals at the expense of meeting demonstrable health needs; not willfully withhold available services or information needed by people to make health choices; not breach confidentiality nor invade personal privacy; not compromise professional credibility by engaging in inappropriate collaboration with commercial enterprises or other organisations whose objectives are incompatible with health promotion principles and practice; not take any deliberate unjustifiable professional action which may bring the Society, the Register or any of their respective members into disrepute; this does not preclude healthy professional criticism.

The 154 SHEPS respondents were most concerned about **budget** allocation (20 people/ 13%), NHS bureacracy/ changes (20 people/ 13%), and **credibility** (19 people/ 12%). The 495 non-SHEPS respondents were most concerned about **budget** allocation (70 people/ 14%), NHS bureacracy/ changes (60 people/ 12%), and **credibility** (53 people/ 11%). Neither budget, credibility nor NHS changes were issues

in the Code of Conduct, although some people did express concern about the co-operation with commercial sponsors, and about inaccuracy of information (related to the issue of 'willful deception'), and some respondents described being asked to participate in health education/ promotion activities for which they were not adequately trained or competent, which overlapped with issues about being told what to do, and having to justify work with evaluation. Thus the SHEPS and non-SHEPS respondents were overall describing having the **same ethical dilemmas** and in the **same proportions**. It is interesting that they did not differ even though they would have more access to discussion papers about professional issues. SHEPS members having the same listed ethical dilemmas as other respondents may well have something to do with the volume of people who had previously been members but had left SHEPS due to dissatisfaction.

Future for SHEPS

Battel-Kirk, the UK chair of SHEPS, in the SHEPS Newsletter, (Oct/ Nov. 2000, page 1) suggested that policy and practice change, limited resources, a disinclination to raise membership fees, and failure to gain charitable status, may mean that SHEPS becomes an interest group within the UKPHA (UK Public Health Assoc.) or revisiting the possibility of a professional register of Health Promotion Specialists.

- **health promotion qualification and ethical dilemmas**

Of those who had **no Health Promotion qualification**, their main ethical dilemmas were **budget** (48 people), **NHS issues** (32 people), **credibility** (30 people), and **none** (29 people). Of those with the **certificate**, the main ethical dilemmas were **NHS issues** (19 people), **credibility** (10 people), and **budget** (9 people); 6 people had none. Of those **studying for the diploma** (23 people), the main dilemma was **budget** (4 people). Of those with the **Diploma**, the main ethical dilemmas were **NHS issues** (21 people), **budget** (16 people), **credibility** (14 people), **working in medical model** (12 people); only 5 people had none. Of those with the **degree** (only 6 people in total), the main dilemma was **budget** (3 people). Of those 47 people **studying for the MSc.**, the main ethical dilemmas were **credibility** (8 people), **budget** (7 people), **NHS issues** (5 people) and **effectiveness or not** (5 people). Of those 139 people with the **MSc.**, the main ethical dilemmas were **NHS issues** (17 people), **budget** (16 people), **credibility** (16 people), **being told what to do** (16 people); only 6 people had none. The only person with a Health Promotion **PhD.** had their main ethical dilemma as **being told what to do.**

Thus a similar picture emerged across Health Promotion qualifications. The main ethical dilemmas were (in order) **NHS issues, budget, credibility.** The only difference

was that those **studying for the MSc.** placed **credibility** higher than other people, and those with the MSc included another category to all the other groups, (apart from the one PhD. respondent) which was **being told what to do.**

- **bad points and ethical dilemmas**

708 people responded to this question, 66 did not. The main bad points about the job were **bureacracy (26.8%)** and **pressure (16.4%).** The rest varied between 0.3% and 8.5%. The bad points about people's work centred mainly around the NHS.
The space allocated for the answers to this question was small, so that meant that most answers were one word only, but some people squashed a comment in the margin, and a selection of these are included below. With regard to NHS issues, people described the NHS as a bad employer, for example, Ref 283 described *"Poor and cramped working conditions in the department, eg. rising damp and falling plaster"* and a common complaint was that *"there is constant change at policy level"* ref 238, 32 y.o. m. manager, a point echoed by Ref 359, a 38 year old female SHPA (schools) whose bad point was *"constant restructuring"*. People seemed very overloaded with work, described by Ref 313, a 29 year old female SHPA (primary care) who had *"Too much to do, as I have both operational and managerial responsibilities"*, reiterated by Ref 305, a 45 year old male HPA (schools sex education) describing *"There's too much to do"*, also lamented by Ref. 389, a 38 year old female community dietitian, whose bad point was *"We don't have enough hours to do our work"* Poor pay was also a bad point, for example, Ref.705, a 45 year old male SHPA (health information) who stated that his bad point was *"Poor pay in relation to those with whom I liaise at senior levels in partnership organisations."*. With regard to **professional issues** the overall tone was one of disillusionment, for example, *"The profession is not respected by those outside health promotion."* ref 213, 28yo f, HPU 60, SHPA cancer awareness, *"having to sell myself"* ref. 388, 52 yo f. SHPA, sexual health, *"I feel as if I'm getting nowhere"* ref 313, 29 yo f. SHPA primary care.

Because there were so many different answers which were, in fact, similar, the 25 different 'bad points' were categorised into 5 groups, namely: NHS issues (355 people/ 50.4%), professional issues (318 people/ 45.2%), people (13 people/ 1.8%), don't know (14 people/ 2%), and none (4 people/ .6%). Thus, over half of respondents cited NHS issues, and nearly half cited professional issues as their bad point about work. When categorised, the bad points listed do seem to match the shape of 'dissatisfaction with work' theorists. Herzberg distinguished between 'dissatisfiers' namely 'hygiene/ maintenance' factors, (eg. company policy, admin., supervision, pay, interpersonal relations and physical working conditions), and 'satisfiers', namely 'motivation factors' (eg. achievement, recognition, work itself, responsibility and advancement). In this research, the majority of bad points, ie. physical factors, NHS issues, stress, when

grouped do make up a large proportion (355 people/ 50.4%) of the bad points listed. The research findings are that people listed many physical factors as bad points, and Maslow would argue that unless physiological and safety needs are met, then people will be less likely to be self-actualising.

Some respondents described bad points about work which seemed to **overlap with ethical dilemmas**, for example, Ref. 630, a 35 year old male HPA (drug education)'s bad point about their job was *"lack of credibility of hp in many people's eyes."* This bad point is in fact to do with ethical issues. 673 people answered both the bad points and ethical dilemmas questions, (and 106 people/ 13.6% were missing.) Some bad points about work were listed, and then seemed to be expanded upon in the question asking about ethical dilemmas, namely **bureacracy**, and **budget allocations**. 33 people stated that bureacracy was their bad point about work and also stated that bureacracy was their ethical dilemma. (This represents 5% of the 673 people who answered both questions.) 12 people stated that budget allocations were their bad point about work and also that it was their ethical dilemma. 102 people whose main bad point about work was bureacracy had ethical dilemmas about bureacracy, credibility, budget allocations, being misunderstood and none. 33 people whose bad point about work was pressure/ stress had ethical dilemmas about budget allocations and NHS issues. Thus the picture seemed to be emerging that bad points about work led to ethical dilemmas. Rather than leave the job, people were having dilemmas.

- **future of Health Promotion**

710 people answered this question, with 64 people (8.3%) 'missing'. It was interesting to note that the largest figure for the suggestion of the future of Health Promotion was **'don't know'** (118 people/ 15.2%). The second largest suggestion was **'positive because of the new Labour Government'** (108 people/ 14.0%), and the third suggestion was **'to be more professional'** (82 people/ 10.6%), and fourthly **'positive'** (79 people/ 10.2%). These four suggestions totalled 50%.

Summary:

Thus, in summary, some **regions** (countries) had different responses to the overall picture of having dilemmas about the NHS, budget and credibility, namely Scotland, Wales, Ireland. Some **jobs** were associated with different dilemmas, namely managers, HIV workers, dietitians. Many people had a **first degree**, but it appeared that studying for or having the **MSc.** in Health Promotion had some impact on raising issues of credibility equal to the standard pattern of NHS and budget dilemmas. No **jobs** stood out as being different in pattern to others. The two **sexes** had broadly similar responses. Some people may have misunderstood the term 'ethical dilemmas' because many

people had the same ethical dilemmas as bad points about their work, or it may have been that the people's bad points about work were leading to ethical dilemmas. The SHEPS and non-SHEPS respondents were overall describing having the same ethical dilemmas and in the same proportions. Of some concern was that only one respondent mentioned the SHEPS 1990 Code of Professional Conduct.

- **preliminary studies**

Each study was meant to inform the next, but each became of interest in itself. However, for reasons of time the preliminary studies could only be seen and used as overviews.

- **Lengthy mailout**

The national questionnaire mailout took 6 months to complete, which must have some implications for appropriateness of timing for some Units or staff. It may be that there were differences in the numbers of staff at different times of the year. The solution would be to enlist help with a mailout.

- **Covering letter**

The covering letter was addressed to the office manager, so it may be that some HPU manager felt bypassed. However, it appears that it was correct sending the materials to the office manager, because it is they who open and distribute the mail .

- **Complaints**

3 HPUs complained about the questionnaire, one that the questionnaire was intrusive, one that there had recently been a very similar questionnaire (which was, in fact, a SHEPS audit, and not the same at all), and the third HPU felt that persmission should have been sought before distributing the questionnaires directly. Ideally, each HPU could have been teleephoned and the nature of the research explained, but it would perhaps be impractical with a national survey.

- **Allocated space on questionnaire**

It was purposeful that the questionnaire was very brief, and some people did write in the allocated space very succinctly. Others added extra sheets of paper. A lengthier questionnaire may have reduced participation by many people.

Research questions and answers summarised:

- what ethical dilemmas do Health Promotion workers report about their work?

The main ethical dilemmas were NHS issues, budget and credibility.

- does regarding Health Promotion as a profession detract from its intended impact?

This question was not directly asked, but respondents described credibility as their third largest ethical dilemma, yet very few respondents were members of the professional body available to them.

- does the educational background of people who work in Health Promotion feature as a factor in determining their dilemmas?

No, because many respondents had a first degree, but those with or studying for the MSc in Health Promotion described credibility issues equal to NHS and budget issues.

- does the work experience, (for example, ex-nurses, ex-teachers, ex-social workers) of people who work in Health Promotion feature as a factor in determining their dilemmas?

It appeared that ex-nurses, ex-teachers and ex-social workers were having the same ethical dilemmas to the rest of the whole sample.

- does membership of the professional body, SHEPS, correspond with particular ethical concerns?

No, it appeared that they were having the same pattern of ethical dilemmas to the rest of the sample.

- are recent structural changes to the NHS perceived by staff as detrimental to the standard and efficacy of Health Promotion?

Yes, very detrimental. Half of the respondents listed bureacracy and pressure (NHS issues) as a bad point about work, and NHS issues and budget as their main ethical dilemmas.

- do Health Promotion workers perceive the concern about their ethical dilemmas about Health Promotion as posing a barrier to the practice of Health Promotion?

No, people seemed to be just getting on with their job. However, many people had a very short length of service in Health Promotion. It may be that people who have ethical dilemmas about their work are leaving the job. Very few described the theory-practice issue as being an ethical dilemma.

- can specific variables which influence ethical dilemmas be identified?

No, it appeared that no specific variable could be used as a predictor for ethical dilemmas, other than bad points about the job and ethical dilemmas were very similar.

- do those Health Promoters who have ethical dilemmas about their work leave the job?

It will take another study to determine this.

Conclusions:

It was originally intended to find out whether Health Promotion Advisors had ethical dilemmas about their work

It is concluded that Health Promotion needs to define its philosophy role and services to its partners in health care, and those who hold the budgets. From the preliminary studies, it seemed as though there are a lot of people 'running around' trying to do some 'good', but the profession has little credibility, no induction or training structure, lack of clear direction and is little understood by those most affecting health services, i.e. the decision makers and budget holders. The 8 initial decision makers who were interviewed about Health Promotion as a service all had a very different view of Health Promotion, its current functions and its future. The replies to the region Health Promotion staff questionnaires revealed a massive difference in people's length of

service, training, styles of working, line of management, ethical dilemmas and hopes for the future. Many people stated that they liked their job because of the freedom and flexibility and disliked the bureacracy and change associated with the NHS. People were very concerned about the truth of the information they were imparting, and not so concerned about inequalities in health because they felt they could do nothing about that. It was suggested by some that Health Promotion should return to Health Education and work direct with the public, or actually do something - some kind of political action. The majority of respondents had ethical dilemmas about their work, but had little or no opportunity to express their concerns or discuss them in a non-judgemental way with colleagues. Those respondents who were subsequently interviewed found that the lack of opportunity to work through their concerns had either led them to become cynical, or dismiss their concerns as silly. The cynicism was leading to people to suggest that they might leave the service. When general public were approached by questionnaire in a G.P.'s surgery, they had similar opinions to Health Promotion staff on the concept of health, Health Education and Promotion and what they felt were today's health problems. It could be said that today's public are 'articulate consumers'.

It does seem that Health Promotion has little respect or credibility from colleagues. The public however, seemed to have definite ideas for Health Education and Promotion. The profession seems to be understood by those it is serving, but not by those directing the service, and holding the budgets. The lack of credibility will have repercussions on loyalty. Health Promotion will increase its credibility with a more united voice if practitioners were made aware of SHEPS more quickly and if a co-ordinated approach to induction and training are initiated. French, in his PhD research, 2000, described how the thirty four people he interviewed found that analysing values and looking at theoretical perspectives were not a 'top of the mind' issue and that *"...theory was indeed important and that a perceived failure to root practice in theory was seen as a significant weakness and a block to further progress."*. He subsequently coined the term *'intuitive rightness'* (2,000:152) to describe how Health Promotion Specialists 'retreat from theory' and feel unwilling to explain or justify their work. In addition, French, 2000:158, found that some of his interviewees thought that reflection about Health Promotion theory created unnecessary confusion, a *'muddying of the waters'*. The apparent lack of reflection on theoretical issues may be caused by the lack of agreed definitions of key words, such as health education, promotion, public development, etc. and lack of consistency and specificity. He concluded that *"It is presumably very difficult to verbalize theory if you do not have a consistent and commonly understood language to do it with."*

In the main study, the primary ethical dilemmas concerned NHS issues, budget and credibility. Thus the NHS as a poor employer was raising more ethical concerns than

the philosophy or content of the people's work. But, for example, although the issue such as 'budget' was being described, it was in fact, other issues surrounding the allocation of the budget that were in fact the ethical dilemmas, for example, resentment at allocation, the equity of distribution and the hypocrisy or even deceit in some allocations. Thus, some people's ethical dilemmas were, on the face of it, the same, but their explanations and therefore, their reasoning were vastly different. This is where the labelling became difficult and in some instances, pointless. However, a future study could investigate the deeper reasoning behind what was, on the face of it, the same label.

Recommendations:

Induction and training

'New' Health Promoters join the Society of Health Education/ Promotion Specialists only if they want to, undertake the Diploma or MSc only if they want to and their lina manager allows it, and there is no formal induction course. Other districts get to hear about or meet the 'new' Health Promoter by chance, after they have perhaps spent a lot of time reinventing the wheel. A national body, perhaps SHEPS or the HDA needs to co-ordinate induction and training of new staff.

Society of Health Education and Promotion Specialists

Many new staff do not know about SHEPS, who should have a recruitment drive. It would be useful for support staff to have some sort of membership available to them, especially when they have so much direct contact with the public. It is only those who join SHEPS who are made aware of the Code of Conduct.

Position of Health Promotion Service

Health Education was placed in Local Authorities, and subsequently in the NHS, then became Health Promotion in Community Health, or Public Health Departments, and then separated into Purchaser or Provider Units or a dual role, and some back again into Environmental Health Departments, Public Health Departments, or Health Promotion Agencies. Health Promotion Specialists need to decide where they want to be, not where their service is politically 'pushed and shoved'.

Prestige/ status/ pay

NHS Health Promotion Advisors are paid on the Admin. and Clerical Scale, and not on the Professional Scale. Health Promotion Advisors earn less than their Local

Authority, nursing, teaching and Public Health colleagues. Because many people do not know the content or nature of Health Promotion work and philosophy, the work seems undervalued. This was made apparent by the respondents to the questionnaire. The undervaluing is reflected in the pay. Health Promoters need to have their pay reflecting their competencies.

Campaigning role

Health Promotion seems to have lost, had removed, or feels guilty about its campaigning role. Health Promotion needs to resuscitate its campaigning role. "Energy needs to go into campaigning not research."(Feder, 1990.) Since the Government disbanded the HEC and formed the HEA, the campaigning role of Health Education has lost ground to community development and letting an ill informed (but not unknowledgeable) public decide what Health Education measures they want to see.

Code of Ethics

If people join the SHEPS, then they receive a photocopy of the Code of Conduct. However, it cannot just be assumed that a Code Of Conduct has the same implications for practitioners. Health Promotion needs a regularly updated Code of Ethics which *"...is a statement of belief. It is a statement about what the profession believes itself and its purpose to be, and, therefore, embodies a statement of belief about human nature."* (Rumbold, 1993:230.) Each new Health Promoter should receive the Code of Conduct, not just those who join SHEPS. A Code of Ethics should be devised.

Training in Ethics

Many health issues are emotive ones, which means that decisions are made on emotional responses. Thus Health Promotion practitioners need guidelines about coming to such decisions. Ethics as a philosophy and the Code of Ethics should be included on 'new' Health Promotion Advisors' induction and in addition on professional courses. People need the time to look at their own beliefs and values and understand how they arrived at them. *"Ethical decisions, like other professional decisions, should be informed."* (Rumbold, 1993:233). Johns, 1995, suggests that practice decisions are not based on technical rationality but are rather guided by an interaction of experience and theory, and Eraut, 1994 argues that people want to engage in developing professional reasoning abilities. Thus training courses must allow for their students to describe and analyse and perhaps find some solutions to their ethical dilemmas at work. People were not used to discussing ethical dilemmas without it sounding as if they were issues that they had not thought through fully and come to some conclusion about.

If Health Promoters are given the time and the opportunity to consider the ethical issues in their work and the impact their views and opinions have on others, then this opportunity for critical self reflection is also an opportunity for renewal. Ethical analysis needs to avoid being naive, ambiguous or too broadly based by encompassing individual analysis and keeping specific topics or situations in mind- a 'harm minimisation' approach may feel justified with regards to say drug use, but not cigarette consumption. People need the time to assess and justify their beliefs with regards to a particular issue.

From the individual's point of view, the ideal outcome of moral debate is an answer- a reassurance, a consistency, but from the social point of view, the ideal outcome of moral debate is not the acceptance of one standpoint, but healthy moral testing, and a sharing of ideas. Health Promotion needs to find some way of ensuring that their work is of the best possible kind. The answer is ethical enquiry. However, there must be a structure to facilitate the transformation of the rhetoric of health promotion into practice, and to increase the presence of moral deliberations and models in the health education professional literature. Thus Health Promotion is not falling apart, but is at the stage of redefining itself.

Further research:

It would be interesting in subsequent studies to investigate the relationship between:

- age, job and length of service
- sex and ethical dilemmas
- current job and previous work
- the psychological dynamics of Health Promotion workers as a team
- people's stated ethical dilemmas and their suggested practical solutions
- bad points about work and ethical dilemmas
- membership of SHEPS and ethical dilemmas
- impact of Public Health Specialists on Health Promotion
- whether Health Promotion Specialists who have many ethical dilemmas leave the job

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APPENDICES

- Preliminary studies raw data
- Questionnaire
- Variable lists
- Raw data for questions
  - district
  - age
  - qualifications
- Crosstabulations:
  - job and ethical dilemma
  - health promotion qualification and ethical dilemma
  - bad points about work and ethical dilemmas
- Profile of 36 respondents
- Selection of the 36 verbatim questionnaires
- Profile of managers
- Profile of dietitians
- Profile of HIV/ sexual health workers
- Profile of SHEPS members
- Profile of ex-teachers
- Profile of ex-nurses
- Profile of ex-social workers

1. PRELIMINARY STUDIES

Focus group notes

The first discussion was on defining health, health education and promotion.

p How would you define health?
d There are good and bad definitions of health. Health is the absence of disease.
f There is a relationship between health and ill health.
n It's an individual concept
d There are levels of health.
g But who decides who is healthy. These are value judgements.
f You're as healthy as you can be in your condition. An asthmatic might consider herself healthy or unhealthy.
n You tell people about your health.
g Let individuals define their own health.
f health has been defined for us
n such as by the World Health Organisation
d health is physical, mental, and to do with housing and unemployment.
g if you're unemployed are you therefore not healthy
d if you're having a good time.
g it's to do with self esteem.
f you can't be healthy when you're unemployed because you need money.
d money and housing go together.
g health is about enjoyment.
n there are stages in health.
g health is transient.
d homelessness and health can't lead to happiness.
d you can't go to the dentist.
f some dentistry gives you bad teeth anyway.
p can we go back to defining health education and promotion now.
d education is about imparting knowledge to an audience.
g healthy environments need to be built.
f health promotion is wider. The environment needs to be conducive.
d health education healthy eating sessions involve groupwork. Health promotion is about making changes.
n the role of the government is the most important, especially taxes and influencing manufacturers.
f but does the government know what health promotion is.

d with regards to food its about reducing fat, and making sure people get healthy options.
n you must let people make their own choices.
d sometimes I eat because I'm offered something, and I feel I have to. I generally try to be a role model though and eat the healthy option if it's there. I even make a point of saying something about it to the people providing the food.
f one health promotion unit all took up smoking to demonstrate free will.
d diet can vary in its effect, but smoking kills.
f but there's the freedom to smoke.
g is health promotion about being evangelical and waving banners.
d some units will because staff evolve in units.
g you're restricted by your workplace and its philosophy.
d you couldn't dye your hair and be a HPA.
g well I think I will now.
d No, you have a professional image to keep up. It's all about credibility. You have to look smart, especially for the older people.
f some areas of work need a different kind of credibility, such as a sexual health worker.
d you have to look professional not glamorous.
n you have to dress appropriately.
g you have to be yourself.
f the best nurse I knew was a punk. She was really approachable.
d professionals have to look professional.
n you're judged by your appearance.
d dietitians are anyway.
p we have to finish now.

<u>The second focus discussion was around targeting.</u>

p is it ethical to target?
g is it ethical to do health promotion at all.
n you target high risk people to avoid future illness.
f if you appropriately meet needs, then you lead to positive health.
n you do it by research and needs assessment
f and a gut feeling.
g its all about scapegoating.
d its about minorities.
f young people are a target group.
g we target because our jobs are designed to do so.
d my target group is 5 to 75.

f my target group is my staff.
d I don't like being a target group. It's OK if you're the target of affection but not bullets.
n I don't mind if someone's trying to help me.
g but who are they to interfere.
d I want to make my own decisions and not listen to busybodies.
g aren't we busybodies, even health fascists. Is health above everything.
f let's define health again.
g we should be looking at positive targeting.
f we're employed to target.
g we should be globally targeting.
n we're helping those who need it most.
g that's a white middle class work ethic.
n we're just caring for people.
g if we want quality we should target everyone.
d information should be given freely.
g everyone should get the same information.
n should people come to you for the information.
g the philosophy of working in health promotion and targeting young people is that you never get to see a young person, you work with youth club leaders. We're pyramid selling.
d young people have got different needs to adults, so they have to be a different target group.
g they're going through massive changes, both cognitive and physical.
f we're trying to maximise change.
g it's social control.
p we have to finish now.
g we're social moralisers.
f we're trying to facilitate change.
g we're trying to make people fit in with society. It's a right wing philosophy.
n we're trying to make people tolerant.
g we should be trying to get people to maximise their own growth potential.
n empower people to make their own change.
d the approach is different.
d the way of targeting groups should vary.
p we have to finish now.

<u>The last discussion was on the social and economic factors in health.</u>

p What are the social and economic factors involved in health?
n it's all about money, and trying to save the Government money.

g we should all cycle to work.
f pollution is a problem.
n reducing CHD figures is a cost effectiveness measure.
d is health promotion about saving the government money.
f cost reduction is used in a lot of arenas.
g does healthy eating cost more.
d it shouldn't, but it can.
g should we be doing any health education in this country, what about other countries.
d yes, the health gaps are actually widening in this country.
g the last centuries gap was worse.
f is health better because you live longer.
d sewerage and water used to be the problems.
f there's still pollution in some areas.
g unemployment is the problem.
f those figures are milked.
p what figures do you believe in?
f I look at figures, and compare them to my experience as a nurse.
g we should be looking at the quality of life, not quantity.
f we should be looking at mental health.
d there are repercussions, social and economic everywhere. We could be looking at unemployment or VD figures.
n should we just be doing global work.
d take shopping at Marks and Spencers, they are meant to have less checkouts with sweets on them as a result of our campaign, but in reality they replace sweets with biscuits.
g children like sweets. Let them have them if they want.
n the work we're doing is nothing compared with the impact the Government could have on these issues.
f we should be dispelling myths.
d the role of advertising is massive. Why doesn't the HEA use it more often.
n there should be health adverts on the T.V.
p we have to finish now.

.....

The interviewer is transcribed in *italics*.
Hesitations or thinking time is transcribed ....
Interviews took 15 minutes unless otherwise indicated. A dictaphone was used to tape record the interviews. Transcriptions are verbatim.

Interviewee 1: DHPM, 58, F, 19 years in post.

Please could you define health- what is health?
To me health is being alive, feeling alive, feeling good and being able to enjoy yourself.
How would you define Health Education?
Education about health, education on how to feel reasonably good about yourself.
How would you define Health Promotion?
Health Promotion is... the promotion of the fact that you can feel good about yourself, that health is something that you can have and that it can be a valued commodity. It doesn't tell you how to get there, but it promotes the fact that health is a good thing to have.
Using the Ewles and Simnett 'models' of Health Education, which way of working would you say is nearest to you own?
I can't say, because quite frankly, I use a bit of all of them.
Is a bit of all of them appropriate, or should you be striving towards one way of working?
No, I don't think you should strive towards one way.
Do you have any ethical or moral dilemmas about Health Education or Promotion?
Yes, I mean, what is health for one person needn't necessarily be health to another. Have we the right to take what we think is health and try to promote it? I don't know... What is always so difficult is how you gauge health and how you get there. The medical profession themselves don't even agree on lots of things. I do find that difficult.
Any other areas?
I wonder whether or not we're doing any good. I've been in Health Education for so long, and I wonder whether forcing us into the Health of The Nation targets is right. I'm not sure that that's what we should be doing, but I'm forced to do it. All our work now has to be geared to Health of The Nation, and I'm not sure, because it misses out so much - unemployment, low income people, and the difficulties for these people. O.K., so they take into consideration bringing down teenage pregnancies, but the people who say that, don't look at why these people get pregnant, and I think there's a lot we can't do anything about. How can you make people feel good about themselves? How can you? Many people want more basic things.
Where do you see Health Promotion going?

As a profession?
Yes.
I can see it landing up within the FHSA, and become mainly primary prevention with general practitioners.
Where would you like to see Health Promotion going?
I would like to see more community development, and more Health Education. That's the way it's done in the States, I've never been able to analyse it but I'd rather like to. You need to try to work along the lines of community development, and then you can start thinking along the lines of what's happening in the the real world, in the environment, and really get amongst the people and see where they're at, and what they want, because Health of The Nation doesn't do that. And we haven't got the resources to do it either, but it would be nice to have a Health Education Officer on say a Council Estate, perhaps, and get the people together and ask them what they want and start from where they're at. It probably wouldn't be anything to do with health to begin with, it might be better living conditions, it might be having a play area, for the kids or somehwere to leave the kids so that mums can go away for a bit. I think that's just as much Health Education as telling them not to smoke.
Are these ethical dilemmas that you've always had, or have they arisen?
That I've always had. I don't think I've been able to work through any of them because you end up getting cynical about them.
Can you tell me what are the good points about your job?
I have a fantastic team that I work with- they really are great. A certain amount of autonomy, which is good, and I've got a Health Authority that's pretty supportive if I want to do things, which is useful. Those are the sorts of things that I like. It's a nice, good atmosphere.
And what don't you like about your job?
Ha, masses of paperwork! I dread to think how many forests have been cut down because of it. There isn't time to read through everything as well, there just isn't the time, you just can't. And I do feel very tied to Health of The Nation.
Does your department get the time to have days to define things, such as what Health Education means to them?
Yes, we did that for our Mission Statement. The managers also had an Away Day for managers to write their Business Plan... Actually the other thing I dislike about this job is that planning is on annual cycle, you're chasing your tail thinking about purchasing intentions for next year before you've finished doing what you're doing this year. It would be much more sensible to have a 2 year cycle.
When you've had awareness raising days have you included Ethics as a concept in them?
No we haven't, perhaps it would take up too much time - you'd be going round in circles.

OK. Um... do you belong to the Society of Health Education and Pomotion Specialists?
I used to but I don't bother now. I used be ferverent member, but not now.
Do you have a Health Promotion qualification?
Yes, I've got the Diploma. I did it at South Bank.
What is your main work history?
Originally nursing, and then selling. I was a medical rep. for four years. I was also in Occupational Health for a while.
Do think that your sales background reflects on your way of working in Health Promotion?
Yes, that's what got me into Health Promotion I think, in the first place. I learned about people, interviewing, talking to people, techniques. I've also got a counselling background, which is useful for managing people. You can listen to their problems. Whether it's helpful in Health Promotion I don't know, but it's useful in managing.
Have you got any comments generally about the questionnaire or this interview?
Yes, it made me think. It made me stop and think. I guess there are ethical issues, and why haven't I done anything about them? Is it time, or where does it get you just thinking about them?
Do you think that ethical considerations are considered something of a 'luxury' when there's work to be got on with?
Yes I think I do...what's the word I want?... I suppose in a way you compromise. The ethical issues are there, but where's it going to get me. You carry on with your job.
Any more comments?
Yes, you see I left the Health Service, and now I'm back there's an awful lot of changes- purchasers and providers, and that's throwing up ethical issues on it's own. You don't get time to look at ethical issues in the internal market. You're having to decide who gets a certain amount of money to use, then you have to divide it up for treated in the NHS, and if you do a Needs Assessment, you only have beds or run stop smoking clinics. Health Education goes to the back.
O.K., thank you.

<u>Interviewee 3.</u> SHPA, 28, M, 2 months in post.

Can you define health for me?.
Um .... that's ... it's really difficult to answer ... health is ... everything - it's mental, physical, spiritual, emotional, so ... all of these ... the way I look at it, health is about people exercising healthy choices.
Can you define Health Education.
It's about trying to empower people, to enable them to make informed, and hopefully, less risky choices.
Can you define Health Promotion.

Health Promotion in a way is about me trying to work with client groups, helping them to make healthy choices, rather than about me addressing a specific issue, such as alcohol or drugs or HIV. It's actually addressing, from where they're at, and looking at what's not going right for them, or what it is that's stopping them from making what may be considered healthy choices. But that's like a judgement, maybe, you know...

If you were going to look at a health promotion model which would you say is nearest to your style of working?

Without trying to fudge the whole thing it's probably a number of elements involved in the work that I would do, but if you asked me to pick one I would say 'client directed' approach, working from wherever they're at and to go wherever they want to go to because if they're happy with the situation they're in, and they're not interested with your intervention in any way, then I'd have to respect that, and not try to force them to take on any message that I may have for them.

Could you tell me if you have any ethical or moral dilemmas about Health Education or Promotion?

Well, I just touched on that issue of intervention, have I set myself up as some sort of um... paragon of virtue? You know, I have an understanding of your situation and I'm going to tell you what's going to make your situation better, and I've got an understanding of your health and I will tell you what will be better for your health in the long term or the short term or just generally. Should I set myself up in that way? I don't think I am, I hope I'm not. So that's the first thing. Do I have the right to actually involve myself in other people's lives? It can also come down to more specific issues, of ... say I'm working with young people and they're involved with crime what are my legal duties ... what's my duties to them, what's my duties to myself. Trying to balance all those things. It's the same with confidentiality. If in a confidential environment they disclose something maybe it has implications for a third party, you know, where does my duty lie, and those sorts of things. I'm trying to develop some work with a group of young offenders, and if they disclose within the context of the group that they are still offending, what do I do with that information?

Do you have guidelines for these ethical dilemmas, and how would you advise a person new to Health Promotion in the areas you mentioned?

Ah...well, a lot of those I would probably take a pragmatic approach, which means that I would probably go with whatever I felt was best at the time, which of course would not easily fit into a policy. I don't think I'm in a position to offer any definitive thing...I don't think so...

As a relatively 'new' Health Promotion Advisor have you got any advice for another new Health Promoter?

I'd suggest they try and move away from the concept of Health Promotion at all costs. I don't think the two words are ... valuable put together ... health and promotion because I think you end up ... and you do it to yourself ... in a situation where you put up displays and provide leaflets and um ... that's as far as it goes ... waving flags and

waving banners ... and health is personal and about individuals and we should be trying to work with individuals to allow them to be truly healthy. That would encompass the environmental issues, mental health issues and emotional issues, and all that. We're not about just sticking up a no smoking poster, or a use a condom leaflet, or whatever, we have to think in much wider terms of what the whole concept is ... we're trying to enable people to meet their individual resources.

In which case, where do you see Health Promotion going?

Yeah ... I think it's in a state of change you know ... it probably was initially a leaflet and work pack and whatever ... resource service ... and we still provide that, but I think we'll be moving into areas ... a lot has been talked about in terms of community development, working with groups within specific communities to enable them to better their health, and I think that it will be the way it goes ... more specific and more defined, and it will also mean that ultimately there will be a lot more evaluation, which people get a bit edgy about. I see it moving more out ... out into the community ... and almost as 'outreach' ... 'outreach' that's what I feel I do. I don't do any work in here, you know, I do my work out there with other groups. I need to demonstrate my credibility to them ...

And what does credibility mean?

You'd have to ask them that! But to me, that would mean that I'd have to have some knowledge and abilities and some resources that they can use.

Does it involve respect?

What ... them respecting me? Um ... I think you need to be careful with the word respect, it very often means humbling yourself to someone and it's not about that it's about acknowledging in a genuine fashion that someone has got something that you can use..

And what sort of things do you like about your job?

Hum ... what do I like about my job? ... The good points are difficult to pick out at this precise moment in time but I'd go for ... the fact that I've got a relative freedom to develop work, as I see fit. But that may not always be the way ...so I quite like the freedom. I quite like being used on a 'consultancy' basis for want of a better word. I suppose I like the acknowledgement that I have something people want .. I get the opportunity to demonstrate my knowledge.

And what do you dislike about your job?

I dislike the concept of Health Promotion ... I feel people would like me to walk up and down a high street handing out leaflets to people. I have a difficulty with that. I don't like that. I have specific difficulties with what feels like having two part time jobs at the minute. In terms of management there seem to be two very different approaches being used, and inconsistent messages. I just want to get on with things.

Do your previous jobs reflect on your current style and approach?

Oh ... yeah ... my work seems to be the same, equipping people with skills, knowledge and information ... developing choices.

Do you have any comments about the questionnaire or this interview, or want to expand on any areas?
Where do I start? ... I do find Health Promotion a strange concept. I think people are becoming aware of my opinions and my approach, so that's a positive aspect ...

Please could you fill in this questionnaire. You don't have to put your name on this answer sheet.
If you can't answer any questions or don't want to, then just leave a gap.

1.About how long ago did you last visit the doctor?

2.Who do you think is best to talk to you about your health, for example, the Government, doctors, nurses, parents, friends, etc.

3.What does 'health' mean to you?

4.What is 'health education'?

5.What is 'health promotion'?

6.What do you think Health Education/ Promotion Advisors do?

7.What do you feel are the major health problems of today?

8.Which poster or leaflet, if any, do you find the most useful in the surgery, and why?

9.Please state the following...
age..... sex.....
occupation or last job.....

~ Please leave this answer sheet in the box near reception ~
~ Thank you very much for taking the time to fill in this questionnaire ~
Penny Walters, Merton and Sutton Health Promotion Service.

(a). HEALTH PROMOTION ADVISORS QUESTIONNAIRES: RESULTS

South West Thames Health Promotion Unit by district

District.	Staff	Response.	%
Merton and Sutton	10	9	90%
Croydon	11	9	82%
Wandsworth	15	2	13%
Richmond Twickenham and Roehampton	8	3	38%
Kingston and Esher	5	2	40%
East Surrey	11	6	55%
Mid Surrey	15	10	67%
Worthing	12	8	67%
N.W. Surrey	20	3	15%
Chichester	8	1	13%
W. Surrey and N. E. Hants	8	4	50%
Mid Downs	10	6	60%
S.W. Surrey	7	2	29%
	140	**65**	**46%**

Key:
HPA: Health Promotion Advisor
SHPA: Senior Health Promotion Advisor
DHPM: Deputy Health Promotion Manager

Job title.

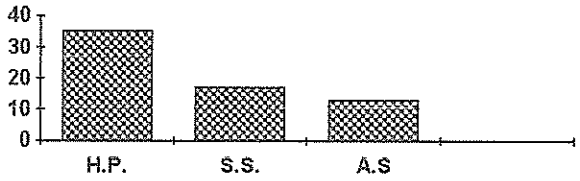
Manager	4 (6%)	Deputy Manager	3 (5%)
Senior HPA	16 (25%)	HPA	9 14%)
Trainee HPA	1 (2%)	Office Manager	2 (3%)
Secretary	5 (8%)	Resources Manager	4 (6%)
Resources Assistant	4 (6%)	Dietitian	6 (9%)
Acting DHPM	2 (3%)	Mental Hlth. Facilitator	1 (2%)
Graphics Officer	2 (3%)	Counsellor	3 (5%)
Public Health Specialist	2 (3%)	District HIV co-ord.	1 (2%)

Summary.

Health Promotion	35 (54%)	Support staff
17(26%)		
Associated staff	13 (20%)	

Distribution of Health Promotion service staff in South West Thames.

~ Frequency ~



~ Staff ~

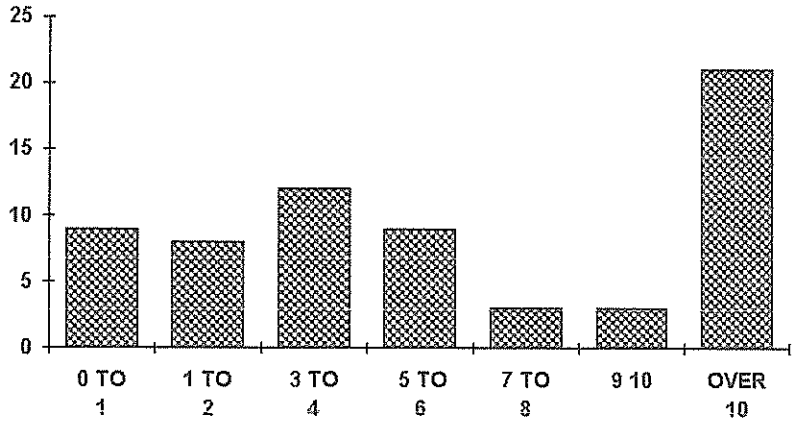
Key: HP-Health Promotion; SS-support staff; AS-associated staff.

Length of NHS service.

0-1	9 (14%)	1-2	8 (12%)
3-4	12 (18%)	5-6	9 (14%)
7-8	3 (5%)	9-10	3 (5%)
10+	21 (32%)		

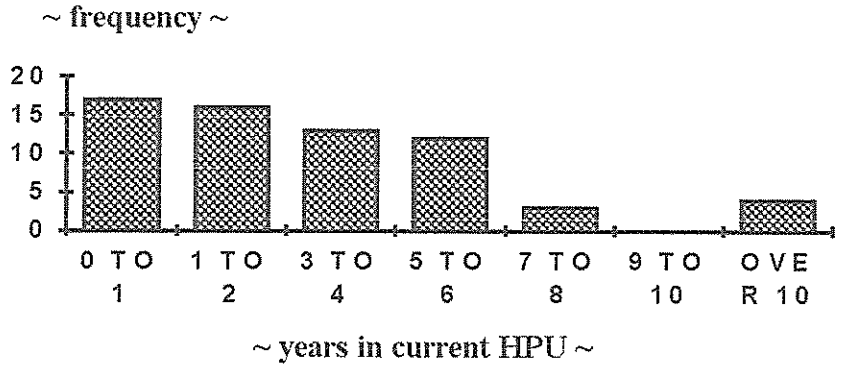
Length of service in NHS Health Promotion staff in S. W. Thames.

~ frequency ~

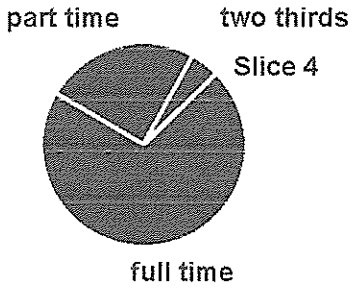


~ years in NHS ~

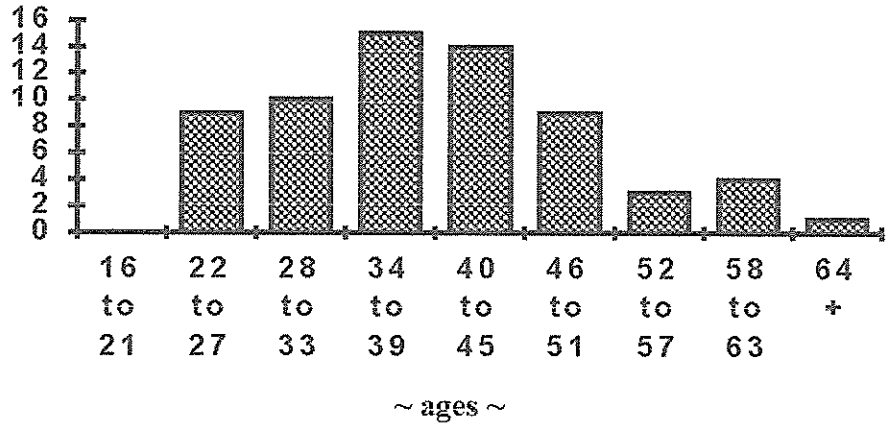
Length of service in current HPUs in S. W. Thames.



Working week

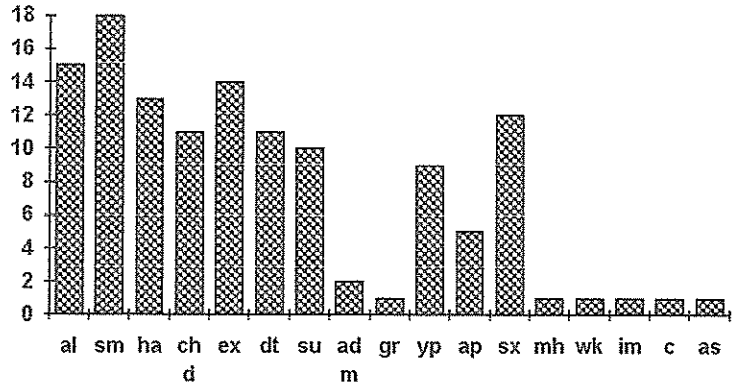


Age.



Current distribution of work by HPA's in S. W. Thames.

~ frequency ~

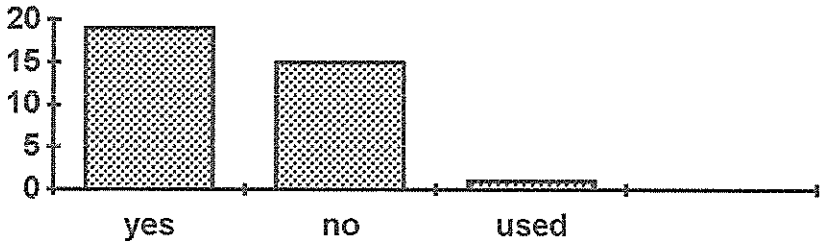


~ topics ~

Key: al-alcohol; sm-smoking; ha-HIV/AIDS; chd-CHD; ex-exercise; dt- diet; su-substance use; adm-admin.; gr-graphics; yp-young people; ap- accident prevention; sx-sexual health; mh-mental health; wk- workplace; im-infant mortality; c-cancer; as-asthma.

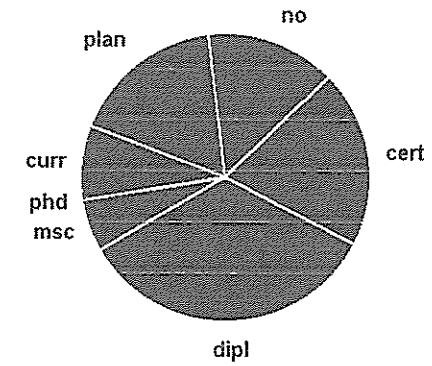
Membership of SHEPS.

~ frequency ~



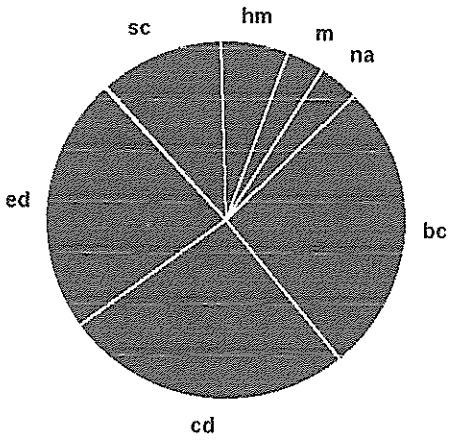
~ membership ~

Qualifications.



'Model' of working.

There were 6 categories suggested, and the opportunity to define one's own. Three of the categories suggested were stated to be the preferred style. These were behaviour change 48%, client directed 46%, and educational 42%. The other categories were social change 20%, harm minimisation 11%, medical 6%. 6% ticked 'not applicable'.



Dear colleague,
The purpose of this questionnaire is to provide me with some quantitative and qualitative data for my PhD. in Health Promotion. I am interested primarily in what sort of people work within Health Promotion, whether people enjoy their work, and whether they have any dilemmas about parts of their work. Most of the questions here are hopefully brief enough for you to be able to fill in the questionnaire quite quickly, however, if anyone filling in this questionnaire would like to discuss any of the issues addressed here further, I would welcome a discussion with you. Please feel free to contact me on 0181.789.3712. Thank you for your time and interest.
Best wishes,
Penny Walters.

~ ~ ooOOoo ~ ~

Please answer all questions, and feel free to add any comments on the page as you go along.

What is your job title? .....

How long have you worked in this position? .....

How long have you worked in this Health Promotion Unit? .....

Have you worked in any other Health Promotion Unit(s)? .....
If so, where? .....

What is your main area of work? .....
.....

How many hours are you scheduled to work per week? .....
How many hours do you tend to put in?.....

What is your age?
in years and months.....

Are you a member of the Society Of Health Education and Promotion Specialists (SHEPS)?
If yes, how long for?.....
If no, is there a reason why not?.....

Do you have any Health Promotion qualifications?
If so, please tick any of the following, or add as appropriate.
Certificate Diploma MSc
Do you have any other academic qualifications?

If so, please list them.....

Have you worked in any other jobs prior to your present Health Promotion position?
If so, what jobs did these include, most recent first.....

Do you have a particular model of working, eg. medical, behaviour change, harm minimisation? .....

What do you feel are the good and bad points about your present job?
good.....
bad.....

Do you have any areas that present you with dilemmas in your work? .....
If yes, please describe
.....
.....
.....
.....
.....

Are there any particular ethical dilemmas that you face/ have faced in your work?
.....
.....
.....
.....
.....
.....

What do you feel is the future for Health Promotion?
.....
.....
.....
.....
.....

Please feel free to make any comments about this questionnaire here .....
.....
.....

Many thanks for filling in this questionnaire. Please could you return it in the enclosed envelope by 1998

~~ ooOOoo ~~

Variable lists

List of variables on the working file

HPU

Value	Label
1	Tees
2	Tees
3	Tees
4	N. Cumbria
5	Furness & S. Lakes
6	N. Cumbria
7	S. Durham
8	N. Durham
9	Easington
10	S. Durham
11	Northumberland
12	Gateshead
13	Newcastle
14	Newcastle
15	S. Tynside
16	Sunderland
17	E.Yorks
18	Hull
19	Grimsby
20	Scunthorpe
21	N.Allerton
22	York
23	Scarborough
24	N.Yorks
25	Bradford
27	Calderdale
28	Huddersfield
29	Dewsbury
30	Leeds
31	Leeds
32	Wakefield
33	Wakefield
34	N.Derby
35	S.Derby
36	Leicester
37	Lincs
38	Lincs
39	Bassetlaw

40	N.Notts
41	Notts
42	Barnesley
43	Doncaster
44	Rotherham
45	Sheffield
46	Cambs.
47	Cambs.
48	N.W.Anglia
49	N.W.Anglia
50	Norwich
51	G.Yarmouth
52	Allington
53	Mid Anglia
54	Beds
55	Beds
56	Herts
57	Herts
58	Herts
59	Herts
60	Barnet
61	Brent
62	Brent
65	W.London
66	Kensington
67	Kensington
70	S.Essex
71	N.Essex
72	N.Essex
73	N.Essex
74	S.Essex
75	Barking
76	Redbridge
77	Redbridge
78	New River
79	New River
80	E.London
84	Camden
86	E.Sussex
87	Eastbourne
88	Hastings
89	S.Kent
90	Canterbury
91	Quest
92	Tunbridge Wells
93	Medway
94	Dartford
95	Bromley
96	Greenwich
97	Bexley
98	London SE1
100	London SE14
101	W.Surrey

102	Mid Surrey
103	Kingston
104	Kingston
105	Merton, Sutton & Wandsworth
107	W.Sussex
108	W.Sussex
109	W.Sussex
110	Croydon
111	W.Surrey
112	W.Surrey
113	E.Surrey
114	Dorset
115	Dorset
116	Southampton
117	Winchester
118	Basingstoke
119	Portsmouth
122	Swindon
123	Bath
124	Northampton
126	Oxford
127	Bucks
128	Bucks
129	Bucks
130	W.Berks
131	E.Berks
132	N.Devon
133	Exeter
134	S&W. Devon
136	Cornwall
137	Glouc.
138	Weston
139	Bristol
142	Somerset
143	Dudley
144	Shrewsbury
145	Sandwell
146	Walsall
147	Wolverhampton
148	Herefordshire
149	Worcester
150	Kidderminster
151	N. Worcs
152	N.Warwickshire
153	S.Warwick
154	Rugby
155	Coventry
156	N.Staffs
157	Cannock
158	S.Staffs
159	Solihull
162	S.Birmingham
163	Birmingham

164	N.B'ham
165	Chester
166	E.Cheshire
167	N.Cheshire
168	Cheshire
170	Wirral
171	St.Helens
172	Southport
173	N.Mersey
174	St.Helens
175	Mersey
178	W.Pennine
179	Rochdale
182	Wigan
183	Bury
185	Blackburn
186	N.W.Lancs
187	Burnley
189	W.Lancs
190	N.W.Lancs
191	Chorley
192	Manchester
195	Clywd
197	Pembroke
198	Gwent
199	Gwynedd
200	Mid.Glam
201	North Glam.
203	W.Glam
204	Rhondda
205	Hengoed
206	Monmouth
207	Newport
208	Pontypool
221	Honddu
222	Cardiff
238	Edinburgh
239	Lothian
241	Stirling
242	Lanarckshire
243	Shetland
244	Highland
245	Argyll
246	Borders
249	Glasgow
250	Orkney
322	Jersey
323	Midland
324	N.Western
325	Western
326	N.Eastern
327	Eastern

REGION

Value	Label
1	N.East
2	N.West
3	Yorks./Humberside
4	E.Anglia
7	E.Mids
12	London
16	Midlands
17	W.Mids
19	SEThames
20	SWThames
21	London
30	S.West
35	Wales
36	Scotland
37	Channel Islands
38	N.Ireland

JOB

0	director/manager
1	SHPA
2	HPA
3	HP assistant
4	resources
5	HP trainer
6	sec/admin
7	dietitian/healthy eating HPO
8	trainee HPA
9	accident prevention
10	PHC/primary health care/NHS liaison
11	CHD/cancer
12	graphic designer
13	gay men project
14	youth/schools HP/ teacher
15	HIV/sexual health HP/outreach-prostitutes
16	HP youth worker/drama
17	community development
18	office manager
19	locality manager
20	campaigns/bus HPA/media
21	HP researcher
22	smoking /project co-ordinator
23	exercise/physical activity co-ordinator
24	deputy manager
25	Snr. public health
26	drugs HP/substance misuse
27	mental health
28	workplace/industry HP
29	HON co-ordinator
30	dental HP
31	black/Asian health

HPQUAL

Value	Label
0	none
1	certificate
2	diploma
3	degree
4	MSc
5	PhD
6	studying for diploma
7	studying for MSc

PREVWK

Value	Label
1	nursing
2	education/training
3	management
4	admin/clerical/library
5	youth work
6	health
7	research/computers
8	dietetics/dental
9	none/student
10	graphic design
11	fitness/ exercise/ leisure
12	health education/promotion
13	environmental health
14	self employed
15	social work/refuge/community/project/charity
16	sales/marketing/journalism/media
17	hairdresser/waitress
18	shop work/factory
19	army
20	counselling

QUALIFICATIONS

Value	Label
1	MA/MSc
2	degree
3	diploma
4	certificate
5	none
6	PhD
7	BEd
8	MBA
9	C&G
10	RGN
11	RSA/Secretarial/IT/music
12	BTec
13	CertEd/PGCE
14	state registered radiographer
15	C&G 7307
16	O'Level/GCSEs
17	RNMH
18	dental quals
19	management/health service m'm
20	counselling certificate
21	SRdietitian
22	LAY tutor
23	CQSW/youth work

APPROACH

Value	Label
1	medical
2	behaviour change
3	educational
4	social change
5	client directed
6	harm minimisation
7	all
8	varies
9	Ottawa Charter
10	community development
11	no
12	n/a

GOOD POINTS ABOUT WORK

Value	Label
1	autonomy
2	clients/public
3	variety
4	interesting/enjoyable
5	useful/worthwhile/important
6	colleagues/manager/staff
7	environment/location
8	none
9	prevention/make changes
10	opportunities/training
11	teamwork/interagency work
12	action/progressive
13	creativity
14	rewarding/challenging/good at job
15	flexibility/flexitime/stress free
16	don't know
17	pay/hours

BAD POINTS ABOUT WORK

Value	Label
1	NHS/changes/uncertainty
2	pay/temp.contract/hours
3	Bureacracy
4	manager/management
5	no training/direction
6	no career path/promotion prospects/short contract
7	budget/funding
8	colleagues/staff/"politics"
9	effectiveness/waste of time/evaluation
10	no status/power/poor image/fragmentation/isolation
11	pressure/stress/workload
12	not valued/misunderstood/not supported
13	meetings
14	practicalities/resources/conditions
15	remit too big
16	workplace/travelling
17	don't know
18	medical/disease focused
19	need to be motivated/low morale/boring
20	inequalities in health
21	purchaser conflicts/constraints
22	none
23	understaffed
24	training others/ no contact-public
25	working with under 16's/homophobia

ETHICAL DILEMMAS

Value	Label
0	none
1	inequalities in health/root causes
2	campaigns/short term proj./sponsorship/media coverage
3	targeting
4	budget allocations/understaffed/ resourcing/income gen.
5	victim blaming
6	credibility/low status
7	'politics'/instit'l rac/sexism/territoriality/int.pol./mana
8	job description changes/no career development
9	policies
10	effectiveness/or not
11	NHS/bureacracy/changes/cuts/arguments
12	lack of skills/communication probs
13	medical model/NHS/GP interference/P&P/HON
14	misunderstood/undervalued
15	condoms to under age/harm minimisation/sexuality
16	too many to list
17	being a role model
18	theory vs. practice
19	evaluation/evidence needed
20	told what to do/hidden agendas/interagency work/conspiracy
21	time
22	breadth of role/pressure

FUTURE OF HEALTH PROMOTION

Value	Label
0	Purchaser
1	new Government-positive
2	don't know
3	Local Authority/Environmental Health
4	Public Health
5	policy/strategy/in all jobs
6	to be more professional
7	positive
8	community development/empowerment/locality
9	bleak/poor
10	PHC/ NHS/medical model
11	trainers
12	get/need larger budget
13	health agencies/projects
14	Provider/Commissioning
15	social model/ Ottawa Charter
16	effectiveness;to be seen as effective/evidence based
17	computer/IT/internet
18	targeting

JOB SUMMARY

Value	Label
.00	manager
1.00	Health Promoter
2.00	support staff
3.00	affiliated staff

AGEGRP

Value	Label
.00	-20
1.00	20-29
2.00	30-39
3.00	40-49
4.00	50-59
5.00	60+

QUALIFICATIONS SUMMARY

Value	Label
.00	none
1.00	cert.
2.00	dip/degree
3.00	prof.qual.
4.00	MSc.
5.00	PhD.

HEALTH PROMOTION QUALIFICATIONS SUMMARISED

Value	Label
.00	None
1.00	Certificate
2.00	Dip/degree
4.00	MSc
5.00	PhD

PRVWKSUM previous work summary

Value	Label
1.00	nursing
2.00	educ.
3.00	management
4.00	admin/cleric/library
5.00	youth/social work
6.00	health
7.00	research/IT
9.00	none
10.00	various

GOOD POINTS ABOUT WORK SUMMARISED

Value	Label
.00	none/DK
1.00	autonomy issues
2.00	people issues
3.00	workconditions
4.00	make change

DILEMMAS SUMMARISED

Value	Label
.00	none
1.00	inequalities in health
2.00	type of work
3.00	NHS issues
4.00	professional issues
5.00	missing

LOYALTY (+/- 5 YEARS)

Value	Label
1.00	> 5
2.00	6 +

WORK 2YRS OR MORE (+/- 2 YEARS)

Value	Label
1	>2 years
2	2 years +

BAD POINTS SUMMARISED

Value	Label
1.00	NHS
2.00	prof.issue
3.00	people
4.00	don't know
5.00	none

Response rates from individual districts

The largest response was13 questionnaires from HPU 245 (Argyll) and HPU 2 (Tees), and 12 questionnaires from each of HPUs 8 (N. Durham), 12 (Gateshead), 28 (Huddersfield)

Reference	District	response rate	region
1	Tees	1	
2	Tees (2)	12	
3	Tees (3)	0	
(1, 2, 3	*Tees*	*13)*	
4	N.Cumbria	8	
5	Furness and S. Lakes	0	
6	N. Cumbria	1	
(4, 6	*N.Cumbria*	*9)*	
7	S. Durham	3	
8	N. Durham	12	
9	Easington	5	
10	S. Durham	0	
	(sent back 9 'extra' questionnaires)		
(7, 10	*S. Durham*	*3)*	
11	Northumberland	5	
12	Gateshead	12	
13	Newcastle	0	
14	Newcastle	3	
(13, 14	*Newcastle*	*3)*	
15	S.Tyneside	0	
16	Sunderland	0	
17	E. Yorks	4	
18	Hull	6	
19	Grimsby	6	
20	Scunthorpe	0	
21	N. Allerton	3	
22	York	1	
23	Scarborough	0	
24	N. Yorks	7	
	(sent back 7 'extra' questionnaires)		
25	Bradford	0	
26	no district name/ address given on HEA list		
27	Calderdale	6	

28	Huddersfield		12
29	Dewsbury		0
30	Leeds		0
31	Leeds (2)		0
(30, 31	*Leeds*		*0)*
32	Wakefield		9
33	Wakefield (2)		0
(32, 33	*Wakefield*		*9)*
34	N. Derby		5
35	S. Derby		8
36	Leicester		9
37	Lincs.		7
38	Lincs. (2)		0
(37, 38	*Lincs.*		*7)*
39	Bassettlaw		0
40	N. Notts		6
41	Notts.		9
42	Barnesley		8
	(sent back 4 'extra' questionnaires)		
43	Doncaster		5
44	Rotherham		4
45	Sheffield		7
46	Cambs.		0
47	Cambs. (2)		2
(46, 47	*Cambs.*		*2)*
48	N.W. Anglia	2	
49	N.W. Anglia	0	
(48, 49	*N.W. Anglia*		*2)*
50	Norwich		2
51	Great Yarmouth		0
52	Allington		0
53	Mid Anglia		7
54	Beds.		6
55	Beds. (2)		0
(54, 55	*Beds.*		*6)*
56	Herts.		9
57	Herts. (2)		0
58	Herts. (3)		0
59	Herts. (4)		0
(56, 57, 58, 59	*Herts.*		*9)*

London

60	Barnet	1
61	Brent	0
62	Brent (2)	0
(61, 62	*Brent*	*0)*
63	no district name/ address given on HEA list	
64	no district name/ address given on HEA list	
65	W. London	8
	(sent back 4 'extra' questionnaires)	
66	Kensington	4
67	Kensington (2)	0
(66, 67	*Kensington*	*4)*
68	no district name/ address given on HEA list	
69	no district name/ address given on HEA list	
70	S. Essex	2
	(sent back 7 'extra' questionnaires)	
71	N. Essex	7
72	N. Essex (2)	0
73	N. Essex (3)	0
(71, 72, 73	*N. Essex*	*7)*
74	S. Essex	5
(73, 74	*S. Essex*	*5)*
75	Barking	9
76	Redbridge	5
77	Redbridge (2)	0
(76, 77	*Redbridge*	*5)*
78	New River	8
79	New River (2)	0
(78, 79	*New River*	*8)*
80	E. London	10
81	E. London	0
82	E. London	0
(80, 81, 82	*E. London*	*10)*
83	no district name/ address given on HEA list	
84	Camden	2
85	Islington	0
86	E. Sussex	8
87	Eastbourne	6
88	Hastings	4
89	S. Kent	10
	(sent back 4 'extra' questionnaires)	

90	Canterbury	6	
91	Quest	2	
92	Tunbridge Wells	3	
93	Medway	0	
94	Dartford	2	
95	Bromley	1	
96	Greenwich	6	
97	Bexley	7	
98	London SE1	3	
99	Health First	0	
100	London SE14	2	
South West Thames			37
101	W. Surrey	2	
102	Mid Surrey	11	
103	Kingston	3	
104	Kingston (2)	0	
105	Merton & Sutton	1	
106	Wandsworth	0	
107	W. Sussex	4	
108	W. Sussex (2)	2	
109	W. Sussex (3)	3	
(107, 108, 109	*W. Sussex*	*9)*	
110	Croydon	0 refused to respond	
111	W. Surrey	2	
112	W. Surrey (2)	7	
(111, 112	*W. Surrey*	*9)*	
113	E. Surrey	2	
114	Dorset	6	
115	Dorset (2)	0	
(114, 115	*Dorset*	*6)*	
116	Southampton	0	
117	Winchester	2	
	(sent back 11 'extra' questionnaires)		
118	Basingstoke	2	
119	Portsmouth	4	
120	Isle of Wight	0	
121	Salisbury	0	
122	Swindon	7	
123	Bath	6	
124	Northampton	7	

125	Northampton (2)	0
(124, 125	*Northampton*	*7)*
126	Oxford	8
127	Bucks.	4
128	Bucks. (2)	4
129	Bucks. (3)	2
(127	*Bucks.*	*10)*
130	W. Berks.	2
131	E. Berks.	5
132	N. Devon	0
133	Exeter	1
134	S. & W. Devon	5
135		
136	Cornwall	3
137	Glouc.	0
138	Weston	7
139	Bristol	1
	(sent back 14 'extra' questionnaires)	
140	Bristol (2)	0
141	Bristol (3)	0
	(sent back 11 'extra' questionnaires)	
(139, 140, 141	*Bristol*	*1)*
142	Somerset	1
	(sent back 12 'extra' questionnaires)	
Midlands		
143	Dudley	7
144	Shrewsbury	4
145	Sandwell	5
146	Walsall	0
147	Wolverhampton	8
	(sent back 2 'extra' questionnaires)	
148	Herefordshire	0
149	Worcester	6
150	Kidderminster	3
151	N. Worcs.	2
152	N. Warwickshire	8
153	S. Warwick	0
154	Rugby	3
155	Coventry	2
156	N. Staffs	4
157	Cannock	0

158	S. Staffs	10
159	Solihull	11
160	no district name/ address given on HEA list	
161	no district name/ address given on HEA list	
162	S. Birmingham	6
163	Birmingham	0
164	N. Birmingham	4
N. West		
165	Chester	2
166	E. Cheshire	8
167	N. Cheshire	4
168	Cheshire	2
	(sent back 13 'extra' questionnaires)	
169	Warrington	0
170	Wirral	4
171	St. Helens	8
172	Southport	5
173	N. Mersey	8
174	St. Helens (2)	0
(171, 174	*St. Helens*	*8)*
175	Mersey	3
176	Stockport	0
177	Bolton	0
178	W. Penine	6
179	S. Rochdale	5
	(sent back 7 'extra' questionnaires)	
180	Salford	0 refused to respond
181	Trafford	0 refused to respond
182	Wigan	7
183	Bury	1
	(sent back 13 'extra' questionnaires)	
184	West Penine	0
(178, 184	*W. Pennine*	*6)*
185	Blackburn	2
186	N. W. Lancs	6
187	Burnley	4
	(sent back 11 'extra' questionnaires)	
188	Lancaster	0
189	W. Lancs.	4
190	N. W. Lancs. (2)	3
(186, 190	*N. W. Lancs*	*9)*

191	Chorley	1	
192	Manchester	7	
193	Manchester (2)	0	
(192, 193	*Manchester*	*7)*	
Wales			
194	Cardiff	0	
195	Clwyd	6	
196	E. Dyfed	returned by postal service (no longer exists)	
197	Pembroke	6	
198	Gwent	3	
199	Gwynedd	9	
200	Mid. Glamorgan	3	
	(sent back 7 'extra' questionnaires)		
201	N. Glam.	3	
202	no district name/ address given on HEA list		
203	W. Glam.	0	
204	Rhondda	3	
	(sent back 12 'extra' questionnaires)		
205	Hengoed	3	
	(sent back 7 'extra' questionnaires)		
206	Monmouth	3	
	(sent back 11 'extra' questionnaires)		
207	Newport	3	
	(sent back 11 'extra' questionnaires)		
208	Pontypool	2	
	(sent back 5 'extra' questionnaires)		
221	Honddu	10	
222	Cardiff	6	
	(sent back 5 'extra' questionnaires)		
(194, 222	*Cardiff*	*6)*	
Scotland			**70**
238	Edinburgh	7	
239	Lothian	8	
240	Fife	0	
241	Stirling	8	
242	Lanarckshire	8	
243	Shetland	1	
	(sent back 12 'extra' questionnaires)		
244	Highland	7	
245	Argyll	13	
246	Borders	7	

247	Tayside	0	
248	Western Isles	0	
249	Glasgow	9	
250	Orkney	2	
Channel Islands			**5**
322	Jersey	5	
	(sent back 9 'extra' questionnaires)		
Ireland			**13**
323	Midland	2	
324	N. Western	10	
325	Western	1	
326	N. Eastern	6	
	(sent back 7 'extra' questionnaires)		
327	Eastern	4	

Numbers of respondents from districts

13 respondents

245	Argyll

12 respondents

2	Tees (2)
8	N. Durham
12	Gateshead
28	Huddersfield

11 respondents

102	Mid Surrey
159	Solihull

10 respondents

89	S. Kent
80	E. London
158	S. Staffs
221	Honddu

9 respondents

32	Wakefield
36	Leicester
41	Notts.
56	Herts.
75	Barking
199	Gwynedd
249	Glasgow

8 respondents

4	N.Cumbria
35	S. Derby
42	Barnesley
65	W. London
78	New River
86	E. Sussex
126	Oxford
147	Wolverhampton
152	N. Warwickshire
166	E. Cheshire

171	St. Helens
173	N. Mersey
239	Lothian
241	Stirling
242	Lanarckshire

7 respondents

24	N. Yorks
37	Lincs.
45	Sheffield
53	Mid Anglia
71	N. Essex
97	Bexley
112	W. Surrey (2)
122	Swindon
124	Northampton
138	Weston
143	Dudley
182	Wigan
192	Manchester
238	Edinburgh
244	Highland
246	Borders

6 respondents

18	Hull
19	Grimsby
27	Calderdale
40	N. Notts
54	Beds.
90	Canterbury
87	Eastbourne
96	Greenwich
114	Dorset
123	Bath
149	Worcester
162	S. Birmingham
178	W. Pennine
186	N. W. Lancs
197	Pembroke
195	Clwyd

222	Cardiff
326	N. Eastern

5 respondents

9	Easington
11	Northumberland
34	N. Derby
43	Doncaster
74	S. Essex
76	Redbridge
131	E. Berks.
134	S. & W. Devon
145	Sandwell
172	Southport
179	S. Rochdale
322	Jersey

4 respondents

17	E. Yorks
44	Rotherham
66	Kensington
88	Hastings
107	W. Sussex
119	Portsmouth
127	Bucks.
128	Bucks. (2)
144	Shrewsbury
156	N. Staffs
164	N. Birmingham
167	N. Cheshire
170	Wirral
187	Burnley
189	W. Lancs.
327	Eastern

3 respondents

7	S. Durham
14	Newcastle
21	N. Allerton
92	Tunbridge Wells
98	London SE1

103	Kingston
109	W. Sussex (3)
136	Cornwall
150	Kidderminster
154	Rugby
175	Mersey
190	N. W. Lancs. (2)
198	Gwent
200	Mid. Glamorgan
201	N. Glam.
204	Rhondda
205	Hengoed
206	Monmouth
207	Newport

2 respondents

50	Norwich
47	Cambs. (2)
48	N.W. Anglia
84	Camden
91	Quest
94	Dartford
100	London SE14
101	W. Surrey
108	W. Sussex (2)
111	W. Surrey
113	E. Surrey
117	Winchester
118	Basingstoke
129	Bucks. (3)
130	W. Berks.
151	N. Worcs.
155	Coventry
165	Chester
168	Cheshire
185	Blackburn
208	Pontypool
250	Orkney
323	Midland

1 respondent

1	Tees
6	N. Cumbria
22	York
60	Barnet
95	Bromley
105	Merton & Sutton
133	Exeter
139	Bristol
142	Somerset
183	Bury
191	Chorley
243	Shetland
324	Western

0 respondents

3	Tees (3)
5	Furness and S. Lakes
10	S. Durham
13	Newcastle
15	S.Tyneside
16	Sunderland
20	Scunthorpe
23	Scarborough
25	Bradford
29	Dewsbury
30	Leeds
31	Leeds (2)
33	Wakefield (2)
38	Lincs. (2)
39	Bassettlaw
46	Cambs.
49	N.W. Anglia
51	Great Yarmouth
52	Allington
55	Beds. (2)
57	Herts. (2)
58	Herts. (3)
59	Herts. (4)
61	Brent
62	Brent (2)

67	Kensington (2)
70	S. Essex
72	N. Essex (2)
73	N. Essex (3)
77	Redbridge (2)
79	New River (2)
81	E. London
82	E. London
85	Islington
93	Medway
99	Health First
104	Kingston (2)
106	Wandsworth
110	Croydon
115	Dorset (2)
116	Southampton
120	Isle of Wight
121	Salisbury
125	Northampton (2)
132	N. Devon
137	Glouc.
140	Bristol (2)
141	Bristol (3)
146	Walsall
148	Herefordshire
153	S. Warwick
157	Cannock
163	Birmingham
169	Warrington
174	St. Helens (2)
176	Stockport
177	Bolton
180	Salford
181	Trafford
184	West Penine
188	Lancaster
193	Manchester (2)
194	Cardiff
196	E.Dyfed
203	W. Glam.
240	Fife

Summary of number of respondents:

1 district: 13 respondents
2 districts: 12 respondents
2 districts: 11 respondents
4 districts: 10 respondents
7 districts: 9 respondents
15 districts: 8 respondents
16 districts: 7 respondents
18 districts: 6 respondents
12 districts: 5 respondents
16 districts: 4 respondents
19 districts: 3 respondents
23 districts: 2 respondents
13 districts: 1 respondent

ethical dilemmas (summarised) by region

	regions			
	N.East		N.West	
	Count	%	Count	%
none	6	8.5%	10	10.6%
inequalities in health	4	5.6%	8	8.5%
type of work	8	11.3%	8	8.5%
NHS issues	34	47.9%	43	45.7%
professional issues	19	26.8%	25	26.6%

	regions			
	Yorks./Humberside		E.Anglia	
	Count	%	Count	%
none	2	4.8%	2	11.1%
inequalities in health	2	4.8%	1	5.6%
type of work	4	9.5%	1	5.6%
NHS issues	18	42.9%	11	61.1%
professional issues	16	38.1%	3	16.7%

	regions			
	E.Mids		London	
	Count	%	Count	%
none	3	6.5%	5	5.7%
inequalities in health	4	8.7%	3	3.4%
type of work	5	10.9%	10	11.5%
NHS issues	21	45.7%	41	47.1%
professional issues	13	28.3%	28	32.2%

	regions			
	Midlands		W.Mids	
	Count	%	Count	%
none	1	3.3%	2	4.3%
inequalities in health	2	6.7%		
type of work	1	3.3%	6	12.8%
NHS issues	20	66.7%	24	51.1%
professional issues	6	20.0%	15	31.9%

	regions			
	SEThames		SWThames	
	dilemmas summary		dilemmas summary	
	Count	%	Count	%
none	5	13.5%	2	5.6%
inequalities in health	1	2.7%	1	2.8%
type of work	3	8.1%	6	16.7%
NHS issues	14	37.8%	20	55.6%
professional issues	14	37.8%	7	19.4%

	regions			
	S.West		Wales	
	Count	%	Count	%
none	2	3.1%	3	6.3%
inequalities in health	6	9.2%	4	8.3%
type of work	6	9.2%	5	10.4%
NHS issues	26	40.0%	20	41.7%
professional issues	25	38.5%	16	33.3%

	regions			
	Scotland		Channel Islands	
	Count	%	Count	%
none	5	7.5%		
inequalities in health	4	6.0%		
type of work	7	10.4%	2	50.0%
NHS issues	25	37.3%		
professional issues	26	38.8%	2	50.0%

Ireland

	Count	%
none	2	11.1%
inequalities in health	1	5.6%
type of work	3	16.7%
NHS issues	7	38.9%
professional issues	5	27.8%

ethical dilemmas by region

	regions			
	N.East		N.West	
	Count	%	Count	%
none	6	8.5%	10	10.6%
inequalities in health/root causes	4	5.6%	8	8.5%
campaigns/short term proj./sponsorship/ media coverage	5	7.0%	2	2.1%
targeting			4	4.3%
budget allocations/ understaffed/ resourcing/income gen.	11	15.5%	20	21.3%
victim blaming	1	1.4%		
credibility/low status	7	9.9%	8	8.5%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	2	2.8%	3	3.2%
job description changes/no career development			2	2.1%
policies	1	1.4%		
effectiveness/or not	2	2.8%	2	2.1%
NHS/bureacracy/changes/ cuts/arguments	13	18.3%	10	10.6%
lack of skills/communication probs			5	5.3%
medical model/NHS/GP interference/P&P/HON	4	5.6%	4	4.3%
misunderstood/ undervalued	8	11.3%	4	4.3%
condoms to under age/harm minimisation/ sexuality	2	2.8%	1	1.1%
too many to list	1	1.4%		
being a role model	1	1.4%		
theory vs. practice			3	3.2%
evaluation/evidence needed			3	3.2%
told what to do/hidden agendas/interagency work/conspiracy	3	4.2%	4	4.3%
time breadth of role/pressure			1	1.1%

	regions			
	Yorks./Humberside		E.Anglia	
	Count	%	Count	%
none	2	4.8%	2	11.1%
inequalities in health/root causes	2	4.8%	1	5.6%
campaigns/short term proj./sponsorship/ media coverage	2	4.8%	1	5.6%
targeting budget allocations/ understaffed/ resourcing/income gen.	4	9.5%	4	22.2%
victim blaming	1	2.4%	1	5.6%
credibility/low status 'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	5	11.9%		
job description changes/no career development policies	1	2.4%	1	5.6%
effectiveness/or not NHS/bureacracy/changes/ cuts/arguments			1	5.6%
lack of skills/communication probs	3	7.1%	4	22.2%
medical model/NHS/GP interference/P&P/HON	1	2.4%		
misunderstood/ undervalued	7	16.7%	2	11.1%
condoms to under age/harm minimisation/ sexuality	5	11.9%	1	5.6%
too many to list				
being a role model	2	4.8%		
theory vs. practice evaluation/evidence needed	2	4.8%		
told what to do/hidden agendas/interagency work/conspiracy	3	7.1%		
time	1	2.4%		
breadth of role/pressure	1	2.4%		

	regions			
	Midlands		W.Mids	
	Count	%	Count	%
none	1	3.3%	2	4.3%
inequalities in health/root causes	2	6.7%		
campaigns/short term proj./sponsorship/ media coverage			5	10.6%
targeting budget allocations/ understaffed/ resourcing/income gen.	7	23.3%	9	19.1%
victim blaming credibility/low status	5	16.7%	5	10.6%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	1	3.3%	2	4.3%
job description changes/no career development	1	3.3%	3	6.4%
policies effectiveness/or not			3	6.4%
NHS/bureacracy/changes/ cuts/arguments	7	23.3%	6	12.8%
lack of skills/communication probs	1	3.3%	1	2.1%
medical model/NHS/GP interference/P&P/HON	2	6.7%	2	4.3%
misunderstood/ undervalued			4	8.5%
condoms to under age/harm minimisation/ sexuality	1	3.3%		
too many to list			1	2.1%
being a role model			1	2.1%
theory vs. practice evaluation/evidence needed			1	2.1%
told what to do/hidden agendas/interagency work/conspiracy	2	6.7%	2	4.3%
time				

	regions			
	E.Mids		London	
	Count	%	Count	%
none	3	6.5%	5	5.7%
inequalities in health/root causes	4	8.7%	3	3.4%
campaigns/short term proj./sponsorship/ media coverage	4	8.7%	6	6.9%
targeting	1	2.2%	1	1.1%
budget allocations/ understaffed/ resourcing/income gen.	1	2.2%	16	18.4%
victim blaming				
credibility/low status	3	6.5%	8	9.2%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	2	4.3%	3	3.4%
job description changes/no career development	3	6.5%	1	1.1%
policies effectiveness/or not	2	4.3%	7	8.0%
NHS/bureacracy/changes/ cuts/arguments	9	19.6%	10	11.5%
lack of skills/communication probs	1	2.2%	4	4.6%
medical model/NHS/GP interference/P&P/HON	2	4.3%	4	4.6%
misunderstood/ undervalued	6	13.0%	4	4.6%
condoms to under age/harm minimisation/ sexuality			2	2.3%
too many to list				
being a role model			1	1.1%
theory vs. practice			2	2.3%
evaluation/evidence needed	1	2.2%	2	2.3%
told what to do/hidden agendas/interagency work/conspiracy	4	8.7%	7	8.0%
time			1	1.1%

	regions			
	SEThames		SWThames	
	Count	%	Count	%
none	5	13.5%	2	5.6%
inequalities in health/root causes	1	2.7%	1	2.8%
campaigns/short term proj./sponsorship/ media coverage	1	2.7%	3	8.3%
targeting	1	2.7%		
budget allocations/ understaffed/ resourcing/income gen.	5	13.5%	4	11.1%
victim blaming				
credibility/low status	7	18.9%	2	5.6%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	3	8.1%	2	5.6%
job description changes/no career development			1	2.8%
policies effectiveness/or not	1	2.7%	2	5.6%
NHS/bureacracy/changes/ cuts/arguments	5	13.5%	8	22.2%
lack of skills/communication probs	1	2.7%		
medical model/NHS/GP interference/P&P/HON			1	2.8%
misunderstood/ undervalued	4	10.8%		
condoms to under age/harm minimisation/ sexuality	1	2.7%	3	8.3%
too many to list				
being a role model				
theory vs. practice			1	2.8%
evaluation/evidence needed	1	2.7%	2	5.6%
told what to do/hidden agendas/interagency work/conspiracy	1	2.7%	4	11.1%
time				

	regions			
	S.West		Wales	
	Count	%	Count	%
none	2	3.1%	3	6.3%
inequalities in health/root causes	6	9.2%	4	8.3%
campaigns/short term proj./sponsorship/ media coverage	4	6.2%	5	10.4%
targeting	1	1.5%		
budget allocations/ understaffed/ resourcing/income gen.	5	7.7%	8	16.7%
victim blaming	1	1.5%		
credibility/low status	13	20.0%	6	12.5%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	2	3.1%	2	4.2%
job description changes/no career development	3	4.6%	1	2.1%
policies effectiveness/or not	1	1.5%	3	6.3%
NHS/bureacracy/changes/ cuts/arguments	8	12.3%	6	12.5%
lack of skills/communication probs	2	3.1%	3	6.3%
medical model/NHS/GP interference/P&P/HON	3	4.6%	1	2.1%
misunderstood/ undervalued	1	1.5%	2	4.2%
condoms to under age/harm minimisation/ sexuality	1	1.5%		
too many to list				
being a role model				
theory vs. practice				
evaluation/evidence needed	7	10.8%	2	4.2%
told what to do/hidden agendas/interagency work/conspiracy	5	7.7%	2	4.2%
time				

	regions			
	Scotland		Channel Islands	
	Count	%	Count	%
none	5	7.5%		
inequalities in health/root causes	4	6.0%		
campaigns/short term proj./sponsorship/ media coverage	4	6.0%	1	25.0%
targeting	1	1.5%	1	25.0%
budget allocations/ understaffed/ resourcing/income gen.	7	10.4%		
victim blaming	1	1.5%		
credibility/low status	9	13.4%	1	25.0%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	3	4.5%		
job description changes/no career development	1	1.5%		
policies effectiveness/or not	4	6.0%		
NHS/bureacracy/changes/ cuts/arguments	7	10.4%		
lack of skills/communication probs	4	6.0%	1	25.0%
medical model/NHS/GP interference/P&P/HON	4	6.0%		
misunderstood/ undervalued	6	9.0%		
condoms to under age/harm minimisation/ sexuality	1	1.5%		
too many to list				
being a role model	1	1.5%		
theory vs. practice	1	1.5%		
evaluation/evidence needed				
told what to do/hidden agendas/interagency work/conspiracy	3	4.5%		
time	1	1.5%		

	regions	
	Ireland	
	DILEMMAS	
	Count	%
none	2	11.1%
inequalities in health/root causes	1	5.6%
campaigns/short term proj./sponsorship/ media coverage	1	5.6%
targeting	1	5.6%
budget allocations/ understaffed/ resourcing/income gen.	2	11.1%
victim blaming		
credibility/low status	1	5.6%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	3	16.7%
job description changes/no career development		
policies effectiveness/or not		
NHS/bureacracy/changes/ cuts/arguments	1	5.6%
lack of skills/communication probs	1	5.6%
medical model/NHS/GP interference/P&P/HON	1	5.6%
misunderstood/ undervalued	3	16.7%
condoms to under age/harm minimisation/ sexuality		
too many to list		
being a role model		
theory vs. practice		
evaluation/evidence needed		
told what to do/hidden agendas/interagency work/conspiracy		
time	1	5.6%

Q. 2. WHO RESPONDED TO THE QUESTIONNAIRE BY NUMBER OF YEARS IN CURRENT POST

Years	Frequency	Percent
.1	18	2.3
.2	10	1.3
.3	3	.4
.3	19	2.5
.4	7	.9
.5	29	3.7
.6	1	.1
.7	6	.8
.8	8	1.0
.8	13	1.7
.9	9	1.2
1.0	67	8.7
1.1	4	.5
1.2	5	.6
1.3	4	.5
1.3	6	.8
1.4	2	.3
1.5	34	4.4
1.6	2	.3
1.8	4	.5
1.8	4	.5
1.9	3	.4
2.0	80	10.3
2.1	2	.3
2.2	2	.3
2.3	1	.1
2.3	3	.4
2.4	1	.1
2.5	35	4.5
2.6	2	.3
2.8	2	.3
2.8	5	.6
3.0	60	7.8
3.1	1	.1
3.3	2	.3

3.3	1	.1
3.4	1	.1
3.5	25	3.2
3.7	1	.1
3.8	1	.1
4.0	54	7.0
4.5	14	1.8
4.8	2	.3
4.8	1	.1
5.0	48	6.2
5.5	6	.8
6.0	38	4.9
6.5	3	.4
7.0	27	3.5
7.5	3	.4
7.8	1	.1
8.0	29	3.7
8.5	1	.1
9.0	14	1.8
9.5	2	.3
10.0	18	2.3
10.5	1	.1
11.0	4	.5
11.5	1	.1
12.0	5	.6
13.0	2	.3
14.0	1	.1
15.0	2	.3
16.0	5	.6
17.0	1	.1
18.0	1	.1
19.0	2	.3
21.0	3	.4
28.0	1	.1
Missing	1	.1
Total	774	100.0

Valid cases 773 Missing cases 1

Q.5 WHO RESPONDED TO THE QUESTIONNAIRE BY AGE

Value (Age)	Frequency	Percent
18	1	.1
19	1	.1
21	2	.3
22	1	.1
23	11	1.4
24	13	1.7
25	17	2.2
26	32	4.1
27	20	2.6
28	18	2.3
29	25	3.2
30	32	4.1
31	27	3.5
32	31	4.0
33	28	3.6
34	26	3.4
35	39	5.0
36	52	6.7
37	22	2.8
38	29	3.7
39	23	3.0
40	31	4.0
41	24	3.1
42	24	3.1
43	24	3.1
44	18	2.3
45	32	4.1
46	22	2.8
47	20	2.6
48	15	1.9
49	11	1.4
50	19	2.5
51	12	1.6
52	8	1.0
53	16	2.1
54	9	1.2

55	16	2.1
56	2	.3
57	5	.6
58	5	.6
59	3	.4
60	1	.1
62	1	.1
Missing	6	.8
Total	**774**	**100.0**

Q.8. WHO RESPONDED TO THE QUESTIONNAIRE BY CONTRACTED HOURS PER WEEK

Hours	Frequency	Percent
4	1	.1
7	1	.1
8	2	.3
10	1	.1
12	2	.3
13	1	.1
15	3	.4
16	1	.1
17	1	.1
18	13	1.7
19	40	5.1
20	15	1.9
21	4	.5
22	13	1.7
23	17	2.2
24	7	.9
25	8	1.0
26	5	.6
27	1	.1
28	4	.5
29	1	.1
30	36	4.6
31	2	.3
32	5	.6
33	10	1.3
34	3	.4
35	12	1.6
36	40	5.2
37	400	51.7
38	100	12.9
39	3	.4
40	10	1.3
45	2	.3
Missing	10	1.3
Total	774	100.0

Valid cases 764 **Missing cases** 10

Q.9. WHO RESPONDED TO THE QUESTIONNAIRE BY WORKED HOURS PER WEEK

Hours	Frequency	
4	1	.1
8	1	.1
9	1	.1
10	1	.1
12	2	.3
15	3	.4
17	2	.3
18	8	1.0
19	1	.1
19	17	2.2
20	16	2.1
21	7	.9
22	13	1.7
23	12	1.6
24	11	1.4
25	14	1.8
26	7	.9
27	2	.3
28	6	.8
29	1	.1
30	31	4.0
32	10	1.3
33	5	.6
34	3	.4
35	8	1.0
36	11	1.4
37	164	21.2
38	1	.1
38	47	6.1
39	37	4.8
40	130	16.8
41	9	1.2
42	50	6.5
43	28	3.6
44	6	.8

45	46	5.9
46	1	.1
47	10	1.3
48	7	.9
49	1	.1
50	18	2.3
52	2	.3
53	2	.3
55	3	.4
60	1	.1
70	1	.1
Missing	16	2.1
Total	774	100.0

Valid cases 758 **Missing cases** 16

Q.12 WHO RESPONDED TO THE QUESTIONNAIRE BY OTHER QUALIFICATIONS

Label	Frequency	Percent
degree	410	40.1
RGN	110	14.2
none	59	7.6
MA/MSc	50	6.5
diploma	44	5.7
RSA/Secretarial/IT	34	4.4
CertEd/PGCE	26	3.4
SRdietitian	24	3.1
O'Level/GCSEs	18	2.3
management/health service	12	1.6
PhD	11	1.4
BEd	9	1.2
certificate	9	1.2
dental quals	8	1.0
CQSW/youth work	8	1.0
C&G	5	.6
MBA	3	.4
BTec	3	.4
LAY tutor	3	.4
counselling certificate	2	.3
state registered radiographer	1	.1
C&G 7307	1	.1
RNMH	1	.1
Missing	23	3.0
	---	---
Total	774	100.0

Valid cases 751 Missing cases 23

Q.12. WHO RESPONDED TO THE QUESTIONNAIRE BY OTHER QUALIFICATIONS

summary:

<u>academic:</u>		
PhD	11	1.4
MA/MSc	50	6.5
degree	410	40.1
management/health service	12	1.6
MBA	3	.4
<u>nursing:</u>		
RGN	110	14.2
RNMH	1	.1
<u>education:</u>		
CertEd/PGCE	26	3.4
BEd	9	1.2
C&G 7307	1	.1
<u>profession:</u>		
dental quals	8	1.0
SRdietitian	24	3.1
CQSW/youth work	8	1.0
counselling certific	2	.3
state registered rad	1	.1
BTec	3	.4
<u>pre-degree:</u>		
O'Level/GCSEs	18	2.3
C&G	5	.6
certificate	9	1.2
diploma	44	5.7
RSA/Secretarial/IT/m	34	4.4
LAY tutor	3	.4

Q. 13 WHO RESPONDED TO THE QUESTIONNAIRE BY PREVIOUS WORK

Label	Frequency	Percent
admin/clerical/library	120	15.5
education/training	113	14.6
nursing	111	14.3
health	89	11.5
health education/promotion	62	8.0
social work/refuge/charity	38	4.9
dietetics/dental	36	4.7
research/computers	34	4.4
youth work	28	3.6
sales/marketing/journalism	28	3.6
none/student	24	3.1
management	18	2.3
fitness/ exercise/ leisure	13	1.7
environmental health	11	1.4
shop work/factory	10	1.3
graphic design	9	1.2
counselling	9	1.2
self employed	4	.5
hairdresser/waitress	2	.3
army	2	.3
Missing	13	1.7
Total	**774**	**100.0**

Valid cases 761 Missing cases 13

Q. 13. WHO RESPONDED TO THE QUESTIONNAIRE BY PREVIOUS WORK

summary:		
health	**211**	**27.3%**
health	89	11.5
health education/promotion	62	8.0
dietetics/dental	36	4.7
fitness/ exercise/ leisure	13	1.7
environmental health	11	1.4
admin/clerical/library	**163**	**21.1%**
admin/clerical/library	120	15.5
research/computers	34	4.4
graphic design	9	1.2
education/training	**113**	**14.6%**
nursing	**111**	**14.3%**
caring	**75**	**9.7%**
social work/refuge/charity	38	4.9
youth work	28	3.6
counselling	9	1.2
other	**42**	**5.5%**
hairdresser/waitress	2	.3
army	2	.3
shop work/factory	10	1.3
self employed	4	.5
none/student	24	3.1
sales	**28**	**3.6%**
sales/marketing/journalism		
management	**18**	**2.3%**
missing	**13**	**1.7%**

Q.16. WHO RESPONDED TO THE QUESTIONNAIRE BY BAD POINTS

708 people responded to this question, 66 did not. 25 different 'bad points' were mentioned. These were categorised into 7 groups.

in descending order

Label	Frequency	Percent
pressure/stress/work	116	15.0
NHS/changes/uncertainty	86	11.1
pay/temp.contract/hours	67	8.7
manager/management	60	7.8
budget/funding	44	5.7
no training/direction	41	5.3
Bureacracy	37	4.8
not valued/misunderstood	37	4.8
no status/power/poor image	34	4.4
need to be motivated	25	3.2
practicalities/resources	24	3.1
colleagues/staff/"politics"	22	2.8
purchaser conflicts/	19	2.5
effectiveness/waste of time	17	2.2
remit too big	14	1.8
no career path/promotion prospects	13	1.7
workplace/travelling	13	1.7
medical/disease focused	12	1.6
none	7	.9
meetings	2	.3
inequalities in health	4	.5
working with under 16's	4	.5
don't know	4	.5
training others/ no contact-public	3	.4
understaffed	3	.4
Missing	66	8.5
	---	---
Total 774	**100.0**	

Q.16. WHO RESPONDED TO THE QUESTIONNAIRE BY BAD POINTS

708 people responded to this question, 66 did not. 25 different 'bad points' were mentioned. These were categorised into 7 groups.

Summary:

professional issues	**183**	
no training/direction	41	5.3
not valued/misunderstood	37	4.8
no status/power/poor image	34	4.4
need to be motivated	25	3.2
no career path/promotion prospects	13	1.7
effectiveness/waste of time	17	2.2
medical/disease focused	12	1.6
inequalities in health	4	.5
physical factors	**148**	
pay/temp.contract/hours	67	8.7
budget/funding	44	5.7
practicalities/resources	24	3.1
workplace/travelling	13	1.7
NHS	**144**	
NHS/changes/uncertainty	86	11.1
purchaser conflicts/	19	2.5
Bureacracy	37	4.8
meetings	2	.3
stress	**133**	
pressure/stress/work	116	15.0
remit too big	14	1.8
understaffed	3	.4
people	**89**	
manager/management	60	7.8
colleagues/staff/"politics"	22	2.8
working with under 16's	4	.5
training others/ no contact-public	3	.4
don't know	4	.5
none	7	.9
Missing	66	8.5

CORRELATIONS BETWEEN

JOB AND

ETHICAL DILEMMA

	DILEMMA			
	none	inequalities in health/root causes	campaigns/ short term proj./ sponsorship /media coverage	targeting
JOB				
director/manager	1	3	2	2
SHPA	1	1	2	1
HPA	9	6	7	
HP assistant			1	
resources	6	1	3	1
HP trainer	1			1
sec/admin	16	1	2	
dietitian/healthy eating HPO	3	1		
trainee HPA				
accident prevention			1	
PHC/primary health care/NHS liaison	1	2		
CHD/cancer	1	3	2	3
graphic designer	1			
gay men project				2
youth/schools HP/ teacher	2	5	7	
HIV/sexual health HP/outreach-prostitutes		2	6	
HP youth worker/drama	1	1		
community development	1	2		
office manager				
locality manager		2	1	
campaigns/bus HPA/media			1	
HP researcher				
smoking /project co-ordinator	3	3	3	
exercise/physical activity co-ordinator		1		1
deputy manager		5		
drugs HP/substance misuse	1		2	
mental health				
workplace/industry HP		1	2	
HON co-ordinator	1	1		
dental HP				
black/Asian health	1		2	

Correlation between job and ethical dilemma (continued)

	DILEMMA			
	budget allocations / understaffed/ resourcing/ income gen.	victim blaming	credibility /low status	'politics'/ instit'l rac/sexism/ territoriality/ int.pol./ manag
JOB				
director/manager	8		5	1
SHPA	9	1	3	2
HPA	4	1	6	1
HP assistant	1	1		
resources	9		6	1
HP trainer	3		2	
sec/admin	7		2	3
dietitian/healthy eating HPO	6		1	2
trainee HPA	1			
accident prevention	1		1	
PHC/primary health care/NHS liaison	8		9	3
CHD/cancer	4		4	1
graphic designer	1		1	
gay men project	2			
youth/schools HP/ teacher	5		6	2
HIV/sexual health HP/outreach-prostitutes	10		9	4
HP youth worker/drama	1		1	
community development	2		4	1
office manager	1		1	
locality manager	5	1	4	1
campaigns/bus HPA/media	3			2
HP researcher			2	
smoking /project co-ordinator	3		1	
exercise/physical activity co-ordinator	3		3	
deputy manager	1		1	1
drugs HP/substance misuse	1	1		1
mental health	1		2	1
workplace/industry HP	3		4	2
HON co-ordinator				1
dental HP			2	
black/Asian health				

Correlation between job and ethical dilemma (continued)

	DILEMMA			
	job description changes/no career development	policies	effectiveness/or not	NHS/ bureacracy/ changes/ cuts/ arguments
JOB				
director/manager			3	12
SHPA			1	4
HPA			5	7
HP assistant	1			1
resources	2	1	1	8
HP trainer			1	
sec/admin	5		1	7
dietitian/healthy eating				
HPO				2
trainee HPA				
accident prevention			2	
PHC/primary health				
care/NHS liaison			2	10
CHD/cancer	2		1	7
graphic designer				1
gay men project				
youth/schools HP/				
teacher			3	3
HIV/sexual health				
HP/outreach-				
prostitutes			5	11
HP youth worker/drama				1
community development			1	2
office manager	1			1
locality manager	1		1	1
campaigns/bus HPA/media				
HP researcher	1			1
smoking /project				
co-ordinator				4
exercise/physical				
activity co-ordinator				
deputy manager				3
drugs HP/substance				
misuse	3		1	2
mental health				2
workplace/industry HP				5
HON co-ordinator				
dental HP				2
black/Asian health				

Correlation between job and ethical dilemma (continued)

	DILEMMA			
	too many to list	being a role model	theory vs. practice	evaluation/ evidence needed
JOB				
director/manager	1			4
SHPA				2
HPA		1	1	
HP assistant		1		
resources			1	
HP trainer				
sec/admin				
dietitian/healthy eating				
HPO				3
trainee HPA				
accident prevention			2	
PHC/primary health				
care/NHS liaison				1
CHD/cancer			1	1
graphic designer				
gay men project				
youth/schools HP/				
teacher				1
HIV/sexual health				
HP/outreach-				
prostitutes			2	3
HP youth worker/drama				
community development	1			
office manager				1
locality manager				
campaigns/bus HPA/media				
HP researcher		2		
smoking /project				
co-ordinator		1		
exercise/physical				
activity co-ordinator				2
deputy manager				
drugs HP/substance				
misuse		1		1
mental health				2
workplace/industry HP				
HON co-ordinator				
dental HP				
black/Asian health				

Correlation between job and ethical dilemma (continued)

	DILEMMA		
	told what to do/hidden agendas/ interagency work/ conspiracy	time	breadth of role/ pressure
JOB			
director/manager	1		1
SHPA			
HPA	2	1	
HP assistant resources			
HP trainer			
sec/admin	1	1	
dietitian/healthy eating			
HPO	2		
trainee HPA			
accident prevention	2		
PHC/primary health care/NHS liaison	4		1
CHD/cancer	3		
graphic designer			
gay men project	1		
youth/schools HP/ teacher	5		
HIV/sexual health HP/outreach-prostitutes	4	1	
HP youth worker/drama	1		
community development	1		
office manager			
locality manager			
campaigns/bus HPA/media			
HP researcher	1	1	
smoking /project co-ordinator	4		
exercise/physical activity co-ordinator			
deputy manager	1		
drugs HP/substance misuse	1		
mental health	2		
workplace/industry HP	3		
HON co-ordinator	1		
dental HP			
black/Asian health			

correlation between job (summarised) and ethical dilemma

	HPQUAL			
	none	certificate	diploma	degree
manager	12	6	20	1
Health Promoter	202	50	89	5
support staff	114	22	6	
affiliated staff	16	9	6	

	HPQUAL			
	MSc	PhD	studying for diploma	studying for MSc
	job summary	job summary	job summary	job summary
	Count	Count	Count	Count
manager	27		1	3
Health Promoter	111	1	22	41
support staff	3		2	2
affiliated staff	1			1

HPQUAL by JOBSUM job summary

HPQUAL	Count	JOBSUM manager .00	Health P romoter 1.00	support staff 2.00	affiliated staff 3.00	Row Total
none	0	12	202	114	16	344 44.5
certificate	1	6	50	22	9	87 11.3
diploma	2	20	89	6	6	121 15.7
degree	3	1	5			6 .8
MSc	4	27	111	3	1	142 18.4
PhD	5		1			1 .1
studying for dip	6	1	22	2		25 3.2
studying for MSc	7	3	41	2	1	47 6.1
	Column Total	70 9.1	521 67.4	149 19.3	33 4.3	773 100.0

Chi-Square	Value	DF	Significance
Pearson	142.60067	21	.00000
Likelihood Ratio	159.93527	21	.00000
Linear-by-Linear Association	63.94283	1	.00000

Minimum Expected Frequency - .043
Cells with Expected Frequency < 5 - 14 of 32 (43.8%)

Statistic	Value	ASE1	Val/ASE0	Approximate Significance
Pearson's R	-.28780	.02649	-8.34428	.00000
Spearman Correlation	-.34599	.02769	-10.2396	.00000

Number of Missing Observations: 1

CORRELATION BETWEEN

HEALTH PROMOTION

QUALIFICATION AND

ETHICAL DILEMMA

Correlation between health promotion qualification and ethical dilemma

HPQUAL	Count	none 0	inequali ties in 1	campaign s/short 2	targetin g 3	budget a llocatio 4	Row Total
none	0	29	10	19	7	48	295 41.5
certificate	1	6	4	6	3	9	82 11.5
diploma	2	5	9	8		16	116 16.3
degree	3			1		3	6 .8
MSc	4	6	12	8	1	16	140 19.7
PhD	5						1 .1
studying for dip	6	1	3			4	23 3.2
studying for MSc	7	3	3	2		7	47 6.6
	Column	50	41	44	11	103	710
(Continued)	Total	7.0	5.8	6.2	1.5	14.5	100.0

Correlation between health promotion qualification and ethical dilemma (continued)

		DILEMMAS					
HPQUAL	Count	victim b laming 5	credibil ity/low 6	'politic s'/insti 7	job desc ription 8	policies 9	Row Total
none	0	2	30	12	10		295 41.5
certificate	1	1	10	1	3		82 11.5
diploma	2		14	5		1	116 16.3
degree	3						6 .8
MSc	4	1	16	9	1		140 19.7
PhD	5						1 .1
studying for dip	6		2	2			23 3.2
studying for MSc	7	1	8	1	2		47 6.6
	Column	5	80	30	16	1	710
(Continued)	Total	.7	11.3	4.2	2.3	.1	100.0

Correlation between health promotion qualification and ethical dilemma (continued)

HPQUAL	Count	DILEMMAS effectiveness/or 10	NHS/bureacracy/c 11	lack of skills/c 12	medical model/NH 13	misunderstood/un 14	Row Total
none	0	13	32	14	10	22	295 41.5
certificate	1	3	19	4	1	6	82 11.5
diploma	2	3	21	3	12	4	116 16.3
degree	3	1				1	6 .8
MSc	4	3	17	2	9	10	140 19.7
PhD	5						1 .1
studying for dip	6		3	1	2	2	23 3.2
studying for MSc	7	5	5	1	3	3	47 6.6
(Continued)	Column Total	28 3.9	97 13.7	25 3.5	37 5.2	48 6.8	710 100.0

Correlation between health promotion qualification and ethical dilemma (continued)

HPQUAL	Count	DILEMMAS condoms to under 15	too many to list 16	being a role mod 17	theory v s. pract 18	evaluation/evide 19	Row Total
none	0	8		3	2	5	295 41.5
certificate	1	1		1	1	2	82 11.5
diploma	2		1	1	3	5	116 16.3
degree	3						6 .8
MSc	4	2	1	1	1	7	140 19.7
PhD	5						1 .1
studying for dip	6	1				1	23 3.2
studying for MSc	7					1	47 6.6
(Continued)	Column Total	12 1.7	2 .3	6 .8	7 1.0	21 3.0	710 100.0

Correlation between health promotion qualification and ethical dilemma (continued)

	Count	DILEMMAS told what to do/ 20	time 21	breadth of role/ 22	Row Total
HPQUAL					
none	0	14	4	1	295 41.5
certificate	1	1			82 11.5
diploma	2	5			116 16.3
degree	3				6 .8
MSc	4	16		1	140 19.7
PhD	5	1			1 .1
studying for dip	6	1			23 3.2
studying for MSc	7	2			47 6.6
	Column Total	40 5.6	4 .6	2 .3	710 100.0

Number of Missing Observations: 64

CORRELATION BETWEEN

BAD POINTS ABOUT JOB

AND

ETHICAL DILEMMA

Correlation between bad points about job and ethical dilemma

Count	BADPTS					
	NHS/changes/uncer 1	pay/temp.contrac 2	Bureacracy 3	manager/management 4	no training/dire 5	Row Total
DILEMMAS						
0 none	4	6	3	1	5	43 6.4
1 inequalities in	1	6	1	1	1	37 5.5
2 campaigns/short	3	2	2	2	3	38 5.7
3 targeting	1			3		10 1.5
4 budget allocatio	11	8	2	13	2	98 14.6
5 victim blaming	1				1	5 .7
6 credibility/low	8	7	6	7	5	78 11.6
7 'politics'/insti	3	2	1	6	3	29 4.3
8 job description	4	1		1	1	15 2.2
9 policies						1 .1
10 effectiveness/or	5	3	1	2	1	28 4.2
11 NHS/bureacracy/c	19	7	7	3	7	89 13.3
12 lack of skills/c		4	1	2	3	24 3.6
13 medical model/NH	3	4	3	2	2	35 5.2
Column Total	82 12.2	59 8.8	36 5.4	58 8.6	41 6.1	671 100.0

(Continued)

Correlation between bad points about job and ethical dilemma (continued)

DILEMMAS	Count	BADPTS no caree r path/p 6	budget/f unding 7	colleagu es/staff 8	effectiv eness/wa 9	no statu s/power/ 10	Row Total
0 none		2	1	1	1	1	43 6.4
1 inequalities in			5	1		1	37 5.5
2 campaigns/short		2	6	1		1	38 5.7
3 targeting			1				10 1.5
4 budget allocatio		1	12	3	3	3	98 14.6
5 victim blaming			1				5 .7
6 credibility/low		2	5	3	1	4	78 11.6
7 'politics'/insti		1	1	1	2		29 4.3
8 job description		1	1	1	1		15 2.2
9 policies					1		1 .1
10 effectiveness/or		1			3		28 4.2
11 NHS/bureacracy/c			5	1	2	5	89 13.3
12 lack of skills/c				2	1	2	24 3.6
13 medical model/NH			1	2		4	35 5.2
	Column	12	42	21	16	33	671
(Continued)	Total	1.8	6.3	3.1	2.4	4.9	100.0

Correlation between bad points about job and ethical dilemma (continued)

Count	BADPTS pressure /stress/ 11	not valu ed/misun 12	meetings 13	practica lities/r 14	remit to o big 15	Row Total
DILEMMAS						
0 none	10	1		1		43 6.4
1 inequalities in	6	3		1	2	37 5.5
2 campaigns/short	4	6		1	1	38 5.7
3 targeting	3					10 1.5
4 budget allocatio	18	4		3	2	98 14.6
5 victim blaming						5 .7
6 credibility/low	8	4		4	2	78 11.6
7 'politics'/insti	3	1	1	1		29 4.3
8 job description	2			1		15 2.2
9 policies						1 .1
10 effectiveness/or	4	2			1	28 4.2
11 NHS/bureacracy/c	15	6		3	1	89 13.3
12 lack of skills/c	6	1		1		24 3.6
13 medical model/NH	4	2		3	2	35 5.2
Column	108	36	2	22	13	671
(Continued) Total	16.1	5.4	.3	3.3	1.9	100.0

Correlation between bad points about job and ethical dilemma (continued)

DILEMMAS	Count	BADPTS workplac e/travel 16	don't kn ow 17	medical/ disease 18	need to be motiv 19	inequali ties in 20	Row Total
0 none		1	2				43 6.4
1 inequalities in		1		1	2	2	37 5.5
2 campaigns/short		1			2		38 5.7
3 targeting					1		10 1.5
4 budget allocatio		1		1	3	1	98 14.6
5 victim blaming				1	1		5 .7
6 credibility/low		2	1	5	3		78 11.6
7 'politics'/insti					2		29 4.3
8 job description					1		15 2.2
9 policies							1 .1
10 effectiveness/or		1		1			28 4.2
11 NHS/bureacracy/c		1		2	1		89 13.3
12 lack of skills/c					1		24 3.6
13 medical model/NH							35 5.2
(Continued)	Column Total	13 1.9	3 .4	12 1.8	23 3.4	4 .6	671 100.0

Correlation between bad points about job and ethical dilemma (continued)

DILEMMAS	Count	BADPTS 21 purchaser conflı	22 none	23 understaffed	24 training others/	25 working with und	Row Total
0 none		1	2				43 6.4
1 inequalities in		2					37 5.5
2 campaigns/short		1					38 5.7
3 targeting			1				10 1.5
4 budget allocatio		3	1	2		1	98 14.6
5 victim blaming							5 .7
6 credibility/low					1		78 11.6
7 'politics'/insti		1					29 4.3
8 job description							15 2.2
9 policies							1 .1
10 effectiveness/or		2			1		28 4.2
11 NHS/bureacracy/c		4					89 13.3
12 lack of skills/c							24 3.6
13 medical model/NH		2				1	35 5.2
(Continued)	Column Total	19 2.8	6 .9	3 .4	3 .4	4 .6	671 100.0

Correlation between bad points about job and ethical dilemma (continued)

	BADPTS					
Count	NHS/chan ges/unce 1	pay/temp .contrac 2	Bureacra cy 3	manager/ manageme 4	no train ing/dire 5	Row Total
DILEMMAS						
14 misunderstood/un	8	1	5	4	2	48 7.2
15 condoms to under		1		1		12 1.8
16 too many to list	1					1 .1
17 being a role mod		1	2	2		6 .9
18 theory vs. pract	2		1	1		7 1.0
19 evaluation/evide	2	2	1		3	21 3.1
20 told what to do/	6	3		7	2	40 6.0
21 time						4 .6
22 breadth of role/		1				2 .3
Column (Continued) Total	82 12.2	59 8.8	36 5.4	58 8.6	41 6.1	671 100.0

Correlation between bad points about job and ethical dilemma (continued)

DILEMMAS	Count	BADPTS 6 no career path/p	7 budget/funding	8 colleagues/staff	9 effectiveness/wa	10 no status/power/	Row Total
14 misunderstood/un		2	1	2	1	3	48 7.2
15 condoms to under						2	12 1.8
16 too many to list							1 .1
17 being a role mod							6 .9
18 theory vs. pract							7 1.0
19 evaluation/evide				1		2	21 3.1
20 told what to do/			2	1		5	40 6.0
21 time				1			4 .6
22 breadth of role/							2 .3
(Continued)	Column Total	12 1.8	42 6.3	21 3.1	16 2.4	33 4.9	671 100.0

Correlation between bad points about job and ethical dilemma (cont)

DILEMMAS	Count	BADPTS pressure /stress/ 11	not valu ed/misun 12	meetings 13	practica lities/r 14	remit to o big 15	Row Total
14 misunderstood/un		7	3	1		2	48 7.2
15 condoms to under		4					12 1.8
16 too many to list							1 .1
17 being a role mod		1					6 .9
18 theory vs. pract		1					7 1.0
19 evaluation/evide		5	2		1		21 3.1
20 told what to do/		5	1		2		40 6.0
21 time		1					4 .6
22 breadth of role/		1					2 .3
	Column	108	36	2	22	13	671
(Continued)	Total	16.1	5.4	.3	3.3	1.9	100.0

Correlation between bad points about job and ethical dilemma (cont)

DILEMMAS	Count	BADPTS workplace/travel 16	don't know 17	medical/disease 18	need to be motiv 19	inequalities in 20	Row Total
14 misunderstood/un		1			4		48 7.2
15 condoms to under						1	12 1.8
16 too many to list							1 .1
17 being a role mod							6 .9
18 theory vs. pract		2					7 1.0
19 evaluation/evide					1		21 3.1
20 told what to do/		1		1	1		40 6.0
21 time		1					4 .6
22 breadth of role/							2 .3
	Column	13	3	12	23	4	671
(Continued)	Total	1.9	.4	1.8	3.4	.6	100.0

Correlation between bad points about job and ethical dilemma (cont)

Count	BADPTS purchase r confli 21	none 22	understa ffed 23	training others/ 24	working with und 25	Row Total
DILEMMAS						
14 misunderstood/un		1				48 7.2
15 condoms to under	1				2	12 1.8
16 too many to list						1 .1
17 being a role mod						6 .9
18 theory vs. pract						7 1.0
19 evaluation/evide	1					21 3.1
20 told what to do/	1	1		1		40 6.0
21 time			1			4 .6
22 breadth of role/						2 .3
Column Total	19 2.8	6 .9	3 .4	3 .4	4 .6	671 100.0

Appendix: Profile of 36 respondents

36 people (5% of the total respondents) offered to be followed up after their questionnaires were received. Due to time constraints, they were not re-questioned, but their questionnaires were transcribed verbatim to give a 'snapshot' of the respondents.

jobs

These respondents consisted of 3 smoking project co-ordinators, 3 HIV/sexual health/outreach workers, 3 Primary Health care (PHC) workers, 3 Health Promotion Advisors (general), 2 managers, 2 Senior Health Promotion Advisors, 2 Health Promotion trainers, 2 youth/ school workers, 2 community development workers, and 11 others.

sex

	sex	
	male	female
FOLLOWUP yes	12	24

There were 12 males (1/3), a higher proportion than were in the whole sample (1/5).

age

They varied in age from 26 to 62 years, but 4 were aged 26 years and 3 were aged 48 years, a similar age pattern to the whole sample.

district

	HPU			
	Tees	Tees	N.Cumbria	N.Durham
FOLLOWUP yes	1	1	2	1
	Gateshead	Newcastle	Hull	Grimsby
FOLLOWUP yes	1	1	1	1
	N.Allerton	Lincs.	Doncaster	Sheffield
FOLLOWUP yes	2	1	1	2
	Beds.	N.Essex	New River	T.Wells
FOLLOWUP yes	1	1	1	1
	London SE14	W.Surrey	Kingston	Oxford
FOLLOWUP yes	1	1	1	1
	Bucks	Bucks(2)	E.Berks	Devon
FOLLOWUP yes	1	1	1	1
	Weston	Wolverh'ton	N.Warwicks.	Southport
FOLLOWUP yes	1	1	1	1
	N.W.Lancs	N.W.Lancs 2	Lothian	Midland/Eire
FOLLOWUP yes	2	1	1	1

The 36 were from a **geographical spread**, including Scotland Ireland, all of England, but not Wales.

qualifications

	QUALS			
	degree	certificate	none	PhD
FOLLOWUP yes	20	1	1	1

	MBA	RGN	CertEd/PGCE	dental quals
FOLLOWUP yes	2	6	2	1

	SRdietitian
FOLLOWUP yes	1

20 of the respondents also had a degree, 6 were RGN (nurses), 2 with PGCE (teachers), 1 with an MBA, 1 with a PhD., 1 with dental qualifications, 1 with dietetic qualifications, and 1 with a certificate, a similar pattern to the whole sample.

health promotion qualifications

	HPQUAL			
	none	certificate	diploma	MSc
FOLLOWUP yes	10	3	6	11

	studying for diploma	studying for MSc
FOLLOWUP yes	2	4

11 respondents had the MSc in Health Promotion, and 10 had no qualifications, 6 had the Diploma, with 6 studying for the Diploma or MSc. and 3 with the certificate in Health Promotion, a similar pattern to the whole sample.

previous work

	PREVWK			
	nursing	education/ training	management	admin/ clerical/ library
FOLLOWUP yes	8	5	2	1

	youth work	health	research/ computers	dietetics/ dental
FOLLOWUP yes	1	4	2	2

	none/ student	graphic design	health education/ promotion	social work/ refuge/ community/ project/ charity
FOLLOWUP yes	2	1	2	3

	sales/ marketing/ journalism/ media	shop work/ factory
FOLLOWUP yes	2	1

With regard to previous work, 8 people's last job was nursing, 5 was teaching, 4 were in the health field, and the others varied a similar pattern to the whole sample.

model

	MODEL			
	behaviour change	educational	social change	client directed
FOLLOWUP yes	4	4	3	1

	all	varies	Ottawa Charter	community development
FOLLOWUP yes	1	15	1	3

	no	n/a
FOLLOWUP yes	1	2

membership of SHEPS

	SHEPS		
	yes	no	n/a
FOLLOWUP yes	9	25	2

25 were not members of SHEPS, 9 were (36%), and 2 were 'not applicable'. There were thus more SHEPS members than for the rest of the whole sample.

model of working

15 of the 36 felt that they called upon various ways of working, 4 categorised their model of working as being behaviour change, 4 as educational, 3 as social change, the rest varied a similar pattern to the whole sample.

good points about work

	GOODPTS			
	autonomy	clients/ public	variety	useful/ worthwhile/ important
FOLLOWUP yes	10	3	6	2
	colleagues/ manager/ staff	environment /location	none	teamwork/ interagency work
FOLLOWUP yes	2	1	1	3
	progressive	challenging /good at job	/flexitime/ stress free	
FOLLOWUP yes	1	3	3	

The main good points were autonomy (10), variety (6), teamwork (3), rewarding/ challenging (3) and flexibility (3).

bad points

	BADPTS			
	pay/ temp.contra ct/hours	Bureacracy	no training/ direction	no career path/ promotion prospects/ short contract
FOLLOWUP yes	6	4	1	2
	budget/ funding	colleagues/ staff/ "politics"	no status/ power/poor image/ fragmentati on/ isolation	pressure/ stress/ workload
FOLLOWUP yes	2	1	1	6
	not valued/ misunderstoo od/not supported	medical/ disease focused	need to be motivated/ low morale/ boring	purchaser conflicts/ constraints
FOLLOWUP yes	4	1	1	2
	none	understaffe d	training others/ no contact- public	
FOLLOWUP yes	1	2	1	

The main bad points were pay (6), and pressure/stress(6), and not feeling valued (4).

ethical dilemmas

DILEMMAS	
none	2
inequalities in health/root causes	1
campaigns/short term proj./sponsorship/ media coverage	2
targeting	2
budget allocations/ understaffed/ resourcing/income gen.	4
credibility/low status	5
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	2
effectiveness/or not	2
NHS/bureacracy/changes/ cuts/arguments	3
lack of skills/communication probs	1
medical model/NHS/GP interference/P&P/HON	3
misunderstood/ undervalued	3
being a role model	1
evaluation/evidence needed	1
told what to do/hidden agendas/interagency work/conspiracy	3
time	1

Within this group of 36, with regard to ethical dilemmas, 5 had credibility issues, 4 had budget issues, 3 had NHS issues, 3 felt misunderstood, 3 were concerned about hidden agendas, and the rest varied.

Thus it could be argued that the 36 who offered to be followed up represented the whole sample, rather than were a skewed sample, because these figures represent a similar picture to the whole sample's.

The verbatim case studies were transcribed:

Ref. 1

Resources officer/ office manager;19 years in post; has worked in present HPU for 9 years; aged 50; contracted to do 37 hrs p.w.; does 37.5 hrs p.w.; is not currently a member of SHEPS. cert HP; previously worked as Manageress of a dry cleaners, shop assistant and typist; has no particular way of working; good points: variety, interesting, helpful; bad points; understaffed department.

Ethical Dilemmas: the only problem occurs whilst the department is one member of support staff short - with the result that overall I agree with all Health Promotion Policies; future of HP continues to grow and that the 'powers that be' do not close it down - giving people a choice to become more health conscious cannot be a bad thing - providing the messages are correct.

Ref. 3

Accident Prevention Co-ordinator; 3 yrs. in post; 4 yrs. in current unit; has not worked in other units; female, aged 36; contracted to do 37 hrs p.w.; does 42 hrs p.w.; is not currently a member of SHEPS; has BA. RGN. HP; previously worked in Occupational Health; particular way of working, behaviour change, educational, social change; Good points: Multi agency working: diversity of work; Bad points; no career: health gains are long-term, so difficult to assess if HP is effective.

Ethical Dilemmas: the lack of understanding from other health professionals of what HP is about. Not enough marketing of health professionals to gain credibility with other professions. Although I've never had to do it I would have difficulty promoting fluoridation of water as I am against mass medication which is what fluoridation of water is tantamount to. Sometimes have difficulty with the concept of 'middle class' health promotion specialists advising those from really deprived backgrounds. Welcome the change of government, perhaps more money could be made available, however unless we get involved in more research/ evaluation this is not likely to happen. I wonder how GP fundholding is going to affect HP in the long-term. Most GP's only use a medical model.

Ref. 14

Director of Health Development; 4yrs in position; 10 yrs. in current unit; has worked in other units; male, aged 41; contracted to do 37.5 hrs p.w.; does 45 hrs p.w.; member SHEPS; MSC. HP; has BA, Cert Ed., MBA, studying for PhD; previously worked

way up in HP, previously primary school teacher; preferred way of working is a silly question, but prefers health development model; good points: autonomy; bad points: lack of power, lack of money.

Ethical dilemmas: NHS is not a good home for HP services, ethics are based on values and beliefs, I think the Society's Code of Principles of Practice are my guide in this area; the future is very good: it will become the dominant theoretical and practice issue for a new kind of health focused agency.

Ref. 17

Manager of Outreach ....., gay and bisexual men's health project; has worked in position for 4.5 years, has not worked in any other HPU's; is a male aged 50; contracted to do 37 hrs p.w., does 40 hrs p.w.; is not a member of SHEPS; does not have any HP qualifications; has a BA and postgrad.dip. in teaching English as a second language and University certificate in counselling; has worked as a teacher, postman, social worker; preferred way of working is: behavior change, educational, client directed, and community development; good points are: high level of satisfaction, client contact: very rewarding, am allowed high degree of independence; bad points: really can't think of any significant ones, amazingly.

Ethical dilemmas: I would like to see more of our HIV prevention budget spent on targeting gay and bisexual men. Currently it's about 15%, which is low, compared to 60% of new infections being amongst gay men. However, Cumbria is a low prevalence area for HIV, and, as it stands, the project gets a lot of support locally, so- this is not a major gripe. In gay men's health, professional boundaries are a big issue. Particularly, when is a client no longer a client and can become a friend and even a sexual partner. This is a bigger issue in a small town/ rural area, like Cumbria, than in a city, where it's easier to socialise and meet partners outside one's own client network. The future: I would like to see it taken right out of NHS funding. I don't see it sitting well with the medical model and the medical mind, which places prevention very low down on the list of priorities. I'm sure governments and the general public have faith in HP and prevention being 'better than cure', but it gets a raw deal within the NHS.

Ref. 26

Health Promotion Specialist; worked in post for 2 yrs.; in unit for 4 yrs.; has worked in 3 other HP units; female, aged 40; contracted to work 37.5 hrs p.w.; does too many; is not a member of SHEPS - was a member but gave up; has Cert. HP, BA diploma in community and social studies; previously worked in Hotel Management and Social

worker; particular way of working, educational/radical; good points; autonomy: 'doing good': variety; bad points; finance: lack of understanding.

Ethical Dilemmas: Problems are finance ie. lack of money and being pushed for CIP within a hest trust. Too much work not enough time or staff. My own ethical issues are. a) returning services, b) sponsorship/ chasing c) quick fix funding. eg. SRB. Long term outcomes. I honestly don't know. I hope that it continues, but like most of my team I have 'an exit strategy' I hope that the specialist rate has a higher profile with the new gut.

Ref. 58

Health Promotion specialist- Primary care; worked in position for 9 years; has worked in other HPU's; is a male aged 39; contracted to do 37 hours p.w., but has TOIL; is not a member of SHEPS, because is a member of Unison, and believe my energies are more productive in this organisation; has the Diploma HP, and is undertaking the MSc currently; has a BA and is a RGN; has had various nursing jobs; has no preferred way of working, as it is a combination of many depending on the situation; good points: flexibility, supportive environment, being able to influence policy makers; bad points: Health Of The Nation, covering 2 areas, being seen as a twighlight service.

Ethical dilemmas: credibility is a major problem we face particularly within our provider trust, medics would rather use the finance to treat patients!! (no change here), addressing inequalities in health when the agenda is one of disease management, within the rigid HON framework has been an ongoing problem, changes in the NHS which incorporate the free market, individualism, choice and competition fly in the face of ideals which we are striving to work towards, if our raison d'etre is addressing inequalities in health and our contract specifies work on the HON key areas, how to do this while not sacrificing our ultimate goal. Income generation is a particular anathema to myself and whether we should be expected to do this as part of our workload. When you know from the evidence of the effectiveness of a particular intervention and somebody decides to use an approach that has been shown to be inappropriate, do you continue to participate in this steering group? The future for HP: I am particularly optimistic in light of the sounds being made by the incoming govt. I know that SHEPS have put together a paper on options for HPs and would like to think that these will be investigated by current govt. and that this will lead to a greater role for health promotion specialist service.

Ref. 62

Health Promotion Officer - H.I.V. and Sexual Health; worked in position for 10 months; has not worked in any other HPU's; is a female aged 34; contracted to work 37 hours and does due to working on flexi-time, so if worked too many hours take time back, manager very supportive of claiming time back; is not a member of SHEPS, haven't got around to it but discussed department joining instead of ;individual membership; has an Advanced Diploma in Health Services, MSc - studying towards, has completed one year; is a RGN and SEN and has a 7306 - Teaching certificate; has worked previously in Community Health Development work, VSO in West Africa, clinic nurse, health co-ordinator for a water and sanitation project, before this general nursing; preferred work - educational - giving people knowledge and skills to enable informed choices, however at times more towards behaviour change as promoting use of condoms for safer sex; good points - multi agency approach, variety of initiatives, support re: study.

Ethical dilemmas: Credibility - responsible for development of work with black communities. I'm a white worker and got off to a bad start with some black workers not accepting me in this role. Following various training events I'm only just starting to feel comfortable about developing this area. Campaigns/budgets - responsible for World Aids Day initiatives. Want to make an impact but budget very tight. Want to develop drama work this year but difficult due to money restrictions. Also, effectiveness of awareness raising events - need to incorporate in every day work. Faced an ethical dilemma at World Aids Day last year - organised an information caravan in city centre, explicit materials inside. Two young people (male approx. 10) interested in materials, do you allow them to help self or restrict access due to young age??? Issue not cleared yet. Also organised licensed street collecting for local Aids charities, afterwards found out not Trust policy - big headache sorting this one out. Condoms and under 16's constant discussion. Also drugs and harm reduction versus just say no message. Colleagues have conflicting values/beliefs but all work for same organisation. The future of HP: Difficult one- purchasers want to see numbers, evaluation difficult, effectiveness difficult to assess, don't market ourselves effectively. Some organisations not aware of what we can offer, some feel threatened by us too.

Ref. 70

Market Research Placement Student; in post for 1 yr.; in unit for 1 yr.; has not worked in any other HP unit; male, aged 21; contracted to work 37 hrs p.w.; has to work 37 hrs p.w.; is not a member of SHEPS, didn't know they existed; HP Cert.; no previous jobs; Particular way of working: influential - behavior change - happy people; good points: flexi time, research time, annual time; bad points: a boss, the mornings, everything else.

Ethical Dilemmas: No perks; travel expenses-to and from work- not even paid!!! I'm not bitter though, since the work is simple. I drink, smoke all kinds of things, smoke cigarettes, eat unhealthy, and generally lead a lifestyle which probably makes me the biggest hypocrite at work. However, I am good at any work, and don't see why my work should influence my lifestyle if I am happy. eg. cognitive dissonance. Who knows what the future holds!! Do you think you are God!

Ref. 74

Health Promotion Specialist-young people; in post for 6 yrs.; in unit for 6 yrs.; has not worked in any other units; male, 47; contracted to work 37 hrs p.w.; does 37 hrs p.w.; is not a member of SHEPS - local branch totally 'shambolic'; HP MSc, PGCE; previous work: Assistant Director, therapeutic community, 83 - 90, science teacher 71-83; particular working way, empowerment; good points; clients: colleagues: freedom to plan work: bad points; contracting tedium: travelling.

Ethical Dilemmas; Most of the problems you list either do not affect me or I ignore them. Sponsorship from firms for events/schemes who do not share same ethical perspective. eg. Pharmaceuticals companies. Do you mean a professional, dedicated HP service??

Ref. 79

Health Promotion Specialist; in post for 1.5 yrs.; in unit for 3 yrs.; has not worked in any other unit; female, aged 26; contracted to work 37 hrs p.w.; does 37 hrs p.w.; is not a member of SHEPS - not interested in social groups; diploma in HP. BSC biochemistry; previous work, trainee HP specialist researcher, hotel receptionist; preferred way to work, aim to use educational, client directed - but depends on limitations of time and resources; good points: varied and interesting, autonomy, work with other agencies; bad points: low budgets, medical profession-power of, volume of work.

Ethical Dilemmas; I feel that I could write an essay about this - in brief. Others expectations of what HP is. Current climate of competition prevents co-operation and understanding at a crucial time in the development of HP. Ultimately funders = government, therefore little freedom of speech and opportunity to address 'real issues'. Encouraging clients to take control etc. but having no ability to really change the environment in support of their choices-raising expectations. Depends very much on area and personalities in commissioning positions, and how they view HP. Often they have a medical background so HP is not viewed very positively.

Ref. 80

Health Promotion Specialist; in post for 2 yrs.; in unit for 2 yrs.; has worked in other units; male, aged 26; contracted to work 37 hrs p.w.; does 37 hrs p.w.; is not a member of SHEPS-cost and dubious about professionalisation of HP; has diploma in HP, MSc, BA; no previous jobs; no single model adopted, if anything, focuses on behaviour change and education; good points: people, location, pay; bad points: range of interpretations: funding, status, focus of HP work.

Ethical Dilemmas; Principal problems concern the range of interpretations of what constitutes HP promotion activity. The 'balloons, leaflets and health fayre/ roadshow' model is jh71 reckoned to be effective by lots of people! (including practitioners). everybody has an opinion on how HP should be practiced, by whom, in what setting of with what outcome, the service suffers from low credibility partially the result of misguided commissioning from the HP. Constant demand for raising campaigns and leaflets. Lack of debate about wider influences on health beyond individual behaviour. Helping people change training is patronising, long winded and ineffective and is based on an overly simplistic, individualisation model. Appointment of minister for Public Health may raise its profile, but otherwise GLOOMY! I see it becoming more of an academic exercise, an intellectual pursuit rather than as a viable practical activity.

Ref. 140

Community Heart health facilitator; in post for 10 months; in unit for 10 months; has not worked in any other units; female, aged 36; contracted to work 37 hrs p.w.; does 37-45 hrs p.w.; is not a member of SHEPS - too much of an effort to find forms; BA Hons. social policy and admin, registered general nurse and registered midwife and 7307 C&G in adult education; previous work, domestic engineer - housewife and mother, practice nurse, midwife, renal nurse; no particular way of working; good points: flexi time; autonomy; intellectually challenging; bad points: over worked; driving; alliance working.

Ethical Dilemmas: Yes loads! very negative relationship with purchaser; believing in community development as an approach, but not being able to operate it; Being based in an Environmental Health Dept, which has an enforcement role and mine which is facilitative; District council trying to raise its own kudos and political expediency by staging naff' campaigns' to be seen but which I know are a total waste of money. I believe the purchase/provider split to be immoral and totally alien to good working relationships and of health services. Despite my job being 'community' based it is very much lifestyle oriented - I am trying to be innovative and link with Agenda 21 and Health For All etc., but have to be fairly underhand about it. I am ambivalent about No

smoking Day - but there is great pressure from professionals for us as a HPU to support it. We need to really be sure of the arguments around evaluation and outcomes, slow work if we are to attract decent funding. We have more of a chance with Labour complimented by central Gov. policies eg. the food industry and made to account for the crap they produce and their pricing policies against healthy options - viz. inequalities.

Ref. 345

Senior Health Promotion Advisor: Primary Care; has been in position for 6 years; has not worked in any other HPUs; is a female aged 29; contracted to do 36 hrs. p.w.., but does 40+; has the Diploma and MSc in HP; has a BA Hons. degree; has previously worked in advertising, market research and was a PE teacher; does not have a preferred way of working; good points: variety, sense of helping others, friendship with colleagues; bad points: uncertainty about direction, work load, pressure.

Ethical dilemmas: credibility- something you have to work at to obtain and continue to build upon. Professionalism/ skills - are we the right people to do this job, expertise needed in this area, also a changing environment- changing skills. Uncertainty about the role- continual assessment of HP roles- continually on the 'hot spot' continually scrutinised by GPs, even colleagues in this organisation. The approaches that are being used by health promoters- do we have the right to determine how health professional work, eg., behaviour change approach- could become victim blaming, rather than looking at external factors. Too often H. promoters raise an issue- this opens a can of worms - which again cause alarm and concern with people who are already stressed/ smoking/ alcoholic, etc. The future: unsure, I feel that we may have a stronger role to play when looking through documents produced by SHEPS for the Gov. Also, having a Minister for Public Health is positive, also revisiting the Black report - all stands in good stead. I feel that the position could be quite positive, but a case of saying what is effective, working with stakeholders, eg. GPs, community network, voluntary org's, etc. to promote own role.

Ref. 407

Senior HPA, community, mental health, women's health; been in position for 7 yrs.; has not worked in any other HPUs; is a female aged 42; contracted to do 31 hrs. p.w., but sometimes does more; is not a member of SHEPS; has no HP quals.; is an SRN, SCM, has an adult teaching cert. and cert. in counselling; has previously worked in district nursing, as an occupational health nurse, and worked abroad in community development health jobs; prefers social change way of working; no good points listed

for job; bad points: lack of real commitment from Health Authority, inter-team relationship with manager.

Ethical dilemmas: being accountable, having to show HA how effective Health Promotion is using medical model methods, HA rhetoric sounds good but often when its translated into practice everyone in PR. mode and wants to be seen to be doing something, unit being seen to be doing something, ie. for No Smoking Day campaign and skin cancer campaign. future: I always feel both hopeful about the potential and some of the ideas that are around and hopeless that all these ideas will yet again be translated into short term behaviour change related work, and that HP gets squeezed by hitech curative health care.

Ref. 442

Publicity and Marketing officer; worked in position for 3 months; has worked in other HPUs; is a female aged 48; contracted to do and does 18.5 hrs. pw; is not a member of SHEPS, as I don't consider HP to be a profession; has the Diploma in HP; has a BSc. Hons, Dip. Adult Ed., Dip. Spanish; previously worked for the Health Education Authority as the smoking project co-ordinator, in Oxfam as an education officer, and as a volunteer; believes in the medical model as the preferred way of working, but is obliged to fit in with all models; good point: believes in HP, likes media, covers all aspects; bad points: little time and lousy pay, other HPAs don't share campaigning zeal, systems and bureacracy.

Ethical dilemmas: everyone is watching their back, lack of motivation and enthusiasm, everyone sticks with the do-able issues so whilst poverty and health is talked about, nothing really meaningful is done. I am the media person and yet Hops don't rate media as effective. It creates a hard task. I was sacked by the HEA because of an ethical disagreement over the HEA's relationship with ASH. and because a smoking and pregnancy project got in the tabloids and I was scapegoated. smoking and tobacco control has caused me endless ethical problems- the HA chairman stopped me doing anti-ads stuff!! The future of HP: it needs to get more competitive and show evidence of effectiveness. It needs to be more opportunistic and reactive to news. It's slow to respond and loses lots of opportunities.

HPU 152

Health Promotion Specialists, sexual health and young people; has worked in position for 5 years; has not worked in any other HPU's; is a male aged 36; contracted to do 37 hours per week, and does about 37 hours per week because of flexi-time; is not a member of SHEPS, because he has seen little benefits/ reasons to join; has the

Diploma and MSc. in HP; has a BA and Dip.Ed; previous jobs were teaching English overseas, care work, outdoor activities, and a health educator in Africa; preferred way of working is educational; good points about job: freedom to develop ideas, opportunities for multi-disciplinary work, flexi-time system; bad points are: poor management, reducing budget for projects etc, and low salary for what is expected of us.

Ethical dilemmas: HP not recognised as being as professional as clinical medicine; training opportunities in terms of the rigmarole involved in applying for courses through our Trust; difficult working as part of a countrywide AIDS action group where members compete for bids/ contracts/ funding, etc; resources and staff being spread increasingly thinly; uncertainty over NHS structural changes in Warks; the local press twisting stories around sexual health- we need/ like the coverage but not always the way they represent/ reproduce our words and comments. The future: lack of real career structure has encouraged some workers to leave; I doubt the continuity of many colleagues' work in HP (pay related). They leave for other more lucrative/ rewarding tasks. Unless it receives better resourced funding- future may be bleak- we can't compete with other - often unhealthy promoting- influences. I can see HP continuing to 'potter' along as a fairly low-key and unrecognised discipline.

Profile of managers

- **sex of managers**

	MANAGERS			
	manager		others	
	Count	%	Count	%
male	20	36.4%	140	19.5%
female	35	63.6%	579	80.5%

There were more male managers than other jobs.

- **age of managers**

	MANAGERS			
	manager		others	
	Count	%	Count	%
-20			2	.3%
20-29			139	19.4%
30-39	19	35.8%	290	40.6%
40-49	24	45.3%	197	27.6%
50-59	10	18.9%	85	11.9%
60+			2	.3%

Managers ages ranged from 32 to 59 years, and were more likely to be in the 40-49 age group than the rest of the respondents who were in the 30-39 age group.

- **managers and membership of SHEPS**

	MANAGERS			
	manager		others	
	Count	%	Count	%
yes	28	50.9%	126	17.5%
no	26	47.3%	469	65.2%
n/a	1	1.8%	124	17.2%

A greater percentage (**50.9%**) of managers were a member of SHEPS than the rest of the group, but still only half of the managers were members.

- **Health Promotion qualifications of managers**

	MANAGERS			
	manager		others	
	Count	%	Count	%
none	8	14.5%	336	46.8%
certificate	4	7.3%	83	11.6%
diploma	19	34.5%	102	14.2%
degree	1	1.8%	5	.7%
MSc	21	38.2%	121	16.9%
PhD			1	.1%
studying for diploma			25	3.5%
studying for MSc	2	3.6%	45	6.3%

38.2% of managers had the **MSc.**, and **34.5%** had the **Diploma**, totalling **72.7%** having Health Promotion qualifications, compared to 16.9% of the others having an MSc. and 14.2% having the Diploma, totalling **31.1%**.

- Managers and good points about work

	MANAGERS			
	manager		others	
	Count	%	Count	%
autonomy	12	23.1%	102	15.3%
clients/public	1	1.9%	53	7.9%
variety	11	21.2%	144	21.6%
interesting/enjoyable	3	5.8%	49	7.3%
useful/worthwhile/ important	3	5.8%	34	5.1%
colleagues/manager/staff	8	15.4%	76	11.4%
environment/location			15	2.2%
none			3	.4%
prevention/make changes	4	7.7%	30	4.5%
opportunities/training			15	2.2%
teamwork/interagency work	5	9.6%	32	4.8%
action/progressive			10	1.5%
creativity			6	.9%
rewarding/challenging/ good at job	4	7.7%	27	4.0%
flexibility/flexitime/ stress free	1	1.9%	56	8.4%
don't know			4	.6%
pay/hours			12	1.8%

Managers listed **autonomy** (23.1%), **variety** (21.2%) **and colleagues** (15.4%) as the main good points, and the rest of the respondents listed the same points but in a different order, namely: **variety** (21.6%), **autonomy** (15.3%) and **colleagues**(11.4%).

- **Managers and bad points about work**

	MANAGERS			
	manager		others	
	Count	%	Count	%
pay/temp.contract/hours	5	9.6%	55	8.4%
Bureacracy	11	21.2%	179	27.3%
no training/direction	1	1.9%	40	6.1%
no career path/promotion prospects/short contract	1	1.9%	12	1.8%
budget/funding	5	9.6%	39	5.9%
colleagues/staff/ "politics"	2	3.8%	20	3.0%
effectiveness/waste of time/evaluation			17	2.6%
no status/power/poor image/fragmentation/ isolation	5	9.6%	29	4.4%
pressure/stress/workload	11	21.2%	105	16.0%
not valued/misunderstood/ not supported	3	5.8%	34	5.2%
meetings			2	.3%
practicalities/ resources/conditions			24	3.7%
remit too big	1	1.9%	13	2.0%
workplace/travelling			13	2.0%
don't know			4	.6%
medical/disease focused	2	3.8%	10	1.5%
need to be motivated/low morale/boring	1	1.9%	24	3.7%
inequalities in health			4	.6%
purchaser conflicts/constraints	4	7.7%	15	2.3%
none			7	1.1%
understaffed			3	.5%
training others/ no contact-public			3	.5%
working with under 16's/homophobia			4	.6%

- Managers listed **bureacracy** (21.2%), **pressure** (21.2%), and joint third: **pay** (9.6%), **status** (9.6%), and **budget** (9.6%), as the main bad points about work, and the rest of the group similarly listed **bureacracy** (27.3%), **pressure** (16%), **pay** (8.4%), although in different percentages. The other respondents had a broader list of bad points.

- **previous work of managers**

	MANAGERS			
	manager		others	
	Count	%	Count	%
nursing	6	11.1%	105	14.9%
education/training	12	22.2%	101	14.3%
management	4	7.4%	14	2.0%
admin/clerical/library	1	1.9%	119	16.8%
youth work			28	4.0%
health	15	27.8%	74	10.5%
research/computers			34	4.8%
dietetics/dental	1	1.9%	35	5.0%
none/student	1	1.9%	23	3.3%
graphic design			9	1.3%
fitness/ exercise/ leisure			13	1.8%
health education/promotion	10	18.5%	52	7.4%
environmental health	3	5.6%	8	1.1%
self employed			4	.6%
social work/refuge/ community/project/ charity			38	5.4%
sales/marketing/ journalism/media	1	1.9%	27	3.8%
hairdresser/waitress			2	.3%
shop work/factory			10	1.4%
army			2	.3%
counselling			9	1.3%

Managers' previous work was health (27.8%), education (22.2%), Health Education/ Promotion (18.5%), nursing (11.1%) compared to the others whose previous work was admin/clerical (16.8%), nursing (14.9%), education (14.3%), health (10.5%). Managers came from 10 different jobs, whereas the others came from 20 different jobs.

ethical dilemmas of managers

	manager		others	
	Count	%	Count	%
none	1	1.9%	49	7.5%
inequalities in health/root causes	3	5.6%	38	5.8%
campaigns/short term proj./sponsorship/ media coverage	2	3.7%	42	6.4%
targeting	2	3.7%	9	1.4%
budget allocations/ understaffed/ resourcing/income gen.	8	14.8%	95	14.5%
victim blaming			5	.8%
credibility/low status	5	9.3%	75	11.4%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	1	1.9%	29	4.4%
job description changes/no career development			16	2.4%
policies			1	.2%
effectiveness/or not	3	5.6%	25	3.8%
NHS/bureacracy/changes/ cuts/arguments	12	22.2%	85	13.0%
lack of skills/ communication problems	1	1.9%	24	3.7%
medical model/NHS/GP interference/P&P/HON	6	11.1%	31	4.7%
misunderstood/ undervalued	3	5.6%	45	6.9%
condoms to under age harm minimisation/ sexuality			12	1.8%
too many to list	1	1.9%	1	.2%
being a role model			6	.9%
theory vs. practice			7	1.1%
evaluation/evidence needed	4	7.4%	17	2.6%
told what to do/hidden agendas/interagency work/conspiracy	1	1.9%	39	5.9%
time			4	.6%
breadth of role/pressure	1	1.9%	1	.2%

Managers main ethical dilemmas were NHS (22.2%), budget (14.8%), working in medical model (11.1%), credibility (9.3%), whereas the others main ethical dilemmas were budget (14.5%), NHS (13%), credibility (11.4%), none (7.5%).

Profile of dietitians

	DIETITIAN
all jobs	748
dietitians	26

	sex	
	male	female
alljobs	159	589
dietitians	1	25

	agegrp			
	-20	20-29	30-39	40-49
all jobs	2	132	300	213
dietitians		7	9	8

	agegrp	
	50-59	60+
all jobs	93	2
dietitians	2	

	GOODPTS			
	autonomy	clients/ public	variety	interesting /enjoyable
all jobs	112	50	151	52
dietitians	2	4	4	

	GOODPTS			
	useful/ worthwhile/ important	colleagues/ manager/ staff	environment /location	none
all jobs	36	81	14	3
dietitians	1	3	1	

	GOODPTS			
	prevention/ make changes	opportuniti es/training	teamwork/ interagency work	action/ progressive
all jobs	31	14	35	10
dietitians	3	1	2	

	GOODPTS			
	creativity	rewarding/ challenging /good at job	flexibility /flexitime/ stress free	don't know
all jobs	6	30	55	4
dietitians		1	2	

	BADPTS			
	pay/ temp.contra ct/hours	Bureacracy	no training/ direction	no career path/ promotion prospects/ short contract
all jobs	59	187	40	13
dietitians	1	3	1	

	BADPTS			
	budget/ funding	colleagues/ staff/ "politics"	effectivene ss/waste of time/ evaluation	no status/ power/poor image/ fragmentati on/ isolation
all jobs	40	22	16	34
dietitians	4		1	

	BADPTS			
	pressure/ stress/ workload	not valued/ misunderstoo od/not supported	meetings	practicalit ies/ resources/ conditions
all jobs	111	35	2	22
dietitians	5	2		2

	BADPTS			
	remit too big	workplace/ travelling	don't know	medical/ disease focused
all jobs	13	13	4	12
dietitians	1			

	BADPTS			
	need to be motivated/ low morale/ boring	inequalitie s in health	purchaser conflicts/ constraints	none
all jobs	23	4	18	7
dietitians	2		1	

	CONTRACT			
	4	7	8	10
all jobs		1		1
dietitians	1		2	

	CONTRACT			
	12	13	15	16
all jobs	1	1	2	1
dietitians	1		1	

	CONTRACT			
	17	18	19	19
all jobs	1	11	5	1
dietitians		2		

	CONTRACT			
	19	20	21	22
all jobs	34	14	3	13
dietitians		1	1	

	CONTRACT			
	23	24	25	26
all jobs	16	7	8	3
dietitians	1			1

	CONTRACT			
	33	34	35	36
all jobs	9	1	12	40
dietitians	1	2		

	CONTRACT			
	37	38	38	39
all jobs	390	11	87	3
dietitians	10		2	

	dilemmas summary			
	none	inequalities in health	type of work	NHS issues
all jobs	47	40	75	311
dietitians	3	1		13

	dilemmas summary
	professional issues
all jobs	214
dietitians	6

	GOODPSUM			
	none/DK	autonomy issues	people issues	workconditions
all jobs	7	401	166	81
dietitians		9	9	3

	GOODPSUM
	make change
all jobs	41
dietitians	3

1 in HP2 in HPU 53, 2 in HPU 76, 1 in HPU 87, 1 in HPU 102, 1 in HPU 103,
1 in HPU 118, 2 in HPU 122, 2 in HPU 131, 1 in HPU 133, 1 in HPU 143,
1 in HPU 158, 1 in HPU 172, 1 in HPU 195, 1 in HPU 241, 1 in HPU 244,
1 in HPU 246, 2 in HPU 324, 2 in HPU 327

	DILEMMAS			
	none	inequalities in health/root causes	campaigns/ short term proj./ sponsorship /media coverage	targeting
all jobs	47	40	44	11
dietitians	3	1		

	DILEMMAS			
	budget allocations / understaffed/ resourcing/ income gen.	victim blaming	credibility /low status	'politics'/ institl rac/sexism/ territorial ity/ int.pol./ manag
all jobs	97	5	79	28
dietitians	6		1	2

	DILEMMAS			
	job description changes/no career development	policies	effectiveness/or not	NHS/ bureacracy/ changes/ cuts/ arguments
all jobs	16	1	28	95
dietitians				2

	DILEMMAS			
	lack of skills/ communicati on probs	medical model/NHS/ GP interferenc e/P&P/HON	misunderstoo od/ undervalued	condoms to under age/harm minimisatio n/sexuality
	DIETITIA	DIETITIA	DIETITIA	DIETITIA
	Count	Count	Count	Count
all jobs	25	36	46	12
dietitians		1	2	

	DILEMMAS			
	too many to list	being a role model	theory vs. practice	evaluation/ evidence needed
all jobs	2	6	7	18
dietitians				3

	DILEMMAS		
	told what to do/hidden agendas/ interagency work/ conspiracy	time	breadth of role/ pressure
all jobs	38	4	2
dietitians	2		

profile of HIV/ sexual health workers

sex of HIV/ sexual health workers

	HIVOTHER			
	others		HIV/ sexual health worker	
	Count	%	Count	%
male	136	19.3%	25	33.8%
female	568	80.7%	49	66.2%

age groups of HIV/ sexual health workers

	HIVOTHER			
	others		HIV/ sexual health worker	
	agegrp		agegrp	
	Count	%	Count	%
-20	2	.3%		
20-29	126	18.1%	14	18.9%
30-39	276	39.5%	36	48.6%
40-49	203	29.1%	18	24.3%
50-59	90	12.9%	5	6.8%
60+	1	.1%	1	1.4%

previous work of HIV/ sexual health workers

	HIVOTHER			
	others		HIV/ sexual health worker	
	PREVWK		PREVWK	
	Count	%	Count	%
nursing	98	14.1%	13	18.1%
education/training	100	14.4%	13	18.1%
management	15	2.2%	3	4.2%
admin/clerical/library	118	17.0%	2	2.8%
youth work	17	2.5%	11	15.3%
health	85	12.3%	6	8.3%
research/computers	32	4.6%	2	2.8%
dietetics/dental	36	5.2%		
none/student	22	3.2%	2	2.8%
graphic design	9	1.3%		
fitness/ exercise/ leisure	13	1.9%		
health education/promotion	56	8.1%	6	8.3%
environmental health	9	1.3%	2	2.8%
self employed	4	.6%		
social work/refuge/ community/project/ charity	31	4.5%	8	11.1%
sales/marketing/ journalism/media	28	4.0%	1	1.4%
hairdresser/waitress	2	.3%		
shop work/factory	10	1.4%		
army	2	.3%		
counselling	6	.9%	3	4.2%

length of service for HIV/ sexual health workers

	HIVOTHER			
	others		HIV/ sexual health worker	
	WK2YRS		WK2YRS	
	Count	%	Count	%
>2 years	308	43.8%	34	45.9%
2 years +	395	56.2%	40	54.1%

	HIVOTHER			
	others		HIV/ sexual health worker	
	LOYALTY		LOYALTY	
	Count	%	Count	%
> 5	545	77.4%	61	82.4%
6 +	159	22.6%	13	17.6%

HIV/ sexual health workers and ethical dilemmas

	HIVOTHER			
	others		HIV/ sexual health worker	
	Count	%	Count	%
none	50	7.8%		
inequalities in health/root causes	39	6.1%	2	2.9%
campaigns/short term proj./sponsorship/ media coverage	38	5.9%	6	8.6%
targeting	11	1.7%		
budget allocations/ understaffed/ resourcing/income gen.	93	14.5%	10	14.3%
victim blaming	5	.8%		
credibility/low status	71	11.1%	9	12.9%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	26	4.1%	4	5.7%
job description changes/no career development	16	2.5%		
policies	1	.2%		
effectiveness/or not	23	3.6%	5	7.1%
NHS/bureacracy/changes/ cuts/arguments	86	13.4%	11	15.7%
lack of skills/communication probs	21	3.3%	4	5.7%
medical model/NHS/GP interference/P&P/HON	35	5.5%	2	2.9%
misunderstood/ undervalued	45	7.0%	3	4.3%
condoms to under age/harm minimisation/ sexuality	8	1.3%	4	5.7%
too many to list	2	.3%		
being a role model	6	.9%		
theory vs. practice	5	.8%	2	2.9%
evaluation/evidence needed	18	2.8%	3	4.3%
told what to do/hidden agendas/interagency time	3	.5%	1	1.4%
breadth of role/pressure	2	.3%		

Summary: HIV/ AIDS/ sexual health workers

There were 74 people who stated that they were HIV/ AIDS/ sexual health workers (9.6% of total and the second largest group after secretarial/ admin.). These workers presented a somewhat different 'profile' to other groups, for example, they were more likely to be male than those in other jobs (33.8% compared to 19.3%), and were predominantly aged 30-39 years. Also, they were more likely to have no Health Promotion qualifications (56.8% compared to 43.4%). The 'other' group also includes the many sec/ admin staff who did not have a Health Promotion qualification, which inflates the figure. However, the figure for having the Diploma was slightly higher than others at 17.6% compared to 15.4%, but less likely to have the MSc. than others, 8.1% compared to 19.3%. But they were more likely to have the qualified social worker certificate, 5.6% compared to 0.6% of others, or be an RGN, 21.2% compared to 13.9%. Thus they had received their academic training elsewhere, a fact borne out by the fact that their previous work history differed too, for example, 15.3% had previously worked in youth work, compared to 2.5% of the others, and 11.1% had worked in social work or refuges previously compared to 4.5% of others.

The three main ethical dilemmas were **NHS issues (15.7%), budget (14.3%), credibility (12.9%)** which are the same issues, namely: **budget (14.5%), NHS issues (13.4%), credibility (11.1%)**, as the rest of the respondents but in a slightly different order but very similar percentages for budget and credibility. **None** of the HIV workers had **no ethical dilemmas** whereas 7.8% of the rest of the respondents had no ethical dilemmas. Thus all of the HIV worker respondents were having ethical dilemmas about their work.

membership of SHEPS

	SHEPS	
	Count	%
yes	154	19.8%
no	499	64.1%
n/a	125	16.1%

SHEPS and sex

	sex	
	male	female
SHEPS		
yes	26	128
no	125	370
n/a	9	116

SHEPS and age group

	SHEPS	
	n/a	
	agegrp	
	Count	%
-20	1	.8%
20-29	24	19.4%
30-39	37	29.8%
40-49	34	27.4%
50-59	28	22.6%
60+		

SHEPS and job

	SHEPS			
	yes		no	
	Count	%	Count	%
director/manager	28	18.2%	26	5.2%
SHPA	7	4.5%	25	5.0%
HPA	15	9.7%	46	9.2%
HP assistant			4	.8%
resources	4	2.6%	15	3.0%
HP trainer	1	.6%	8	1.6%
sec/admin			18	3.6%
dietitian/healthy eating HPO	2	1.3%	11	2.2%
trainee HPA			2	.4%
accident prevention	4	2.6%	8	1.6%
PHC/primary health care/NHS liaison	15	9.7%	34	6.8%
CHD/cancer	12	7.8%	26	5.2%
graphic designer			3	.6%
gay men project			10	2.0%
youth/schools HP/ teacher	18	11.7%	36	7.2%
HIV/sexual health HP/outreach-prostitutes	8	5.2%	66	13.2%
HP youth worker/drama	2	1.3%	9	1.8%
community development	2	1.3%	14	2.8%
office manager	2	1.3%	1	.2%
locality manager	4	2.6%	18	3.6%
campaigns/bus HPA/media			9	1.8%
HP researcher			10	2.0%
smoking /project co-ordinator	5	3.2%	21	4.2%
exercise/physical activity co-ordinator	1	.6%	12	2.4%
deputy manager	9	5.8%	6	1.2%
Snr. public health				
drugs HP/substance misuse	2	1.3%	17	3.4%
mental health	4	2.6%	10	2.0%
workplace/industry HP	6	3.9%	19	3.8%
HON co-ordinator	1	.6%	3	.6%
dental HP	2	1.3%	4	.8%
black/Asian health			8	1.6%

(continued)

	SHEPS	
	n/a	
	Count	%
director/manager	1	.8%
SHPA		
HPA		
HP assistant	2	1.6%
resources	35	28.0%
HP trainer		
sec/admin	62	49.6%
dietitian/healthy eating		
HPO	13	10.4%
trainee HPA		
accident prevention		
PHC/primary health		
care/NHS liaison		
CHD/cancer		
graphic designer	7	5.6%
gay men project		
youth/schools HP/		
teacher		
HIV/sexual health		
HP/outreach-		
prostitutes		
HP youth worker/drama		
community development		
office manager	3	2.4%
locality manager		
campaigns/bus HPA/media		
HP researcher		
smoking /project		
co-ordinator	1	.8%
exercise/physical		
activity co-ordinator		
deputy manager		
Snr. public health	1	.8%
drugs HP/substance		
misuse		
mental health		
workplace/industry HP		
HON co-ordinator		
dental HP		
black/Asian health		

SHEPS and Health Promotion qualifications

	HPQUAL			
	none	certificate	diploma	degree
SHEPS				
yes	29	14	30	1
no	220	50	88	5
n/a	95	23	3	

	HPQUAL			
	MSc	PhD	studying for diploma	studying for MSc
SHEPS				
yes	59		9	12
no	83	1	14	34
n/a			2	1

	SHEPS			
	yes		no	
	GOODPTS		GOODPTS	
	Count	%	Count	%
autonomy	43	29.3%	67	14.3%
clients/public	6	4.1%	32	6.8%
variety	31	21.1%	98	20.9%
interesting/enjoyable	8	5.4%	32	6.8%
useful/worthwhile/ important	9	6.1%	22	4.7%
colleagues/manager/staff	10	6.8%	63	13.4%
environment/location	1	.7%	7	1.5%
none	1	.7%	2	.4%
prevention/make changes	10	6.8%	22	4.7%
opportunities/training	3	2.0%	10	2.1%
teamwork/interagency work	9	6.1%	22	4.7%
action/progressive	2	1.4%	8	1.7%
creativity	3	2.0%	3	.6%
rewarding/challenging/ good at job	3	2.0%	27	5.8%
flexibility/flexitime/ stress free	6	4.1%	45	9.6%
don't know			4	.9%
pay/hours	2	1.4%	5	1.1%

	SHEPS	
	n/a	
	GOODPTS	
	Count	%
autonomy	4	3.8%
clients/public	16	15.4%
variety	26	25.0%
interesting/enjoyable	12	11.5%
useful/worthwhile/ important	6	5.8%
colleagues/manager/staff	11	10.6%
environment/location	7	6.7%
none		
prevention/make changes	2	1.9%
opportunities/training	2	1.9%
teamwork/interagency work	6	5.8%
action/progressive		
creativity		
rewarding/challenging/ good at job	1	1.0%
flexibility/flexitime/ stress free	6	5.8%
don't know		
pay/hours	5	4.8%

SHEPS and model of working

	MODEL			
	medical	behaviour change	educational	social change
SHEPS				
yes	1	9	4	13
no	1	39	28	24
n/a		4	4	1

	MODEL			
	client directed	harm minimisation	all	varies
SHEPS				
yes	3	1	10	76
no	32	4	31	196
n/a	5		3	14

	MODEL			
	Ottawa Charter	community development	no	n/a
SHEPS				
yes	4	11	5	14
no	7	21	12	79
n/a			6	83

SHEPS and bad points

	SHEPS			
	yes		no	
pay/temp.contract/hours	16	11.1%	40	8.7%
Bureacracy	37	25.7%	126	27.3%
no training/direction	9	6.3%	27	5.8%
no career path/promotion prospects/short contract	1	.7%	8	1.7%
budget/funding	10	6.9%	28	6.1%
colleagues/staff/ "politics"	7	4.9%	15	3.2%
effectiveness/waste of time/evaluation	2	1.4%	14	3.0%
no status/power/poor image/fragmentation/ isolation	7	4.9%	22	4.8%
pressure/stress/workload	23	16.0%	67	14.5%
not valued/misunderstood/ not supported	7	4.9%	23	5.0%
meetings			2	.4%
practicalities/ resources/conditions	7	4.9%	10	2.2%
remit too big	1	.7%	12	2.6%
workplace/travelling	3	2.1%	8	1.7%
don't know			4	.9%
medical/disease focused	3	2.1%	9	1.9%
need to be motivated/low morale/boring	3	2.1%	19	4.1%
inequalities in health			3	.6%
purchaser conflicts/constraints	5	3.5%	14	3.0%
none	2	1.4%	4	.9%
understaffed			2	.4%
training others/ no contact-public			2	.4%
working with under 16's/homophobia	1	.7%	3	.6%

(continued)

	SHEPS	
	n/a	
pay/temp.contract/hours	4	3.8%
Bureacracy	27	25.7%
no training/direction	5	4.8%
no career path/promotion prospects/short contract	4	3.8%
budget/funding	8	7.6%
colleagues/staff/ "politics"		
effectiveness/waste of time/evaluation	1	1.0%
no status/power/poor image/fragmentation/ isolation	5	4.8%
pressure/stress/workload	26	24.8%
not valued/misunderstood/ not supported	7	6.7%
meetings		
practicalities/ resources/conditions	8	7.6%
remit too big	1	1.0%
workplace/travelling	2	1.9%
don't know		
medical/disease focused		
need to be motivated/low morale/boring	3	2.9%
inequalities in health	1	1.0%
purchaser conflicts/constraints		
none	1	1.0%
understaffed	1	1.0%
training others/ no contact-public	1	1.0%
working with under 16's/homophobia		

SHEPS and dilemmas summarised

DILSUM	Count	SHEPS yes 0	no 1	n/a 2	Row Total
.00 none		6	24	20	50 7.0
1.00 inequalities in		12	28	1	41 5.8
2.00 type of work		17	53	5	75 10.6
3.00 NHS issues		72	207	45	324 45.6
4.00 professional iss		45	151	24	220 31.0
	Column Total	152 21.4	463 65.2	95 13.4	710 100.0

NHS issues		
budget allocations	103	13.3
NHS/bureacracy/changes	97	12.5
told what to do/hidden agendas	40	5.2
medical model/NHS/GPs	37	4.8
'politics'	30	3.9
job description changes	16	2.1
policies	1	.1
professional issues		
credibility/low status	80	10.3
misunderstood/undervalued	48	6.2
effectiveness/or not	28	3.6
lack of skills/communication	25	3.2
evaluation/evidence	21	2.7
theory vs. practice	7	.9
being a role model	6	.8
victim blaming	5	.6
none		
none	50	6.5
inequalities in health	41	5.3
type of work carried out		
campaigns/short term	44	5.7
condoms to under age	12	1.6
targeting	11	1.4
time	4	.5
too many to list	2	.3
breadth of role/pressure	2	.3
Missing	64	8.3
	---	---
Total	774	100.0

Valid cases 710 Missing cases 64

EX-TEACHERS

PROFILE

ex-teachers

	Frequency	Percent
all jobs	652	83.7
teachers	113	14.5
missing	14	1.8
Total	779	100.0

Valid cases 765 Missing cases 14

sex of ex-teachers

	TEACHERS			
	all jobs		teachers	
male	129	19.8%	29	25.7%
female	523	80.2%	84	74.3%

age groups of ex-teachers

	TEACHERS			
	all jobs		teachers	
-20	2	.3%		
20-29	137	21.2%	1	.9%
30-39	269	41.6%	35	31.3%
40-49	165	25.5%	54	48.2%
50-59	72	11.1%	22	19.6%
60+	2	.3%		

ex-teachers who are currently managers

	TEACHERS			
	all jobs		teachers	
manager	42	6.4%	12	10.6%
others	610	93.6%	101	89.4%

ex-teachers bad points about job

	TEACHERS			
	all jobs		teachers	
pay/temp.contract/hours	49	8.3%	10	9.3%
Bureacracy	152	25.7%	31	28.7%
no training/direction	31	5.2%	9	8.3%
no career path/promotion prospects/short contract	12	2.0%	1	.9%
budget/funding	41	6.9%	4	3.7%
colleagues/staff/ "politics"	18	3.0%	3	2.8%
effectiveness/waste of time/evaluation	14	2.4%	3	2.8%
no status/power/poor image/fragmentation/ isolation	24	4.1%	10	9.3%
pressure/stress/workload	103	17.4%	13	12.0%
not valued/misunderstood/ not supported	33	5.6%	4	3.7%
meetings	2	.3%		
practicalities/ resources/conditions	23	3.9%	1	.9%
remit too big	11	1.9%	3	2.8%
workplace/travelling	11	1.9%	2	1.9%
don't know	3	.5%	1	.9%
medical/disease focused	11	1.9%	1	.9%
need to be motivated/low morale/boring	21	3.6%	4	3.7%
inequalities in health	2	.3%	2	1.9%
purchaser conflicts/constraints	15	2.5%	4	3.7%
none	5	.8%	2	1.9%
understaffed	3	.5%		
training others/ no contact-public	3	.5%		
working with under 16's/homophobia	4	.7%		

ex-teachers length of time in current job (in years)

	TEACHERS			
	all jobs		teachers	
> 5	517	79.3%	80	70.8%
6 +	135	20.7%	33	29.2%

ex-teachers summary of ethical dilemmas

	TEACHERS			
	all jobs		teachers	
none	46	7.8%	5	4.5%
inequalities in health	35	5.9%	6	5.4%
type of work	63	10.6%	13	11.7%
NHS issues	267	45.1%	50	45.0%
professional issues	181	30.6%	37	33.3%

ex-teachers professional or otherwise ethical dilemmas

	TEACHERS			
	all jobs		teachers	
others	387	70.9%	72	67.9%
prof.dil	159	29.1%	34	32.1%

	TEACHERS			
	all jobs		teachers	
none	46	7.8%	5	4.5%
inequalities in health/root causes	35	5.9%	6	5.4%
campaigns/short term proj./sponsorship/ media coverage	40	6.8%	5	4.5%
targeting	8	1.4%	3	2.7%
budget allocations/ understaffed/ resourcing/income gen.	87	14.7%	13	11.7%
victim blaming	5	.8%		
credibility/low status	68	11.5%	12	10.8%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	27	4.6%	3	2.7%
job description changes/no career development	13	2.2%	2	1.8%
policies	1	.2%		
effectiveness/or not	18	3.0%	8	7.2%
NHS/bureacracy/changes/ cuts/arguments	76	12.8%	18	16.2%
lack of skills/communication probs	22	3.7%	3	2.7%
medical model/NHS/GP interference/P&P/HON	30	5.1%	7	6.3%
misunderstood/ undervalued	41	6.9%	7	6.3%
condoms to under age/harm minimisation/ sexuality	9	1.5%	3	2.7%
too many to list	1	.2%	1	.9%
being a role model	5	.8%	1	.9%
theory vs. practice	6	1.0%	1	.9%
evaluation/evidence needed	16	2.7%	5	4.5%
told what to do/hidden agendas/interagency work/conspiracy	33	5.6%	7	6.3%
time	4	.7%		
breadth of role/pressure	1	.2%	1	.9%

EX-NURSES

PROFILE

sex of ex-nurses

	NURSES			
	nurse		all jobs	
male	17	15.3%	141	21.6%
female	94	84.7%	513	78.4%

age groups of ex-nurses

	ex-nurse	all jobs
agegrp		
-20		2
20-29	9	128
30-39	52	249
40-49	33	186
50-59	14	80
60+	2	

health promotion qualifications of ex-nurses

	NURSES			
	nurse		all jobs	
none	40	36.0%	301	46.0%
certificate	18	16.2%	70	10.7%
diploma	14	12.6%	104	15.9%
degree			6	.9%
MSc	24	21.6%	115	17.6%
PhD			1	.2%
studying for diploma	8	7.2%	17	2.6%
studying for MSc	7	6.3%	40	6.1%

ex-nurses professional or otherwise ethical dilemmas

	NURSES			
	nurse		all jobs	
others	74	71.2%	385	70.3%
prof.dil	30	28.8%	163	29.7%

ex-nurses bad points about their job

	NURSES			
	nurse		all jobs	
pay/temp.contract/hours	8	7.9%	51	8.5%
Bureacracy	26	25.7%	157	26.3%
no training/direction	6	5.9%	34	5.7%
no career path/promotion prospects/short contract			13	2.2%
budget/funding	5	5.0%	40	6.7%
colleagues/staff/ "politics"	4	4.0%	17	2.8%
effectiveness/waste of time/evaluation	3	3.0%	14	2.3%
no status/power/poor image/fragmentation/ isolation	6	5.9%	28	4.7%
pressure/stress/workload	19	18.8%	97	16.2%
not valued/misunderstood/ not supported	7	6.9%	30	5.0%
meetings			2	.3%
practicalities/ resources/conditions	2	2.0%	22	3.7%
remit too big	2	2.0%	12	2.0%
workplace/travelling	2	2.0%	11	1.8%
don't know	1	1.0%	3	.5%
medical/disease focused	3	3.0%	9	1.5%
need to be motivated/low morale/boring	4	4.0%	21	3.5%
inequalities in health			4	.7%
purchaser conflicts/constraints	2	2.0%	17	2.8%
none	1	1.0%	6	1.0%
understaffed			3	.5%
training others/ no contact-public			3	.5%
working with under 16's/homophobia			4	.7%

ex-nurses ethical dilemmas

	NURSES			
	ex-nurse		all jobs	
none	2	1.9%	49	8.2%
inequalities in health/root causes	6	5.7%	35	5.9%
campaigns/short term proj./sponsorship/ media coverage	9	8.5%	36	6.0%
targeting	2	1.9%	9	1.5%
budget allocations/ understaffed/ resourcing/income gen.	15	14.2%	85	14.2%
victim blaming			5	.8%
credibility/low status	9	8.5%	71	11.9%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	6	5.7%	24	4.0%
job description changes/no career development	2	1.9%	13	2.2%
policies			1	.2%
effectiveness/or not	7	6.6%	19	3.2%
NHS/bureacracy/changes/ cuts/arguments	20	18.9%	74	12.4%
lack of skills/communication probs	2	1.9%	23	3.9%
medical model/NHS/GP interference/P&P/HON	7	6.6%	30	5.0%
misunderstood/ undervalued	11	10.4%	37	6.2%
condoms to under age/harm minimisation/ sexuality	1	.9%	11	1.8%
too many to list	1	.9%	1	.2%
being a role model	1	.9%	5	.8%
theory vs. practice			7	1.2%
evaluation/evidence needed	2	1.9%	19	3.2%
told what to do/hidden agendas/interagency work/conspiracy	3	2.8%	37	6.2%
time			4	.7%
breadth of role/pressure			2	.3%

ex-nurses ethical dilemmas summary

	NURSES			
	nurse		all jobs	
none	2	1.9%	49	8.2%
inequalities in health	6	5.7%	35	5.9%
type of work	13	12.3%	63	10.6%
NHS issues	53	50.0%	264	44.2%
professional issues	32	30.2%	186	31.2%

EX-SOCIAL WORKERS

PROFILE

ex-social workers

Value Label	Frequency	Percent
all jobs	701	90.0
social work	76	9.8
missing	2	.3
Total	779	100.0

sex of ex-social workers

	Social work			
	all jobs		social work	
male	139	19.8%	21	27.6%
female	562	80.2%	55	72.4%

age groups of ex-social workers

	Social work			
	all jobs		social work	
-20	2	.3%		
20-29	120	17.3%	20	26.3%
30-39	273	39.3%	38	50.0%
40-49	206	29.6%	15	19.7%
50-59	92	13.2%	3	3.9%
60+	2	.3%		

length of service in current job for ex-social workers

	Social work			
	all jobs		social work	
> 5	534	76.2%	71	93.4%
6 +	167	23.8%	5	6.6%

ethical dilemmas summarised of ex-social workers

	Social work			
	all jobs		social work	
others	417	70.4%	49	71.0%
prof.dil	175	29.6%	20	29.0%

current job of ex-social workers

	Social work			
	all jobs		social work	
director/manager	54	7.7%		
SHPA	28	4.0%	4	5.3%
HPA	55	7.8%	6	7.9%
HP assistant	6	.9%		
resources	53	7.6%	1	1.3%
HP trainer	7	1.0%	2	2.6%
sec/admin	80	11.4%		
dietitian/healthy eating HPO	26	3.7%		
trainee HPA	2	.3%		
accident prevention	12	1.7%		
PHC/primary health care/NHS liaison	48	6.8%	1	1.3%
CHD/cancer	35	5.0%	3	3.9%
graphic designer	10	1.4%		
gay men project	9	1.3%	1	1.3%
youth/schools HP/ teacher	47	6.7%	7	9.2%
HIV/sexual health HP/outreach-prostitutes	52	7.4%	22	28.9%
HP youth worker/drama	9	1.3%	2	2.6%
community development	13	1.9%	3	3.9%
office manager	6	.9%		
locality manager	19	2.7%	3	3.9%
campaigns/bus HPA/media	8	1.1%	1	1.3%
HP researcher	10	1.4%		
smoking /project co-ordinator	23	3.3%	4	5.3%
exercise/physical activity co-ordinator	12	1.7%	1	1.3%
deputy manager	13	1.9%	2	2.6%
Snr. public health			1	1.3%
drugs HP/substance misuse	14	2.0%	5	6.6%
mental health	13	1.9%	1	1.3%
workplace/industry HP	22	3.1%	3	3.9%
HON co-ordinator	3	.4%	1	1.3%
dental HP	6	.9%		
black/Asian health	6	.9%	2	2.6%

ethical dilemmas of ex-social workers

	Social work			
	all jobs		social work	
none	49	7.6%	2	2.8%
inequalities in health/root causes	31	4.8%	10	14.1%
campaigns/short term proj./sponsorship/ media coverage	41	6.4%	5	7.0%
targeting	10	1.6%	1	1.4%
budget allocations/ understaffed/ resourcing/income gen.	93	14.5%	9	12.7%
victim blaming	5	.8%		
credibility/low status	69	10.8%	11	15.5%
'politics'/instit'l rac/sexism/ territoriality/ int.pol./manag	27	4.2%	3	4.2%
job description changes/no career development	16	2.5%		
policies	1	.2%		
effectiveness/or not	24	3.7%	4	5.6%
NHS/bureacracy/changes/ cuts/arguments	92	14.4%	5	7.0%
lack of skills/communication probs	25	3.9%		
medical model/NHS/GP interference/P&P/HON	33	5.1%	4	5.6%
misunderstood/ undervalued	46	7.2%	2	2.8%
condoms to under age/harm minimisation/ sexuality	7	1.1%	5	7.0%
too many to list	2	.3%		
being a role model	4	.6%	2	2.8%
theory vs. practice	7	1.1%		
evaluation/evidence needed	20	3.1%	1	1.4%
told what to do/hidden agendas/interagency work/conspiracy	34	5.3%	6	8.5%
time	3	.5%	1	1.4%
breadth of role/pressure	2	.3%		

	Social work			
	all jobs		social work	
medical	2	.3%		
behaviour change	49	7.3%	3	4.1%
educational	27	4.0%	9	12.3%
social change	35	5.2%	4	5.5%
client directed	32	4.7%	9	12.3%
harm minimisation	4	.6%	1	1.4%
all	41	6.1%	2	2.7%
varies	255	37.8%	32	43.8%
Ottawa Charter	11	1.6%		
community development	29	4.3%	3	4.1%
no	21	3.1%	2	2.7%
n/a	168	24.9%	8	11.0%

	HIVOTHER			
	others		HIV/ sexual health worker	
	agegrp		agegrp	
	Count	%	Count	%
-20	2	.3%		
20-29	126	18.1%	14	18.9%
30-39	276	39.5%	36	48.6%
40-49	203	29.1%	18	24.3%
50-59	90	12.9%	5	6.8%
60+	1	.1%	1	1.4%