ISSUES IN THE DESIGN OF PROFESSIONAL TRAINING PROGRAMMES FOR HEALTH EDUCATORS
THE CASE OF TRINIDAD AND TOBAGO

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Within recent times, health educators have been recognizing the need for professional in-service training. This has resulted in various attempts by relevant institutions to design suitable training programmes. This paper highlights the global and local context that has contributed to the perceived need for training. The universal issue of professional training and the current roles, qualifications, and experiences of the health educator in Trinidad and Tobago are discussed. A typical training approach utilized by one institution in Trinidad and Tobago is also examined, in relation to theories of design methodology. The paper concludes by drawing attention to the operational and theoretical issues that must be addressed in designing suitable, in-service professional training programmes for health educators in Trinidad and Tobago.

Introduction

Health education shares the philosophical perspective of public health, which is a belief that regulation of individual behaviour and social control of the population is necessary to protect the health of all. This means that in a democratic society, people are encouraged to alter their behaviours or lifestyles for the greater "public good" (Bates & Winder, 1984). The basic challenge of health education, therefore, is to find appropriate ways to influence individual behaviours and lifestyles. In Trinidad and Tobago, health educators accept this challenge of encouraging individuals within the community to alter their behaviours. These health educators bring a range of training, experiences, and skills to their respective roles. However, notwithstanding the range of expertise that they already possess, practitioners within the field constantly express a need for even more professional training. Given this perceived need, this paper examines the global and local context that has given rise to this perception. It also seeks to highlight issues that must be considered in the design of professional training programmes for health educators in Trinidad and Tobago. The focus, however, is on preliminary or preparatory

considerations, which can inform the design of training programmes. As such, the scope of the discussion does not include recommendations on specific training approaches.

The Need for Professional Training – The Global Context

The recognition of a need for "professional training" is by no means peculiar to Trinidad and Tobago; rather it is part of a growing global trend within many occupations. Collier (1985) and Breckon, Harvey, and Lancaster (1994) reviewed the various factors contributing to the growing search for professional training.

Collier (1985), states that the growing search for professional education, professionalization, and professional status, with their accompanying controversies about what constitutes a profession, is a feature of 20th century society. He further points out that as various social, political, and economic changes have taken place, the body of occupations identified as professions have increased and so, too, has the nature of the work and the needs of the persons filling these positions. Some of the changes identified by Collier include increasing access to education, information and communication, transportation, and other resources. These societal developments, he states, have led to a more informed and demanding society.

Apart from identifying factors influencing the *need* for professional training, Collier also looks at factors influencing the *nature* of training. These he identifies as:

1. A high demand for pre-service training; difficulties in adequately meeting this demand have made professional bodies increasingly conscious of the need for more *in-service* training of various kinds.

2. The team approach to problem solving in professional life, which has become popular, particularly in large organizations. Collier points out that this is a radical change from the way professionals such as doctors and lawyers, for example, operated in the past. He says this change has led to the need for team-building and "team-based" training--activities that were not commonly part of training programmes for professionals in the past.

3. The effect on professional life of contemporary political/ethical issues, such as culture clashes, large-scale natural and man-made

disasters, and new chronic "lifestyle" diseases like HIV/AIDS. Professionals now need to examine their own personal and social values in order to function in multicultural contexts.

While Collier focuses on global changes that have affected the way professionals generally perceive themselves, their roles, and their training needs, Breckon et al. (1994) focus on health education as a profession. They point out that perceptions of training needs in the health education profession were influenced by global changes and developments within the field. Breckon et al. (1994) also point out that the call for professional training and certification of health educators came within the last 50 years, in response to four factors:

1. the growing interest in, and demand for, health education in the market place;
2. the tendency of some to call themselves or their staff, health educators, to satisfy market demand;
3. evolving professional organizations becoming increasingly concerned about professional standards and quality assurance;
4. educational institutions offering training for health educators and facing many constraints.

Breckon et al. state that, with spiralling health care costs in many nations, and increasing evidence that health education could help prevent diseases and reduce health care costs, there was (a) an increased demand for health education services, and (b) more and more individuals gradually entered the profession, some with formal training and some without. They note that these two situations caused uneasiness among those who were professionally trained and led to three actions: a demand for in-service professional training; the establishment of regulating agencies for enforcing standards regarding the establishment of schools of public health; and the establishment of a commission for health education credentialing in the United States. The focus here will be on the first of these actions--a demand for in-service professional training.

The Health Educator and Professional Training in Trinidad and Tobago

Within Trinidad and Tobago, trends in the health education profession mirrored global developments. From as early as 1943, a Health Education Unit was set up by the government to carry out a "mobile

cinema programme" (Stanley, 1977, p. 3). This involved visiting communities, showing films on various public health issues, and lecturing to the public about prevention and treatment. The Unit was staffed by a health education officer, who conducted the "lectures," a typist, and two mobile operator/chauffeurs. In 1947, the Unit was given responsibility for developing and implementing a full-time training course for public health inspectors and health visitors to prepare them for the Royal Society of Health Examinations. This latter function was perceived as the main programme of activity of the Unit. In the following years, the health education profession underwent a series of changes, among which were the calls for increased professional training, a wider scope of operation for health education officers, and a movement away from a "public health" approach to a "wellness" or "lifestyle-change" approach. This new approach required a change in the role of the health education officer and in the structure and operations of the Unit. This was reflected locally in a reorganization of the Unit. In 1976, the Health Education Unit became the Health Education Division (HED) of the Ministry of Health. This Division was staffed by a Director; two assistant directors, one with responsibility for training in health education and the other with responsibility for community and school health programmes; four health education officers; an audio-visual specialist, and clerical support. However, the problems in health education were not over. In the 1977 Annual Report of the Health Education Division, the then Director stated:

> The major problem which continued to affect the work of the Division was the lack of trained personnel. Five (5) officers attached to the Division are not trained health educators. The re-organisation and expansion proposals submitted in 1972 called for university training for all health educators. . . more importantly, the health educator cannot be appointed if he/she does not hold at least the Diploma in health education. (p. 1)

Currently, health education officers of the Ministry of Health all have entry-level qualifications in the form of university-level training in a relevant area. However, requests for in-service training continue.

In the early 1990s, the Government of Trinidad and Tobago embarked on a health sector reform programme. As part of the reform process, a new

organizational structure was proposed for the Ministry of Health. This structure envisioned the establishment of a Directorate of Health Promotion and Public Health, subsuming the current HED.

Historically, therefore, health education emerged from state/ government-run Bureaus or Units. Eventually, however, the objective of encouraging healthy lifestyles became part of the mission of many non-governmental organizations (NGOs) as well. Within Trinidad and Tobago, therefore, various individuals who conduct health education activities now consider themselves health educators. These individuals work in both governmental and non-governmental organizations. The NGOs include the Family Planning Association of Trinidad and Tobago (FPATT) and the Rape Crisis Centre. Governmental organizations include HED, the Regional Health Authorities, the Ministry of Social Development, the Ministry of Sport and Youth Affairs, and the National AIDS Programme of the Ministry of Health. Based on size of staff, and scope and range of health education projects carried out, two of these organizations, FPATT and HED, play a lead role in health education in Trinidad and Tobago. Given their level of training and their official designations, health educators operating within these two organizations will be the focus of this examination. It should be noted, though, that within both these organizations, health educators have different areas of focus, based on the mission or goals of their respective organizations.

The mission of FPATT is to "promote reproductive health and responsible sexual behaviour in order to improve the quality of life of individuals and families in our communities" (Family Planning Association of Trinidad and Tobago [FPATT], 1998, p. 1). The 1998 Annual Report of FPATT states that it provides clinic services and sexual and reproductive health information. Two categories of workers perform these functions: outreach/community coordinators and family life educators.

HED seeks "to provide information and skills to enable individuals and communities to take responsibility for their health and to mobilize for the creation of an environment which promotes wellness" (Trinidad and Tobago. Health Education Division [HED], 1999a, p. 1). A paper (HED, 1999b) outlining the role of the Health Education Officer points out that the mission of the HED is achieved through the formulation, execution, and evaluation of health education programmes, and the promotion of an appreciation of the importance of healthy lifestyles.

Health Education Officers working in HED have very broad-based functions. Their job description indicates that they must function as part of a regional health team (HED, 1999). They are responsible for planning, organizing, directing, and evaluating the regional health programme in health education and health promotion. The job description also points out that Health Education Officers must identify priority health issues in the region, which can be addressed through health education programmes, identify training needs, and develop appropriate curricula and training materials for community workers and others involved in community health education. Health education officers operate at the programme planning and programme implementation levels.

Differences among health educators are also reflected in the range of job titles they carry. This is evidenced by information collected at a one-day training workshop on sexuality education, conducted by FPATT, for persons involved in health education in Trinidad and Tobago. This workshop will be discussed more fully later in this paper. However, an analysis of the participants at the workshop by job titles indicates that there were three district health visitors, two nurse educators, and one health educator. Despite the variety of titles, all these individuals saw themselves as health educators. One medical doctor, five nurses, one outreach coordinator, one manager, one AIDS coordinator, four community coordinators, and five community workers/social workers who were present at the workshop also indicated that health education was a part of their regular duties.

Further diversity is also evident in the level of qualifications of the health education personnel attending this workshop. The levels of qualifications ranged from GCE O Levels/CXC passes to masters degrees: three persons had masters degrees in public health, eight had postgraduate diplomas in health or related fields, five had first degrees, six had certificates, one had GCE A Levels, and two had GCE O Levels/CXC passes.

The range of roles and functions also emphasized the diversity among the groups, and indicated the difficulty of designing an all-encompassing professional training programme. The main duties identified by health educators ranged from conducting health promotion activities, to counselling, working with families, and carrying out administrative duties. This level of divergence suggests

that any consideration of professional training cannot assume a homogeneous programme that can cater to the needs of all. The question posed by the training dilemma or educational problem seems to be: How does one design a suitable training programme for such a diverse group, with specific professional needs? Perhaps, an example of a typical training approach currently being adopted can guide the discussion.

The Typical Training Approach

As mentioned earlier, while health educators in Trinidad and Tobago recognize a need for professional training, there is no clear indication of what form this training should take. Consequently, organizations such as FPATT and HED have been organizing a range of programmes. These include, in both cases, in-house training ranging from one day to one week in duration, covering such aspects of health education as counselling skills, sexuality issues, community education, chronic diseases, and environmental health. One such in-service programme was organized by FPATT in March 2000. This programme was selected as a model for review since it was the only in-service programme being conducted at the time, and its target group spanned all organizations involved in health education.

This workshop, entitled *Sexuality Education Workshop: Training the Trainer*, which was referred to earlier, was intended to "facilitate the sharing of experiences in the field, to enhance the ability of health educators to influence women to take charge of their reproductive health" (FPATT, 2000, p. 1). The agenda identified such topics as the role of sexuality education in the prevention of sexual dysfunctions and health problems; tools for the opening session of a sexuality education programme; deciding and choosing; and values clarification.

The target group was trainers and other related personnel in the field of sexual and reproductive health. Based on this target population, 47 persons were invited. According to FPATT's evaluation report (FPATT, 2000), 39 persons attended the workshop, representing the following organizations: FPATT, the Ministry of Social Development, the National AIDS Programme, RapPort, the Central Regional Health Authority, the Ministry of Sport, and the Rape Crisis Centre.

The process adopted was very flexible and largely experiential--with the facilitator drawing on her past experiences as a sex therapist and

calling on the participants to apply their experiences in the field. To facilitate this process, three strategies were adopted during the workshop:

1. The facilitator commenced with a brainstorming session, in which participants were asked to discuss in groups, and then to verbalize their expectations of the workshop.
2. A decision-making model, which could be used in a counselling situation, was demonstrated.
3. A group game was used to highlight the need for health educators to clarify their personal values.

The workshop process seemed intended to encourage two types of learning in the participants--self-directed and experiential learning. Merriam and Caffarella (1999) state that self-directed learning involves instructors organizing instructional processes and situations, which allow learners to carry through the learning primarily by themselves. In self-directed learning, the instructor works to give more control to learners about what and how they learn. By providing the participants with tools such as the decision-making model and the game for use in their own practice, the facilitator of the FPATT workshop allowed participants to reflect on their practices and, perhaps, find ways to revise their own methods of operation, if and as necessary. The extent to which the workshop process encouraged participants to reflect on their practice is reflected in the participants' responses to the workshop.

By encouraging the participants to recall and share experiences, and by validating their approaches and bringing their training needs into question, the workshop seemed to promote reflection and, in a sense, represents a form of experiential learning. Houle (1989) describes experiential learning as education occurring as a result of direct participation in the events of life. He states that experiential learning can stimulate individuals to be more "self-educative."

Responses to the Workshop

The responses to the workshop were elicited by two methods--direct observation and the use of an evaluation questionnaire administered by FPATT at the end of the workshop. From direct observation, the workshop was well received by the participants but for varying reasons:

1. Some participants seemed to welcome the opportunity to share experiences.
2. Other participants felt that some of their own approaches were validated.
3. There were some participants who did not seem to follow the training process, nor did they seem able to apply what was being presented to their respective situations. However, they seemed to welcome the opportunity to meet others in the same field.
4. The values clarification exercise, in particular, highlighted the biases of many of the participants, and seemed to promote reflection on common sexuality issues and dilemmas for the professional.
5. Queries about expectations led some to consider their requirements for training.

An evaluation report prepared by FPATT, and based on the responses of participants at the workshop, indicates that the reaction of participants to both the facilitator and content was positive. Comments from the participants revolved around the limited time for discussion, and the fact that the workshop could not cover some of the expectations identified earlier. In summing up the comments of the participants, the evaluation report stated:

> From the perspective of the respondents, it seems that the workshop was certainly beneficial. They were pleased that the facilitator took such a practical and realistic approach to sexuality and its many issues. This practical approach seems to have inspired them to consider changing or modifying their approach and response to concerns and questions about the subject. (FPATT, 2000, p. 6)

While, from the responses, participants all seemed to agree that the training workshop was beneficial to them, there were some reservations about the validity of the training approach. Some participants were not sure how the process was helping them. This suggests the need to address the issue of changing current attitudes to learning.

A Systematic Approach

Over time, instructional designers have addressed the problem of designing suitable professional training programmes as an educational problem. Methods for solving such educational problems have been devised, and fall within the field of study known as educational technology. David Hawkridge (1992) suggests that the term educational technology came into use some time during the late 1960s, originating from the field of behavioural psychology. He defines educational technology as involving the systematic application of knowledge derived from scientific research. In other words, as Plomp (1992/1999) suggests, educational technologists seek to answer the question: How does one proceed in a systematic way to design a most satisfactory solution to a problem in a training context? Plomp suggests a design theory in which problem characteristics are coupled with relevant knowledge and methods, in a systematic way, to reach a solution. The basis of this design theory is summarized in the form of a general model for educational problem solving. This general model comprises five phases or steps:

1. Definition of the educational problem in a preliminary investigation. In other words, what are the critical factors in the problem situation and what are the roles of persons in the situation?
2. Design of the solution. Characteristic activities in this phase are generation of alternative solutions, comparison and evaluation of these solutions, and choice of the most promising one.
3. Realization or construction of the solution.
4. Testing, evaluation, and revision of this solution
5. Implementation of the solution.

This phased approach suggested by Plomp is referred to as a systems approach. While this approach has been used widely in educational technology, Romizowsky (1996) and Hawkridge (1992) criticize the model for its emphasis on prior design and development of materials; for emphasizing behaviours mastered rather than ideas processed; and for correction of errors rather than reflection on the implications of viewpoints. They suggest that the model is too rigid and, consequently, does not allow sufficient adaptation. However, the model's strengths, according to Romizowsky and Plomp, lie in its ability to bring focus and

order to a complex situation, and its usefulness in developing programmes which can be easily evaluated. The model, therefore, seems useful as a framework for analysis, which can be used to guide the process of designing a suitable training programme. Relating this to the results of the programme evaluation conducted by FPATT, it is evident that in designing suitable training, it may be beneficial to us a systematic approach. This approach involves conducting needs assessments, developing strategies based on these assessments, evaluating and revising as necessary.

Methodology for Adult Learners

At the level of methodology, the concept of experiential learning also needs to be explored further. While, arguably, all learning comes from experience, the concept of experiential learning, as a separate approach to teaching and learning, has its roots in the work of those theorists who argue for more autonomy for the learner. In its simplest form, experiential learning connotes learning from experience or learning by doing (Knox & McLeish, 1985). All of this is tied to the concept of adult learning. The concept of experiential learning has evolved over the years, largely as a reaction to the traditional schools of thought on education, which were concerned with transferring information to passive students. It now encompasses a gamut of related ideas and views which focus on specific, non-traditional methods and techniques to facilitate learning; the assessment of prior experience; the role of reflection and autonomy in learning; and the role of experience in social change.

Conclusion

This preliminary examination of one model of in-service training for health educators has raised the following issues, which can inform the design of further training programmes:

- **Defining the health educator in Trinidad and Tobago**

Although health education emerged as a state-run activity, currently, there are a number of persons throughout the community engaged in health education activities. This suggests the need for a clear definition of the contemporary health educator. This should encompass persons operating both at the state and community levels, and include identification of characteristics and competencies of these individuals.

- **Inspiring adult learners**

Theoretical considerations based on adult education, and including the concept of experiential learning, should form a part of any programme design. In particular, attention should be paid to making the climate of the classroom more amenable to adults; encouraging a spirit of mutual respect between teachers and students as joint inquirers; and involving students in the diagnosis of their needs, and in the planning and implementation of learning experiences. More importantly, students need to be oriented to this approach to learning to ensure that they may benefit.

- **Reviewing and evaluating existing programmes**

There is need for evaluation of current teaching/learning approaches with the aim of identifying the advantages and disadvantages of the approaches used.

References

Bates, I., & Winder, A. (1984). *Introduction to health education.* Palo Alto, CA: Mayfield Publishing Company.

Breckon, D. J., Harvey, J. R., & Lancaster, R. B. (1994). *Community health education: Settings, roles and skills for the 21st century.* Gaithersburg, MD: Aspen Publishers.

Collier, K. G. (1985). Professional education, Initial. In T. Husen & T. N. Postlelthwaite (Eds.), *The international encyclopedia of education: Research and studies* (Vol. 2C, pp. 4069-4073). Oxford: Pergamon Press.

Family Planning Association of Trinidad and Tobago. (1998). *Annual report 1998.* Port of Spain: Author.

Family Planning Association of Trinidad and Tobago. (2000). *Evaluation report: Sexuality Education Workshop - Training the Trainers.* Port of Spain: Author.

Hawkridge, D. (1992). *Feel the width: Quality in modern educational technology.* Milton Keynes: Open University, Centre for Information Technology and Education. (Report No. 159)

Houle, C. O. (1980). *Continuing learning in the professions.* San Francisco: Josssey Bass.

Knox, A. B., & McLeish, A. P. (1985). Continuing education of the professional. In T. Husen & T. N. Postlethwaite (Eds.), *The international encyclopedia of education: Research and studies* (Vol. 2C, pp. 995-1001). Oxford: Pergamon Press.

Merriam, S. B., & Caffarella, R. S. (1999). *Learning in adulthood: A comprehensive guide* (2nd ed.). San Francisco, CA: Jossey-Bass.

Plomp, T. (1999). Educational design: An introduction (Trans.). In T. Plomp, *Fundamental issues in design methodology in education and training (pp. 1-9).* Enschede, The Netherlands: University of Twente. (Original work published 1992)

Romizowski, A. J. (1996). Systems approach to design and development. In T. Plomp & D. P. Ely (Eds.), *International encyclopedia of educational technology* (2nd ed., pp. 37-43). Oxford: Pergamon.

Stanley, L. (1997) *History of the Health Education Division of Trinidad and Tobago.* Unpublished manuscript.

Trinidad and Tobago. Ministry of Health. Health Education Division. (1977). Annual report 1977. Port of Spain: Author.

Trinidad and Tobago. Ministry of Health. Health Education Division. (1999a). *Mission statement. Background on HED.* Unpublished manuscript.

Trinidad and Tobago. Ministry of Health. Health Education Division. (1999b). *The role of the health education officer in Trinidad and Tobago.* Unpublished manuscript.

Appendix

Students Responses to BALLI Items 19, 24, 26, and 28

19. If students learn to speak French very well, it will help them get a job.

	No. of Students	Percentages
strongly agree	1	2.86
agree	10	28.6
neither dis(agree)	16	45.71
disagree	5	14.23
strongly disagree	3	8.57

24. People in Trinidad and Tobago place a lot of importance on learning foreign languages.

	No. of Students	Percentages
Strongly agree	1	2.86
Agree	2	5.71
Neither dis(agree)	8	22.86
Disagree	14	40
Strongly disagree	10	28.6

26. People in Trinidad and Tobago are good at learning languages.

	No. of Students	Percentages
strongly agree	0	0
agree	8	22.86
neither dis(agree)	24	68.57
disagree	3	8.57
strongly disagree	0	0

28. It is necessary to speak their language in order to communicate successfully with native speakers.

	No. of Students	Percentages
strongly agree	7	20
agree	15	42.86
neither dis(agree)	7	20
disagree	6	17.14
strongly disagree	0	0