Educating Adolescent Students in Health and Wellness: A Review of Policies, Systems and Approaches in the Ministries of Education and Health in Trinidad and Tobago

Carol-Ann Senah

Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Education

School of Education

January 2012

Acknowledgements

The decision to undertake studies for the Education Doctorate came with encouragement from my husband Emmanuel Kwaku Senah and I am eternally grateful for his patience, love and support over these six long years.

Sincere appreciation is extended to the Sheffield Caribbean Team who ensured that our study schools provided the opportunity to learn and to share our individual stories. I also wish to thank my supervisor Dr. Tim Corcoran who has a deep interest in health inclusive education and who used his extensive experience and knowledge of the subject to guide me through the research and writing process. I am fortunate to have had a study partner, Bernice Dyer-Regis and wish to thank Bernice for providing companionship and friendship during our shared research experiences.

I am thankful to all my relatives and friends for their understanding during those times when I did not participate fully in family gatherings and festive occasions, and who always had the faith that I would successfully reach my destination of completing my research study. Sincere appreciation is also extended to Michelle and Natalie for using fresh eyes towards the end when my energy began to wane.

To all my fellow researches in the Sheffield Caribbean EdD programme and colleagues at the organisations where I have worked during the period of my research, thank you for your words of advice and encouragement.

Finally, this study could not have taken place without the willingness and enthusiasm of all my Key Informants who shared their stories as well as their interest in the education of adolescents in health and wellness. Thank you all.

DEDICATION

This study is dedicated to my two children who are now young adults. Thank you Jorteh and Kemi for the lessons you have taught me.

ABSTRACT

Educating Adolescent Students in Health and Wellness: A Review of Policies, Systems and Approaches in the Ministries of Education and Health in Trinidad and Tobago

In this thesis I examine policies, systems and approaches in the Ministries of Education and Health in Trinidad and Tobago, in the education of adolescents for health and wellness. I utilise an interpretive qualitative approach to examine how students age 10 - 15 years are educated on health and wellness in the secondary school system. I begin by looking at the historical influences on the development of education in post emancipation and post-colonial Trinidad and Tobago. However, the context of my research is health and the complex social determinants of health in particular, education and the education system provided for adolescents.

I analyse data obtained from education and health policies and other documents produced during the early 1990s to 2000s, and from key informants - educators and health professionals with responsibility for educating adolescents, as well as reflect on my own professional experience as a health educator. My framework for analysis focuses on Foucault's (1969, 1972) concept of genealogy and the history of the present; Fairclough's (1995) Critical Discourse Analysis; and social constructivist theories of knowledge to explore how dominant discourses become social practice. However, I also engage in an eclectic approach to explore and explain the complexity of meanings created in relation to adolescents and their health.

Findings suggest that the dominant discourse of adolescence is that of a period characterised by deviance and sexual and psychosocial problems. Additionally, that education and health professionals engage in practice based on their individual life experiences that reflect the historical development of education in Trinidad and Tobago. This is demonstrated by their silence on aspects of denominational control over schools that encourage educational inequality according to social class and also the stratification of subjects taught in different secondary schools.

My recommendations include a review of past research studies to assist in shaping new research to look at present practice in both the Ministries of Education and Health in educating adolescents in health and wellness. I argue that new research is required in Trinidad and Tobago that begins with the premise that adolescence is a normal stage in the life cycle. I also recommend new approaches between the Ministries of Education and Health that ensure structures and systems supported by a legal framework providing an environment supportive of adolescent health and wellness.

TABLE OF CONTENTS

LIST OF APPENDICES

LIST OF ACRONYMS AND ABBREVIATIONS

CARICOM	Caribbean Community and Common Market
CCHP	Caribbean Charter for Health Promotion
CSEC	Caribbean Secondary Education Certificate
CSO	Central Statistical Office
CXC	Caribbean Examinations Council
GSHS	Global School-Based Student Health Survey
HBSC	Health Behaviour in School-age Children
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
HPS	Health Promoting School
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-Government
PAHO	Pan American Health Organisation
RHA	Regional Health Authority
UTT	University of Trinidad and Tobago
UWI	University of the West Indies
WHO	World Health Organisation

CHAPTER 1 - INTRODUCTION

1.1 Introduction

My focus in this study is the health and wellness of adolescents. Adolescents in Trinidad and Tobago, like their counterparts in the Caribbean are experiencing this stage of their life cycle in societies, characterised by the history of their past and present location in a global community. In Trinidad and Tobago, adolescents spend most of this period of their lives in the school environment and there are many examples in the literature of school-based health education programmes targeting adolescents. However, I believe that it is necessary to pause and examine the bases of the objects of knowledge contained in programmes addressing adolescent health and wellness and in defining adolescence. I begin by looking back at the development of education, as one contributor to the formation of knowledge related to adolescent health and wellness.

The purpose of this Chapter is to position the development of education in Trinidad and Tobago in the historical experience of the country by outlining some of the factors which have shaped the education system. It also serves to provide a brief demographic description of the country including the factors that shape the health profile of the population. I begin to give context to my study by introducing the major forces that continue to influence the directions of the Ministries of Education and Health; the two Ministries that are the focus of this thesis. I introduce my own life experiences, including professional training and education that have shaped my perspectives on adolescent health and wellness. Additionally, I state my positionality in undertaking this study, as well as the limitations of the study. Finally, I provide a brief outline of subsequent chapters in this thesis.

1.2 Profile of Trinidad and Tobago

Trinidad and Tobago became independent from Britain just forty-nine years ago. Its experience of development as a nation and physical location have contributed to a country which historians have referred to as holding "an infinite promise of prosperity" (Wood 1998, p.1.). This has been so in spite of its complexity of peoples, ethnicities,

classes and religions and serious doubts as to whether a viable society was ever capable of being formed. Governor Harris was almost prescient about the end of African slavery and indentureship in Trinidad and Tobago in 1838 when he stated; "... a race has been freed, but a society has not been formed..." (cited in Williams 1942, p. 96). This statement came even before the arrival of 145,000 thousand East Indian indentured labourers from 1845 to 1912 to add to the difficulties of forging a multifarious society of religions, cultures, and races. Thus, a review of the history and development of education is necessary to give context and insight into factors which helped to shape the education system and the type of society it serves, as we know it today.

Trinidad and Tobago is situated at the southernmost end of the Caribbean archipelago and is strategically located at the crossroads of North, Central and South America. It is one nation comprised of two islands, often referred to as a twin island Republic. Trinidad is the larger of two islands and has an area of 4,828 square kilometres (1,864 sq. miles) and is situated at 10.5 degrees north of the equator. Tobago is 300 square kilometres (116 square miles) in area and is situated just 32 Kilometres (20 miles) off the north-east coast of Trinidad; 11 degrees north of the equator.

The population of Trinidad and Tobago in 2009 is estimated at 1.4 million of which 50,000 persons live in Tobago (Central Statistical Office, Trinidad and Tobago, 2010). People of African and East Indian descent represent the majority of the population while the remainder comprises mainly people of mixed ancestry, as well as those of Chinese, Middle Eastern, European and Native Amerindian descent. This population mix reflects the history of the country: First inhabited by the Amerindians, the country was colonised initially by the Spanish and later the British. Enslaved Africans worked on the plantations however, when transatlantic slavery was abolished in 1807, and later the emancipation of slaves in 1834, the shortfall was met by the importation of indentured labourers from India (Williams, 1942). Other indentured labourers came from China and Portugal as well. The Syrian and Lebanese when they arrived became involved in commerce, specialising in the textile and retail industries. Additionally, traders from European

countries such as England, Scotland, Germany and France settled in Trinidad as salesmen, entrepreneurs and bankers.

The island of Tobago also experienced several colonisers; Dutch, Spanish, English and French among others, changing administrations over 30 times. Eventually it was officially ceded to the English in 1814 at the end of the Napoleonic Wars. The islands of Trinidad and Tobago were enjoined administratively by the British in 1889 and were essentially agricultural producers until this changed with the discovery of oil in 1866 and the production of crude oil in 1908 (Williams, 1942). This characteristic of the economy has also been an influencing factor in the development of education and access to education for the majority of the population. According to Wood (1998), in the post slavery era, "there were misgivings about the consequences of educating the lower ranks of society...Discontent and an aversion to agriculture might be instilled in those whose proper role in life was to use their muscles and not their minds" (p. 214). Indeed, when the first government secondary school, Queen's Collegiate School, was established, children of African descent were explicitly excluded from admission. By 1900, the oil economy and growing prosperity contributed to the broadening of the educational base of the society to include more persons.

1.3 Early Education in Trinidad and Tobago

The Education system today reflects the post emancipation diversity of nationalities, culture, religion and language as well as colour and class divisions. As will be shown later on in this study, this diversity is also reflected in the quality of education accessed by the different groups. The main providers of elementary schools in the decade after emancipation were "the Church of England, the Roman Catholic Church and the Micro Charity, a non-denominational but Protestant educational trust..."(Campbell 1992, p. 11). Of the fifty-four schools known to exist in 1845, twenty-seven were run by the Church of England and thirteen by the Roman Catholics (Wood 1998).

Additionally, it was felt that Trinidad was a colony where there was an urgent need to use education as a means of integrating the community on the basis of English culture. The Keenan Report of 1869 said of this period; "The polyglot character of the people is at present nearly as remarkable as when Lord Harris founded the education system" (p. 21). Children of all cultures were expected to attend the same schools where the English Language and English text books were to be used. Further, from the post emancipation era, throughout the nineteenth and twentieth centuries, advocates such as the late Dr. Eric Williams, historian scholar and first Prime Minister of Trinidad and Tobago, argued that "denominational schools were socially divisive and financially wasteful; fomented religious rivalries and hardened cultural differences"(Campbell 1996, p. 5). Although the rationale for such opinions was originally based on the fact that in those early years denominational schools, in particular the Roman Catholic Schools, promoted French and Spanish cultures, as opposed to English culture, there exists today, as has been the case since 1870, "a dual system of education comprised of government schools and denominational schools" (Campbell 1992, pp 16-17).

This is in spite of historical reports which claim that from as early as the 1840s there was dissatisfaction with the denominational system and there were persistent calls for reform (Wood 1998). Additional complexities in the history of education in Trinidad came with the arrival of people from India in the mid-nineteenth century. For about two generations, people from India were largely educated separately through elementary schools of the Canadian Presbyterian church thereby adding a racial dimension to schooling in addition to the differences between Catholics and Protestants in Trinidad. However, in the 1930s - 1940s Hindus and Muslims from Indian also wanted their own denominational schools included in the dual system of Christian and State schools. The revolt of Hindu and Muslim leaders in the 1930s against the domination of the education of their people by the Canadian Presbyterian missionaries resonates to this day.

Still, the religious bodies gained a victory in the approval by the pre-Independence Cabinet of the Government of Trinidad and Tobago of Concordat of December 1960 -

(See Appendix VII). The agreement gave a measure of autonomy over the curriculum and the right for denominational schools to object to the hiring and firing of teachers on moral and religious grounds. Later, the Education Act of 1966 gave legal and institutional backing to this agreement which has serious implications for what government can and cannot do in denominational schools and what students are exposed to in schools today.

Curriculum direction for elementary education at the beginning of the twentieth century was problematic; the main subjects were reading, writing and arithmetic, English grammar and geography. In the 1880s school gardening was introduced and other attempts were made to 'enrich' the curriculum. For instance, in the 1890s hygiene and crafts were introduced (Campbell 1992). Policy makers in education at that time were attempting to make elementary schooling for children ages 6 to 11 or 12 years old more practical and relevant to the lives of some children. But these changes also increased the gaps between the urban white elite and the aspiring urban black middle class, and the rural poor of all races.

In relation to the history of secondary schools, there are issues which warrant attention as they relate to the education of adolescents today. Such issues include the purpose of education as evidenced by the grammar school type aspirations of schools during the 19th century, the role of religion, socio economic status of students, race and colour, and approaches to educating boys versus girls. Between 1836 -1869, five single-sex secondary schools were founded in Port of Spain (Campbell 1992). Three of these schools were private Roman Catholic schools; the fourth, a Church of England Grammar School and the fifth, a government, non-denominational college. Four of these schools were joined by one or two others to form 'recognised' secondary schools based on a syllabus which prepared students to sit Cambridge examinations in England with the possibility of scholarships to study at universities in England (Campbell 1992). Such a system could only accommodate a small group in society; mainly from the prominent families in Trinidad. The experience in Tobago was slightly different; their first secondary school, Bishop's Secondary, was Anglican and was established in 1932. Its

students were mainly of African descent with a principal of Anglican descent and a curriculum that included "agriculture, domestic science and carpentry...because Tobagonians needed these skills" (Campbell 1992, p.30). Religious education was pervasive and unquestioned in Trinidad and in Tobago.

It was only many years later after two World Wars and Independence from the British that the first Prime Minister, Dr. Eric Williams, reorganised the dual system of education in the late 1960s. He described the denominational schools as a "breeding ground of disunity" which he based on his belief that the "churches had traditionally been supporters of the white colonial ruling class" (Campbell 1992, p.70). However, at present in 2011, the 612 primary and secondary schools include government, as well as government assisted or denominational schools (MOE 2011), with the latter being managed by religious boards. A visit to denominational secondary schools today will reveal a student population that reflects their early history, as the denominational schools have maintained a degree of autonomy, small but crucial, with regards to student intake, staff employment and management of the school. Although curriculum is developed nationally by the Curriculum Division of the Ministry of Education, religious boards of denominational schools influence how the curriculum is interpreted and delivered in subject areas such as Religious Knowledge, Social Studies and Health and Family Life Education. This is in spite of the fact that "the authority of the government before 1960 was already ample in relation to denominational primary schools (and with) the Education Act of 1966, denominational secondary schools were brought under the inspection of government" (Campbell 1992, p. 72).

Education for boys and education for girls did not begin on equal standing in the history of education in Trinidad and Tobago. The trend before 1870 was that there were more boys than girls in primary schools. Later, when girls entered the education system female teachers joined the teaching work force. Initially there were far less places available for girls than for boys in Secondary Schools, but by the 1960s, "the deficits in female

secondary education were in 1986, qualitative rather than quantitative" (Campbell 1992, p.90).

In conclusion, I have tried to show in this brief history of education in Trinidad and Tobago, the complexities of an education system which evolved alongside a complex and young nation. My experience as a student in the education system from the late 1950s to the year 1970 and my experience as a health educator going into both primary and secondary schools have shown that though so much has changed, much remains the same. Those early denominational schools referred to in this historical account are today among the group of schools referred to as 'prestige schools' and they continue to produce the largest group of academic achievers. The denominational boards still struggle for autonomy although they depend on the government for their existence. They continue to resist change with regard to what is taught, especially what is considered extra-curricular, such as adolescent health and wellness, and more so if such programmes address issues of adolescent sexual health. As will be seen later on, the government schools are far more open to health programmes for their students. Professional teachers I have worked with in government schools openly admit that some of the students have 'problems' which warrant health education interventions. Government schools in the main are also co-educational schools unlike their denominational counterparts with separate schools for girls and boys which again influences what is included in the curriculum. Further, these differences in what is taught in which schools give credence to the argument that there are differences in what are seen by policy makers and health and social practitioners as the purpose of education, and begs the question of whose needs are being met in our education system.

1.4 Context of Research

In Trinidad and Tobago, like other countries in the Caribbean; "the health problems of today and tomorrow are increasingly complex and evermore related to social, economic and behavioural factors" (PAHO 1996, p. 339). The health profile of Trinidad and Tobago has changed from Communicable diseases fifty to sixty years ago to Chronic

Non Communicable Diseases (CNCDs) today; "the major causes of death are diseases of the circulatory system, followed by neoplasms" (PAHO 2007, p. 663). In addition, there is the advent of new sexually transmitted infections such as the Human Immunodeficiency Virus or HIV and the less talked about Human Papilloma Virus (HPV). Although HIV is classified as a communicable disease, it is increasingly taking on the characteristics of a chronic disease based on individuals' ability to live with HIV for longer periods if receiving Anti Retroviral Therapy (ART). Examples of lifestyle practices such as food choices, regular physical activity, stress management, safe sex and an overall attitude to individuals taking charge of their lives have their foundation in early habit information.

Since the school represents a significant experience in any individual's life, its structures, systems and those who manage these institutions also contribute to the creation of an environment which impacts on habit formation. WHO (1998) reinforces this point in identifying School health programmes as a way to improve the school environment and the efficiency of the education system. Further, the WHO Commission on Social Determinants of Health (2008) has also identified investment in education to reduce health inequities and calls for quality education for all children. However, in Trinidad and Tobago, emphasis is instead placed on education for economic development. Less attention is paid to the role of education in ensuring the health and wellness of the nations' greatest assets, their human resource.

Alleyne (2008) also illustrates the importance of the relationship between health and education, especially as it relates to youth: "Education in terms of formal inculcation of information is a proxy for the individual and that gives us the capacity to extend our options. The relationship of health to education ...especially at an early age, health or lack thereof affects the ability to learn" (p. 205).

Juxtapose Alleyne's (2008) statement above with the evolution of the health and education sectors in Trinidad and Tobago and we begin to see the challenge before us.

Health institutions and health professionals have always had core functions that relate to curing the sick. This was rightly so fifty to sixty years ago when the main objective was to treat and cure diseases which were mainly communicable diseases. Today, however with the prevalence of CNCDs and other health issues whose determinants are behavioural and psycho-social, the core functions of the health sector has to be expanded and its approach has to respond to the social determinants of the health of the population (WHO 2008). Social determinants refer to the circumstances, in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (WHO 2010). It is therefore important to review the role and functions of the Ministry of Health and its divisions in Trinidad and Tobago to understand whether their structure and functions are designed for an expanded approach to tackle the conditions of daily living. The Report of the WHO Commission on Social Determinants of Health (2008) recommends such an approach and calls on countries to:

> Adopt a social determinants framework across the policy and programmatic functions of the ministry of health and strengthen its stewardship role in supporting a social determinants approach across government (WHO 2008, p.11)

These recommendations reinforce the principles of a public health approach to improve the quality of life and prolong life through disease prevention strategies and health interventions (WHO, 1998). Even more relevant to addressing social determinants of health is what has been described as the 'new public health', which requires:

> a comprehensive understanding of the ways in which *lifestyles* and *living conditions* determine health status and a recognition strategy to mobilise resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive *environments for health* (WHO 1998, p.3 emphasis in original).

The Ministry of Health Trinidad and Tobago, has made attempts at an expanded approach to health care provision and has identified its mission statement as follows: "The Ministry of Health is in the business of promoting wellness and ensuring the availability of quality health care to the people of Trinidad and Tobago in an affordable, equitable and sustainable manner" (Ministry of Health, 2001, p. 3). At the same time, as is illustrated later in this chapter, the practice coming out of the decentralised health sector does not reflect the concept of the new public health.

As a member of staff and part of the management executive team of the Ministry of Health at that time, I remember the discussions around developing and later refining this mission statement as part of the decentralisation process of the health sector. Four Regional Health Authorities (RHAs) had been formed; each authority would be managed by a local board to ensure that the peculiar needs of the population in that particular region were met. The role of the Ministry of Health would be national policy development, as well as, monitoring and evaluation. Further, the Ministry of Health would purchase the services of the RHA through a Corporate Agreement. The rationale for this purchaser/provider split was to ensure that the services provided by the RHAs were responding to the needs of its 'clients' and the Ministry holding the purse strings, would make sure this happened through its monitoring system. Unfortunately, my own professional experience would suggest this system has not worked and a different study would be required to find out why this is so. For the purpose of my present study however, my observations are that no system for conducting regular needs assessment at the level of the RHA was established, so that monitoring and evaluation remain problematic.

Nonetheless, the RHAs have been made responsible for the delivery of school health services under the RHA Act 1994. School health services include school health assessment for primary school entrants and leavers which cover children ages 5 – 6 years and 11 – 13 years. With regard to health education for adolescents, the Ministry of Health depends in the main on its Health Education Division, a vertical Programme established

in the 1940s. A vertical programme in the context of the MOH is one where a particular service, in this case Health Education, is coordinated through to support the implementation of that service by other departments and units of the MOH. In addition, a Public Health, Health Promotion and Communications Directorate were established in the year 2000 to develop policy and strategies for monitoring and evaluation. However, the Health Education Division has been severely short staffed from the mid 1990s, with only one Health Education/Health Promotion Specialist functioning in the Ministry of Health in 2011. Another Vertical Programme of the Ministry of Health which continues to exist alongside RHAs is the Population Programme. Under health sector reform its mandate was to expand its services from Family Planning to Sexual and Reproductive Health. Its target population includes adolescents, and like the Health Education Division, its small staff provides support in both policy formulation and implementation.

As the person responsible for Health Promotion in the Ministry of Heath during the period of health sector reform, I experienced having to engage in both policy making and programme implementation due to a weakened Health Education Division. Collaboration with the RHAs was also limited as the RHAs directed most of their resources to secondary and tertiary health services providing hospital care, and limited resources to Health Promotion.

Additionally, those adolescent health services provided by RHAs are done within a clinical environment which was designed for a wider adult population. Adolescent psychiatric and mental health services are limited. One Child Guidance Clinic located in a hospital complex provides services which include school visits and support for school-based interventions through a multi-disciplinary team. Regarding children with special needs and disabilities, such as the mentally and physically challenged, there are limited specialised school health services to this group and access is even less than the general school population's access to the range of health services available (MOE 2008). What seems to be more consistent in its delivery, are community health services provided by

the RHAs in the monitoring of the physical school environment, water supply and School Feeding programme.

In recent times, the Government of the Republic of Trinidad and Tobago felt it necessary to develop a National Strategic Plan that would guide all its government ministries and their divisions and authorities in identifying and performing their roles and functions.

The National Strategic Plan named Vision 2020, outlines in its goals that: "All citizens will be empowered to lead long, healthy lifestyles and have access to good quality health care" (GORTT, 2006 p. 103). Included among the strategies to achieve this is "to improve the general health status of the population and promote healthy lifestyles" (GORTT 2006 p. 108). Further, that promotion of healthy lifestyles at the level of the school should be implemented "through diagnostic screening services for children; dental hygiene; promotion of physical education and sport; interventions in the School Nutrition Programme to ensure the adequate nutritional content of food and sexual and reproductive health sessions" (ibid).

My observation from my experience in the system is that what is recommended under Vision 2020, the National Plan of Action 2006 – 2010 and the School Health Policy 2008 continue to present a challenge for implementation. Where attention is given to the health of students, the focus is mainly in the early years. Just as the health sector has traditionally given more attention to Maternal and Child Health, the education sector has focused its attention to the health of children in the Early Childhood Centres and Primary Schools. As children enter the secondary school system, academic pursuits take first preference.

In addition, at the secondary school level there is also an emphasis, as was the case in post-colonial times, on vocational skills-building, to put it simply, to earn a living. This is evident when one traces the development of Trinidad and Tobago's education system

which has over time been influenced by the education system of its colonisers. Tikly points out that:

> ... colonial education provided a key mechanism and template for the spread of contemporary forms of education.... colonial education spread a common structure of schooling.....a form of curriculum based on *episteme* (ground base of knowledge).....and has provided the basis on which on which post colonial efforts have had to build (2001 p.157 original emphasis).

Tikly (2001) further states that colonial education sought to develop "global trade and commerce in the colonial era.....by providing indigenous labourers with the basic skills and dispositions required by the colonial economic and administrative systems" (p.158). Over the years, education planners have sought to develop the education system in keeping with the needs of an independent developing nation. However, present day education planners in Trinidad and Tobago are still those who were themselves products of colonial and early post-colonial education, although they now find themselves contending with the forces of globalization (Senah 2006). At the same time, receptiveness to globalisation reinforces the role of education in preparing citizens to service the economy. This openness to globalization is evident in the mission statements of the Ministry of Education and the Curriculum Division and also stated in their education modernisation policy document, which I will cite later on in this thesis.

Trinidad and Tobago gained its independence in 1962 and the first formal education plan, also referred to as the Fifteen Year Plan was drafted for the period 1969 – 1983. However, universal Primary Education had begun in the mid-1950s (GORTT 2002, p. 3). The education plan drew upon deliberations of June 1968 UNESCO –ECLA Buenos Aires Conference on Educational Planning (London 2003).

Ten years later, when the 1968 Plan was reviewed to formulate a New Education Policy the emphasis was on expansion of secondary education. This time the main areas of focus were "Post-primary education for all students, curriculum diversification to satisfy the

educational and training needs of marginalised groups, and provisions of additional school places ... "(London 2003a, p.66).

Two decades later in April 1992, the Cabinet of the Republic of Trinidad and Tobago appointed a task force led by Carol Keller, a University Lecturer in Education from The University of the West Indies, St. Augustine Campus, Trinidad and Tobago. The Terms of Reference of the Task Force included:

> To evaluate the existing education system and identify the changes and adjustments to the system, which are necessary to take the society into the twenty-first century and address its needs during the first decade (Ministry of Education 1993, p. ix).

The Ministry of Education's White Paper (1994) which came out of the report of the Task Force was an instrument for educational planning. Its mission statement was:

> ... to promote equity and excellence by providing a viable, humane and comprehensive educational policy framework and essential ingredients for a plan leading to the attainment of knowledge, values, competencies and skills which will equip each learner to function as a useful citizen (p.3).

Under the New Education Policy, a system of Junior and Senior Secondary schools was established. Children spent three years at the Junior Secondary School before going on to a Senior Comprehensive Secondary School for another two years. This new system existed alongside and in the position at the bottom of the hierarchy with the five and seven year schools. Unfortunately, this approach to universal access to secondary education, transformed into children of lower socio-economic status attending Junior Secondary Schools with poor examination results, while their counterparts of higher socio-economic status attended seven year secondary schools.

According to London (2003):

> The White Paper, therefore illustrates a major shortfall common in educational planning throughout the developing world: it is a symbolic gesture rather than a reliable instrument for guiding educational development and socioeconomic transformation. The final outcome of the White Paper – as experience with similar plans elsewhere reveals – will be determined by the role that the state performs... (p. 20).

Universal access to secondary education seemed to mirror the socioeconomic divisions which exist in the country and therefore had the potential to reinforce the negatives existing in the society. Further, adherence to the principles in the Draft Education Plan or Fifteen Year Plan of 1968 which outlined the need to address health and social issues in education was peripheral in the education of secondary school students in general and almost non-existent in Junior Secondary Schools. The shortened period of classroom hours for Junior and Senior Secondary Schools compared to the previous five and seven year system resulted in limited time for activities outside of the core curriculum. Unfortunately, with the high number of reported cases of violence in Junior and Secondary schools in later years, some began to view them as 'high risk schools' (Deosaran, 2003, p. 304).

For us in the health sector, there was a concern for the negative impact of the changing economic and political climate and an education system which did not appear to be responding to the needs of students, in particular adolescent students at such a critical period in their life cycle.

Comments from students and teachers from a period covered by this plan, 1971 – 1981 were telling. In 1971, the year after the "Black Power Uprising" in 1970 which was marked by social unrest, a National Conference of Secondary Schools was held at the Chaguaramas Centre, in the North West Peninsula of Trinidad. It was reported that this provided an opportunity to bring to the open, student unrest during that time (Braithwaite, 1983 p. 2).

Among the several issues students were asked to comment on were on the topic of aims and content of education as well as physical problems of the school. The views of students attending this conference which was chaired by the Prime Minster and attended by some of his Ministerial Colleagues were documented, as well as follow-up discussions between students and Teachers on the Diploma in Education Course at the University of the West Indies, St. Augustine Campus, Trinidad. The latter took place yearly for a number of years during sessions entitled Teacher/Pupil Relationships in Adolescence. The importance placed on the views of the students was evidenced by the Prime Minister holding "an occasional cabinet meeting....to make an immediate decision" (Braithwaite, 1983 p.2). I have attached (see Appendix VIII) the views of these students to demonstrate that even in those early days students recognized the value of education that goes beyond academic or vocational learning.

What changes came about as a result of the 1971 National Conference of Secondary schools and follow-up discussions with students are not clear. The Ministry of Education themselves seemed to recognise the need for continued change. A Secondary Education Modernisation Programme (SEMP) began in 1999 coming out of the recommendations of the 1994 Task force on Education as well as "several other studies and reports that diagnosed the ills of the system and suggested solutions" (GORTT 1999, p. 2). From the year 2000, the Ministry of Education guaranteed placement at the secondary level for all students who complete the Secondary Entrance Assessment at the end of primary school (MOE 2005).

SEMP's overall objective is stated as:

> ... the reform and expansion of the secondary system... (to) result in five years of high-quality secondary education for all the nation's children regardless of their social and economic status, the creation of a curriculum that is relevant to the very demanding and dynamic world of work, and the development of teaching techniques that will produce graduates who can adapt to the rapid change being brought about by technological advances and globalization (MOE 2000, p.2).

It is clear that the rationale for SEMP was to improve access to secondary education and ultimately access to the world of work in a 'global village'. SEMP was said to be responding to a decline in the transition rate from primary to secondary education and "Secondary school student frustration with low employment prospects and their limited grasp of the secondary curriculum [which] expressed itself in increased indiscipline and violence in many schools" (MOE 2000, p.3).

Today there has been curriculum reform and universal primary and secondary education which recognizes the role of partnerships. The Ministry of Education's Corporate Plan 2008 – 2012, includes in its support systems at the level of the school several stakeholders such as Student and Parent Teachers' Associations, identifying as its major customers, learners, parents and teachers, as well as business community trade unions, non-governmental organizations, other government ministries and agencies and members of the public.

A strategic objective to achieve the first priority of the 2008 - 2012 Corporate Plan is that of "Establishing a safe, nurturing learning environment" (MOE 2008, p. 37). Targets identified in the Plan to achieve this would require the establishment of all public schools as health promotion institutions and to achieve this, approaches would include health and safety, screening and immunization for children, including physical education and Health and Family Life Education at all levels of primary and secondary schools, as well as drug education, anger management, and a culture of peace and tolerance. The expectation is that these targets would be identified in 75% of School Development Plans (Ministry of Education, Trinidad and Tobago, 2007).

This current plan of the Ministry of Education, described as "ambitious" (MOE 2008, p. 8), seeks to include all the necessary components for a holistic approach to educating all children, including adolescents and describes how infrastructural and human resources will be prepared to meet the targets set out in the plan.

This then, is the context of my research; a small Caribbean island with health issues similar to its metropolitan neighbours and the development of an education system in a changing economic climate. The response I see is the reorganisation of systems and development of plans, and it is this response I will seek to explore in my thesis, as it relates to the education of adolescents for health and wellness.

1.5 Outline of Research

1.5.1 Purpose of Study

This study seeks to identify policies and practices, systems and structures, approaches and interventions within the Ministries of Health and Education that contribute to the education of adolescents in health and wellness. I also look at collaborative efforts between the two ministries and other ministries and no-governmental organisations in recognition of the multiple determinants of adolescent health and wellness as part of the wider social determinants of health. I make the assumption that collaboration among the two ministries and other sectors would allow for an expanded and efficient response to adolescent health and wellness. This assumption is influenced by my experience as a Health Education and Health Promotion Specialist for the past twenty-two years, engaging in collaboration with other stakeholders in the planning and implementation of health and wellness interventions that target adolescents. I will examine documents such as policies, draft policies and curricula that address adolescent health and wellness. In addition, I engage in and analyse conversations with health and education professionals. Thus, my review will not only be on what is stated in the written documents, but on lived experiences and insights that professionals reveal about their work with adolescents, to understand how policies and practices became established.

My intention is to explore discourses and the historical context that underpin these policies and practices. My expectation is that information revealed from this study will contribute to efforts to educate adolescents in health and wellness utilising approaches that reflect an appreciation of the factors which impact on their health and well being and the relevance of collaborative approaches to addressing these determinants. Further, I will

make recommendations for further research to improve our understanding of the particular experience of the development of education in Trinidad and Tobago; to provoke a revisiting of the purpose of education and how we can better meet the needs of our adolescents, through the integration of health and wellness in the learning experiences of adolescents.

1.5.2 My Positionality

My positionality or how I approach this research topic is based on my fundamental assumptions which have been shaped by my life experiences. In my professional experience as a Health Education/Health Promotion Specialist in the Ministry of Health, much of my collaborative efforts have been with the education sector. Looking back, the interest must have arisen during undergraduate studies in the Social Sciences in London, in the 1970s, immediately after graduating from a three year programme in general nursing. My studies in education at that time challenged me to look at the factors which impacted on student academic performance and behaviour in Inner London Primary and Secondary Schools. Most of those children were of West Indian immigrant parents and the argument put forward by my then lecturer, Dr. David Milner, was that these children were experiencing a clash of cultures in the British School system.

Studies in education and my nursing experience would have both influenced my choice of a final paper which looked at the role community facilities have in enhancing the education of children living in urban areas and who were experiencing limited extra-curricula activities at that time. Five years later, as a post graduate student in Public Health in Community Health Education, my literature-based research looked at Cross National Perspectives on Adolescent Sexuality, a study that reviewed systems for facilitating positive adolescent sexual development in Sweden, the Caribbean and Nigeria (where I had lived for four years).

Two decades later, I am again focusing on health and wellness of adolescents although I have not consciously selected these topics as a follow up to my previous work. I however believe that this journey has been guided by a concern for the positive development of

youth with a deep conviction that much of what is experienced during these formative years contribute to the adults they become in later years and that we the adults have a responsibility to make this happen. I now bring my past experience to this present study, with the belief that my total life experience is interdependent to the research process and is of benefit to the process. It is my expectation that my life experiences will assist me in the understanding and interpretation of the information gained from documents and key informants, even as I reflect on past experiences and the assumptions that come with them.

Further, my personal, education and career experiences have exposed me to both the natural and social sciences. I am paradigmatically and philosophically positioned as defined by Sikes in "the interpretative, naturalistic, subjective (and) qualitative paradigm" (Opie and Sikes 2004, p.18). However, I adopt an eclectic approach to capture the many sidedness of this thesis; theoretical frameworks, life experiences, practices associated with documentation, anecdotal reports and orality.

Thus, in using a qualitative approach in my research, I am seeking to understand not just what policies and systems exist to enable positive development of adolescents through education in health and wellness, but the social context in which this is taking place and how this context is interpreted by policy makers and health and education professionals.

I acknowledge that there are multiple realities which are based on fundamental assumptions as described by Opie and Sikes (2004):

> ... social reality - their ontological assumptions; the nature of knowledge – their epistemological assumptions; and human nature and agency – specifically their assumptions about the way in which human beings relate and interact with their environment (p.18).

I therefore also acknowledge that my ontological assumptions will influence my approach in obtaining and interpreting the information I receive from the informants in my study. I believe that I can gain insight into individual experiences and the environment of the Ministries of Health and Education, by hearing the views of the informants through the use of Key Informant interviews. Although I will also be conducting documentary analysis, I believe I can better understand the contents of these documents by hearing from those who are meant to use them, and how they interpret and apply the concepts and principles outlined in the documents. I will also seek to gain information from my informants to find out how they give meaning to their life experiences and their experiences as health and education practitioners. My epistemological assumptions are, that individuals learn from experience and that this shapes their knowledge, therefore knowledge is "experiential, personal and subjective" (Opie and Sikes 2004, p.21).

My axiological assumptions are that human nature is intrinsically good and that education can contribute to the 'good society'. I would be interested in finding out how my informants value education for health and wellness and how this can contribute to our collective understanding of the role of education for health and wellness in improving the lives of adolescents. However, I must be aware of how my own values will influence how I obtain and interpret the information. Nonetheless, my intention is that I will be able to make recommendations to enhance collaboration between the health and education ministries through analysis and interpretation of this information. I am aware that my informants can sometimes give answers they think the interviewer wants to hear, however, my belief is that the input from my informants is a critical contribution to developing new knowledge. I am also making the assumption that my informants have been both honest and sincere, and as experienced professionals who also have "social power" (Opie and Sikes 2004, pg 21), they are interested in lending their voices to the discussion and are not saying what they think I may want to hear. At the same time, I expect them to be confident that I have maintained my commitment to the best of my ability, to prevent their identities from being revealed in my report and that it is my intention to share my report with those I have interviewed. I am acutely aware that the

information I receive may be viewed differently by others who may have had different experiences but my belief is that this does not make the information less relevant in contributing to new knowledge about addressing adolescent health and wellness.

1.5.3 Statement of the Problem

Education and socialization for health and wellness should start as early in life as during the pre-school years. It is also critical that students acquire knowledge and skills to practise healthy living during adolescence. As a Health Educator in Trinidad and Tobago, I have observed that students are provided opportunities through activities both in and out of school to learn about health and wellness through ad hoc interventions and initiatives. However, having participated in the implementation of some of these activities, I have also observed that education for health and wellness is not central to the school curriculum, as is the case of the more 'traditional' subjects such as languages or science or mathematics. In addition, such activities which are often initiated from the Ministry of Health are not sufficiently integrated into the core subject areas of the Ministry of Education's curriculum, as an on-going part of education. On the other hand, the Ministry of Education's interventions, to be discussed in Chapter 4 are focused upon cognitive and intellectual understanding when skills acquisition and habit formation should be treated with equal importance. I will argue that it is necessary and essential that key stake holders, particularly in the Ministries of health and education ensure that health and wellness in adolescence is seen as critical to their successful growth and development and transition to healthy adulthood. Further, that it is important that those agencies responsible for facilitating this process are well equipped to do so.

1.5.4 Research Questions

1. What are the official and unofficial documents (documents prepared within the ministry but never adopted as formal policy) which inform the education of adolescents in health and wellness?
2. What do these documents reveal about the concept and principles of addressing health and wellness in adolescents?

3. How are these documents interpreted and utilized by health and education professionals in the health and education ministries?
4. How do health and education professionals perceive their role in addressing adolescent health and wellness and what are some of their 'self made' creative devices for promoting adolescent support?
5. Are there mechanisms for collaboration in existing policies and practices in the health and education ministries to educate adolescents about health and wellness?

1.5.5 Limits/Boundaries of the Research

This research study is looking at policies, systems and approaches which guide programmes addressing health and wellness in two government ministries, namely Health and Education. This study is therefore limited to programmes initiated by these ministries. I am well aware that in Trinidad and Tobago health and wellness programmes targeting adolescents are not initiated by these government ministries alone. Several other agencies such as non-governmental organisations and religious bodies expose this age group to information and opportunities for skills building for the achievement of health and wellness. In addition, the print and electronic media and the internet also provide information on health and wellness which this age group might access. This study may refer to such programmes, but for the purpose of investigation, the study will be limited to the two ministries.

My investigation will require access to documents and policy makers and practitioners in the two ministries. I will have to depend on the willingness of persons, as well as the accessibility of the documents. Time constraints can be a limitation in my conversations with respondents who will have to sacrifice their time from their desks and their class rooms. A major limitation in conducting research in government ministries in Trinidad and Tobago is related to the practice of documentation and policy development. Policies may be formulated but not ratified nor published as formal documents of ministries. Similarly, other documentation may be partially completed reports, while systematic reporting and cataloguing is weak. On the other hand, oral reporting remains pervasive. Although documentation normally refers to written material, in Trinidad and Tobago documentation may take the form of institutional memory. Indeed, it is common practice

to be referred 'to speak to someone' when searching for information in government ministries. My intention is to use my long relationship with the Ministry of Health and familiarity with staff of both the Ministries of Health and Education to circumvent some of the forgoing institutional practices. I therefore acknowledge this difference in the ways in which information is captured, stored and retrieved in countries like Trinidad and Tobago compared to more developed countries.

All my respondents are previously known to me, having had past professional relationships with them at different times during my long practice as a Health Education/Health Promotion Specialist. There is a small cadre of professionals involved in adolescent health and education programmes in Trinidad and Tobago and it would be unlikely that I would not have interfaced with any of them at some point in time. I also acknowledge that familiarity with my respondents would influence the information I receive from them. I am also aware that my respondents may view my reasons for conducting this research differently from how I see them. At the time of the interviews I was no longer working in a government ministry, therefore, they may be suspicious of my motives and concerned that I might be critical of the system. I will therefore have to ensure that I make my motives clear and be honest about the information I am seeking to gather.

It is important that I also clarify my expectations for the outcome of my research. From past experience working in the Ministry of Health and a brief experience in conducting research in the Ministry of Education, there may sometimes be expectations by informants that a particular research study is conducted in order to 'fix' problems. I would therefore have to establish that my exercise may not result in the fixing of problems which may have been identified through the study and that the report is limited to providing recommendations which I would share with policy makers and practitioners.

1.6 Overview of the Chapters

Chapter 1 introduces the research topic and provides context to the study by briefly describing the development of education in Trinidad and Tobago and the health profile of

the population. It also provides an outline of the research, highlighting the purpose of the study, identifying the research questions and the limitations and boundaries of the research. I also state my positionality and establish my role in the research process, reflecting on my personal and professional journey before I began this study.

Chapter 2 continues to give context to this study through a review of the literature and the defining of key concepts as they are applied in the study. I provide examples from around the world where health education for adolescent health and wellness has been implemented, including the Health Promoting School Initiative. I return to the Caribbean and Trinidad and Tobago to review studies addressing adolescence and to locate my study in past research conducted in this part of the world. I continue to reflect on my own experience as a Health Educator and in keeping with the focus of my study I engage in a brief discussion on policy considerations in health and education.

Chapter 3 outlines the research methodology and methods, and provides details of data sources. I identify the documents to be analysed and provide a brief background to each document. Similarly, I provide a profile of my Key Informants and the institutions they represent. At this point I also discuss ethical considerations and my position as an inside researcher. I end this Chapter with a discussion of the framework for analysis and introduce the writers and their methods for analysis which I have applied in this study.

Chapter 4 captures my representation of the findings and analysis of these findings. I highlight emerging discourses and themes and provide my interpretation of the ways in which discourses became established as dominant discourses. I also discuss how these discourses relate to key concepts of my study, such as adolescence, the purpose of education and collaboration between the Ministries of Education and Health.

Chapter 5 is my last Chapter and is a reflection of the research process highlighting my engagement throughout this study, of my personal research experience, my assumptions and my learning journey. I revisit my research questions to provide answers from the findings and make recommendations for future research.

1.7 Conclusion

This chapter has sought to define the parameters of my research study by providing an overview of the education system in a young nation and the social and cultural factors which continue to shape this system. Further, I described relationships between Ministries of Health and Education in addressing the health of students. I also outlined the context and the research process for my study. In the following chapter, I will focus on how the issues of adolescents and youth internationally, and in Trinidad and Tobago are captured and interpreted, and how these interpretations and models are used in the Trinidad and Tobago context.

CHAPTER 2 - REVIEW OF LITERATURE

2.1 Introduction

In this Chapter, I continue to establish the context for my study by defining frequently used terms and clarifying how they are being used in this study. These include adolescence, health and wellness, social determinants of health, Health Education and Health Promotion. I cite studies that have focussed on school-based programmes addressing health internationally, in the Caribbean and in Trinidad and Tobago, including examples of my experience implementing school-based programmes as a Health Education/Health Promotion Specialist. I also identify the successes and challenges in implementing Health Promoting School (HPS) initiatives, including collaborative efforts between the education and health sectors as well as involving other stakeholders, which are necessary to mitigate the negative impact of social determinants on the lives of adolescents. Finally, I discuss education policy and considerations for health policy in relation to the integration of health in the school curricula.

2.2 Adolescence

Adolescence is described as "a period of transitions: biological, psychological, social and economic" (PAHO/WHO 2005, p.256). The age range given for the period of adolescence varies however, in my research I am focussing mainly on the age range of 10 – 16 years, as this represents a period in the life of the adolescent when school attendance is mandatory by law in Trinidad and Tobago. My interest is to investigate how the education and health sectors provide for this group.

Adolescence has also been described as spanning the second decade of life (Lerner and Steinberg 2004). Lerner (2005) has expanded this definition in the context of human development, stating that:

> ...adolescence may be defined as the life span period in which most of a person's biological, cognitive, psychological, and social characteristics are changing in an interrelated manner from what is considered childlike to what is considered adult-like. When most of a person's characteristics are in this state of change the person is an adolescent (p.3)

At the same time, the experience of adolescents during this period is dependent upon environments in which they are placed and the impact these may have on their lives. Related to adolescents' interaction with their environment is the concept that adolescence is a second period of 'brain plasticity' (Giedd, Blumenthal & Jeffries, 1999). Giedd et.al. (1999) describe this as a period when the brain is quickly changing and acquiring new skills. The implication here is that adolescents learn and adapt quickly which may have positive or negative effects according to the environment in which they are placed, as they may not have yet acquired critical thinking skills to make the best choice. This in turn will impact on their growth and development.

In reflecting on the needs of adolescents for positive growth and development, I remain sensitive to perceptions of adolescence as problematic and the depiction of positive behaviour during adolescence as "... someone who was *not* taking drugs or using alcohol, not engaging in unsafe sex, and *not* participating in crime or violence" (Lerner 2005, p.3, original emphasis). I will argue in this paper that adolescence as a stage in the life cycle should not be viewed pathologically and that the concept I am considering is 'promoting wholeness' (discussed below) which I believe lays the foundation in adolescence for wholeness in adulthood.

Therefore, adolescents need information and skills which help them to relate to society as they transition through this stage of their lives and to address the problems they will inevitably face. Most importantly, adolescents need safe and enabling environments. They have a right to accessible health and counselling services that are suitable to their

needs and the right to an education system that fosters positive growth and development and promotes health and wellness.

2.3 Health and Wellness

Sir George Alleyne, physician, educator, UN ambassador for HIV and AIDS and a proponent of the concept of health and wellness as a resource for living, cites the original derivation of the word 'health' to emphasise this point:

> ... the Anglo-Saxon word "hal", from which health is derived, means to be whole and complete. But in addition, we must advocate that this state of "wholeness" at the individual level and at the population level is important for our society if it is to exercise other options such as economic growth and the access to the means of acquiring knowledge (Alleyne 2008, p. 202).

Health is viewed here as a "resource for everyday life, not the object of living ... a positive concept emphasising social and personal resources as well as physical capabilities" (Nutbeam 1998, p. 351). This view of health is relevant to how adolescent health and wellness is addressed. The definition I am using for wellness is "quality of life, emphasising the experiential as well as behavioural dimensions of human existence" (PAHO/WHO 1996 p. 358). Therefore, programmes seeking to facilitate wellness would be expected to take into consideration the multi-dimensional holistic nature of health, "focusing on lifestyles, rather than risk behaviours and risk factors" (PAHO 1996 p. 358). Further, the recognition that lifestyles and quality of life are socially determined requires health and education institutions to seek to reduce the negative impact of social determinants by providing opportunities for nurturing positive adolescent development.

2.4 Social Determinants of Health

In the previous Chapter, I cited WHO's (2008) definition of social determinants of health, in outlining the context of my research. These are factors which are mostly outside of the

control of individuals, but which are inextricably linked to their health and personal development. Therefore, adolescent health behaviour must be viewed within their social context; the wider society and the social domains that they inhabit (Currie 2009). WHO's (2008) Commission on Social Determinants of Health makes the following recommendations that aim to manipulate social determinants to have a positive impact on the lives of children and adolescents:

> ... governments provide quality education that pays attention to children's physical, social/emotional, and language/cognitive development ... It requires joint working across health and education sectors ... increased attention to life skills-based education ... as a way of supporting healthy behaviours (pp 57, 58).

2.5 Health Education

The Report of the 2000 Joint Committee on Health Education and Promotion Terminology defined Health Education as: "Any combination of planned learning experiences based on sound theories that provide individual, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions" (Joint Committee on Terminology 2001, pp 3-7).

WHO (1998) however, provides a definition that includes those factors that impact on the ability to act based on information received:

> Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve *health*. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on *health*, as well as individual *risk factors* and *risk behaviours*, and use of the health care system. Thus, health education may involve the communication of information, and development of skills which demonstrates the political feasibility and organizational possibilities of various forms of action to address social, economic and environmental *determinants of health* (p. 4 original emphasis).

The above definition captures for me, some of the main principles on which educating adolescents for health and wellness should be based. It goes beyond individual agency, acknowledging the multiple and dynamic factors which impact on and shape the lives of adolescents and influence their ability to receive and utilise information. This definition of Health Education also signals that health and wellness cannot only be planned as an integral part of bureaucratic systems, but must be fluid and respond to changes in the needs of adolescents as well as changes in the factors which impact on their lives. Health Promotion supports such an approach.

2.6 Health Promotion

Health Promotion is said to represent:

> ... a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health Promotion is the process of enabling people to increase control over the *determinants of health* and thereby improve their health (WHO 1998 pg.1).

Countries of the Americas adopted the Ottawa Charter for Health Promotion at an International Conference on Health Promotion (WHO 1986). In the Caribbean, the Caribbean Charter for Health Promotion was formulated at the Caribbean Conference on Health Promotion in the year 1993. The concept was described as "a new approach: in the Caribbean context it will strengthen the capacity of individuals and communities to control, improve and maintain physical, mental, social and spiritual well-being" (PAHO 1996, p.340). Health Promotion thus represented a global trend to recognise the role that consumers of health services should play in achieving health and wellness; as well as a recognition that achieving 'good health' is a goal in itself, as opposed to the prevention of illness or in the case of adolescents, positive development and avoidance of circumstances which put them at risk.

Both the Ottawa and Caribbean Charters provide strategies which should provoke the Education and Health practitioner to pay attention to determinants of health. In the Caribbean Charter for Health Promotion (CCHP), there are six strategies expected to guide the application of the Health Promotion approach. These are "Formulating Healthy Public Policy, Developing Personal Health Skills, Reorienting Health Services, Empowering Communities to achieve well being, Building Alliances with Special Emphasis on the Media, and Creating Supportive Environments" (PAHO 1996, p.340). All these strategies are relevant to addressing both individual and social determinants of health and call for a multi-sectoral approach to health and wellness and partnerships between those who provide and receive services. The strategies of the Charter also indicate that there needs to be appropriate systems, human resource and an overall strategy to facilitate and support action for health and wellness, as well as an approach that highlights the value of reaching people through settings, such as schools and workplaces.

Thus, the concept and principles captured in the definition and strategies of the Caribbean Charter for Health Promotion provide a framework for the Health and Education Ministries in Trinidad and Tobago and other Caribbean Countries, for shaping the learning experiences of adolescents, by creating structures and systems to sustain a learning environment which facilitates health and wellness. The approach also provides an opportunity for moving the spotlight from adolescence as pathology to adolescence as a stage in development.

2.7 Health Promoting School

A global initiative to apply the Health Promotion approach at the level of the school is the Health-Promoting School, which has been described as:

> A school that constantly strengthens its capacity as a healthy setting for living, learning, and working. A Health-Promoting School strives to improve the health of students, school staff, families, and community members by engaging the entire community in its efforts (WHO, 1998a p. 11).

This initiative is not static nor does it have an end, but is rather a process. Health Promotion strategies, like those outlined in the Caribbean Charter for Health Promotion, are applied to develop and increase personal health skills among students and teachers; empower the school and surrounding communities to achieve well being, as well as build alliances and create supportive environments to facilitate the practice of positive lifestyles among the entire school population.

The Health Promoting School (HPS) initiative is implemented through the settings approach. This approach utilises the opportunities provided in the environment or space where the target group spends extended periods of time. The school provides that setting where children are in an environment designed for learning and positive personal and social development, and where group or corporate learning can facilitate the reinforcement of positive lifestyle practices. Interaction between students and education administrators, principals and teachers, and ancillary staff of the school, for example; drivers, cleaners, security guards and cafeteria staff as well as members of the community where the school is located, contribute to the learning process. There is therefore available, a broad framework provided by the Health Promotion approach which includes the use of Health Education as a tool to operationalise the strategies of Health Promotion charters, such as the Ottawa Charter and the Caribbean Charter for Health Promotion.

2.8 Adolescent Health and Wellness: Initiatives and Studies

2.8.1 Australia and Hong Kong

Countries around the world have sought to implement the Health Promoting School Initiative (HPS). In Hong Kong, the establishment of the HPS was based on six components: school health policy; school health services; personal health skills; the schools' physical environment; social environment of the school; and community relationships. Baseline data was gathered to establish the status of HPS at the initial stage and also assisted schools in identifying their health profile, for planning their health

promotion initiatives. The data showed that Hong Kong schools gave a low priority to staff health, student involvement in decision-making, on-going professional development for staff, and engagement with the local community. Many schools, although recognising these as important, see them as a lower priority compared with curriculum programmes.

The report states that Special Schools (for differently-able children), which participated in the Hong Kong study, provided better school health services because of extra resources from government to meet the special needs of students. However, there was a substantial lack of health policies in schools and health services in schools were not readily accessible to students and staff. Results also cited insufficient staff training in health promotion and education although most schools were implementing initiatives in environmental protection and had established safety strategies for managing students with emotional problems, rewarded positive behaviours of students, and acknowledged their improvement in academic performance. They also rewarded participation in community services (Lee et. al 2007). The researchers concluded that although they saw gains with the HPS initiative, challenges remained related to integrating health into the day to day functions and structures of the school. More integration was evident in the special and primary schools and less in the secondary schools. There was also more high risk behaviour exhibited in secondary schools (Ibid.).

In Australia, an initiative was started in 2000 to establish a National Framework for Health Promoting Schools and increase the number of HPSs through inter-sectoral collaboration (Rissel and Rowling 2000, p. 248). The education system, history of colonisation by the British and inheritance of a British education system in Australia, are similar to the English speaking Caribbean, including Trinidad and Tobago. As was described in the previous Chapter, this experience of colonisation left particular characteristics of an education system which are evident today. One example relates to the purpose of education. School health was given low priority compared to other curriculum areas in the Australian education sector and it was mainly the health sector which led the process. According to Rissel and Rowling (2000), a policy was established

which involved building on a practice which had already existed, even if there had been deficiencies and inconsistencies in the approach in the past. Key stakeholders participated in the process and the concept of schools as a healthy setting was established. Guided by the Ottawa Charter (1983), attention was paid to reviewing practice and building capacity to contribute to the healthy school setting. The importance of building on what is already in place is evident. A national forum was held to provide an opportunity for comments on the National Framework for Health Promoting Schools, and according to the evaluation assessments, most respondents indicated their organisation's interests were represented in the National Framework. They agreed that their plans and activities were represented in the action plan. They also felt that the process legitimised their work (Rissel and Rowling 2000).

At the same time, the initiative also highlighted a range of problems: These included teachers not having the necessary preparation in health education; crowded curricula; schools differing in how they prioritised health promotion; need for attention to funding; and other processes "to facilitate departments of education and health working together" (Rissel and Rowling 2000, p. 250). This aspect of the Australian experience in implementing the HPS initiative contrasts with a HPS Project in Latvia, where the Ministry of Education appointed a national co-ordinator and established a Health Promotion School Advisory Board with representation from WHO, Ministries of Education, Health and Social Welfare, and the Centre for Health Promotion. Further, intensive teacher training was included in the development of the project, and health was established as an integral part of school curriculum and policy. In Latvia, what started as a project with ten participating schools extended to 150 schools over a five year period (Omarova, Mikelsone and Kalnins 2000).

Rissel and Rowling (2000) highlighted another issue which can impact on national initiatives, which is also experienced in the Caribbean namely, political influence. They noted that a change in the political leadership in Australia impacted negatively on the endorsement of the National Framework. This lack of endorsement at the political level,

as well as at the senior levels of participating organisations, as was stated by representatives at the national forum, indicated insufficient commitment where it is needed most. Interesting information shared by my thesis supervisor in relation to a change in government in Australia at that time, also highlighted that conservative governments are less supportive of 'non-traditional' school initiatives, while liberal governments are more likely to support initiatives that benefit wider populations.

Tones (2005), also makes reference to political influences on what curricula is taught in schools:

> Decisions must be made about what is most worthwhile in a particular culture and a choice must be made...that choice is the curriculum – which is grounded in ideological and ... ... philosophical values... a particular government might be driven by an economic imperative and insist that its schools should ensure that pupils acquire skills and motivation needed for a successful enterprise culture. On the other hand, an educational philosopher might assert that the main purpose of schooling is to nurture children's creative urges and to ensure that teachers foster young people's mental, physical and social growth and development (pp.25, 25).

Later in my review of policy documents in this thesis, I examine how ideological systems in Trinidad and Tobago as well as, the history of the development of education relate to what is included in curricula and how subjects are taught in secondary schools in Trinidad and Tobago.

2.8.2 Multi-national agencies Initiated Research

In an earlier course work assignment for the Sheffield Education Doctorate, I highlighted the role of international agencies in setting the agenda for countries like Trinidad and Tobago:

> For Trinidad and Tobago and the Caribbean, this has been strongly influenced by international technical cooperation and funding agencies with their own agendas...post-colonialism education policy and practice is strongly influenced by international agencies and organisations

> which provide funding and technical cooperation. This type of support comes with stated and un-stated 'conditionalities' and expectations (Senah 2006, p.10).

Further, as seen in the research studies which I cite in this chapter, the international agencies decided on the areas of focus for their research which they were funding, although sometimes the focus may not always be relevant to the local environment.

Caribbean Researchers, Louisy (2001) and Braithwaite (2009) have highlighted the problems associated with this practice: According to Louisy (2001), small states in the Caribbean;

> ... have limited institutional capacity at the national level to carry out the research needed in respect of issues Caribbean, hemispheric and global. To cope with some of these challenges they have turned to hemispheric alliances or functional co-operation (p. 430).

Braithwaite (2009) concurs that related to the use of research led by foreign agencies:

> ... there had never been an organic definition of risk that was birthed and grown to reflect Caribbean realities. A number of agencies have therefore been implementing risk reduction programmes in the Caribbean using foreign norms in the absence of a regional conceptual framework... (p.2)

Consequently, research conducted in Trinidad and Tobago, like other Caribbean countries have been influenced by global surveys and have also directly participated in surveys which are international in scope. Similarly, Caribbean countries have engaged in the implementation of interventions funded by other multi-lateral agencies, such as the Inter-American Development Bank (IADB) with developmental agendas, and which use such global surveys as a reference point. An example is the Secondary Education Modernisation Programme (2000) in the Ministry of Education. Additionally, PAHO/WHO has provided technical assistance to the health and education sectors in Trinidad and Tobago for more than fifty years.

One such study that Caribbean researchers use as a reference point is WHO's Health Behaviour in School-age Children (HBSC) study established 1983. According to WHO (2004), the HBSC study sought to establish:

> .... health as a resource for everyday living ... [focussing on] ... family, school and peer settings, and the socioeconomic environment in which young people grow up, to understand what factors shape and influence their health and health behaviour ...(p.1).

The HBSC report highlights its usefulness for education policy makers and planners as well as for sensitising the media with the expectation that the media can influence others such as politicians. Recommendations are made for consideration of "the complex social arena in which health develops... and integrate them into the design of interventions and preventive programmes (WHO 2004, p. 4). The writers acknowledge that although the social and developmental context of the children's behaviour was seen as relevant, the approach to investigating this variable was illustrative rather than comprehensive. In the Caribbean, those of us engaged in programmes and research studies on adolescent health and wellness saw the HSBC as a marker for our own research and programming (CARICOM 2010).

In 2007, Trinidad and Tobago conducted its first Global School-Based Student Health Survey (GSHS) which was reported on by the Project Manager for the School Health Programme in the Ministry of Health. The survey was conducted by representatives of the Ministry of Health in collaboration with the Ministry of Education. The *GSHS for Trinidad and Tobago* (2007) was placed in the context of other international linked studies such as, the Global Youth Tobacco Survey (2000) and (2007) and a PAHO/MOH led *Adolescent Survey* (1998) referred to earlier in this chapter. The report of the study states that "no comprehensive study of the health behaviours and practices of students in the age group 13 – 15 years have been done" (Procope-Beckles 2007, p. 3). It is instructive that the writer, the School Health Programme Manager for the Ministry of Health did not refer to past national school-based research, even if such research was not considered comprehensive.

The issues addressed in the self-administered questionnaires of the above-cited survey represent a combination of issues related to illness, with limited attention to issues of health. These included "alcohol and drug use; BMI and dietary behaviours; hygiene...;mental health...; physical activity; protective factors; sexual behaviours that contribute to HIV infection, other STI and unintended pregnancy; tobacco use; and violence and unintentional injury" (Procope-Beckles, 2007, p. 3). Results revealed alcohol use in as many as 42.5% of those participating in the study, and according to these results, a significant percentage had considered suicide; males missed school and had engaged in violent behaviour, and males as well as females reported early initiation of sexual activity (Ibid.,p.4). The GSHS (2007) study also revealed that "students are engaging in unhealthy behaviours and dangerous lifestyle practices" (Procope-Beckles, 2007, p 22).

Another example of an internationally led study is the World Bank (2003) commissioned study *Caribbean youth development: issues and policy directions* which looked at youth 10 – 24 years, within which they identified early adolescents, 10-14 years and middle adolescents 15 – 17 years (p.7). The writers acknowledged that they used the terms youth and adolescents interchangeably and outlined an ecological framework for the study that would show the "relationship between the individual adolescent and his or her environment" (p. xiv). The report outlined three objectives, to:

> (1)Identify the risk and protective factors and determinants of youth behaviours and development; (2) demonstrate that the negative behaviours of youth are costly not only to youth themselves but to society as a whole, and (3) identify key intervention points for youth development, taking into account identified risk and protective factors for the Caribbean. (World Bank 2003 p.xiii)

According to this World Bank 2003 report, Caribbean youth are considered to be generally happy and healthy however, the study's focus was on those youth whom they claim were at risk of deviating or who had already deviated from healthy behaviours. The

study included in its data sets, data from the late 1990s on adolescent students from nine Caribbean Community (CARICOM) countries and data from household and labour force surveys.

Problems of youth in the Caribbean were compared with the rest of the world and the report highlighted some astounding comparisons. For example, the pervasive phenomenon in some Caribbean countries of:

> ...barrel children, whose parents have both migrated are at particular risk because they do not have the protection of either parents;...Another issue particular to the Caribbean is that of forced intercourse (among adolescents);... no region in the world for which data are available have such early sexual initiation ...(World Bank 2003, p. 15).

HIV and AIDS were also included in these comparisons and Trinidad and Tobago is cited as having a concentrated HIV epidemic in the 25 – 34 year age group with implications that infection would have occurred during the 15 -24 year period (Ibid. p. 16). However, this study did not include HPV in its study although individuals at risk of HIV are also at risk of HPV. There is also less awareness of HPV among adolescents (Read et. al 2010). I mention this lack of inclusion of HPV as there are implications for Health Education messages for the prevention of HIV which may not be relevant for HPV, but this may not have been part of the agenda of those who initiated the survey.

Yet another example of example of external influence on national research relates to a personal experience in the Ministry of Health in Trinidad and Tobago. An assessment of Adolescent Health Behaviour in the Caribbean was proposed by the Pan American Health Organization in the late 1990s. However, before Trinidad and Tobago participated in this study, the questionnaire to be used in the survey which was provided by PAHO, was reviewed by a national team of public health professionals and educators. As a Health Education practitioner at the time, I was a member of this team and we found the questionnaire to be unsuitable for our adolescents in Trinidad and Tobago. We were also concerned that staff of an international organisation, based in Washington had developed an instrument which they felt could be used in all Caribbean countries, yet the questions

showed clearly that this was not so. Still, when we developed the questionnaire for Trinidad and Tobago it remained a modified version of the original document, an indication that we were still being influenced by the international organisation which was providing financial and technical support for conducting the survey and any interventions which would follow.

It is interesting to note that the PAHO office in Trinidad and Tobago which supported the implementation of the survey on behalf of their Washington headquarters is also the agency which supported the national drive to operationalise the Caribbean Charter for Health Promotion in Trinidad and Tobago. However, although the intention was for the results of the survey to inform interventions which would impact positively on the lives of adolescents in this country, the study did not include in its assessment, a review of health and education institutions, nor the existence of policies to facilitate adolescent health and wellness. Yet, this latter approach would have been in keeping with the WHO/PAHO Health Promotion and Health Promoting School approaches.

2.8.3 Caribbean led Research

A Caribbean study, investigating factors which impact on the development of adolescents, looked at "individual risk behaviours and the impact of environmental factors" on the health of adolescents in the Caribbean, conducted a school-based study, "to design and implement effective programmes to improve and monitor trends in youth health..." (Halcón et. al. 2003, pp.1851-1857). The survey was conducted among 10 – 18 year olds in nine countries in the Caribbean Community and Common Market, although not including Trinidad and Tobago. The researchers identified factors which they relate to "physical, psychosocial and environmental domains....General Health, Nutrition and Health Care Services....Mental Health, Violence and Abuse....Tobacco, Alcohol and other Substances (and) Sexuality" (Ibid.); and according to the researchers, they found that "Most youths reported good health, however, 1 in 10 reported a limiting disability or significant health problem" (Ibid.). The results for early initiation of sexual intercourse and drinking and driving were also cited as cause for concern. The authors recommend

the need for youth involvement in policies and strategies which affect them. They also recommend that "strategies must be built on a framework that makes a link between healthy behaviour and the broader context of family, community, society and culture" (Ibid.).

I disagree with the use of a quantitative approach in this study although it is noted that the researchers themselves referred to methodological considerations which affected the 'generalisability' of their findings. They also point to the fact that the research was limited to adolescents attending secondary schools which according to the researchers, meant that based on the selection process for secondary school attendance in the selected secondary schools, "youths in the academic track are selected for their academic potential and are more likely to have personal assets and support systems needed to stay in school. This may also affect their behaviour and their health patterns" (Halcón et. al. 2003 pp.1851-1857). There are other methodological limitations which I have observed in the report, in that teachers were involved in preparing the students the day before the interviews and this could have influenced how students responded to the questionnaires and whether the students might have had concerns about their responses being seen by their teachers.

Halcón et. al. (2003) concluded that "there are some significant health-related issues facing youths in the Caribbean, but it is equally clear that most young people are doing well ... results serve as an information source for designing and implementing strategies aimed at reducing risk and promoting healthy youth development..." (pp.1851-1857). However, as in previous studies cited earlier in this chapter, the researchers do not explore in depth, the role of the school. Halcón et. al. (2003) also report that there are adolescents in schools who perform well academically and are likely to have support systems, but the researchers stop there and do not discuss how the school could be supportive to all students, nor what may be required for schools to perform this role.

Taking a different perspective, research was conducted in Tobago to inform the development of a Health Promotion Project to "meet the sexual health needs of youth in Tobago" entitled: *The Sexual Behaviour of Youth in Tobago, A Report on the Development of a Health Promotion Project* (Allen et al 2002, p.197). This is a collaborative study between the following agencies: the Special Programme on Sexually Transmitted Infections, Caribbean Epidemiology Centre, the Family Planning Association of Trinidad and Tobago and individuals from community health and community based programmes. The report begins with an expression of concern for risk-taking behaviour and the need to do more than change knowledge in order to reduce such behaviour among youth in Tobago. The researchers establish that their organisation "utilises a health promotion approach in its work to prevent the spread of Sexually Transmitted Infections and to improve quality of care for people living with (Sexually Transmitted Infections) STIs" (Allen et.al. 2002, p. 197). They also express their interest in supporting youth "whose risk-taking behaviour is aggravated by discrimination and low levels of participation in critical decisions affecting their own lives" (Ibid.). Thus, the research study also sought to investigate the sexual and reproductive health needs of adolescents from the perspectives of adolescents themselves.

Allen et. al. (2002) also looked at the socio-economic and policy environment of the population being investigated, as well as the views of persons described as influential in the lives of the young people, and the views of the young people themselves. Description of influential persons is limited in the study; examples given are of sports clubs leaders and religious leaders with no justification stated on the choice of influential persons. The results were described as "reflecting general patterns found in sexual behaviour surveys conducted among young people in the Caribbean...early sexual initiation...low levels of condom use...a large age gap between females and their first partners and multiple partnership by males" (p.198). The researchers followed this study with the development of an intervention which took the form of a workshop where young people voiced their views and debated on the topic of youth sexual health. Policy makers and practitioners were invited to attend the workshop which they described as the first step in the intervention. Information obtained through focus group discussions was used in the

development of a health promotion programme for a group they identified as a representative population.

An important component of this study was the involvement of adolescents, to obtain their views on adolescent health. Green et.al (1999) includes the process in their PRECEDE-PROCEED model: that is, the practice of gathering of information from adolescents themselves on what they see as their needs. Such information can assist programme planners to develop goals with adolescents in response to their expressed needs. Adolescent involvement would also contribute to their becoming aware of and understanding the challenges and opportunities of this stage in the life cycle. Therefore, application of this model allows planners to address needs articulated by adolescents as well as, the need to strengthen the capacity of institutions.

However, although Allen et. al. (2002) sought to develop a Health Promotion intervention with participation of adolescents as an outcome of their study; once again, not enough is said about strengthening the institutions in support of such interventions, neither is anything stated about building on past interventions or being guided by existing policies which speak to youth health. The researchers seemed to be seeking to meet the mandates of their institutions first and foremost; two of the agencies are mainly involved in sexual and reproductive health. One of their conclusions was that "communication on sexual matters is lacking between men and women, parents and children, teachers and students...(and) that there is no sexual education in schools despite the existence of the Caribbean Health and Family Life Education (HFLE) curriculum" (p. 198).

The HFLE Policy on which HFLE curricula are based will be analysed in a later Chapter of my thesis. However, the following discussion focuses on a recent study of the HFLE policy conducted by Rampersad (2008) which was conducted for a doctoral thesis at the University of the West Indies, St. Augustine Campus, entitled *Inside the CARICOM Multi-agency Health and Family Life Education (HFLE) Project: A Poststructural Analysis of Policy and Practice* investigated the development of the HFLE Policy from

an inside perspective. According to Rampersad (2008), the central issues which have informed the development of the HFLE Policy Project were based on the perception that "young persons ... exhibit poor physical, or emotional, or mental or social health ... and how this impacts on families and the demand for health, education and social services" (pg. 36). Although the researcher acknowledges the relevance of the latter point, she describes the problem that the policy seeks to address as "messy" and sees as problematic the "resources capability of the various sectors needed for such a task (health, education, social, legal etc.)" (Rampersad 2008, p. 37).

In my personal experience of attempts by the Ministry of Education to implement HFLE in Trinidad and Tobago, capacity and capability have indeed been the challenge. Over the years, there have been constant calls for the Ministry of Education to establish the HFLE programme without meaningful offers of support from policy makers in both Government Ministries and Non-Governmental Organisations. HFLE seemed unable to find a champion. According to Rampersad (2008), the movement towards HFLE as a policy option had "multiple voices...each pushing institutional and/or political agendas. In the process some views have been silenced and other views have formed part of the dominant discourses that have influenced HFLE direction" (p. 27). Additionally, Rampersad (2008) sought to illustrate this point by investigating the HFLE direction in different countries in the Caribbean using the following criteria: "the initiation of a national HFLE Policy development process; the establishment of a national HFLE Coordinator; the development of curriculum documents; and the inclusion of HFLE at the teachers' colleges and schools"(Ibid.).

Trinidad and Tobago's progress in implementing HFLE appears to 'hit and miss' according to Rampersad's criteria. HFLE is included in teacher education in Trinidad and Tobago but Rampersad is critical of the content of the programme. Significantly, Trinidad and Tobago utilised a Curriculum Officer to coordinate HFLE without ever appointing a National HFLE Coordinator. Developing curricula has also been challenging for Trinidad and Tobago, having only finalised an HFLE curriculum for secondary school

students in 2009. I am aware however, that although an HFLE curriculum may not have existed at the time of Rampersad's study, HFLE was being included in some subject areas such as Social Studies and was being addressed by teachers in their Form Classes. Thus, there were schools and teachers who were not dependent on the existence of an HFLE curriculum to include HFLE subject areas, and who gave meaning to and interpreted what was required to educate students about health and wellness. I am also aware that during the period of Rampersad's research, there were in existence, collaborative approaches among the health and education ministries and non-governmental organizations to implement programmes that addressed health and wellness for secondary school students. I was intimately familiar with some of these efforts, but it was as if those trying to implement HFLE were swimming against the tide.

Rampersad (2008) refers to these programmes, but makes the point that such initiatives assumed "that young people simply need factually correct information and that they will make a *sensible* decision" (p. 21 my emphasis). I am unsure of the extent to which this assumption was made by those engaged in Family Life Education at the time, but I am of the opinion that the issues which hindered those programmes may be the very issues that have prevented the HFLE initiative from taking root in Trinidad and Tobago and some of the other Caribbean countries. My question is whether the shaping of life experiences can take place with only the establishment of a curriculum in a particular subject area.

Rampersad (2008), herself makes the point that when:

> ...the health and wellness of young persons became part of the dominant discourse (in the Caribbean). When such a dominant discourse calls for a policy option such as programme interventions for children and young people, it immediately constrains other discourses that may, for example, speak to wide scale government-run social programmes to reduce poverty and inequity...The predominant discourse conveys to the population that a family life programme, or a health-related programme for young persons, can successfully address their health problems without significant barriers in the way (p. 96).

Rampersad (2008) has highlighted that the CARICOM, Multi-Agency HFLE policy is based on a premise that the principal goal of HFLE is individual behavioural changes to promote healthy personal and family life. Thus, the task remains for the school population; principals, teachers, Guidance Officers to accept that they have a role to play in creating opportunities for collaboration that would extend the discourse beyond the education sector, to assist in overcoming those barriers referred to by Rampersad.

Rampersad's (2008) study, as an academic exercise to fulfil the requirements of a doctorate programme contrasts significantly with the other studies reviewed in this chapter as the researcher makes clear her positionality and the subjectivity of her approach. Her life experience at different levels of the education system in Trinidad and Tobago can be clearly identified in the rationale for her undertaking her choice of study, as well as what she expects to come out of the study. She also expresses her concern for young people and the impact of risk taking behaviour on the lives of students.

In my experience in the 1980s as a Nurse Educator with an NGO, the Family Planning Association of Trinidad and Tobago, we engaged in collaboration with health and education ministries and our work involved interaction with parents, teachers and students in the context of Family Life Education as it was referred to at that time. The focus was that of skills building, for parents and teachers to support their understanding and ability to meet the needs of adolescents. The adolescent students themselves were taught about growth and development, in particular, puberty and adolescence. All of this was done through periodic visits to schools and meetings with Parent Teachers' Associations where mainly parents attended, with the exception of the school principal and vice principal. This approach of the health educator visiting schools and meeting students in and out of school venues, such as vacation camps and religious institutions continued for at least a decade. I recognized then, as did my colleagues in the health sector (other health educators, Environmental Health Officers, District Health Visitors, Medical Social Workers, Dental Nurses and Medical Practitioners) that we needed to find alternatives to this piecemeal approach to addressing health and wellness in schools.

Further, that coming outside of the education sector, our collaborative efforts depended on the willingness of individual school principals as there was no education policy to support practice.

We saw research as a first step in informing the process of establishing a sustained system for educating students about health and wellness and supporting schools to provide enabling environments. The Health Education Division of the Ministry of Health, with support from the Pan American Health Organization, sought to conduct formative research which would inform a sustained health and wellness programme for secondary school students. Initially, we paid attention to students only. Thus, research was conducted among Secondary School students to assess lifestyle practices (Republic of Trinidad and Tobago, Ministry of Health 1994, 1998) with similar results of more recent studies already cited in this chapter. However, we also investigated adolescents' access of health centre services and results revealed that adolescents did not like accessing services as they did not find the centres to be youth friendly, citing attitude of health centre staff to be judgmental (Republic of Trinidad and Tobago, Ministry of Health 1996).

A second step in our attempt to improve our approach to addressing adolescent health and wellness, was the formation of partnerships with the Ministry of Education as our main partner and in particular, the Student Support Services Division, the Trinidad and Tobago Unified Teachers' Association and the National Parent Teachers Association. It was also important that among health professionals there would begin a reorienting of their approach and practice of health service delivery. We therefore undertook the introduction of Health Promotion into the curricula of Nursing, Medical and Environmental Health Education which contributed to the orientation of health professionals to Health Promotion. Partnerships were also formed with large Non-Governmental Organisations (NGOs) like the Family Planning Association with its innovative youth drop-in centre and relaxing ambience and called 'D Living Room'; as well as smaller NGOs and Faith Based Organizations (FBOs), all with a mission to engage adolescents in and out of school to adopt healthy lifestyle practices, utilising a Health Promotion approach. It

could not be said that there were not several and varied programmes targeting adolescents, yet adolescent deviant behaviour was evident and seemed to be escalating. Unfortunately, educators and health educators myself included, focused our efforts on addressing behavioural problems in adolescents for many years before attempts were made at an approach that would contribute to making the school an enabling and supportive environment. This may have occurred because we had been able to build relationships with individual schools but not with policy makers in the education sector.

It became critical that we engage in a third step which was to seek to influence the school system to become an enabling environment, with support from stakeholders. Although a Health Promotion Policy has never been developed in Trinidad and Tobago, my fellow Health Education/Health Promotion practitioners deemed it necessary to develop a first Health Promotion plan to operationalize the Caribbean Charter for Health Promotion (1993), which would give context to later plans utilising a Health Promotion approach and engaging other partners that would examine the social determinants of health of the populations we served. These were exciting times for us in the Health Education Division of the Ministry of Health and we were able to spread this excitement to other sectors where we developed relationships, which facilitated implementation of workshops to strengthen competencies of teachers and adult facilitators of youth development for the health and wellness of their students.

One such initiative included a "Healthy Lifestyle Empowerment Programme for Teachers in the North West Health Region (Trinidad and Tobago)" and "Workshops for Teachers to become School Health Education Coordinators"; both initiatives were funded by and documented by PAHO (2007). In the former initiative, the rationale was to help teachers to assess and reflect on their own health and to provide them with knowledge and skills to make informed choices about their health. This programme aimed to sensitise teachers to the concept of school health and their role in implementing school health. Further, it was thought that "teachers by virtue of their strategic positions of role models and educators are well placed to influence the lifestyle practices of their young charges" (PAHO 2007,

p. 40). These initiatives which were piloted in two secondary schools and involved teachers assessing and documenting their weight, blood pressure and other health indicators and being sensitized to the fact that these results were linked to lifestyle practices; in addition, that lifestyle practices in adult life are influenced by habits acquired in youth. The expectation was that this approach would help teachers to appreciate the importance of the school being an enabling environment for students to engage in positive lifestyle practices. As health educators, we were convinced that teachers play an important role in the lives of their students but that they needed to understand this relationship and more importantly feel comfortable about their own health and their role in the health and well being of adolescents.

A flagship in my experience in implementing health education and health promotion programmes in Trinidad and Tobago was a schools-based programme, Project Lifestyle, which was initiated by the Caribbean Food and Nutrition Institute, PAHO. (PAHO, 2007 p.45) Project lifestyle aimed:

> ... at developing healthy lifestyles in school children with the full involvement of teachers and parents. The emphasis of the programme is on skills development by the students as well as providing them with knowledge and motivation to continue practising healthy lifestyles after leaving school. The programme does not disrupt academic teaching, but is designed to be infused gradually and systematically in the existing subjects being taught (Ibid.).

What was missing however was a national policy which would facilitate the expansion of and sustainability of such programmes which require collaboration between health, education and other stakeholders; as well as systems established for integrating health into education curricula with the participation of parents and teachers, and with the students themselves playing a major role.

These health and wellness initiatives implemented in Trinidad and Tobago were executed with limited human and financial resources but with infinite enthusiasm. The enthusiasm was also shared by some members of the school community at various levels, including

teachers, principals, school supervisors and curriculum officers. However, expansion of these initiatives beyond the pilot stage was an uphill task and sustainability was elusive. The urgency of implementing the pilot programme overshadowed the need to address infrastructural and systemic issues which we as health educators discussed, but arrived at the conclusion that if we could make a pilot work and demonstrate its success, the rest would follow. Eventually, a lack of staff and attrition of senior health educators in the Health Education Division, the unit of the Ministry of Health with responsibility for leading these initiatives, impacted negatively on the sustainability of these programmes.

2.8.4 Protective Factors

Among the protective factors identified in the World Bank (2003) report, the school is identified as one protective factor for youth, but the authors also state that the education system is an example among the Caribbean countries investigated, of "a national institution that does not provide equal services to the majority and contributes to excluding a large segment of the youth population" (World Bank 2003, p.13; Deosaran, 2003). However, according to the World Bank (2003) report, where there is connectedness to school, the benefits are comparable to parental connectedness. The report also cites that "88 percent of students feel connected to a teacher who also gives positive reinforcement" (p. 35). At the same time, the report states that the structure of the educational system in the Caribbean, based on performance on exams and its link to self-worth and confidence, induces risky behaviour. Examples cited in the report include, rage and violence; "40% of school–going CARICOM students reported feelings of rage... one fifth of students had carried a weapon to school in the 30 days previous to the survey, and nearly as many had been in a fight using weapons" (p.23). World Bank (2003) report also cited problems of physical and sexual abuse, adolescent pregnancies, substance abuse and social exclusion among adolescents and youth (pp 16, 23, 24). However, systems which should be supportive, such as health care systems do not provide confidentiality and there is a lack of youth-sensitive health services (ibid. p. 40). The health system is thus failing in its role to be a protective factor.

The authors of the World Bank (2003) report conclude that there is a bundling of risk-taking behaviours among youth in the Caribbean countries they investigated and recommend focussed preventive measures as an:

> An efficient means to simultaneously address several different types of risk-taking behaviour... Youth respond to incentives and environments that are taught and presented to them, suggesting that youth themselves are not the problem. Instead, the environments in which they exist and their supportive structures either force risky conditions upon them...or set up conditions where engagement in risky behaviour is a reasonable option...a more holistic approach [is required for] ... working with youth to improve their situations (p.42).

The results and recommendations of the World Bank study highlight that attention has to be paid to the role institutions such as schools play in influencing the lives of adolescents.

Braithwaite (2009) in looking at perceptions of protective factors through 'voices of youth', identified "access to education and learning opportunities ... as protective against risk-taking behaviour" (p.5) At the same time the youth in Braithwaite's (2009) study expressed that "People who are paid to deal with youth problems behind a desk don't see what young people face ... (recommend) create safe places and safe zones in and around schools" (pp.10, 11).

The GSHS (2007) report recommends that "interventions, policies, and programmes must be implemented to enable students to adopt and make healthy lifestyle choices at this stage of their lifecycle..." (Procope-Beckles 2007, p 22) The recommendations specify that a national school health policy and adolescent health services are required and that schools create an environment, including modifying the curriculum to accommodate health issues. These are noble recommendations however, the research did not include an investigation of existing policies and services, so this recommendation is based on the health problems investigated and the assumption is that the school as an institution has the capacity to address the problems.

The school as an influencing factor in adolescent health has also been highlighted in relation to support for adolescent sexuality and in the past two decades in relation to the prevention of HIV and other Sexually Transmitted Infections. Michael Kelly and Brendan Bain (2000) argue that ensuring young people attend schools can reduce their vulnerability to HIV infection. Kelly and Bain (ibid) suggest that the "The Triangular Model for School and Community Links to serve as the bedrock of prevention and alleviation strategies" (p. 114). The authors also outline an elaborate and comprehensive 'Rapid Appraisal Framework for HIV/AIDS and Education' which includes Policy, Regulatory Framework, Leadership, Partnerships, Vulnerability and risk profile, Impact Assessment, Social Assessment, Strategic Planning, Cost and Financial Resources, Management Framework, Curriculum and Teacher Development, Awareness Advocacy and Sensitization, Counseling and Testing and Health Services (ibid). The expectations of the authors are that the school system can adopt this framework to support sexuality management and HIV prevention. However, this framework demonstrates that there is a gap between what schools can do best –teach- and what they have been 'burdened' with and have difficulty achieving as would be required in the application of this framework. The question remains as to whether there is capacity within schools to retain all adolescent students, especially those students who need school the most.

The research studies cited in this Chapter, from countries outside of and within the Caribbean, including Trinidad and Tobago indicate that there are gaps in policies and limited capacity within health and education institutions, which can impact negatively on adolescent development. Further, schools are faced with the challenge of prioritising and competition between subjects taught and this is based on complex issues related to what educators, policy makers, religious leaders and other members of society, view as the purpose of education. This is a question debated from the times of Plato to Einstein, to Dewey (1897) and Young (1972, 1999) among many others and continues today. Dewey (1897) for example, viewed "Education ... [as] a process of living and not a preparation for future living ... that the school must represent present life – life as real and vital to the child as that which he carries on in the home, in the neighbourhood, or in the play-ground" (pp. 77 - 80). Today, the debate continues and the question of the

purpose of education in small nation states like Trinidad and Tobago becomes even more complex.

2.9 Policy Considerations

Louisy (2004) points out that; "A key challenge for educational policy-makers is how to provide quality education that is sensitive to local context while responsive to the demands of the global market" (p. 287). In Trinidad and Tobago, there are repeated calls for education policy and practice to be national in scope, while having the capacity to prepare nationals to function globally as well as participate in nation-building that would establish the country's comparative advantages in the global market. Louisy (2004) makes the plea for Caribbean education systems to ensure that education seeks to: "carry out its social, cultural and reproductive functions" (p.427). Similarly, Ball (2001) asks the question,

> . . . to what extent are we seeing the wearing away of nation-state specific policy making, in the education, social and economic fields, and concomitantly, the collapse of these fields into a single over-riding emphasis on policy-making for economic competitiveness. That is, an increasing neglect or side-lining (other than in rhetoric) of the social purposes of education (Ball 2001, p. xxviiii).

In the present economic crisis, countries like Trinidad and Tobago are seeking to ensure that their populations are prepared to meet the demands of a global economy, so policies are formulated based on particular values and expectations. Kogan and Bowden (1975) refer to policy as "operational statements of values -'statements of prescriptive intent', 'the authoritative allocation of values, programmatic utterances" (p.55). However, Ball (1990) makes the claim that "education policies project definitions of what counts as education and is not simply a direct response to dominant interests" (p.3).

The National Strategic Plan for Trinidad and Tobago (2006), "Vision 2020", which provides the context for education in the country, identifies education as:

> ..one of the critical links in the development chain; it assists in the building of core competencies such as numeracy and literacy, but equally important it affords the opportunity to constantly improve our human resources to become responsive and adaptable to changing national and global circumstances...Additionally, a quality education system produces a cadre of academically, intellectually and skilled individuals who possess relevant life skills as well as positive attitudes, to facilitate and enable quick employability locally, regionally and internationally (p.23).

Measurements for success in the National Strategic Plan refer to quality of the system and schools, enrolment at all levels, improved student performance, as evidenced by certificates attained and entry into the workforce. Vision 2020 therefore, sets out parameters for what counts as education in Trinidad and Tobago. However, pressure groups are critical of Vision 2020 as the country's overarching blueprint for nation building. Political rivals of the government claim that policies are born out of the need to control and exercise power over others. Whether this is reality or perception, the practice in Trinidad and Tobago is that when governments change, policies are aborted or actions related to such policies are reduced. Foucault (1980) referred to the concept of the technologies of domination and the genealogy of the modern state, where governing others is integrated into structures of domination and governments rationalise the exercising of power. Thus policies are related to politics and policies vary according to whose power is being redistributed.

Within the health sector, a call was made for national health policy to "promote health as a dynamic state varying between well- being and disease, the balance being directed by (a) genetic factors (b) the environment (c) the choices that people make and (d) the quality and appropriateness of both health and social services" (Spotlight on Health, undated, p. 3). Again, the question arises on the purpose of health institutions, to prevent and treat illness or to promote health and wellness, and how the institutions organise themselves to ensure they meet the various needs of the population through the services they provide. Trinidad and Tobago continues to be challenged by health issues such as

the range of Chronic Non Communicable Diseases described earlier in this paper, which also have a range of mainly social determinants, together with a population with thirty percent under the age of 15 years and an elderly population expected to double in the next 25 years (Republic of Trinidad and Tobago Central Statistical Office 2008). A recommendation was made that health policy should address four issues to meet the needs of this complex profile:

> ... first identifying the major disease problems, assessing their social and economic implications and evaluating the cost-effectiveness of alternative intervention strategies; second designing health care delivery systems, including human resource and physical infrastructure which are well supplied and managed; third defining and choosing what Government can do through the entire range of policy instruments related to health promotion, provision of services, taxation and regulation, fourth stimulating the private sector to join in the task of promoting health
>
> (GORTT, Spotlight on Health undated p.3).

The author concludes that in order to plan for better health and to meet the needs of all groups in the population, policy is needed to guide an inter-sectoral approach among the health sector and stakeholders including the community, Unfortunately, from my experience in the health sector in Trinidad and Tobago, when policy calls for action by the government, the politics of power steps in and determines whether the action is taken.

In the absence of a formalised national multi-sectoral body to facilitate collaboration, it is challenging for the health sector to negotiate strategies, such as joint funding for programmes where different sectors play key roles. In a report on Health Promotion initiatives in Trinidad and Tobago (PAHO 2007), the recommendation was made for inclusion of Health Promotion in the curricula of health and education professionals in order to take the process of partnership and collaboration forward.

2.10 Conclusion

In reviewing HPS initiatives and studies of school-based health initiatives, I have found that a main challenge to school-based programmes addressing health and wellness in adolescents is related to both the content and implementation of policies and the absence of national policy on integrating health into school curricula. Additionally, studies revealed that readiness of teachers also influence the implementation process of school-based initiatives. I have cited Caribbean researchers who highlight the challenge of small nation states in ensuring that education is local in context, who acknowledge the social purpose of education and lament the lack of a conceptual framework for reducing risk among Caribbean youth (Braithwaite 2009; Louisy, 2004). I referred to the overarching strategic plan for Trinidad and Tobago and its vision for 'quality education' and the recommendation for a health policy to respond to the needs of all populations.

In the following chapters of this thesis, I will present and analyse the information received from policy documents and key informants in this study to add to what has been revealed in this review of literature. My expectation is that this information can contribute to an understanding of how the education and health sectors, with their individual complex institutions can respond to the needs of adolescents and whether the existing policies in these institutions provide the necessary support to achieve this.

CHAPTER 3 - RESEARCH METHODOLOGY AND METHODS

3.1 Introduction

In this Chapter, I describe the methodology or approach and my choice of methods to obtain and interpret information on adolescent health and wellness. Among my research questions for this study, my key research question is: How do health and education professionals perceive their roles in addressing adolescent health and wellness? In Chapter 1, I outlined my epistemological and ontological positions and how these have influenced my approach in conducting my research and concluded that my approach in this study is interpretive. I also acknowledged that there are multiple realities; therefore my approach to obtaining information is through involvement and interaction with my informants, acknowledging that as the researcher, I represent the main instrument in the collection and analysis of the data in my research study.

I wish to reassert at this point my position, that given the nature of the fluidity of the realities in my study: a multi-racial and multi religious Third World, post-colonial context with strong tendencies toward oral expression and practices in documenting reality; I do not apply theoretical models with defined boundaries. Indeed, my position is that the strength of my use of theoretical models lies more in the grey areas where they criss-cross and provide possibilities for explanations and meanings that are not a total fit. Consequently, the theoretical frameworks that I employ will have an eclectic bias.

3.2 Methodology

My methodology is located within what has been described as the interpretive, naturalistic and subjective qualitative paradigm, which claims: "that human behaviour can only be explained by referring to the subjective states of people acting in it...as opposed to positivism which claims that social life can only be explained by the examination of observable entities" (Wellington 2000, p.198).

I have chosen a qualitative approach as I am investigating peoples' experiences, as well as how they relate to socially constituted institutions where they function and how this in turn

influences documents they produce. At the same time, I acknowledge the 'false dualism' in the polarisation between quantitative and qualitative research (Pring 2000). My approach is based on the premise that the research process is complex. I have found in my experience in Health Education that quantitative approaches for example, can provide useful statistics, while qualitative approaches have helped me to understand the factors which may have contributed in shaping the statistics that are made public. I also recognise that these factors can change in different situations and that the same factors can be interpreted differently by researchers. Indeed, " ... as people, as social beings, located in space, time, cultural milieu, researchers (like anyone else) have been influenced by the particular understandings about, and interpretations of the world to which they have been exposed" (Sikes and Goodson 2003, p.34).

Therefore, it is not possible for the researcher to be isolated from the research process. I engage in reflexivity, again acknowledging that "we are part of the social world we are studying and that the researchers' own interpretation processes and authorial position need to be taken account of (Goldbar and Hustler 2005, p. 17). I have been reflexive in my choice of study as highlighted in Chapter 1, having always had a special interest in adolescents and youth in my academic and professional lives. The location of my study in the Ministries of Health and Education, my key informants and documents chosen are also influenced by my reflexive practice. At the same time, in the process of interviewing Key Informants, I sought to be careful in letting my informants tell their story, even if it meant moving away from the sequence and flow of my interview guideline.

Bourdieu (2000) makes the point that:

> the social world is an object of knowledge for those who belong to it and who, comprehended within it, comprehend it, and produce it, but from the point of view they occupy within it ... agents take up positions which, far from being interchangeable...always depend in reality, on their position in the social world of which they are the product but which they help to produce (p.70).

I therefore explore how knowledge, as it relates to adolescent health and wellness is produced, maintained and translated into practice in the Health and Education Ministries.

My approach employs Social Constructivist theories of knowledge. I subscribe to the world view, that:

> What we take to be knowledge of the world is not a production of induction, or of the building and testing of general hypotheses... is not automatically driven by the forces of nature, but is the result of active cooperative enterprise of persons in relationship (Gergen 1985, pp 266, 267).

Individuals construct meaning within social contexts based upon social experience and this in turn influences their social world. Social constructivism, which shares views with hermeneutics, affirms that:

> Human beings do not find or discover knowledge so much as we construct or make it. We invent concepts, models, and schemes to make sense of experience, and we continually test and modify these constructions in the light of new experience. Furthermore, there is an inevitable historical and sociocultural dimension to this construction. We do not construct our interpretations in isolation but against a backdrop of shared understandings, practices, language, and so forth (Denzin and Lincoln 2000, p. 305).

Thus, knowledge is seen as historically, socially and culturally specific and not dependant on empirical validity (Gergen 1985). This approach questions the existence of absolutes and focuses on the processes which contribute to the creation of the social world.

According to Bourdieu (1986):

> [the] ... construction of social reality...is not carried out in a social vacuum but subjected to structural constraints; secondly that structuring structures, cognitive structures, are themselves socially structured because they have a social genesis; thirdly that the structure of reality is not an individual enterprise but may also become a collective enterprise (p.18).

Social realities as a collective enterprise also relate to my consideration of the post-colonial experience and globalization influences on education in Trinidad and Tobago and how the colonial experience has contributed to education practice. In Chapter 1, I briefly outlined how the education system was established in Trinidad and Tobago during the post-emancipation period, leading up to Independence from Britain in 1962, ushering in a post-Independence period. Later in this chapter, in outlining my framework for analysis, I also refer to my application of Focault's (1972, 1977) concept of genealogy to explain the history of the present ways in which earlier British approaches to education are reflected in education practice today in Trinidad and Tobago.

3.3 Methods

The process of obtaining information in this study involved the use of purposive samples to identify specific documents and informants. Purposive sampling has been described as sampling "done with deliberate aims in mind as opposed to a random sample or one chosen purely for its convenience and accessibility" (Wellington 2000, p. 199). I have chosen to use purposive sampling as I am seeking to get in-depth information from the experiences of my informants and from specific documents. It is not my intention that the information I receive from these sources would be generalised as applicable to a wider population. I utilised Key Informant Interviews and Documentary Analysis to obtain information. In the context of my research, through interviews, I will explore how documents are interpreted by practitioners and how these documents may relate to their social practice. Utilising documents to obtain data allows me to analyse and interpret the documents in terms of language used and assumptions made by those who have produced the selected documents. In a small country like Trinidad and Tobago, there is often an overlap between those who produce documents and those who are meant to implement what is stated in the documents. Therefore, how a particular issue is addressed may actually be in the hands of a small group. Analysing documents developed by and /or used by this group will provide information about the groups, their world views and their interests.

My analysis will also focus on what the information I have obtained reveals about the practice of health and education professionals in their particular settings and professional community. I follow a process of reading the transcripts of the key informant interviews and the texts of the documents to identify general themes using a generic approach. Themes are identified based on what they reveal about the background of the key informants and their core functions and interactions as professionals.

3.3.1 Data Sources

3.3.1.1 Documents

The documents I have identified for analysis represent documents which have informed action for educating adolescents in health and wellness. These are: The Report of the National Task Force on Education (1993), The Caribbean Charter for Health Promotion (CCHP) (1993), and The National Policy on Health and Family Life Education (2001). These are all public documents which I had previously accessed for use as a public health professional engaged in Health Promotion, including School Health. Each of the documents was chosen based on individual criteria as will be explained in the following paragraphs. A guide for extraction of data from the documents was developed (See Appendix III).

- The Report of the National Task Force on Education

This is a policy/planning document prepared on behalf of the Ministry of Education and represents a seminal document developed to guide the education system in Trinidad and Tobago. In Chapter 1, in discussing the history of education in Trinidad and Tobago, I highlighted that the Task Force Report came after the first, post-independence formal education plan (1968 - 1983), which was followed by an expanded Secondary Education Policy; the latter introducing a Junior and Senior secondary education system where some children accessed less hours of Secondary Education than their peers. The request for a task force to evaluate the existing system was a first attempt at education reform in Trinidad and Tobago after Independence. Education policies which came after this Report were therefore based on the recommendations coming out of the Report. The

Mission Statement of the Task Force was "To promote equity and excellence by providing a viable, humane and comprehensive educational policy framework and essential ingredients of a plan leading to the attainment of knowledge, values, competencies and skills which will equip each learner to function as a useful citizen" (MOE 1993, p.3). The Task Force Report also outlines the aims and objectives, and general philosophy on education development in Trinidad and Tobago and makes recommendations for adolescent education. I therefore view the analysis of this document as important to the discussion of educating adolescents for health and wellness.

- The Caribbean Charter for Health Promotion (CCHP)

The CCHP was adopted by Ministers of Health in the Caribbean including Trinidad and Tobago and provides a foundation for implementing WHO's Health Promoting School (HPS) Initiative. In Chapter 2, Review of Literature, I highlighted that the Health Promotion Approach includes strategies to address the multiple determinants of health. This was in recognition of the 'interplay' among social determinants of health, health status and education. There are many studies from around the world which have focussed on implementing and evaluating the Health Promoting School Initiative, some of which I have cited in Chapter 2. The HPS Initiative facilitates the application of policies, examination of the role of physical and social environments, promotion of health skills and collaboration among agencies (St. Leger, 2004). I have therefore included CCHP for analysis as a document developed in the Caribbean, with the potential to guide the HPS Initiative.

- The National Policy on Health and Family Life Education (HFLE)

This policy was chosen for analysis as the goals outlined in the document make direct reference to promoting health and well-being. According to the Policy, its goals are:

> ... to prepare children and youth in the context of school, family and community to take control of their health and lifestyle choices; promote the health and well-being of children and youth by encouraging policy and decision makers at all levels to integrate HFLE goals into the national agenda; implement in Trinidad and Tobago the mandate given by CARICOM

> [Caribbean Community] Ministers of Health and of Education in 1996 and the objectives underlying the CARICOM Multi-Agency Project (GORTT, 2001, p. 7).

In addition to what is captured in these goals regarding HFLE being placed on the national agenda, implementation of HFLE in schools has been part of national discussions for nearly three decades. However, as I pointed out in Chapter 2, Trinidad and Tobago has experienced challenges in establishing HFLE in the school system, while 'concerned citizens' continue to call for it to become part of the school curriculum. This is notwithstanding attempts by the Ministry of Health, in partnership with the Trinidad Office of the Pan American Health Organization, to introduce the HPS initiative. In my own practice as a Health Educator, I have collaborated with colleagues in the Ministries of Health and Education 'labouring' to find suitable approaches that would nurture adolescent health and wellness although there was a constant question lurking in my mind with regard to suitability of the approaches being utilised and the capacity of agencies and agents to apply these approaches. However, in spite of tremendous goodwill from Government Ministers and a range of senior professionals, we never got beyond the practice within schools of treating health and wellness as a pin–on to 'the real role' of the school.

3.3.1.2 Key Informant Interviews

Cohen et. al. (2000), describe interviews as a "social encounter" (p.281). Wellington (2000) however, sees the purpose of a research interview as being "to probe a respondent's views... the exchange should be far more in one direction than another...rather more than a conversation with a purpose" (p. 72). My own experience in interviewing my key informants is that as professional colleagues, we were at the same level and although my key role was to listen and probe, a more natural approach was to engage in an exchange of views, guided by questions I had developed but not limited to these questions. Interviews therefore took the form of frank conversations between colleagues (See Appendix IV).

Barbour and Schostak (2005) outlined key concepts in interviewing which they argue can 'problematise' the interview process. These include; "issues of position...Value...Trust...Meaning...Interpretation...and Uncertainty" (pp 42 – 43). Such issues may influence the interview process, when for example, the interviewer exerts power, or there is a perception of unequal power over the interviewee; similarly, differences in social position may impact on the interview process negatively and the value that is placed on the information will influence how the information is interpreted, as well as the meanings given to the information received are also open to different interpretations (Barbour and Schostak 2005). Thus, as the researcher, I had to bear all these factors in mind as I went through the interview process and engaged in conversation with my key informants. My approach was to gain the trust of my informants by making clear my intentions and establishing a rapport, using an informal approach and establishing common ground by identifying common interests and purposes. At the same time, recognising at all times that both interviewer and interviewee brought our subjectivities to the process. My experience in conversations with informants, who were all colleagues at some point in my professional career, was that of mutual professional interest.

Profile of Key Informants

Six Key Informants, three from the Ministry of Health and its agencies and three from the Ministry of Education were interviewed for this study. I have given all my informants fictitious names to avoid easy identification. Informants consist of four males and two females and are between the ages of forty–five and sixty years old. In the Ministry of Health, Alexis and Anna are two middle managers who head Units/Divisions of the Ministry of Health with mandates that include addressing the health and wellness of adolescents' and Allan is a middle manager/practitioner at the operational level. Allan works in one of the four Regional Health Authorities which provide health services to the population on behalf of the Ministry of Health.

From the Ministry of Education, Jason and Jill are also two middle managers. Jill, who has recently retired from the Ministry of Education, worked in the Curriculum Development Division and at present works with the Roman Catholic School Board for

Primary Schools. Jason works in a Unit which provides support services to students. Josh is a Primary School Principal with specialised training in Social Studies and Health and Family Life Education. He is also a pastor in a small church.

My choice of informants is based on my assumptions that these informants should be familiar with programmes addressing adolescent health and wellness through their practice. I have deliberately chosen not to seek information from those persons in the Ministries of Health and Education who are not directly involved in adolescent health and wellness. My hope is to be able to contribute to on-going work of my informants in addressing adolescent health and wellness.

Agencies represented by Key Informants

The following brief descriptions of the Ministries of Health and Education, and their agencies were obtained through their websites.

- Ministry of Health and its Authorities

The Ministry of Health (MOH) is described as the national authority with oversight of the entire health system of the country. Further, the MOH is said to have a central role in protecting the population's health and in ensuring that all health-related goods and services conform to standards of safety. Included among the core values of the MOH are client-centeredness, being responsive to consumer needs and preferences and relying upon research and information–driven decision making at all levels (MOH, 2010). The MOH has the responsibility of ensuring that health facilities are efficiently run by the Regional Health Authorities (RHAs). To achieve this, they have developed policies, goals and targets for the RHAs in relation to the assessment of health needs. Priorities of the MOH are listed as reducing the prevalence of communicable diseases, including HIV/AIDS and addressing chronic diseases and mental health.

Regional Health Authorities (RHAs)

RHAs were formed according to the RHAs Act no. 5 in 1994 (MOH, 2010). RHAs were made autonomous bodies to own and operate health facilities in specific geographical areas on behalf of the MOH. The RHA represented in this study has outlined as its vision

as a dynamic, people-focused, quality driven health care organization providing comprehensive health care in a safe and healthy environment. School Health is listed among the twenty-two types of services the Health Centres of this RHA provides.

The Health Education Division (HED)

The HED was established as a vertical programme of the MOH in 1943. The Health Education Division includes in its mission, education through the provision of information and skills to enable individuals and communities to take responsibility for their health and to mobilise communities for the creation of an environment which promotes wellness (MOH, 2010). School Health Programmes are included among the list of functions of the HED.

The Population Programme Unit (PPU)

The PPU is also a vertical programme of the Ministry of Health and was established in 1969, to facilitate the delivery of fertility and management services. Today, the PPU's stated mandate is to provide Sexual and Reproductive Health (SRH) Services through all the primary care facilities in the country. In its list of additional services to be offered are adolescent, youth and SRH services (MOH 2010).

- Ministry of Education (MOE) and its Divisions

The Ministry of Education is the national authority with responsibility for oversight for education from Early Childhood to Secondary Level. Another Government Ministry, the Ministry of Tertiary Education, Science and Technology is responsible for tertiary level education. The MOE includes in its Vision and Mission statements, the intention to be a pacesetter in the holistic development of individuals through an education system which enables meaningful contributions within the global context and to lead the modernisation and renewal of the system of education (MOE 2010).

Within the organisational structure of the MOE are Divisions and Units which include the Curriculum Development Division and Student Support Services where two of my key informants practice.

The Curriculum Development Division (CDD)

The CDD is said to be placed at the 'heart' of the Ministry of Education. Core functions are described as designing, developing, implementing, monitoring, evaluating and reviewing curricula that are appropriate and relevant to the needs and interests of developing/interacting in a globalized context (MOE 2010). The CDD describes its role in performing these functions as assisting teachers in implementing classroom teaching and learning activities which reflect national goals. Additionally, the CDD has highlighted its role in contributing to the achievement of our national goals for education and to the attainment of first-world status by the year 2020 (MOE 2010).

Student Support Services (SSS)

Student Support Services Division is a relatively new Division of the MOE, having been established in 2004. Its present structure represents a combining of its former unit, Central Guidance with Special Education Units and a School Social Work service which functioned at the primary school level. The Mission of the SSS is outlined as to provide ongoing support for all students to maximise their learning potential, do well at school, to achieve their capabilities and develop holistically (MOE, 2010). In addition, the SSS lists very specific goals which are worth noting here as they relate to what my research study is seeking to investigate. These are identified below:

- Increase student success by providing support through counselling and specialised intervention strategies for students on extended suspension and other at-risk students.

- Increase student success by providing specialised services for students with moderate and severe special educational needs as well as mainstreamed students with special educational needs.

- Increase student success by providing social work services for students with psycho-social and behavioural difficulties at selected primary schools in each educational district.

- Increase student success by providing support through early intervention, diagnosis and remediation for selected primary schools in each educational district.
- Increase student success by providing guidance and counselling services for all students at the secondary level (MOE 2011).

I expect that my conversations with my Key Informants from the Ministry of Education would allow me to probe the relationship between the stated goals of this Division of the Ministry of Education and what actually happens in schools and classrooms. I also expect to gain insight into how the Ministry of Education relates to other Ministries and organisations which serve the health and wellness needs of adolescents.

Negotiating Interviews with Key Informants

The process for making appointments with Key Informants began with a telephone call to discuss with them the research I was embarking on and to solicit their participation and set up an interview date. I met with each informant from the Ministry of Health at the end of the workday, however in the case of each interview with MOH informants, we had to pause occasionally for my informants to receive phone calls and in one case the informant had to leave the interview for a few minutes so that she could meet with a colleague in another department. That meeting was said to be urgent as the MOH was responding at that time to the threat of the H1N1 flu. On that day, I noted in my field notes the anxiety and energy linked to the H1N1 response and reflected in my own thoughts how dramatic and visible issues continue to be treated with urgency by the MOH, compared to other health issues that were not as visible. In spite of this particular interruption, my informant came back and was willing to continue the interview. I was however sensitive to the fact that it was now late in the evening and sought to quickly complete that interview. She however agreed, as did all my informants, that we would make contact by telephone should it become necessary.

Of the three informants from the Ministry of Education, I met only one of them at the workplace and he offered the interview time of seven in the morning, which was the time before the official start of the workday. His explanation was that that was the only period

of the working day when his time is not cut into pieces by a multitude of criss-crossing seemingly urgent activities and requests. In spite of this, the interview was interrupted by a few phone calls and a staff member came into the office while the interview was taking place. One other Ministry of Education informant was visited in his home because he did not believe that his workplace in a school setting would have provided a suitable environment. The third informant suggested that the interview take place at my home.

All interviews began with my greeting informants and providing an overview of my research study. I then gave them the information sheet to read and consent form to sign if they were in agreement with what was required of them. Each interview lasted between one and a half hours to two hours. My opening question dealt with their background and professional development. All interviews were audio recorded with permission from my informants; however I took notes not only of what was being said but also the non-verbal communication and other incidents.

3.4 Ethical Considerations

In embarking on this research, I have ensured that the methods or procedures used and the report of my results would not cause harm to my key informants or their agencies. It was made clear to all my informants that my research was being conducted as part of the requirements to obtain an academic qualification and materials used would be strictly confined to that purpose. I also highlighted that although I am a major beneficiary of this exercise, it was my expectation that my research would benefit others. I added that my hope was that my conversations with them would provide the opportunity for reflection on ways in which addressing education of adolescents for health and wellness can impact on their work and the lives of their students.

I also alerted my informants of the possibility of persons guessing their identities, since in our small society, their work and professional designations may be recognized and linked to them. I was guided by the definitions of ethics which highlight the avoidance of harming or wronging others and being respectful and fair; but also promoting good so that there are positive benefits to informants participating in the research (Cohen et.al 2000, Piper and Simons 2005). The relationship established between my informants and

myself as researcher is therefore based on mutual respect and a mutual understanding of the principles central to academic freedom.

In approaching my key informants, I enquired of their willingness to participate as individual senior professionals in their field. I shared with them the information sheet outlined in the Appendix which was approved through the University of Sheffield's Ethics Review process. I also enquired from them whether anything in the content of the information sheet needed clarification and requested their signature as their consent to participate. I obtained their written permission to record the interview as well as to take detailed notes, assuring them that the information would be used solely for the purpose of this research exercise. I explained that the information received would be treated as confidential.

3.5 Insider Research

Although I am not employed at either the Education or Health Ministry at this time, I consider myself as an 'insider' as described by Sikes and Potts (2008), having "an a priori attachment to and involvement with, the institutions or social groups in, or on, which (my) investigations are based" (p.2). This may be an advantage in my being able to easily access my informants. However, there may be disadvantages if my familiarity with my research environment leads to bias. Louisy (1997), in her experience in conducting research in an institution with which she was associated in her homeland of St. Kitts, claims that: "Concentrating on in-depth interviews and documentary analysis as methods of inquiry seemed to lessen the probability of bias associated with insider research" (p. 202). Like Louisy (Ibid.), in undertaking research on this particular topic, I am delving into an area in which I have been involved over much of my professional life, so it is also a self-critical exercise. It is also an exercise where I am seeking to interpret what occurs in the Ministries of Health and Education and the role the 'actors' play in these 'worlds'. I am not aiming to 'objectively' observe, nor measure, nor try to ascribe causality for actions. Rather, explanation is being replaced by interpretation and understanding (Ricoeur 1981). I therefore acknowledge my subjectivity and affirm my purpose to contribute to improvement in the approach to addressing adolescent health and wellness. Further, in researching the familiar to 'make the familiar strange,' I have chosen methods

which I believe allow me to explore and dig deeper to find out what lies beneath the familiar.

3.6 Frameworks for Analysis

My approach to analysing my findings is related to hermeneutic traditions which claim that:

> ... interpretation is holistic and circular: *holistic* because any part of the text or message to be interpreted is dependent on the interpretation of the whole; and *circular* because any interpretation rests on a prior interpretation, that is a pre-interpretation, pre-conception, that orients and structures the interpretive act
>
> (Medina 2005, p.79 original emphasis).

I acknowledge that in analysing my findings, I am interpreting the interpretations of those who wrote the documents and those who shared information during the interviews. I also acknowledge that the ways in which information is communicated and the language used are important to the process of interpretation.

First step in the analysis process was to extract data from the documents utilising the guide in (See Appendix V for data extracted) and to transcribe the information obtained from the Key Informant Interviews. Interviews were not transcribed verbatim but capturing the main points as I heard them, including statements where informants spoke with emphasis (See Appendix VI - transcript). I acknowledge that even in this first step of my analysis I am bringing my own world view in how I represent the data.

I approach my analysis using Fairclough's (1993) Critical Discourse Analysis (CDA) and "the way discourse constructs and stabilises versions of the world" (Potter 2009, p.610). Additionally, I focus on Foucault's (1972, 1977, 1991, 1997) genealogical side of discourse and the history of the present. Foucault (1977) posits that:

> ... if the genealogist refuses to extend his faith in metaphysics, if he listens to history, he finds that there is 'something altogether different' behind things: not a timeless and essential secret, but the secret that they have no essence or that their essence

> was fabricated in a piecemeal fashion from alien forms (p.142)

Further, "a body of anonymous historical rules [is] always determined in the time and space that have defined a given period, and for a given social, economic, geographical, or linguistic area ..." (Foucault 1972, p.117). I therefore analyse documents and interview transcripts, to explore those 'historical rules' and 'fabrications' underlying meanings given to adolescence, education, health, and roles and responsibilities of health and education professionals.

Further, I explore how these meanings contribute to the production of discourses which becomes institutionalized through internal rules, exercising their own control (Foucault 1972). I examine how practices in both documents and as related by Key Informants, become established and specialised "with the aim of grasping the conditions which make these acceptable at a given moment... a question of analysing a 'regime of practices' – practices being understood here as places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect" (Foucault 1991, p. 75).

In analysing documents, I recognise that I am required to go beyond the stated functions of the document, since texts are also representative of social action related to established social structures. According to Fairclough (1992), texts " ... constitute a major source of evidence for grounding claims about social structures, relations and processes....Texts provide evidence of ongoing processes such as the redefinition of social relationships between professional and publics, the reconstitution of social identities and forms of self, or the reconstitution of knowledge and ideology" (p. 211). However, it is important to note that my use of 'texts' is slightly at variance with the interpretation of texts proposed by Fairclough. I employ a version that accepts a wider variety of texts and their capacities in professional, social and intellectual life in the context of Trinidad and Tobago. For example, text may come from spoken reports and reports that are not included in formal institutional processes, yet still provide evidence about 'social structures and relationships'. Therefore, I pay attention to what Key Informants say

about documents produced by their institutions and the role of these documents in their practice.

My expectation from my conversations with health and education professionals is to explore the genesis of their perceptions of their many-sided roles in educating adolescents and the extent to which they are influenced by the history of the system in which they function. I examine whether health and education professionals contribute to maintaining the established system and whether this is also reflected in the documents which inform practice in the Health and Education Ministries.

It is therefore important for me to be able to identify in my sources of information, what are the dominant issues which are revealed about what defines the parameters of education and health for adolescents in Trinidad and Tobago and how this came to become:

> ... interconnected networks of social practices [which] allow one to combine the perspective of structure and the perspective of action – a practice is on the one hand a relatively permanent way of acting socially which is defined by its position within a structured network of practices, and a domain of social action and interaction which both reproduces structures and has the potential to transform them (Fairclough 1993 p. 122).

The assumption is that knowledge can be created based on the practice of those who are seen as the dominant forces of society, for example, males; or the views of those who have responsibility for particular kinds of knowledge in society, such as health and education professionals and representatives of Religious Organisations who monitor the adherence to morals and values of our society. My intention is to explore how these forces interconnect and the "genealogy of morals" related to how the education of adolescents is approached (Foucault 1991, p. 74).

3.7 Conclusion

In this Chapter I have focussed on the methodology or my approach to this research process; the methods or techniques used to obtain information and the frameworks for analysis. I have located my approach in an interpretive paradigm, based on Social Constructivists' theories of knowledge. At the same time, I am also influenced by the fact that in any institution, dominant realities emerge and it is important to understand how this came to be so. I have related my approach to my personal experiences and the particularities of a small developing country to the use of methods of analysis that are eclectic rather than confined by theoretical boundaries. I have utilised Fairclough's (1993) Critical Discourse Analysis and Foucault's (1972, 1977) Discourse Analysis, and the concept of genealogy which will guide my analysis of the findings of my research. The following Chapter will describe my interpretation of the information I have obtained, guided by the methodology outlined in this Chapter.

CHAPTER 4 – REPORT AND ANALYSIS OF RESULTS

4.1 Introduction

In interrogating the information obtained from documents and interviews, my quest has been to answer the research questions formulated at the start of this study. However, my experience in this process has taken directions not anticipated at the time the questions were developed. Research questions were developed to identify concepts and principles for addressing adolescent health and wellness, as well as utilisation and interpretation of identified documents by health and education professionals. The key research question focuses on health and education professionals' perceptions of their roles in addressing health and wellness. In seeking to answer these questions, issues related to the history of Trinidad and Tobago as a young nation and the history of the education system in particular, have surfaced in my readings as well as in the findings from the documents and interviews. In addition, in my review of literature and introduction to educational theories and practices, I have been exposed to paradigms which in the past I would have thought were beyond the boundaries of my familiar domain of Public Health. These revelations have increased awareness of the expanse of disciplines which have influenced the evolution of education systems in different parts of the world, including Trinidad and Tobago.

Further, my journey in education research has shown me how engaging in social research can assist in exploring the multiple determinants of health in general and the social determinants of health in particular. My introduction to Critical Discourse Analysis (CDA) and Discourse Analysis (DA) as methods of analysis has also come with my present research journey and has assisted me in my attempts at answering the 'what' and 'how' through the research questions developed for my study. Thus, in looking at perceptions of adolescence and education for health and wellness, I am also seeking to find out how these perceptions were formed.

In the previous Chapter on Methodology and Methods, I stated that my data sources are from documents from the Ministries of Health and Education, and from Key Informants from these two Ministries. I also stated my intention to employ Focault's (1972, 1977,

1991, 1997) Discourse Analysis (DA) and Critical Discourse Analysis as described by Norman Fairclough (1989) in my analysis. I begin this Chapter with the report and analysis of the documents which will be followed by the report and analysis of the information received through Key Informant Interviews.

Three documents were selected for analysis: The Report of the National Task Force on Education (1993), Ministry of Education; The Caribbean Charter for Health Promotion (1993), World Health Organization/Pan American Health Organisation; The Health and Family Life Education Policy (2001), Ministry of Education. Although all these documents have official ownership as stated above, responsibility for the production of the documents and actual implementation are more complex, as I will show in the analysis below.

4.2 Report and Analysis of the Report of National Task Force on Education: Trinidad and Tobago (Ministry of Education [MOE] 1993)

This report was prepared by a task force appointed by the then Prime Minister of Trinidad and Tobago in 1990, "to develop a comprehensive policy framework and the essential ingredients of a Plan for Educational Development over the next decade" (MOE, p. i). According to the Terms of Reference, the Task Force would "clarify the role of the education system in realizing [the Government's] vision of the society of Trinidad and Tobago...and adjustments to the system which are necessary to take the society into the twenty-first century" (MOE, p.vii).

In looking at this seminal document for education in Trinidad and Tobago, I focus on what is revealed about educating adolescents, the purpose of education, collective action and collaboration in education. I explore the language used in the Task Force Report and whether the use of language is linked to what have become dominant socio-political discourses in education in the past and present in Trinidad and Tobago. Further, since this Report has been used to guide other policy documents in education, I explore how what is stated in the Report relates to the Post Colonial experience of Trinidad and Tobago

4.2.1 Educating Adolescents

The National Task Force on Education was charged to prepare a 'Comprehensive Policy Framework' for education. Members of the Task Force acknowledge in the Report the need for schools to go beyond academic pursuits. For example, a recommendation was made that, "Curriculum engineering should ensure that new curriculum issues in Health, Human Sexuality, Family Life, Political, Social and Environmental Activities, Disaster Management are infused in existing curricula" (MOE, p.43). However, what is stated in the Report has not been followed in practice; in the year 2010 this had yet to take place as the required human and other resources were not provided to implement this recommendation. With regard to the education of adolescents, there appears to be an inconsistency between identifying adolescence in the context of the life cycle and ways in which adolescents are characterised in the Report. Adolescence is described as "The Middle Years [which] mark very critical transition points in the life of an individual" (MOE, p.145). At the same time, adolescents are described in the Report as 'problematic' with the education system being charged to address the "inherent problems of adolescence" (Ministry of Education MOE, p.197). According to the Report, there exists a "pervasiveness of a number of problems associated with adolescence and its expression in indiscipline among students [which] need to be urgently addressed" (MOE, p. 197).

The use of the words "inherent problems" gives an indication of the tone that is being set for the approach to educating adolescents. It demonstrates a limited approach to the education of adolescents focussing on the "deficit view" of adolescence (Lerner and Steinberg 2004 p. 7); rather than an approach that acknowledges "the system of relations between individuals and contexts that is at the core of the study of human development" (Ibid.).

The stated objective of the Report refers to an education system that would ensure the achievement of personal goals in addition to obligations to society. At the same time, personal goals appear to be secondary to what may be viewed as wider national and societal needs.

A review of the list of the twenty-three members who prepared the Report reveals individuals with years of experience in a diverse sphere of academia who had been involved in writing previous education reports. The profile of the membership gives a particular status to the Report, as well as maintains the practice of involving religious groups in education. Other educators and parents, myself included, on reading this Report would recognize the writers as persons who may have influenced our lives and careers - university lecturers, practitioners in the field of psycho-social development, and a Roman Catholic Priest and Nun who were heads of education institutions. Therefore, the dominant discourses in this report which include the role of education in producing useful citizens who would contribute to nationhood would be acceptable to those teachers and parents who have similar interests which support the existing social order. The pedagogical outcome of such dominant discourses may in the end reflect "the conscious or unconscious cultural choices which accord with the values, beliefs and interests of dominant groups at a particular time" (Young 1999, p. 67). The question then arises as to whether the writers of the Report are merely representing the values of those ministers and their affiliates who selected them and outlined their Terms of Reference. An example of the Terms of Reference include; "to clarify the role of the education system in realizing [the Government's] vision for Trinidad and Tobago and spell out a *philosophy* which would underpin the education plan" (MOE, p. vii; my italics).

Further, there are two issues I wish to highlight in relation to what I view as the philosophy which underpins the education plan. First, within the Task Force Report the repeated call for nation-building and nationhood indicates a subtle struggle between issues of nationhood and issues of maintaining religious domination in education. The role of Religious Organisations in education in Trinidad and Tobago was introduced in Chapter 1of this thesis and will continue to be discussed as I explore the purpose of education and how religion relates to adolescents' education. Historically, "at any period in the pre-independence history of the country, denominational boards would have been found to own and control more Secondary Schools than the State did" (Jules 1994, p.2). Today, Religious Organisations, continue to work to preserve the 'religious character' of

their schools. This is an issue I referred to in Chapter 1, and which continues to characterise our present system.

The call to a national consensus also serves as a necessary preamble to address this divisive factor in the education system in Trinidad and Tobago. The other issue is that those of us who have 'benefited' from education and function as 'successful' members of our society have difficulties looking at our education system critically to examine whether it serves the needs of all children today. I make the distinction between all children and our children, in that the children of members of the Task Force for example, are likely to be among those children of the nation who 'make it' in the system and would have had a different education experience from children with lower socio-economic status. In Chapter 1, I highlighted that in the early history of the development of education in Trinidad and Tobago, education was meant for only children of a particular race and class, but even when access to education was expanded, the curricula also differed for different groups in society. Today, we still do not have an education system that is capable of facilitating the positive growth and development of all children.

The academic training and professional experience of task force members however, should have contributed to ensuring that the education plan would be more student centered, acknowledging the developmental needs of students as well as nation-building needs. When the dominant discourse is nation-building, there is the potential to exclude those students who may not have reached the developmental stage to have the capacity to be part of this movement at this particular time in their social and emotional development. The report also does not make a distinction between developing people and developing a nation. Nation-building as a dominant discourse in education may be what is expected at a particular period in the history of Trinidad and Tobago. Most Trinidad and Tobago nationals are familiar with a famous quote of the first Prime Minister of independent Trinidad and Tobago, the late Dr. Eric Williams, often repeated by politicians and calypsonians, which profess that 'the future of the nation is in the book bags of the nation's children.' Thus "the idea of nation-building has been at the centre of

the discourse ... [and] tension between the nation as peoplehood and the nation as state" (Harney 1996, pp 6 &10).

The Report states that "The future of Trinidad and Tobago demands a philosophy of education which stresses the need to be relevant to each individual in the process of schooling" (MOE, p. 5 original emphasis). However, the Report also characterises adolescents as problematic and this compromises the philosophy of relevance to each individual, if there is a lack of understanding or appreciation of the developmental needs of adolescents. Thus, if the education system is to ensure the achievement of personal goals of the adolescent, then the discourse as it relates to adolescent education would have to include how physical and social environments may be made supportive of adolescent students, with less emphasis on education for creating 'useful citizens'. This would require an understanding of how the environments in which adolescents are placed can complicate or facilitate the adolescent life experience. The focus would also be on the family as well as, the geographical, historical, social and political setting in which the family is living. Environments are facilitative when there is a "goodness of fit" between adolescents and their environments (Coleman and Hendry 1999, pp 12 – 13).

4.2.2 Purpose of Education

The view that the purpose of education is for nation-building is highlighted in both the Terms of Reference of the Task Force and in the Mission Statement of the report of the Task Force. Reference is made to the role of education "in *realizing* [the Government's] *vision* of the society of Trinidad and Tobago" (MOE, p.vii; my emphasis). There is an aura of patriotism created in the Report, where members of the population are being called upon to be part of a movement. Those who are part of the education system, those who will become "*useful citizens*" (MOE, p.3) and those who should be aware of the relationship between education and "the development of the national community of Trinidad and Tobago" are called upon to "*serve*" (MOE, p.6). Thus the Mission Statement speaks to equipping "each learner to function as a useful citizen" (MOE, p.3). There is also a sense of "*obligation*" for all who are involved in education; "every child

has an inalienable right to an education which facilitates the achievement of personal goals and the fulfillment of the obligations to society" (MOE, p. 5).

In the context of the management of the education sector, the language continues in that same vein, "those who manage the system...must all be *seized* of the fundamental and critical importance of their collaboration" (MOE, p.9 my emphasis). The language which I have italicised above, contributes to the creation of a sense of collective service to nationhood. This is also highlighted in the call for education professionals to share and be guided by a particular set of beliefs and values in relation to education:

> ... the Educational System must be served by professionals who share and are guided in their operations by a set of systematic and incisive understandings, beliefs and values about education in general and its relationship to the development of the national community of Trinidad and Tobago (MOE, p. 6).

Language used in the Report has the potential to influence how society views the purpose of education, while at the same time the language is influenced by social practice. This is illustrated in language which reflects a particular social practice and contributes to the creation of a social reality (Fairclough 1989). The practice may result in the creation of a particular identity and purpose of education and the language used in the Report thus contributes to maintaining a 'social order', with the education system being instrumental in maintaining that order (Berger and Luckman 1966). Berger and Luckman (1966) also emphasise that social order is a product of human activity, past and present and so the purpose of education reflected in the early history of education in Trinidad and Tobago is being maintained in education practice today. However, it is difficult to believe that the members of the Task Force were not conscious of the existing tension in the Secondary Education system which is bifurcated into secular and denominational schools and the latter do not necessarily have to follow government's directives and vision on education.

The belief that education also serves as a means to an end is revealed in the context in which the development of the policy framework is placed, "at a time of uncertainty in our

economic and social development [and] the case for education as investment" (MOE, p. 10). In this context the Report defines what is termed:

> Essential Curriculum Goals of Secondary Education
> ...understanding of self, family and society, values and ethics, human sexuality, health, recreation, aesthetics, work, mathematics,' science and technology, consumer education, entrepreneurial and problem solving skills and information literacy
> (MOE, p.42).

Among the several content areas in the curriculum that relate to personal development of the student, the Report identifies areas that the writers of the Report claim prepare students for "contemporary society" which they classify as a "More Relevant Curriculum: An emphasis on technology studies, entrepreneurship training together with the inclusion of courses on human and social values" (MOE, p.217). The paradox here however, is that having a curriculum that includes social values does not compensate for the fact that the dominant forces in society are not addressing those social and economic issues of the country which prevent some members of the student population from benefiting from an education system that responds to individual differences from a mainly 'remedial' approach. This is demonstrated in the approach to educating adolescents outlined in this Report. Foucault (1991) refers to "lines of transformation of what one might call 'moral technologies'" (p.74) which question how for example, perceptions of adolescence become linked to deviance, how deviance is defined and decisions made to educate adolescents within this context. The result is the normalisation of adolescence characterised by deviance, which makes the remedial approach 'acceptable'.

4.2.3 Collective Action and Collaboration

The National Task Force Report calls for collective service and the language symbolises the noble intentions of those who answer the call to participate. The writers of the report would have been aware that these sentiments would find favour with dominant groups in society in Trinidad and Tobago at that time. London (2003) makes the point that in the 1993 Task Force Report:

> A major departure from previous reports is the input from private individuals and dissenting coalitions ... their contribution informs the Report's knowledge base and provides perspectives on its political and ideological orientation. But despite the hearing given in marginal groups, the Report was promulgated by the nation's political and economic elite ... [the Report] could not be divorced from the socio-political and economic thinking that requested it (p. 12).

At the same time, as I have highlighted earlier, the Task Force Report includes recommendations for curriculum content and implementation, including collaborative efforts and these recommendations appear to be based on a technical as opposed to an ideological approach. However in practice, the fragility of collaborative efforts may in fact be linked to ideological principles which determine what subject areas are included as part of the core curriculum.

The Report calls for partnership in determining goals and objectives, in implementation and in "internal self examination as well as external examination of the operations of the [education] sector" (MOE, p.12). The Health Ministry is identified by name among a list of 13 support organisations that are recognised as essential to the delivery of quality education. The Report recommends "Dialogue between these organisations and the schools through meetings" (MOE, p.216). However, when the call for collaboration is made in the context of education for adolescents, it is not as part of the core curriculum. Addressing the 'problems' of adolescents is not perceived as central to the education process, but rather in the manner of sporadic 'add on' programmes to fix the problems. In later policy documents, as I will show in this thesis, addressing adolescent health in the core curriculum is articulated but is not manifested in practice. On the one hand, the present document refers to "early adolescence [when] changes...manifest themselves in social, emotional, moral and spiritual strivings of the young adolescent..." (MOE, p. 145); and "human resources development as a permanent priority" (MOE, p.9 original emphasis). However, on the other hand, the Report highlights in its "contextual concerns...the case for education as investment that enhances economic productivity..."

(MOE, p.10). Thus, the case of producing 'useful citizens' highlighted throughout the document, would need to be defined.

4.2.4 Post-Colonial and Globalisation Influences in Education

The choice of particular subject areas as part of the core curriculum in present times is related to the early education system in Trinidad ahd Tobago. In reviewing the history of the development of education in Trinidad and Tobago, I highlighted that Secondary Education was established to serve a particular purpose, which included preparing students to write the Cambridge Examinations to go to the United Kingdom on Scholarships, or in a Tobago example, to obtain skills which were needed by the island at that time. Further, the education system was serving students from a multiplicity of ethnic and religious backgrounds, so that over the post -colonial and post - independence years, and with the influence of globalisation, there have been on-going changes to the education system. In spite of the changes, there are some characteristics in education related to our colonial experience that persist, complicated by the continued reliance on multi-lateral and bi-lateral agencies for financial and technical support, in the planning and implementation of education reform initiatives. Our Secondary Schools remain stratified and the more 'successful' schools continue to school children from the dominant groups in society and from groups of higher socio -economic status.

The question arises as to whether the Ministry of Education in Trinidad and Tobago should follow the recommendations of the Task Force, which were meant to 'take the society into the twenty-first century', but which in reality reflected the aspirations of a group of education planners who are themselves products of colonial and early post-colonial education? A famous writer, born in Trinidad and Tobago once made the statement; "To be a colonial was to know a kind of security; it was to inhabit a fixed world" (Naipaul 1974, p. 233). Foucault (1967) challenges us to understand "how two events can be contemporaneous ... In trying to make a diagnosis of the present in which we live, we can isolate as already belonging to the past certain tendencies which are still considered to be contemporary" (p. 92).

However, as challenging as it may be, education planners will need to acknowledge and articulate "the deep implications of colonial imagination on education and learning systems on the one hand, but also [create] opportunities, glimpses and insights into post-colonial discontinuities and aspirations for decolonising practice" (Lavia and Sikes 2010, p.87). This is necessary if education is to respond to the demands of an ever changing Trinidad and Tobago society and to ensure social justice and fairness in access to education.

4.2.5 Summary

The expectations for the education sector as outlined in this Report are many, including recommendations for a "more relevant curriculum [to] provide a more adequate preparation of students for the work role and broader social challenges in contemporary society" but in a context that prioritises economic development (MOE 1993, p. 217). Reference is made in the Report to the education system having failed in the past to integrate health and wellness and the need for collaboration. However, reference to failure only highlights the inability to recognise the challenges of meeting such expectations within the existing structure and organisation of the education sector. Young(1999) refers to the concept of "stratification of knowledge...[and]suggests that the stratification of knowledge is not only deeply implicit in our ideas of what education 'is'...the degree of stratification of knowledge is a social and historical product that can change"(p. 65). Thus, the Task Force Report was prepared at a particular period in the history of Trinidad and Tobago as a young nation, with the expectation that it would guide future approaches to education which would contribute to nation-building. My concern however, is that although the Report refers to the achievement of wellbeing, to be included in future approaches to education, this is secondary to traditional academic subjects.

4.3 Report and Analysis of the Caribbean Charter for Health Promotion (CCHP) (PAHO/WHO1993)

In Chapter 2, the Review of Literature, I introduced CCHP as a document which has guided the implementation of the Health Promoting School initiative in Trinidad and

Tobago. CCHP was developed at the First Caribbean Conference on Health Promotion and was fashioned closely to the Ottawa Charter for Health Promotion (1986). The Ottawa Charter was formulated at the First International Conference on Health Promotion to guide action that would contribute to the achievement of "Health for All by the year 2000 and beyond" (WHO/HPR /HEP /1986, 95.1).

In analysing the CCHP, I review what has been defined as the rationale for Health Promotion in the Caribbean; how the health of Caribbean populations is described and determinants of health identified. I also explore what this document sets out to achieve, the expectations as outlined in the document, of those who should implement the Health Promotion approach, and the assumptions of such participation. In addition, what are the implications for addressing adolescent health and wellness? In exploring these issues, I examine the use of language and its relationship to dominant discourses on health and historical approaches to health as illness in the Caribbean.

4.3.1 Rationale for Health Promotion

The CCHP begins by identifying the individuals responsible for producing the document and immediately establishes that policy makers at the highest levels had initiated the process. The language of the document communicates the concept of 'high level policy-making.' The CCHP states that Government Ministers in the Caribbean with responsibility for health "seized of the relevance of Health Promotion...called for the development of a Caribbean Charter for Health Promotion" (CCHP, p.1). Definitions of the term 'seized' such as "to take hold of suddenly and forcibly" and "understand clearly and completely" (http:/dictionary.reference.com), convey a sense of urgency and sudden realisation and create a particular context for the need for a Health Promotion approach.

The writers of the CCHP are described as individuals from "the health and other kindred sectors, and representing the Social Partners active in Caribbean life" (CCHP, p.1). CCHP highlights among its stated opportunities, "the uniqueness of [Caribbean] culture, its racial and religious tolerance, its recognition of the valuable role of family and friends" (ibid). This is notwithstanding that at the time of the formulation of the Charter,

globalization and urbanisation were challenging the traditions of Caribbean nations and influencing the health problems of their populations. Thus, the CCHP justifies the urgency of the formulation and application of the Charter:

> Urgency of action is heightened not only by the changing patterns of health problems of the people, but also by the adverse effects on their wellbeing, of the structural adjustment programmes that their economies have undergone (CCHP, p.1)

Further, CCHP outlines the multiple determinants of health, stating, "the health problems of today and tomorrow [in the Caribbean] are increasingly complex and evermore related to social, economic and behavioural factors, [thus there is a need for] a new approach" (ibid). Health Promotion is defined as the new approach to addressing these factors and the health of Caribbean People as compared to a bio-medical approach. CCHP makes clear the extent of its expectations for addressing health and cites the definition of health as "physical, mental, social and spiritual well-being" (CCHP, p.1). This is in keeping with the World Health Organisation's definition that goes beyond the absence of disease.

CCHP recommends that "Ministers of Health [in the Caribbean] should adopt this Charter and so strive and work in collaboration with all the relevant social partners to take actions than can transform this Charter into a living instrument"(CCHP, p.3). This communicates to me that the Charter is expected to spur action through a dynamic Health Promotion approach. According to CCHP, the approach should be a "multi sectoral, multi disciplinary formulation of healthy public policy" (CCHP, p.2), and that there should be an "imperative reciprocal relationship between the media and health related sectors" (CCHP, p.3). In my experience as a Health Educator in Trinidad and Tobago, there has been an on-going debate about the role of the print and electronic media in communicating health related information in a way that would impact positively on their target audiences. In keeping with this discourse, the CCHP directs , governments "to achieve a healthy, physical, social, economic and political environment [and] media ...to bring their considerable power and influence to bear on the formulation of policies and programmes that affect the health of the people"(CCHP, p.3).

CCHP seeks to guide the approach to applying its six strategies and recommends that in applying the strategy of developing health skills for example, users should recognise "the critical importance of early childhood education and take account of the values, beliefs and customs of the community" (CCHP, p.3). My experience, as part of the leadership of the Health Education Division of the Ministry of Health in Trinidad and Tobago for the first twelve years after the formulation of the CCHP, has been that only a small number of health care providers utilised CCHP to guide activities. The concept of the health professional giving attention to community challenged their roles as health experts. Interrogating such institutionalised beliefs and exploring the operationalising of the CCHP became the responsibility of a group of health professionals functioning outside the traditional health institution. Thus, the Health Education Division was given the responsibility for operationalising the Charter. Therefore, we were responsible for sensitising both our health and non-health sector partners to the CCHP and the Ministry of Education was viewed as a major partner. Later on in this Chapter, I will return to a discussion on how traditional perceptions of health by health professionals as well as educators relate to their perceptions of adolescent health and wellness.

In fulfilling our responsibility, Health Educators, who like myself have applied this framework to our health and wellness programmes in schools, would not have considered the issues which have become evident to me as I revisit CCHP through a researcher's lens and which I discuss in the following sections.

4.3.2 Collective Action and Collaboration

The CCHP posits that health is a resource for living and calls for collective action; acknowledging that 'health problems' in the Caribbean today are related to multiple determinants, including social determinants. I view this call for collective action as being based on two different premises; the first is that there are multiple determinants of health, therefore requires a multi-sectoral approach to achieving health and wellness. Related to this premise, is the view that health is a resource for living and that the health status of Caribbean people is determined by existing "social, economic and behavioural factors"

(CCHP, p.1). CCHP is communicating that health has become an input, another reference to seeing health not just as an absence of disease. Secondly, the CCHP makes several references to 'community action' and the 'tradition of the extended family,' the implication here is that in the Caribbean there is a tradition of working together. Such choice of language may not be "merely a reflection of expression of social processes and practices, it is a *part* of those processes and practices" (Fairclough, 1989, p. 23, original emphasis). Thus, the dominant discourses point to the virtues of Caribbean nations such as family life and cooperation, sisterhood and brotherhood. Within this context, Caribbean people are asked to "assume more control and improve their health" (CCHP, p. 12). However, the discourse does not focus on action necessary to engender a facilitating political, social and economic environment required for individuals to control and improve their health. This is not unlike the neglect in discourses in the education system that relate to the social determinants of students' ability to benefit from the existing education system.

The CCHP's call for community action and focus on family traditions was taking place at a time when in the Caribbean, including Trinidad and Tobago, 'traditional' families seemed to be under threat. For example, in Trinidad and Tobago in 1997, it was reported that 513 domestic violence cases were referred to Probation Services by the District Courts and it was indicated that there may have been gross under reporting (PAHO 2008, p. 9). Further, a new phenomenon had emerged in the 1990s of parents migrating to North America and the United Kingdom, and sending remittances to their children who were left behind in the care of their teenaged siblings or elderly grandmother (Bakker et.al 2009). New diseases such as HIV were also calling attention to the fragility of the family and the inability of families to cope with the stigma and discrimination associated with living with HIV. Yet, there were no revolutionary national policies related to social and economic development to address these social dysfunctions. Who then would undertake the role of guiding community action, could health professionals reorient both their approach to health and wellness and how the health system is organised as recommended in the second strategy of the Charter for Health Promotion? As will be

seen in the following section which looks at health in the Caribbean, the health issues appear to demand this reorientation.

4.3.3 Health in the Caribbean

Public Health reports, during the period of the formulation of the CCHP, highlight that: "A violent culture is taking root in the wider Caribbean. The threat that this development poses to PHC [Primary Health Care] is very real and direct" (Mullings and Paul 2007, pp. 159 – 160). Reports in Trinidad and Tobago state: "Violence (criminal and domestic) is considered to be a social problem which is increasingly contributing to mortality" (PAHO 2008, p.9). Additionally, diseases like HIV and Chronic Non-communicable Diseases (CNCDs) were affecting populations through their most productive lives (University of the West Indies 2009). Calculations made in the year 2001, on the cost of HIV and AIDS "predicted significant impact on GDP, principally through reduction in labour supply" (CARICOM/PAHO 2005, p. 6).

There was the increasing recognition among Public Health practitioners that the Caribbean was experiencing new social determinants of health and that; "With the adoption of a Caribbean Charter for Health Promotion, the Caribbean is being challenged to look more deeply at the fundamental determinants of health and to tailor programs to address these issues" (Mullings and Paul 2007, p.161). Against this backdrop, the CCHP though referring to determinants of health does not promote a discourse that would examine governments' role in tackling the Social and Economic Determinants of Health and by extension social and economic inequities which impact on health, as an approach to improving the health status of Caribbean Populations. The strategies listed in CCHP encourage personal empowerment, collective community action, and the reliance on Caribbean traditions, even as there is a call to embrace change.

The formulation of the CCHP symbolises a movement in International Public Health and adds to a group of strategic guidelines which emphasise inter-sectoral action for health. "Health Promotion [is viewed] as a persuasive model for the new public health movement which emerged during the late 1980s...in part as a reaction to some of the

perceived failures of traditional health education" (Nutbeam and Blakey 1990, p. 304). At the same time, 'traditional Health Education' was being replaced by approaches linked to policies which emphasise "individuals' personal responsibility for health improvements; an understanding of health promotion as behavioural change; and the need for individuals to increase their personal responsibility by adding social capital to their endowment" (Navarro 2008, p. 425). This presents a dilemma, as the health issues challenging the Caribbean relate to social determinants and require an approach which goes beyond individual responsibility.

There is an interesting mix of approaches in the CCHP as a document based on a movement coming out of industrialised countries and as a document which promotes the role that Caribbean social traditions can play in improving the health of their populations. Paradoxically, it is well documented that health problems in the Caribbean today (and this was so during the period that CCHP was written) and the factors which put individuals at risk of developing these health problems are related to aspects of globalization and trade practices in the Caribbean, especially in the more metropolitan islands like Trinidad and Tobago. Examples of areas of influence are the kinds of food the population is now exposed to, as well as the leisure activities Caribbean people now engage in. For example, in Trinidad and Tobago over the past ten years, there has been a rapid establishment of several fast food chains from North America. Reports state that the Caribbean has been spending over one billion United States dollars annually on food imports (Alleyne, 2003). Further, "in some [Caribbean] countries, at least half of the adult population is almost completely sedentary as a result of increasing urbanization and different styles of living often induced by images and practices that are not indigenous to the Region"(Ibid. p.8). In the case of adolescents, the availability of cable television and video games has contributed to their spending more time on non-physical leisure activities. Advertising which increases when countries experience economic development has been of influence here (Wallack and Montogomery 1996, p. 256). Yet, although the CCHP highlights the "adverse effects on their well-being of the structural adjustment programmes that [Caribbean] economies have undergone", no mention is made of the potential impact of globalisation (CCHP p.1).

Obesity, for example represents a major concern for the health of Caribbean populations and addressing this concern will need to go beyond lifestyle practice (Henry, 2006). Obesity is linked to the foods high in fat content now easily available from fast food outlets. Poverty is also of concern and has been identified as one of the factors driving the HIV epidemic in the Caribbean (Centre for Health Economics, University of the West Indies, 2009). Other strong forces which have been identified as driving the epidemic in the Caribbean are stigma and discrimination and the unequal distribution of power between the sexes (Alleyne, 2003). Thus, these socio-economic determinants of health have been influencing the health profile of Caribbean nations negatively. Seven years after the establishment of the Millennium Development Goals (United Nations, 2000) for example, there were concerns expressed that achievement would be elusive "unless radical steps are taken to influence factors that shape social position: Income, social cohesion, food availability, gender imbalances, and living, employment, and working conditions create barriers to adopting healthy behaviours" (Mullings and Paul, 2007 p.155).

4.3.4 Summary

The dominant discourse of behaviour change has become embedded in our 'health care practice' and puts the spotlight on individual responsibility and away from policy makers and Government responsibility. The 'old' bio-medical approach focussed on the individual and his or her illness, this may have been relevant to those diseases which were treatable with medication or surgery. Addressing social determinants and promoting health and wellness require a different approach and a different discourse. The strategies of the CCHP provide an opportunity to address the Social Determinants of health of Caribbean populations, notwithstanding the lack of attention given to this in the CCHP, as it relates to taking action. Health Professionals would need to use their technical knowledge and experience to steer the dominant discourse away from "excessive emphasis on the individual's responsibility for health" (Buck 1985, p. 6). Further, Health Professionals and their social sector partners, including Non-Governmental Organisations would need to advocate for inter-sectoral action proposed

by the CCHP, but at the level of policy makers, to improve the circumstances in which people are born, grow, work and age (WHO 2008). This approach would support the Health Promoting School Initiative by seeking to establish a system that would not only nurture adolescents in their positive development but would include advocacy for relevant social and economic changes. In order to achieve this, the Ministries of Education in the Caribbean would need to strengthen schools' capacity to fulfill this mandate.

4.4 Report and Analysis of the National Policy on Health and Family Life Education (HFLE Pol.) (MOE, 2001)

The National Policy on Health and Family Life Education for Trinidad and Tobago, arose out of a Caribbean Initiative - The CARICOM (Caribbean Community) Multi-Agency Project - which was endorsed in 1996 by "the CARICOM Standing Committee of Ministers of Education and Ministers of Health based on recommendations submitted to them by the Chief Education Officers and the Chief Medical Officers" (HFLE Pol. p.13).

According to the Policy, Government Ministers from Ministries of Health and Education in the Caribbean agreed that HFLE would be part of the core curriculum in education at all levels and that there would be the provision of mechanisms and resources necessary to make this happen (ibid). Further, the CARICOM Secretariat was mandated by the Standing Committee "to liaise with governments" to ensure implementation. The decision to establish this Policy was made by politicians and supported by technocrats with the expectations that the outcomes of their decisions would be adopted at the national level and be implemented in schools and communities.

In analysing the HFLE Policy, I first look at how HFLE emerged as a subject area to be included in the school curriculum, how HFLE is defined and its approach to addressing adolescent health and wellness. Further, how this approach to adolescent health relates to dominant discourses on perceptions of adolescence and adolescent sexuality and the possible implications of this approach for educating adolescents about health and

wellness. I also explore expectations for implementation of the Policy and Collective Action and Collaboration.

4.4.1 Health and Family Life Education

The National Policy on HFLE was developed following an earlier attempt to introduce a Family Life Education (FLE) curriculum in Trinidad and Tobago in 1988, which "failed to have desired results" (HFLE Pol. p. 5). The Policy cites reasons for 'failure' of the FLE curriculum as:

> ...failure of most primary school principals to create a spot for FLE on the timetable; unpreparedness of teachers ... lack of interest ... for a non-examinable subject; lack of manpower for effective monitoring by the Ministry of Education and no ownership (Ibid. p. 5).

In this 2001 initiative, health is added to the title and gives another dimension to the subject of FLE. The HFLE Policy outlines the rationale for establishing a Health and Family Life Education Curriculum in schools, as a response to "emotional and behavioural disabilities [which] rank high among the health conditions affecting young persons in the [Caribbean] Region" (HFLE Pol.p.1). It is within this context that HFLE is located in an education practice which, according to the HFLE policy, represents 'quality education' which would address these 'disabilities'. In the HFLE Policy, disabilities are described as health conditions affecting youth today and are contrasted against infectious diseases which affected this age group in the past (HFLE Pol. P. 1). According to the Policy, quality education is education:

> ... that caters for the holistic development of the individual ...[It] should not only equip them with knowledge and practical skills, but should provide an avenue for the development of social and emotional skills as well as acquisition of positive attitudes and values (MOE 2001, p.1).

This description gives an indication of what the writers of the policy would expect the HFLE curriculum to achieve in relation to the development of the individual. However,

establishing a system that would facilitate the achievement of these expectations as outlined above, has been difficult. Even after the CARICOM resolution in 1996, HFLE was not being implemented in Trinidad and Tobago beyond the Primary School Level; as is stated in the policy document: HFLE is non-existent at the Secondary and Tertiary Levels of the education system in Trinidad and Tobago.

At the same time, the National HFLE Policy justifies its approach as a solution to address all the "Major Concerns for the Children and Youth of Trinidad and Tobago" (HFLE Pol. p. 1). The Policy document cites studies and reports which highlight risk factors for early termination of education and potential negative consequences. HFLE is presented as "a positive step towards the promotion of the holistic development of our children and youth and the eradication of the social, psychological and physical ills that plague them" (Ibid.). This statement at once indicates an unrealistic approach to health and wellness. Such 'ills' which are listed over three pages of the Policy, are described as "poverty, teenage pregnancy, juvenile delinquency, HIV/AIDS, drugs, alcohol and tobacco habits, child abuse and neglect, violence, influence of the media, inadequate recreational facilities, lifestyle related diseases and new sub-cultures"(ibid). An examination of the list of ills, highlights the unrealistic expectation of a policy document seeking to eradicate realities which are experienced by societies around the world. Additionally, the policy is creating a perception that these 'ills' threaten all adolescents and ultimately threaten the future workforce.

The point is made that "maintaining an efficient and productive workforce is ultimately dependent on the full realization of the potential of children and youth" (HFLE Pol.p.1). The solution being offered is the attainment of 'Life Skills' which would be taught through HFLE at the level of the school with parent and community involvement. The Policy recommends that the home and community should be reached through public education and that the HFLE programme in schools would be implemented by teachers in partnership with parents and health and community professionals (HFLE Pol. p. 6). The Policy identifies "The most striking feature of Health and Family Life Education [as being designed] to promote psychosocial competence...a person's ability to deal

effectively with the demands and challenges of everyday life" (Ibid.). What also needs to be said is how the education system will seek to meet the needs of all children, since even the teaching of life skills require an environment which supports learning for all children.

The HFLE Policy's rationale, which has been identified as focusing on the problems of adolescence, belies its title. It stresses the potential threat to economic development from the 'ills' which according to the document, plagues adolescents. The role of education in supporting economic development is repeated throughout the document and creates an impression that there is urgency to 'fix' the problems of adolescence, to mitigate its effects on economic development. The list of 'deviant behaviours and problems' associated with adolescence emphasises the role of HFLE in 'eradicating' these problems. Although reference is made to the need for 'holistic' development of children, the document takes a problem-centred approach and promotes a 'risk' based discourse. The problem is with adolescents, not the school system, nor parents, nor policy makers. However, Ungar (2005) has highlighted the resilience of youth in the context of adversity, but he also makes the point that:

> Resilience is more than internal capacities or behavior that allows one to overcome adversity. There is growing evidence that resilience is as much dependent on the structural conditions, relationships and access that children experience as it is any individual capacities (p.446).

Placed in a context that is not meaningful to them, adolescents fall on their own resources to survive in the situation where they are placed and will not respond to 'interventions' that are not meaningful to them.

The Policy recommends a 'teacher/parent partnership', but this has been historically challenging in Trinidad and Tobago. My own observation and experience in participating in Parent Teacher Association (PTA) gatherings is that they are attended primarily by parents and school principals, and not teachers. However, there is an assumption that all sectors of the community "teachers...parents and health and

community professionals" will work together (HFLE Pol. p. 6). This is necessary to support positive development of adolescents in the school environment.

There are so many expectations of this National Policy on HFLE which calls for multi-sectoral national coordination and implementation in both schools and community. Anyone with responsibility for children and adolescents in Trinidad and Tobago who reads this Policy would be overwhelmed by what it is trying to achieve. The Policy states that one of the challenges of the previous attempt to introduce Family Life Education in schools in Trinidad and Tobago was the issue of ownership. In an education system where there is timetable overload and stratification of subjects in the curricula in schools, the potential challenges related to implementation of this Policy are many. It is worth remembering that one of the factors that influences how a school's performance is assessed relates to students' examination results and as has already been stated in this research paper, HFLE is a subject for which there is no examination and this influences the status of HFLE, compared to other subject areas.

4.4.2 Collective Action and Collaboration

Although the responsibility for leading the implementation process of the Policy is with the Ministry of Education, collaboration is expected with other Government Ministries such as the Ministry of Health. However, since the Policy is placed in the context of ill health, this presents a challenge for the Ministry of Education as this would require a re-orientation of its roles and functions. There is an instruction however, for "HFLE to be a compulsory component of the core curriculum at all levels of education beginning September 2002" (MOE. p. 9). Yet in my conversations with informants from both the Ministries of Health and Education, seven years after the Policy was established, the systems for implementing the HFLE curriculum are only partially in place at Primary Schools and are still to be determined for Secondary Schools.

During a visit I made to the Curriculum Development Division of the Ministry of Education in October 2010, I spoke briefly and informally with the Curriculum Development Officer with responsibility for HFLE among her other responsibilities.

She indicated that at the level of the Secondary Schools, a few principals are implementing some aspect of the HFLE Curriculum. This highlights a practice where policy makers may identify what should be included in the Core Curriculum in schools; however, implementers may be of a different view. The Policy identifies several agencies with responsibility for ensuring implementation of HFLE: "Led by the Ministry of Education, there shall be collaboration among the Curriculum Development Division (MOE), School of Education, UWI [University of the West Indies], Board of Teacher Training [and] Division of Schools Supervision, to design training programmes" (HFLE Pol. p.12). At tertiary level institutions, HFLE has been an elective for Undergraduate and Post-Graduate teachers. However, in recent times with the advent of the University of Trinidad and Tobago, and the Department of Cognitive and Learning for Teacher Education, a specialization in Health and Family Life Education is available to Undergraduate Teachers. A verbal enquiry made to a senior lecturer at the University of Trinidad and Tobago, revealed that the number of student teachers who choose to specialise in HFLE over a two year period are approximately 18 – 20 students, out of a group of almost six hundred. Not all student teachers are exposed to the HFLE curriculum.

The HFLE Policy outlines roles and responsibilities of those expected to implement the Policy and a system for coordination. However, the Policy does not identify mechanisms for ensuring that the system functions, neither is it clear how all the expectations of the Policy would be met through leadership from the Ministry of Education and within the school environment. A Management Committee of twelve members from other Government Ministries and Non-Governmental Organisations has been set up to manage implementation of the Policy. The HFLE Policy highlights the promotion of psychosocial competence (HFLE Pol. P. 6); however, the Policy document does not outline how teachers, parents and community members would acquire skills to nurture psycho-social competence, assuming that they are themselves psychosocially competent. The model of the Health Promoting School has been introduced to policy makers and educators in the Ministry of Education and in this model, teachers' well-being is addressed. However, the Health Promotion and HFLE

models have not been linked in the Ministry of Education. In Chapter 2, Review of Literature, I compared studies that showed that preparation of teachers to participate in HPS initiatives contributed to the success of the initiative. Additionally, I cited a Trinidad and Tobago HPS school-based health initiative where teachers' health improved with improved life style practices.

Like the other documents being analysed in my research, the assumption of people coming forward to work together is based on a premise that they are working together for a common good. In this case, the good is about helping society to cope with the problems of adolescence and helping adolescents to become 'good' adults. In Chapter 1, I referred to the role of religious organisations in education in Trinidad and Tobago and their approach to education. For example, when schools were being established in the mid-nineteenth century and attempts were made to stop direct religious teaching; religious leaders argued that any system of education which is not founded on religion could not be beneficial to society (Keenan, 1851). In today's education system in Trinidad and Tobago, the expectation is that HFLE would serve to fill the gap in those schools where Religious Education is absent to address the 'problems of adolescence' as listed in the Policy document. Further, the reification of the 'common good' justifies the imposition of solutions by dominant groups. The need for solutions is also fed by sensationalising in the media of incidents when adolescents engage in deviant behaviour, especially when this takes place in the school environment. One newspaper reported on the circumstances around the murder of a 16year old student:

> ...there are other disturbing aspects of 16-year-old Shaquille's death. It is reported, for example, that the dispute which led to his stabbing was over a $40 gambling debt.
>
> One school source told Newsday that three Form Five students accosted Shaquille over the matter and there was a fight during which one of them stabbed Shaquille with a kitchen knife.
>
> So here are a set of students whose prime concerns apart from their studies, would normally be girls and music and sports, but who are also involved in gambling and a

> network of conflicts. Not only that, but they also see $40 as sufficient reason to fight and, whether intentionally or not, kill. The core tragedy here is that there are clearly a set of children growing up in this country who have never really had a childhood. For, if they had, they would not at this still tender age have acquired the worse habits of the worse adults around (www.newsday.co.tt February 28, 2008).

The writer has drawn his own conclusions about students being involved in what the writer describes as 'a network of conflicts' linking the behaviour of the students with their significant adults.

In the list of 'Major Concerns for the Children and Youth' the HFLE Policy cites a World Bank Study (1995) which reported that in Trinidad and Tobago "25% of households are headed by females in rural areas and 32% in urban areas" (p.2). At the same time the Policy states that "there is mounting evidence of male irresponsibility which has put a tremendous burden on mothers and wives" (HFLE Pol. p. 3). In another study cited in the Policy, it is stated that families described as dysfunctional, represent a risk factor to teen pregnancy (University of the West Indies 1997). This is corroborated by other studies which claim for example, that problems in the lives of adult family members impact on the health and well-being of their children (Qvortrup 1990). Yet, having cited these studies in this Policy, there is the expectation that parents would have the capacity to assist teachers in implementing HFLE.

4.4.3 Policy Expectations

Notwithstanding the challenges of establishing an HFLE Curriculum in schools in Trinidad and Tobago, there have been for the past twenty-five years, repeated calls for implementing the curriculum; in response to the dominant discourse on the 'problems of adolescence.' Governments in the Caribbean and Ministries of Education needed to respond even if all the pieces of the puzzle were not in place. Like the Caribbean Charter for Health Promotion, there is much reliance on traditions of the Caribbean. In the appendices of the HFLE Policy, the writers of the Policy appeal for implementation of the Policy. One such appeal is linked to being part of a larger movement, that

Trinidad and Tobago, as a member of the Caribbean Community, should participate in "The Mandate of the CARICOM Multi-Agency Project" on which the Policy is based (HFLE Pol. p. 13). Another appeal is the need for Caribbean students to aspire to becoming the "Ideal Caribbean Person" and the Policy document lists the characteristics of such a person (ibid p. 15). Some examples include:

> ... a strong appreciation of family and kinship values, community cohesion, and moral issues including responsibility for and accountability to self and community; a positive work ethic; has developed a capacity to create and take advantage of opportunities to control, improve, maintain and promote physical, mental and welfare of the community and country (Ibid. p.15).

This highlights the discourse of service to community and country captured in this document and reflects the discourse of service also present in the Report of the National Task Force which I discussed earlier.

Finally, the Policy closes with an appendix on the "Characteristics of HFLE ... Beliefs and Values [and] Desired Characteristics for Effectiveness" In addition, statements of Beliefs and Values are taken from existing international and national declarations such as the "Convention of the Rights of the Child" (Office of the United Nations High Commission for Human Rights 1989); and Trinidad and Tobago's Declaration on Education for all:

> That education of the child be directed as to develop to the fullest potential the child's personality, talents, mental and physical abilities (Article 24 of the Convention on the Rights of the Child) [and] That educational development should be provided to ensure transmission of common cultural and moral values (GORTT2001 p. 16).

Thus, the HFLE Policy juxtaposes the problems of adolescents with aspirations for creating an ideal Caribbean Person. There are many nice words and concepts identified as characteristics of the Ideal Caribbean Person. However, the policy's description of adolescents' behaviour, does not exemplify characteristics of the 'Ideal Caribbean Person'

as outlined in the policy. The HFLE Policy, in responding to the call for solutions to the problems of adolescents contributes to the dominant discourse of adolescence as deviance and to the attention given to finding solutions to adolescents' deviant behaviour as social practice. The resulting approach focuses on skills-building, with less attention to the role of the life experiences of adolescents in the school and other environments, in supporting positive development.

4.4.4 Summary

Of the three documents I have reviewed in my research study, the National Policy on HFLE is the one that relates most directly to adolescents and which was formulated to support adolescent health. The Policy concludes by identifying "Characteristics of HFLE", a "Statement of Beliefs and Values" and "Desired Characteristics for Effectiveness" (HFLE Pol. Appendix III pp.16-17). Further, effectiveness is expected to be achieved by learning through teaching and instruction. Yet in practice, schools have not exhibited readiness for implementing HFLE as outlined in the Policy document. Paechter (1999) highlights how schools marginalise subjects such as Home Economics and Physical Education which were seen as important subjects for working class students in state institutions in England and Wales (p. 223). HFLE appears to be experiencing a similar fate alongside other subject areas in the Secondary School curricula which address social issues and which are left out of the curriculum by those schools described as prestige schools in the Secondary School system in Trinidad and Tobago. Later, in the section which focuses on the results of my Key Informant Interviews I will seek to explore this occurrence further. However, I also wish to state at this time that I am not advocating that a curriculum in itself is the answer to addressing adolescent health and wellness, but that the concept of Health and Family Life Education can contribute to schools beginning to engage in a process of becoming social institutions as described by Dewy (1897).

4.5 Conclusion

The Report of the National Task Force on Education, the Caribbean Charter for Health Promotion and the Health and Family Education Policy document have revealed health and education approaches related to adolescence from different but similar premises. The Task Force Report and the HFLE Policy acknowledge the need for adolescence to be given special attention. However, providing this attention comes with conditions; whatever attention is required must be given within the parameters of the purpose of education as perceived by dominant groups in society. This perception is illustrated in a discourse of service and the role of education in preparing adolescents to be productive and 'useful' citizens. The Task Force Report places emphasis on nation-building, while the HFLE Policy seeks to promote in adolescents, what the documents describe as characteristics of the ideal Caribbean person. The Caribbean Charter for Health Promotion emphasises the 'Caribbeaness' of strategies of CCHP which call for working together but ignores the threats to this 'Caribbeaness'. All the documents emphasise what individuals, students, parents and communities can do differently, but no radical changes are being proposed for government agencies. It is as if governments and policy makers are seeking to continue the roles they have always played in pursuing nation building expecting that everything else will fall into place.

Written in the fabric of these documents are expectations and conditions that underpin present orthodoxy instead of radical changes to transform these present orthodoxies which are not addressing challenges in the health and education sectors today. In the following section, I will examine information received from my key informants, as it relates to their personal and professional experiences in the health and education sectors; and their views on policies of those sectors.

4.6 Reports from Key Informants

4.6.1 Introduction

In the previous Chapter on Methodology, I outlined my intention to explore how my key informants constructed realities of adolescent health and wellness. I argued that realities are constructed in relation to individual life experiences, as well as in relation to the

social systems and structures in which individuals function. Further, that there are underlying 'fabrications' that over time influence how these realities became established. Thus, in analysing the data obtained from my informants I look for what is revealed about their individual personal and professional backgrounds, information which describes how they interpret their functions in their workplaces and factors which may have influenced how they practice.

In the following discussion, I refer to my informants by fictitious names to avoid their being easily identified; Alexis, Allan and Anna are health professionals, while Jill, Jason and Josh are education professionals. In referencing the words of my informants, I use page numbers from the interview data appendix and cross reference the interview data with the page numbers in the body of this Chapter. Informants' references are in brackets without 'p' before the page numbers to distinguish them from the conventional references used throughout the thesis.

The subject areas I use to categorise the information include; background of informants, core functions; approaches to and mechanisms for addressing adolescent health and wellness, collective action and collaboration, policy development, policy and programme implementation, and communication and use of technology. Responses revealed that informants referred to existing policies, while at the same time describing their own practice which may not always be related to the policies to which they referred. So that informants reported that they engaged in individual initiatives in their practice which may or may not be guided by policy. I am therefore interested in how as individuals they function within their group as education and health professionals, and similarities in practice as revealed in their accounts of their lives and professional practice in institutions.

4.6.2 Background of Informants

All of my informants, with the exception of Jill shared that they had all had an interest in youth development in their own youth before embarking on their professional careers in

health and education. Jill however had begun her career in education as a pupil teacher. They attribute this early interest in youth development as influencing their engagement in their present occupations. Interestingly, all of the informants participate in religious life and are active in lay ministry activities at different levels in different Christian faiths. This was a surprising finding and required careful analysis to avoid my being influenced by particular expectations of educators who engage in religious life. I have captured several examples which informants shared in which they link their present practice in their professional careers with their personal religious life. They spoke of encounters with youth through various religious 'outreach' and community activities.

Allan has a background in Human Resource Management but has been functioning as the focal point for Health Promotion among other duties at a Regional Health Authority (RHA). He expressed his commitment to youth development in both his private and professional lives. According to Allan; "[There are] many troubled young people...I have encountered the problems of young people and took on what solutions were possible" (194). At present, Allan is involved with youth in the field of sport and performs as a marriage counsellor in his church.

Alexis' career has moved from Nursing Education to Health Education in the Ministry of Health and stated that "[Health Education] fits my background ... youth leader, church leadership, mentoring" (190). At present, Alexis is actively involved in youth development in his church.

Anna who had worked with grass roots communities in the past, explained that she had an interest in empowerment of people who are underserved"(188) and decided to study "counselling and guidance as a way to help young people" (188). She had in the past and continues to be involved with young people on a voluntary basis, engaging in leisure activities with youth and in youth programmes in church. On a professional level, Anna had worked for ten years as a science teacher in Secondary Schools and became interested in "preventive medicine – that's what they called it at the time" (188), before studying and then practising Health Education in the Ministry of Health. Anna has

conducted research to investigate lifestyle practices of school children during post graduate studies in Community Health and Health Education. Jason, who is now a manager in the Ministry of Education, has also been involved with youth in the field of sport and in Boys' Scouts. As a youth, he had begun training for the clergy before embarking on a professional career in counselling at a youth vocational centre. He later became a Guidance Officer in a Secondary School before taking up his present position in management. On the issue of how people choose careers, Jason commented "People first move with their hearts" (200).

Jill began her career as a Primary School Teacher and had received her 'Teacher Training' at a Catholic Women's Teachers College. She later became a Secondary School Teacher and then a Curriculum Development Officer. Now a Vicariate Manager, with the Roman Catholic School Board, she visits Primary Schools to ensure "that the [Roman] Catholic ethos is pervasive (197). Jill describes herself as being "very involved in church ... giving service and giving back to community" (197).

Josh has been a teacher at Primary School level and is now a Primary School Principal. He describes himself as a Social Studies Specialist who has also worked as a Social Studies Facilitator in Curriculum Development for Primary Schools. He is a member of the executive of the National Parent Teachers' Association (PTA). According to Josh, "parents' relationships are important to working with youth and being a father has influenced my work too" (203). Josh is active in his church and is also a Marriage Counsellor.

Among the six informants, five had been teachers at some point in their careers; this was the case for all of the three health informants. All informants have been involved in educating adolescents and spoke enthusiastically about their work, making the point that their early life experiences prepared them for their professional careers.

According to Sikes and Goodson (2001):

> There is a crucial interactive relationship between individuals' lives, their perceptions and experiences, and historical and social contexts and events...individuals negotiate their identities and, consequently, experience, create and make sense of the rules and roles of the social world in which they live (p. 2).

From their reports, my informants have given meaning to their professional careers by bringing to their practice their past experiences and personal interests. As a colleague of all my informants, I am familiar with their professional backgrounds but know less about their personal lives and had not been aware of the extent to which they related their personal lives to their professional practice. However, I am aware that although my informants have identified particular aspects of their lives and practice in the context of the social world of educating adolescents, their stories may be different in other areas of their social lives. I am also sensitive to the phenomenon that these past experiences and present practices may exemplify dominant societal beliefs and expectations of what is viewed as being required in educating adolescents; for example, the expectations of those who believe that there are "inherent problems of adolescence [and recommend] teaching of values and morals ...to address some of the critical problems [of] adolescents" (Ministry of Education 1993, pp.197 -198). Thus, it is important to understand how these values and morals came to be defined and identified to be included as an approach to adolescent education. More specifically, how characteristics of the adolescent became established as moral or immoral. Foucault (1991), in his study of the prison, referred to the concept of:

> ...'a genealogy of morals' one which worked by tracing the lines of transformation of what one might call 'moral technologies'. In order to get a better understanding of what is punished and why, I wanted to ask: *how* does one punish... rather than asking *what* in a given period is regarded as sanity or insanity, as mental illness or normal behaviour, I wanted to ask *how* these divisions are operated (p. 74 original emphasis).

The relationship between religion and education is well established in the education system in Trinidad and Tobago. This is evident in the early history of education and continues today as I have highlighted in Chapter 1 of my thesis. My informants' stories linked to

their religious lives and interest in youth development characterise what has been described as the use of "schematic resources or prior scripts...where people tell their storylines derived from the general cultural milieu [and] private issues are also public matters " (Sikes and Goodson 2001, p.75). Thus, the personal life experiences which informants bring to their practice in educating adolescents do not inherently contradict the ethos of the institutions in which they practice nor that of the wider society. In particular, informants from the Ministry of Education brought their religious convictions to a school system influenced by religious dominance from pre-independence to the present. According to Foucault (1980), "... religions ... impose on those who practice them obligation[s] of truth ... the obligation to accept the decisions of certain authorities in matters of truth (p.169).

Such obligations are reflected in the practice of my Key Informants, even as they express dissatisfaction with the institutions in which they work, as I will show in the following section where informants describe their core functions.

4.6.3 Core functions

In describing their core functions, informants made statements such as 'I chose', 'I decided' or 'I worked with', indicating that, as well as their key role-related responsibilities, there are activities that are not necessarily guided by existing systems, documented protocols or organisational standards.

Allan indicated that although he had core responsibilities, he interpreted how he would implement his functions. One of Allan's functions is to identify gaps in the RHA's programming and in his view "health promotion was needed" (194). He has chosen to focus on youth and remarked; "Let me put it this way, I have taken responsibility for working with teachers to make the school a supportive environment and building capacity in schools in terms of readiness for emergencies" (196). He reports that he took the initiative to collaborate with other health professionals to implement Peer Counselling Programmes in Secondary Schools and sourced financial support for Sexual and Reproductive Health (SRH) programmes in Secondary Schools. Allan has therefore utilised his position in the system to access resources for his programmes.

Alexis has accelerated initiatives implemented by his Unit to address adolescent health and advocate for adolescent health services – "sexual and reproductive health is quite a challenge for adolescents... principals request our help in teaching sexual behaviour...and applied skills, ...effective communication, decision making, values, etc." (191). Alexis' report indicates that requests for sex education for adolescents isolate the topic, thus reinforcing the discourse of adolescent sexuality. According to Alexis, he also initiates programmes for adolescents in Secondary Schools, training Secondary School students as peer leaders and peer educators. Alexis' programmes target Forms 3, 4 and Lower 6. He explained that students in Form 5 who are writing Caribbean Examinations as well as, Upper Sixth Form students preparing for Advanced Level Examinations do not participate in these programmes.

Alexis is voicing here a common practice in both Primary and Secondary Schools in Trinidad and Tobago, where students are not allowed to pursue non-academic subjects for at least two years prior to their Final Examinations, unless those subjects are being pursued as part of their Final Examinations. This is an indication of how such subjects are viewed by educators who ensure that the emphasis is placed on some subjects and not on others. In looking at the history of education in Chapter 1, I indicated that interpretation of curriculum can vary among different schools for example, between the denominational schools and those schools not affiliated to a religious board. An interesting example is the teaching of SRH or sex education, which both Allan and Alexis have identified as having taken on the responsibility to address at the Secondary School level. The 'problematising' of adolescent sexuality has lead to schools choosing to teach or ignore subjects which include aspects of sex education. Foucault (1978) refers to the concept of the:

> ... pedagogization of children's sex: a double assertion that practically all children indulge or are prone to indulge in sexual activity; and that, being unwarranted, at the same time "natural" and "contrary to nature," this sexual activity posed physical and moral, individual and collective dangers ...Sexuality must not be thought of as a kind of natural given which power tries to hold in check or as an obscure domain which knowledge

> tries gradually to uncover. It is the name that can be given to a historical construct: not a furtive reality that is difficult to grasp... but a great surface network in which ... the incitement to discourse, the formation of special knowledges... are linked to one another... .(pp.104 - 106).

Thus, in my experience I have found that there is a tendency to highlight sexuality in approaches to the education of adolescents in Trinidad and Tobago, with the resulting debate to include or exclude Sex Education in schools. In the end, adolescent health is neglected.

Educators therefore make individual decisions about how they address education for health and wellness. Anna reported that she is involved in policy development and uses existing policies in her practice; "when government policy emerges we find ways to incorporate these in our programmes...operationalise documents and previous decisions" (189). She referred to a draft School Health Policy which targets students 6yrs to 18years, which at the time of the interview was still a draft policy. She reported that she engages in capacity-building for teachers and development of training materials for school-aged children, for example a "reader for nutrition" (189).

In seeking to address health and wellness, these health professionals give attention to skills building, but this raises the issue as to whether 'skills' alone are what is needed. I have already highlighted that all informants from the Ministry of Health have been teachers in the past and may be bringing their world view of social change through education to their present practice. Allan remarks that he wants to make the school a supportive environment, Alexis is responding to School Principals' request for help and Anna uses a teaching tool that attempts to teach students how to read, as well as the rudiments of nutrition. Cocoran (2011) refers to this health education approach as:

> ... substance-oriented view of ontology ... Within this kind of knowledging practice, we find the means by which professionals (e.g. educational psychologists and teachers often as representatives of State authority) adjudicate students' abilities in

> relation to their performance inside normative frameworks (p9).

Practitioners come up with education approaches within education institutions, but the deeper issues relating to social determinants of health which may influence some children entering Secondary School without reading skills or the inability of schools to support positive adolescent development or schools' reinforcement of inequities are ignored as they are not part of the dominant discourses.

- Ministry of Education

Jason raised his concern for the influence of wider societal issues, but like Key Informants from the MOH, he reported that he sought:

> ... to develop skills in management and see the holistic child – all issues affecting children...special education, HIV education, drug abuse. Gradually [I] saw that learning disabilities are real and beyond the scope of counselling. Larger questions [arose] as to why children fail to read...learning disabilities... behaviour problems ... Children could not read! Children could not read! (200)

The issue of adolescents reaching Secondary School level without being functionally literate has been raising concerns in Trinidad and Tobago. Although there are initiatives for remedial classes for reading, students slip through the cracks and complete their experience in Secondary Schools still not functionally literate, this goes back to a point raised earlier regarding the school's role in reinforcing inequities and ignoring social issues. This also raises other concerns regarding adolescents' inability to read and how this may impact on their capacity to manage the 'transition challenges' they might face at this stage of the life cycle. A study looking at perceptions of health and health literacy found that "those who found health messages difficult to understand were less likely to be interested in or to follow what they are taught" (Brown 2007). The study acknowledged that health literacy is influenced by health and education systems as well as societal factors.

Jason reported that in his early career, he had thought all children's problems as he described earlier could be addressed through counselling, but as his career path advanced as a Guidance Officer, he realised that there were deeper social issues. He readily responded that he considers adolescent health and wellness as a core function in his present roles in Student Support Services. Like the Ministry of Health informants, his staff responds to requests from School Principals to provide training for teachers on personal development. Jason spoke passionately about what he describes as "untold stories coming from School Principals who pay attention to personal development" (200). However, without appearing to diffuse Jason's enthusiasm I questioned whether the attention to personal development continued in to the Secondary Schools. Jason's response was "No doubt about that, although there is lessening off" (201).

Josh also spoke passionately about his functions, but his view is that Adolescent Health and Wellness is not a core function in the Ministry of Education. He however sees adolescent health and wellness as a core function in his practice. Josh reported that he initiated Health and Family Life Education (HFLE) sensitisation for the National Parent Teachers Association (NPTA), having himself received training in HFLE through the Pan American Health Organization (PAHO). He also has experience in Curriculum Development in Values Education and Social Studies. As a Primary School Principal, he can promote these subject areas in his school but he expressed the view that the Ministry of Education's approach is "only reactive" (203).

Jill's response to what she views as her core functions was specific and unlike other informants, she referred to her formal job description as a Curriculum Development Officer, and gave her interpretation of how this relates to adolescent health and wellness. Jill described her core functions as: "Develop, implement and evaluate curriculum... you ensure that adolescent health and wellness would be in the curriculum, but implementation would call for teacher training" (199).

Informants from the Ministry of Education, like those from the Ministry of Health describe their core functions as determined by themselves. That is, they have interpreted their job

descriptions as they saw necessary. From our conversations, they demonstrated passion and genuine interest in implementing what they interpreted as their core functions. Most of them mentioned that they also engaged others, parents and teachers in sensitising them to what they perceived as being required to address adolescent health and wellness. However, in interpreting their core functions, none of my informants, even those involved in policy formulation, identified themselves as having a role to play in influencing policy with regard to issues impacting on their students, such as social and economic inequities in and outside of the school system. They are aware for example, that the number of children who can't read at Secondary level is disproportionate among the different Secondary Schools. Jason spoke of the role his Unit played in having 'personal development' addressed in schools, but did not explore why he was only able to influence some School Principals and not all to focus beyond 'the academics'.

In the following section, I look at informants' perceptions of existing approaches and mechanisms to addressing adolescent health and wellness.

4.6.4 Approaches/Mechanisms to addressing Adolescent Health and Wellness

- Ministry of Health

Anna reported that the Ministry of Health addresses health and wellness:

> But there is weak structure...driven by individual choices and interests... no structured adolescent health and wellness programmes...the services that we offer are for everyone...services are all omnibuses...when we talk about adolescents it is mainly in relation to pregnancy... (188).

Alexis bemoaned the fact that specialised services for adolescents do not exist in the health sector. He gave the example of pregnant adolescents who access pre and post natal services alongside adults. "Those sexually active [adolescents are] inhibited by a system which is not youth friendly" (191). Further, Anna explained that the approach to addressing health and wellness varies in the different RHAs:

> There are pockets of focus... for example, [one RHA] has structured activities ...in HIV and AIDS and wellness for adolescents and a syllabus was

> developed. [Another RHA] has adolescent programmes on reduction of risk and chronic diseases. There are fitness clubs counselling etc. (188).

The issue of lack of structure in approaches was corroborated by Allan; "There is no system or structure for adolescent health ... hard to look at youth, far more wellness for youth...youth are left out" (194).

The lack of health services for adolescents was reiterated by all health informants. Alexis, who had worked in Nursing Education before his present position, made the point that in Nursing Education, although the curriculum was meant to cover 0 – 18years, "the adolescent is invisible" (193). According to Alexis, nurses focussed on Maternal and Child Health but seemed uncomfortable with adolescents. Allan made the point that health facilities provide child health services that stop at pre-teens. "We have clear guidelines for children, but nothing really for adolescents as a group ... adolescents tend to slip and fall through the cracks" (195). Anna also referred to lack of specialised services for adolescents; "The services that we offer are for everyone... not necessarily targeting adolescents" (188). These reports highlight the contrast in the health sector in Trinidad and Tobago between health services for children and for adolescents. For example we have a concept of the 'well baby clinic' but there is no equivalent formalised system for adolescents. Rather health and education professionals reify what society has established as the problems of adolescence. Steinberg and Morris (2001) point out:

> The notions that adolescence is inherently a period of difficulty, that during this phase of the life-cycle problematic development is more interesting than normative development, and that healthy adolescent development is more about the avoidance of problems than about the growth of competencies have persisted virtually unabated since ... a century ago (p.85)

However, it is important to distinguish "between occasional experimentation and enduring patterns" (Ibid.). It is also important to ensure that the discourse of problematic adolescents does not reinforce the concept of 'enduring patterns' of negative behavior.

Allan raised the issue of WHO's Universal Access to health services and how it is interpreted in Trinidad and Tobago for example, in relation to young people under 16 accessing HIV testing. According to Alexis, "this does not happen in practice without parental consent ... Youth under 16 years of age encouraged to access Sexual and Reproductive Health Services" (191).

Allan, speaking on the issue of policies and plans developed by the Ministry of Health and Regional Health Authorities, made the point "that there is no system of communicating plans to the rank and file [staff at the operational level in the health sector]... communication is problematic... there is a gap between the vision of the RHA and the vision of the practitioners" (195). Further, Allan sees the operationalising of policies and plans as problematic; "the language of the strategic plans and policies and [what occurs at] the operational levels is different" (195). Alexis referred to the National Strategic Plan for Sexual and Reproductive Health which does not address adolescents specifically. Alexis also referred to the Caribbean Charter for Health Promotion and highlighted the strategy 'Reorienting Health Services' as important to ensuring adolescent health and wellness services are provided by the health sector.

Both Alexis and Anna identified non-health sector policies which they view as relevant to adolescent health and wellness, for example, the National Youth Policy. However, Alexis made the point that "the limitation is that it does not formally address in a serious way, the broader issues of Sexual and Reproductive health...at least in my recollection" (191) this is another example of separation or avoidance of a normative stage of an adolescent's life.

Common to all informants from the health sector is that there is the tendency to implement activities without the guidance of formal policies. Anna reflected; "on the whole lack of policy documents means that we managers must find ways to serve the nation in the best way possible" (189). She also highlighted that agendas may be set by

technical managers but such agendas may be set aside when other issues come up, "[Government] Ministers' priorities [are] important" (190).

- Ministry of Education

There was consensus from informants from the education sector that Health and Family Life Education (HFLE), as well as other subject areas in the school curriculum are approaches which could be used to address adolescent health and wellness. However, in reality implementation is problematic. HFLE for example, was only being offered at the time of the interview, at Primary Schools for two sessions each week. At Secondary Schools, it was expected to be included in subject areas such as Social Studies, Physical Education, Home Economics, Integrated Sciences, Human and Social Biology, Food and Nutrition and Chemistry. My own experience is that this is what is expected in theory but does not occur in practice and this is confirmed in my conversations with informants. The subjects listed above, are all subjects that are examined at different levels including on completion of Secondary School. However, informants indicated that unless there is an HFLE component in the examination papers of these subjects, HFLE would be ignored. Informants expressed concern regarding the weighting given to subjects for which there are examinations and did not all agree that subjects such as HFLE should be examined. However, they cited that one of the reasons for the reluctance to include HFLE in Secondary School curricula was the absence of examinations in that subject.

In relation to examinations and certification, Jill spoke of the use of a National Examination for subjects related to health and wellness. She clarified that "In [Secondary Schools], the National Certificate of Secondary Education (NCSE) includes personal development and health and wellness" (197). Jill also spoke of an issue that has plagued the education system in Trinidad and Tobago which relates to the different types of Secondary Schools which exist in Trinidad and Tobago. She gave the example of a Secondary School, which is classified as a 'Prestige School' referred to earlier in Chapter 1. Jill told of an incident in a particular Prestige School where "all students sent in blank

papers for the NCSE except for a comment stating that this examination was a waste of time" (p.14). She gave another example, of a Secondary School Principal, also from a 'Prestige School' who refused to allow students to write the NCSE examination in Social Studies because they saw it as a "non-subject" (199).

Josh provided additional information on attitudes to curriculum areas which included topics which relate to health and wellness; "Poor achievers get Social Studies and those are the classes that get left without teachers especially in the prestige institutions" (199) Unfortunately, this practice of encouraging "poor achievers" to undertake particular subject areas which some educators deem as more suited to students with poor ability is also apparent in the subjects taught in the different types of schools which make up the Secondary School system in Trinidad and Tobago. Josh also made the claim that more students in 'Prestige Schools' and seven year Secondary Schools choose traditional subjects, such as Mathematics and the Sciences, while the five year Secondary Schools, many of which were recently reorganized from being three year Junior and Senior Comprehensive Schools, choose subjects such as Social studies as well as vocational subjects such as Technical Drawing (TD), Home Economics (HE), Woodwork and Metalwork, and auto-mechanics. The infrastructure of the schools is related to the subjects taught, such that 'Prestige Schools' have Science Laboratories while the five year Comprehensive and Composite Schools have TD and HE Rooms and facilities for Woodwork and Metalwork.

This practice is related to the history of 'prestige schools' in Trinidad and Tobago, which for the most part represent the first secondary schools established in Trinidad and Tobago. Those schools began with students from a small section of society who came from prominent families in post-emancipated Trinidad and Tobago, as I indicated in the introductory chapter of this research paper. However, even when secondary education was expanded, stratification of students continued as a study cited later in this chapter reveals (UWI 1994). Stratification also extends to subject areas with the implication that it is the 'problematic adolescents' in the non-prestige schools who need Health Education. Thus, the deeper issue here is the reinforcement of inequities; and an

'inclusion through exclusion' as described by Foucault (1980), whereby those who have the power and authority to do so determine what they see as valuable knowledge.

Informants from the education sector reiterated that subjects which are deemed unnecessary to some Prestige Secondary School Principals and their students are also linked to the issue of certification. Josh spoke of recommendations made to have subjects like HFLE examined, "it shouldn't be so" (204). While Jason commented, "The holistic is known but the reality is that passes [obtained through] the CXC [Caribbean Examination Council] surpass everything...bottom line is ... certification" (p.200).

However, even among those subjects which are examined, the MOE practises 'examination stratification' similar to the practice of stratification of subjects in the school system. At present, there are two types of exit proficiency examinations for Secondary School students, the Caribbean Examinations which provide a Caribbean Secondary Education Certificate (CSEC) and the National Examinations which provide a National Certificate in Secondary Education (NCSE). Students, like their teachers, view CSEC as the preferred qualification compared to the NCSE for obtaining employment, as well as for entrance to tertiary education institutions. This preference is demonstrated in the behaviour of the students and the School Principal mentioned by Jill in her example of how the NCSE Social Studies examination is viewed.

The practice of division among students and the subjects they are taught in the Trinidad and Tobago Secondary School system is similar to what has been practised in the British Secondary School system in the 1970's. Young (1999) writing about the Secondary School curricula in England and Wales referred to:

> ... the stratification of knowledge in the academic curriculum and ...suggest[s] that we ... consider the social basis of different kinds of knowledge and ... raise questions about relations between the power structure of society and curricula, the access to knowledge and the opportunities to legitimize it as 'superior' and the relation between knowledge and its functions in different kinds of society (p.64).

The present Secondary School system in Trinidad and Tobago consists of Seven Year Grammar type schools, Comprehensive, Composite and five year Secondary Schools. Of these, the seven year Secondary Schools are also referred to as 'prestige schools' where there is emphasis on academic subjects, while the remaining three types of Secondary Schools (many of which were transformed from the Junior and Senior Secondary School system) include vocational subjects and other subjects, viewed as non-academic, such as Social Studies. In a study of the 'Secondary School Population in Trinidad and Tobago Placement Patterns and Practices' by the Centre for Ethnic Studies (UWI St. Augustine 1994), reference is also made to the concept of stratification among Secondary Schools:

> The schools were also stratified by academic ability. Traditional schools (5-7yrs) [accepted students] with higher average scores on the common entrance examination and so on down to the Junior Secondary P.M. shifts with those with least or lowest mean scores ...The schools were also stratified by socio-economic status – 50% of the population of new sector schools students come from low or no income homes (p.436).

This translated to students being exposed to different curricula depending on the type of school attended. Jason shared how the MOE is trying to 'raise the status' of some subject areas; "The MOE has now made Physical Education compulsory up to [Secondary] Form 3, it used to be optional" (201).

Even though Jason bemoans the emphasis that is placed on certification, he spoke of a programme for Secondary School Students which was being formalised at the time of the interview which he claims would foster voluntarism. Students would participate in social services programmes, such as visits to homes for the elderly. According to Jason, "there is a voluntarism policy before Cabinet to make this service a more central part of student social development. We are linking the voluntarism with certification because if you link it with certification it gets a little push" (202). Jill added that students are now writing the examination for the NCSE in Social Studies in Form 3 at the Secondary level "based on the realisation that it prepares [students] for the Caribbean Secondary Education Certificate (CSEC)" (198). This practice demonstrates that students are utilising this

system of stratification to see how it would best benefit them, having acquired an understanding of how the existing system works and the value that is placed on particular subject areas and certification. Thus, students were merely expressing the dominant beliefs of their teachers regarding the exam and its objectives; "if you cannot examine or test for it, it's not worth knowing" (Young 1999, p. 66).

Josh acknowledged that HFLE curricula exist, but his words, as well as his expression and body language demonstrated his disapproval of the system, according to Josh;

> There is an HFLE Curriculum and few people teach [HFLE], they say they are not equipped to teach. You have a Curriculum Officer; when it was presented [to school principals] the Curriculum Officer said that the role of Curriculum Development is to prepare curriculum and send to schools. It is principals' responsibility to ensure it gets done (204).

Josh was voicing his frustration with the system and it was obvious from his statement that no group of education professionals was taking responsibility for the teaching of HFLE, not even the Curriculum Officer. This approach to HFLE contrasts with other subjects such as Mathematics and English Language which must be taught in all schools in Trinidad and Tobago. However, in my experience interacting with education professionals, I have not yet heard anyone debating who should be responsible for ensuring these subjects are taught.

Josh also referred to "piecemeal... adhoc initiatives" (p.204), repeating the point that it was left to individual school principals to implement and "most of the time they don't bother" (Ibid.). Such initiatives which were not sustainable had no formal guidelines for implementation. Jill bemoaned the lack of continuity of programmes which she believes would contribute to students' health and wellness. She recalled when Primary Schools were linked with health centres and more subjects were taught:

> With Common Entrance and Secondary Entrance Examinations schools specialisation became the norm. Post Primary Centers [for children over 11 years] prepared

> students for living: life skills, grooming etc. Post Primary Centres were removed by a previous Prime Minister and everybody was sent to secondary schools. In some of the Primary Schools, Social Studies and Science were not taught from 1986-2006 and teachers concentrated on Mathematics and English (199).

Jill's comments are related to earlier practices when Primary Schools for children ages 5 years to 11years, had established linkages with neighbouring health centres. The practice then was that children would make regular visits to the health centres for services such as dental health and the District Nurses would visit schools teach children subjects such as Personal Hygiene and Grooming. Jill was also making the point that the Primary School Curriculum had 'narrowed' with specialisation geared to the content of the Secondary Entrance Examination, and how students performed on this examination would determine the type of Secondary School in which they gained entry.

The above comments from Josh and Jill point to examples of a lack of cohesion in approaches in the Ministry of Education as it relates to health and wellness. Thus at the early Primary School level the Ministry of Education attended to the physical aspects of students' health and also put systems in place to improve student nutrition. On the other hand, when students attain the ages of between 10 years and twelve years, they are forced into a rigid education system that focuses only on their ability to pass an examination that would determine the kind of Secondary Education they receive which also has the potential to determine their future. However as has been revealed by informants, the Secondary Education system in its present forms, does not utilise the required structures and approaches necessary for their adolescent students. Even when health and wellness is included it is within a context focusing on individual learning with prescribed content; rather than "a holistic concept of health geared to practical activity and welcoming active participation in learning" (Corcoran 2011, p.7).

Jason spoke of expectations of the Ministry of Education's role in the emotional and social development of students. He referred to a programmatic approach to personal development "through a curriculum promoted by [Secondary school] Guidance Officers

for academic, personal, social and career development – this is done up to [Secondary] Form 3" (203). Guidance Officers function within the Student Support Services of the MOE. It was pointed out that the number of Guidance Officers for Secondary Schools had doubled in the last fifteen years. Nonetheless, according to Jason the work of Guidance Officers is a "side programmatic approach" (201). He explained that the curriculum which is delivered by Guidance Officers is not part of the core curriculum for Secondary Schools.

Jill's opinion of the role of Guidance Officers is that "when they are present in schools, they provide enhancing programmes in adolescent health and wellness"(199). However, she added that Guidance Officers and other contracted specialists (for example, child psychologists employed on contract by the Ministry of Education) assisted 'dysfunctional students'. Jill is also of the opinion that Guidance Officers have a role to ensure inclusion in education. At the same time, Jill indicated that Student Support Services seemed to be more involved in dealing with problems rather than being proactive.

Jason identified a practice in some Secondary Schools which he described enthusiastically. He referred to the 'Form Teacher' programme, where the Form Teacher is responsible for a particular Form Class and meets with them for one period a week to discuss non-academic subjects. According to Jason, this is meant to facilitate "emotional bonding between children and their teachers" (201). He expressed with regret that although the Form Teacher programme was meant to be implemented in all Secondary Schools, "it is as good as the principal wanted it to be" (201); and he also reported that some principals request support from Student Support Services for training of their Form Teachers. Later on in our interview Jason lamented that he was not sure whether the Form Teacher programme still exists. Again, later on Jason stated that "Form Teachers in schools are beginning to happen again ... I have suggested that the morning should be preceded by Form Teaching or Form Briefings before formal lessons can take place" (201). Since Jason seemed convinced of the benefits of the Form Teacher programme, I asked whether there were avenues outside of the scheduled Form Teacher Class when a student could access a Form Teacher. Jason's response was "one or two times" (201) and

he was keen to make suggestions of how the Form Teacher programme could operate. However, he confessed that "[school] principals and teachers are not willing to buy into this type of programme" (201). Jason's yearnings for an 'ideal' approach to addressing health and wellness were evident during our conversation. He seemed to be sensitive to the fact that our education system is based on what Young (1999) describes as the social organisation of knowledge and not its social functions.

Like my other informants who demonstrated such earnestness, I had difficulties in pressing Jason to identify what roles he could play in influencing policy makers and advocating for change within and beyond the education system. I also did not want to appear as if I were judging their practice. I too had spent many years in the system and continue my journey of reflection and being self-critical of my participation in addressing adolescent health and wellness. Thus all of us, education and health professionals must advocate for change. Young (1999) also reminds us that; "Stratification of knowledge is a social and historical product that can change" (p.65). Further, stratification of knowledge and "special knowledges ... [are] in accordance with a few major strategies of knowledge and power" (Foucault 1990, p. 106). Therefore, reflection on those factors that have influenced the development of education in the past and present is necessary to see why this practice continues today, and what action is required for change; thus constructing a history of what we have done and a diagnosis of what we are (Foucault 1990, 1991).

The overall impression given by informants on approaches to adolescent health and wellness in both the Ministry of Health and Ministry of Education is that activities at the level of the school and the health system are a mixture of initiatives guided by policies where they exist, as well as by the interests of individuals. Informants indicated that there was more structure at the level of the Primary School for addressing health and wellness than at the level of Secondary Schools. It should be noted however, that the age range of children in Primary Schools is usually between ages 5 – 11 years and the structure being referred to by informants would not apply to students, ages10 – 11 years who are preparing for Secondary Entrance Examinations. At the time of these interviews, a School Health Policy was still in draft. A Health and Physical Education Curriculum was

developed in 2008. At the Ministry of Health and the Regional Health Authorities, the three informants indicated that there are practices and protocols regarding adolescent health and wellness which were not necessarily documented, but that there are also policies in and outside of the Ministry of Health which guide programmes. An example given was the National Plan of Action for Children, although it was pointed out that practitioners in the health sector were not informed of the role of the health sector in implementing this action plan. Anna indicated that she became aware of the role of the health sector in implementing this plan only when a report is called for. Anna's comment is an indication of the absence of a formal system for communication and collaboration between Government Ministries in Trinidad and Tobago, even when there is an activity which requires participation from more than one Ministry.

4.6.5 Collaboration

- Ministry of Health

All informants agreed that collaboration between the Health and Education Ministries is beneficial to both Ministries; according to Alexis, "collaboration is critical for our success" (p.8). Anna viewed the implementation of the HFLE Curriculum as facilitating collaboration between the Ministry of Health and the Ministry of Education. Both Anna and Alexis shared examples of their participation as MOH representatives on the HFLE committee which was lead by the Ministry of Education. Anna also participated in the Ministry of Education's committee for HIV. She provided examples of how collaborative efforts were implemented, where the Ministry of Health initiates a joint activity and provides the financial resources for the activity but receives technical support from the Ministry of Education. Additionally, support is provided by the Ministry of Education in disseminating materials to students utilising existing distribution systems within the Ministry of Education. However, this system is not always reliable depending on the Ministry's priorities at that time.

Alexis described his own initiatives for collaboration with Non-Governmental agencies such as the Inter Religious Organisation (IRO) and the National Parent Teachers' Association (NPTA) and described successful interventions involving parents.

All Ministry of Health informants made the point that requests from schools to implement education sessions related to health and wellness had an adhoc approach. It was also stated that there was more collaboration between the Ministries of Health and Education at the operational level than at the policy level and that joint planning was limited. An opinion was shared that Health Promotion and HIV Education are main avenues for collaboration. Allan commented that the health sector as part of its responsibility for health care provision "should include building capacity of the schools to tackle health" (196).

Informants identified the practice of international agencies in facilitating collaboration through the provision of technical and financial resources for joint initiatives which brought the two government Ministries together, as well as Non-Governmental Organisations involved in youth development. Anna remarked that "External agencies sometimes determine what we do in their (planning and budgeting) documents" (190). Other informants corroborated on this issue providing examples of bodies which influence education practice and policy content. Notably, the Inter-Religious Organisation (IRO) and the National Parent Teachers' Association (NPTA) as well as Government Minsters were cited as influencers of policy and practice on issues such as adolescents accessing contraceptives and access to Sexual and Reproductive Health Services. Alexis raised the issue of the availability of safe abortions for adolescents and blurted out "safe abortion...at the end of the day, the politician takes responsibility [makes the decisions] and is very careful about divisive issues" (193). Alexis was making the point that an issue such as safe abortions for adolescents would be sensitive to the different groups in society, in particular religious organisations. Although this might be an extreme example, it illustrates the complex mix of individuals and organisations which can influence both education and services accessible to adolescents. Allan made the comment that "the political directorate directs and funds, so we follow that lead" (196). As mentioned in Chapter 2 in my review of the literature, there continues to be a tension between politics and policy development and implementation.

- Ministry of Education

Jason as the most senior manager among my group of informants appeared to have the most up- to-date information as it relates to policy and in several instances, new policies and plans that are being considered by the MOE. For example, he spoke of the establishment of monthly stakeholders meeting within the MOE to "talk policy" (p.19). This group included the Teachers' Trade Union - TTUTA; representatives of the NPTA and the denominational education boards. He described other examples of 'mechanisms for collaboration', which he referred to as committees who meet "on an as needed basis – These are not standing committees" (202). Jason also reported that the MOE participates in Cabinet-appointed committees to address issues which impact on children; for example, a committee for citizen security, mental health and HIV and AIDS and others established in response to crises that affect children. These mechanisms for collaboration involved participation of senior professionals such as heads of divisions from the relevant Government Ministries.

However, Josh's point of view is that as a teacher, his experience of collaboration was less structured and depended on relationships between individual principals and teachers with other agencies, mainly non-governmental organisations, in particular religious organizations, but at an operational level as opposed to the policy level. This last statement concurs with a similar statement made by Alexis from the Ministry of Health. Josh emphasised that this was usually linked to particular issues such as abstinence programmes and the prevention of teen pregnancy. This information shared by informants from both the Ministries of Health and Education, confirm the emphasis on those 'problems' highlighted in documents analysed earlier in this Chapter, namely, teen pregnancy, and Sexually Transmitted Diseases among adolescents in the school system.

Informants did not qualify their examples of collaborative efforts with examples of mechanisms to facilitate sustained collective action; further, these examples indicate a narrowed and skewed vision for addressing adolescent health in secondary schools. At

the level of Primary Schools, there is an established system where school nurses visit the schools to provide health services, but there are no examples of such established systems at the Secondary level. Where inter-sectoral committees were set up for collaborative initiatives between the Health and Education ministries, this was generally in reaction to an issue or crisis attracting national attention and the groups did not sustain their collaborative relationships. In addition, examples of collaboration at the operational level though more pro-active, were also not sustained. Information cited in this study highlight the difficulties of collaboration. Policy documents which were analysed at the start of this Chapter also revealed a great deal of rhetoric regarding the relevance of collaboration, but this does not transform into sustained practice from the information provided by Key Informants.

Understandably, collaboration is challenging as it requires a change in how the Ministries function traditionally. Multi-sectoral partnerships also increase the complexity of agencies such as education systems which are already complex. However, collaboration supports the premise that partnerships are necessary for today's complex education system and its relationship with other human services. Collaboration also supports an approach at addressing the 'whole' child (Kochhar-Bryant, 2010). Further, there is the argument that the tensions which can arise from the partnerships in such complex systems may actually facilitate adaptation to change and acknowledgement of diversity (Plesk and Greenhlagh 2001). Thus, despite the challenges related to collaboration which have been identified, I am of the opinion that collaboration is necessary for addressing adolescent health and wellness and that policy development is a good place to begin the collaborative process. Establishing systems for collaboration as necessary and important to educating adolescents in health and wellness also facilitates a normative approach to adolescent health and wellness. I will now look at the processes for policy development as described by informants and what is revealed about collaboration.

4.6.6 Policy Development

- Ministry of Health

Informants reported that the process of developing policy involves collaboration among different stakeholders through policy development committees. Anna described her involvement in policy development from the drafting of templates to guide the process to forwarding policy to the Cabinet of the Government for approval. A caveat to this process however, is that according to Anna, there needs to be a "policy agenda to follow up on policies as they evolve" (190). HFLE was identified as an example of a policy where there is difficulty in implementation. Anna asked the question; "Where were the teachers when the HFLE was happening?" (190). She was questioning whether there was sufficient involvement of teachers in the process of developing the HFLE Policy. My own observation of policy development in the Ministry of Health is that there is a lack of communication between those developing policy and those expected to implement. This is in spite of the fact that in a small country like Trinidad and Tobago, there is overlap between policy makers and practitioners in both the MOH and MOE.

Alexis easily listed policies which he thinks are relevant to adolescent health and wellness, some of which he said were not developed with consideration for adolescents. He indicated that he had limited participation in policy development, for example he had not seen a national policy document for the Ministry of Health. He however commented that his knowledge of policy development is that it goes through several stages and implied that the stages may differ, so that sometimes national consultations are held and other times a draft policy from the Ministry of Health is sent to senior technical officers to evaluate. Alexis' expressions and body language exhibited dissatisfaction with policy development practices; shaking his head, he spoke lengthily about the subject:

> Limited documents circulated. No consideration for those who are affected by the policy. End users are not often aware that policy is being developed. Selected persons who see policy documents are not usually affected [implementers]. No roll down written into policy...Our interventions are not informed by policy. Interventions are driven by personal interest (p.191-192).

Alexis was voicing his concern for what he sees as exclusivity in the process of policy development and the absence of an implementation component to existing policies. He described the present practice as 'weak'.

- Ministry of Education

Jason shared his experience of developing policy such as the National HIV Policy for the Education Sector which he described as "a 'protracted' process...which engaged school principals...students...Teachers Trade Union (TTUTA), Parent Teachers Association, denominational organizations, International Labour Organization and Ministry of Health" (201). Jason indicated that there was involvement of a wide cross section of the population invited to participate, coming from health, education tertiary education, parents, and church groups.

The involvement of politicians was again identified; according to Jason, after the HIV policy went through several drafts and was seen at the level of the management executive of the MOE, the Minister of Education changed. Jason paused before adding that Ministers change, the new minister "took [the Policy] to Cabinet and approval came in 2007" (202).

Regarding dissemination and the implementation of the HIV policy, Jason added that having a dedicated person for disseminating the HIV policy made the difference. He remarked that "it was about dissemination of the policy, as well as discussing the sensitive issues, how do you [principals] feel about the policy?" (202). Jason, who is himself a senior manager, emphasised the importance of satisfying School Principals in the process of developing an HIV policy for the Ministry of Education. Jason commented that "Principals [are] still very old fashioned in their understanding about sex and sex education...so we decided to put together a seminar – Let us talk sex education" (202).

He explained that the HIV policy document was sent out to schools but did not elaborate about what happened after the document reached the schools.

Jason also referred to the process of developing a No Smoking Policy: "We have s strong No Smoking position" (202). He however added that there were challenges of implementation at the level of the school. It was noted that posters on the dangers of smoking were placed in schools; however, teachers were seen going to their cars to smoke. According to Jason; "There is no system for monitoring the implementation of policies" (202).

In a 2010 report entitled *Rapid Situation Analysis of the Education Sector Response to HIV and AIDS in the Context of School Health and Nutrition in Trinidad and Tobago*, conducted by the Imperial College, London in partnership with the Ministry of Education, the following statements were made about policy and policy implementation in the MOE in Trinidad and Tobago:

> Currently a large number of Policy Documents and Operational or Strategic Plans exist pertinent to the education sector response to HIV. Their sheer number creates confusion as their terms frequently overlap, their nomenclature can be confusing and they often refer to different or contradicting objectives, targets and indicators. Many of these documents are pending ratification and endorsement while others need to be updated...The lack of management log frames translating policy documents into programmatic activities has resulted in fragmented HIV prevention programmes with segregated outputs. (MOE 2010 p.ix)

This statement corroborates with reports from informants from both the Ministries of Health and Education sectors on policy development and implementation. Policies are drafted but the process of ratification and dissemination may be stunted with no clear protocols for ensuring that ratification and dissemination take place.

Ball (1997) has examined the problems of education policies and the 'policy – practice gap' which he claims policy researchers assume "represents an implementation failure ..."

(p.265). Further, he points out that "Policies pose problems to their subjects ... When ensembles of uncoordinated or contradictory policies are in play then they resort to satisficing (sic) strategies and secondary accommodations may be the only reasonable and feasible response at certain points in time" (Ibid.). Thus, health and education professionals in Trinidad and Tobago will need to revisit not only the policy development process but also policy content and relevance, and the implementation process.

4.6.7 Programme Implementation

- Ministry of Health

With regard to the implementation process, all Ministry of Health informants spoke of a reliance on support from the Ministry of Education for access to adolescents. Almost all their examples of programmes which were implemented, demonstrate the development of personal relationships with professionals from the Ministry of Education. For example Anna commented, "We just identified persons who had the skills to help us" (189). Anna also referred to reliance on International Agencies for financial and technical support. Further, Anna described strategies that focus on the learning experience and not just the content... "we did a lot of capacity building" (189). Anna identified Sexual Health and Nutrition as the main subject areas she has been focussing on. Alexis, whose job functions relate to Sexual and Reproductive Health, also implements programmes for adolescents with this focus. Even as he lamented the constraints of human and financial resources, Alexis engaged in training of adolescents in Peer Education and Peer Counselling. This lack of structure in the approach to adolescent health and wellness contrasts with the expectations of the HFLE Policy document which were outlined earlier in this Chapter and as will be seen in the following section.

- Ministry of Education

Education informants referred to constraints in implementation due to limited resources to implement policies and programmes in the Ministry of Education. Jill shared an example of the process for the development of Social Studies curricula, she referred to; "the bringing together of teachers drawn from Primary and Secondary Schools. After

curricula are drafted, it is sent to schools to be taught and questionnaires are sent for feedback after a year or two" (198). Jill further explained that in the past Curriculum Facilitators would assist with implementation of the subject area, especially in new specialised areas like Health and Family Life Education, but "curriculum facilitators no longer exist" (198). Jill was referring to the fact that the Ministry of Education had discontinued the employment of Curriculum Facilitators for the HFLE Curriculum. According to Jill, Curriculum implementation is dependent on the Curriculum Development Division in collaboration with the School Principal. Jill's discussion about the process for curriculum development specifically related to Social Studies and Health and Family Life Education. She referred to Curriculum Facilitators, whom I am aware had participated in training in Barbados alongside their Regional counterparts, through the United Nations Agency, UNICEF. Yet after receiving specialised training the Curriculum Facilitators who were expected to train teachers to deliver HFLE were sent back to their individual schools to work as teachers, thus any opportunity to support the implementation of HFLE in other schools was prevented. "Remember we work in a system where discontinuities are frequent and whole programmes are stopped because personnel move or new persons come in who are not enthused or trained" (198).

All of my Key Informants were of the opinion that HFLE was important to adolescent health and wellness; however none of them seemed able to influence implementation of the curriculum in Schools. Earlier in my analysis of the HFLE policy document, I pointed out that it was an ambitious policy document with expectations of the bringing together of many partners. However, herein is the policy –practice gap; and the MOE's inability to prepare the school system for the implementation of HFLE. Yet, the HFLE policy document extends the involvement in HFLE implementation even beyond schools, to involve parents and other stakeholders. It should be remembered that this document came out of a high level meeting of Caribbean Ministers of Health and Education, but it should also be noted that one of our my key informants bemoaned the lack of implementation of HFLE and asked the question, where were the teachers when policy formulation was taking place.

4.6.8 Communication and use of Technology

I asked informants about the use of communication technology, in order find out whether there are existing communication systems in place which would support collaboration within and between the two Ministries. Responses indicated that communication is mainly through the use of telephones and to a lesser extent the use of emails. No one mentioned Skype or teleconferencing. Concerns were raised about the lack of timely responses from emails, as colleagues either did not access emails in their offices or did so infrequently. One constraint identified was that office based computer servers would often mal-function. Allan from the Regional Health Authority spoke of wanting to set up an electronic database to lodge research reports but was sceptical about getting support from his colleagues. Jill from the Ministry of Education mentioned that an exchange of educational compact discs occasionally took place among her colleagues in the Curriculum Development Division to share information.

The limited use of technology for communication in both Ministries contrasts with recent publicised initiatives: In 2009, the Ministry of Health launched its network for documenting research to inform policy, Evidence Informed Policy Network (EVIPNet). This is a web based network to facilitate interactive collaboration between policy makers and researchers (WHO 2010); in 2010, the Ministry of Education provided Laptop computers to all children who obtained pass scores in the Secondary Entrance Examination (SEA) and also developed an eConnect and Learn Programme Policy. This programme targets children entering Secondary Schools as well as parents and teachers (Ministry of Education, 2010). Yet, from the information received from my Key Informants there are many health and educational professionals who do not routinely use electronic communication. There appears to be a disparity between national policies and what is practised, but there has been no assessment of the outcomes of these initiatives so far. At the same time, basic infrastructure such as reliable electricity supply and internet connectivity, as well as human capacity are inadequate.

I acknowledge that communication technology is but a small piece of the puzzle of the collaboration process however, it is also a basic requirement to facilitate the process.

Nationally, internet companies continue to expand but the required reliable electricity supply, and infrastructure in schools and health centres in rural and inner city areas, restrict communication between ministries.

4.7 Discussion

In analysing the data received from the three documents and my Key Informants, there are findings which I would like to revisit, as well as my own observations, before revisiting the research questions and findings in the final Chapter. The first point of discussion which relates to an issue discussed in the overview of the History of Education in Trinidad and Tobago is the role of religion in education. This is particularly relevant to the topic of my research as health education for adolescents in Trinidad and Tobago has tended to focus on adolescent sexuality and religious organisations are suspicious of the content of such programmes. The Roman Catholic Church for example as well as the national organisation representing the Hindu Community have been publicly vocal in relation to who should be responsible for sexuality education in schools and what should be taught, having isolated sex education from school health education activities. I have personally experienced the influence of religion on in my practice of health education in schools, when I was asked to bring in the materials I planned to use in a Family Life Education class in a Roman Catholic Secondary School.

Religious Organisations have played a highly visible role in influencing the discourses in education in Trinidad and Tobago through their direct involvement in the management of schools and their overall influence on what is taught in schools. This has been so since before Trinidad and Tobago gained its independence from Britain in 1962. Earlier in this thesis, I made reference to a concordat approved by the then pre-independence government in 1960, which gave religious organisations partial autonomy of schools administered by them (see Appendix VII).

In 2011, fifty-one years later the concordat is still in effect and continues to dominate what is taught in denominational schools but with implications for all schools.
Foucault (1978) referred to secondary schools of the eighteenth century when;

> one can have the impression that sex was hardly spoken of at all in these institutions...[but] what one might call the internal discourse of the institution – the one it employed to address itself , and which circulated among those who made it function – was largely based on the assumption that this sexuality existed, that it was precocious, active and ever present (p.28).

As was seen earlier in this Chapter, 'Prestige Schools' in Trinidad (which are mainly denominational) did not include Health and Family Life Education in their curriculum and their schools are same sex education institutions managed by religious boards. To date, the girls' institutions employ mainly female teachers, giving credence to Foucault's claim: "the sexuality of children ... [is] problematized in the spiritual pedagogy of Christianity" (1978, p117).

The second and competing issue which came out in the Task Force Report and the HFLE Policy is the role of education in nation-building and citizenship, and preparing individuals for the workforce. Thus the struggle between religious domination and nation-building seem to override attention to the individual needs of those being educated. Added to this mix, is the attention given by Education Planners in Trinidad and Tobago to the role of education in preparing Trinidadian and Tobagonians citizens to be part of a 'global workforce.' The relevance of developing policy to address the particularities of these competing issues and guiding education practice to be student – centered are not evident from the information I have obtained in my research study.

In this regard, education and health professionals with responsibility for educating adolescents bring to their practice, what I describe as 'limited engagement'. Their engagement is related to their personal perceptions of adolescents' needs and personal interpretations of policies and their compensating for the lack of policies. Education and health professionals are also engaged in the discourse which characterises adolescents as problematic and much of their approach is about fixing these problems. They describe adolescents as troubled and respond to requests from school principals to address sexual health. There are examples in information received by Key Informants, that reveal use of

personal relationships at the operational level to implement school-based health 'initiatives', but this does not auger well for the sustainability of long term programmes. I was also told, as quoted earlier in this Chapter that policy implementation as in the case of the HFLE policy, is left to the decision of individual school principals. This reinforces the policy- practice gap I referred to earlier as well as the politicising of policies and lack of attention to policies that may not be acceptable to particular groups in society.

Among the three policy documents reviewed, there is little emphasis on national dialogue and negotiating processes for joint implementation among stakeholders. Key Informants spoke of collaboration at the operational level, but not at the policy level, although collaboration is articulated in policy documents. Further, that policy documents are not well communicated by policy makers to those expected to implement and that policies may be written but never ratified and formally adopted by the relevant government ministry. As I have indicated earlier, Trinidad and Tobago's society is based on oral traditions and policy documents may be written, filed and never be read by those for whom they were intended. Additionally, lack of implementation may be politically expedient for those who hold the power in determining what is taught in schools in Trinidad and Tobago, as lack of implementation and visibility of some polices would avoid the risk of displeasing dominant forces in society.

In the days I spent writing my research paper in the library of the Faculty of Education at the University of the West Indies in Trinidad, I initiated discussion with practising teachers who were undertaking Diplomas and Masters Degrees in Education, to ask them about policies which guide them in their practice. The general responses were that their familiarity with Policies such as the Task Force Report and the National Policy on HFLE came with their studies in Education, but neither they nor their colleagues were guided in their practice by these policy documents. Two students studying for the Masters in Education went on to say that as they neared completion of their studies there was a reluctance to return to the classroom as there appeared to be contradictions between what they had been exposed to as education students and what is practised in the classroom.

This relationship between policy and practice as expressed by these students, echo the views of my Key Informants.

The Key Informants in my study have articulated the need for things to be done differently but do not seem able to step away from their own circumstance to recognise the extent to which they are themselves products of the institutions in which they practice. They describe practices that they suggest reflect their individual approach to facilitating adolescent health and wellness, but which in my opinion do not represent the revolutionary approach which is required to address the social determinants impacting on the lives of adolescents. The policy documents state the expectations of the authors of the documents and though there were different levels of consultation in developing those policies, implementation is determined by one group in society representing the denominational school boards. Those of us with responsibility for educating adolescents must engage in an analysis of the process of policy development and implementation; and in relation to what we are willing to accept in our world and what we are willing to accept and refuse, and change both in ourselves and in our circumstances (Foucault 1991).

As I have pointed out at different stages of my analysis, there is need for collective action in addressing adolescent health and wellness, which is the only way to address the multiple determinants of adolescent health and wellness and overcome the barriers identified by Key Informants and evidenced in the documents reviewed in this Chapter.

4.8 Conclusion

I have now described and analysed the findings from my study and put forward an approach of collective action and collaboration. In the following and final Chapter, I will revisit the research process and research questions to examine the extent to which I have been able to provide answers to my research questions from my findings. I will also suggest recommendations to address these factors and for further research into education practice.

CHAPTER 5: FINAL REFLECTIONS

5.1 Introduction

In this Chapter, I reflect on my research journey and how the research experience has influenced my thinking about educating adolescents on health and wellness in Trinidad and Tobago. I also consider what I would have done differently, as the direction taken in this study is not what I had intended when I began. I revisit my research questions and consider whether I have been able to answer them and whether I have been able to achieve what I had set out to do. Finally, I look at the implications for my findings and their limitations, and make suggestions for possible future research.

5.2 Reflecting on the Research Process

I have indicated that my interest in this subject is based on years of experience as a Health Education and Health Promotion Specialist in the Ministry of Health, during which time I have worked extensively with educators from the Ministry of Education. However, throughout my experience efforts at collaboration in the field or developing policy between the two Ministries have not been sustained. Therefore, I began this research study with the expectation that the study might contribute to a clearer understanding of approaches to adolescent health and wellness and would highlight possible mechanisms for collaboration between the Ministries of Health and Education. My research questions are based on the premise that an exploration of existing documents which may impact on adolescent health and wellness, as well as in-depth conversations with health and education professionals who interface with adolescents as part of their job functions, would provide information which may be useful in improving our approach to addressing adolescent health and wellness in Trinidad and Tobago.

I sought to analyse how concepts and principles of addressing adolescent health and wellness are described in documents and interpreted by health and education professionals. Very early in my research journey I had read about Social Constructivist theories of knowledge, which I believe explained how I wanted to approach my examination of the education of adolescents in health and wellness. I came to the research

process with a life experience which exposed me to different cultures and social environments as I have lived in six different countries during my adult life. I have experienced the different social realities created in these different countries and as a health professional in my own country, I have experienced the perceptions of adolescence and youth that have become established in the Trinidad and Tobago society. I needed to understand and explain this phenomenon as I believe that this would assist me in contributing to improved approaches to addressing adolescent health and wellness. I wrote the first draft of my review of literature after extensive reading of research related to programmes targeting adolescents, reviewed documents for analysis, and obtained information from informants. However, when I approached the analysis of the data, I began to stumble. I had not heard of Critical Discourse Analysis as a method of analysis before it was introduced to me by my supervisor. Both my supervisor and my husband, who is a teacher educator, directed me to writers who had already written about some of the issues I was identifying from both my review of the literature and from my data sources. Now, I am able to link my new knowledge with the 'discourses' I experienced as a young West Indian student in London in the 1970s; exposed then to the thinking of British scholars such as Michael Young, Basil Bernstein, John and Patricia White, R. S. Peters; and generally, with the clashes between politics of the Left and Right in Britain in the 1970s.

Before embarking on my research study I was convinced that the social determinants of adolescent health and development were being ignored. Yet, I had not considered political influences and the role of power and domination by some groups in society in the management of health and education in Trinidad and Tobago, as examples of social determinants of adolescent health and wellness. Like my informants, I came to the research process with the premise that better polices, better systems and collaboration between critical Government Ministries, such as the Ministries of Education and Health, and appropriate use of Public Health Frameworks such as Health Promotion would improve how adolescent health and wellness is addressed. However, as I examined the documents I had selected for analysis, I experienced a discomfort with realities constructed about adolescents' behaviour and education practice as these realities

contrasted with my own beliefs. Further, I discovered through my readings on Critical Discourse Analysis, a description of discourse "as a category for designating particular ways of representing particular aspects of social life ... e.g. different political discourses, which represent for example problems of inequality, disadvantage, poverty, 'social exclusion', in different ways" (Furlough 2003, p. 2). Thus, as my experience in the process took a 'critical researcher' turn, I began to view my own practice differently. Although my informants and I share a concern that approaches to adolescent health and wellness are inadequate, we have neglected to tackle the underlying social determinants critically; in particular, issues such as inequality in our education system and our health systems in providing for adolescents as a group. We are also guilty in participating in approaches that universalise adolescents, ignoring social determinants of health in population groups to which some adolescents belong and failing to include in our discourse on educating adolescents, social determinants, such as race, gender and social class (Navarro, 2008).

At the initial stage of my data analysis I began to regret not adding additional questions to the interview guideline for my Key Informant Interviews and also questioned the guideline I had developed for the analysis of the documents. I believed that my guidelines did not allow for sufficient probing that would provoke responses related to socio-political influences in policy development and practice in the Ministries of Health and Education. I therefore returned to some of my informants for clarification of some of their responses, after the initial interviews. I had to look deeper at the responses from my informants to identify some of the underlying factors in their responses, to note repeated omissions, and gaps in the information shared by them. For example, responses to questions such as those related to core functions of Ministries or the process of policy formulation and implementation where adolescents are excluded and the reasons they gave for this exclusion.

Similarly, I had to pay attention to expectations for implementation revealed in policy documents as those expectations relate to readiness for policy implementation, suitability of environments for facilitating policy implementation, and lack of recognition or

acknowledgement of the socio political climates. I came to the realisation that documents which I believed could facilitate positive adolescent health and development did not address the social and economic conditions necessary for this to happen. Rather, emphasis is placed on negatively universalising adolescents and the need to fix their problems through interventions. I believe that all my informants were engaging in practice that they felt was the best that they could achieve in the given context. Further, they were unable to link their practice to the very system they were critical of, not recognising that they are products of and contribute to the production of the existing system (Bourdieu 1986, 2000).

Data from my study showed that my Key Informants' participation in the health and education systems is linked to their personal and early professional backgrounds. As indicated earlier, their strong religious affiliations came as a surprise finding and from the information they shared, they had brought these life experiences to their practice. Further, these life experiences represent part of who we are as a people in Trinidad and Tobago, shaped by the history of the country. When I first conceived of this study I had not placed the topic I was investigating in the context of the history of Trinidad and Tobago as a young nation and the development of education in a country with a history of colonisation and the influence of globalization. However, my research experience in reviewing documents and engaging in conversations with informants brought home the realisation that these factors were important to understanding present practices. In particular, the silence of my informants on the endless struggle between government officials and leaders of the Denominational schools, both sides quoting the Concordat of 1960, was revealing. Government policies that sought to move away from parochial interests were always the victim in this struggle. Now, I am able to see the wider struggle of all participants, including myself. We were caught up in present practices reflecting our historical past in spite of the difference in realities between then and now.

Through my readings for this thesis I have also been reminded that in a 'developing country', like Trinidad and Tobago, School health still conjures in the minds of educators and health professionals issues of hygiene, as communicable diseases, more common in

the past but with modern versions today like the H1N1 virus demand that we attend to hygiene and the school population is typically targeted. As our education system evolved, Secondary Education expanded and with it increased 'adolescent health problems' like Sexually Transmitted Infections, Teen Pregnancy, child poverty, etc. Responsible health and education professionals were ambivalent in our responses and blamed it on the family and lack of parenting and took an 'I am not able' position. Adolescent health issues and their determinants have changed as the country 'developed' and adults with responsibility for supporting our youth would need to catch up.

It was only after I had conducted my review of literature and been persuaded by Fairclough and Focault that I returned to my introductory Chapter to include a historical context. I now believe that I could have approached this study from a different perspective by exploring approaches to adolescent health and wellness in the context of the history of the development of education in Trinidad and Tobago. However, as I progressed in my research journey I turned to our history and the life experiences of my informants to seek out explanations for how we approach adolescent health and wellness. We as Health and Education practitioners, our partners outside of our ministries who influence what adolescents are taught in schools would need to reflect on the 'genealogy' of our practice and how we developed our personal and professional selves.

> Understanding how this way of doing things – ancient enough in self – was capable of being accepted at a certain moment ... It's a matter of shaking this false self-evidence.... Of demonstrating its complex interconnection with a multiplicity of historical processes, many of them of recent date (Foucault 1977, p. 73).

5.3 Revisiting the Research Questions and Findings

I now return to my research questions:

- What are the documents which inform the education of adolescents in health and wellness?

I identified for analysis three main documents: The Report of the National Task Force; The Caribbean Charter for Health Promotion and the Health and Family Life Education

Policy. I referred to several documents from the Ministries of Health and Education, as well as other Government Ministries as identified by my Key Informants, as influencing education approaches to adolescent health and wellness: The National Strategic Plan for Sexual and Reproductive Health; the National Youth Policy; A School Health Policy which is not yet ratified; the HIV/AIDS Policy, Drug Use and No Smoking Policy for the Education Sector. Informants also referred me to the Ministry of Education's Strategic Plan and the Ministry of Education's Corporate Plan.

In addition, informants spoke of subject areas on the Secondary School Curricula, but from the list of subjects provided, all of them with the exception of Social Studies only include information on limited aspects of health and focus mainly on physical health. In the case of the curriculum for Social Studies, information cited earlier in this Chapter demonstrates that there are Secondary School Principals who are unwilling to include Social Studies in their timetable. From the perspective of the Ministry of Education, the National HFLE Policy was identified as the 'main vehicle' which would inform the education of adolescents in health and wellness. The Ministry of Health Informants did not offer any main document, but rather reported that many of the programmes which they implemented were not informed by policies.

- What do these documents reveal about the concept and principles of addressing health and wellness in adolescents?

The overriding perception of the concept of adolescent health and wellness as revealed by the documents reviewed in this study is related to physical and psychosocial 'problems' of adolescence, and these problems need to be fixed. This contrasts with an integrated approach to school-based programmes. One document which refers to wellness, or more specifically 'well-being' is the Caribbean Charter for Health Promotion (WHO/PAHO 1993), and although this document focuses on the health of populations, it does not identify adolescents specifically. The other documents highlight a concern that problems of adolescents would impact on their future performance in the world of work; Trinidad and Tobago's National Plan of Action For Children, the National Youth Policy and the

National Policy on HFLE all refer to the need for positive development and the development of positive attitudes in adolescents. However, such expectations articulated in the documents are not translated in practice. Further, although some of these documents refer to the role of the school in addressing health and wellness, this is not placed in the context of the core curriculum of the school. In addition, the concepts and principles identified in these documents refer to the inclusion of non-academic subjects in the curriculum, but reports from informants demonstrate limited practice in going beyond academic subject areas in the classroom and lack of structure and systems in the Ministry of Health to accommodate adolescents.

- How are documents interpreted and utilised, by health and education professionals in the health and education ministries?

Informants from the Ministry of Health spoke of a lack of systems for communicating policies and plans and of problems they experience implementing these policies and plans. Although they shared their awareness of some policy documents, they admitted that these documents did not always inform their practice. Informants also spoke of not being consulted by policy makers when policies are being formulated and as a result 'end users' may not be aware that policies are being developed and the process of implementation is not included in the policy document. Awareness of policies and perceptions of the usefulness of policies differed among informants depending on their seniority in the system; the more senior professionals from both Ministries spoke more confidently about the existence of policies and draft policies, even when they had not been ratified. The most senior informant from the Ministry of Education appears to have greater expectations for implementation of policies among all the informants. However, informants from both Ministries referred to the lack of structure in addressing adolescent health and wellness at the level of the Secondary School.

- How do health and education professionals perceive their roles in addressing adolescent health and wellness and what are some of their 'self made' creative devices for promoting adolescent support?

All informants acknowledged that addressing adolescent health and wellness is a core function and that their personal and professional background had prepared them for this function. Their personal interest in adolescent health and wellness influenced their interpretations of their roles. Informants spoke of filling in what they see as missing links between policy and practice, and policy gaps. Since they are all middle managers, they also interpreted their roles as preparing others to support adolescent health and wellness. Their descriptions of programmes in which they participate reveal a mixture of approaches, some targeting what one informant described as 'dysfunctional students'; other programmes described, focus on sexuality education and nutrition. They therefore continue to engage in the discourse of adolescence as a problematic period in the life cycle. Some informants articulated the need to address the 'holistic' development of adolescents but did not provide examples of this in practice. As referred to earlier, without policy documents and implementation systems which they perceived as necessary, informants have settled for limited engagement in meeting the health and wellness needs of adolescents, without searching for strategies to address the deeper social issues that impact on the lives of adolescents.

- Are there mechanisms for collaboration in existing policies and practices in the health and education ministries to educate adolescents about health and wellness?

From the information provided there is a mix of approaches to collaboration between the Ministries of Health and Education. The three documents analysed in this research paper all recommend collaboration without concrete suggestions for how mechanisms for collaboration could be established and sustained. My interpretation of the views of informants is that there is a lack of political will to engage in collaboration across the two ministries. No example was given of strategies on the simple and clear issue of budgeting for joint programmes and projects, the end result is that joint meetings became talk shops

and well intentioned projects may never get off the ground, nor be sustained. Informants spoke of Committees established with participation from Government Ministries and Non-Governmental Organisations and linked to particular initiatives. An example of such an initiative is an Abstinence Programme for adolescents in Secondary Schools with the aim of promoting the postponement of their sexual debut as part of sexual and reproductive health. There were no examples provided of sustained mechanisms for collaboration. However, informants from the Ministry of Health spoke of their initiatives for collaboration with for example, the Ministry of Education and the Ministry of Youth and Sports. The Ministry of Education informants reported less operational collaboration. The practice of external agencies such as International Organisations and Non-Governmental Organisations initiating activities at the operational level also brought the two Ministries together for the planning and implementation of specific initiatives. In addition to the weak linkages for implementing policies and programmes, communication technology systems are underdeveloped to support collaboration.

5.4 Implications and Limitations of Findings; Recommendations for Further Research

I have used information from my data sources to answer the research questions as listed above however, I am aware that my research study has only been able to highlight some of the discursive practices and historical factors which may have influenced approaches to addressing adolescent health and wellness by the Ministries of Health and Education. Additionally, my findings are limited to my interpretation of the data I obtained and cannot be generalised as applicable to all approaches to adolescent health and wellness in Trinidad and Tobago. However, based on my limited findings, I have put forward the following recommendations:

My first suggestion for future research is a review of past research studies which looked at the way in which students are defined by their socio-economic status to consider how this influences what they are taught in the different types of Secondary Schools in Trinidad and Tobago. My own review of past research and from what was reported by

informants suggest that the different types of Secondary Schools have different approaches to educating adolescents about health and wellness and this practice is linked to perceptions of what subject areas are more suited to students from different socio-economic populations.

Examples of related past research include, Jules (1994), who looked at placement patterns and practices in Secondary Schools in Trinidad and Tobago and highlighted the differences in the socio-economic status of students in the different types of Secondary Schools and the history of social 'exclusivism' in education. Deosaran (2003) identified the complex relationship between children's socio-economic status, single and both parent families, access to the different types of secondary schools and deviant behaviour and violence in secondary schools. Other reports have identified the influence of race, religion, social class and exclusivity on education practice in Trinidad and Tobago (Jules 1994, Maurice 1957, Samaroo and Dabydeen1987). I have learnt from this research experience that change has to start with how we in Trinidad and Tobago continue to perpetuate the negative characteristics we have attributed to adolescents. Further, we have to isolate and prohibit those practices which we have come to accept, which promote exclusivity, exclusion and stratification in education, before there can be a change in policies and systems.

I have been critical of the emphasis on Behaviour Change for adolescents but I have also been guilty of focussing on systems and policies and less on the socio-political factors affecting approaches to adolescent health and wellness. I am therefore suggesting that a review of past research studies would assist in shaping new research to look at present practice in both the Ministries of Health and Education as it relates to the recognition of social determinants of adolescent health and wellness.

In this regard, my second suggestion is for future research to identify the current social determinants of adolescent health which could contribute to relevance and appropriateness of guidelines for policy development. In addition, that there be involvement of policy makers and practitioners as social determinants are explored so

that there is participation and not prescription between the two groups. I believe that an awareness of these determinants can contribute to policies that reflect differences among adolescents and do not make assumptions of homogeneity. This would also allow policy development to be guided by evidence coming out of research and not by political, religious or other agencies.

My third suggestion relates to the practice of collaboration. According to informants, collaboration and joint ownership of initiatives between the Ministries of Health and Education are not formalised and sustained. I believe that Trinidad and Tobago can benefit from looking at international practices in collaboration for addressing adolescent health and wellness. I am interested in collaboration based on the premise that since all aspects of a child's life impact on his or her potential for positive development and transition into adulthood; different agencies and sectors working together increases the possibilities for a successful transition. In addition, among all other agencies, the school represents a learning environment and partnerships have the potential to enhance learning by providing services through a system already familiar to children and adolescents (Kochar-Byant 2010). Health Educators and other health professionals with responsibility for adolescent health, teachers and teacher educators must be educated about the total interplay of social determinants on the lives of adolescents through pre and in-service training. This new knowledge would serve to enhance their understanding of the benefits of collaboration between these two critical ministries of government.

My last suggestion is for long term monitoring of how adolescent health and wellness is addressed by both the Ministries of Health and Education. It is important for policy makers to be aware of the dynamics of the adolescent population in Trinidad and Tobago. Health and Education approaches to adolescent health where they exist, have been universalised in Trinidad and Tobago even though the rhetoric coming from policy makers indicate differently. Research studies (Deosaran 2003; Jules, 1994) have highlighted the challenges faced by adolescents from lower socio-economic groups in our education system. This group also has to access health services from a system that does not cater for them, while their peers of higher socio-economic status can access private

health services. More attention has to be given to this group, to determine size, geographic location, family types and special needs, and this has to be monitored over time. This should include how financial, human and material resources are allocated for the provision of services. The issue of adequate and efficient financial, human and material resources is critical to ensuring that health and wellness needs of all adolescents are addressed.

5.5 Final Words

On more than one occasion, in discussing the topic of my research study with individuals outside of the field of health and education, I have been asked whether the school should be responsible for the health of students. This is certainly not a new question and in light of the fact that the determinants of health are many and varied, the role of the school in addressing some of these determinants, widens the debate further. One reason put forward is that learning is hindered when a student is in poor health (World Bank 1993). My own thoughts are that although I have outlined challenges faced by the school in addressing health and wellness, the 'problems of adolescence' to which I have so frequently alluded, should be put in the context of adolescents' particular ability to respond to positive environments. This is related to the characteristic of the "relatively plastic relations between adolescents and their contexts" referred to in an earlier Chapter (Lerner and Steinberg 2004 p. 8). My recommendation therefore is for a systematic approach to preparing school environments to become supportive environments for adolescent health and wellness. The Health Promoting School Initiative provides the necessary framework. This would also require preparation of the Ministry of Health and its agencies to partner with the Ministry of Education in the context of the requirements for collaboration outlined earlier in this Chapter. Further, education for health and wellness requires a radical shift in curriculum engineering that moves away from the promotion of inert knowledge towards social action programmes in an environment that promotes empowerment of adolescents.

Finally, at this stage in the history of Trinidad and Tobago, we need to continue to move away from the model of education that was assumed to be the norm when the Concordat with the

Religious Denominations was established in 1960. The model was located in the exclusivity of race, religion and class that espoused the right to 'preserve the religious character' and not the 'national character' of schools and schooling. This phrase continues to hinder all attempts to broaden the educational base to incorporate equity, social justice and fairness. The new direction should recognise adolescence as a normal stage in the life cycle and support adequate provision of resources for health and education for all children and adolescents. This new model should also use approaches that extend education practice beyond the classroom by engaging adolescents, their parents and communities and encouraging adolescents to be participants in their own education.

REFERENCES

Allen C, Da Costa-Martinez D, Wagner U, Mc Letchie K, De-Gazon W, Chapman-Smith A and Wright M (2002) 'The Sexual Behaviour of Youth in Tobago: A Report on the Development of a Health Promotion Project' *West Indian Medical Journal* 51 (3)197.

Alleyne G (2003) 'The Prospect for Health and Wellness in the Carribean' Presented at the 50th Anniversary of the University Hospital of the West Indies Kingston Jamaica www.caribank.org (Accessed on: 20 Oct. 2010).

Alleyne G (2008) *Health and Development in our Time: Selected Speeches of Sir George Alleyne* Prof. Henry Fraser (ed.) Jamaica: Ian Randle.

Bakker C Elings-Pels M and Reis M (2009) 'The Impact of Migration on Children in the Caribbean' UNICEF Office for Barbados and the Eastern Caribbean www.unicef.org/barbados/impact_of_migration (Accessed on:16 Nov.2010).

Ball S J (1990) 'Policy Matters!' *Politics and Policy Making in Education* London: Routledge.

Ball S J (1997) 'Policy Sociology and Critical Social Research: a personal review of recent education policy and policy research' *British Educational Research Journal* 23(3)257 -274.

Ball S J (2001) 'Global Policies and Vernacular Politics in Education' *Curriculo sem Fronteras* 1 (2) xxvii-xliii.

Barbour R S and Schostak J (2005) 'Interviewing and Focus Groups' in B Somekh and C Lewin (eds.) *Research Methods in The Social Sciences* London: Sage Publications pp.41-48.

Bartholomew L K, Parcel G S, Kok G and Gottlieb N H (2001) *Intervention Mapping: Designing Theory and Evidence based Health Promotion Programs* Mountain View California: Myfield Publishing Company.

Berger P L and Luckman T (1966) *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* New York: Anchor Books

Blum R W (2003) 'Protective Factors in the Lives of Youth: The Evidence Base' World Bank HDNCY Youth Development Lecture Series www.worldbank.org/childrenandyouth (Accessed on: 15 June 2010).

Bourdieu P (1986) 'Social Space and Symbolic Power' *Sociological Theory* 7 (1) (Spring, 1989) pp. 14-25 http://www.soc.ucsb.edu/ct/pages/JWM/Syllabi/Bourdieu/ SocSpaceSPowr.pdf (Accessed on: 15 May 2010.)

Bourdieu P (2000) 'Against Objectivism: the reality of the social fiction' in P Sikes, J Nixon and W Carr *The Moral Foundations of Educational Research: Knowledge, Inquiry and Values,* Maidenhead: Open University Press pp.68-85.

Braithwaite B A (2009) *An Exploration of Youth Risks in the Caribbean, through the Voices of Youth.* sta.uwi.edu/conferences/09/salises/ (accessed November 6, 2011.)

Brathwaite R H E (1983) 'Comments of Secondary School students on Teachers, Schools, Education, etc. 1971-1981: The Still Small Voice of the Student'. Unpublished paper: The University of the West Indies, Trinidad and Tobago.

Buck C (1985) 'Beyond Lalonde: Creating Health' in Pan American Health Organization PAHO (1996) *Health Promotion: An Anthology* Scientific Publication No. 557 Washington D.C: PAHO pp.6-13.

Brown S L Teufel J A and Birch D A (2007) 'Early Adolescent Perceptions of Health and Literacy' *Journal of School Health* 77 (1) 7-15.

Campbell C (1992) *Colony and Nation: A short history of education in Trinidad and Tobago 1834-1986* Jamaica: Ian Randle Publishers.

Campbell C (1996) *The Young Colonials: A Social History of Education in Trinidad and Tobago1834-1839* Jamaica UWI.

Cannell C F and Kahn R L (1968) cited in L Cohen, L Manion and K Morrison (2003) *Research Methods in Education* London: Routledge Falmer p. 269.

CARICOM/PAHO (2005) 'Report on the Caribbean Commission on Health and Development Overview for the Twenty-sixth Meeting of the Caribbean Heads of Government' www.vision2020.info.H/pdf/ (Accessed on: 16 Nov. 2010).

CARICOM (2010) Report of the CARICOM Commission on Youth Development (CCYD) http://www.caricom.org/jsp/community_organs/cohosod_youth/eye_on_the_future (Accessed on: 22 June 2011).

Carr W (1998) *For Education: Towards Critical Educational Inquiry* Buckingham: Open University Press.

Carr W (2003) 'Educational research and its histories' in P Sikes, J Nixon and W Carr (eds.) *The Moral Foundations of Educational Research: Knowledge Inquiry and Values* Maidenhead: Open University Press pp. 6-17.

Central Statistical Office - CSO (2000) *Population and Housing Census 2000: Demographic Report* Ministry of Finance, Trinidad and Tobago: CSO Printing Unit.

Clift S and Jensen B B (2005) *The Health Promoting School: International Advances in Theory, Evaluation and Practice* Copenhagen: Danish University of Education Press.

Cocoran T (2011) 'Health Inclusive Education' *International Journal of Inclusive Education* 15 (1) 1-14.

Codd J A (1998) 'The construction and deconstruction of education policy documents' *Journal of Education Policy* 3(3) 235-247.

Cohen L, Manion L and Morrison K (2000) *Research Methods in Education* London: Routledge Falmer.

Coleman J C and Hendry L B (1999) 'The Nature of Adolescence' Adolescence *and Society Series* 3rd ed. London and New York: Routledge.

Commission on Social Determinants of Health - CSDH (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health* Geneva: World Health Organization.

Currie C (2009) 'Social Determinants of Adolescent Health' *International Journal of Public Health* 54 S125-S127.

Denzin N K and Lincoln Y S (2003) *The Landscape of Qualitative Research: Theories and Issues* London: Sage Publications.

Deosaran R (2003) 'Benchmarking Violence and Delinquency in Secondary School: Towards a Culture of Peace and Civility' unpublished paper: University of the West Indies, Trinidad.

Dewey J (1897) My Pedagogic Creed *School Journal* 54 pp 77-80.

Fairclough N (1992) 'Discourse and text: Linguistic and Intertextual Analysis within Discourse Analysis' *Discourse and Society* 3 (2)193-217.

Fairclough N (1993) Critical Discourse Analysis and the Marketization of Public Discourse: *Discourse and Society* (4) 133 http://das.sagepub.com

(Accessed on: 5 June 2010).

Foucault M (1972) *The Archaeology of Knowledge and the Discourse on Language*, translated by A. M. Sheridan-Smith.

Foucault M (1977) Nietzsche, genealogy, history, in Bouchard (ed.) *Language, Counter-memory, Practice: Selected Essays and Interviews* Ithaca NY: Cornell University Press pp. 139-164.

Foucault M (1980) *Power/Knowledge* Gordon C (ed.) London: Harvester Wheatsheaf.

Foucault M Carette J R (1980) 'About the beginning of the hermeneutics of the self' in Carette J R (ed.) (1999) *Religion and Culture* Manchester: Manchester University Press pp. 158-182.

Foucault, M. (1990/1978/1976) *The History of Sexuality: Volume 1 An Introduction Part 3 Domain* Translated by Robert Hurley New York, NY: Vintage Books pp. 103-114.

Foucault M (1991a) 'Governmentality' in Burchell G Gordon C and Mille P (eds.) *The Foucault Effect: Studies in Governmentality* Hemel Hemstead: Harvester Wheatsheaf pp. 87-104.

Foucault M (1991b) 'Questions of Method' Burchell G Gordon C and Mille P (eds.) *The Foucault Effect: Studies in Governmentality* Hemel Hemstead: Harvester Wheatsheaf pp. 73-86.

Focault M (1997) cited in Brown T and Heggs D (2005) 'From Hermeneutics to Poststructuralism to Psychoanalysis' in B Somekh and C Lewin (eds.) (2005) *Theory and Methods in Social Research* London: Thousand Oaks.

Gergen K (1985) 'The Social Constructionist Movement in Modern Psychology' *American Psychologist* 40 (3) 266-275.

Giedd J N, Blumenthal J, Jeffries N O, Castellanos F X, Liu H, Zijdenbos A, Paus T, Evans A C and Rapoport J L (1999) 'Brain development during childhood and adolescence: a longitudinal MRI study' *Nature Neuroscience* 2(10) 861-863.

Golbart and Hustler 'Ethnography' (2005) in B Somekh and C Lewin (eds.) *Research Methods in the Social Sciences* London: Sage Publications pp.16-25

GORTT (2004) *Vision 2020 National Operational Plan 2007-2010* Government of the Republic of Trinidad and Tobago.

Green L W Kreuter M W (1999) *Health Promotion Planning: An Educational and Ecological Approach* 3rd ed. Mountain View California: Mayfield Publishing company.

Halcón L, Robert W B, Beuhring T, Pate E, Campbell-Forrester S, and Venema A (2003) 'Adolescent Health in the Caribbean: A Regional Portrait' *American Journal of Public Health* 93 (11) 1851-1857.

Harney S (1996) 'Nationalism and Identity' *Culture and the Imagination in a Caribbean Diaspora* London: Zed Books.

Health and Human Development Programs (2005) 'HHD Partners to Develop a Curriculum Framework for Health and Family Life Education in the Caribbean' *HHD News* http://www.hhdnews/hhdstories/fs_09_2005.asp Accessed 12 Jan 2010.

Henry Fitzroy (2004) 'The Obesity Epidemic – A Major Threat To Caribbean Development: The Case For Public Policies' *Cajanus* 33 (1) 3-21.

Joint Committee on Terminology (2002) *Journal of School Health* 72(1) 3-7.

Jules V (1992) 'Cooperative Learning: Student Perceptions of the Changing Structure of Learning' *Contemporary Education* LXIII(3) 191-194.

Keenan P J (1869) 'Report upon the State of Education in the Island of Trinidad and Tobago' Dublin: Her Majesty's Stationery Office.

Kelly M J and Bain B (2005) *Education and HIV/AIDS In the Caribbean* UNESCO Jamaica: Ian Randle Publishers.

Kogan M and Bowden K (1975) *Educational Policy Making: A Study of Interest Groups and Parliament* London: Allen & Unwin.

Lavia J and Sikes P (2010) 'What part of me do I leave out?: in pursuit of decolonizing practice' *Power and Education* 2 (1) 85-96 http://www.wwwords.co.uk/power/content/pdfs/2/issue2_1.asp Accessed 20 (accessed March 2011).

Lee A St Leger L Francis F K (2007) *The status of health-promoting schools in Hong Kong and implications for further development* Oxford Journals Medicine Health Promotion International Volume22, Issue4 Pp. 316-326.

Lerner R M Steinberg L (2004) *Handbook of Adolescent Psychology* (2nd ed.) Hoboken, N J: John Wiley & Sons.

Lerner R M (2005) *Promoting Positive Youth Development: Theoretical and Empirical Bases* White paper prepared for: Workshop on the Science of Adolescent Health and Development, National Research Council, Washington, DC.

London NA (2003) *Pathways To Educational Transformation And Development: Policies, Plans and Lessons* Toronto: Canadian Scholars' Press.

Louisy P (2001) 'Globalisation and comparative education: a Caribbean perspective' *Comparative Education* 37(4), 425-438.

Louisy P (2004) 'Whose context for what quality? Informing education strategies for the Caribbean' *Compare* 34 (3) 285-292.

Louisy P (1997) 'Dilemmas of Insider Research In a Small Country Setting – Tertiary Education in St Lucia' in Crossley and Vulliamy (eds.) Qualitative *Educational Research in Developing Countries* New York and London: Garland Publishing Inc pp. 199-205.

Marmot M (2009) Social Determinants and adolescent health International *Journal of Public Health* 54 S125- S127.

Mc Kenzie J F, Neiger B L and Smeltzer J L (2005) *Planning, Implementing & Evaluating Health Promotion Programs: A Primer* San Francisco: Pearson Benjamin Cummings.

Medina J (2005) *Language: Key Concepts in Philosophy* London: Continuum.

Ministry of Education - MOE (2000) SEMP *Secondary Modernisation Programme Providing Quality Secondary Education For All* Republic of Trinidad and Tobago: Government Printery.

Ministry of Education - MOE (1993) National Task Force *Education Policy Paper 1993 – 2000* Republic of Trinidad and Tobago: Government Printery.

Ministry of Education - MOE (2001) *National Policy on Health and Family Life Education* Republic of Trinidad and Tobago.

Ministry of Education - MOE (2005) Division of Educational Research and Evaluation, Republic of Trinidad and Tobago.

Ministry of Education - MOE (2006) *Draft Curriculum Policy for the Education System in Trinidad and Tobago: Preschool to Secondary* Republic of Trinidad and Tobago.

Ministry of Education - MOE (2008) *Ministry of Education Corporate Plan* Unpublished Document: Republic of Trinidad and Tobago.

Ministry of Education - MOE (2010) *The Rapid Situation Analysis of the Education Sector Response to HIV/AIDS in the Context of School Health and Nutrition in Trinidad and Tobago* London: Imperial College.

Ministry of Education – MOE website: www.moe.gov.tt (Accessed on: 10 January 2011).

Ministry of Health -MOH (1996a) Adolescents *accessing Health Services in the North West Regional Health Authority* Unpublished Focus Group Report. Republic of Trinidad and Tobago.

Ministry of Health - MOH (1996b) *Spotlight on Health: Report on the health situation of Trinidad and Tobago* Republic of Trinidad and Tobago.

Ministry of Health - MOH (1998) *Adolescent Health Survey* Republic of Trinidad and Tobago.

Ministry of Health - MOH (2001) *Report on Revised Organizational Structure Technical Systems* (Unpublished Report) Republic of Trinidad and Tobago.

Ministry of Health - MOH (2008) *School Health Policy* Republic of Trinidad and Tobago.

Ministry of Health - MOH website: www.health.gov.tt (Accessed 10 January, 2011)

Ministry of Social Development - MOSD (2005) *National Plan of Action for Children 2006-2010* Republic of Trinidad and Tobago.

Mullings J Paul T (2007) 'Health sector challenges and responses beyond the Alma-Ata Declaration: A Caribbean Perspective' *Pan American Journal of Public Health* 21(2/3) pp 155-161.

Naipaul V S (1974) 'Conrad's Darkness' in *The Return of Eva Peron: The Killings in Trinidad* New York: Knopf.

Navarro V (2009) 'What We Mean by Social Determinants of Health' *International Journal of Health Services* 39 (3) 423-441.

Nutbeam D (1998) 'Health Promotion Glossary' World Health Organization - WHO WHO/HPR/HEP/98.1.

Nutbeam D and Blakey V (1990) 'The Concept of Health Promotion and AIDS Prevention: A Comprehensive and Integrated Basis For Action in the 1990s' *Health Promotion International* 5(3): 233-242.

Omarova S Miklesone V and Kalnins I (2000) 'An Evaluation of the Impact of Health Promoting Schools in Latvia 1993-2000' in Clift S and Jensen B B (2005) *The Health Promoting School: International Advances in Theory, Evaluation and Practice* Copenhagen: Danish University of Education Press pp. 423 - 426

Opie C Sikes P (2004) *Doing Educational Researchers: A Guide to First Time Researchers* London: Sage Publications Ltd.

Pan American Health Organization - PAHO (1996) *Health Promotion: An Anthology* Scientific Publication No. 557 Washington D.C: PAHO.

Pan American Health Organization - PAHO (2005) *Youth: Choices and Change Promoting Behaviours in Adolescents* Washington DC: PAHO.

Pan American Health Organization - PAHO (2007) *Health Promotion in the Republic of Trinidad and Tobago 1993 -2006* Unpublished document, Trinidad and Tobago Country Office: PAHO.

Piper H Simons H (2005) 'Ethical Responsibility in Social Research' in Somekh B Lewin C (eds.) (2006) *Research Methods in the Social Sciences* London: Sage Publication pp. 56 - 61

Potter J (2004) 'Discourse Analysis' in A Bryman and M Hardy (eds.) *Handbook of Data Analysis* London: Sage Publications pp. 607 - 624

Procope-Beckles M (2007) *Trinidad and Tobago GSHS Report* PAHO CDC GSHS http://www.who.int/chp/gshs/2007_GSHS_Trinidad_and_Tobago_Report.pdf

Pring R (2000) *Philosophy of Educational Research* London: Continuum Publishing Co.

Qvortrup J (1990) *Childhood as a Social Phenomenon: An Introduction to a Series of National Reports* Vienna: Eurosocial.

Rampersad J (2008) *Inside the CARICOM Multi-Agency Health and Family Life Education (HFLE) Project: A Postructural Analysis of Policy and Practice* Unpublished PhD Thesis, The University of the West Indies.

Read D S Joseph MA Polishchuk V and Suss AL (2010) 'Attitudes and perceptions of the HPV vaccine in Caribbean and African-American adolescent girls and their parents' Journal of Paediatric and Adolescent Gynaecology 23(4): 242-5

Ricoeur P (1981) *Hermeneutics and the human sciences* in J B Thompson (Ed) Cambridge UK: Cambridge University Press pp

Rissel C and Rowling L (2000) 'Intersectoral Collaboration for the Development of a National Framework for Health Promoting Schools in Australia'

Journal of School Health 70 (6) 248 -250.

Rogers E (1993 'Diffusion of Innovations' in R Bunton and G McDonald *Health Promotion Disciplines and Diversity* London: Routledge.

Samaroo B and Dabydeen D (eds.) 1987 *India in the Caribbean* London: Hansib Publishing Company.

Samaroo Brinsley, *Education as socialization form and content in the syllabus of Canadian Presbyterian Schools in Trinidad.* Caribbean Curriculum School of Education, UWI, Trinidad. Vol.6 No.1 1996 pp.23-37.

Senah C (2006) '*Curriculum Reform and Innovations in Education in Trinidad and Tobago'* unpublished Sheffield Ed.D Assignment.

Sikes P Goodson I (2003) 'Living research: thoughts on educational research as moral practice' in Sikes P, Nixon J and Carr W *The Moral Foundations of Educational Research: Knowledge, Inquiry and Values* Maidenhead: Open University Press pp. 32 – 51.

Sikes P and Potts A (eds.) (2008) *Researching Education From the Inside: Investigating Institutions From Within* London: Routledge/Falmer.

Somekh B Lewin C (eds.) (2006) *Research Methods in the Social Sciences* London: Sage Publication.

Steunberg L Morris Sheffield A (2001) 'Adolescent Development' Annual Review Psychology 52:83-110 arjournals.annualreviews.org University of Colorado.

St Leger L (2004) 'What's the place of schools in promoting health? Are we too optimistic?' *Health Promotion International* 19(4) 405-408.

The International Bank for Reconstruction and Development / The World Bank (2003) *A World Bank Country Study, Caribbean Youth Development Issues and Policy Directions.*

The University of the West Indies - UWI Centre for Health Economics (2009) *Poverty and HIV/AIDS in the Caribbean* unpublished report to PANCAP Caricom Secretariat.

Tikly L (2001) 'Globalism and Education in the Postcolonial World; towards a conceptual framework' *Comparative Education* 31 (2) 151-171.

Tones K (2005) 'Health Promotion in Schools, the Radical Imperative' in Clift S and Jensen B (eds.) *The Health Promoting School: International Advances in Theory, Evaluation and Practice* Copenhagen: Danish University of Education Press pp. 23-39.

Ungar M (2005) 'Resilience among Children in Child Welfare, Corrections, Mental Health and Educational and Settings: Recommendations for Service' *Child & Youth Care Forum* 34 (6) pp. 445-464.

Wallack L and Montgomery K (1992) 'Advertising by the year 2000: Public Health Implications' *Journal of Public Health Policy* 13 (2) 204-223.

Wellington J (2000) *Educational Research Contemporary Issues and Practical Approaches* London and New York: Continuum Publishing Co.

Williams E (1942) *History of the People of Trinidad and Tobago* NY A &B Publishers Group.

Wood D (1998) *Trinidad in Transition: the years after slavery* London: Oxford University Press.

Woodside-Jiron H (2003) 'Critical Policy Analysis: Researching the Roles of Cultural Models, Power, and Expertise in Reading' *Reading Research Quarterly* 38(4) 530-536.

World Bank (2003) 'Caribbean Youth Development Issues and Policy Directions' A World Bank Country Study http://www.obrayouthalliance.org/sites/default/files/Caribbean_Youth_Development_WB.pdf (Accessed on: 14 January 2010).

World Health Organization- WHO (1986) *Ottawa Charter for Health Promotion* http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ (Accessed on: 20 March 2009).

World Health Organization - WHO (1998a) *Health Promotion Glossary Geneva*: WHO http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf (Accessed on: 12 Jan.2009).

World Health Organization-WHO (1998b) WHO's Global School Health initiative: Helping Schools to Become "Health Promoting Schools." *Fact Sheet* 92 http://www.who.int/school_youth_health/gshi/hps/en/index.html (Accessed 12Jan 2009).

World Health Organization-WHO (2004) *Young people's health in context: Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey* Geneva: WHO.

World Health Organization - WHO (2010) Key Concepts of Social Determinants of Health http://www.who.int/social_determinants (Accessed on: 30 Oct 2010).

World Health Organization - WHO (2011a) 'Global School Health Initiative' http://www.who.int/school_youth_health/gshi/en/ (Accessed on: 6 April 2011).

World Health Organization - WHO (2011b) 'Evidence-informed Policy Network' http://www.who.int/rpc/evipnet/en/ (Accessed on: 16 June 2011).

Young M (1999) 'The Curriculum as Socially Organised Knowledge' *in* R McCormick and C Paechter eds. *Learning and Knowledge publication details.* pp56-101

Zubrick S, Silburn S, Vimpani G and Williams A (1999) 'Emergent Demand for Measurement Indicators of Social and Family Functioning' in L St. Leger (2000) 'Developing Indicators to enhance school health 'Health *Education Research Theory and Practice,* 15 (6)719-728.

Appendix I - Information Sheet

Research Topic: The Education of Adolescent Secondary School Students (10-19 years) in Health and Wellness: A Review of Policies, Systems and Approaches in the Ministries of Health and Education in Trinidad and Tobago.

You are being invited to take part in a research project. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part.

Early habit formation in children has been linked to health status in adult life. In Trinidad and Tobago, the Ministry of Health and the Ministry of Education have been implementing health and wellness programmes targeting adolescent secondary school children, however these programmes are not implemented as part of the core functions of the two ministries. My proposed research is seeking to review policies, systems and approaches being utilised to educate adolescent students about health and wellness and the nature of collaboration between the two ministries.

To obtain this information I will examine and review documents such as policies, plans, organisational frameworks and protocols; and conduct Key Informant Interviews with selected persons from the Ministries of Health and Education. You have been selected as you can provide information to assist me in gaining insight into the approaches used to educate adolescent secondary school students in health and wellness. Your interview is not expected to last more than one hour, however it may be necessary to follow the interview with a phone call to clarify information received.

Whilst there are no immediate benefits for individuals participating in this project, it is hoped that this research will provide new knowledge on educating adolescent secondary school students about health and wellness, which in turn can contribute to our collective understanding of some of the issues involved in the education of adolescents.

All the information that you provide will be kept strictly confidential. You should not be able to be identified in any reports or publications. Only code numbers will be used in analysing the information and neither your name nor designation will be included in the report. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form) but you can withdraw at any time without giving a reason.

The research proposal has undergone ethical review by the School of Education of the University of Sheffield. I am the only investigator and am conducting this research as a requirement for an Education Doctorate and should complete the research in the first quarter of 2010. The report will be shared with the Permanent Secretaries and staff of the Ministries of Health and Education.

If you have any complaints, you may contact my supervisor, Dr. Tim Cocoran at the Department of Educational Studies, The Education Building, 388 Glossop Road, Sheffield S10 2JA, England. Tel 44(0)114 222 8185.
For further information you may contact me: **Carol-Ann Senah 3 Silk Cotton Drive, Champs Fleurs. Tel. 662 2756 or 488 6202**

Thank You for participating in this project.

Appendix II

Participant Consent Form

Title of Project: ***Educating Adolescent Students in Health and Wellness: A Review of Policies, Systems and Approaches in the Ministries of Education and Health in Trinidad and Tobago***

Name of Researcher: Carol-Ann Senah

Participant Identification Number for this project: 50220500

Please initial box

1. I confirm that I have read and understand the information sheet dated 14/07/08 for the above project and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. Contact number of researcher 662 2756/488 6202 ☐
3. I understand that my responses will be anonymised before analysis. I give permission for members of the research team to have access to my anonymised responses. ☐
4. I agree to take part in the above research project. ☐

Name of Participant (*or legal representative*)	Date	Signature
Name of person taking consent (*if different from lead researcher*) *To be signed and dated in presence of the participant*	Date	Signature
Lead Researcher *To be signed and dated in presence of the participant*	Date	Signature

Research and Innovation Services

New Spring House

231 Glossop Road

Sheffield S10 2GW

17 February 2010

Head of School
Professor Jackie Marsh

Department of Educational Studies
The Education Building
388 Glossop Road
Sheffield S10 2JA

Telephone: +44 (0114) 2228115
Fax: +44 (0114) 2796236
Email: t.a.earnshaw@sheffield.ac.uk

Ethics approval

I confirm that the student(s) listed below are following the EdD programme and their research studies have been ethically reviewed and approved according to School of Education procedures which have been accredited by U-REC.

Carol-Ann SENAH 050220500

Yours sincerely

Dr Simon Warren
Chair School of
Education Research Ethics Committee

Appendix III - Analysis of Documents: Guide

1. What are the main points in this document?
   What is the hierarchy of importance accorded to these points?

2. What are the stated or indicated implementation expectations or activities?

3. Are the implementing agencies clearly identified in the document?
   What is the level of difficulty expected?

4. What does the document expect in the area of general collaborations and multi sector support?

5. Does the document mention the specific roles of individuals either in guiding or taking direct action?

6. Does the document indicate broad interests with previous studies?

7. How often do the following concepts and terms appear in the document?:
   Adolescent
   Youth
   Working Together,
   Collaboration
   Government
   Ministries
   Sex/Sexuality
   Supervision/Guidance
   Lifestyle
   Nurturing
   Behaviour Change
   Deviance
   Hope/Aspirations
   NGOs/CBOs/FBOs
8. What does the document expect in the area of general collaborations and multi sector support?

9. Does the document mention the specific roles of individuals either in guiding or taking direct action?

10. Does the document indicate broad interests with previous studies?

11. How often do the following concepts and terms appear in the document?

12. How are the following defined in the document:
    - Health/wellness –
    - Purpose of education –

END

Appendix IV - Key Informant Interview Guide

Ministries of Health and Education

1) Can you tell me a little bit about your background/professional development

2) Does your ministry address health and wellness in adolescents?

3) How does your ministry address/meet the needs of adolescents?

4) Do you know of any policies in your ministry addressing adolescent health?

5) If yes, what are the policies?

6) Are policies individual policies or policies emanating from a broader policy?

7) Do you know if there are any particular processes for developing such policies in your ministry?

8) If yes, can you tell me a little bit about the process?

9) How are policies made known to staff?

10) Is there an implementation/action plan policies?

11) Do these policies inform activities/initiatives in the organisation?

12) If yes, can you give examples of such activities/initiatives?

13) Is there a Monitoring and Evaluation Plan for policy implementation?

14) How are adolescent health and wellness interventions implemented?

15) Who participates in the process?

16) Tell me a little about the departments and units of your ministry: Are there units/departments assigned with special responsibility for adolescent health and wellness?

17) What about procedures and protocol for addressing health and wellness?

18) Are there dedicated resources for adolescent health and wellness?

19) What do you think are your core functions in your ministry?

20) How do you view adolescent health and wellness in terms of your core functions?

21) What about working with other ministries and/or stakeholders? Are there existing structures or planned opportunities for collaboration?

22) Do you use information technology in communicating with other ministries and stakeholders?

23) If not, why not?

24) Are there stakeholders outside of your ministry who influence your policies and programmes?

25) Does any of the following take place in your ministry: joint planning, joint policy development or joint implementation between your ministry and any other organisation?

26) If yes, who initiates joint activities?

27) Does your performance appraisal acknowledge your functions in relation to adolescent health and wellness?

28) Is there anything else you would like to add about addressing adolescent health and wellness in your ministry?

End

THANK YOU

Appendix V - Documents Data

Document: Caribbean Charter for Health Promotion

13. What are the main points in this document?
    What is the hierarchy of importance accorded to these points?
    (pg1, col1, pr5):
    The health problems of today and tomorrow [in the Caribbean] are increasingly complex and evermore related to social, economic and behavioural factors, [thus there is a need for] a new approach
    (pg1, col 2, hd - health promotion):
    Heath promotion is the new approach.
    - It focuses on health and wellness and demands close collaboration among health and other sectors.
    - (pg2, col 2, last pr)It must build on the aspect of Caribbean Culture that embraces community action and the tradition of the extended family.
    - (pg3, col1, hd - developing/increasing personal health skills)It must recognize the critical importance of early childhood education and take account of the values beliefs and customs of the community
    - (pg 3, col2, pr 2) Media must be key players in this partnership, bring their considerable power and influence.

14. What are the stated or indicated implementation expectations or activities?
    (pg 2, cl1, hd – strategies)
    - Formulating healthy public policy
    - Reorienting health services
    - Empowering communities to achieve well-being
    - Creating supportive environments
    - Developing/increasing personal health skills
    - Building alliances with special emphasis on the media
    - (pg 3, cl2, last pr) that the Ministers of Health should adopt this Charter and so strive an work in collaboration with all the relevant social partners to take actions than can transform this Charter into living instrument

15. Are the implementing agencies clearly identified in the document?
    What is the level of difficulty expected?
    No; the two broad agencies mentioned are government and media. The level of difficulty is expected to be high due to the need for
    - (pg 1, cl2, hd – health promotion) close collaboration among health and other sectors
    - (pg2, cl2, pr1) Consensus among critical actors and sectors
    - (pg 2, cl2, last pr) embracing Caribbean culture and tradition of the extended family
    - (pg3, cl2, pr3) imperative reciprocal relationship between the media an health related sectors

16. What does the document expect in the area of general collaborations and multi sector support?
    - (pg2, cl1, last pr) multi sectoral, multi disciplinary formulation of healthy public policy
    - (pg 1, cl2, hd – health promotion) close collaboration among health and other sectors
    - (pg3, cl2, pr3) imperative reciprocal relationship between the media an health related sectors

17. Does the document mention the specific roles of individuals either in guiding or taking direct action?
    - (pg3, cl2, pr 2) Governments – to achieve a health physical, social, economic and political environment
    - (pg 3, cl2, pr2) Media – bring their considerable power an influence to bear on the formulation of policies and programmers that affect the health of the people

18. Does the document indicate broad interests with previous studies?
    - (pg 1, cl1, pr3) the cooperative action of Caribbean people in health is the tradition of previous efforts, declarations and initiatives dating back to 1978 Declaration on Health for the Caribbean Community'
    - 1986 Caribbean Cooperation in Health Initiatives join framework and
    - 1191-1194 pan American Health Org's Strategic Orientation and Programme Priorities for the Quadrennium.

    How often do the following concepts and terms appear in the document?:

Adolescent	0
Youth	0
Working Together, Collaboration	pg1, cl1, pr2 pg1, cl1, pr 3 pg1, cl2, pr 3 (hd:health pro) pg2, cl1, hd:strats pg2, cl1, last pr pg3, cl2, pr2
Government Ministries	pg1, cl1, pr1 pg1, cl1, pr3 pg3, cl2, last pr
Sex/Sexuality	0
Supervision/Guidance	pg3, cl1, 2nd last pr
Lifestyle	0
NGOs/CBOs/FBOs	building alliances with media
Nurturing	0
Changing Behaviour	pg2, cl2, last pr

Deviancy	0
Aspirations/Hopes	0

How are the following defined in the document:

- Health/wellness – (pg1, col2, hd health promo) physical mental, social and spiritual well-being

- Purpose of education – N /A

Document: National Policy on Health and Family Life Education (HLFE)

1. What are the main points in this document?
   What is the hierarchy of importance accorded to these points?

   a. (pg1, pr1): Children and youth (0-24 yrs) are threatened by emotional and behavioral disabilities as well as infectious diseases. (pg1, pr3): quality education should equip them with an avenue for the development of social and emotional skills as well as the acquisition of positive attitudes and values.

   b. Healthy and family Life Education (HFLE) [in particular] promote the holistic development of children and youth and the eradication of the social, physiological and physical ills that plague them.

2. What are the stated or indicated implementation expectations or activities?
   - (pg6, last pr) HFLE will be implemented at the level of home and community on a systematic basis as a through-going program of public education
   - (pg6, last pr) Program in schools will be implemented by teachers in partnership with parent s and health and community professionals
   - (pg 9, vii) HFLE [will be implemented] as a compulsory component of the core curriculum at all levels of education beginning September 2002

3. Are the implementing agencies clearly identified in the document?
   What is the level of difficulty expected?
   Yes. High level of difficulty due to:
   - The scale of implementation - (pg 9, vii) at all levels of education from pre-primary to primary, secondary and tertiary
   - Number of contributions – (pg8, iv) UWI, Teachers' College, Ministry of Health, Ministry of Human Development, Youth and Culture, Ministry of Community Empowerment, Sport and Consumer Affairs, teachers from primary and secondary schools and representatives from religious organization and NGOs

4. What does the document expect in the area of general collaborations and multi sector support?
   - (pg8, iv) Collaborate with representatives from UWI, Teachers' College, Ministry of Health, Ministry of Human Development, Youth and Culture, Ministry of Community Empowerment, Sport and Consumer Affairs, teachers from primary and secondary schools and representatives from religious organization and NGOs to develop HFLE curricula

   - (pg8, x) Collaborate with above to develop appropriate curriculum materials

   - (pg10, pr1) The Ministry of Education will play the leading role in the execution of the HFLE Project with support from the Ministry of Healthy and the Ministries of Human Development, Youth and Culture, Community Empowerment, Sport and Consumer Affairs.

   - (pg12, pr2) Collaboration among the Curricula Development Division (MOE), School of Education UWI, Board of Teacher Training Division of Schools Supervision (MOE) to design training programs

   - (pg12, hd – monitoring and evaluation) There will be collaboration among Curriculum Development (MOE), Division of Education Research and Evaluation (MOE) and the School of Education UWI to develop standardized forms of formative and summative evaluation of both the cognitive and affective domains.

5. Does the document mention the specific roles of individuals either in guiding or taking direct action?
   - (pg8, hd VII) The Ministry of Education will
     - work with stakeholders to develop a cohesive and coherent approach to implementation;
     - appoint an HFLE Coordinator ("National Coordinator") in the Ministry of Education to provide overall coordination of the program identify coordinators at the four district level offices ("District Coordinators") and request schools to elect a focal point for the HFLE coordination ("School Coordinators")
     - establish a National Committee on HFLE to provide effective mechanisms for coordinator and management and broad-based involvement of stakeholders;
     - develop and implement a plan of action to undertake the following: (see #4 i-iv on pgs 8-10)

   - (pg10, pr2) National HFLE Coordinator will be responsible for coordination of activities nationally and for linkage at the regional level with the CARICOM Health and Family Life Education Project and the UNICEF Caribbean Area Office

- (pg10, pr3)The Ministry of Education will ensure that School Coordinators are identified to improve implementation and sustainability of the program.

- (pg10, pr3) Both National and District level coordinators will promote and monitor the implementation of HFLE in the school, home and community

- (pg12, hd IX, last pr) The Ministry of Community Empowerment, Sport and consumer Affairs will play the leading role with respect to the training of facilitators operating in the non-formal sectors.

- (pg 12, hd monitoring and evaluation) There Curriculum Development Division will be entrusted with the responsibility for monitoring implementation of the program at the school level and will be assisted by School Supervisors and District and School Coordinators

6. Does the document indicate broad interests with previous studies?
   - (pg4, last pr) 1994 CARICOM Multi-Agency Health and Family Life Education Project
   - (pg5, top) 1988 Ministry of Education draft curriculum on Family life Education
     a. How often do the following concepts and terms appear in the document?:

Adolescent	pg2, pr2
	pg2, pr4
Youth	pg1, pr1
	pg1, pr2
	pg1, pr3
	pg1, last pr
	pg2, pr3
	pg3, pr1
	pg3, pr2
	pg3, last pr
	pg4, top
	p4, pr2
	pg4, pr3
	pg6, last pr
	pg7, hd V, #1
	pg7, hd V, #2
	pg7, hd VI, #1
	pg9, #xii
Working Together,	pg8, iv
Collaboration	pg8, x
	pg10, pr1
	pg12, pr2
	pg12, hd

Govt Ministries	pg4, last pr pg5, top pg5, last pr pg7, hdV, #3 pg8, hdVII, #2 pg8, hdVII, #4 - iii, iv, vii, x, pg10, pr1 pg10, pr2 pg10, pr3 pg10, pr4 pg12, pr2 pg12, pr3 pg12, hd IX
Sex/Sexuality	pg2, pr2 pg2, last pr
Supervision/Guidance	pg 6, pr1
Lifestyle	pg1, last pr pg4, top pg7, hd V, #1 pg8, iii pg10, top
NGOs/CBOs/FBOs	pg9. top pg9, ix, x, xi, xii pg10, bullet pts pg 12, last pr
Nurturing	0
Changing Behaviour	pg7, hd V, #1
Deviancy	pg1, pr1 pg1, last pr pg2, pr2 pg2, pr3 pg2, pr4 pg3, pr 4
Aspirations/Hopes	0

How are the following defined in the document:

- Health/wellness – (pg 1, pr 3) health refers to physical, emotional, psychological and spiritual health

- Purpose of education – (pg1, pr2) quality education caters for the holistic development of the individual

Document: Caribbean Charter for Health Promotion

1. What are the main points in this document?
   What is the hierarchy of importance accorded to these points?

   (pg1, col1, pr2) In a world of ever more connected markets and cultural intersections, globalization and its attendant changes....We now have the unique opportunity to harness the creative energies of our people...

2. What are the stated or indicated implementation expectations or activities?

3. Are the implementing agencies clearly identified in the document?
   What is the level of difficulty expected?

4. What does the document expect in the area of general collaborations and multi sector support?

5. Does the document mention the specific roles of individuals either in guiding or taking direct action?

6. Does the document indicate broad interests with previous studies?
   How often do the following concepts and terms appear in the document?
   How are the following defined in the document:
   - Health/wellness –
   - Purpose of education –

Document: Report of the National Task Force on Education (White Paper)

Statements that define the Aims and Objectives of the Plan vis a vis, adolescent health and wellness in the context of Health Promotion in Schools:

1. Mission Statement – The promotion of greater public awareness and involvement in the attainment of the goals and objectives of the school system. (pp.3 and 4).
2. Philosophy and Educational Objectives – That the parent and the home have a major responsibility for the welfare of the child and that the well-being of the child can best be served by a strong partnership between the community and the school. (p.5)
3. That we must be alert to new research and development in all fields of human learning and the implications of these developments for more effective teaching and school improvement. (p.6)
4. That the educational system must be served by professionals who share and are guided in their operations by a set of systematic and incisive understandings, beliefs and values about education in general and its

relationship to the development of the national community of Trinidad and Tobago. (p.6)

5. Commitments – the ability to apply principles for sound mental, emotional and physical health (p.7)
6. Contextual Concerns – This Task Force Report comes at a time of uncertainty in our economic and social development (assumes that in the context of the economic downturn of the period, education must be seen as investment in people with emphasis upon ensuring an equitable distribution of resources among the various sections of the population.). p9 and 10)
7. Management of the Sector – (Does not mention collaboration in general or specific terms)
8. Strategic Initiatives – The system of schooling: Mentions "community health programmes" in the context of providing avenues for the school feeding programmes (p.13)
9. Summary of Recommendations: Primary Education "... with the 0 – 5 old group of children, the Ministry of Health, the Ministry responsible for Family Services and the Ministry of Education should be responsible." (p.25)
10. Secondary Education: "Essential Curriculum Goals of Secondary Education should include the understanding of self, family and society, values and ethics, human sexuality, health, recreation, aesthetics, work, mathematics, science and technology, consumer education, entrepreneurial and problem solving skills and information literacy." (p.42)
    a. "Moral and Values education should be infused in the curriculum, a Pastoral/Form/Personal/Guidance period once a week and a weekly Assembly period should be instituted to ensure that religious/moral/ethical concerns are addressed."(43)
    b. "Curriculum engineering should ensure that new curriculum issues in Health, Human Sexuality, Family Life, Political, Social and Environmental Activities, Disaster Management are infused in existing curricula." (43).
11. That a Teachers' Training Unit be established within the Curriculum Division to administer an in-service training programme and plan new programmes to respond to changing needs." (47)?
12. The Middle Years: "while human beings are in transition at nearly every stage in their lives, these middle years (10+ to 15+ years) mark very critical transition points in the life of an individual." (p.145) (needs your analysis)
13. The Problems of the Adolescent: "The curriculum should be adjusted/expanded to include more emphasis on human and social development. The teaching of values, morals, ethics, family life education, and a basic skills component should be included. Student and parents should become more involved in addressing these problems, to this end a vibrant student council and parent-teacher association is recommended."(p.197. See p198-199 as your attachment)
14. 'Health Ministry' is identified by name among a list of 13 'support organizations that are recognized as essential to the 'delivery of quality education.' The document recommends "Dialogue between there

organizations (sic) and the schools through meetings." Also, "Promote more community involvement through public relations programmes to encourage these organizations (sic) to play an important role in the educational process." (p216)

15. More Relevant Curriculum: "An emphasis on technology studies, entrepreneurship training together with the inclusion of courses on human and social values is recommended as a means of preparing students for contemporary society. (p217)
16. Appendix II: Mentions "Health Education" as part of Teacher's Diploma course. Worth 40 hrs of study as compared to Maths 120 hrs. (p.272)

Appendix VI - Interviews Data

Anna: Ministry of Health

Background/Core Functions

Background in Science ... Zoology, Maths, and Teaching background. Teaching science and Maths from age 19. Shift from teaching science to being involved in preventive medicine after 14 yrs. That's what they called it at that time (115). Post graduate diploma in Jamaica in Community Health Education, conducted research in health of school children. Research consultancy with PAHO and that set my course in 1992 ...watershed... Community Health Education next. Focus on community and education. Masters in Education ... Studying for the EdD with (University of) Sheffield in Community Education and Education for Health.

In the 1970s worked with Church groups – youth groups. Even while in teaching I studied counselling and guidance as a way to help young people (115)more about empowerment of people... work with church groups, counselling in psychology and working with young people. Support community organizations with grass roots. .. empowerment of people who are underserved (115) in particular. Interested in Research... employed in the MOH for 15years in Health Education.

Approaches/Mechanisms to addressing adolescent health and wellness

Ministry addresses health and wellness ...But there is weak structure driven by individual choices and interests. ..County Health Administration Office driven by individual choices and interests (123). We (Health Education Div) have structured activities. San Fernando programmes in HIV/AIDS and wellness for students have content, syllabus. The adolescent health programme of San Fernando ... the one that was started by me. We started processes going from 1997 and more structured. Pockets of focus one RHA. (Regional Health Authority) implements programmes related to HIV/AIDS and wellness for adolescents and a syllabus was developed for this on reduction of risk and chronic diseases (123). These programmes included fitness clubs, counselling, etc. No overarching strategies or plans that are collaborative across sectors – with well articulated with goals etc. People accept me and I start programmes. No national vision or framework for adolescent health. No structured adolescent health and wellness programmes. The services that we offer are for everyone. Pregnancy ... ante natal care ... not necessarily targeting adolescents (124). When we talk about adolescents, it is mainly in relation to pregnancy. Services are all omnibuses(123). Adolescents may attend and access the service: contraceptives, counselling, etc. There is no special focus of these programmes on adolescents. Services for pregnant women are available for adolescents. .. same with counselling etc relating to sexuality. Now, the Population Programme with PAHO is developing programmes for young people and adolescents. We do not have Adolescent Health Services.

Policies and Protocols

School Health Project...GSHS (Global School Health Survey). Identified a focal person. ..their personal points of focus may not coincide with the project's focus. The School

health project was specific. But the National School Health Policy covers from 6 to 18yrs and provides some structure. It is a draft policy and yet to be accepted by Cabinet (of the Government of Trinidad and Tobago).. .We have GSHS 2007 Report ...We still try to strengthen community health services to serve school heath services. **Q.** Any informal protocols? **A.** Protocols exist and guide work but they are not Cabinet approved or policy. Outside of protocols there is a plethora of activities with no clear focus or policy directives.
Primary school age programmes are a bit more structured. Secondary age group tends to be less structured with interventions from NGOs and community and other organizations. Primary school HFLE (Health and Family Life Education) is well supported by MOE School Supervision ... Secondary school HFLE being prepared. I took part in preparing it and it was collaborative from Ministry of Education ... including Sexual Abuse. In MOH, there is a policy on collaborative approach. E.g. Managing sexuality etc. Std 3 and 5 we taught sexual health, we used Rapport (HIV Youth Programme) to implement. We developed it using encounters with children ... 4 modules on HFLE and 1 on Sexual Health. Various levels for various groups. Gender roles and responsibilities was one. Initiated programme implementation from the Ministry of Health. A Ministry of Education (MOEd) Representative from the HIV Unit collaborated from Student Support Services in the MOEd. Also talked with a representative from the Curriculum Development Division MOEd about HFLE Values (as outlined in the HFLE Policy). We in the Ministry of Health as Managers fill in all the policy missing links. We create the means for collaboration and articulation etc. When gov't policy emerges we find ways to incorporate these in our programmes ... operationalise documents and previous decisions. (120) We sometimes have to liaise with and report to certain Cabinet Committees. But on the whole the lack of policy documents means that we as managers must find ways to serve the nation in the best way possible (125). We are guided by some policies of the Ministry and outside of the Ministry. There are different focal points and we trash out implementation with other Managers and they are in the end implemented by the line Ministries.

<u>Collaboration</u>
Q. Any other individuals and groups who have helped you in implementing?
A. Youth council is helpful with joint implementation. PAHO is very good. .. Meetings between management teams from Ministry of Education and Health.
Sexual health and Nutrition are the main areas for adolescents. CFNI (Caribbean Food and Nutrition Institute) has a presence. The HIV unit of the MOH is supportive. We just identified persons who had the skills to help us (141). We did training of persons who went back to the RAPPORT. We did a lot of capacity building (141).
Nutrition programme... was a quiz...We brought in CFNI and Ministry of Education. National School Dietary Services Ltd. (NSDS) was brought on board too. We developed a reader for nutrition (120). 105 schools involved with Nutrition Reader. Focus on learning experiences rather than content. Group format... Operationalise documents and previous decisions and guidelines. We tried to give out presents ... we had pens and pencils etc. to give out. We got RAPPORT to facilitate the process.

Q. Any joint funding of projects from the Ministry of Health? **A.** MOH funds these programmes ...we initiate entirely. We got educational material support from NSDS. No common funding. We used facilities from our partners.
Project for screening of primary school children for sight and hearing came to an end. ..issues of sustainability. School Nurses in the regions helped us. School Supervision , MOE was also very supportive. They distribute education materials which we send to them and identify venues. They do a good job within the school system – especially Primary schools and lower secondary – adolescent years.
Q. Are there opportunities for sharing of outcomes? Prioritizing? **A.** We set agendas but they are put aside by whatever pressure issues come up ... visible issues of national importance. Ministers' priorities important...(125).Under National Plan of Action for Children we have definite deliverables but for the MOH ...What are our commitments to children? It is during reporting time that we see relevant documents. May follow MOEs agenda, or RHA or MOH. ..Also work with NADAP (National Association against Alcohol and Drug Abuse) re. Tobacco use. Policies internal to the MOH and policies external to the MOH all provide guidance. It is a question of Focus. The focus is sometimes in the MOH. Other times it is the MOEd. So, really our focus comes from different documents.

<u>Approaches /Mechanisms to addressing Adolescent Health and Wellness</u>
Q. In your budget is it up to you to determine what goes to adolescent health? **A.** Yes... External agencies sometimes determine what we do in their planning and budgeting documents. Youth health issues attract our attention so long as they concern T and T – from advocates, National Youth Council, PAHO, UNAIDS, UNFPA, etc. You may also be invited to joint committees set up by others. MOE, YMCA.
Q. Does performance appraisal include addressing adolescent health? **A.** Not specifically but as it relates to the life cycle. **Q.** Any programmes that impact on adolescent health? **A.** Yes, through policies emanating from bigger policies...Vision 2020. Stakeholders e.g. TTUTA etc Difficult to determine stakeholders...Policy dev. Committee exists. I am a member. Put together policy from draft to approval. Develop templates... involved in preparation to take it forward to Cabinet. Communication with other partners is done at this level too. Policy agenda to follow up on policies as they evolve. Ministry is finding it difficult to operationalise the HFLE. HFLE is a good example. Where were the teachers when the HFLE was happening (138)? There is a Joint Implementation Committee...Attempts have been made for a meeting of national executive heads from different ministries. But not sustained.
Q. Are there Management Executive Meetings in your Ministry for reporting? **A.** Not anymore. It is also the competition of things that are happening. Joint programmes with the MOE ... school supervision took part in this particular initiative – it is a good model. Initiation of Joint activities- Executive heads have met in the past but not sustained, a very good initiative however as it provided the opportunity for heads to meet. Performance Appraisal includes addressing programmes throughout the life cycle. Committee exists in the MOH for policy implementation to have policies finalized and move from draft to final policy.

Alexis: Ministry of Health

Background/Core Functions. My orientation....General nursing. Then teaching nurses for 7 years. I then opted for Health Education at the P. P.U. Fits my background... youth leader in church leadership, mentoring (115). Sexual and Rep health real challenge and needed my experience and skills. Moved from Nursing Education.

P. P.U. addresses adolescent health on behalf of the MOH and deals with adolescent services which included Sex and Reproductive health. Speaks to services.

Approaches/Mechanisms to addressing Adolescent Health and Wellness

Q. How is adolescent health addressed? **A.** Sexual and Reproductive Health is a quite a challenge for adolescents, principals request our help in teaching sexual behaviour and applied skills, effective communication, decision making, values, etc.(118-119)

Addressed at different levels: Ministry of Education/ School principals request our help in teaching sexual behaviour and development of applied skills (effective communication, decision making, values, etc). One college had young people trained as peer leaders and to provide leadership. Last term we trained another group of youth. Started in 2003 and it's going since. Peer Educators came from forms 3 or 4 or lower 6. (Form 5s not included)

MOH addresses adolescent health through National Strategic Plan for Sexual and RH. There is a National Youth Policy. .. Limitation is that it does not formally address in a serious way the broader issues of sexual and rep health..... At least in my recollection (125). Students below 16 yrs. come in for condoms etc. Access pre natal and post natal services alongside adults too....Having babies. Those sexually active are inhibited by system which is not youth friendly (123). Youth under 16 of age not encouraged to access sexual and reproductive health services (125).

Policy Development

Q. Who developed the Youth Policy? **A.** I was not involved ...maybe a colleague from the MOH. **Q.** What policies formal or informal exist? **A.** Caribbean Charter for Health Promotion ... *One of the pillars is Re-orienting Health Services*. Documents state that our clients are over age 18. ..1999 - Policy on Universal Access, the question is What is Universal Access, as it is interpreted differently. .. HIV Testing policy which allows young people to access HIV Testing – within the MOH...youth under16 not encouraged to access the services of SRH (sexual and reproductive health). ..This does not happen in practice without parental consent.

Q. Is there such a national health policy? **Y.** Not seen a national policy document for the MOH but has seen a National Plan of Action for Health...Children Policy and HIV policy...Seen strategic sectoral plans but some actions are informed by international policies and requests (from international donors)... Regional Action Plan ICPD... Caribbean context...Millennium Development Goals ... Regional action plan came out of ICPD conference. National Strategic Plan for SRH 2003 – 2008 / Draft STI policy.

Q. You are middle management ? **A**. "VERY MIDDLE" Q. Are you aware of processes in developing policy? **A.** Usually Committee is formed and terms of ref. Technical expertise is major qualification. Policy development goes through several stages: Sometimes national consultation. Sometimes draft comes to senior tech to evaluate. **Q.** Do you usually involve outsiders? **A.** No, not routinely. Limited to health sector. HIV testing Policy involved others. ..but this is not routine – mainly health sector. **Q.** What is

your observation regarding how draft policies are made known to staff or leaders? **A.** Limited documents circulated. No consideration relating to those who are affected by the policy. End users are not often aware that policy is being developed. Selected persons who see policy documents are not usually affected. No roll down written into policy. Process development and roll off not normally included in policy... Never seen an implementation plan for a policy. Steps for the policy development process: Establishment of Technical Expertise Committee, development of terms of reference, national consultation, document sent to CMO for review, Does not routinely involve persons outside of the MOH in policy development.
Q. There is a unit for policy development in the MOH– did this improve the policy development process? **A. Yes** The Policy Planning, and Research Unit ... Recommends how policy should be developed. *Identification of the problem is usually weak. Collection of data to determine* is *weak.* Identification of the problem must be based on empirical data...Policy is weak and understanding is weak. **Q.** Are interventions informed by policy? **A.** No it depends upon the interests of the person in the position to implement. Individual level process – that is how interventions originate.
I do not believe Managers in the MOH understand what is a policy, it is a cliché – A policy really is developed to address a particular problem. As a society we do not appreciate policy. Our interventions are not informed by policy. Interventions are driven by personal interest (138).
Q. If for example, there is no personal interest in an issue, will this become evident in the performance appraisal of those responsible? **A.** As a middle manager, I have never had a personal performance review done. Middle managers will take responsibility for implementation, but the follow up is weak. The mandates required of us not implemented not even expected...It depends upon individuals and their interests. I have never had a Performance Appraisal although I conduct performance appraisal on my staff. Protocols and Procedures are there on paper. But on the ground it is who is there (in charge). In the early days, Family Planning was the main focus in the Population Programme. The involvement of social workers heading the population programme introduced Family Life Education. They came from social service background and the evolution was based upon interest and history of the unit. Many technical Managers at the level of the MOH had little understanding of the scope of the work. The Guidelines and protocols are there. Some as old as 1982...We need national Guidelines. But really we depend upon international guidelines. We need service delivery guidelines ...there is no document that outlines the core functions of the Population Programme.
I never got a document defining the core functions of the Unit. .. In 2002 the PAHO Advisor was not getting any direction from MOH in terms of providing assistance to the Population Programme. I developed the Strategic Direction for the PPU. This helped PAHO to find a framework for working with us. I developed a Strategic Direction – it informs what I do. We then looked at a policy for reorganizing this unit. Policy monitoring, training and capacity development especially for RHAs... Adolescent Development is core to our work, it was included in the Strategic Direction Also policy development was important.
Implementation, includes training and capacity building for the RHAs, this is relevant to adolescent sexual and reproductive health – not services.

Q Budgeting? **A.** We identify resources for training. Training for Peer educators is a budgeted item and staff involved in training in values and counselling of young people. Health Professionals are not ready! Many seem incapable of meeting the adolescent challenges. Religious beliefs also interfere with the professionalism of practitioners in the area. Yes, some professionals are unable to separate client relationships from their roles as parent and get emotionally involved. Professional Curriculum (for nurses and doctors) does not identify adolescent as client. Child issues are clear. This group (i.e. adolescents) is lost in a maze.

My Studies for Master in Public Health did not focus on adolescence. Population Leadership was my pre Masters. Youth and Adolescent health was central to my MA. Straight Talk was one of the programmes that came out of my experiences and visits to Uganda. Academic training is important. Nurses miss out the adolescents in their training ... "Beginning Family Curriculum" looked at 0 -18years BUT the adolescent is invisible (124) – Focus is on childhood. Part of it is that adolescence is not sickness. Need to revise the nursing curriculum to take cognizance of adolescent issues. Maybe Sociology courses can deviate from Weber etc and deal with adolescent issues in sociological terms ... Very academic. We need to deal with contemporary issues affecting adolescents. We do not connect adolescent experimentation with the risks.

<u>Collaboration</u>

MOEd is represented on National HIV committee and before that on committee to develop National HFLE Policy ... ad hoc requests from schools ... Ministry of Youth ..., collaboration at the implementation level as opposed to policy ... work with post SEA (Secondary Entrance Assessment students) in primary schools ... Collaboration with Guidance Officers at the Operational level

Q. Any Joint Planning with the MOEd? **A.** Ah... we get education requests from schools. Life skills programme is accepted by MOE HIV Committee... Ministry of Community Development ... Ministry of Youth Caravan programme ... limited not on a consistent basis... more ad hoc.

Collaboration is critical for our success ... especially when looking at adolescent health.

<u>Use of technology</u>

Facilitates collaboration ...use of telephone ...Would grade use of technology at 6 out of 10 ... depends upon personal interest of officers. Email is about 60% helpful. Communicating with those at the top is helpful by email.

Q. Is informal policy influenced by outside agencies? Yes. IRO (Inter Religious Organisation) concerned with Values, HFLE ... Very supportive ... NPTA (National Parent Teachers Association) has been supportive too. Access to contraceptives is controversial. **Q.** Who influences access? **A.** The politicians, Political authority. At the end of the day, the politician takes responsibility and is very careful about divisive issues 135).

Q. Any joint Planning on any activity?

A. Yes, through Guidance Counselling. At NACC (National AIDS Coordinating Committee) I was always involved with AIDS education in Ministry of Education. Lots of joint programme development and implementation... Pre Carnival ... Post SEA, etc. Post SEA programme in Tobago successful because parents also participated... Parental participation ... critical. The Nurses at the Health Centres helped us to meet parents through a community intervention. ... Mostly it depended upon the need and where the

initiative started...Combination; Sex. Discipline, Parents. We then would craft the agenda/ intervention according to the need.
Q. Any monitoring and evaluation specific to intervention?
A. Usually done to the specific intervention. Weak over-arching framework.
Additional Views
Health Promotion and HIV ... main avenues for collaboration
Q. What is the status of the School Health Programme ?
Need more than screening for hearing and vision.... The politicians see more PR. The technical officers must think Public Health ... sometimes the PR swamps the technical part of the work ... and flexibility important. Adolescent health is not a priority. .. Services for adolescents should focus on counselling, health services/screening, physical screening programme. We need baseline on blood cholesterol for young people... Availability and use of contraceptives...After age 12 we throw them out and ask them to come back at 18. Need to be exposed to social development programmes, civility, social skills, etc. ...Not just in Ministry of Health.
Q. What is your wish list? **A.** Counselling, screening, availability of contraceptives, integrating adolescence health in family services,
Adolescent Health (is not a priority) has to become a core issue for Family studies/population studies. Problems are clear but the reorientation is weak.... Crime and violence....Social skills programmes must be part of the programmes... User friendly centres. Need to build alliances ...The agenda of the political elite and the technicians must meet.

Allan: Ministry of Health
Background and Core Functions
Manager of a Health Facility, Executive Assistant to CEO, performs health promotion duties, participates in poverty reduction programmes ... Worked as a teacher in the past, also worked in Human Resource management. Open Bible minister and marriage counsellor ... Full Gospel Church member within the church. I identify with them (adolescents). Have a programme where I work with about 3000 youth through the church. Even now, work with the OJT and help them to deal with their issues as they come up and we help. Work with youth in sport and helping young people to get scholarships ... other issues coming up related to sexuality etc. Had started a Health Promotion committee with different departments within the RHA (Regional Health Authority) Health Promotion was needed (118), so made it part of his core functions. Within functions as Assistant to the CEO was given the role to identify gaps, saw HP as a need. Many troubled young people I have encountered the problems of young people and took on what solutions were possible(115) Youth club leader, counsellor, teacher, and work in the Ministry of Health. Last 10 years have focused upon particular sports; coaching young people and preparing them for scholarships abroad.
Collaboration
Q. Is there collaboration between Ministries of Education and Health? What is on the ground? No formal structures in RHA for adolescent health(124) RHA not functioning to sort out these problems formally but we have programmes that support youth. Engage in community based programmes for 15 to 28 year olds. Collaborated with another health professional in this community ...on training in Peer Counselling. .. We also fund/ part

fund other similar type programmes in other communities. In schools too. .. Funded by the RHA... I had a wellness programme, but wellness programmes not well operationalised within the RHA ...There is no system or structure for adolescent health... Hard to look at youth ...far more wellness needed for youth... Youth are being left out (124). I tried to focus on youth, health and wellness.

Approaches/Mechanisms to addressing adolescent health and wellness

Q. What guides the work of the RHA? Does the RHA have health policies with regard to youth? **A.** We have MOH strategic plan and our own strategic plan that provides the basis for our Health problem programmes...Overall health care. ..We have clear guide lines for children. But nothing really on adolescents as a group. We cover some of these e.g. Child Health Initiative with proposals etc. took us to pre teens ... but (programmes for) adolescents weak. Adolescents tend to fall through the cracks (124). Started Child Health Initiative and a Youth Health Initiative . Engaged and worked with the Paediatric team to implement radio programmes to support child health. Worked with Community based Radio Station... Every Friday morning radio programme.

Prenatal, postnatal care targeting parents... mental and emotional issues for children....

Q. Any adolescent issues? **A.** Yes. Early adolescent and middle adolescent issues. Psychosocial issues were addressed. Support from the Paediatric Association. Consultant specialists helped us. They were most enthusiastic. One psychiatric social worker was involved. I did a promotional jingle and we promoted the programme during the week. ..Targets parents and caregivers...Call in segment etc. Radio programme included developmental issues for children and adolescents. Now no radio station in the community, they took it to Port of Spain.

Policy

Education not dealing with prevention and community – *The Health Promotion Charter is on the shelf.* Ministry (of Health) has its plan. And the RHA has their plans. .. No system of communicating plans to the rank and file ... stays at the top administrative levels. Communication is a problem. But groups need to meet to work to suit. Purely bureaucratic affair and the community was not really involved in working out these plans. There is a gap between the vision of the RHA and the vision of the practitioners (125). the language of the strategic plans and policies and [what occurs at] the operational levels is different (125). We have a Child Health Clinic, we have a counselling centre, but these are individual Health Centre initiatives, adolescents might get fitted into that. These initiatives are not spread out among all centres as an RHA policy

At point of implementation the community comes in and identifies what their role could be and we help them to articulate the plans and implementation parameters. I tried Child Health and Youth health. ..They were stand alone. But these were not institutionalised in the RHA. Particular centres may have programmes that are similar but there is no overarching policy document that must be followed. Inconsistent roll outs. .. not really into looking at performance indicators and guidelines etc. Challenge is how to get people moving from policy to operationalising - try to develop cross sectional teams within the RHA. There is a gap.

Q. Who monitors? There is a Quality Department for Monitoring and Evaluation and they have developed systems of accreditation and standardisation, building systems for standardising and monitoring.

We have a quality team which monitors and evaluates. Each project lead appoints someone to monitor programme implementation.

Collaboration can only happen when the process is clear and strong. There is a lot of self monitoring. But monitoring is not part of our culture, monitoring is weak. A real challenge.

Q. Any other examples of initiatives with adolescents? **A.** Health fairs etc. Mainly done through the schools. With health marches and seminars and etc. But mainly ad hoc. Schools get involved during health week or month (Health Promotion Month) etc. The DHVs (District Health Visitors) go into schools, do a little talk here and there ... The Health system will focus on international days and schools will be encouraged to participate. Issues such as First Aid. We teach teachers CPR and related issues, capacity - building but these are not formalized.

I have taken the position that we (Health Personnel) are responsible for Health. This includes building of capacity of the schools to tackle health (135). It is about building capacity in schools.

Human Resource issues... Lots of different things happening... How do we bring them together?

There is a missing dimension with community health, too much emphasis on tertiary care. We are not dealing seriously with prevention.

Problem is funding which comes from the top. Caribbean Charter is on the shelf.

My concern is about how things are cyclical, we start things, stop and years later come back again.

Political Directorate directs and funds. So we follow that lead (135). The Prime Minister launched a Productivity Council recently and we have done that already? Remember the song/jingle: Productivity is the way to go? There are other programmes which are good but not appealing to the Political Directorate or the direction it wants to go.

Lack of Community programmes ... Lack of coordination within the health sector. Resources go into institutional health with little support for community or even school health.

Q. Do you have County Health Visitors? We have Community Health Officers... Five different programmes by the same County. Coordination within is important before we can collaborate with others. **Q.** Is adolescent Health in your core functions now? **A.** Yes. We are now talking about forming a HP dept

<u>Revisit roles and functions</u>

Functionally, I am still doing executive assistant to the CEO, doing Disaster Preparedness now but I am still asked to mobilise the personnel to achieve certain objectives, e.g. Health Promotion month etc. A Health Promotion Committee existed in the past, is being revived. .. Now a strategy within the RHA but not really with outside agencies. I perceived a gap and proceeded to fill it with programmes. Health Promotion Committee – we have revisited the community partnership board.

Let me put it this way, I have taken responsibility for health, for working with teachers to make the school a supportive environment and building capacity in schools in terms of readiness for emergencies. (118)

Use of Technology

Staff do not use emails, there is a joke about sending an email with the request to call and get 500dollars? Looking at e health programme for diabetes, and include young persons". Trying to encourage the use of Email ... not enough in individual use to help us to depend upon that medium. Not aware of Global School Health Programme, saw reference to the survey done in T&E, but never saw results, they do the research but do not come back.

Collaboration with MOEd

In 7 years I cannot remember Ministry of Education officials coming to sit with us to plan anything. They are mainly trying to educate and that to me is for them.

We and the Ministry of Education need to remodel our approach to youth health so that we can work together. Our approach is to develop it as we go along as opposed to plan something and then go in. I intend to target local govt. and Education Committees of the City or boroughs, work with school principals. We have good avenues for collaboration here. Ministries think differently. Social Welfare thinks differently as compared to Education or Health. The RHA has the structure to bring about collaboration to address health issues that will be community based. Collaborate with Youth Council.

Additional views

International agencies or even NGOs intervene and sometimes the community and the money is spent and that is an event and that is it.

Getting fed up of the events! Preference for projects, prevention of injuries in youth in sports...I wish the gov't and SWRHA will develop a focused programme for youth. We need to get people to shift from the remedial mind set, we want to engage youth and get them to take the leadership role.

Lots of projects that we have identified should happen. Sports, for example and it s medical programmes...We want to educate to prevent injuries. Holistic health programmes in sports and health. And we can make an impact there.

I would want to get 10 persons to put their research reports on line as the basis for us building a data base.

Jill - Ministry of Education

Background, Functions

Primary school teacher since1967. Attended Catholic Women's Training College. Studied for BA History and Literature. Taught at the Secondary School level and then went on to Curriculum Development Division of the MOEd. Now retired from the MOEd and works as the Vicarious Manager at the Catholic Education Board in charge of rural area in Central Trinidad...Relate to students indirectly...Visit classrooms to check curricula and evaluate the Catholic content of teaching and the teaching...ensuring that Catholic ethos is pervasive (116) Special interest in repeat students who did not make 30% in Secondary School Entrance Examination. Personal Interest: Very involved in Church activities and giving service and giving back to the community (116). In the church, I am a lecturing and involved in administration and planning of feast days and activities in the Church...Vocation to the church. Train children and adolescents in music, pan, piano, voice etc. from about 8 to 18/19yrs.

Approaches/Mechanisms for addressing Adolescent Health and Wellness

The MOEd addresses the issues of youth and adolescent in a way. Our new National Certificate of Secondary Education (NCSE) includes personal development and health and wellness (126) But the concentrations are in curriculum areas. HFLE, Social Studies, Physical Education, Home Economics, Integrated Science, Human and Social Biology and Chemistry. Nutrition also addressed. A curriculum Officer for Home Economics was put in charge of the cafeteria at the Learning Resource Centre. The cafeteria manager she saw it as a nuisance...more interested in the money. The nutritional value was not core... never factorised in health and balanced meals. Concessionaires must be made to appreciate the healthy food aspects and should be a condition for granting licences for canteens. MOH should take into consideration, person health issues when they go to assess schools (environment). MOEd has a School Feeding Programme. We comment on the food quality when we visit schools. The University of Saskatchewan helped in formulating Health and Wellness component of the HFLE for Secondary Schools. The experience with the Saskatchewan was useful in providing a baseline for what to teach in terms of health and wellness. Also looked all aspects of health including sexual, emotional ... Have to be clear about the laws of T and T...the Curriculum was not to supersede the law. Condom use was not included ...Abstinence Programmes were introduced...HFLE must be vehicle for promoting health and wellness among adolescents in tandem with Social Studies.

NCSE is offered to students in Forms 1- 3 and 4 -5, the NCSE addresses Health and Wellness, the Minister of Education wanted to make it mandatory but DERE (Department of Educational Research and Evaluation) was not ready and so the consensus was that it would be voluntary. All schools eventually expected to offer NCSC in all subjects to replace the CXC (Caribbean Examinations) in Form 3some schools writing NCSE in 3 based on the realisation that it prepares them for CSEC (129). Personal dev. is in Social studies. It is possible to go through the school system without experience of Social studies. In one prestige school, students who were to write the Social Studies examination returned blank pages with a messages stating that Social studies was a waste of time. Some prestige schools have shelved the exams to write it in Lower Six. Now these schools are realizing that you cannot do well in Caribbean Studies in CAPE (Caribbean Advanced Proficiency Examination) if you do not have the Social Studies background.

HFLE is a Caribbean initiative...Weak implementation because of wrong persons in charge. In one instance, the person in charge of HFLE was did absolutely nothing to push the subject. And too there is shortage of human resources in managing the implementation across the country. Remember we work in a system where discontinuities are frequent and whole programmes are stopped because personnel move or new persons come in who are not enthused or trained (142).

Policy

The process of policy development: Teachers with specialisation are drawn from the level of the school and provide technical support to develop the documents. This applies to all subjects. The practitioners are the main persons who write the documents. This is then sent out to schools for comments and for teaching and pretesting. Sometimes UWI (Faculty of Education) invited to look at the documents. When I was a Secondary School teacher I did not know about HFLE. I discovered HFLE when I went over to Curriculum.

Q. How are new documents disseminated? **A.** Same as stated above, through schools and also UWI, unfortunately, there was never a coming together of minds regarding the HFLE... personal interests a factor in how the dissemination took place and even preparation. You can send documents to schools and find there is no follow up with the schools... or shoddy responses. **Q.** Any school initiatives in Health and Wellness at schools? **A.** Not to my knowledge. The Physical Education officers reported to me that they held workshops in Health and Wellness. **Q.** Any community, health nurses etc participation in health and wellness at schools? Yes, at the primary schools, milk was provided to students and schools linked with neighbourhood health centres for medicals and dental care for students. When I was teaching in primary school there was the College Exhibition examination that covered all subjects including health. With Common Entrance and SEA specialization became the norm. Post Primary Centres prepared for students for living; life skills, grooming, etc. Post Primary Centres were removed by a previous Prime Minister and everybody was sent to secondary schools. ..teachers concentrated on Maths and English (130). In some secondary schools poor achievers (127) get social studies and those are the classes that get left without teacher especially in the prestige institutions.

Health and Wellness

At a Secondary School where I taught there was a Guidance Officer on site, lots of Health and Wellness courses and programmes were provided, concentrating on Forms 3 and 5. That is a big school and it took a lot of effort to organize these things. I was there for 18 years. Social Studies was taught, we saw CFNI (Caribbean Food and Nutrition Institute) as one of the important institutions in the Caribbean. CARICOM's food security plan was discussed in Social Studies.

Curriculum development involves the bringing together of teachers drawn from Primary and Secondary Schools. After curricula are drafted, it is sent to schools to be taught and questionnaires are sent for feedback after a year or two (141). Principals and staff are responsible for implementing the curriculum... school-based management...they are front line. Curriculum Division is next in line to support butcurriculum facilitators no longer exist (141). Some principals see Social Studies as a non-subject(126).

Q. In your opinion, which unit would be best situated to supervise Health and Wellness curriculum? The Director of Curriculum is the boss. Her boss is the Chief Education Officer. The point is if officers at these levels know their short comings and are willing to obtain technical support. **Q.** What about Student Support Services (SSS)? **A.** Yes, they have an important role and we are collaborative. When they are present in schools, they provide enhancing programmes in adolescent health and wellness (132). SSS is charged with inclusive education and that means taking on board many of the problems we have talked about and in the case of students who are dysfunctional. SSS seemed to be more involved in dealing with problems rather than being proactive. Example, they are now working on school walls that are cushioned so that children will not hurt themselves when they bang their head against the wall at certain centres... responsible for capturing certain problems before they become entrenched. There are no dedicated resources, nor dedicated time for health and Wellness.

Core functions

As curriculum officer, DIE. Develop, Implement, and Evaluate curriculum ... you ensure that adolescent health and wellness would be in the curriculum, but implementation

would call for teacher training. The Health and Wellness comes in when the subject area includes it. You ensure that adolescent health and wellness would be in the curriculum, but implementation would call for teacher training (122). Sometimes emotional hindrances for teachers... eg. Incest victims cannot teach the subject easily.

Collaboration

In addition to involving teachers, we also invite wider stakeholders, eg.IRO (Inter Religious Organisation) and PTA; there was an HFLE consultancy that included a survey with persons outside of the MOEd.

Use of Technology

Internet service not reliable, but when it works would take email addresses after workshops with teachers to improve communication...use of email helped to decrease time. Curriculum is getting E Beam – a teaching technique to transmit information so that education products can go straight to schools from Curriculum...Providing teachers with support through the use of technology. Also individuals collect CDs and Power Point presentations to support their teaching.

Additional views

Post primary syllabus now has Abstinence in it. It is being recommended for the lower standards too. For the Catholic schools by the Catholic Board, there is a catechism programme...instructions in principles of the Catholicism. Who am I? In the Hindu and Moslem schools the religion determines the nutrition education and health and wellness choices and issues. Schools participate in many of the Fairs that target community, etc. Mobile units for health screening, etc.

Jason – Ministry of Education

Background

As a young person entered the catholic seminary, joined community Cub Scouts group and basket ball group, worked with youth and their parents - lead to studying psychology, studying Sociology, Spanish, History and other subjects. Youth leadership. Went abroad to the states and studied counselling. Came back and worked at Youth Camp for one year. Went into Guidance counselling and within two years became a Guidance Officer at a school before I moved up to Director of Student Services. Had to develop skills in management and see the holistic child all issues affecting children... special education, HIV education, drug abuse...Student discipline. Thought counselling could work. Gradually saw that learning disabilities are real and beyond the scope of counselling. Larger questions as to why children fail to read and that leads to learning disabilities, behaviour problems and social effects and the very nature of society... children could not read (120). On the issue of how people choose careers – people first move with their hearts (116)

Adolescent Health and Wellness

Q. Does the ministry address adolescent health and wellness issues? **A.** Does indirectly. The holistic is known but the reality is that passes in CXC surpass everything. The Ministry of Education sees itself as primarily putting out qualified individuals ...Bottom Line is SEA, CXC and CAPE passes – Certification (128). Directly you have HIV and Substance Abuse policies, No-Smoking policy and HFLE. These are policy documents. **Q.** Do these come from national policy or education policy? **A.**Yes, from Ministry of

Education strategic plan 2003 - 2008. The Strategic Plan – identifies four strategic pillars related to curriculum that speak to: Learning to be, to do etc. the Curriculum is based upon 6 Essential Learning Outcomes including Personal Development. There are *untold stories* coming from principals who pay attention to personal development(122). They go beyond academics. At the primary School it is clearer in terms of topics on basic hygiene ... wash your hands, dressing grooming, etc. then also support services for children with chronic illnesses e.g. Asthma... more than sympathetic to children. Nurses go to schools to check teeth and lines of children going to the dentist etc ...Collaboration of schools and health centres. It is a joy to go into the primary schools and see them checking the mouth, ears, etc. of primary school children. This is not too well known but these are there.

Q. Why did you go straight to Primary school level? Do these collaborative interventions continue at secondary levels? **A.** No doubt about that although there is lessening off... Natural progression of self- actualisation as children grow into adolescents....Girls take care of their bodies...health interventions in Forms 1 and 2...Attention is paid to issues of puberty ...menstrual care. MOEd has now made physical education compulsory up to Form 3.it used to be optional (129). For emotional development there are two sides: one side deals with direct link between teacher and student. Form teacher programme was the flagship. (not sure if that still happens) ... created emotional bonding between children and their teachers (132). Other side, programmatic approach (131) to personal emotional and social development - is engagement of children in emotional development through a curriculum promoted by Guidance Officers re academic, personal, social and career development – this is done up to Form 3 (131). In 1995 we only had 28 Guidance Officers... Lack of human resource ...125 secondary schools in Trinidad and Tobago. We have Guidance Officers in 60schools or 50% of the secondary schools; another 50 in primary schools (207). In the remaining schools we have a visiting guidance service. Form teacher programme is supposed to happen in all secondary schools but is dependent on the principal - is as good as the principal wants it to be (132). In secondary schools where there are teachers who came in from the Primary Schools into the Junior Secondary Schools, there was continuity of the Form Teacher approach which they seem to have brought from their primary school experience. But when these teachers retired and were replaced by graduate teachers this fell down and fell out.

Today Student Support Services provide training for Form Teachers, in response to concerns raised by school principals. One period a week for Form teachers, **(Interviewer questioned whether there were other avenues outside of the scheduled form teacher class when a student could access a Form Teacher) A.** One or Two times (132) ...Form periods existed in the time of Junior Secondary Schools, now that there are no more Junior secondary schools, there should be more time.

Form teachers in schools are beginning to happen again. I have suggested that the morning should be preceded by form teaching or form briefings before formal lessons can take place (132). This could be based on an issue that a student identifies based on a personal experience related to social or emotional issues. Again, all principals and teachers are not willing to buy into the programme (132).

<u>Policy Development</u>

Development of HIV policy was protracted. It began with a need for a policy, need for sex education. National level policy... engaged principals, then students were involved,

participated in focus groups. Issues of sensitivity and stigma and discrimination fuelled the development of the policy which must be sensitive to children. Other stakeholders TTUTA (Trinidad and Tobago Union of Teachers Association), NPTA (National Parent Teachers Association), and principals' associations were involved; denominational organisations; ILO and Ministry of Health. Brought in a guy from South Africa to help in the policy writing component and he had a workshop with key stakeholders. A CARICOM grant through PANCAP made this possible. They helped to pull it all together. We had several drafts. Ministers changed and a new Minister took it Cabinet and approval came in 2007 (139).

There is the practice that all policies go through a process of national consultations and collaboration. **Q.** How do others find out about your policy e.g. teachers, students? **A.** Not very successful with the drug policy, was better with the HIV policy. We had a dedicated person for the HIV policy, that made the difference. Last year we disseminated draft HIV policy to all school principals. It was about dissemination of the policy as well as discussing the sensitive issues, how do you (principals) feel about the policy (139)? Principals still very old fashioned in their understanding about sex and sex education as it relates to students. So we decided to put together a seminar 'Let us talk sex education' (139).
Q. Is there an implementation plan to go with policies? **A.** HIV yes but not for others, there is a need for dedicated persons to communicate, follow up etc. We also met with school supervisors who were supposed to engage the principals but this part never happened. With other policies such as the drug policy, for the purpose of implementation there were posters in all schools about the negative effects of smoking for instance. Now, teachers hide to smoke which is an indication of the success of the programme. We have a strong No Smoking position (139) but the implementation is sometimes weak. I have seen teachers go to their cars to smoke because there is an implementing principal and there must be leadership with the principal. There is no system for monitoring the implementation of policies (140). No monitoring and evaluation components yet for policy implementation. Other adolescent wellness and health programmes...Stretch it to include mental health and wellness - Voluntarism package. We get the children to engage in social service programmes, visit old peoples' homes etc. Now there is a voluntarism policy before Cabinet to make this service a more central part of student social development. We're linking the voluntarism with certification because if you link it with certification it gets a little push (129). Physical Education and HFLE have specific functions to address adolescents. We also purchase the services of specialists and we pay for the service for emotional support, e.g. psychologists, psychiatrists. In some cases when we confront negative group behaviour, we counsel everybody. Adolescent Health is a core function for Student Support Services.

<u>Collaboration</u>

Collaboration between MOEd and others: There is a monthly meeting within the Ministry with stakeholders in education to talk policy, for example, TTTUTA, NPTA, the education boards. Meetings with other Ministries on as needed basis. These are not standing committees (136). National Security and MOH., Community Dev., Social Dev., not very much with Youth and Sport.

Q. What levels of professionals are involved? Depends, usually heads of Divisions. There is the collaboration of Cabinet Appointed Committees – formal structures. There is a Cabinet appointed committee for Citizen Security, includes national security, also a committee on mental health , workplace HIV Committee with ILO and NACC (National AIDS Coordinating Committee). Mental Health is MOH. None of these is led by the MOEd, but we sit on these committees. Cabinet appointed a committee to look at preventing putting children at risk. (This was in response to crises). After a particular highly publicised incident of the death of a child due to physical abuse, key recommendations were made *to ensure that it does not happen again.*

Use of information technology

Good responses from using e-mails - Yes. They work, I come in early to respond to emails. _IT in the MOE working to give all employees email addresses to make the system work better. They are working towards giving everyone an email address, this does not exist at the moment.

Q. Any more stakeholders that influence what happens in the MOEd? American School Counselling Association. (ASCA) who assisted and provided guidelines for developing a national curriculum, UNESCO, UNICEF, etc. support with consultants, they conduct training, assist in research. We need to get a grip on Stigmatisation- HIV. So there is a consultants coming in.

Josh – Ministry of Education

Background

Interested in social issues. .. Social studies facilitator for Primary Schools in the Curriculum Division, now Social Studies teacher. Went to Barbados to specialize in HFLE – for both Primary and Secondary schools. Started as curriculum facilitator in 2001

I can tell you that the first set of workshops that the NPTA had on HFLE, I was the facilitator ... Member of NPTA ... each of the education districts had a session for parents, PAHO supported I was the First Vice Chair. Also went throughout the country including Tobago doing workshops for Values Education for over a year and Social Studies education.

In 1999 did a Certificate in Education, then Bachelors and Masters in Education. I am a parent with one son. I am a marriage Officer as well, for Christian Brethren Association, that too has also helped, in addressing all those teen issues...pregnancy etc. Parents' relationships are important to working with youth and being a father has influenced my work too(116). Work with youth outside of education sector, parents too. Believe in parents having relationship with children. I am consultant to the PTA now...used to be an officer within the PTA.

Approaches/Mechanisms to address adolescent health and wellness

Q. Does the MOEd address health and wellness for adolescents? **A.** I don't think so, I think they pay lip service, there are no organised programmes...only reactive! (122). Ministry not hot on the issue. They are writing HFLE for secondary schools, parents have participated. They do not have enough teachers on the HFLE programme, the person who is at present in the role is not qualified and has no experience in HFLE. So I have not been involved with the ministry on this in spite of my background. There is a lot of talk

on the matter of Health but now they have very much reduced staff in the Curriculum Division. My colleague trained in HFLE and I went back to teach other subjects in primary schools. The present curriculum officer for HFLE does not have any HFLE background. No organized programme to meet the needs of adolescents.
There are piece meal programmes e.g. "together we light the way"; PALS (Peace and Love in School), and others. There were a number of initiatives that were ad hoc and the school system did not have the means to sustain these programmes. No research , no concrete programmes on health and wellness. In my school, I am trying to introduce the selling of fruits ... there is no systemic implementation of health in schools. School concessionaires should be involved but the Principals have little control on the matter. Addressing health is left to individuals schools. With regard to cafeteria, there should be a policy on criteria for what the concessionaries should sell.
Social Studies deal with STDs, and Nutrition and so on. **Q.** What about other subjects? There was Health and Human Biology, but that is not there anymore. Physical Education treats some of these subjects. The policy is that HFLE is the vehicle for Health...came out of a CARICOM initiative that sought to address youth problems. Consultation with civic society, aside from these is the concept of the Ideal Caribbean Man. Out of all of these developed the HFLE. There was the sense that the courses and their evaluation must be standardized. There was a Curriculum Officer who led during that period. Help came from Health Ministry. School of Nursing now doing some HFLE. Collaboration with groups and organisations.
Policy Development
There is no systematic policy development and implementation. There is an HFLE curriculum and few people teach [HFLE] it. They say they are not equipped to teach HFLE. You have a Curriculum Officer; when it was presented [to school principals] the Curriculum Officer said that the role of Curriculum Development is to prepare curriculum and send to schools. It is principals' responsibility to ensure it gets done (130). Curriculum Development is only about writing curriculum and putting it in the schools. There is a weak means of implementation; a train the trainer strategy which is not monitored later for effectiveness. Teachers in schools are not pushed to implement the programme. Maths is different. It is a prestigious subject and better supported by teachers. There is an imbalance between the subjects. Sports is also not reinforced. But the main fact is that Maths and Language have been Common Entrance and SEA subjects. This exam does not apply to HFLE. It shouldn't be so (128). Even at the universities, the number of courses and sessions for HFLE are thin and not well supported. Little avenues for studying the subject or profiting from studying it, HFLE now being taught at UTT (University of Trinidad and Tobago)...But the lecturers may not have the required skills.
Implementation of policy ... School Supervisors are officially those expected to lead the process in the schools especially guide the teachers. But I used to identify many of the participants. I knew those who were willing and capable and made sure they were pushed forward. That way I was able to help provide crucial support for the process. So there was generally an Action Plan but it stopped after the training of the trainers. No backup resources, books, school broadcasting, etc. Remember we work in a system where discontinuities are frequent and whole programmes are stopped because personnel move or new persons come in who are not enthused or trained.

The detailed attention that has accumulated in favour of Maths and Language is enormous. Maths has no of periods that must be taught per week. **Q.** Is there nothing about doing a minimum no. of periods a week of HFLE? **A.** No, this must be done. But in most primary schools you get about 5 periods of HFLE a week, while some have less. Sometimes a little HLE ... and a little Integrated Science. Teacher shortage for the subject is another problem. Making subjects examinable is not the way to go. But some system of reward is important. Good workers must be encouraged. University admission should demand academia but also something that deals with character.
Monitoring is weak. Most of the Supervisors can't monitor anything. Their backgrounds do not make it easy for them to supervise.
Many of them come out of the secondary school system. National Certificate in Secondary Education is the examination for Social Studies. I lecture part time at the School of Advanced Nursing. Measurement and Evaluation is one of my strengths. I do teach teaching strategies and use HFLE for illustration. I was never a nurse but my HFLE background is very useful. At the beginning of my teaching Curriculum Development at the SANE, the students were not enthusiastic and wondered the relevance of their nursing to curriculum. I taught them Curriculum as planning and implementing. The PTA too; I did the same sorts of training and education for the PTA.
In Barbados, we were supported by UNICEF. Now I use much of my training to cross fertilize my teaching. **Q.** Is there sex education in secondary schools? **A.**I know about RAP Port (Youth Drop in Centre of the National AIDS Programme, MOH that visit secondary schools. There is little comparable teaching in primary. But after SEA a number of schools invite health personnel to talk to children. Leadership skills also. Now there are additional Curriculum Officers for Social Studies.
No dedicated materials and staff for adolescent health. I do not see that HFLE as core to the work for the Ministry of Education. There is always talk but giving resources to establish the core is weak...working with other Ministries and with religious leaders. Religions are united on Abstinence ... I had a session with adolescents at a Camp last week. They were not aware of many of the things I told them about condom use, STIs and others. We were secular and spiritual. Organized by the Church but those invited were not necessarily members of the church.

<u>Use of Technology</u>

The ministry communicates through the internet, but just starting ...in initial stages. Will help when developed – in the spread of materials, pictures, etc. Use of videos etc will help in the process of demystifying health issues.

Appendix VII

THE CONCORDAT OF 1960
Assurances for the Preservation and Character of Denominational Schools

As approved by Cabinet

The Minister of Education and Culture wishes to clarify for general information some of the proposals on Education with reference to the re-organization of Education so far as those proposals affect the Denominational Boards of Management, the Governing Bodies and Principals of Assisted Secondary Schools.

1. In relation to property, the ownership and right of direct control and management of all denominational primary and secondary schools will be assured to the denominations in whatever modifications of the existing system that may subsequently be introduced in the New Education Ordinance, and all existing rights, so far as property is concerned, will be respected.

2. In denominational schools, no books or apparatus to which the denominational authority formally objects, will be introduced or imposed.

3. In denominational schools (unless the Denomination concerned otherwise gives its consent) the religion of the particular denomination which owns the school will be taught exclusively and by teachers professing to belong to that Denomination. In Government Schools all recognized religious denominations will have access through their accredited representatives during the times specified in the time-table for the teaching of Religion to the pupils belonging to their faith. Pupils attending the schools of a denomination not of their own faith will not be compelled to take part in the religious exercises or lessons of that denomination.

4. The right of appointment, retention, promotion, transfer and dismissal of teachers in Primary Schools will rest with the Public Service Commission. A teacher shall not be appointed to a school if the denominational board objects to such an appointment on moral or religious grounds. Similarly, if a teacher be found unsatisfactory on these very grounds, moral or religious, the denominational authority shall have the right to request his removal to another school after due investigation. For these reasons it is proposed (provided the legal and constitutional arrangements allow) "that vacancies as they occur in all schools should be advertised and applications submitted in the first instance to the respective Board of management which will examine them and forward them all, with their recommendations, to the Public Service Commission for final action."

SECONDARYSCHOOLS

5. The existing relationship between Government and the Governing Bodies and teachers in Assisted Secondary Schools will remain subject however, to negotiated

changes inevitable with the introduction of Free Secondary Education and to a system of inspection of these schools by persons authorized to do so by the Ministry of Education and Culture. The Governing Bodies of these schools will continue to be responsible for the administration of these schools and for their maintenance, repair and furnishing. Those schools will continue to qualify for Government Aid. The Principals of Assisted Secondary Schools will make available a minimum of 80 per centum of the First Form entry places to those who, by passing the test, qualify on the results of the Common Entrance Examination for free secondary education. The Principals will be represented on the panel of examiners to be set up to administer the test. The Principals will be free to allocate up to 20 per centum, the remaining places as they see fit provided normally that the pass list of the Common Entrance Examination serves to provide the pupils. Entry above the First Form will be under the control of the Ministry of Education and Culture and will require the approval of the Minister.

6. Where the need arises for disciplinary reasons or unsatisfactory progress to remove a pupil from the school, the right to request such removal will remain with the Principal who may for the same reasons suspend a pupil pending investigation. Authority to expel a pupil is vested solely in the Cabinet. For disciplinary reasons the same principle will apply to Primary Schools.

7. All new Central Schools may be established only by Government for the simple reason that these schools are to be fed from the Primary Schools of all Denominations, as well as Government Schools, which may be in the area served by the Central School. Where, however, the need arises for converting an existing denominational school into a secondary school, the denominational character of that school will be allowed to remain.

8. The selection of teachers for training at the teachers' college is to remain solely with the Ministry of Education and Culture. Selection of teachers for training in the existing denominational training colleges may be made by the Denominational Boards, but such selection must be approved by the Ministry of Education and Culture.

9. It is the desire of the Government that all teachers be trained at the teachers' college under Government supervision and administration. Government will however respect the rights of the existing training colleges conducted by the denominations; but no expansion of those facilities will be allowed without the expressed permission of Government.

Signed by Hon. J.S. Donaldson, Minister of Education & Culture, on behalf of Cabinet on 22 December 1960, and published on 25 December, 1960

Source: *www2.nalis.gov.tt* ***The Concordat*** of 1960 National Library of

Trinidad and Tobago

Appendix VIII

Newspaper article November 11, 2011

Gopeesingh: Take up issue with Equal Opportunity

Story Created: Nov 11, 2011 ECT
Story Updated: Nov 11, 2011 at 3:10 PM ECT

Minister of Education Dr Tim Gopeesingh has advised People's National Movement (PNM) MP Patricia McIntosh to take the issue of alleged discrimination by the Maha Sabha at the Tunapuna Hindu Primary School to the Equal Opportunity Commission for a ruling.

He was speaking on Wednesday night in the House of Representatives at Tower D, Waterfront Complex, Port of Spain, in response to a motion on the adjournment brought by PNM MP Patricia McIntosh.

In giving a chronology of the events, Gopeesingh said on June 17, 2011, the principal, Sita Gajadharsingh Nanga, wrote to the Teaching Service Commission (TSC) requesting a transfer, in which she made numerous allegations about the Sanatan Dharma Maha Sabha (SDMS) board.

He said the letter was copied to no one at the ministry, except a School Supervisor 3.

He said on August 10, 2011, a letter from the secretary general of the Maha Sabha was sent to the TSC, supporting Gajadharsingh Nanga's request for the transfer and making allegations against her. That letter was also not sent to the Ministry of Education. On August 22, a memorandum from the TSC came to the ministry, seeking its comments and recommendations on the issue.

Gopeesingh said on August 30, 2011, the permanent secretary sent a letter to the Commission, indicating the following: The principal had not followed the established procedures in applying for a transfer since the Public Service Commission regulations require such an application to be made through the school board to the permanent secretary; the issues raised by both the principal and the secretary general of the Maha Sabha contained many substantiated allegations; the decision on the transfer remains a matter for the Commission to decide.

Gopeesingh said on September 26, the Director of Personal Administration wrote to the Ministry of Education, requesting that the permanent secretary take steps to ensure that the principal be allowed to carry out her duties at the school. He said a letter was sent to the Maha Sabha on October 14 confirming that unless Gajadharsingh Nanga is transferred or otherwise directed by the TSC, the Maha Sabha board had no authority to debar her from reporting for duty at the school.

Gopeesingh said MTS, on October 20, confirmed the principal would be allowed entry to the school. But on October 24, the same day the principal was debarred from entry to the school, the Maha Sabha advised MTS that it had been relieved of its responsibility at the school. In addition to a report from the School Supervisor 3, the ministry also received a letter from the TSC asking for an investigation. The minister said the permanent secretary appointed a School Supervisor 2 and a School Supervisor 1 to do a probe, and their reports are due today (Friday). He said the Ministry of Education "has behaved in a very responsible manner".

Gopeesingh, however, noted it was the "height of hypocrisy" that the PNM, which for years resisted an Equal Opportunity Commission ("set up as a result of the UNC and the Privy Council"), was asking what the Equal Opportunity Commission would say on this issue.

"You (McIntosh) have a matter that is close to your heart; you should probably send it to the Equal Opportunity Commission for their deliberations on it", he advised.

Source: www.newsday .co.tt Accessed Nov. 11 2011

KEITH

Mr. Chairman, for the whole morning I have sat there and listened to what many teachers, students, principals and others have had to say about the aims of education in our society, but I firmly believe that how could we know the aims of education in our society when we have a faulty educational system. We must first change this system and then we will know the needs for education in our society. What our children need is a basic understanding, a general understanding of what education is on the whole, and not to give them the idea that it only means to go to school, learn something from a book and then vomit it back out.

This is the problem all around in that people who have a lot of initials by their name, I don't mean everyone, but too many of them cannot perform all that the initials say they can. And with this going on how could we ever know what are our true aims? We first need a basic understanding of what education is. We must tell them that education is not only going to school and learning from a book, but also from personal experience. That is how many of us have gained our education. I can tell you that is how I have been able to gain something daily as I live. Because if I had waited on my teachers to help me along with my education, I would have gotten practically nowhere.

Sometimes we ask the teachers questions and they simply cannot answer it. Why? Because many of them have never really gained from personal experience. They have only read things from text books alone so that as I am tired telling my friends, it is not how much that is shown on the paper that a man can do but how much he can do when you see him actually doing it. Because I have recently had an experience with an elderly gentleman who is an apprentice engineer, for forty-four years he has been working, and something went wrong with the engine of a ship. Another fellow who had a lot of initials by his name came along and say, so so so so so about the engine, but the man now who I am speaking about who is practising his work every day, simply just looked at it and told them what the problem was. Of course they

present educational system as it is and just say well OK, we have the rejects. Those who are not intellectually capable of getting four or five passes in the G.C.E.and tell them well OK brother man, I think it is best if you say you do a bit of farming, a little bit of woodwork, No.

You have to say well OK, I think that if you are intellectually capable and you still have the talent to be a good little carpenter, mason, farmer, anything like that, go right ahead. I don't think that rejects, those who aren't quite capable, if I may use 'upstairs', I don't think we can depend too much on them if we are to hope for any good things. And finally, Mr. Minister, please expose students in Trinidad to a lot more. I earnestly beg that, because I don't think I was ever exposed to anything beyond what the Government gave us, what they put for us and I really didn't like that. I tell you that frankly. Dialogue has to be sincere. It is indeed true that this is just the beginning, but somehow I feel that unless you are sincere, I think this will be a fruitful venture for you, and most futile for us.

I thank you very much.

CAMILLE

First of all I would like to read a quotation from Ralph W. Tyler. He says, "Is democratic education to be defined solely in political terms or is democratic education a way of life at home, in the school and in economic matters as well as a form of political life?"

What is the aim of ~~education?~~ An education is to liberate one, to free free the student from adolescent obstructions. Education itself is training, discipline in one's moral and mental faculties, to be able to train a student and guide him into creating standards and ideals of his own. Something that they can look to - aspirations, perhaps. The main thing that hinders this is fear. Fear is not only the ghost of the dark but also an obstruction to students. To be able to eliminate this emotion of fear is to have an educated child. To be able to get up on the pulpit and take worship, to be able to stand in front the crowd and voice an opinion, to be able to command respect from the student body

is probably the triumph of courage. But fear really is one of the most destroying factors. Schools, through education must make a desperate effort to combat the fear of students. Some fear the Principal's whip, some the consequences of not doing home lesson. Eradicate this and this is what education is to aim at.

At my school, we have counsellors who guide students into making a decision, to find the root of the troubles of the student. The aim of an education in this case is to set free, to liberate the student. Liberal coming from Latin word 'liber' meaning to set free, and in this case to set free a student from fears, from mental obstructions, things which could prove to be a destroying force to personality in the future.

The second point I would like to emphasize is promotion of dialogue. This is the most fruitful way of educating one. The classroom must be one of freedom whereby a student can discuss and openly criticise points of views, to be able to express themselves, their thing, as they call it. To be exposed to every controversial aspect of society whether it be black power or what. Let them know what this really is. The classroom must be one that is conducive to open discussion and not the monologue of the teacher speaking and the student listening.

In Form Six in my school there are still students who lack the ability to speak clearly, to express themselves. And it will be found that the minority does the speaking. After all this in the year for national dialogue and you still find in schools teachers telling students 'Shut up and listen' or 'Silence is golden'. This is not national dialogue. Let everybody participate. Let the students participate in decision making process. Inculcate in them that the doctor's degree or becoming a lawyer is not the final result. Inculcate in them that being academically qualified is not all. But inculcate in them that education, education is filling that gap between the older and younger generation. Education should be directed so as to make a man more aware of his society. A liberally educated man who is able to have a generous outlook on his fellow man.

Thank you.

Source: Brathwaite R H E (1983) 'Comments of Secondary School students on Teachers, Schools, Education, etc. 1971-1981: The Still Small Voice of the Student'. Unpublished paper: The University of the West Indies, Trinidad and Tobago.