Policy reform in nurse education and its implementation in the Caribbean region

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Abstract

In 2006, the Caribbean Community (CARICOM) – a federation of sovereign Caribbean states – decided that the Bachelor of Science in nursing degree would be the standard qualification for entry to nursing practice in its English-speaking member countries. Indications were that by 2011 all of the English-speaking states had not implemented the regional policy. This research study was conducted to reveal the origin and nature of the 2006 CARICOM nursing education reform, trace its pattern of implementation, and determine the implications of that pattern for the coverage and coherence of healthcare in the region. An interpretive study with a multiple case design was conducted. Six case units were investigated through a staged approach to this empirical study. The research drew on the findings of interviews with selected policy actors, and on findings from the review of relevant documentary sources.

The main findings were that the reform was not fully adopted in the region; that system tensions delayed its implementation; and that country-specific factors produced the variation in its adoption by member states. These findings have implications for the harmonization of nursing across CARICOM and, by extension, for CARICOM's functional cooperation in nursing services. They also have implications for the region's accomplishment of the World Health Organisation's objective of universal access to quality healthcare – part of its Universal Health Coverage by the year 2030 agenda. The results should be useful to Caribbean and international health and education policy scholars and actors.

Key words: *nursing, higher education, education reform, policy implementation, Caribbean, CARICOM*

Acknowledgements

"If I've seen further, it's by standing on the shoulders of giants."

Sir Isaac Newton, 1676

In tribute to the Caribbean nurse leaders of the past and those who continue their struggle today. With profound gratitude to this study's participants, my supervisors, and my supportive family and friends. Thanks for letting me stand on your shoulders!

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Commonly Used Abbreviations

ANEU	Advanced Nursing Education Unit
BCC	Barbados Community College
BScN	Bachelor of Science in Nursing
BTCC	Brown's Town Community College
CARICOM	Caribbean Community
CARIFTA	Caribbean Free Trade Area
CCJ	Caribbean Court of Justice
CNO	Chief Nursing Officer
COHSOD	Council for Human and Social Development
CXC	Caribbean Examinations Council
DANE	Department of Advanced Nursing Education
EU	European Union
EXCED	Excelsior Community College
GNC	General Nursing Council
ICN	International Council of Nurses
MOU	Memorandum of Understanding
NCJ	Nursing Council of Jamaica
NCU	Northern Caribbean University
NNA	National Nurses Association
RENR	Regional Examination for Nurse Registration
RNB	Regional Nursing Body
SGU	St. George's University
TAMCC	T A Marryshow Community College
UCH	University College Hospital
UTech	University of Technology, Jamaica
UWI	University of the West Indies
UWISON	University of the West Indies' School of Nursing
WHO/PAHO	World Health Organization/Pan American Health Organization

PART 1

INTRODUCTION AND BACKGROUND

Chapter 1

Introduction to the Research

This chapter introduces the research study. It explains the study's importance and outlines key elements of the research and thesis. The importance of the research is linked to the need for further empirical research in the Caribbean Community (CARICOM) policy space – particularly its nursing education policy system. It is also linked to the realization of policy intentions in the region. The chapter proceeds by listing the research questions and outlining the research design, methods and data sources. The format of how the findings are presented is indicated and the chapter continues by explaining the research's significance. The final section outlines the structure of the thesis.

1.1 Aim and importance of the research

This study was conducted to enable the researcher to understand the origin and nature of the 2006 CARICOM Bachelor of Science in Nursing (BScN) reform, how it was implemented across selected states, and why the character and extent of its adoption varied between territories. The researcher also aimed to consider the implications of the reform's implementation pattern for the future coverage and coherence of nursing provision in the Caribbean. The information from this investigation would be useful because it sheds light on CARICOM's nursing education policy system – a system on which there is little empirical data.

CARICOM is a federation of sovereign states established to promote cooperation and economic integration among its members (CARICOM Secretariat, 2017b). The states in the federation are primarily Caribbean countries with a common history of colonial

rule. The majority are English-speaking territories but there are one Dutch and one Francophone territory in the union. The union is comprised of fifteen full members and five associate members. Further details on the structure of CARICOM are provided in Chapter 2.

1.2 Core and supplementary research questions

The core research question was:

How, and to what extent, was the 2006 decision by CARICOM to establish the Bachelor of Science degree in nursing as the standard entry requirement for nursing practice, implemented across the region?

The supplementary research questions were:

1. What were the reasons for the 2006 BScN reform?

2. What was encompassed by the reform?

3. What goals, plans or expectations were attached to the reform?

4. How was the reform acted upon by member states?

5. What factors promoted or inhibited the realization of this policy?

6. What are the implications for this pattern of implementation?

1.3 Research design, methods and data sources

The research was an empirical interpretive study that applied the case study approach with a multiple case design. To understand the reform, six case units were investigated through key informant interviews and the review of related documents. The research was conducted in three stages. Stage 1 involved the collection of background data on the provision of nurse education in the region and the implementation of the CARICOM BScN reform. This information provided the basis for case selection.

Stage 2 involved the conduct of interviews and the review of documents. Stage 3 involved analysis of the findings and the determination of their implications. The interview and documentary data were analysed thematically to build pictures of the policy's evolution in case units. The analysis also enabled mapping the reform's trajectory through the region, and suggested explanations for its uneven implementation pattern.

1.4 Presentation of the findings

The findings are presented in narrative form with participant quotes, diagrams and tables for illustration. The research revealed issues that beset the region's nursing education policy system. Issues raised included the capacity of tertiary level institutions to deliver baccalaureate nursing education, tensions and deficiencies in the policy system, and the role of partner organisations in education policy-making.

1.5 Significance of the research

The study extends the literature on education policy implementation by mapping the trajectory of this international nursing education reform in CARICOM - a federation of sovereign Caribbean states. The empirical literature on Caribbean policy, particularly Caribbean nursing education policy is quite sparse. Therefore, the analysis of this reform, hitherto not subjected to systematic investigation, represents a contribution to knowledge in an area that is significantly underrepresented in the empirical literature.

The findings of this research could provide CARICOM's partners with insight into the nuances of the region's policy system. As such, the results should be particularly

useful to CARICOM's nursing policy advisors, its nurse educators and its international partners.

The results should also be useful to Caribbean policy scholars and actors working with CARICOM health and/or higher education policy because they provide insight into the dynamics of the region's nursing education policy system. To realize regional policy intentions it is important for CARICOM policy actors to comprehend their operating environment. Understanding how the BScN reform was implemented in member states would give insight into how CARICOM does policy. Such insight would empower relevant actors to realize the region's policy intentions in local spaces, and promote the reversal of the trend of uneven implementation in the CARICOM policy system.

1.6 Structure of the thesis

The thesis is presented in three parts with twelve chapters. Part One introduces the problem and provides the background for the research. Part Two examines the related literature and describes the design and methodology of the investigation. In Part Three, the findings and their implications are presented.

Chapter 2

The Caribbean Community: Structure, History and

Responsibilities for Nursing

This chapter describes the complex regional context that the CARICOM BScN reform entered. It details the historical, social and political developments that steered nursing education in the Anglophone Caribbean and describes CARICOM. In addition to tracing CARICOM nursing's history and describing its context, the chapter highlights the conditions and decisions that influenced its development over the period. It begins by describing CARICOM's governance structure and rules.

2.1 CARICOM members, structure and governance

MAP 1

Figure 2.1: Member States of CARICOM

As illustrated in Figure 2.1, fifteen nations make up the Caribbean Community (CARICOM Secretariat, 2001a and The Heritage Foundation, 2012). The Community

is a federation of sovereign states. Following the signing of the 1973 Treaty by the four founding members, eight other members signed in 1974 and the remaining three joined subsequently. Of the fifteen states in CARICOM thirteen are English-speaking and two - Haiti and Suriname - speak French and Dutch respectively. The original objectives of the union were economic integration, coordination of foreign policy, and functional cooperation in health, education, culture and other areas related to human and social development (CARICOM Secretariat, 2001a). This group of predominantly liberal democratic nations has made good progress with overcoming the challenges which drove them to unite in the first instance – namely poverty, overpopulation and illiteracy (Sutton, 1999 and Insulza, 2014). However today crime, economic decline and slowed development afflict the region (CARICOM Secretariat, 2014). Some of these social features will be addressed in Chapter 3.

Functional cooperation in CARICOM health services includes cooperation in nursing education and nursing service. Consequently, the governance of nursing has been incorporated into the regional governance structure. The supreme policy-making body of CARICOM is the Heads of Government Conference comprised of the Heads of Member States (O'Brien, 2011). This organ formulates strategic policies in all areas of cooperation (Hall and Blake, 1977). The Conference is assisted by the Community Council of Ministers, to which it delegated its authority for development and operation of the common market (O'Brien, 2011). The Community Council of Ministers, hereafter called the Council, is made up of the Head of Government of each Member State, or a senior Minister of the Cabinet. This organ controls the daily affairs of the Community, including its financial affairs. The Conference and the Council are CARICOM's two principal organs (Hall and Blake, 1977 and O'Brien, 2011).

The principal organs are assisted in their functions by four Ministerial Councils. These are the Council for Finance and Planning, the Council for Trade and Economic Development, the Council for Foreign and Community Relations and the Council for Human and Social Development (COHSOD). These ministerial councils generate and submit proposals to the Council for approval (O'Brien, 2001). COHSOD has policy-making authority for nursing in the union. It has a wide mandate which includes improvement of the Community's health and health services; the promotion and development of all levels of education and training in CARICOM; and responsibility for other areas related to cultural and social development in the Community (CARICOM Secretariat, 2001a).

Another organ of the Community is the Bureau. This organ may initiate proposals for development by the ministerial councils. It is comprised of the current Chairman of CARICOM, his predecessor and his intended successor. It is responsible for facilitating the implementation of Community decisions at the regional and national levels (CARICOM, Secretariat, 2001a and O'Brien, 2011).

The Secretariat is the administrative organ of the Community and is responsible for monitoring the development and implementation of proposals, achievement of the Community's objectives, and keeping the Community Council informed accordingly. It is headed by a Secretary-General who is assisted by a deputy and five directors, each responsible for a separate division of operation. The divisions are those of Trade Economics and Statistics, Sectoral Policy and Planning, General Services and Administration, Functional Cooperation, and the Legal Division (Hall and Blake, 1977 and CARICOM Secretariat, 2001a). The Secretariat services meetings of the organs

and institutions and provides services to member governments in areas related to the aims of the Community. It should be noted that the Secretariat "has no decision-making power, and its authority is strictly inter-governmental" - not supranational (Hall and Blake, 1977, p. 217).

The Community also includes a number of bodies, institutions and associate institutions. The bodies are the Legal Affairs Committee, the Budget Committee and the Committee of Central Bank Governors. There are nine institutions of the Community and five associate institutions. The associate institutions are designated thus because they are independently chartered organisations which were established before CARICOM itself (CARICOM Secretariat, 2001a). The University of Guyana (UG) and the University of the West Indies (UWI) are two such institutions.

In 2001 the Treaty of Chaguaramas was revised and made provision for the establishment of the Caribbean Single Market and Economy (CSME), and the Caribbean Court of Justice. The main objectives of the CSME are full use of labour and the other factors of production, and competitive production to enhance trade with other countries. Key elements of the CSME are the harmonization of standards to facilitate free movement of goods and service intra-regionally, and free movement of labour including harmonizing social services (CARICOM Secretariat, 2001b). The Court has compulsory and exclusive jurisdiction to interpret the Treaty and is the ultimate dispute resolution mechanism for member states that have agreed to designate it as such (O'Brien, 2011). Figure 2.2 illustrates the Community's structure.

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HEADS OF GOVERNMENT CONFERENCE ——————— CARIBBEAN COURT
                                                    OF
                                                  JUSTICE
              THE BUREAU

     COMMUNITY COUNCIL OF MINISTERS

     MINISTERIAL COUNCILS

The Secretariat

Secretary General

Assistant Secretary General          Institutions, Associate Institutions
                                              and Bodies

     Directors

     Divisions
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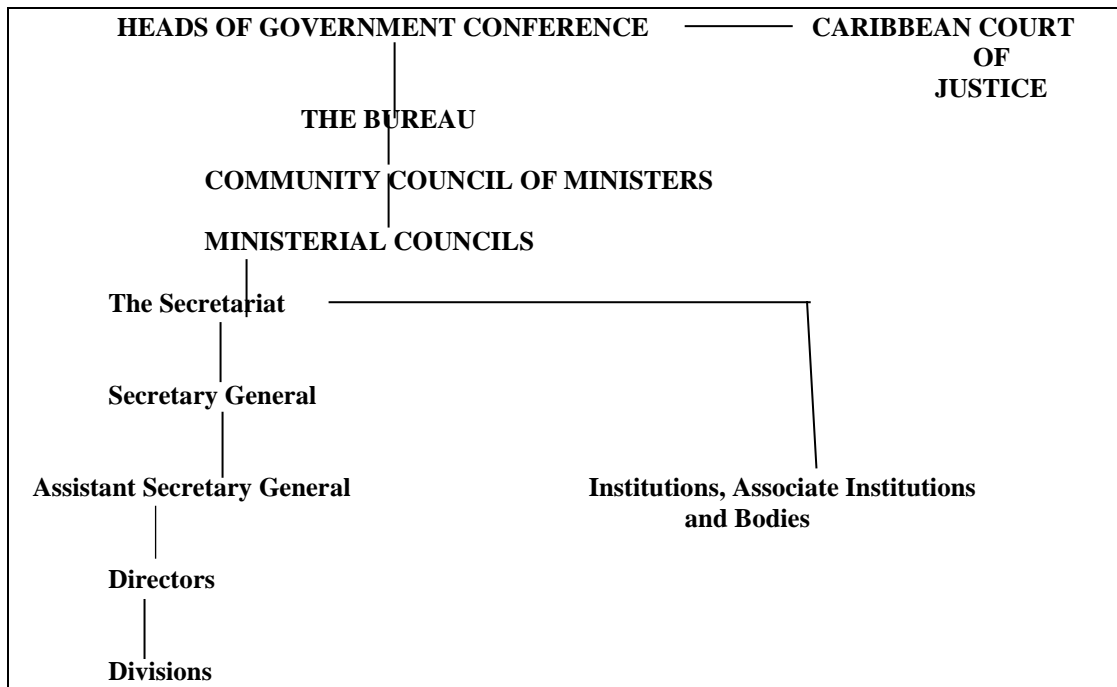
Figure 2.2: Organisational Structure of CARICOM

Each Member State represented on CARICOM's organs and bodies has one vote. Recommendations of the organs are made by a two-thirds majority of member states but are not legally binding. States not wishing to comply with a recommendation may do so and inform the Secretariat in writing within six months stating the reasons for non-compliance (O'Brien, 2011).

Decisions of the Community Council and the Ministerial Councils are made by a three-quarters affirmative vote of member states and these decisions are binding on any member state that has transposed them into its municipal law. To safeguard national autonomy, decisions of the Conference require a unanimous vote. This means that each member state has veto power in the decision-making process of this organ. Moreover, once made, such decisions are also not legally binding on a State until they have been transposed into the municipal law of that State (CARICOM Secretariat,

2001a and O'Brien, 2011). This means that CARICOM decisions have no authority in member territories unless they are enacted nationally.

Thus, the decision-making mechanisms of CARICOM provides for the maintenance of national sovereignty and do not encompass the elements of supra-nationality that would ensure uniformed implementation of CARICOM policies in member states. Additionally, there is no mechanism for the coordination of regional policies at the national level, although the Secretariat has a duty to monitor and report on the implementation of such policies to the Council of Ministers (Hall and Blake, 1977). The Secretariat functions mainly as a reporting and technical assistance agency. These conditions facilitate persistent variation in CARICOM policy implementation. They may also be some of the factors that contributed to the uneven implementation of the CARICOM BScN reform in member states. This will be explored further in the discussion chapter of the thesis. The following sections detail the historical events that steered the development of Caribbean nursing education and of CARICOM.

2.2 Development of nursing education in the Anglophone Caribbean

Although Caribbean nursing dates back to the seventeenth century, formal nurse training in the region only started after World War II (Hewitt, 2002; Hunte, 2009). Significant advances were made in the structure of nurse training in the Anglophone Caribbean, through the implementation of recommendations from the Athlone Committee and the Rushcliffe Committee on the Training of Nurses for the Colonies, established in 1943. However, there remained a shortage of nurse educators in the region.

To ameliorate the nursing educator shortage, Sister Tutors were recruited from Britain through the Colonial Nursing Service. Unfortunately, the attractive remuneration packages they were awarded were not enough to retain them in the region. The push of the difficulties they experienced in adjusting to the West Indian society, the low status they occupied as nurses in that society, and their tense work conditions was stronger than the attraction of the salaries and allowances that had lured them to the islands (Rafferty and Solano, 2007). It became necessary to have locally trained nurse tutors and administrators who could be actively involved in the leadership of the profession in their territories – as had been recommended by the Rushcliffe Committee (HMSO as cited in Hewitt, 2002).

The Royal West Indian (Moyne) Commission, established after riots in the 1930s, had recommended that a university be set up in the West Indies to allow a greater number of residents access to university education. Specifically, the university was expected to make medical education more culturally relevant to the region. Another commission, the Irvine Commission was formed to "review existing facilities for higher education in the British colonies in the Caribbean and make recommendations regarding future university development in the colonies" (United Kingdom Report of the West Indies Committee of the Commission on Higher Education in the Colonies as cited in Hewitt, 2002, p. 22). The University College of the West Indies (UCWI later UWI) was established in Jamaica in 1948 with a medical school. Soon after, the UCWI set up a teaching hospital, the University College Hospital (UCH), with senior nursing staff initially recruited from Britain. In 1954, Miss Ruth Nita Barrow (later Dame Nita), a Barbadian, was appointed the first West Indian matron of the UCH. Two years later, to fill the void of locally trained nurse leaders Miss Barrow, in the

capacity of Principal Nursing Officer (PNO) for Jamaica, approached the University College of the West Indies' (UCWI) authorities to deliver advanced training in nursing education and nursing administration to senior nurses in the region.

After some resistance, the Advanced Nursing Education Unit (ANEU) was opened in the Department of Social and Preventive Medicine, UCWI in 1966. The Unit opened with funding from the Pan American Health Organisation (WHO/PAHO), and from the governments of Barbados, Jamaica, Trinidad and Tobago and Grenada (Hewitt, 2002). To this day nurse tutors and nurse administrators are trained, through this unit, to service the region's nursing leadership needs.

2.3 Mobilization to advance nursing in the Caribbean

During the 1950's there remained serious problems in Caribbean nursing (Walters, n.d.). British trained nurses still held the most senior positions in the nursing hierarchy, a situation which promoted tension between the nursing administrators and their juniors – who saw little opportunity for promotion if the status quo remained (Walters, 1995).

Additionally, although a few schools of nursing, like the Tercentenary School of Nursing in Barbados, were recognised by the General Nursing Council (GNC) for England and Wales, many schools were not. Graduates from unrecognised schools had to undergo additional training in Britain in order to be eligible for registration there and for promotion in their home territory. Many graduates migrated to Britain for additional training and registration but many did not return - compounding the shortage of trained nurses to service the region (Walters, n.d.). Those who returned

and those who remained in the region collaborated to enhance the quality of care provided and to elevate the status of the profession. They formed local National Nurses Associations to facilitate networking and to act as a voice for change in nursing.

In the years following the Moyne Commission investigation, nurses in the islands who had the knowledge, expertise, and the social and political awareness seized opportunities to improve the status of nurses in the region. These nurses included notable West Indian nurse scholars, administrators and practitioners like Nita Barrow, who spearheaded the establishment of the ANEU at the University of the West Indies; Mavis Harney, who established the Caribbean Nurses Organisation; and Ena Walters, the first West Indian matron of the Barbados General Hospital (BGH) and first Chairman of the Regional Nursing Body (RNB) (Walters, 1995 and Hewitt, 2002).

In 1957 Miss Mavis Harney - an Antiguan nurse - established the Caribbean Nurses Organization by convening a group of Caribbean nurses to discuss the problems affecting nursing in the region (Walters, n.d.). This regional organization later became the umbrella body for National Nurses' Associations (NNAs) in the Caribbean. Moreover, it helped to propel the regionalization of nursing by facilitating discussion and solidarity among the Caribbean nurses. Over the years, the Caribbean Nurses' Organization, the NNAs and the Nursing Councils (hereafter called GNCs) have collaborated to develop and maintain the standards for nursing in the region.

2.4 Federation, independence, political union and their influence on nursing

As advancement and unification were taking place in Caribbean nursing, a significant regionalization movement was occurring in the political sphere. This inevitably

impacted the governance of nursing in the region. In 1958 the short-lived West Indies Federation was formed from ten former British territories and, through this medium, a Federal Nursing Conference was convened in Barbados in 1959. The conference sought to "examine the standard of nursing in the Caribbean, including Guyana, Belize and The Bahamas" (Hunte, 2009, p.318). These three territories were specified because, although former British territories, they were not members of the Federation (Walters, n.d.). The conference was attended by nursing administrators and educators, representatives of the GNC of England and Wales, the Caribbean Nurses Organization and representatives of the NNAs.

All territories in the English-speaking Caribbean except Antigua were represented at the conference. Among the topics discussed were basic and post-basic nursing education, the administration of the region's nursing schools, the role of the GNCs and the NNAs, reciprocity of nurses trained in the region, and conditions of service for nurses (Hunte, 2009). A steering committee was formed out of the Conference attendees, and it recommended that a survey of the nursing schools be conducted in the territories to ascertain the region's educational standards and needs.

The survey team, led by Miss Nita Barrow, investigated the twenty-three schools of nursing in the region and submitted its findings to a Board of Review which was chaired by Miss Ena Walters, Chairman of the Federal Nursing Conference. From the findings the Board of Review concluded that:

- there should be two categories of nurses in the region to meet the demands of nursing services for patient care;

- a seminar should be held for teaching staff in the region to devise a suitable curriculum to guide the training of nurses and;

- a Regional Nursing Body should be established to set and maintain standards for the schools of nursing in the region (Hunte, 2009).

Consequently, in 1969, at the first Conference of Caribbean Health Ministers (CCHM) a resolution was passed to endorse the establishment of the RNB. The RNB was established in 1972. Notably, the CCHM was the precursor to the Health Ministers of CARICOM's Council on Human and Social Development (COHSOD).

2.5 Governance of nursing in the Anglophone Caribbean

The Anglophone Caribbean's drive for regionalization was strongly influenced by some territories' challenges with poverty, overpopulation and high illiteracy in the early post-independence period (Wallace, 1962). These challenges impacted the health of the people and, by extension, the demand for nursing service. To overcome the challenges, the Caribbean Free Trade Area (CARIFTA), a cooperative mechanism, was formed by some of the West Indian governments in 1968.

CARIFTA was configured based on the European Free Trade Area model (O'Brien, 2011). Mr. Errol Barrow, first Prime Minister of the newly independent Barbados, and brother of Miss Nita Barrow - who was already identified in this thesis as an influential regional nurse leader - was instrumental in establishing this regional group and its derivative, the Caribbean Community and Common Market (CARICOM). CARICOM was established by the Treaty of Chaguaramas that was signed by the leaders of Barbados, Trinidad and Tobago, Jamaica and Guyana in 1973. Its headquarters and secretariat were set up in Georgetown, Guyana. Notably, from

CARICOM's inception, a Health Desk - staffed by a nurse - was provided at the headquarters to address nursing and health policy matters at the regional level (Hunte, 2009). This immediate allocation of space for nursing policy at the Community's headquarters suggested that nursing was regarded as a priority policy area for the region when CARICOM was established.

The RNB, established in 1972, became the policy link between CARICOM's COHSOD and the Community's nursing professionals. Undoubtedly this resulted because the Caribbean Conference of Health Ministers and the Heads of Government Conference had given approval for its establishment in February and October 1972, respectively (Walters, n.d.). As early as the 1959 Federal Nursing Conference, the goal of "internal and external reciprocity" amongst Caribbean nurses - internal reciprocity being a form of functional cooperation - was signalled as part of RNB's raison d'être (Walters, n.d.). RNB works closely with the CARICOM Secretariat through the Secretariat's Health Desk to formulate nursing policy and monitor its implementation in member states. The meetings of the RNB are serviced by the Secretariat and RNB remains the key policy-making body for nursing in the Anglophone Caribbean (Hunte, 2009; Hewitt, 2002). Despite RNB's efforts however, harmonization of nursing education across the region remains a challenge. The section following explores issues of policy-making in CARICOM that may account for the non-attainment of regional objectives like harmonization.

2.6 Perspectives on Caribbean policy-making

The literature provides evidence of international policies entering CARICOM's policy space but not achieving their associated intentions. In writing about policy-making in

a Caribbean context, Jones and Schoburgh (2004) emphasized that there is need to strengthen the social policy agenda and subsystem in the contemporary Caribbean because currently, its policy-making tends to be an expression of policy transfer. This spoke to the international influence on policy-making in the Caribbean region. The writers explained that prevailing discourses in the wider policy arena, make their way into the Caribbean policy space through the influence of lending agencies and other interest groups. It is possible that this could have been the case with the 2006 CARICOM BScN reform because of Caribbean nursing's strong ties with various international health and nursing organisations.

According to Jones and Schoburgh (2004) prevailing discourses shape the context into which a policy decision enters and influences the views of actors about how and/or if it should be implemented. The authors opined that Caribbean policymakers feel pressured to appear to be in sync with the latest policy solutions and so pursue fad policies − sometimes with untoward effects. It was explained that the motivation for pursuing such policies tends to outstrip the Caribbean's capabilities for implementation. As such, there exists an imbalance between policy formulation and implementation in the Caribbean region. Jones and Schoburgh (2004) argued that outcomes like implementation delay, policy neglect and symbolic political responses have been encouraged in the region by the excessive social demands that these fad policies place on the countries' limited available resources.

Additional insight into the region's policy system was found in an article by O'Brien (2011). O'Brien argued that because CARICOM - unlike the EU - has no mechanism for ensuring that regional decisions are implemented locally, the potential for uneven

implementation is strengthened. Given the policy implementation trend outlined by Jones and Schoburgh (2004) and given O'Brien's perspective on CARICOM change management, it is worthwhile to empirically investigate the drivers behind the BScN reform, its outcomes and the factors that influenced its implementation. Chapter 3 describes related contemporary features of CARICOM, the background to the latest nursing education reform, and preliminary steps that have been taken toward its implementation.

Chapter 3

The CARICOM 2006 BScN Reform

The current chapter outlines recent developments in CARICOM's nursing education system. Contemporary economic and social features of CARICOM are presented. The chapter continues with a description of the origin of the BScN reform. The development of the related curriculum model, and the intentions associated with the reform are presented. The chapter culminates by describing the contemporary provision of nursing education in CARICOM.

3.1 Contemporary economic and social features of CARICOM

From the colonial period, CARICOM member states' economies were predominantly agriculture based. Diversification into mining, manufacturing and tourism ensued after the Second World War. Today tourism is the leading industry in most of the states, although international banking is a growing service area (CARICOM Secretariat, 2005 and 2017b). The Region, along with Latin America, has been regarded as "the hardest hit developing region during the most recent global deceleration" (World Bank, 2017b). The six year period of economic slowdown and recession caused loss of jobs and household incomes, and persistent inequality in living conditions. The region has been advised to strengthen economic integration to enhance global competitiveness and build resilience to economic and social shocks (World Bank, 2017b). Additionally, the territories have taken steps to enhance CARICOM's education systems with particular emphasis on the tertiary education sector for optimal human resource development (CARICOM Secretariat, 2017a).

In the post-independence period most member states sought to promote development by investing heavily in education. Most territories offered free primary education and the region has enjoyed universal primary education since then. All countries provide universal access to secondary education up to age fifteen, with at least four having free access up to age seventeen (Miller, 1998). Tertiary education, an area of concern in this study, had a slow start in the region because there was minimal investment in that sector during the colonial period (Miller, 2000).

By 1972 the Caribbean Examinations Council (CXC) was established, as the group pursued an education system that was more relevant to its development goals (CARICOM, 2005). The CXC examinations replaced the United Kingdom secondary level exams. The CXC exams were based on common regional curricula. The CXC is one of CARICOM's institutions.

Efforts to provide tertiary education in the region only started in the nineteenth century. The first college in the Commonwealth Caribbean was Codrington College – a theological college established in Barbados in 1835 (Miller, 2000). Tertiary education provision grew marginally over the years prior to independence with the main providers being teachers and theological colleges, one agricultural college and a few schools of nursing.

The UCWI, introduced earlier in this report, was the first regional tertiary institution (CARICOM, 2005). It was established as a College of the University of London at Mona, Jamaica in 1948. In 1960, it established its first faculty outside of Jamaica at St. Augustine, Trinidad and Tobago and in 1962 it received its second Royal Charter

from Queen Elizabeth II. This replaced the Royal Charter of 1949 and granted the new institution, the University of the West Indies (UWI), independent degree-granting status (UWI, 2017a and 2017b). In 1963, the UWI started its third campus in Barbados – the Cave Hill Campus. This campus serves Barbados and the sub-regional group of territories in the Organization of Eastern Caribbean States (OECS). These include territories like Dominica, St. Lucia, and St. Vincent and the Grenadines. The newest campus of the institution, the Open Campus, was launched in Antigua/Barbuda in 2008. The UWI now hails as the largest higher education provider in the Anglophone Caribbean and offers undergraduate and postgraduate education in various disciplines, including nursing (UWI, 2017a).

In recent decades there has been a significant reduction in British influence on the region's education system due to its geographical proximity to North America, and the United States' increasing influence in the hemisphere. The Caribbean expanded its tertiary education provision by establishing state and community colleges. In recent years, the region has also experienced a proliferation of private universities (Miller, 1998 and 2000). One of those private universities, the St. George's University, has been included in this study because of its involvement in nursing education in Grenada. The community colleges, the main providers of tertiary education in the region, are the principal providers of nursing education and consequently, also warrant closer attention. Given this study's focus on nursing education, the status of the region's nursing manpower supply and its current health challenges must be presented.

The World Bank Report of 2009 indicated that the Caribbean region is facing a rapidly growing shortage of nurses as demand for quality healthcare increases due to an aging

population. Additionally, large numbers of nurses emigrate to Canada, the United Kingdom and the United States of America to take up higher paying jobs and pursue opportunities for education and training to enhance their professional skills and knowledge base (World Bank, 2009). The increasing prevalence of HIV and non-communicable diseases (NCDs) places additional demands on nursing services because high quality nursing care is required to combat the adverse effects of these diseases.

In the 2009 study the World Bank estimated that there were 7,800 nurses working in the English-speaking CARICOM territories, or 1.25 nurses per 1,000 people. That was, roughly one-tenth of the concentration in some OECD countries (World Bank, 2009). From these and other data on the demand for nurses in the Caribbean, the World Bank determined that the region's demand for nurses exceeded its supply, a situation that was identified in each territory evaluated. Thirty three hundred (3,300) or 30 per cent of all positions in the regional nursing sector were vacant at the time of the study (World Bank, 2009). This shortage in the complement of nurses and the shortage of critical nursing skills in key areas reduced the capacity of the region to offer quality healthcare. This loss is even more profound in the current period when some Caribbean territories are aiming to attract businesses and offer health tourism - as important pillars for economic growth.

It was anticipated that in the coming years, demand for nurses in the English-speaking Caribbean will increase due to the health needs of the aging population and the needs of those with long term diseases. Under current education and labour market conditions however, supply will slightly decrease. The World Bank (2009) expected

that unmet demand for nurses will more than triple – from 3, 300 nurses in 2006 to 10, 700 nurses by 2025. These data presented a clear picture of the dire demand for an increased complement of well trained nurses to address the region's healthcare needs. Therefore, following the reasoning of Aiken, Clarke, Cheung, Sloane and Silber (2003) implementation of the BSN programme would be a strategic intervention to address the region's nursing labour force challenges and enhance the quality of care delivered to its residents and visitors. This study therefore aimed to consider the implications of the BScN's implementation pattern for the coverage and coherence of nursing care provision in the region. Aiken et al.'s (2003) reasoning will be expanded upon in Section 3.2

3.2 Origin and nature of the BScN reform

In 1901, the founder of the International Council of Nurses (ICN) asserted that it was time for nursing education to be delivered in universities to help nurses develop the skills to address national and international health issues (Scheckel, 2009). True to the Caribbean tendency to adopt international policy, the Caribbean Conference of Health Ministers, acting on recommendations made from regional nursing education workshops, resolved that nursing education should be delivered in the mainstream of general education in the region. Thus the BScN reform was transferred from the international arena to the English-speaking Caribbean's policy space. Additionally, the CCHM resolved that curricula in the region's nursing schools should be updated (Reid, 2014). Notably, participants in the workshops included influential nurse educators like Miss Nita Barrow, who was by this time a PAHO nursing advisor, and Dr. Mary Seivwright, the Head of the UWI ANEU.

By 1976 WHO/PAHO had provided assistance to the region towards effecting the transfer and updating the curricula. The assistance took the form of a Regional Advisor for Nursing Education in the Caribbean. The advisor, herself a Caribbean national trained in Canada, was mandated to transfer the schools of nursing to tertiary education institutions (TEIs) and develop primary healthcare oriented curricula for all nursing education programmes – in keeping with the 1978 WHO Alma Ata Declaration. She assisted the Ministries of Health to transfer their schools from hospitals into tertiary education institutions and also assisted the schools with developing their curricula.

During the 1970s and 1980s, a few of the territories had founded community or state colleges, based on the United States' model, to prepare their secondary school graduates for university. But many territories did not have such institutions. Where they existed, the colleges were expected to provide continuing education for persons who did not graduate from secondary school and to provide training for various professional groups – mainly allied health professionals (Miller, 2000). It was within this tertiary education landscape that Caribbean nursing education commenced the transfer from hospitals to colleges, under the guidance of the WHO/PAHO Regional Advisor.

Because all territories did not have colleges, a phased approach to the transfer was adopted. The transition started with the establishment of semi-autonomous training programmes within the hospitals. Under this system, the educational programme was managed by a Principal Tutor but the hospital's Matron had ultimate authority for the school because she controlled the budget. While this step was intended to enhance the

students' learning experiences, it created legendary conflict between the Matrons and Principal Tutors.

Despite the fact that nursing administrators had advocated for changes in the delivery of nursing education at the Federal Nursing Conference, this phase of the transition was marked by strong power struggles between the Matrons and Principal Tutors. The Matrons saw the change as infringing on their authority. This was an indication of the trend of conflict that would accompany nursing education reform in the region.

The second phase of the transfer was transitioning the hospital schools from the Ministries of Health to the Ministries of Education, based either in colleges or in universities - as in the case of Jamaica. The findings of this study indicate that this phase is yet to be completed.

The international movement of nursing education into universities began in 1909 with the support of Dr. Richard Golding Beard, a supporter of baccalaureate nursing education (Scheckel, 2009). Dr. Beard lobbied the University of Minnesota in the USA to deliver a baccalaureate nursing program. Other universities gradually followed suit. Debates erupted about the value of degree level education to quality nursing care. In the 1960s and 1970s calls were made by interest groups for research to illuminate the skills and responsibilities required for high quality patient care (Scheckel, 2009). This research came approximately forty years later in the form of a series of studies by Aiken and colleagues that showed hospitals with more baccalaureate-prepared nurses had lower mortality rates. Momentum for baccalaureate nursing education picked up internationally.

The former trend in nursing education was several educational routes to licensure as a Registered Nurse (RN). These included the Certificate in General Nursing, Associate Degree in Nursing and the Bachelor of Science Degree in Nursing. However, this practice of multiple entry routes into the profession became unacceptable to the governing bodies of the profession because it limited the number of nurses in service with enhanced critical thinking skills. It also limited the number of nurses who transitioned into postgraduate programmes to become eligible for faculty, administrative and advanced practice positions (Goode et al., 2001; Aiken, 2009; Aiken et al., 2011). Steps were taken to ensure that the Bachelor of Science degree in nursing was established as the basic entry qualification for the profession, thereby establishing nursing as a degree level discipline and providing avenues for its members to pursue postgraduate studies (American Nurses Association, 2000; Canadian Nurses Association, 2007). Additionally, the education and training of nurses at the baccalaureate level was linked to the improvement of nurses' critical thinking skills and to improvement in patient care outcomes (Aiken et al., 2003). During this international movement, nursing professionals in the Caribbean took steps to establish the BScN degree as the entry level qualification for the profession in the region.

3.3 RNB's BScN surge

During the 1990s RNB repeatedly discussed establishing the BScN as the entry level qualification for professional nursing practice in CARICOM. Finally, in the year 2000, RNB passed a resolution to establish the baccalaureate degree as the entry to practice qualification for nursing in CARICOM by 2005. This step was not only intended to advance their agenda for transforming nursing education in the Caribbean, but it also aligned RNB's agenda with the International Council of Nurses' (ICN) direction for

nursing internationally. The policy decision was bolstered by the region's nursing manpower shortage and the prevalence of HIV and NCDs in the region – which demanded enhanced nursing skills. To advance this policy direction, in 2002 the RNB made a proposal to COHSOD that the BScN should be the entry to practice qualification for nurses in the region. The proposal was not supported. Instead, COHSOD requested that the RNB, the CARICOM Secretariat, and PAHO examine its implications for health services.

In 2003, the RNB, through the CARICOM Secretariat, hired two consultants to conduct an evaluation of the Regional Examination for Nurse Registration (RENR) – which had been in operation from 1993. The consultants, Paula Mark and Syringa Marshall-Burnett – a prominent Jamaican nurse-politician and UWI nursing education administrator - submitted their report to RNB and COHSOD in 2004. The consultants recommended, inter alia, that the BScN be the standard for the curriculum and examination of nursing education in CARICOM, "regardless of where it is offered" (Marshall-Burnett and Mark, 2004). A presentation was made to the Ministers of Health and to COHSOD in this regard and, in 2006 at its fourteenth meeting, COHSOD agreed that,

> "…the BScN should be the minimum requirement for the Registered Nurse and…a determination of the timeframe for the implementation of this standard be made after consultations among the relevant stakeholders, including the Regional Nursing Body…" (CARICOM Secretariat, 2006).

Following the COHSOD agreement, a series of workshops was held with various stakeholders between 2006 and 2011. The participants included nurse educators, members of GNCs in the region, RNB members and representatives of partner organisations like WHO/PAHO and tertiary education institutions. The workshops were conducted to prepare for delivering the BScN in the region's nursing schools. Accomplishments from the working group sessions included:

- a review of the Blueprint for the RENR,

- a review of the standards for nursing education,

- preparation of the administrative manual and guidelines for the RENR and,

- preparation of the 2011 CARICOM Model BScN curriculum.

The section following briefly outlines the processes undergone to develop the 2011 Model curriculum. It begins with a historical outline of CARICOM's curriculum development practices in nursing.

3.4 Building the model curriculum

Throughout the years regional cooperation in nurse education led to the development of a common curriculum, with revisions, which were circulated to training schools in the region for implementation. Further, to standardize nursing in CARICOM, a common registration examination for nursing graduates in the English-speaking Caribbean, the RENR, was commenced in 1993. This common examination was another early goal of the RNB (Walters, n.d.). Through these measures, RNB sought to establish a common standard for licensure and reciprocity of nurses in the region

(Walters, 1995). Although common standards for nursing education and practice were developed as well, the implementation of these guidelines remained uneven.

The previous versions of the common curriculum provided for nursing students to be instructed in the broad content areas of growth and development, basic human needs, factors affecting needs satisfaction, common health problems of the Caribbean, the Nursing Process, man and his environment, nursing, biological and psychosocial factors promoting needs satisfaction throughout the life cycle, and application of the Nursing Process to individuals with basic needs interferences. The curriculum was expected to be implemented by member states. All nursing students were expected to receive instruction in the same content areas - with room for adjustment of emphasis according to the country's needs - and progress to take the common regional examination.

During the 2006 to 2011 workshops, selected nurse educators, members of regional GNCs, representatives of partner organisations like the Caribbean Nurses' Organisation and WHO/PAHO, and the RNB members developed the 2011 Model Curriculum and its supporting documents. Member countries suggested content for input into the Blueprint and Curriculum. These took the form of draft standards, draft competences, and the national curriculum of each member state that participates in the RENR.

Workshop participants were organized in teams to develop different sections of the curriculum and Blueprint. Dr. Hermi Hewitt, Head of the University of the West Indies' School of Nursing (UWISON) at the time, provided the RNB with expert

guidance on the curriculum development process. The sections developed by the participants were then compiled by a consultant from St. Vincent and the Grenadines to produce the curriculum and Blueprint. The draft BScN curriculum and Blueprint were then sent to member states, through the RNB, for review and comments. The feedback was considered and included, where feasible, and the final documents were approved by COHSOD in 2011.

3.5 Expectations and plans for implementation

It was expected that member states would use the Blueprint and Model Curriculum as guiding documents when they embark on transitioning their general nursing programmes from certificate, diploma or associate degree level to the baccalaureate level. The Global Standards for the Initial Education of Professional Nurses and Midwives, and the Regulations of the member states' GNCs were expected to guide the administration of the degree programme. The underpinning assumption was that all these documents would be used to guide CARICOM nurse training and that the training would take place in a university. The theoretical framework of the curriculum states in part,

> "The curriculum will be delivered through a baccalaureate four-year, credit based, programme consisting of two Semesters and a summer practicum with a maximum of five courses per semester. The preparation of the practitioner will take place in a university setting at the level of a first degree. The administration of the programme will reflect the application of the *Global Standards for the Initial Education of Professional Nurses and Midwives*, and the regulations of the General Nursing Councils" (CARICOM Secretariat, 2011, p.5)

Following this groundwork member states were expected to follow through with implementing the programme as national conditions allowed. No evidence was obtained regarding the conduct of situational analyses prior to implementation. Neither was there evidence of testing the curriculum before region-wide roll out. To provide an understanding of the conditions within which this reform was expected to be implemented therefore, the next section describes the current context of CARICOM nursing education.

3.6 Contemporary provision and governance of nurse education in CARICOM

In 2004, Dr. Hermi Hewitt of UWISON conducted a PAHO-funded research study to determine the rate of migration of nurses from the region, the reasons for nurses' resignation, and the resources available for conducting nurse training in CARICOM countries. The survey project's results suggested that the nursing schools – most of them in community or state colleges - did not possess the capacity to adequately train nurses. While inadequate capacity was not explicitly stated, the findings and recommendations suggested that this was the prevailing circumstance. Findings in the report that led to this understanding included:

- high student/teacher ratios, which were well above the regional standards of 1:8 in clinical practice and 1:20 in the classroom setting;

- a majority of the faculty qualified at the baccalaureate level only;

- an inadequate number of clinical instructors;

- inadequate facilities for accommodation and;

- inadequate teaching/learning resources (Hewitt, 2004).

Study recommendations that reinforced the understanding that the community colleges did not possess the capacity to adequately train nurses included:

"Update the qualifications of tutors with certificates and bachelor's

degrees to graduate degrees…prepare more clinical preceptors…assign

at least one administrative staff and one secretarial staff in each school

of nursing…expand library facilities and provide access to electronic

resources…increase the supply of current books and journals…reform

teaching/learning methodologies…each school should have at least one

overhead projector…[and] put in place infrastructure to facilitate web-

based learning…(Hewitt, 2004, p. 26).

These findings and recommendations revealed the teaching/learning conditions within

most of the territories' nurse training institutions at the time. A time when RNB was

laying the groundwork for the delivery of baccalaureate nursing education in the

region.

A 2009 World Bank study revealed no less than forty-three pre-registration general

nursing programmes in the English-speaking Caribbean. The majority of these

programmes were being delivered within CARICOM territories. The study identified

three types of nursing schools in the region: public schools which receive government

funding; semi-autonomous schools which are co-funded by governments and private

enterprise; and private schools (World Bank, 2009). It was found that there was still

an insufficient number of nurse tutors to meet the training needs for nursing in the

region and, despite earlier efforts at harmonization, there remained a variety of training

programmes offering different levels of qualification for general nurses trained in the

region. In some territories there was a mixed system of training in which a student

could choose the type of programme he or she wanted to undergo. See Table 3.1 for

the notable example of the Trinidad and Tobago jurisdiction. These findings pointed

to persistent fragmentation in the delivery of nurse training in the region despite the establishment of the RNB and the history of efforts towards harmonization.

Further evidence of fragmentation rested in the fact that only two of the three campuses of the UWI deliver nursing education. The UWI is the regional university which was established to facilitate access to university education for a greater number of Caribbean residents, as recommended by the Moyne Commission. In part, the Cave Hill Campus of the University, located in Barbados, explains its mission as the advancement of education through providing opportunities for the region's population to access higher education and foster critical and creative thinking skills. Furthermore, the Campus, in its most recent strategic plan, articulated one of its three strategic goals as facilitating access through, inter alia, increasing participation in higher education for all with the capacity and desire to learn by ensuring that its offerings reach the underserved and diaspora Caribbean populations (UWI, 2017c). Yet those desiring to pursue higher education in nursing – while they are part of the Cave Hill Campus' underserved population in the Eastern Caribbean – remain without access to the Cave Hill Campus to pursue their preferred area of study. Moreover, the World Bank data indicate that quality nurse training is one of the region's critical human resource development needs. These findings suggest that the delivery of undergraduate and graduate education in nursing is one avenue through which the Cave Hill Campus could make significant strides towards accomplishing its access goal, in the short term. Yet, only the Mona and St. Augustine Campuses currently offer Bachelor of Science and Master of Science Degrees in Nursing. The Cave Hill Campus does not.

The Bachelors' programmes at the Mona and St. Augustine Campuses are offered as pre-registration and post-registration (post-basic) options via face to face and online modalities. As illustrated in Table 3.1, a number of institutions apart from the UWI also award the BScN to their graduates. Given RNB's original objective of nursing education being delivered in universities, and given the Global Standards for the Initial Education of Professional Nurses and Midwives; further, given the 2011 Model curriculum's expectation that the training will take place in a university, it is imperative that the implications of the current implementation pattern be considered. Table 3.1, on the following two pages, illustrates the institutions that currently deliver nursing education in the English-speaking Caribbean, and the qualifications they award.

Table 3.1. Recent Nurse Education Provision in the English-speaking Caribbean

Territory	Institution	Funding Status	Qualifications Awarded
Antigua/Barbuda	Antigua State College	Public	Dip GN
	University of Health Sciences	Private	BScN
Bahamas	College of The Bahamas	Public	BScN
	Nassau Community College (part of the State University of New York)	Private	ASDN
Barbados	Barbados Community College	Public	ASDN/BScN
Belize	University of Belize	Public	BScN
Dominica	Dominica State College	Public	ASDN
Grenada	T A Marryshow Community College	Public	ASDN
	St. George's University	Private	ASDN/BScN
Guyana	Georgetown School of Nursing	Public	Dip GN
	New Amsterdam School of Nursing	Public	Dip GN
	Charles Rosa School of Nursing	Public	Dip GN
	St. Joseph's Mercy Hospital School of Nursing	Private	Dip GN
	University of Guyana	Public	BScN

KEY:

ASDN – Associate Degree in Nursing   BScN – Bachelor of Science degree in Nursing
Dip GN – Diploma in General Nursing   Psych - Psychiatric

Table 3.1 Cont. Recent Nurse Education Provision in the English-speaking Caribbean

Territory	Institution	Funding Status	Qualifications Awarded
Jamaica	Excelsior Community College	Public	BScN
	Brown's Town Community College	Public	BScN
	Knox Community College	Public	BScN
	Sigma College of Nursing and Applied Sciences	Private	BScN
	University of Technology	Public	BScN
	University of the West Indies, Mona Campus	Public/Regional	BScN
	Northern Caribbean University	Private	BScN
Montserrat	Montserrat Community College	Public	No General Nursing Programme
St. Kitts/Nevis	Clarence Fitzroy Bryant College	Public	BScN
	Robert Ross International University	Private	BScN
St. Lucia	Sir Arthur Lewis Community College	Public	ASDN
St. Vincent and the Grenadines	St. Vincent School of Nursing	Public	Certificate in General Nursing
Trinidad and Tobago	Ministry of Health (Port-of-Spain/San Fernando/St. Ann's Psychiatric and General Hospitals)	Public	Dip GN/Psych Nursing
	College of Science, Technology and Applied Arts of Trinidad and Tobago (COSTAATT)	Public	ASDN/BScN
	University of the West Indies (UWI TT)	Public/Regional	BScN

KEY:
ASDN – Associate Degree in Nursing   BScN – Bachelor of Science degree in Nursing
Dip GN – Diploma in General Nursing   Psych - Psychiatric

PART 2

CONCEPTUALIZING THE RESEARCH

Chapter 4

Features and Dynamics in Policy Systems

A search was made of the scholarly literature to inform the conceptual framework for the investigation. Literature from the fields of education policy, political science, policy science and public administration was examined. Chapters 4 and 5 present aspects of that literature. They examine facets of policy systems which impact reform outcomes. Together the two chapters represent those aspects of the literature that informed the conceptual framework underpinning the analysis of the CARICOM BScN reform's implementation. The current chapter begins by introducing the concept of policy dynamics.

4.1 Understanding policy dynamics

To effectively analyse policy systems, it is important for policy analysts to understand the dynamics at play in these systems. As explained by Bardach (2013) policy dynamics is concerned with the roles of authority, power and influence in the policy process. According to this author, interested analysts make policy formulation and implementation their objects of inquiry. Focus may be confined to an institutional setting, or the analyst may investigate the evolution of a policy beyond the institutional context.

Bardach's (2013) essay presented various types of policy dynamics, as advanced by other authors. The author categorised the policy processes as either feedback processes or unidirectional processes that operate in the international and domestic arenas. The feedback processes were sub-divided into positive and negative feedback mechanisms. Positive feedback mechanisms were described as developments within a system that

drive change. Negative feedback mechanisms were characterized as having equilibrating effects in policy systems.

Momentum, which drives movements like community consensus, was advanced as an example of a positive feedback mechanism. Kingdon's 1995 agenda-setting theory was proposed as another example of this type of policy dynamic. The author described the balance of power dynamic in the international arena as a negative feedback process. Baumgartner and Jones' 1993 theory of punctuated equilibrium was also categorised as this type of dynamic - albeit occurring at the domestic level.

Bardach's essay focused primarily on domestic policy dynamics. Therefore the unidirectional dynamics described were confined to domestic politics. Two unidirectional processes were described. Selective retention was described as applicable to dynamics involving feedback and those that are unidirectional. This process was associated with dynamics involving the filtering of inefficiencies and propulsion towards efficiency. The author applied selective retention and filtering to the evolution of common law rules. This evolution resulted in the retention of efficient laws and the filtering of relatively inefficient laws in conditions where presiding judges are not biased towards those pieces of legislation considered to be inefficient. Event cascades were described as another type of unidirectional process. This type of dynamic was likened to rock slides – each rock initiating the roll of another beneath it.

The author's explanation of these processes provided conceptual schema for categorising policy processes. While this heuristic is useful, there remains a need for

the analyst to consider the features of policy systems at play in these dynamics for a fuller understanding of policy processes to be derived. I therefore propose to analyse the dynamics and features within the CARICOM nursing education policy system to derive a deeper understanding of why the reform evolved as it did.

4.2 Actors in policy systems

Key features of policy systems are the actors, the context, the policy itself, actors' responses to the policy and the policy's outcomes. Actors' responses to a policy initiative are influenced by their understanding of that policy. Spillane, Reiser and Reimer (2002) explained that the actors' understanding of a policy is determined by the interaction of their existing knowledge, beliefs and attitudes with their situation and the policy's signals. The writers posited that when a policy is inconsistent with their own or their agency's interests and agendas, implementers fail to notice, intentionally ignore, or selectively attend to it. It was noted that policies which fit with implementers' agendas are more likely to be implemented whereas those which do not are likely to be opposed. Nonetheless, if the decision is made to implement, such policies will be modified – especially in situations where the implementers are opposed to the policy.

The likelihood of actors ignoring a policy should not be overlooked when analysing policy dynamics. Ignoring policy is a means of protest that cannot be monitored or constrained by authority figures. It gives implementers power in the policy-making process. Spillane et al. (2002) proceeded to explain that although implementers have agency in policy-making, it should not be assumed that they understand what policymakers are asking them to do. A policy is likely to be ignored if actors do not

understand what it requires of them. Analysis of the CARICOM BScN reform should therefore consider the actors' understanding of the policy. However, given the complexity of human "sense-making", the analyst should be cautious about comparing this aspect of the process amongst participants.

4.3 Contextual and actor influences on policy implementation

The complexity of "sense-making" was elaborated by Spillane et al. (2002). It was noted that different agents will construct different meanings of a policy's content, because they view it in the light of their individual ideologies, expertise and experiences. The interjection of the policy into a context, demands that implementers decode it and reorganize their existing mental constructs to assimilate the policy's message. The understanding they derive determines whether the policy is viewed as one to be implemented or as one to be opposed or disregarded (Spillane et al., 2002).

The writers also revealed that institutional and professional affiliations, as part of the context, impact how actors interpret policy. The resultant interpretations in turn determine the actors' attitudes toward implementation. This explanation suggested that different professional lenses contribute to multiple understandings of the same policy and can promote or hinder a policy's implementation. Moreover, Spillane et al. (2002) argued that strong personal ties with colleagues and friends may undermine policies because the shared beliefs promote the status quo in the implementers' thinking.

According to Spillane et al. (2002), history is another facet of the context that influences actors' attitudes towards a reform. They explained that how an institution

historically responded to change would shape its agents' attitudes toward reform implementation. If an institution has a history of change and adaptation, it is more likely that its agents will take on the challenge to implement a reform. However, if that institution has a history of stagnation and resistance to innovation, this increases the likelihood of policy neglect, symbolic responses or other such undesirable responses to the reform (Spillane et al., 2002).

Also significant in the context is the actors' capacity to implement the reform. If implementers do not possess such capacity, it is unlikely that they would be inclined toward implementation. Actors' implementation capacity encompasses their experience and understanding of what the reform requires. This point and the foregoing suggested that there is no way of accurately predicting the outcome of a policy when it enters a context because that outcome is dependent upon a plethora of factors. Such factors include the actors' interpretation of the policy, their capacity to implement it, and their tendency toward the particular policy. This brings into focus the characteristics of the policy and their interaction with the contextual and actor factors to produce an outcome.

4.4 Policy characteristics and policy outcomes

The outcome of a policy is influenced by a variety of factors including the characteristics of the actors involved and the nature of the policy itself. Policy characteristics highlighted in the literature as influencing outcomes include the clarity of the wording, the forcefulness of the policy, the policy's contextual relevance, its communication and its fit with the context.

London (1993) and Trowler (2002) acknowledged that the way a policy is worded shapes its outcome. This was supported by Psacharapoulos' (1989) observation that most policies fail because they are vaguely stated. Furthermore, when the content of the policy does not fit with the context the desired outcomes are also threatened.

Fit and forcefulness, as policy characteristics, must be clarified for a fuller understanding of their influence on policy outcomes. Fit may be defined as the degree of consistency the policy has with the actors' or institutions' agendas (Psacharapoulos, 1989). Forcefulness, as an influence on outcome, was defined by Ball, Maguire and Braun (2012) as the degree of compulsion to act which the policy promotes. Discourse, as a mechanism of policy transmission, was cited as a determinant of a policy's forcefulness. Ball et al. (2012) argued that there are some policy discourses which weigh heavily on practice and compel practitioners to act in a particular way whilst others are not as forceful and do not in themselves drive action. Furthermore, since language, the medium of discourse, is symbolic and open to multiple interpretations (Yanow, 1993) the discourses around a policy can render it vulnerable to varying interpretations and possible disregard or opposition.

Ball (2013, p. 7) posited that "the way policies are spoken and spoken about" influence whether they are accepted and implemented. This discourse determines whether the policy is viewed as a viable solution to the relevant social problem. According to the author, even policy texts do not necessarily translate directly into intended outcomes because they are subject to varying interpretations depending on the interpreter's standpoint. Indeed the text itself may be unclear and open to multiple interpretations and unintended outcomes (Psacharapoulos, 1989). It should be acknowledged,

however, that the openness of some statements may be a strategy employed by policy formulators to facilitate contextual adaptation in implementation (Palumbo and Calista, 1990). The aforementioned characteristics will therefore be considered in the analysis of the BScN reform's evolution.

Communication, another characteristic of policies, also influences policy outcomes. The flow of communication shapes responses to the policy and its implementation. Trowler (2002) stated that top-down attempts to impose policy would likely cause resistance and other forms of opposition to the policy. He proposed that there must be dialogue between top-level actors and implementers to facilitate implementation. This point was corroborated by Canary (2010) who stated that, as a form of communication, *amplification* (that is, egalitarian and detailed discussions) facilitates understanding of the policy. Johnson and Chrispeels (2010) elaborated on this when they wrote that communication is critical to fostering a shared ideology and enhancing commitment to implementation. They further argued that both formal and informal communication are critical to building knowledge of the reform. They encouraged the use of traditional and non-traditional communication methods like face-to-face communication with stakeholders, emails, newsletters and podcasts to promote reform implementation. This research study will therefore analyse the forms and flow of communication about the CARICOM BScN reform to determine their influence on its implementation and outcomes.

Relevance is another characteristic of policies cited as impacting their implementation. In a paper that explored policy processes in the Caribbean context, Jones and Schoburgh (2004) wrote of the prevalence of policy transfer in the contemporary

Caribbean. The authors explained that such prevalence resulted from local policymakers' desire to share consensus with the international policy community. It was further stated that the situation exists because of the involvement of international policy actors in the region's affairs. Consequently, policies from other spaces are frequently introduced into the Caribbean. Such policies may reap unintended outcomes because they may not be relevant to the context. The fact that they were not formulated for the Caribbean per se predisposes them to misunderstanding and misfit with the policy context (Milio, 2010). Therefore, to increase the likelihood of a policy being implemented, that policy should be relevant, even if achieving relevance requires tailoring the policy to fit the implementing context (Turbin, 2001). The influence of relevance and contextual fit in relation to the BScN reform will also be considered in this investigation.

4.5 Policy dynamics in federal systems

Given that CARICOM is a federation of sovereign states, the dynamics of federal policy systems will be considered in this section. Writing about the implementation of United States federal education policy, Garn (1999) agreed with McLaughlin (1998) that local capacity and will are the factors that most critically affect the outcome of the implementation process. However, he went on to identify communication, financial support and bureaucratic structure as other factors that significantly influence implementation. The writer explained that when these factors were attended to by policymakers, the likelihood that the policy's intentions were realized was increased.

In acknowledging the importance of financial support and local capacity to policy implementation in the Caribbean, London (1993) stated that the lack of money for

implementation, and the lack of political capability, are domestic constraints which hamper the implementation of policy in the region. The author went on to cite the absence of instruments to guide implementation as a hindrance to policy implementation – a proposition which tied in with Garn's (1999) point that there is a need to attend to bureaucratic structure if policy intentions are to be preserved. The proposition also resonated with Grindle and Thomas' (1989) theory for sustaining reforms in developing states – this view is examined further in the subsequent chapter.

Despite the usefulness of guidelines, Psacharapoulos (1989) cautioned against policymakers' tendency to rely on them to effect the desired results rather than considering the policy context. The author argued that policymakers should examine the context the policy will enter and consider how that context and the policy can be managed to promote the desired outcomes. Notably, although over-reliance on implementation guidelines may lead to unintended outcomes, the absence of such guidelines may cause similar results. Consequently, I am of the view that to support the preservation of the policy intentions, it would be prudent to provide implementation guidelines that would be judiciously employed. The impact of implementation guidelines will be considered in the analysis of the CARICOM BScN reform.

In a text that explored reasons for implementation deficit in the European Union (EU), Milio (2010) wrote about the challenges of policy implementation in that multi-level governance system – a system with elements similar to CARICOM. Milio argued that domestic constraints, regional constraints and the misfit between EU level policy and national institutions impede those policies at the national level. The domestic

constraints identified were the desire to avoid compliance costs; pressures from interest groups; lack of capacity to comply; and lack of political will for compliance. As cited in Palumbo and Calista (1990), Lazin (1980) and Smith (1973) agreed that, at the national level, interest groups pressure can impede policy implementation. However, as Lukes' (1974) perspective highlighted, such groups can also work to realize reforms. Given that CARICOM and the EU are both regional economic unions of sovereign states; and given that CARICOM'S structure has not evolved far beyond that of its predecessor CARIFTA – which was modelled after the European Free Trade Area (O'Brien, 2011) - these same factors could influence the implementation of CARICOM policies in member states. It is therefore worthwhile investigating whether this was the case with the BScN reform.

4.6 Insight from education policy scholars

Trowler (2002) posited that an educational institution's political and educational ideology, combined with its capacity and differing interpretations of the policy problem are important contextual factors that impact on the policy process. He further stated that education policy is formulated in different locations but is always implemented by individuals and groups in educational organizations. While this view acknowledged the multi-level nature of educational policy, in my view, it limits policy-making to the encoding of policy statements by policy elites, and strips implementation of its policy-making potential. It may be concluded that implementation here refers to actions by subordinates to give effect to the policy directive. However, I do not totally agree with this characterization of implementation. While I agree that despite where formulation of the statement occurs, the implementation of education policy unfolds within educational institutions, I submit

that in the process of implementation, actors manoeuvre to shape the policy in question; and in doing so, they fashion policy. I also propose that the implementation context should be viewed not only from the institutional perspective, but also from the national, regional and international geopolitical perspectives – particularly when analysing implementation in sovereign state federations. Implementing institutions in such systems exist in multi-level contexts that provide the scaffold for their operations. Consequently, these contexts also impact institutional policy implementation and contribute to shaping policy at that level. These insights justify a closer examination of the context in the BScN reform's analysis.

Additional insight into policy dynamics was provided by Ball (1993) who examined the relationships between aspects of the policy system. Ball contended that there exists a complex relationship between policy intentions, texts, interpretations and reactions. He argued that the dynamics of this relationship are circumscribed by contextual constraints and power relations that ultimately influence the policy's outcomes. He explained that the contextual constraints include commitment, understanding, capability, resources, practical limitations, cooperation and intertextual compatibility – which is the interaction amongst different policy texts (Ball, 1993). With regard to intertextual compatibility, Ball noted that the presence of different policy texts in the context could present a situation in which these policies are competing for attention to be implemented. These insights highlighted how context can impact on implementation and substantiated the need for a situational analysis prior to embarking on policy implementation.

4.7 Planning policy implementation

It is expected that policy implementation would be a planned endeavour, and that such a plan would be informed by a careful situation analysis. Haddad and Demsky (1995) opined that once a policy has been chosen, planning for its implementation should ensue. They argued that implementation involves a "concreteness" that is absent in earlier stages of policy-making and that misjudging the ease of implementation is a frequent error in policy planning. Such error could easily occur where no situation analysis has been conducted. They thus advanced that well-designed pilot studies should be conducted before full implementation. This was supported by Ayyar (1996) who stated that the usual economic analysis in education policy planning needs to be complemented by analysis of the institutional and political settings. This should be done to ensure that appropriate guidance is given for policy implementation. It stands to reason therefore that a situational analysis should have been conducted before implementation of the CARICOM BScN reform. Given the importance of such an analysis and/or related pilot study for informing the roll out of this reform, it is important that this investigation ascertains whether situational analyses were conducted prior to implementation.

The WHO declared its support for member states conducting sound situation analyses before policy implementation. The organisation noted that a situation analysis can be the basis for setting policy priorities and can guide the implementation strategy (WHO, 2017). Given the WHO's ideological position on this issue; and given WHO/PAHO's involvement in the CARICOM BScN policy-making process; it is anticipated that such analyses would be conducted – at least at the local level - prior to the implementation of this reform. This expectation is high given the financial austerity

and other challenges currently affecting the region: challenges that have been implicated as contributing to implementation deficit in the literature (Ayyar, 1996 and Smith, 1973).

4.8 Summary

In summation, policy dynamics and the system features influencing those dynamics are crucial to implementing reforms and analysing their evolution. Policy dynamics is concerned with the roles of authority, power and influence in the policy process. To effectively implement a reform policymakers must understand the system's features and how they interact. Consequently a situational analysis should be conducted to inform major reform implementation.

The policy analyst must also be equipped with knowledge of the context, actors and the reform. He/she must have an understanding of the dynamics in operation and apply that understanding to the analysis. A description of a system's features and its dynamics, however, fall short of a comprehensive reform analysis in that system because it does not advance reasons for the reform's trajectory. This study sought to explain the uneven implementation of the CARICOM BScN reform. Consequently, a conceptual model is required that would reveal the links between the system's features, its dynamics, and the reform's outcomes. The chapter following examines perspectives of policy processes to derive such a framework to support the analysis of the CARICOM BScN reform.

Chapter 5

Perspectives of Policy: Models and Processes

The current chapter presents different views of policy and policy processes. It begins by outlining top-down perspectives and continues with a summary of those models that take a multi-directional view of policy. The chapter culminates by advancing a comprehensive perspective of policy to guide this study's analysis of the BScN reform in the Caribbean Community.

5.1 Top-down perspectives

Perspectives of policy advanced by scholars may be categorised as subscribing to either a view of policy as product, as process, or as both. Each view adds another dimension to the concept. According to Bell and Stevenson (2006) policy is commonly viewed as a product, the outcome of a decision-making process. Persons who subscribe to this view tend to see policy as a written decision aimed at resolving a problem. One such subscriber, Harman (as cited in Bell and Stevenson, 2006) described policy as an action plan to follow. However, this one-dimensional perspective does not reflect policy's complexity.

Kogan and Jennings (both cited in Bell and Stevenson, 2006) advanced the view of policy as a linear process. From this perspective policy is sequential and the order of the stages may be summarized as: problem emergence, alternatives emergence, option selection and implementation. While this view acknowledged policy's complexity, it signalled its formulation as the preeminent step in the process thus, privileging the actions of policy formulators and minimizing the impact of other actors on the process. Today's global socio-political environment is replete with interest groups' agendas,

power struggles, conflicts and values contests. These circumstances demand a comprehensive view of policy that acknowledges it as both a product and a process with inherent contests, to underpin policy analysis - if that analysis is to inform social action.

Taylor, Rizvi, Lingard and Henry (1997) acknowledged that conflicts over values unfold in the process of policy development as well as in the policy text itself. These authors therefore argued for a view of policy as both product and process. According to these authors, policy analysis should examine the contexts, texts and consequences of policies.

Bowe and Ball with Gold (1992) agreed with the Taylor et al. (1997) view but they extended it by saying that policy as product and process is continuous. They advanced that policy is reconfigured as it is implemented in different contexts. They concluded therefore, that policy is not a linear process but a cycle unfolding in 'policy contexts' (Bowe et al., 1992). This widened the view of policy. Rather than starting at the point of problem identification and ending at implementation, the authors started at the contest for favouring particular value positions and took policy through the series of steps to implementation. However, in each step, people engage in struggles and contests to favour their values and these contests reshape the policy. Moreover, the values contests occur at different levels of the policy context. Consequently, the authors argued that the policy at implementation is seldom a replica of the policy at formulation because of the values accorded supremacy at each contextual level and in each phase of the process (Bowe et al., 1992).

Adding to the cyclical view of policy, Ball (1993) signalled the influence of power in the policy process by advancing the view of policy as both text and discourse. Viewing policy as text focuses on the struggles and contests that go into encoding or articulating and interpreting policy statements. Viewing policy as discourse attends to how dominant actors influence the framing of policies and the related discourses to control the scope of individual action (agency). This suggests an understanding of policy as the process of constraining thought and action through controlling discourse (Ball, 1993). This perspective moved power centre stage in the policy process. It implied that, in analysing the evolution of the CARICOM BScN reform, the researcher should consider how specific actors in the reform processes helped to shape the discourse, and by extension, shaped how the policy was or was not implemented.

Bachrach and Baratz (1962) addressed the power dimension in policy development and wrote of the policy analyst's need to examine the "two faces of power". These two faces are overt decision-making and, the less obvious, manipulation of procedure rules to control decision options, privilege one's value position and delegitimize a competing position. Succinctly, the analyst needs to examine the overt decision-making face of power *and* the covert agenda-controlling face of power.

Lukes, as cited in Bell and Stevenson (2006) reportedly critiqued both the conflict-minimizing perspectives of policy like Harman's (1984) viewpoint and Bachrach and Baratz's (1962) focus on the observable power-related behaviour of individuals. From the authors' interpretation, Lukes' viewed power as more elusive. He emphasized that power is often exercised through collectives that create the bias in organizations, thereby shaping decision-making indirectly.

Bell and Stevenson's (2006) portrayal of Lukes' view added a third dimension to the concept of power – the subtlety of influence. From the article is was deduced that the dimension is not associated with conflict per se – as are the overt decision-making and covert agenda-controlling faces. This third dimension is associated with consensus. It speaks to the socio-political environment shaping individuals' ideologies and interests by circumscribing the debate on issues. Furthermore, the collective determines what is accepted as given, or 'common sense', thereby defining what may be seen as viable solutions. Following Lukes' view as described by Bell and Stevenson (2006), analysts would seek to understand how policy 'problems' are defined and presented, and by whom, because it is those conditions that effectively frame the solutions. Persons who define the problem and set the limits of possible solutions control the policy agenda. It is therefore appropriate for a study on BScN reform to examine closely the roles of the various actors in the policy context, and the extent to which such actors affected the policy agenda/implementation.

Despite their increasing penetration, the perspectives hitherto presented still do not capture completely the complexities of the policy process because they primarily present policy as an imposition. The complexity of the CARICOM BScN reform context demands an analytical framework that acknowledges the multi-directional flow of power in policy contexts. The following sections examine such perspectives. Table 5.1 summarizes the top-down (managerial) views of policy.

Table 5.1. Top-Down Perspectives on Policy

View of Policy	Proponents	Summary of Perspective
Policy as Product	Lay persons	Guidelines to follow
	Harman (1984)	Action plan to address a problem
Policy as linear process (Conflict minimized)	Kogan (1975)	Sequence: • Problem identification • Solutions development • Implementation
	Jennings (1977)	Sequence: • Problem emergence • Alternatives emergence • Option selection • Implementation
Policy as product and cyclical process (Conflict inherent)	Bowe et al. (1992)	Policy is continuous, extending from discourse to implementation and reforming in different contexts
	Ball (1993)	Policy is text and discourse
	Taylor et al. (1997)	Analyse policy context, text and consequences
Policy as the privileging of specific values and the power to do so	Bachrach and Baratz (1962) (Conflict inherent)	Two faces of policy – the overt decision-making face and covert agenda-controlling face
	Lukes (1974) (Consensus inherent)	Three dimensions of policy – builds on the two faces to include the power of the collective

5.2 Multi-directional perspectives on policy and power

Bacharach and Lawler as cited in Bell and Stevenson (2006) extended the power dimension of policy by differentiating between authority and influence, as two distinct forms of power. The authors defined authority as the use of bureaucratic rule-making processes to impose one's position on others (the overt decision-making face). This form of power has clear expectations that subordinates will comply with superiors' decisions – whether willingly or unwillingly. For the authors the sources of authority were the individual's role and position in the hierarchy of an organization.

Influence, on the other hand, was described as multidirectional. It is the capacity to shape the decisions of others regardless of one's position in the hierarchy. For a study on reform, the implication is that it is therefore justifiable to include participants other than the principals or leaders.

According to this perspective, influence's sources of power are the individual's personal characteristics such as expertise, and the opportunities associated with his/her location in the structure or organization. Bacharach and Lawler were quoted as distinguishing between the two forms of power by indicating that authority is a key source of social control while "influence is the dynamic aspect of power and may be the ultimate source of change" (Bacharach and Lawler as cited in Bell and Stevenson, 2006, Chapter 1). These theorists noted that in periods of change coalitions may be formed by interest groups combining to generate significant influence – either to pursue or oppose the change. Those who exert strong influence shape the way others perceive reality. They define the problem and determine the acceptable solutions. In some cases, they may even impose specific solutions. This picture portrayed the subtle

agenda-controlling face of power operating through individuals *and* groups to privilege their own value positions. The outcomes are shaped by the results of the micro and macro-political processes in which competing groups jostle and partner to shape and influence policy. This is a multidirectional view of policy-making. The perspective showcased policy as change shaped by the agency of individuals and groups from a number of directions. By highlighting the significance of influence and the organization of groups, and by defining policy as change, this view tacitly raised the leadership dimension of the policy process (though not suggesting that leadership necessarily mirrors the hierarchical structure of the organization).

In presenting their perspective on policy, Bell and Stevenson (2006) expanded the examination of policy by acknowledging that it may also be contested and challenged at different levels as it is developed. This bottom-up force combined with the top-down pressure would shape and re-shape a policy. Following this line of reasoning, the analyst should recognize that power in policy-making can flow in multiple directions, and that its exercise directs the configuration of the policy. Bell and Stevenson (2006) described policy, power and leadership as three interdependent themes and noted that policy development is an unclear, complex and messy process. These authors advanced the view of policy development as the result of contests, negotiations and compromise as persons with competing values seek to privilege their value positions (Bell and Stevenson, 2006). They proposed four stages of policy that acknowledge human agency and portray policy development as change advocacy.

As in the cyclical perspective, Bell and Stevenson (2006) portrayed policy development as starting with discourse in the socio-political environment and a

strategic direction developing from the discourse. In the second phase policies become clearly defined and the criteria for their success are determined. The third stage involves formulation of clear policy texts. During this period the institutional ideology is shaped as the discourse continues to facilitate formulation of the text. The ideological principles then shape the practices that actually portray the policy's outcomes at the institutional level. It is noteworthy that this is not a tidy linear process but a multi-directional one in which differences in emphasis, values and interpretations ignite and fuel policy struggles and influence the outcomes. Actors at multiple levels contribute to the shape of the policy. From this explanation it is understood that discourse is the driver of change in this perspective and that the discourse is taking place at all levels.

Although Bell and Stevenson's (2006) perspective of policy acknowledged the multidirectional nature of the policy process, it downplayed the structural dimension of the policy context and therefore represented another incomplete view of the phenomenon. Analysis of the 2006 CARICOM BScN reform's implementation requires a conceptual framework that would facilitate consideration of the context's characteristics. Given that CARICOM's member states are considered developing states in some quarters, a perspective on policy implementation in developing states should inform a framework for analysis of the 2006 CARICOM BScN reform.

Grindle and Thomas (1989) proposed a context-specific multidirectional view of policy as change. These authors considered reforms and their sustainability in developing states – a categorisation applied to the national systems that are the subject of the current study. Their focus was the capacity of developing states' decision

makers to shape and influence what is possible in reforms. They considered three dimensions:

- the scope of decision makers to influence the reform's outcomes;

- the influence of surrounding circumstances (context) on who makes decisions, how they are made and why;

- and what outcomes are possible.

The authors highlighted a critical connection between policymakers and the outcomes they seek. They argued that while the inherent power struggles extend the outcome possibilities beyond the binary of successful or unsuccessful to a range of possible outcomes, policymakers can assist reformers to realize effective, sustainable change by formulating a strategic implementation plan. Despite its optimistic outlook for policymakers securing intended outcomes in developing states, however, this perspective still fell short by portraying policymakers as policy elites. The analysis of reforms demands a comprehensive view of policy that acknowledges the aforementioned complexities of policy-making, the agency of different categories of actors, the different levels of the policy context and key features of those levels. Accordingly, after briefly examining health policy analysis, this chapter will present a model developed to guide the BScN reform's evolution analysis.

5.3 Health policy analysis

The CARICOM BScN reform is a higher education policy with implications for health service in the Caribbean. It is therefore prudent to examine the literature on health policy analysis. Walt, Shiffman, Schneider, Murray, Brugha and Gilson (2008) acknowledged that health policy analysis is a developing field of study that currently, is guided by the public policy frameworks and theories hitherto explained in this

report. However, health policy analysts tend to omit explanations of their assumptions and the theoretical models that underpin their analysis. The authors argued that health policy research could be strengthened by analysts attending to and making explicit the theory bases for their research; the methods they applied; and their positionality. Given this insight and considering the foregoing, the next section explains the conceptual framework that underpinned my analysis of the CARICOM BScN reform. My positionality and methodology are explained in the chapter following.

5.4 The Policy Evolution Model

Given the perceived limits of the aforementioned models, and desiring to undertake a comprehensive analysis of the CARICOM BScN reform's implementation, I set out to develop a framework that would inform the analysis. The Policy Evolution Model represents the researcher's synthesis of the aforementioned scholarly perspectives on policy. Because it is in the early stages of development, further refinement through research is required to enhance the model's utility. The model is intended to show the relationships among the five main elements of the policy system – the policy, the context, the actors, the responses and the outcomes.

In crafting the model, I accepted that policies enter a context and are morphed by various factors therein which influence their outcomes. I also accepted that this influence may be such that when the policy is given effect the original intentions may be obscured (Kohoutek, 2013; Spillane et al., 2002; and London, 1993). Furthermore, I agreed with the propositions of London (1993) and Spillane et al. (2002) that apart from contextual factors, characteristics of the actors and of the policy itself, impact on the policy-making process and influence its outcomes. Along with these insights, the

multi-level nature of CARICOM's context compelled me to develop a comprehensive framework of policy-making to underpin the analysis of the BScN reform.

The framework acknowledges policy-making as an evolutionary cyclical process. While a policy goes through the cycle of formulation, interpretation and implementation in different contexts, it is constantly evolving. Within a multi-level system such as CARICOM, a given policy goes through this cycle numerous times as it enters the regional, national and institutional contexts. From this perspective, policy-making is viewed as a multi-directional process in which policy elites set the agenda, but actors in different spaces shape the policy through their contests and struggles – either as individuals or as coalitions.

The policy is further shaped by the characteristics of the contexts which interact with its own characteristics and those of the policy actors. These characteristics include the socio-political and bureaucratic structures that define the context. Consequently, the outcomes may or may not be consistent with the policy's original intentions (Bowe, Ball and Gold, 1992; Ball, 1998). This interaction is context-specific and it may involve shaping the policy to fit the context. Furthermore, depending on their understanding of the policy and the problem(s) it addresses, actors can mobilize to implement the policy or they can side-line the decision.

In the process of implementation actors debate, negotiate, contend about and reconfigure the policy to accommodate it in their context. Thus implementation is itself part of the policy-making process. Any separation of the two phases would conceal implementers' and interest groups' agency to shape policy. It would also

ignore the influence of actor characteristics, contextual factors and the policy text itself on the policy process. Thus, in presenting this model the separation of the formulation of policy from its implementation is for ease of discussion only.

5.5 Explanation of the model's elements

The key elements of the Policy Evolution Model are the policy, context, the actors, their responses and the policy outcomes. The term policy refers to any decision – written or rhetorical – that is intended to guide actions and other decisions (Haddad and Demsky, 1995). From this perspective, policy is viewed as entering a context and going through changes within the context based on the interaction between its characteristics, those of the context, and those of the policy actors. The actors' interpretation of the policy determines their response to it and that response determines the outcome. While it is acknowledged that individual actors will have individual interpretations, it is also understood that there will be a collective interpretation and an overriding response that will shape the outcome. Figure 5.1 illustrates the key elements of the Policy Evolution Model and their relationships.

Relevance

Clarity

POLICY

Communication

CONTEXT

Political capability

Facilities

Forcefulness

Competing policies

History

Fit

Enforcement measures

Implementation guidelines

Ambivalence

Prevailing discourses

Selective attention

Acceptance

Commitment/Will

Symbolic responses

POLICY
RESPONSE

ACTORS

Interest Groups Participation

Disregard

Interpretation

Financial support

Opposition

Tendency

Bureaucratic structure

Capacity

Implementation delay

Ideology

POLICY
OUTCOMES

Neglect

Rejection

Capacity

Adoption

Cost avoidance

Tailoring

Figure 5.1: The Policy Evolution Model

The significant **policy** factors are the policy's clarity, forcefulness, relevance, fit and communication. The presence or absence of these factors, or any shift in them, can cause variations in actor response and implementation. In keeping with the literature,

clarity relates to how clearly the text can be read and interpreted. Its forcefulness relates to the degree of compulsion for implementation that it creates. Relevance refers to its suitability for the context. Fit may be defined as the degree to which it is consistent with the territory's, actors' and institution's agendas. Communication relates to the methods and mechanisms through which the policy is transmitted. The changes the policy undergoes are subject to the nature of the context and actors, the actors' responses and the interaction amongst these variables. The outcomes are the result of this evolutionary process.

Context is perceived as multi-level and includes the physical, socio-political and bureaucratic structures in which the policy is unfolding. It may extend from the international arena down to the implementing institution. A variety of factors are present in the context which impact on implementation and by extension the outcomes. The factors depicted in the diagram are by no means exhaustive. Although constrained by space, the diagram is intended to incorporate those physical and psychosocial structures that frame the context. These include the physical facilities, prevailing discourses, other policies, ideology and the bureaucratic structure. Other relevant contextual factors are capacity, political capability, and policy enforcement measures. The presence or absence of factors such as implementation guidelines, interest group participation, commitment/will, financial support or cost avoidance also characterise the context. The degree to which these factors are present and interact in the context correlates with the policy's outcomes.

Policy responses are actors' attitudes toward the policy decision and the related actions they take. These responses may favour implementation or they may be actions

taken to side-line the policy. Responses include policy acceptance, opposition, ambivalence, selective attention, disregard and symbolic responses. Acceptance is defined as taking the policy into the system as formulated and taking action to implement it. Opposition is resistance to the policy. Ambivalence is defined as conflicting responses to the policy whereas selective attention is giving attention to parts of the policy and omitting others. Disregard is defined as ignoring the policy. Symbolic responses are posturing or pronouncements intended to give the appearance of implementing the policy.

Actors are all those persons involved in the formulation and implementation of the decision. These persons may operate at the regional, national or institutional levels, or, in some cases, at multiple levels. Significant actor characteristics include their capacity to implement the policy, their interpretation of the policy and their tendency - toward the particular policy and in relation to reform implementation. The actors' capacity may be measured by their qualifications, their understanding of their role in the policy process, and their competence in the policy area and change management. Interpretation is their understanding of the policy while their reform implementation tendency relates to their traditional responses to policy; that is, whether they are prone to ignore or attend to reform initiatives.

Policies evolve through the interaction of these factors and may not unfold as intended. The nature of the evolution and its outcomes depend on the dynamics within the bureaucratic and socio-political structures that form the scaffolding of the context. These dynamics are both subtle and overt, and it is incumbent upon the analyst to reveal both dimensions.

Policy outcomes refer to the results of the evolutionary process at the time of analysis. Because the evolutionary process is continuous, those outcomes are not static but may change according to the nature of the process and the time of analysis. Outcomes may be categorized as policy neglect, rejection, implementation delay, adoption or policy tailoring. Policy neglect is persistent disregard for the policy. Policy rejection is the complete discard of the policy. Implementation delay refers to prolonged precursory activity with minimal action towards implementation. Policy adoption refers to implementation as intended and policy tailoring is defined as shaping the policy to fit the context (Turbin, 2001). While Bowe et al.'s (1992) view of policy as a framing and re-framing in different contexts is accepted, I rejected their proposition that the analyst should talk of policy effects rather than outcomes. This decision was taken to retain policy as a central figure in the analysis, casting it as the main element in the evolutionary process, producing outcomes in context; rather than portraying it as a mere catalyst enhancing reactions that produce contextual effects.

If it is accepted that policy evolves as it is implemented because it is morphed by influential factors, it stands to reason that the policy's outcome can be expected to vary in different contexts because the presence and interaction of influential factors will similarly vary. Policy enters a context with goals, plans and expectations from the formulation phase. Its interaction with the context and the actors therein directs its outcome. The analyst cannot realistically expect to identify and analyse the impact of all possible factors in one investigation. However, she can and should seek to identify, as far as is possible, those factors that significantly influenced the policy's evolution and should do so with the understanding that each case is unique. The analyst therefore needs to remain open to the emergence of unanticipated factors in the context, actors

or policy that impact on the policy-making process and ultimately the evolution of the policy.

5.6 Purpose and Scope of the Model

The model presented is by no means final. It is intended to be applied to policy analysis in general and therefore should be tested on other forms of policy in different settings to evaluate its utility. Given the propensity for Caribbean territories to adopt international policy, this investigation, in part, applied the model to determine whether the factors identified in the literature impacted on the policy's outcomes in the selected CARICOM member states; and whether, from the participants' perspectives, other policy, context or actor factors influenced the policy's evolution. It also sought to make explicit the character of the BScN reform's evolutionary process in those member states, and consider the implications of this style of policy-making for nursing in the Caribbean. The chapter following details the design of this research study in which the Policy Evolution Model was applied to the reform's analysis.

Chapter 6

Research Design, Methodology and Methods

This chapter describes the study's design and explains the researcher's methods. It begins by outlining the research questions and proceeds to an explanation of the researcher's positionality. The chapter continues with a description of the study's design and an explanation of the methods employed in the investigation. The sampling, data collection and analytic procedures are discussed.

6.1 Research questions and design

As stated in the introductory chapter, the core research question was, "how, and to what extent, was the 2006 decision by CARICOM to establish the Bachelor of Science degree in nursing as the standard entry requirement for nursing practice, implemented across the region?"

The supplementary research questions were:

1. What were the reasons for the 2006 BScN reform?

2. What was encompassed by the reform?

3. What goals, plans or expectations were attached to the reform?

4. How was the reform acted upon by Member states?

5. What factors promoted or inhibited the realization of this policy?

6. What are the implications for this pattern of implementation?

Using the case study approach with a multiple case design, I employed documentary and interview methods to conduct an empirical investigation into the implementation of this reform. The first five supplementary questions were addressed in the interviews and the documentary sources accessed were used to supplement and/or corroborate the

interview data. The final research question was addressed by inductive analysis of the interview and documentary data.

Because I aimed to track this policy's evolution across the region, I conducted a multiple case study to gather qualitative data on the reform's implementation. I anticipated that the richness of qualitative data would permit a deeper understanding of the reform's trajectory than quantitative data would allow. This application of the case study approach, as a form of qualitative inquiry, is supported by Stake (1995) and Rosenberg and Yates (2007) who agreed that the case study method is the most appropriate method through which a rich data set could be yielded to give insight into a situation or event. The approach plunged me into the intricacies of the reform process in each territory, as I experienced it through each participant's account. I reasoned that conducting the investigation in at least one third of the territories would help to build a picture of the reform that would approximate the wider regional implementation process. Consequently six territories were selected and were paired according to their policy adoption timeframes, to facilitate comparison of their reform processes.

The reader should note that with respect to most of the CARICOM member states, the terms local and national may be used interchangeably while regional tends to refer to the wider Caribbean context. One of the few exceptions may be Jamaica because that territory has been divided into regional authorities for governance purposes. However, due to the small size of most of the islands, they tend to have one level of sub-division – parishes. 'Local' in this context therefore tends to mean 'national', and regional tends to mean the wider Caribbean area. This may be contrasted with larger countries that have multiple strata of sub-division in which there would be clear distinctions

between the national, regional and local contexts. This characteristic of the Caribbean Community, the researcher's community of origin, must therefore be taken into consideration when reading this thesis.

6.2 Positionality and issues of confidentiality

To assist the reader in his evaluation of the investigation, I present the stance from which I undertook the research. The literature acknowledges that the positionality of the analyst highly influences the analysis of education policy implementation. According to Rizvi and Lingard (2009) the purpose of a piece of policy analysis and the researcher's positionality determine the approach to policy analysis. They proposed that positionality should be examined from three perspectives: the analyst's focus; her political and theoretical stance; and her geopolitical location (Rizvi and Lingard, 2009). These three perspectives frame the following description of my stance in this investigation.

The reader should be aware that as a doctoral student, I am a beginning level education policy researcher and analyst. This study was undertaken to fulfil the requirements for my doctoral studies. But beyond programme requirements, my interest in the topic was kindled by my involvement in Caribbean nursing education at the national and regional levels, and by what I perceived to be the problematic situation of my country's non-compliance with a CARICOM nursing education policy. As a nurse educator in Barbados, the fact that my country had not yet begun delivering the pre-registration BScN programme was at variance with my convictions. As a former member of the Nursing Council of Barbados, a former executive member of the Barbados Nurses' Association – the bargaining body for nurses on the island – and as a former external

examiner for the RENR, the situation created a tension between my professional convictions and my practice. The values that informed my practice were now being challenged by the circumstances in which I was practising. Therefore, for me, the situation constituted an ethical dilemma and a problem worthy of exploration. Naturally, those values – namely patriotism, regionalism, professional loyalty, commitment to my institution and excellence in the delivery of education – would also inform my analysis of the problem. However, by employing a systematic approach to the policy's analysis, I exercised control over the extent to which they guided my analysis and interpretation of the data. In keeping with the interpretive approach to research, credibility, transferability, dependability and confirmability (Bhattacharya, 2012) were the primary values that underpinned my approach to the investigation. These principles also allowed me to be open to the views of others who did not share my perspective.

Because my experiences in nursing span the national and regional spheres, I am familiar with and am known by actors involved in nursing policy at both levels - including some of the participants in this study. Additionally, as one of the more experienced nurse educators in my institution, I led some of the curriculum changes when we commenced meaningful strides towards implementation. Accordingly, this exposure and experience positioned me as both an insider and outsider in relation to this research.

Consistent with my educator training, I believe that knowledge and meaning are socially constructed and that a researcher can develop an understanding of the social world through interpreting the meanings actors give to their experiences. I therefore

view the interaction between interviewer and interviewee as a knowledge-creation endeavour. My interpretive analytical approach helped me to build a picture of the policy episode based on the meanings the participants gave to their own related experiences. Of course, my assumption here was that their accounts approximated their experiences in the reform process. But my analytical approach was also informed by the tacit knowledge I possess as an insider of the system. This knowledge facilitated my interpretation of idioms and other expressions, including non-verbal cues, during the interview process. It helped me to recognise comments, actions, and silences in participants' responses that warranted probing.

The readers should note that the research is being undertaken at a time when CARICOM member states are strengthening their ties with each other, harmonizing their educational qualifications, and realigning their educational practices with international standards. It is also a period in which numerous changes are occurring in nursing education regionally and internationally. This timing should permit the findings to inform further roll out of the policy – an impact which I, as a Caribbean nurse and policy analyst, would like them to make.

It is noteworthy that multiple actors in Caribbean nursing are known to each other because of the region's small size and the territories' close interactions. It is therefore likely that some readers of this study and its contributors would be known to each other. Indeed, some readers may not only identify themselves in the thesis, but may think that they have identified others by virtue of the responses. It must be made clear that the attribution of comments to any particular individual would be nothing more than speculation on the reader's part.

Given the small size of CARICOM and the familiarity that exists in the policy system, anonymity could not be guaranteed. However, participants were assured that their responses would be kept confidential. Only the researcher and her supervisor had access to the raw data and participants' identification information. None of this information was shared with other parties. Additional steps were taken to ensure that the research was conducted in accordance with accepted ethical standards.

6.3 Ethics procedure

Insomuch as anonymity could not be guaranteed, the maintenance of confidentiality was critical to the conduct of this investigation. Congruent with good research practice, I sought and was granted ethics approval for the conduct of this study, from the University of Sheffield through its School of Education.

An information sheet, invitation letter, and a consent form were attached to the participants' invitation messages to facilitate informed consent. Both the letter and consent form assured the invitees that their views would be kept confidential, but anonymity was not assured because it could not be guaranteed in our small context. Confidentiality was upheld throughout the research process and will remain so because of the smallness of the Caribbean society.

To safeguard participants' identities while conveying the pertinence of their contributions, respondents were assigned pseudonyms which referred to their roles rather than more specific identifiers. Other biographical data such as number of years in the position were omitted to protect the participants' identities. In this study, the

actors were classified as RNB representatives, bureaucrats, nursing education administrators (referred to as educational administrators in the findings), or nurse educators. It was hoped that referring to participants in this way would direct the readers to the relevance of the participants' perspective on the reform process rather than to their identity.

6.4 An interpretive design

To track this policy's evolution, I employed an interpretive approach using the case study method. Interpretive research is frequently practised by social scientists like educational, health and policy researchers. It is centred on the idea that all reality and interpretation are socially constructed (Bhattacharya, 2012). This form of inquiry focuses on interpreting the interpretations people give to their own actions and those of others. Unlike positivistic research, it is founded on an ethical/moral basis, not on a particular epistemic position. The methods the researcher employs are therefore judged by their underpinning values rather than on the positivist ideas of reliability and validity (Smith, 2012 and Bhattacharya, 2012). The key criteria employed to judge the quality of interpretive research are credibility, transferability, dependability and confirmability (Bhattacharya, 2012). The researcher justifies the methods by the aim of the research and the values underpinning decision-making in the research process. In interpretive research therefore, the end justifies the means.

Interpretive researchers acknowledge that no one view of reality is correct. For us knowledge is provisional, it is contingent on time and place (Smith, 2012). For this reason one can only offer justification for one's perspective but cannot assert that it is superior to another because of a particular epistemic position. We view the accuracy

of interpretation as dependent on like-mindedness. The more people interpreting the situation in the same way, the greater the probability that the interpretation approximates reality (Smith, 2012).

While positivistic methods have frequently been employed in policy studies, Yanow (1993) asserted that there are attributes of policy implementation that can only be known through interpretation. These attributes include the policy's intentions and policy actors' interpretations. Because I wanted to understand the intentions and other facets of the reform process from the participants' perspectives, the qualitative approach seemed the most appropriate stance from which to make sense of its evolution.

Holloway and Wheeler (2002) explained that qualitative research is an umbrella term encompassing a number of interpretive approaches to research. These include grounded theory, phenomenology, case study and others. The authors explained that grounded theorists investigate social processes and interaction while phenomenologists are concerned with the meanings of experiences, and describe the reality of others. Whilst these areas of interest are indeed aspects of the BScN reform process, it is noteworthy that they relate mainly to its psychosocial dimensions and neglect the structural facets like guidelines and bureaucratic structure. The researcher aimed to understand not only the psychosocial dimension of the reform but also its structural components. For this reason, neither a grounded theory nor phenomenological approach would suffice. The investigation's aim demanded a methodology that would capture both dimensions without theoretical limitation. The

case study approach therefore seemed the most logical method for the conduct of this research.

Yin (2009) posited that the case study approach to empirical inquiry investigates contemporary phenomena in their natural contexts. This point strengthened my decision to utilize this method in investigating this reform. Moreover, CARICOM's complexity, and Stakes' description of the method as one that enables understanding of the "particularity and complexity" of the case reinforced my decision (Stake 1995, p. xi).

Adelman, Jenkins and Kemmis (1976) outlined a number of advantages of the case study. Among these was its strength in the examination of phenomena in their natural contexts. They also stated that the approach provides the researcher with the opportunity to study the intricacies of a case in detail and further noted that case study research is useful for educational policy-making and providing feedback. According to these authors case study reports are more publicly accessible for decision-making and the language of these reports tends to be more amenable to multiple audiences. This was particularly significant for my purposes because I anticipated that this study would be used by Caribbean policymakers to inform future policy-making. The consideration of these potential benefits and the utility of the case study approach for understanding unique situations solidified my decision to use the method for this interpretive study.

The case study approach is not without challenges for novice researchers like myself, however. As suggested by Stake (1995) and Darke, Shanks and Broadbent (1998), the

many approaches to conducting case studies can make a researcher unsure of the appropriate methods to employ that would stand up to the scrutiny of her peers. This certainly resonated with my uncertainties as a novice researcher at the beginning of the research process, but I found guidance in the writings of Patton and Sawicki (1993).

Patton and Sawicki (1993) stated that common sense, experience and logic are the main tools of the policy analyst and that often analysts design their own approach to policy problems. This guidance gave me room to craft my approach. I noted also its consistency with the case study approach which is not bound by a particular theoretical position but is concerned with what works for the purpose of the study (Smith, 2012 and Bhattacharya, 2012).

Additional concerns with the case study method were articulated by Darke et al. (1998). One drawback they identified was the heavy reliance of data collection and analysis on the researcher. They also cited the time-consuming nature of qualitative data analysis as another disadvantage. While these disadvantages are inherent, I argue that they need not disqualify the method for empirical inquiry but, given the benefits of the approach, they should be carefully considered and steps taken to build rigor into the research process. I further argue that the reliance on the researcher as the primary data collection and analytical tool can be overcome by clearly explaining the researcher's interpretive lenses and justifying the measures utilized in the process. Moreover, it builds authenticity into the research process by moving it away from the apparent sterility of a sanitized positivistic approach.

Ensuring triangulation in data collection, systematically analysing the data, carefully attending to ethics in the process, and reporting all procedures transparently for readers to follow should build rigour into the process. As the first step in meeting these criteria, I explain my approach to the investigation in the next section of the chapter. Notably, Patton and Sawicki's (1993) guidance, my interpretive leanings, and my commitment to pursue the necessary steps to understand the reform, informed the investigation's design.

6.5 A staged approach

For the purposes of this study therefore, I crafted a staged approach to the investigation. The investigation was conducted in stages to allow me to develop an initial picture of the policy's implementation across the region and secondly to craft a suitable research design based on this first look. Stage 1 was a desk review of the implementation of BScN programmes in the territories. In this stage, I collected information on the status of nurse training in each territory via email correspondence and telephone conversations with the Chief Nursing Officer (CNO) or other RNB representative of each territory.

Stage 2 involved the collection and review of relevant documents, and interviews with key informants. However, because documentary sources were sparse, the investigation relied heavily on the key informant interviews, not just to help me understand how and why the reform was implemented but also, to help provide the background picture in some instances.

Stage 3 consisted of analysing the data and synthesizing the findings to build the picture of the reform's evolution thus far. I acknowledge that the resultant picture is a partial one, given that I was unable to get the perspective of some key actors, who are now deceased, and also because the respondents are reporting from memory. I also acknowledge that quite some time has elapsed since the decision was made and that territories are in different phases of engagement with the reform. However, given that the reform has not been previously investigated systematically, and given its importance to regional nursing, I advance the view that this empirically derived partial but detailed picture can provide insight into the policy system and be the springboard for further research in the area. I am therefore convinced that a partial picture, in this instance, is potentially very useful for understanding how the reform was implemented and, to an extent, understanding CARICOM's nursing education policy system.

6.5.1 Stage 1 – Desk Review

I corresponded via email and telephone, in one instance, with representatives of the fourteen member countries of the RNB to conduct a preliminary investigation into the delivery of the BScN in member states. The group of representatives consisted of twelve CNOs and two Directors of Schools of Nursing. They were asked to indicate whether the BScN was offered in their territories, to ascertain the status of the reform in each member state. Specifically, the representatives of the thirteen English-speaking territories and Suriname, which comprise the RNB, were asked:

1. Is the BScN offered in your territory?

2. Is it a pre-registration or post-basic BScN?

3. When was the programme started?

4. At what training institution is it being offered?

Haiti, although a member of CARICOM, was omitted from the investigation because it is not a member of the RNB and does not participate in regional decision-making on nursing education.

From the desk review information Jamaica, The Bahamas, St. Kitts/Nevis, Barbados, Antigua/Barbuda and Grenada were selected as the case units for investigation. These territories were chosen because of their variation in uptake of the policy. It was anticipated that selecting two territories that demonstrated early engagement with the policy, two that demonstrated late engagement and two that demonstrated dilatory engagement would allow for case description and cross-case comparison. The first year of delivering the pre-registration BScN programme was taken as the time of policy implementation. As such, Antigua/Barbuda and Grenada, up to the time of interviewing, had not yet implemented the BScN – and as such had demonstrated dilatory engagement. The analysis of multiple cases in different phases of engagement with the policy was expected to reveal similarities and differences in how the reform was implemented in member states. The results of the desk review are reported in Chapter 7. The section following explains my use of computer mediated data collection methods.

6.5.1.1 Computer mediated communication for data collection

The literature points to computer and internet mediated communication as a developing area in social research. McCoyd and Kerson (2006) identified advantages of email communication that included:

- allowing the respondent to respond at their convenience,

- allowing the researcher to access a geographically diverse group and

- facilitating text responses.

Notwithstanding these advantages, the authors opined that there is no rapport between researcher and participant when these methods are employed. They argued that in comparison with face-to-face communication there is loss of non-verbal cues like dress, mannerisms and tone. The loss of opportunity for the participant to reminisce and show artefacts was also proposed as one of this method's drawbacks (McCoyd and Kerson, 2006). In contrast to McCoyd and Kerson's (2006) perspective however, in this study, the access that emails provided to participants and the economic advantages of using them far outweighed the disadvantages. Emailing facilitated the development of rapport between myself and potential participants before the intensive data collection phase. Moreover, some of the disadvantages were offset by employing multiple data collection methods.

Since the data requested via email was factual background data; and since there was provision in the design for me to interact visually and/or aurally with the participants in interviews, I saw little disadvantage in employing email communication in this study. It reduced the length of the interviews and, as was noted by McCoyd and Kerson (2006) allowed the participants to respond at their convenience. It also facilitated a visualization of the field before launching into in-depth data collection.

6.5.1.2 Selection of and access to participants

The interview sample comprised case territories' representatives on the RNB, national bureaucrats, nursing education administrators and faculty members who were involved in establishing the BScN programme. In the case of the two territories that had not yet implemented the BScN programme faculty members were omitted from

the sample but administrators and bureaucrats were invited to participate based on the roles they were expected to play in the reform process.

A combination of purposive sampling and snowballing were employed to derive the study's participants. The initial sample was selected based on the potential participants' actual or potential involvement in implementing the reform. Purposive sampling was decided upon because derivation of an in-depth understanding of the process would require information from persons who were or would be integrally involved. It was not intended to make generalizations from the data, therefore the level and degree of a participant's involvement in the process were deemed stronger criteria for selection than representativeness. Purposive sampling and snowballing allowed the researcher access to the data needed for in-depth understanding of the case. Snowballing allowed the selected participants to suggest others who had integral knowledge of the process. Therefore, probability sampling methods such as random sampling were not undertaken.

The sampling technique also saved time in sample selection - as advanced by Gliner and Morgan (2000) and Denscombe (2007). The initial sample comprised current and former RNB representatives of the selected territories. Access to this initial group of participants was obtained through the Deputy Chair of the RNB, who is the CNO of Barbados. This key informant introduced me and the study to her overseas RNB colleagues by email. In the correspondence she endorsed the study, asked that her colleagues facilitate the investigation and gave her permission for them to communicate with me directly. This greatly facilitated access and pre-empted any tension which may have occurred should I have initiated correspondence with this

group of regional level participants on my own. To add to the sample, these participants were asked to suggest national bureaucrats, nursing education administrators and faculty members in their territories whose involvement would have enabled them to provide ample information on the reform process.

The criteria for participant selection were emailed to the key informants to enable them to suggest suitable participants. They were advised that persons eligible to participate were:

i.   the RNB representative who was integrally involved in the genesis and/or roll out of the reform;

ii.   the Minister, Permanent Secretary (PS) or their representative who was involved with the reform;

iii. the Head of the Division or Department of the educational institution involved in delivering the BScN and;

iv.   a faculty member who was integral to implementing the BScN programme in that institution.

The number of interview participants from the territory was also stipulated so that the quantum of suggested participants would not go below that required by the study design. I proposed to conduct four interviews from each territory that delivers the BScN and three from each that does not because there would be no lead faculty implementer in such territories.

The snowballing technique described above allowed the study to benefit from the input of participants who may have been overlooked by or were unknown to the researcher. The key informants introduced me to their suggested participants by email. This

facilitated my access to participants and initiated our rapport. I followed up the key informants' introductory emails with invitation emails to participants. The initial invitation was followed by reminder emails at weekly intervals in which participation was encouraged. Where responses were not received for an extended period of time, the key informant was asked to follow up with the potential participant to ascertain their willingness and encourage their participation. Table 6.1 displays the final composition of the sample of interviewees.

Table 6.1: Interview Sample Composition

Category of Participant	Jamaica	Bahamas	Barbados	St. Kitts/Nevis	Antigua/ Barbuda	Grenada	Total
RNB Representatives	2	2	1	0	1	1	**7**
Bureaucrats	1	0	2	1	1	1	**6**
Nursing Education Administrators	1	0	2	2	1	2	**7**
Nurse Educators	1	1	1	0	0	0	**4**
TOTAL	**5**	**3**	**6**	**3**	**3**	**4**	**24**

The reader should note that the number of interviewees from The Bahamas and St. Kitts/Nevis fell below the threshold of four for territories that were delivering the BScN programme. In The Bahamas' case, this resulted from the withdrawal of one participant after the island was placed on hurricane warning, and efforts to secure another participant with a similar level of involvement proved futile. The study therefore did not benefit from the contribution of a Bahamian bureaucrat. In the case of St. Kitts/Nevis, efforts to recruit more participants for interview proved futile. Additionally, one participant performed the role of an educational administrator and

that of an RNB representative in this policy episode. Thus, this further limited the number of potential participants, from this territory, with integral knowledge of the reform. Nevertheless, the situation allowed the participant who had dual responsibility to respond to questions about the reform from more than one perspective.

In contrast to those territories from which the number of participants fell below the threshold, Barbados had six participants – one more than Jamaica, and two more than the minimum number targeted. The decision was taken to allow, where possible, more interview participants than the minimum required in any territory in order to prevent the total falling below the desired minimum of twenty-two, thereby facilitating a large enough sample to paint a picture that approximates the regional experience. Consequently, Barbados, Jamaica and Grenada had more participants than the minimum number required from those territories. But, the number of participants from Barbados is worthy of explanation because it has implications for the report on the comparative analysis of its policy implementation experiences with those of St. Kitts/Nevis – which had half the number of participants that Barbados did. It also has implications for what may appear to be a focus on Barbados in Chapter 9.

The reader must be aware that what may appear to be a focus on Barbados' policy engagement at the expense of St. Kitts/Nevis' experiences is not a function of researcher bias. Rather, it is a function of access to suitable participants in both territories, and the amount of data derived in each case. The fact that Barbados is the researcher's home territory, and the fact that so many actors were involved in the policy episode in this territory, provided the researcher with smoother access to a larger pool of potential participants in this case. Any apparent disparity in the quantum

of the report attributed to these two territories therefore, reflects the number of actors involved in the policy episode in the two territories, the number of participants from each territory, and the amount of data derived from both the interviews and document analysis. Notably, while documents were accessed from Barbados for triangulation with interview data, no documents could be procured from St. Kitts/Nevis for similar comparison.

6.5.2 Stage 2 - Interviews and Documentary Review

The study's design entailed multiple data collection methods. Mindful of the need for rigour in the research process, I employed both interview and documentary review methods. While the study relied mainly on the interviews with key respondents, I also collected related documents for analysis. The documentary sources pertaining to territories' engagement with the policy were sparse however, and this made the study heavily dependent on the participants' accounts.

Related documents were requested from the CARICOM Secretariat through its document centre, and from participants and colleagues. The response from the CARICOM document centre was that most of the requested documents could not be found. However, those which were found were made available for analysis. Participants suggested that locating relevant documents was problematic because record-keeping was a challenge in the territories. Notwithstanding, the reader should be assured that those documents which I could procure to give an accurate picture of the reform were collected and analysed to triangulate with the interview data. A number of documents pertaining to the policy from a regional perspective were analysed to inform the findings. Notably, the Report of the Fourteenth Meeting of the

Council for Human and Social Development (CARICOM Secretariat, 2006) which contained the agreement, was obtained and analysed. Section 6.5.2.2 outlines the range of documents which were analysed to triangulate with the interview data in this study.

6.5.2.1 Character and conduct of interview studies

Once invitees agreed to participate, the interview questions were emailed to them for review before the interview. This was to facilitate their accessing any necessary information beforehand. Since it was not economically feasible for me to visit individual states to conduct face-to-face interviews, the overseas interviews were conducted by Skype video call or telephone – where participants requested telephone interviews.

Deakin and Wakefield (2014) noted that face-to-face interviews, although regarded as the gold standard for interviews in social research, can be problematic due to financial and logistical constraints. This was certainly the case for this study which aimed to conduct an investigation spread over six countries. Access to those persons who had in-depth knowledge of the reform also required multiple interviewing methods. This experience was supported by Deakin and Wakefield (2014) who posited that "multiple methods of interviewing are increasingly required to access the ideal research sample..." (p.604). I varied the mode of interviewing to facilitate access to the participants and provide opportunity for detailed conversation.

Overseas participants were asked to engage in Skype interviews to facilitate visual and auditory interaction with the researcher. This method was preferred because it is relatively inexpensive and approximates the face-to-face experience. But it must be

noted that it is not without disadvantages. Verification of identity can be problematic in online interviews (Chen and Hinton, as cited in Deakin and Wakefield, 2014). If she has never met them before, how is a researcher to be sure that the person she sees on the screen is indeed the intended participant? Or, how is the participant assured that the person onscreen is the bona fide researcher?

Madge and O'Connor as cited in Deakin and Wakefield (2014) suggested the exchange of photographs to overcome the identity verification challenge and build rapport. This measure was partially employed in this investigation. I emailed a photograph of myself to the participants but did not require them to reciprocate. I thought it prudent, as researcher, to demonstrate a measure of trust in the respondents prior to the interviews to build that virtue into our communication. I reasoned that the photo would enable them to identify me at the start of our online video interviews. Moreover I considered that building in a mechanism through which participants could verify my identity before revealing detailed information would demonstrate my commitment to confidentiality. Furthermore, I reasoned that only someone keenly interested in my research and having sufficient knowledge to participate, ostensibly would impersonate a respondent – a potentiality that would in itself not be undesirable. Hence sending the photo was used to verify my identity at the interview stage and reassure the participants of the researcher's commitment to ethics in the process. The issue of building rapport was tangential in this undertaking.

A number of emails were exchanged between the participants and myself prior to interviewing. In the course of seeking consent and setting up the interview these exchanges took place. This helped to build the rapport. By the time the interview was

imminent, we had established rapport and both the participant and I were comfortable with having reached that phase of interaction. Although absenteeism was cited as a drawback of the Skype interview (Deakin and Wakefield, 2014) this was not experienced in this research study. Whether this was due to the participants' enthusiasm or their respect for the key informant who initiated our contact I do not know. But whatever the reason, participants kept their interview appointments. When circumstances required a change in the appointment, participants contacted the researcher and an alternate time was set.

On one occasion, a hurricane warning was issued in one of the territories two days before the scheduled interview. The potential participant was a senior bureaucrat in the country and was therefore responsible for ensuring the safety and continued operations of various health facilities in the territory. Aware of the urgency of the situation, I contacted the potential participant, wished her and her territory well and advised her that we could reschedule the interview after the emergency phase had elapsed. The hurricane hit the territory on the day the interview was supposed to be conducted. Unfortunately that interview was never rescheduled despite numerous tries. The potential participant eventually withdrew from the study and a replacement participant could not be recruited.

In some instances, due to participants' schedules, challenges, preferences, or technology failure, we compromised by engaging in telephone interviews. Participants in Barbados were asked to engage in face-to-face or Skype interviews, according to their preference and schedules, to facilitate visual interaction with the researcher. Of the six Barbados interviews conducted four were face-to-face and two were via

telephone. A mutually convenient date, time and mode for the interviews were agreed upon between myself and the participants. Of the twenty-four interviews conducted four were face-to-face, eleven were via Skype video call and the remaining nine were via telephone.

Due to challenges with the internet connection in one overseas interview, the Skype video call had to be abandoned after numerous tries and the interview was completed by telephone. All Skype and face-to-face interviews were audio recorded and notes were taken simultaneously on an interview protocol to guard against recorder failure. The protocol was pre-tested in a pilot interview with a CNO qualified at the doctoral level who was not selected for the sample. She provided feedback on the clarity of the questions and their suitability for the research purpose. She also gave feedback on the interviewer's technique. The telephone interviews were recorded by note-taking on the same protocol. These protocols served as the written records of the interviews.

The interviews were semi-structured and were conducted over a period of seven months. Most lasted between one and two hours. Only two interviews went over two hours and this was because of the participants' enthusiasm and a few interruptions in one instance. However, all of the participants were eager to ensure that I captured the information I wanted before we ended our conversation. Provision was also made for me to contact them subsequently to fill any data gaps I identified.

The interviews were conducted before the documentary analysis phase and, in addition to explaining the policy experience, they were used to solicit relevant documents. The interviews were transcribed verbatim from the audio recordings, using the written

records to guide the transcription. The transcripts were then emailed to the participants to check that their responses were captured accurately. Where errors were indicated by the participant, those transcripts were checked against the recordings and the necessary changes were made. In some cases corrections were made by the participants themselves. In these instances, the original transcripts were checked against the recordings for accuracy and, once accurate, they were used as part of the data set along with the amended transcript sent by the participant. This was done to ensure that the investigation benefitted from as rich a data set as possible. In cases where the participant did not respond to the transcript, it was taken as accurately representing the participant's contribution. The transcripts were then analysed thematically, and the themes derived were applied to the documentary analysis. The data analysis procedure will be described later in this chapter.

6.5.2.2 Search, collection and analysis of documents

Interview participants and key informants were asked to supply any documents which they could access that would give information about the BScN reform process from a national or regional perspective. Additionally, participants who referred to documents were asked to supply the researcher with scanned copies, where possible.

I contacted the CARICOM document centre by email and requested RNB and COHSOD reports related to the reform. A few of these were retrieved from this source. However, I was informed that a number of the documents could not be found and so I resorted to searches in colleagues' document collections and on the internet to retrieve documents related to the reform.

I was also allowed to conduct a limited search of the PAHO electronic database. Documents addressing the transfer of schools of nursing into tertiary education, the delivery of BScN training in the Caribbean or pertaining to the development of Health Human Resources in the region were downloaded from this site. However, these documents mainly pertained to nursing education in the region before the 2006 CARICOM agreement.

The documents which were analysed to inform the findings of this study were the:

- Reports of the Sixth and Fourteenth Meetings of COHSOD;

- 2011 CARICOM Model Curriculum;

- CAAM-HP Accreditation Standards;

- WHO Global Standards for the Initial Education of Professional Nurses and Midwives;

- Report on the Assessment of Education and Training Needs of Registered Nurses in CARICOM Countries;

- Report of the CARICOM RNB Evaluation of the RENR;

- Executive Summary of the Report of the Task Force on Health Sector Manpower, Education and Training in Jamaica;

- Jamaica Nurses Act, 2011;

- Bahamas Nurses Act, 1995;

- College of the Bahamas Act, 1995;

- National Accreditation and Equivalency Council Act of the Bahamas, 2006;

- Barbados Nurses Act, 2008;

- Barbados Nurses Rules, 2008;

- Barbados Community College Act, 1968;

- Grenada Nurses and Midwives Act, 2003;

- Grenada Nurses (Registration) Rules, 1955;

- Grenada Nurses (Training and Examination) Rules, 1954;

- Letter of Agreement between the Grenada Ministry of Health and St. George's University and;

- Antigua and Barbuda Nurses Registration Act, 1954.

This represents a total of twenty documents analysed.

It was anticipated that the synthesis of the participants' responses and the documentary evidence would paint a picture of each territory's engagement with the reform and that the regional implementation pattern could then be extrapolated from the countries' pictures. What actually resulted was that the documents retrieved provided data on the policy's intent from a regional perspective, and on the extent of implementation from the national perspective. As noted before, no documents were obtained pertaining to St. Kitts/Nevis' engagement with the policy.

6.5.3 Stage 3 - Analysis and synthesis of the findings

A combination of deductive and inductive processes directed the data analysis. The analytic procedures employed were influenced by my interpretive stance and by the writings of Miles, Huberman and Saldaña (2014), Willig (2013) and Fereday and Muir-Cochrane (2006). Coding, categorisation of codes into themes, inferring and comparison were the processes that informed the synthesis of the reform's evolutionary process.

The interview transcripts were coded in Microsoft Word looking for semantic and latent themes while using an initially pre-determined code list. The code list was developed from the research questions and concepts in the literature. It was revised during the coding process as codes emerged in participant accounts. Each transcript was coded twice. In the first round of coding I regularly referred to the code list to label chunks of text according to the a priori codes. In the second round of coding I identified emergent codes by looking for ideas the participants repeated in their accounts that were not present in the pre-determined code list. During this second round of coding, I coded ideas related to the research questions and aim which may have been missed in the first round, and coded emergent themes like unexpected ideas, and those which the participants emphasized. Chunks of data were considered significant if they were repeated in the data set, if they were related to the research aim and questions, if they were unexpected, or if they were emphasized by participants. Codes were grouped into themes. The reform's evolution in the territory was inferred from synthesizing the themes. The themes were tabulated by country and compared to determine the similarities and differences between territories. The countries' reform evolutionary processes were illustrated by matching them with the Policy Evolution Model advanced in Chapter 5. The evolution diagrams were also compared for similarities and differences.

To analyse the documents, each was first summarized and then further analysed to identify related themes. The themes derived from the interviews were applied to the document analysis. That is, the documents were read to identify chunks of data that reflected the themes derived from the interviews. The relevant chunks of data in the

documents were then compared with the interview-derived data for consistency. This process was guided by a researcher-developed document analysis worksheet.

Because documents remain unaffected by interaction with the interviewer, I regarded them as a stable data source that could substantiate or refute participants' accounts (Bowen, 2009). Consequently, I deemed interview findings that were consistent with documentary findings as highly credible. However, my assumption here was tempered by my understanding that documents – particularly policy documents – are produced with a particular purpose in mind and therefore privilege the author's or sponsor's position. The possibility exists that documents in the public domain may have been sanitized for public review and may not be transparent. Also, while I valued highly the participants' experience I recognised that their accounts would have been influenced by their prejudices, the passage of time, reliance on their memory and potentially by their interaction with me in the interviews. Additionally, because the interview questions were given beforehand, participants had opportunity to confer. Consequently, corroborating accounts may not be a reflection of shared experience but may be a function of participant collaboration. On the basis of these potential drawbacks therefore, I reasoned that carefully comparing participants' accounts, and careful comparison of the interview findings with the documents findings would be required for rigorous analysis.

Based on the foregoing, when participants' accounts corroborated each other, and the themes were consistent with those in the documents, the findings were regarded as highly credible. Where participant accounts were conflicting a closer look was taken to determine whether the differences could have resulted from the participants'

positions in the policy system. There was no way of determining which participant's account was accurate apart from corroboration by the documents – which in any case may have been sanitized and from which participants may have taken some of their responses. The accounts were therefore taken as given and the differences were highlighted in the report. When participant accounts were consistent with each other but the themes were incongruent with the document findings this occurrence was interpreted as an inconsistency in the policy system and signalled the probability of a greater system deficiency.

In summation, this multiple case policy implementation analysis employed interview and documentary methods in a staged design. The interviews were semi-structured and conducted using multiple modes. A range of documents also provided data. Inductive and deductive reasoning processes informed the analysis of the reform's implementation. Writing, tabulating, and drawing diagrams of the reform's trajectory aided the analysis. The regional implementation pattern was inferred from the pattern that emerged from the case units. Part 3 of the thesis presents the results of the investigation.

PART 3

FINDINGS AND IMPLICATIONS OF THE RESEARCH

Chapter 7

Introduction to Part 3

The current chapter presents the findings of Stage 1 and orients the reader to the analysis and presentation of the interview and document review findings. The chapter begins by presenting the findings of the Desk Review – Stage 1 of the investigation. It continues by highlighting salient aspects of the context which informed the analysis of the data. Section 7.3 outlines what information was sought in the interviews, and the chapter culminates by familiarizing the reader with the format for presentation of the findings.

7.1 Desk review findings

The reader may recall that preliminary information was obtained through telephone conversations and emailed correspondence with the Chief/Principal Nursing Officers (CNOs) of the member states, or their representatives who, by virtue of their office, also comprise the RNB. The emailed responses to the preliminary investigation, and telephone response in the case of Guyana, were tabulated and analysed to develop a picture of the reform's roll out in the region. Informants were asked about the delivery of the BScN in their territories.

The results indicated that seven of the member states were delivering pre-registration baccalaureate education and seven were delivering post-basic baccalaureate education. Six of the pre-registration programmes were reported to have commenced after the CARICOM BScN policy was formulated and one had commenced in 2000. The territory which commenced its BScN programme in 2000, Belize, was therefore

omitted from the sample frame because it seemed unlikely that this programme would have been influenced by the 2006 policy decision.

All six territories which were reported to have commenced their pre-registration BScN programmes after 2006, delivered their programmes through colleges only or through colleges and universities. Two of the six, Trinidad and Tobago and Jamaica – UWI campus territories - offer the degree at the regional university. Jamaica also delivers the pre-registration BScN at its national university, the University of Technology (UTech), and one private university – Northern Caribbean University (NCU). Additionally, the territory offers the degree through its three state community colleges and through the private institution, Sigma College. The islands' three state colleges are Brown's Town Community College (BTCC), Knox Community College and Excelsior Community College (EXCED).

Grenada's situation is also noteworthy in that during the data collection period that territory was not offering the BScN but had recently transferred undergraduate nursing education from the national community college to a private university. This was undertaken with a view to offering the BScN at a later date. As a result of Jamaica's and Grenada's peculiarities, these two territories were flagged for possible inclusion among the case units for investigation. Table 7.1 illustrates the results of the desk review of the implementation of the BScN reform in member states.

Table 7.1:   Desk Review Findings on Implementation of the BScN in CARICOM

TERRITORY	PRE-REGISTRATION BScN	START DATE	POST-BASIC BScN	START DATE	TRAINING SCHOOL/ EXPLANATION	PUBLIC/ PRIVATE
Antigua	No	No	No	No	Antigua State College (Preparing to offer BScN. In early discussion phase.)	Public
Bahamas	Yes	2007	Yes	1996	College of The Bahamas	Public
Barbados	Yes	2015	Yes	2015	Barbados Community College	Public
Belize	Yes	2000	No	No	University of Belize	Public
Dominica	Yes	2014	No	No	Dominica State College	Public
Grenada	No	No	No	No	T A Marryshow Community College	Public
					St. George's University	Private
					(The General Nursing Programme is currently transitioning from the Community College into St. George's University)	
Guyana	No	No	Yes	2002	3 Ministry of Health Schools of Nursing	Public
					1 Private Hospital School of Nursing	Private
					University of Guyana	Public
Haiti	Not a member of the Regional Nursing Body					

Table 7.1 Cont'd: Desk Review Findings on Implementation of the BScN in CARICOM

TERRITORY	PRE-REGISTRATION BScN	START DATE	POST-BASIC BScN	START DATE	TRAINING SCHOOL/ EXPLANATION	PUBLIC/ PRIVATE
Jamaica	Yes	2007 and after	Yes	1983	Four Community Colleges Three Universities	3 Public, 1 Private Two Public, 1 Private
Montserrat	No	No	No	No	Montserrat Community College (Just started discussion with UWI Mona Campus regarding implementation of the BScN)	Public
St. Kitts/Nevis	Yes	2014	No	No	Clarence Fitzroy Bryant College	Public
St. Lucia	No	No	No	No	Sir Arthur Lewis Community College	Public
St. Vincent and the Grenadines	No	No	Yes	2014	Ministry of Health Division of Nursing Education	Public
Suriname	No	No	Yes	2006	Elsje Finck Sanichar College	Public
Trinidad and Tobago	Yes	2013	Yes	2005	University of the West Indies, St. Augustine Campus	Public
	Yes	2009	No	No	College of Science, Technology and Applied Arts of Trinidad and Tobago	Public
	No	No	No	No	The Ministry of Health School of Nursing	Public

Considering the foregoing, the research aims and RNB's member territories, the case units were selected. Case units were paired according to the time they engaged with the reform to allow comparison of their reform processes. In addition, as mentioned previously, only territories delivering the pre-registration degree or other nurse training through public community colleges were considered eligible for selection – to allow some homogeneity in the cases. Based on these criteria, the sample frame from which cases could be selected was reduced by five. Only ten of the fifteen CARICOM territories remained eligible for inclusion in the investigation.

Jamaica and The Bahamas, both reportedly commencing pre-registration BScN training in 2007, were selected as early engagers. The Jamaica nurse education context appeared complex and so warranted further investigation for deeper understanding. Barbados and St. Kitts/Nevis were selected as late engagers. These territories started their BScN pre-registration programmes in 2015 and 2014 respectively. Whilst, based on time of engagement, Dominica may appear to be a more even match for St. Kitts/Nevis, the reader should recall that the impetus for the investigation came from my perception of the responses to the reform in my home territory. Therefore, Barbados could not be omitted from the sample. My reason for conducting the investigation was to understand what was happening with the reform in my home territory *and* the rest of the region. St. Kitts/Nevis was therefore selected as the match for Barbados with respect to time of engagement with the reform. Grenada and Antigua/Barbuda were selected as the two non-implementer territories. Grenada's treatment of nursing education with regard to movement between public and private institutions was interesting in itself, and Antigua/Barbuda was selected because it had not yet implemented BScN education locally and its representative responded to the

email queries promptly. Having selected the case units for interview and documentary studies, I commenced preparation for stage two of the study.

7.2 Key features of the context

Following Haddad and Demsky's (1995) guidance that education policy planning should start with an understanding of the reform sector and its context, I conducted a literature search to develop further insight into the selected territories' nursing education contexts. Haddad and Demsky (1995) advanced that because a reform is normally a response to a problem, the education policy analyst should consider the country's background, political context, economic context and, education sector to develop an understanding of the situation. The authors proposed that the country background should include information related to a territory's location, geography, population, culture and social stratification pattern. Their framework provided for consideration of the country's political environment, its present macroeconomic and human resource situation, and the major issues impacting the country's education sector (Haddad and Demsky, 1995). Using their framework, I outline key features of the selected territories in the following paragraph. Because the CARICOM BScN reform spans health and higher education policy, features of the territories' health and nursing sectors are included.

The islands in this study are dispersed across the Caribbean. The Bahamas is located in the north, Grenada in the south, Jamaica in the west, and Barbados farthest east, with St. Kitts/Nevis and Antigua/Barbuda in between, along the chain. All of these islands, like the rest of their island neighbours were severely impacted by the global

economic recession of 2009, which contributed to their economic decline and slow economic growth or stagnation (World Bank, 2017b).

The states' economies are service dependent. Tourism tends to be their main foreign exchange earner, followed closely by international banking and manufacturing (CIA, 2017). At least one, Jamaica, depends heavily on remittances from abroad. Most have a high public debt and some have low foreign exchange reserves (CIA, 2017). High levels of unemployment among the youth and a steep rise in violence and crime are the main social problems afflicting their populations (CIA, 2017; World Bank, 2017a). Their governments spend between 2.6% and 6.7% of GDP on education.

The islands' main health challenges are NCDs like cardiovascular disease, diabetes mellitus and cancer. They spend between 5.1% and 7.7% of GDP on healthcare. All of the islands have a shortage of nurses (World Bank, 2017b and Salmon, Yan, Hewitt and Guisinger, 2007). These are the key features of the regional milieu that the recent international nursing education reform entered.

7.3 Stage 2 – conducting the interviews and document reviews

To build the picture of the reform in each country, interviewees were asked about different facets of the reform in their territories. Participants were asked how the reform was communicated to their territory to get a sense of how the CARICOM decision entered the local policy spaces. They were also asked to identify the reasons behind their territories' engagement with the reform and the intentions that were associated with this engagement. These questions sought to illuminate the drivers behind the reform in each territory.

Participants were required to describe how their territories engaged with the reform at the national and institutional levels. They were also asked to give reasons for the actions taken. These questions sought to elicit the interactions involved in the engagement with the reform and the extent of engagement.

Finally, to account for the differences in engagement, participants were asked to identify the factors they thought enabled or hindered the reform in their territories. They were required to state factors that they perceived impacted at the national and institutional levels of the context. Participants who engaged with the reform at the regional level were asked to identify those factors they thought impacted the reform at that level.

To triangulate with the interview findings, documents related to the reform in each territory were analysed. The findings from this analysis were combined with those from the interviews to build a picture of the reform's evolution in each territory.

7.4 Introducing the empirical findings

The following chapters present the findings on the reform process in the selected member states. Each chapter describes and then compares the process in two case units, grouped according to their period of heightened engagement with the reform.

Each country's findings begin with a brief description of its nursing education system and its participants. This is followed by the interview and document findings. Each chapter culminates with a comparative analysis of the two countries' reform processes. Chapters 8, 9 and 10 present the empirical findings from the early, late and dilatory

engagers, respectively. Chapter 11 presents a synthesis of the findings and outlines their implications. The thesis culminates in Chapter 12. The chapter following reports participants' perspectives on Jamaica's and The Bahamas' engagement with the CARICOM BScN reform.

Chapter 8

Early Engagers: Jamaica and The Bahamas

8.1 Jamaica's nursing education context and sample description

Currently, all nursing education in Jamaica is delivered through tertiary education institutions. This sector includes four universities – two private and two public – and eight community colleges (Planning Institute of Jamaica, 2009). Additionally, there are several technical/vocational training institutes, six teachers colleges and nine nursing schools. The nursing schools are located in the colleges and universities.

8.2 Jamaica's empirical findings

The following sections present the interview and document findings pertaining to Jamaica's engagement with the reform. For the purposes of this study, the participants from Jamaica were designated the titles Bureaucrat A, Representative A, Representative B, Administrator A and Nurse Educator A. Their accounts spanned regional and national viewpoints, and historical and contemporary perspectives. The reader should note that, with respect to professional affiliation, Bureaucrat A, a former CMO, is a physician. The other participants are nurse educators. The following sections present the interview findings.

8.2.1 Why BScN reform?

The responses suggested that the main reasons behind Jamaica's engagement with the CARICOM BScN reform were:

- concern about the quality of nursing education;

- international trends;

- concern about the quality of nursing service and;

- concern about the status of the nursing profession.

These four issues were most frequently cited as reasons behind the reform.

The evidence indicated that the main reason behind Jamaica's engagement with the BScN reform was concern about the quality of nursing education. This response surfaced eight times. In relation to this concern, one former RNB representative stated,

> "It [the reform] began from the expert committee that met in Barbados
> long before your time and my time. They talked about how to enhance
> the quality of nursing education in the Caribbean and they were moving
> towards that…all basic nursing education programmes should be of the
> quality that would allow for further education at degree and non-degree
> levels…the nurses in the region were striving for quality education."

This response suggested that the former nurse leaders were concerned about the quality of basic nursing education in the region, and its ability to facilitate postgraduate study.

Supporting the need for basic nursing education to facilitate postgraduate studies, Representative B responded in part, "In 1995 RNB looked at Health Sector Reform in the Caribbean. The new levels [that] administrators had to function at required Master's education…." This comment implied that the participant believed the level of basic nursing education at the time did not facilitate Caribbean nurses' entry to postgraduate study and furthermore, did not facilitate their acquisition of the skills needed to function in the reformed health sector. The same participant went on to say, "Sometimes under hospital-based training, nursing tutors were pushed to teach support courses ... but in the university qualified lecturers taught these specialist courses."

Given this claim, it appears that there may have been legitimate concerns about the quality of basic education, if nurse tutors were required to teach topics outside of their area of expertise. It also appears to be the case that transferring the training of nurses to tertiary education institutions was regarded as a means of enhancing the quality of education, as tertiary institutions would have had faculty qualified to teach the support courses. This finding is consistent with findings from the document reviews. But apart from the quality of basic nursing education, participants identified other reasons for the reform in Jamaica.

All five country participants stated that international trends was a reason for the reform. Representative A stated, "We are very good at following international trends – we do not get left behind. So the trend was for entry to practice to be the undergraduate degree." Nurse Educator A remarked, "I'm just thinking that it's because of this global trend. This is what is happening all over, that nursing education should be in mainstream education." The other participants made similar comments, indicating general agreement that international trends was a reason behind the reform. This finding is consistent with the literature on Caribbean policy implementation, in which it is indicated that education policy in the region tends to be a function of international policy transfer (Jones and Schoburgh, 2004). The significance of this finding will be explored further in the synthesis chapter.

Concern about the quality of nursing service also featured as a reason for the reform in Jamaica. Speaking about the quality of service and the effects of migration - among other issues – Bureaucrat A remarked,

"I think the main one [issue] was to be on par because there are many people who would say they haven't seen any real change in the quality of nursing care. But then again, if one is going to be fair one has to look at the conditions of service. The quality of the structures in Jamaica have deteriorated. The quality of the supervision would have deteriorated as well because you're losing your nurses so it would not have been what you wanted it to be."

This comment raised multiple issues including the quality of nursing service, the desire to attain international parity, and some effects of migration on the system. Administrator A explained, "…the need existed for persons to give a higher level of nursing care. The demand was there." Both comments suggested that the quality of nursing service was below what was desired, and that bachelor's degree level education for nurses was seen as a means of improving the quality of patient care. This trend of thought is consistent with the findings of the landmark research study by Aiken et al. (2003) and, if that study's findings influenced the decision-making, it would suggest that the policymakers were seeking to align CARICOM nursing practice with international best practice.

Continuing her point about migration the Bureaucrat A stated,

"The other countries would benefit even more than us because you are now exporting… You know when you look at the World Bank study that was done and you recognize that most of the nurses who migrate, which is a downside for us, most of them really migrate after about five years when they would have done some advanced nursing training."

Representative B noted, "Migration of nurses [was a main issue]. Recruiters were paying off the bond and paying nurses and their families to go overseas to work!" The emergence of migration in these participants' responses, indicated that the emigration of nurses was another feature that impacted decision-making about the reform in Jamaica. Consequently, nurse migration will be explored further in the analysis.

Concern about the status of the nursing profession was cited five times as a reason for the reform. The four nurses in this group of five participants agreed that this concern, among the others, was behind Jamaica's engagement with the policy. While this is congruent with the international literature on the BScN, it must be determined whether this concern was also behind decision-making at the regional level. It is noteworthy that this concern was not raised by the only medical doctor in the sample. This suggested an unawareness of this concern on the participant's part or an unwillingness to identify it – possibly due to professional allegiance. In expressing this concern, Representative B commented,

> "Their [nursing students] entry qualifications were comparable to other
>
> professions but they were receiving a lower recognition at the end of
>
> their training and were undervalued."

In responding to my request to summarize what she regarded as the main issues prompting the reform, Representative A stated in part,

> "… I would say the whole development of the profession…."

While these regional nurse leaders' responses alluded to the concern for the profession's status, it must be noted that their concern may not have been shared by others in the region. Consequently, the extent of this concern across the selected territories will be examined further in Chapter 11.

The participants' responses about the reasons for the reform were ranked by frequency of occurrence, in descending order. The rank order suggested that concern about the quality of nursing education in CARICOM was the main reason behind the reform. This finding will be compared with those from other territories to deduce whether this was the case across the selected countries. Table F1 in Appendix F illustrates the eight reasons participants thought were behind the reform, by frequency and rank.

8.2.2 Jamaica's reform intentions

Participants were asked to state the goals, plans and expectations attached to the reform. Most of the intentions they identified were education related. This was consistent with the finding that concern about the quality of basic nursing education was the main reason for the reform.

The participants identified seven changes in the delivery of nursing education that they anticipated would occur with implementation of the BScN programme. These were categorised under the sub-theme "changes in the delivery of nursing education". The changes included:

- the transfer of nursing education from hospitals to TEIs;
- nursing faculty qualified at the postgraduate level and;
- BScN level education for entry-level nurses.

Participants identified other educational intentions like improvement in the quality of nursing education and the harmonization of nursing education in CARICOM. The remaining intentions related to local and regional nursing service.

Evidence pointing to improvement in the quality of nursing education, as an intention of the reform, was found in comments like this one from Representative A, "…all

basic nursing education programmes should be of the quality that would allow for further education at degree and non-degree levels." Such comments suggested that participants anticipated that delivering the pre-registration BScN would translate to an increase in the standards of basic nursing education to those of a university programme, which would facilitate entry to postgraduate programmes. This was consistent with the concern they expressed about the quality of nursing education, in relation to the preparation of nurses for fulfilling their roles in the reformed health sector – as highlighted by Representative B.

Representative A continued her comment on the intentions associated with the reform by saying,

> "…what they are supposed to be working towards is having one type
> of programme, the undergraduate Bachelor of Science degree across
> the region. That's what we were always working towards…yes, the
> whole harmonization of nursing education."

The other Representative explained that the vision from the inception of RNB was to have nurses prepared at the BScN level. She noted that at the 2000 General Meeting, RNB had passed a resolution that from 2005 the professional nurses' education entry level should be the BScN. These responses suggested that harmonizing nursing education in CARICOM was an intention associated with the reform.

From the evidence it appears that the intentions associated with the reform were mainly related to changes in nursing education – changes in its delivery, quality and outcomes. But the response of Bureaucrat A was interpreted as relating to both educational outcomes and the quality of nursing service because she opined that, "…

theoretically they wanted to improve the nursing product….." This comment suggested that the participant viewed the policymakers as intending to improve both nursing education and nursing service, which was collectively referred to as "the nursing product". However, use of the term "theoretically" also suggested some reservation, on the participant's part, about whether the intention had been realized. Her comment suggested that the policymakers may not have effected an improvement in the quality of nursing education or nursing service by implementing baccalaureate level education for nurses.

Four out of the five participants agreed that improving the quality of nursing service was one of the associated goals. Continuing with her comment on the "nursing product" Bureaucrat A also said,

> "…I think that would have been a goal and possibly in that the quality
> of nursing, however, sometimes we get side-lined by wanting to do too
> much."

This response, in addressing the intentions, raised a feature of CARICOM policy-making identified in the literature – the tendency to be over-ambitious. The association of nine intentions with this particular policy also suggested a measure of over-ambition. The fact that some of the intentions were also cited as what prompted the reform further suggested a lack of clarity regarding what implementing the BScN reform was expected to achieve.

Further evidence of the over-ambition associated with this reform can be found in comments of Representative A. In speaking about harmonization and reciprocity in CARICOM nursing, the participant explained,

> "Another facet of the reform is the RENR, although it was introduced
> before…because it's a requirement for registration…the whole issue of
> the RENR was to foster ease of movement of nurses around the
> region…."

This comment revealed that implementation of the BScN reform was not a stand-alone initiative but just one facet of the wider CARICOM nursing harmonization agenda that included a common registration examination and sharing nurses. The same participant went on to say,

> "Within the harmonization process, there were several activities…the
> undergraduate degree… the Master's and doctoral degrees
> …..Secondly, the curricula for the schools of nursing in the region were
> developed to meet both national and international standards. And
> thirdly, there is the quality assurance programme developed to ensure
> mutuality in managing the schools."

These comments implied that the BScN reform is the continuation of an established CARICOM nursing education agenda. They also implied that the BScN was intended to achieve a number of changes in CARICOM nursing – including quality improvement, harmonization and reciprocity. While they pointed to the specific changes expressed by the nurses in the sample, they also pointed to the tendency towards over-ambition in Caribbean policy-making. Notably, that feature was signalled by the only participant in the sample who would not have been immersed in the BScN discourse at the regional and national levels. Perhaps this exclusion from the professional discourse allowed Bureaucrat A to objectively assess what could be reasonably expected from implementing this policy. Table F2 in Appendix F illustrates

the intentions associated with the reform in Jamaica. The following sections examine the shape of the reform in Jamaica and how it was implemented there.

8.2.3 Jamaica's BScN reform components

To provide a picture of the reform, participants were asked what the reform encompassed. The responses suggested that, in Jamaica, the reform was multi-faceted. Each response included changes in the delivery of nursing education that were cited as intentions associated with the reform. Other responses given included curriculum upgrade, accreditation, stakeholder support and revision of the national nursing legislation. Some responses were cited by more participants than others.

Notably, revision of the national nursing legislation, recruitment of staff, stakeholders support, and changes in the role of nursing faculty were each cited only once by participants. This suggested a divergence of views regarding the nature of the reform. Closer examination of who made the comments suggested that the participants spoke of what occurred, in their area of practice, to realize the reform. Table F3 in Appendix F illustrates the participants' perceptions of the reform's components, and the number of participants who expressed those perceptions.

Particularly striking was the finding that most participants did not consider revising the national nursing legislation to be part of the reform. This suggested that this component was not part of the experience of most of the participants – including one of the RNB representatives and the former CMO. Only Representative A cited the legislation revision as a component when she stated in part, "Firstly, there is the undergraduate degree… Secondly, the curricula… thirdly, there is the quality

assurance programme …Then, the RENR. As well, most GNCs have revised and updated their regulations." This comment suggested that the participant viewed the reform as multifaceted. It also suggested that she perceived that most of the GNCs in the region had revised their nursing legislation. This facet of the reform will be examined further in the thesis because it relates to the permanence of the reform and CARICOM's governance procedures.

8.2.4 BScN reform's evolution in Jamaica

Participants were asked to explain how the decision was communicated to their territory, and describe the actions their organisations took in relation to the reform. From their responses a picture of the reform's evolution was constructed.

8.2.4.1 Communication

Responses suggested that the idea of the entry level BScN for nursing practice was discussed in Jamaica prior to the COHSOD decision. When asked how the policy was communicated to Jamaica and her institution, Administrator A responded, "For years they had been talking about it…but I suppose in the late 1990s they decided that this had gone on long enough, we need to do something about it…." Other responses suggested however, that the COHSOD decision was brought into the country by multiple sources to multiple recipients using multiple modes.

From the evidence it appeared that the RNB direction was introduced in the context before the final decision was made and was initially championed by Senator Syringa Marshall-Burnett, who had conducted the 2003 assessment of the RENR along with Ms. Paula Mark. Administrator A reported,

> "…in 2001 I was asked by the Brown's Town Community College to
> set up a nursing programme on their campus…and I spoke with Mrs.
> Syringa Marshall-Burnett…and she agreed to assist me, but she
> suggested that in view of the fact that the RNB had asked that all
> nursing programmes should now be at the baccalaureate level, that it
> should be a requirement for the baccalaureate programme, we need to
> start that."

From other responses it was deduced that the 2006 decision was communicated to the Minister of Health, PS and CMO through the CNO who was Jamaica's representative on the RNB at the time, and through COHSOD reports and CARICOM communiques.

Bureaucrat A recalled, "So the communication would come back to the Ministry of Health from those meetings to say that the Ministers have ratified this and that countries need to start their implementation process…communication that would have gone to COHSOD from the RNB would have been communicated to us through our CNO." Representative B explained, "The CNOs from each state, who are members of RNB, would communicate its decisions/resolutions in meetings to their respective ministries and nurses." It appeared that the decision was also communicated to nurse educators in national nurse educator meetings held by UWISON, formerly DANE. This was suggested by Nurse Educator A's comment that, "Dr. _____ was the head of UWISON and a member of RNB. She told us that the RNB had decided the way forward was to have all nursing education delivered through educational institutions… she usually have meetings the members of the franchised programme and educators and she would inform us of the way to go forward…" These comments all suggested that communication about delivering the pre-registration BScN entered Jamaica a

different times and via different modes. But the latter comment further suggested that championing of the reform was continued by Senator Burnett's successor.

Overall, the responses regarding communication about the reform suggested that the idea of delivering pre-registration baccalaureate nursing education was a part of Jamaica's nursing education landscape from the 1970s – if not earlier. But the RNB discourse about delivering the pre-registration BScN seemingly entered the policy space before COHSOD's approval was given. Moreover, it appears that this policy direction was championed by Senator Marshall-Burnett who was, at the time, a former President of the Jamaica Senate, Head of the UWI Department of Advanced Nursing Education (DANE), and the UWI's representative on the RNB. The following section examines the championing and other interactions inherent in the implementation process.

8.2.4.2 Championing, Networking and Influence

The responses suggested that both Senator Burnett and her successor championed the pre-registration BScN in Jamaica. This championing of the reform by Senator Burnett and the subsequent UWISON Head and UWI Representative Appeared to be significant in its uptake. Nurse Educator A commented,

> "Dr. _____ had given us the information years ago… I would say that Dr. ____ is very progressive. She charted the way forward and she always makes sure that she educates nurses in the region to ensure that we know what is happening and how to move forward. So that was just one of her conversations for change."

This was corroborated by Bureaucrat A, who commented,

> "I know that _____, who is a colleague of mine in another way, is one of the persons who spearheaded the movement for this transition from the certificate or diploma to a bachelor's degree… Locally she spearheaded it along with other persons; because nursing is extremely strong in Jamaica. So there are persons like Syringa Marshall-Burnett who would have been one of the principals moving it in that direction."

In 2002 the Principal of BTCC apparently bought into this direction; and together with the senior lecturer in nursing who became Campus Director, and Senator Marshall-Burnett, he planned and established the College's BScN programme. It is noteworthy that the Principal and Senator Burnett already had a working relationship from their involvement in national politics. This implies that, along with their working relationship, they had a common powerful network. With these resources at their disposal, it appears that the existing conditions were favourable for establishing the BScN at BTCC.

Also highlighted in the responses was the team's dynamism and strong influence in the community, and with the College's alumni. These dynamics were portrayed in participant responses like,

> "Our Principal had a lot of influence in the community, in the business sector and among his past students – both overseas and local. I'm telling you, it was amazing how he got things done, really amazing!" Also, "It happened fast. I mean these were movers and shakers. You had Mr. ___ who was a politician, Dr. ___ who was the first Campus Director – she is a very progressive person, and Mrs. Marshall-Burnett

who was a Senator and Head of School so whatever needed to happen,

happened - they were quite influential."

These comments suggested that championing, networking and influence were integral processes in implementing the reform in Jamaica. These findings are congruent with the literature on reform implementation and are associated with realizing reform intentions. The significance of these processes in the CARICOM BScN reform's trajectory will be examined further in the synthesis chapter.

8.2.4.3 Bureaucratic leadership

The responses suggested that in 2005 the Jamaican government decided to transfer all nursing education from the Ministry of Health to the Ministry of Education, on a recommendation from the Ying report (1996). They further suggested that in the same year, the UWI absorbed its hospital nursing school into its Department of Advanced Nursing Education (DANE) and the department was renamed the University of the West Indies' School of Nursing (UWISON). Reportedly, these processes involved further curriculum development and approval, selection of faculty, and the development of guidelines for the transition and integration of faculty from the nursing school into the university.

The exercise of bureaucratic leadership to control conflict and steer the reform was evident in participants' accounts of the Ministry of Health's transfer activities. Bureaucrat A commented,

"The PS gave us the mandate. She would sit at the table too when we were discussing…Of course we had to report. Getting the players together wasn't really a major constraint. Once we had them together,

it was really just trying to make sure that we always made the right decisions… That's a bit diplomatic isn't it? (Laughter) You know I sat in a meeting with NCU, UTech, UWI and the GNC and we were really trying to hammer out especially the numbers game…Well we had to come to a decision. At some point the PS said, "listen, we can't continue this arguing so let us agree to X, Y and Z." So, that was that!"

This comment emphasized the Permanent Secretary's role in providing guidance to the process and suggested that stakeholder collaboration also influenced the implementation.

8.2.4.4 Stakeholder collaboration

Responses suggested that the transfer of the government's training programme was influenced by UTech's experience with a previous programme transfer from the Ministry of Health. They further suggested that the transfer process was also swayed by the Ministry's tendency towards stakeholder collaboration for implementing reforms.

Representative A explained, "First, was the update of the KSN curriculum and second, the transfer of the school and its satellite to UTech. The transfer process was both technical and administrative. Guidelines for both processes were developed. I had responsibility for the technical transfer, which dealt with the curriculum and other aspects of programme… the policy agreement between UTech and the Ministry of Health, …seems to have varied as each programme was transferred and there were lessons learned." Representative B commented, "All the costs for facilities and so, UTech bore the majority of the costs; this created great difficulty and made it difficult

to recover costs. So having learned from that experience, UTech, the government university, engaged KPMG and they came up with the model for transfer." These comments suggested that the implementation process benefitted from wide consultation, including technical assistance from a private sector organisation to develop the transfer guidelines.

Bureaucrat A's explanation of the implementation process suggested that the Ministry facilitated stakeholder collaboration to guide the transfer because that was its practice. Her responses further suggested that although UTech was the receiving institution, other providers like UWI and NCU were invited to give input into the process. Furthermore, there was wide nursing leadership participation, and assistance provided for the CNO who was ultimately responsible for implementing the transfer. That participant stated in part,

> "The first thing was the directive formed the basis for the decision making. [There was] teamwork between the institutions, and both Ministries working on the different facets of what goes into starting a new programme. They also included the Directors of Nursing Services in the field because the nurses would eventually come to them. I think we have a tradition in doing that. The MOU and a budget were developed for the programme. A strategy was developed with timelines … we kept records of the meetings and decisions made… examined all of the pros and cons, benefits and risks. Once the MOU was in train, there was a monitoring system between the institutions…The responsibility really fell to the CNO to ensure implementation. There was actually a person assigned to a desk in the Ministry to look after

the training of nurses. She was the liaison between nursing training and

HR within the Ministry of Health and would liaise with the institutions

and help monitor the transition along with the CNO."

Collectively, the accounts implied a collaborative approach to the reform with wide

stakeholder participation and strong leadership. This approach will be addressed

further in the comparative section of the chapter.

8.2.4.5 Enabling factors

Participants were also asked to identify factors that they believed enabled the reform

at the institutional, national and regional levels. The factors that impacted the regional

context will be addressed in the synthesis chapter. However, the institutional and

national factors are presented here. Table F4 in Appendix F illustrates the factors

which participants perceived to have enabled the reform.

The main enablers identified were support, leadership and stakeholder collaboration.

These were reported as enabling the reform in both the national and institutional

contexts.

Regarding what enabled the reform in her institution Administrator A stated,

"I must say that what made it so easy was that the Principal for the

College was the sort of person who actually once he buys into an idea,

he just runs with it and he assisted with everything. What he could not

get from his budget he got his past students or colleagues to bring. So

everything that was required was brought in. He was that sort of person,

a marvellous gentleman."

This comment highlighted the leadership provided by the Principal in the process, and the support of his network in realizing the reform.

Regarding nursing leadership Representative B said,

> "Jamaica possessed more nurse leaders with the will to make it happen. The Nurses Association of Jamaica made education a priority; and the fact that UWI was with RNB from inception; and UWI had respect for nurse academics and had the confidence that they would be able to carry the programme... Also, the ANEU was always the lead in anything to do with education in region... They were a part of all the Nursing organizations...All these things enabled it."

This comment explained the impact of the country's nurse leaders and their connection with the regional university on the realization of the reform. It also highlighted those leaders' and, by extension, the university's championing of the reform, through their involvement in regional and local nursing organizations. Furthermore, it suggested that the presence of the UWI in the context, and its involvement in regional and national policy-making for nurse education, enhanced the system's capacity for implementing the reform.

When speaking of the influence of government support Representative A responded, "The Jamaica Ministry of Health is usually supportive of the health professionals' development." Administrator A stated,

> "At that point in time the government itself was pushing for an increase in tertiary education to get persons better skilled and wanting to see the institutions enhanced so the support was there from all the levels. And

because the Ministers of Health had approved so now they were able

to see something coming out of their decision."

These comments implied that the government desired to enhance its health professionals' skills and follow through on its regional commitment to establish the BScN as the entry level qualification for nursing practice in the region. They suggested that bureaucratic leadership, political will, government support, and supporting policies facilitated the reform's implementation. As indicated in Table F4 in Appendix F, the participants' comments suggested other factors as enabling the reform's realization. These factors will be considered further in the comparative section of this chapter.

8.2.4.6 Reform constraints

In addition to the enablers, participants also identified what they thought constrained the reform. The constraints most cited as impacting the reform locally were inadequate capacity, financial insufficiency and the emigration of nurses. These constraints were implicated in both the national and institutional contexts. They were cited seven, five and four times, respectively by the five respondents. In relation to capacity Bureaucrat A commented,

"I think when you don't have your own institutions to do the practicums

that becomes a constraint. I think the preceptors that they were using

were not sufficiently trained for that... So the supporting structures

around the programme need to find ways and means of supporting the

programme."

Key components of capacity from this viewpoint were the availability and suitability of nursing educators and preceptors for practicums, and clinical sites that are under

the same management as the TEIs. This participant's perception gives insight into one of the drawbacks of transferring nursing education from the hospitals to TEIs. However, the advice of Grindle and Thomas (1989), London (1993) and Garn (1999) regarding the development of instruments to guide implementation, offers avenues for overcoming this challenge. In fact, the reports that the policymakers had developed at least one memorandum of understanding between partner institutions to facilitate the reform's implementation, suggested that the system had put measures in place to mitigate against such possibilities.

Respondents conceded that faculty deficiencies could have retarded the speed of efficiency of policy's uptake and the quality of the training, to the extent that the BScN requirements included enhanced facilitator skills. Additionally, capacity to accommodate the students in the clinical area was deemed relevant to the success of the reform's implementation. Speaking about the availability of nurse educators and clinical area capacity Nurse Educator A explained,

> "Because of where we are we have a problem with recruiting nursing educators. Persons from our region are not doing graduate studies. Nurses are interested in going abroad so they prefer to stay in the hospital until they can go abroad and work. The salary is not competitive and if you look at the workload, it's not attractive. That's holding us back from doing much programmes. Then there is the clinical site. The area is inadequate to train more nurses so we have to just stay with the forty. The hospitals are overcrowded. There are other students going there from other nursing schools."

This comment captured the issue of capacity but it also indicated how emigration diminished human resource capacity in the system, thereby potentially impacting its quality of nursing education.

Financial insufficiency was also cited as constraining the reform from the perspective of government funding and student fees. Representative A simply stated, "I think for Jamaica it would be mostly financial." Administrator A explained, "The number of persons who were qualified to do the nursing programme and also able to pay [was a constraint]. The financing in terms of student fees was a constraining factor." Moreover, Bureaucrat A commented, "The other major issue is one of finances in that there are some students now who are unable to complete payment for their courses, so this would have been a constraint for the institution." These comments suggested that both the government and the potential students experienced difficulty contributing the required funds for optimal programme outcomes and this finding was consistent with the challenges being experienced in the sector, as borne out by the literature. Table F5 in Appendix F illustrates the factors participants perceived to have constrained the reform, and the context levels they impacted.

The foregoing interview findings were considered along with the documentary findings to build the country's reform picture. The section following describes the findings from reviewing the Jamaica documents.

8.2.4.7 Document findings

Two documents were analysed to triangulate with the Jamaica interview findings. These were the Nurses and Midwives Act of Jamaica (2011) and the Report of the

Taskforce on Health Sector Manpower, Education and Training by Ying (1996). The regulations accompanying the Act were not retrieved. Therefore it could not be ascertained whether they were revised to establish the BScN degree as the entry to practice qualification for nurses in the territory. However, the fact that only one participant cited legislation change as a component of the reform suggested that, if changes were made, specific provisions for the BScN may not have been included.

The Act speaks to the functions of the GNC. In the context of this study, its functions in relation to the reform were categorised as interest group participation. The key finding in this document was the responsibility of the Council to control the training and practice of nurses on the island. Section 4 of the Act reads, "The Council shall have power to control the training and practice of nurses and midwives and enrol assistant nurses" and Section 16 states,

"The Council…may make regulations –

(a) prescribing the requirements which shall be satisfied by persons applying for training as nurses, midwives and assistant nurses;

(b) providing for programmes of training and the curricula of study to be followed in the training of nurses, midwives and assistant nurses;

(c) …regulating the instruction to be given in such schools;

(d) prescribing the examinations to be passed and the other requirements to be satisfied,…by persons applying for registration as nurses or midwives or enrolment as assistant nurses;" (Government of Jamaica, 2011).

This finding corresponded with the participants' identification of interest group participation as an enabler of the reform in their accounts of the Council's role in the

curriculum process and in collaboration for the transfer of the Ministry's training programme. Since the Council's participation was linked to the successful implementation of the reform in Jamaica, it must be determined whether the same obtained in the other territories.

The Nurses Act was only one of the documents analysed in relation to Jamaica's engagement with the reform. The Executive Summary of the Report of the Taskforce on Health Sector Manpower, Education and Training by Ying (1996) was also analysed. This section of the document summarised the major issues in the context leading to the report and the major recommendations of the Taskforce. Five of the eleven background issues identified in the report were also identified by the interview participants. The reader may recall that only one participant referred to this document and it was unclear whether the others were aware of it. Nevertheless, whether they were exposed to the document or not, the congruence of the participants' views with the issues identified in the report increased my confidence in the reliability of their accounts.

The report identified three major issues that were cited by the participants as reasons for the reform. These were concern about the quality of nursing education, concern about the status of the nursing profession, and the cost of training nurses. The report also identified the issue of the quantity and quality of health personnel. This finding was regarded as indirectly linked to the participants' responses as it could have been a consequence of emigration, which featured as a reason for the reform in the participants' accounts.

Congruence between what the participants viewed as intentions associated with the reform and recommendations of the Taskforce was also observed. The Taskforce recommended changes in the delivery of nursing education, an improvement in the quality of nursing education and an improvement in the status of nursing. These were identified as intentions of the BScN reform in Jamaica by the participants' accounts. Two recommendations of the Ying Report for improving the human resource development process in the Jamaican Health Sector, were noted among the interview findings on the reform's components. Among other measures, the Taskforce recommended curricula upgrade for health professionals – which would include nurses – and specifically, the transfer of nursing education from the Ministry of Health to the Ministry of Education. The report stated, "Consolidate into a College of Nursing for transfer to the Ministry of Education, all Ministry of Health training programmes for nurses" (Ying, 1996).

The review of this particular report revealed that although participants may not have read it or, simply may not have cited it, its findings and recommendations featured prominently in their understanding of the BScN reform process in their territory. Additionally, it revealed that the reform process in Jamaica was not simply prompted by the RNB discussions and recommendation but that there were forces on the ground advocating some of the same changes that the regional reform intended to accomplish. Rather than coincidentally concurring with the Ying recommendations, it is possible that the regional reform was crafted with these ideas in mind to address the challenges in the Jamaica nursing sector. It is unclear from which set of authors the ideas originated. But, it is apparent that there were common ideas among the authors of these two initiatives. The Ying report would have permitted the BScN reform to be

advocated as an answer to some of the issues in Jamaica's context, thereby giving it traction in the system. The congruence between the Ying (1996) recommendations and the intentions associated with the BScN reform was astounding initially. However, when closer examination revealed that the Ying (1996) report was produced by a UWI academic, and that the UWI's nursing academics had been championing these changes for some time, the shared ideology lost its mystique.

Furthermore, the understanding that prolonged discourse allows ideas to germinate and permits shared ideology; and the understanding that the UWI's nursing academics are highly respected in the system directed me to conclude that there was cross-fertilization of ideas in the system which permitted acceptance of the reform. This understanding also suggested that the UWI representatives on the RNB could have presented the BScN reform as a solution to the region's nursing education challenges while simultaneously promoting its implementation in their home territory.

These findings were consistent with Bell and Stevenson's (2006) view of policy as part of a triad of themes with power and leadership. The leadership exemplified by the UWI academics in championing the reform, and the power of the UWI to influence tertiary education policy-making through its academics' research and consultancies pointed to the role of the regional university in CARICOM nursing education and, by extension, in regional higher education and human resource policy-making. This issue will be expanded upon in the concluding chapters. The document analysis worksheets which informed this phase of the analysis are presented in Appendix F.

8.3 Summary of Jamaica's BScN reform episode

Based on the evidence, it can be concluded that the dynamics in the policy system led to a tailoring of the policy to facilitate its implementation, to the extent that franchise agreements were forged between the UWI and the colleges in the system. These arrangements allow the programme to be delivered through the colleges with the inputs and benefits of the University's resources. Additionally, there is evidence to support the claim that the policy was generally accepted locally. The evidence suggested that Jamaica implemented the 2006 CARICOM BScN policy, to the extent that the degree is delivered at all TEIs delivering nursing education in the system. However, whether the policy was implemented as intended remains unclear because no evidence was found to suggest that legislative changes were made to establish the BScN degree as the entry to practice qualification for nursing on the island. Figure 8.1 illustrates the researcher's understanding of the pre-registration BScN reform's evolution in Jamaica, depicting its trajectory from policy entrance to implementation. The following sections examine The Bahamas' engagement with the BScN reform.
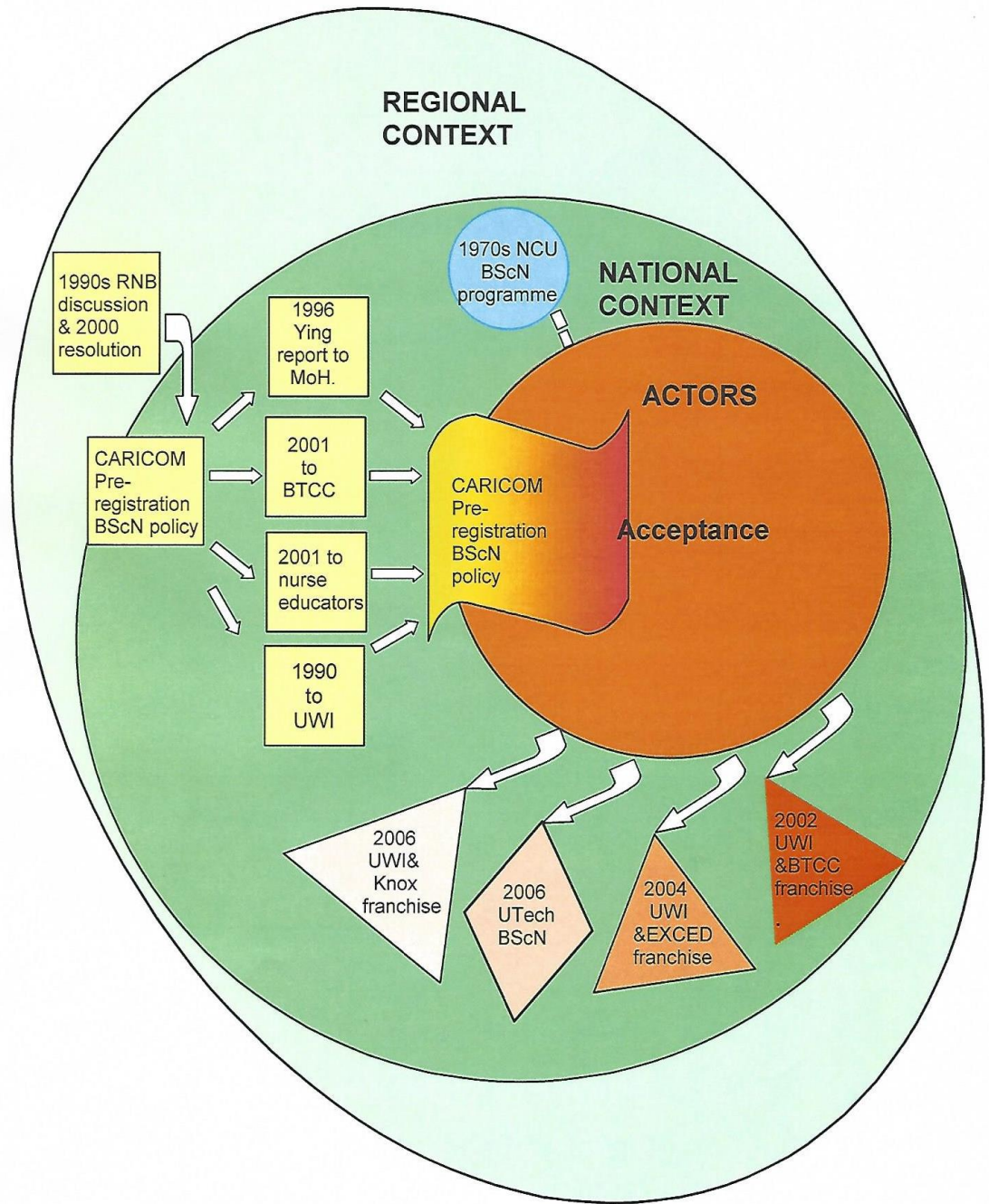
Figure 8.1: Jamaica's BScN Reform Evolution

8.3 Nursing education in The Bahamas

The Bahamas' tertiary education system is comprised of two public-funded institutions and a number of offshore institutions. The public-funded institutions are The Bahamas Technical and Vocational Institute (BTVI) and the College of The Bahamas (COB), where nurse training is conducted (Government of The Bahamas, 2011). The College became the University of The Bahamas in November 2016.

8.4 The Bahamas' empirical findings

The findings from the interviews and document reviews related to The Bahamas' engagement with the reform follow. The participants from The Bahamas were designated the titles Nurse Educator B, Representative C, and Representative D. They were a nurse educator at the College of The Bahamas and two RNB representatives. Efforts were made to secure participation by a bureaucrat and a nursing education administrator but those efforts proved futile.

8.4.1 Why BScN reform?

The responses suggested that the main reasons behind The Bahamas' engagement with the reform were:

- concern about the quality of nursing service;

- international trends and;

- the emigration of nurses.

Each of these issues was mentioned twice by participants. Other reasons suggested, were:

- nurses' demand for the BScN,

- concern about the quality of nursing education and,

- concern about the status of the nursing profession.

When asked what issues prompted the reform, Nurse Educator B responded, "ICN would be one of the driving forces for programmes around the world and the region is no different." This comment implied that The Bahamas, and the rest of the region, had engaged with the reform to keep up with international trends in nursing education, as directed by ICN. To the same question Representative C answered, "…the RNB wanted to keep abreast of what was happening globally." This response too suggested that one of the reasons behind the reform was RNB's desire to attain parity with international trends in nursing education.

Alluding to emigration and the concern about the quality of nursing service, as reasons behind the reform, Representative D remarked, "Recruiters from other countries were coming in and recruiting our nurses and offering them educational incentives. We felt that if we offer the BScN the nurses were more likely to remain. Also we thought that more highly trained nurses would produce better patient outcomes." The identification of the emigration of nurses as a reason behind the reform was supported by Representative C's comment that, "… we had to find a way to keep our nurses in the region. In The Bahamas, our nurses find it very easy to get jobs in the US and they leave … because of the incentives they are offered." Representative D emphasized these issues as key reasons behind the reform when she reiterated that, "Migration of nurses leaving the Caribbean to get a Bachelor's degree and quality of care for patients [were behind the reform]."

Representative C's comment that, "The nurses were thirsty for education and wanted to get a degree," implied that there was a demand placed on the system, by nurses, to

deliver baccalaureate nursing education. As she continued her response she said, "Well, when I was CNO and a member of RNB, every year we discussed the problems and issues related to nursing education in our countries. Leading up to 2006 we were concerned about moving to the Bachelors." This comment suggested that there were challenges with nursing education in the territories which were regularly discussed at the RNB and, further, that delivering the bachelor's degree was considered as a solution to those challenges. Finally, Representative D explained, "Nursing was way behind other professions in the level of basic training, e.g. teachers. So they wanted to bring us on par with other professional groups." This comment suggested a concern about the status of the nursing profession. Together, these comments indicated that demand, concern about the quality of nursing education, and concern about the profession's status were the other reasons that participants believed were behind the reform in The Bahamas. To get a sense of all the drivers behind the reform, participants were also asked about the intentions associated with the reform.

8.4.2 Bahamas' reform intentions

When asked about the intentions attached to the reform, the participants' responses were varied. Nine intentions were stated but none was identified more than once among the participants. The analysis included a comparison of the responses to check for corroboration. However, there was no corroboration amongst the participants' responses regarding the intentions. This suggested that there was no consensus regarding what the reform was intended to achieve in The Bahamas.

In responding to the question, Representative C stated,

> "We hoped it would improve the quality of care given by nursing personnel. We found too that some of our intelligent nurses were reluctant to step up to the plate in the multidisciplinary team because they didn't have a degree and other team members did. In some cases they may have been looked down upon by other team members who have a degree. So we felt that this qualification would increase the confidence of the nurses to make their contribution to the health team. We thought also that having the degree as entry level qualification would enhance the image of nursing and would keep nurses in the region because many of them were going abroad to find opportunities to further their studies because the degree wasn't being offered in their home territories. And as I said before, we wanted to keep abreast of global trends."

This response suggested that the participant was of the opinion that the delivery of the pre-registration BScN programme locally would:

- improve the quality of nursing service;

- improve the competencies of beginning level RNs;

- empower nurses to collaborate with other members of the health team;

- improve the status of nursing;

- retain nurses in the region and;

- facilitate parity with international nursing education.

Expressing her opinion about what her territory's engagement with the reform intended, Representative D stated, "To have all diploma and certificate trained nurses upgraded to the BScN over time." This comment suggested that the participant thought

that implementing the reform was intended to facilitate the upgrade of practising nurses. This was different from the views expressed by the other two participants, and different from those of other participants in the study regarding the intentions associated with the reform. Whereas the evidence suggested that the upgrade of practising nurses was included as a component of the reform by other participants, this comment suggested that Representative D regarded post-basic baccalaureate education as an intention associated with the reform. Given that the CARICOM policy statement expressed the intention that the BScN would be the *entry level qualification* for nursing practice, the implication of this comment is that Representative D either did not fully understand what the reform was intended to accomplish, or did not fully understand the question posed. Consideration of the actors' understanding of the policy was included in the analysis of the responses because, according to Spillane et al. (2002), it would have implications for the reform's implementation.

Regarding the intentions associated with the reform Nurse Educator B stated,

> "I think the whole purpose of introducing it was to streamline the associate degree we presently had which was … very lengthy … for an associate degree…. So we were given the mandate from the College that we needed to do something with this programme…. The College needed to go to university status, which had been in the works for a very long time. To do that, you must be able to offer undergrad or grad programmes. Nursing was just simply included as a part of all programmes."

This response suggested that the participant saw the reform as intending to facilitate the COB's upgrade to university status by requiring the conversion

of the associate degree programme to a baccalaureate programme. It also implied that she saw no connection between the delivery of the pre-registration BScN in her territory and the 2006 CARICOM BScN reform. This claim was substantiated by the participant's comment in relation to communication about the reform. She stated in part, "I can't say what the direct links were. I don't even remember CARICOM's decision being a part of our discussion…." This comment implied that the CARICOM policy may not have been discussed in The Bahamas. The implications of this possibility will be discussed further in the chapter.

The participants' responses seemed to reflect their areas of interest rather than a national consensus. Consequently, the intentions could not be ranked by frequency, as was done for the Jamaica responses. However, the responses were congruent with what the participants perceived as reasons for the reform. When the intentions were matched with the reasons, the intentions suggested represented possible solutions to the challenges identified. So, while there appeared to be no general consensus regarding what the reform was intended to achieve, the responses suggested that the participants saw the BScN reform as a probable solution to the problems they had identified in the system. Table G2 in Appendix G lists the intentions of the reform identified by the Bahamian participants.

8.4.3 Reform components

Apart from identifying the reasons and intentions associated with the reform, participants were also asked to state what the reform encompassed. The responses suggested that the reform involved curriculum upgrade, although Representative C's

response implied that she was not sure. In response to the question she stated, "I noticed a communication … in my capacity as … that came to the Council from the office of the CNO, which said that she was forwarding the CARICOM proposed curriculum to the GNC. So, from that I would say that it encompassed a curriculum upgrade." Representative D responded, "It involved a whole change in the curriculum for undergraduate training … it also involved full funding by the government for qualified students with minimum cumulative GPA of 2.75." In response, Nurse Educator B explained,

> "I really cannot give details from a CARICOM perspective. I can only speak from a tertiary education perspective. I can't shed any light on what's included in the document. All I can say is that whether or not regional reforms or international reforms had any impact on our decision to adopt the bachelor's is really negligible. It really was driven academically. This was really not a case of us being given a mandate to do so but I think it seems that everything lined up at the right time … it really was driven by the College."

This response suggested that there was little connection between The Bahamas' implementation of the pre-registration BScN and the CARICOM direction in nursing education. The extent to which this comment reflects the reality of the situation will be explored further in the analysis. But it should be noted that later in the interview the participant said, "…The College itself was changing in terms of its curriculum frame – what type of programmes are we going to offer as an institution. *That* was one of the driving forces. We had curriculum reform in the College that we streamline our programmes and offer a more liberal arts bachelor's degrees to our students across programmes." This

response suggested that curriculum revision was involved, but again emphasized that the process was driven by the College's agenda – not the RNB's agenda.

Collectively the responses suggested that the reform encompassed curriculum upgrade and government scholarships for selected students. They further suggested that the RNB Representatives in The Bahamas, given that they could not give a detailed account of the reform's components, were not deeply engaged in the local reform process. Furthermore, from the nurse educator's response, it appears to be the case that the CARICOM 2006 decision was not a significant influence on the changes that were occurring in The Bahamas' nursing education system at the time. The veracity of these claims will be examined further in the analysis. The section following examines The Bahamas' implementation of the pre-registration BScN.

8.4.4 Evolution of the BScN reform

The participants' accounts suggested that the territory's engagement with baccalaureate nursing education started in the 1980s. They also suggested that between 1993 and 1994, the College commenced the post-basic BScN degree which ran concurrently with the associate degree. Reportedly, in the early 2000s, a number of general education and elective courses were added to the Associate Degree programme, apparently making completion problematic. That programme was therefore subsequently upgraded to a pre-registration BScN programme in 2007.

The responses suggested that stakeholder collaboration, lobbying, resistance, conflict and consensus building were involved in the process. However, the reader should note that because the RNB representatives could not give details regarding what transpired to implement the pre-registration BScN programme, the analysis was heavily informed by Nurse Educator B's account. Following are the responses participants gave regarding interactions in the reform process.

8.4.4.1 Communication

Participants were asked how the decision about the reform was communicated to their territory and tertiary education institution. Representative C stated, "I assume that through the various Ministers it would have been communicated to their countries. I don't recall written communication. _____, the new CNO, may have seen it. She would have shared the decision with the College at the Advisory Committee meeting." Representative D said, in part, "I'm not sure for this one..." In response to the question, Nurse Educator B remarked,

> "I don't even remember CARICOM's decision being a part of our discussion. What I do know is that this notion of the BScN has always been a part of the makeup of the school and the College. So I can't recall any particular time in which we received this mandate and we decided based on that mandate that it is what we would do. If that occurred I don't recall it."

From these responses, it is evident that no participant recalled communication from CARICOM to The Bahamas regarding the reform. Moreover, the nurse educator's response suggested that the idea of delivering the BScN locally was part of the

Bahamian discourse for some time prior to implementation. She went on to say, "…we were only doing what the College was requiring of us. I can't even think of a document that I've read or even received that put forward CARICOM's position to us; and I've been a part of the framework of the school for quite some time." This suggested that the participant was unaware of any connection between the local discourse around delivering the BScN and the 2006 CARICOM decision. Moreover, collectively, the responses about communication implied that the CARICOM decision was not disseminated in the system.

Representative D continued by saying,

> "…the RNB proposal was taken to the Health Ministers' meeting and the COHSOD meeting. The decision came back to the RNB meeting as an agenda item and PAHO Directing Council meeting attended by Ministers and CMOs in Washington. Once these decisions go to RNB and the Ministers' meeting it comes back to the different countries through the CNO by meeting, sharing reports of the RNB meeting and in the Public Sector Nursing Advisory meeting."

This comment gave the usual process of communication between RNB and the territories. However, it did not describe specifically how the decision was communicated to The Bahamas. When asked why the Public Sector Nursing Advisory meeting was chosen to communicate CARICOM decisions in The Bahamas, Representative D explained, "Well, usually all of the heads of nursing from the areas, once they understand, would take it back to their respective areas and see how best they can meet the need." This suggested that it was customary for the CNO's office to communicate RNB decisions to this select group of nurse leaders in the territory – the

Public Sector Nursing Advisory Committee – and then rely on the committee's members to disseminate and implement the decisions. But, the responses in relation to this reform, suggested that there was a communication gap between the office of the CNO and the rest of The Bahamas' nursing education system about the reform. Since communication is critical in the reform process, it implied that the reform process may have been compromised, as a result of this deficiency. This will be examined further in the analysis. Stakeholder collaboration and consensus building, as interactions in the process, will be examined imminently.

8.4.4.2 Stakeholder collaboration and consensus building

The responses also suggested that stakeholder collaboration featured early in the process of implementing the BScN. Reportedly the College engaged the GNC and the Nursing Advisory Committee in early discussions about the curriculum, to share what the faculty hoped to achieve, and the challenges that they might need assistance with overcoming. The evidence also suggested that the collaboration was intended to determine the adjustments that needed to be made in the clinical areas to facilitate the students' experience. Explaining the reform process, Nurse Educator B said,

> "We have a formula within the School of Nursing of how we
> implement programmes … it's worked for us in the past. That is, we
> form curriculum committees …. A needs assessment would be done on
> who would be interested in the programme …. Then we move to
> advisory meetings to let our stakeholders know very early on what
> we're thinking. We want to tell them our challenges. The nursing
> advisory committee would discuss what we are thinking and what we
> are hoping to achieve. That's the process that I met within the school

and that we continue to use. The new programme then goes through the process of approval in principle. We go to the College and say this is what we want to do. Once we get their approval in principle then we begin writing courses … We present the courses at faculty board and academic board and once approved the academic board assigns code numbers to the courses and it is entered in the system. Only when that happens is it available to be offered to students."

This response detailed the process of programme implementation at the institutional level. It suggested that a situational assessment and stakeholder collaboration were involved in the process. But moreover, it suggested that the process was driven by the educational institution – a claim that was made earlier by the same participant.

This response detailed the process of programme implementation at the institutional level. It suggested that a situational assessment and stakeholder collaboration were involved in the process. But moreover, it suggested that the process was driven by the educational institution – a claim that was made earlier by the same participant.

Nurse Educator B went on to explain, "We also had a lot of discussions with the advisory board, of which GNC was a part and we had to get their permission to streamline the clinical hours …." When asked about the Council's further involvement in the process, specifically in approval of the programme, Nurse Educator B responded, "We would write to the Council asking about statutory requirements to keep abreast of those. They would approve clinical hours but not the programme. When it comes to approval of the programme, that's under the College."   This suggested that the GNC gave permission for changes to the clinical hours in the programme but beyond that, had no involvement in content and quality of the

programme. If this was the case, it threatens the harmonization of nursing education in CARICOM and will therefore be examined further in the analysis.

Continuing with her explanation of the implementation process, Nurse Educator B stated, "…We improved the Memorandum of Understanding with our clinical site the hospital…" This comment suggested that the hospital management was also a part of the early discussions around the implementation. It also implied that the agreement between the College and the hospital regarding delivery of the programme was updated. However, a copy of this document could not be obtained for triangulation. The participant's account went on to suggest that lobbying, resistance and conflict were involved in the implementation process.

Representative D's account of what her organisation did in relation to the reform suggested that at some stage, a government policy was developed that permitted employment of nurses without degrees, only if they were trained in The Bahamas prior to 1997. The representative explained, in part, "We have decided in The Bahamas, through the Ministry of Public Service, that we will not employ any nurses in The Bahamas without a BScN unless it is a Bahamian with a diploma earned in The Bahamas. The National Nursing Advisory Committee decided this." The respondent also explained,

> "In recent times, right now, we have a Midwifery diploma programme
> …. We are discussing making the Midwifery programme into a
> Master's but we need a good cohort of BScN graduates to be eligible
> for this midwifery master's degree, so we are just having initial

> discussions at the moment …. The earlier step was to implement the
>
> BScN but I don't have the specifics on how that occurred."

This comment suggested that the representative was not involved in the BScN planning and implementation processes. Representative C was also asked about what transpired in her territory after the 2006 CARICOM decision was made, her response was, "… it would be best for you to check with … for this one …. Remember that we started offering the generic Bachelor's then in 2007…. I'm not sure what we did to prepare for the generic programme. You'd have to check that with the College faculty." These responses implied that the RNB representatives were not involved in the implementation process and that, as the nurse educator's comments had suggested, the process was indeed driven by the College. They further imply a deficiency in nursing leadership in the system. The remainder of the explanation of what took place in the territory regarding implementing the pre-registration BScN programme was therefore gleaned from Nurse Educator B's responses.

8.4.4.3 Lobbying, resistance and conflict

Nurse Educator B's account of the implementation process suggested that within the COB's department of nursing there was lobbying for changes to the BScN programme's structure and, simultaneously, there was resistance to the proposal. From her account it appeared to be the case that this internal conflict stalled changes to the programme for at least four years. The respondent put it this way,

> "…So this year has been a very exciting year for us in implementing
>
> this traditional bachelor's. We've fought for it from 2012 to get it
>
> implemented to correct some of the things that occurred. It was a
>
> struggle because sometimes when you implement things it's very hard

to acknowledge that errors were made. So the tendency sometimes is to continue with the status quo because the change would mean you must admit that you made some mistakes. So the process of trying to make those changes was slow. From 2012 to this year we rarely had change… a lot of times when we were trying to make the necessary changes a lot of stumbling blocks were put in our way…"

The comment suggested that the nursing education administrator stalled the programme changes.

The account went on to suggest that, in 2016, as the college was preparing to upgrade to university status, there finally was refinement of the BScN curriculum to accommodate the College's development. The respondent stated, "From 2012 to this year we rarely had change. But the mood of the College was also changing. You see things have to happen at the right time. The mood in the College was changing in terms of looking to move to university so we were back to looking at programmes. So the time was ripe again for making the change we were trying to make from 2012."

Reportedly, a number of changes ensued to facilitate the College's transition. These included faculty upgrade, faculty recruitment, curriculum revision, restructuring of the BScN programme, infrastructural upgrade and streamlining the entry requirements. Nurse Educator B explained these occurrences this way,

"We upgraded faculty across the College because they intended to offer bachelor's degrees across the College…. We recruited faculty with Master's degrees and doctoral degrees…. We made infrastructural changes…. we had to revise our programmes … streamlining our

prerequisites and co-requisite combinations; looking at other universities…. We also had a lot of discussions with the advisory board, of which GNC was a part of that and we had to get their permission to streamline the clinical hours because we had a lot of clinical hours in excess of what other programmes have…. We improved the Memorandum of Understanding with our clinical site the hospital and we hired preceptors."

This response also suggested that, beyond curriculum revision, the implementation of the pre-registration BScN in this territory entailed faculty upgrade and recruitment, infrastructure upgrade, and programme restructuring – including changing the entry requirements. When asked why she thought her organisation had addressed the reform in this way, the participant responded, "I think they were very intent on improving the programme offerings of the College as a whole. Nursing was just a part of all programmes."

Notably, the resistance in the process was attributed to a type of parochialism - an unwillingness by principals in the development of the original BScN programme to allow revisions to the programme. It appears to be the case that this outlook hindered the programme's revision for an extended period by stimulating conflict. Parochialism was also identified by two RNB representatives as a constraint at the regional level. The extent to which this factor was viewed as a constraint will be examined further. To complete the picture of the reform's evolution in The Bahamas, the participants were asked what they thought had enabled or constrained the reform in that territory.

8.4.4.4 Reform enablers

When the participants were asked what factors they thought enabled the reform nationally and regionally their responses suggested that support was the primary enabler of the reform. Table G3 in Appendix G lists the factors that participants identified as enablers of the BScN reform, and the context levels they were perceived to have impacted.

Regarding what she thought enabled the reform in The Bahamas, Representative C stated,

> "I would say the willingness of the faculty to transition by doing the extra work required. Also, strong support from the Ministry of Health … Another thing is that the professional organisation lobbied for the BSN. So that helped to push it too …. I think we have strong political support for Nursing in the Bahamas … Also, I have to say the courage and negotiation skills of our nurse leaders help with this as well and it certainly help with establishing the BScN programme … Another thing is that the government sponsored our faculty to upgrade their qualifications. So a number of us had scholarships to do our Masters degrees."

This comment suggested that faculty commitment, government support, nursing leadership, and interest group participation – in the form of the NNA lobby – enabled the realization of the reform in The Bahamas. The participant was asked what she thought enabled the reform at the regional level, to this she responded, "All the CNOs wanted to see their countries progress … The ICN recommended the upgrade and the Caribbean nurses who attended the conferences tried to implement it on return." This

response suggested that the participant thought that nursing leadership was a key enabler of the reform at the regional level.

In response to what she thought enabled the reform in her territory Representative D replied, "We are a Member State of CARICOM and our government attends all the various meetings. Our CNO attends RNB meetings. We already had a College established with a nursing programme in the College from since 1986. So we had all of the infrastructure in place." This comment suggested that the participant thought that government support, nursing leadership, and the national capacity enabled the reform locally. Capacity, in this case, referred to educational infrastructure and programming. Whilst the response seemed to imply that the CNO's attendance at RNB meetings represented a form of nursing leadership.

Regarding what she thought enabled the reform at the regional level Representative D went on to say, "The same above factors but some of the countries cannot afford it. Also, the presence of political will." This comment suggested that the same factors which enabled the reform in The Bahamas also enabled it at the regional level. Furthermore, it suggested that political will was another enabler of the reform. But the participant also seemed to be conceding that despite the presence of enabling factors, some territories may not have the finances to implement the reform.

When asked what factors she thought enabled the reform in the Bahamas Nurse Educator B stated, "…financial support, support from the Ministry of Education and the fact that the College is given a lot of latitude in programme improvement. The College polices itself and is constantly seeking to upgrade itself. The climate within

the College is one of upgrade and improvement." This comment suggested that the participant thought that support – both governmental and financial, institutional capacity – in this case the institution's autonomy, and the policy's fit with the institution's agenda, all enabled the reform's implementation in the country. When asked what she thought enabled it in her institution, the participant responded, "Well, the faculty. A lot of the reform is faculty driven….So I would say the dedicated faculty." This response implied that the respondent saw commitment at the institutional level, in this case the faculty's commitment, as enabling the reform. In addition to what enabled the reform, participants were asked what they thought constrained it. Their responses to this question will be considered in the next section.

8.4.4.5 Reform constraints

Participants were asked for their opinions on what constrained the reform at the national, institutional and regional levels. The responses suggested that nursing leadership deficiencies was the predominant factor that was perceived to have hindered the reform.

Regarding what hindered the reform locally, Representative C stated, "Well, I discussed this with one of the faculty members and I'll tell you what she said. Actually, I think it would be good if you could speak with her." This comment implied that the participant was not sure what hindered the reform at the national level; which further implied that she was not involved in the implementation process. She was then asked what she perceived as hindering it at the regional level. To this, the participant responded, "Well some territories had challenges with their schools of nursing. Like, Guyana had difficulty even being released to attend regional meetings. So they would

not have been involved in a lot of the discussions and may be left behind." This comment suggested that the participant perceived nursing leadership deficiencies and inadequate capacity to have been constraints to the reform, which operated at the regional level. Capacity, in this instance, related to institutional infrastructure, while nursing leadership related to the involvement of nurse leaders in policy-making at the regional level.

Representative D indicated that she could not identify anything that constrained the reform in The Bahamas. She stated, "I can't think of any. I don't know the timespan between the decision and actual implementation." This comment implied that this participant was not involved in regional decision-making regarding the BScN, and had little involvement, if any, in the implementation. However, the participant expressed what she perceived to have hindered the reform at the regional level. Collectively, the RNB representatives' comments suggested that they had little involvement in implementing the reform in their territory.

Regarding what she thought constrained the reform, Nurse Educator B said,

> "Sometimes there can be political interference. Not really in the bachelor's but in other programmes. There is sometimes a desire to have those programmes at times when it is not convenient. The post-basic programmes are usually always politically driven. This push impinges on faculty time for curriculum revision. This year we are offering 4 different post-basic programmes because next year is an election year."

She went on to say,

> "Faculty teaching load [also constrained it] … The willingness of the
> past Chair. I've not had that willingness in past time … Remember the
> opposition I spoke of experiencing from 2012…"

This response suggested a conflict of ideas in the department of nursing that stimulated resistance to the reform. Collectively, Nurse Educator B's responses about the constraints suggested that political interference, nursing leadership deficiencies and conflict were perceived to have hindered the reform at the institutional level. Political interference was perceived to have hindered the reform by diverting the faculty's attention from curriculum revision for the reform to post-basic programmes. Table G4 in Appendix G   illustrates the factors that participants from The Bahamas perceived to have constrained the reform.

The foregoing interview findings were triangulated with documentary findings to build the country's reform picture. The section following describes the findings from related documents.

8.4.4.6 Document findings

The Bahamas Nurses and Midwives Act, The Bahamas Nurses and Midwives Regulations and the College of The Bahamas Act were analysed to triangulate with the interview findings. The findings from the Nurses Act corresponded with interest group participation, one of the reform enablers. As with Jamaica's legislation, this indicated that the GNC has power to direct the training of nurses, the requirements for applicants, the curricula of general nursing programmes and the instruction to be given to nursing students.

The respondents' accounts however did not reveal the exercise of this power by the Council. It was stated that the Council was involved in the curriculum process in the initial stages as a member of the Nursing Advisory Committee. However when I inquired about the Council's approval of the programme Nurse Educator B explained that it was not the practice for the Council to approve the nursing curricula in The Bahamas. This response was supported by the inability of the two RNB representatives, both of whom are associated with the GNC, to give account of the curriculum revision. These two actors hold key positions that should have more in depth knowledge of that phase of the process than they were able to supply. It was noteworthy that for all curriculum-related questions, and for other implementation details, these key actors referred me to the College for a response. This suggested a nursing leadership deficiency in the system, where the Council, for whatever reason, only partially fulfilled its obligation; and where institutional actors were left to implement the nursing education reform with minimal input from two key nurse leaders.

The Bahamas Nurses and Midwives Regulations were similarly analysed. The regulations stipulated the areas that must be included in the curriculum of study for persons who would apply to be registered nurses in the territory. However, they did not stipulate that applicants should be educated at the baccalaureate level in nursing. This finding suggested another deficiency in the system to the extent that the nursing regulations were not revised to require the BScN as the entry to practice qualification for nurses who would practise in the territory. Recognition of these deficiencies in regulating the profession in the country directed me to compare the powers of the College with those of the Council. To this end I reviewed the College's Act.

The College of The Bahamas Act, Section 8 (2) states, "the Council [of the College] shall have power… (e) to determine the programmes and courses of study to be pursued in the College; (f) to confer academic degrees and honours…." From this review, I saw no supersession of the GNC's Act by the College's. What was implied was that although the GNC had power to determine the curriculum of study in the general nursing programme, it had allowed the College to perform this role while the Council limited its involvement to participation in the Advisory Committee.

I also considered the wording of the relevant sections. While Section 4 of the Nurses Act says the Council "shall" have power to control the training Section 15 says it "may" make regulations. This wording bestows on the Council the responsibility to control nurse training with the option to make regulations pertaining to the areas for which it has been given responsibility. The evidence suggested that the Council exercised the option not to make regulations pertaining to the curriculum and other elements critical to controlling the quality of the BScN programme and of nursing service in the country. This may have accounted for some of the challenges that the nursing faculty experienced.

It is unclear whether the Council's soft approach to its duties was by choice or required by other forces. What was implied, was that while the approach allowed the College to exercise significant control over the BScN programme, it did very little to safeguard the level and quality of the programme, and to keep it on par with the quality of similar programmes in the region.

8.5 Summary of The Bahamas' engagement

The evidence suggested that the idea of delivering the pre-registration BScN programme was part of the discourse within the Bahamas since the 1980s. There is no evidence of the 2006 CARICOM decision having been disseminated in the territory. What was suggested by the responses was that the CNO received communication from the RNB about the reform and communicated the decision to the national nursing advisory committee for dissemination in the system. However, no evidence was found to suggest that dissemination occurred. This lack of evidence implied that the reform was impacted by a communication deficit in the system. In such instances policy implementation is likely to be hampered since, there needs to be effective communication between actors at the national and institutional levels for educational reform to be implemented as intended (Trowler, 2002).

The responses suggested that the faculty took the initiative to develop a pre-registration BScN in 2007. They further suggested that the system began delivering the pre-registration BScN because of concern about the quality of nursing service and nursing education, international trends, and the emigration of nurses from the system. The evidence also suggested that the implementation in The Bahamas was not a direct result of the 2006 COHSOD decision but rather, that the regional decision may have coincided with the College's decision to deliver the pre-registration BScN. Despite the dearth of evidence to support a direct link between the 2006 CARICOM decision and the territory's engagement with the reform, there is no evidence to suggest that the 1970s and 1980s RNB discourse around delivering the pre-registration BScN did not lead to the development of the 2007 programme in The Bahamas. If this occurred, it implies that The Bahamas' nursing education system, while drawing ideas from the

CARICOM nursing education system, operates parallel to the regional system rather than being integrated into it.

From the evidence it could be concluded that the RNB representatives did not engage with the implementation process. This suggested a deficit in nursing leadership. Moreover, the suggestion that there was no formal approval of the programme by the GNC or revision of the legislation, which are the Council's statutory responsibilities, also suggested a deficiency in nursing leadership. The reform process in The Bahamas appeared to have been hampered by nursing leadership deficiencies in a number of areas. But, despite the constraints, the evidence suggested that The Bahamas had implemented the pre-registration BScN since 2007. The evidence further suggested that the programme was revised in 2016, after some opposition, to facilitate the College's upgrade to university status. Reportedly, the system is now engaging in discourse about delivering postgraduate nursing education. Figure 8.2 illustrates the researcher's understanding of the pre-registration BScN reform's evolution in The Bahamas.
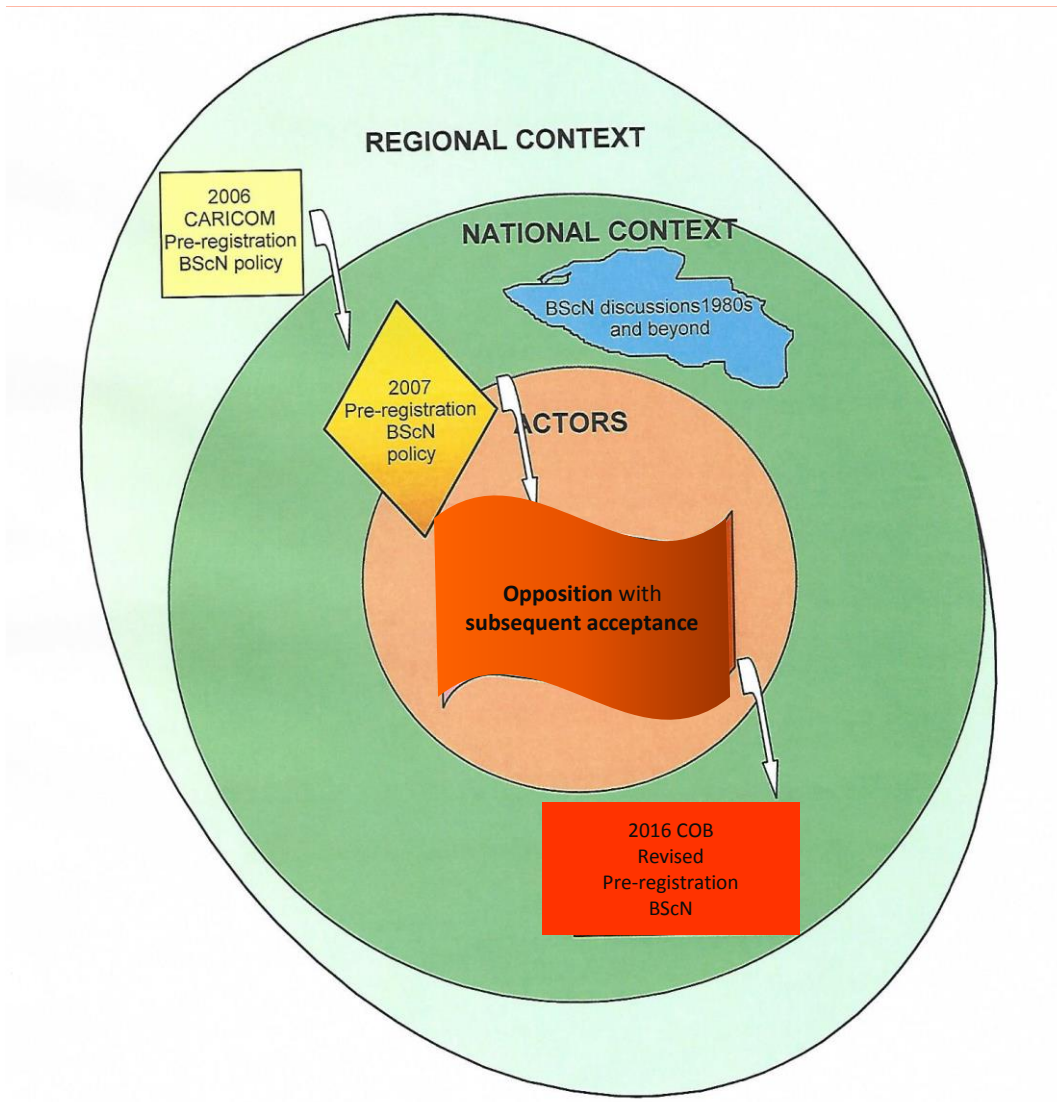
Figure 8.2: Evolution of the BScN Reform in The Bahamas

8.6 Comparison of Jamaica's and The Bahamas' reform processes

The evidence suggested that although there were some differences, the two territories had common reasons for engaging with the reform and intentions associated with the reform. Both territories had concerns about the quality of nursing education and nursing service, and were concerned about the status of the nursing profession. Other reasons for engaging with the reform that they had in common were international trends and the emigration of nurses. The evidence suggested that, in Jamaica, financial

concerns lay behind implementing the pre-registration BScN that did not lay behind the reform in the Bahamas. This finding may be attributable to the economic status of the two countries.

The findings also suggested that there was a demand for the BScN in The Bahamas. This factor was not reported to be a driver of the reform in Jamaica. It was also suggested that attaining regional reciprocity in nursing was a reason behind Jamaica's engagement but not The Bahamas'. Together, these findings suggested that The Bahamas' engagement with the BScN reform was internally driven and was not significantly impacted by the RNB agenda. This claim was also made by one of the Bahamian participants. As alluded to in the discussion on the Bahamas' reform process, this implied that, with respect to the pre-registration BScN, the Bahamas' nursing education system was operating parallel to the CARICOM nursing education system rather than operating as a part of it.

Similarities were also evident in intentions associated with the reform by participants from both territories. The findings suggested that both territories wanted to:

- improve the status of nursing;

- improve the quality of nursing service;

- improve the competencies of beginning level RNs and;

- change the way that nursing education was delivered.

However, there were also differences in their intentions. The findings suggested that participants from both territories perceived improvements in nursing education, nursing service and the status of the profession as associated with the BScN reform. However, whereas the responses suggested that there was an intention to retain nurses

in The Bahamas, this was not indicated for the Jamaica system. Similarly, whereas the reform was associated with regional reciprocity in nursing in Jamaica, no such intention was stated for The Bahamas.

Interestingly, the Bahamian participants suggested that the system anticipated achieving parity with international nursing education. This suggested that interests in the system were looking beyond regional cooperation to international relations. It was also noted that whilst participants from Jamaica suggested that the system had the intention of harmonizing with nursing education in CARICOM, this was not suggested by the Bahamian participants' responses. The differences in the responses between the two territories' participants suggested that engagement with the reform in Jamaica was driven by national and regional considerations, whilst engagement by The Bahamas was driven mainly by national considerations.

The presence of similarities amongst the territories' drivers suggested similarities in the challenges being experienced by the two systems. The evidence further suggested that the reform was seen as a viable solution to the challenges with nursing education by policymakers in both systems. This implied that a common discourse was taking place from which policymakers in both systems were drawing solutions. Given that both territories are represented on the RNB and given that the Bahamian RNB representatives implied a connection between the RNB agenda and the Bahamas' engagement, it can be concluded that the common discourse was taking place at the RNB. It can also be concluded that the common discourse then led to implementation of the pre-registration BScN in both systems but, from the evidence, it appears to be the case that the intentions were slightly different.

The evidence implied that both Jamaica and The Bahamas implemented the pre-registration BScN programme earlier than the other islands, but despite the similarities suggested, the reform's character was different in the two territories. In Jamaica, communication about the reform was multimodal and widespread, with championing of the reform emanating from RNB representatives who were also respected academics in the UWI community and the wider nursing education system. Conversely, evidence from The Bahamas suggested that the reform in that territory encountered communication challenges, and that it was the College's nursing faculty that championed the initiative. While it is evident that the reform was championed by nurse educators in both cases, the significant difference in level and influence of the two groups of nurse educators cannot be ignored. On the one hand, the champions in Jamaica were senior faculty of the regional university with significant national and regional influence. On the other, in The Bahamas' case, the champions were college faculty whose influence seemed restricted.

The evidence suggested that the scope of influence of the champions impacted on the systems' responses to the reform. In Jamaica, the initiative was accepted, received the required support, and its implementation was swift. The process was complex because it encompassed the transition of nursing education from the hospitals to the tertiary education institutions; curriculum upgrade; faculty training; accreditation; the upgrade of practising nurses; and integral interest group involvement – among other components. Despite its complexity and the deficits reportedly incurred in the rapid implementation, the system has progressed to the point of delivering postgraduate nursing education for over ten years.

On the other hand, in The Bahamas, the recent BScN programme changes reportedly encountered opposition that prohibited their realization for approximately four years. The evidence suggested that nursing leadership deficiencies in a number of areas impacted the BScN programme's implementation in this country. These included deficiencies in nursing education leadership. The changes were only accepted and implemented in 2016, to facilitate the College's evolution to a university. Notably, although the programme was implemented earlier than in most territories, it took approximately twenty years from the start of the discourse in the 1980s before the pre-registration BScN could be delivered in the territory, in 2007. Then it took another nine years before it could be revised to what was deemed acceptable for a university programme.

Reportedly, this recent programme revision was also complex. But, unlike the Jamaica process, it did not involve the transition of nursing education to the College, as that step had been taken previously. Reportedly, the system has advanced to discussing the possibility of delivering postgraduate nursing programmes. This evidence suggested that if the influence of the champions for the reform in The Bahamas was as strong as the influence of those in Jamaica, the system may have advanced to a similar position to that of nursing education in Jamaica. Presently, Jamaica's nursing education system, as reported by participants, has moved beyond The Bahamas', although not having transitioned into the tertiary education system until long after that transition was made in The Bahamas. This observation raises questions about the factors that may have impacted the reform in the two contexts and contributed to the variation in the reform's trajectory between the two countries.

The responses suggested that the main enabler of the reform in both territories was support. Leadership, interest group participation, policy fit and capacity were also considered to have enabled the reform's realization. These findings were, to some degree, consistent with the literature on reform implementation that informed the conceptual framework. However, the findings also suggested that other factors, not included in the selected literature, enabled the reform.

The occurrence of capacity amongst the enablers of the reform in both territories was consistent with the view that the context's capacity critically affects a reform's outcomes (McLaughlin, 1998 and Garn, 1999). However, whereas the authors suggested that capacity was one of the most critical factors, the findings suggested that, in these two cases, support was the most critical factor enabling realization. In these cases, the support was provided by other policies, the government, stakeholders, and leaders' networks.

Both sets of findings suggested that leadership was also a critical factor enabling this reform's realization. The predominance of leadership amongst the responses suggested its importance in the implementation of this reform. This was consistent with Bell and Stevenson's (2006) perspective that policy, power and leadership are three interdependent themes in reform implementation. The interdependence of these themes was evidenced by the differences between the implementation processes in the two systems.

Evidence of the interdependence amongst policy, power and leadership was found in the contrast between the effects of the leadership demonstrated by the UWI nurse

educators, and the effects of the leadership demonstrated by the COB nurse educators. The findings suggested that the UWI nurse educators had more influence in their nursing education system than the COB's nursing faculty had in theirs. The findings further suggested that the UWI nurse educators' strong influence on their system contributed to acceptance of the reform. In contrast with this observation, the findings suggested that, in The Bahamas, the COB nursing faculty's championing of the BScN programme's revision was met with strong opposition that stalled progress in implementation. These findings implied that the reform's trajectory was significantly influenced by the exercise of leadership, and the relative power of those who exercised that leadership in the reform process.

The evidence suggested that The Bahamas' BScN programme revision gained traction only when it fit with the College's agenda to transition into a university. The findings also suggested that Jamaica's pre-registration BScN policy was, in the case of BTCC, enabled by that College's agenda to deliver a BScN programme. These two occurrences exemplified the influence of the policy's fit with the institutional contexts on its implementation. The participants' responses suggested that policy fit was an enabling factor in both contexts. These findings were congruent with Spillane et al.'s (2002) observation that a policy is more likely to be implemented when it fits with implementers' and their institutions' agendas.

The findings further suggested that interest group participation enabled the reform's implementation in both contexts. However, the accounts suggested that there was more interest group participation in Jamaica than was reported in The Bahamas. In The Bahamas' case, where such participation appeared to be minimal, the reform

process was stalled, and the system's advancement was slow. However, from the evidence, it appears to be the case that in Jamaica, where there was copious interest group participation, implementation occurred faster and the system has advanced beyond The Bahamas' system. These findings implied that interest group participation was key to the reform's trajectory. This observation is congruent with Lukes' (1974) perspective that interest groups can work to realize policies' intentions. Table 8.1 compares the reform's enablers, by territories.

Table 8.1: Early Engagers' Reform Enablers

Jamaica	Bahamas
1. Support	1. Nursing leadership
2. Leadership	2. Capacity
3. Collaboration	3. Commitment
4. Networks	4. History
5. Capacity	5. Policy fit
6. Interest group participation	6. Support
7. Policy fit	7. Interest group participation
8. Financing	
9. History	
10. Community need	

The factors identified by participants as constraining the reform, in each territory, were also compared. Those not deemed to have impacted the institutional or national contexts were omitted from comparison at this stage. The evidence suggested that only constraint that was common to both contexts was conflict. Interestingly, conflict was identified as occurring amongst working groups of nurses in both territories – between

factions in the department of nursing in the College of the Bahamas; and between the GNC and other nursing groups in Jamaica during collaboration for the transition. The difference between the two cases, on this issue, was that the conflict in the Jamaica transition process was reportedly controlled by the bureaucratic leader. Whereas there were no reports of attempts to control the conflict in the nursing department of the COB by any leadership figure. In fact, what the evidence suggested was that the conflict was between the educational leader for the department and the faculty; and it was further suggested that the leader imposed her will by resisting the change for a protracted period. Table 8.2 illustrates the factors that constrained the reform's realization in the two territories.

Table 8.2: Early Engagers' Constraints

Jamaica	Bahamas
1. Inadequate capacity	1. Nursing leadership deficiencies
2. Financial insufficiency	2. Political interference
3. Emigration of nurses	3. Conflict
4. Conflict	
5. Applicant deficiencies	
6. Lack of commitment	

The failure to make the necessary legislative changes to actually establish the BScN degree as the entry level qualification for nursing practice was evident in both territories. While the evidence shows that pre-registration BScN programmes have been established in both territories, it also shows that the reform has not been implemented as intended by the RNB, to the extent that neither system has actually

established the BScN as the entry to practice qualification for nursing. As it stands, it appears to be the case that neither territory has demonstrated full compliance with the COHSOD decision, as there is no evidence to suggest that the necessary legislative changes have been made. This situation threatens the permanence of the reform in the territories and will therefore be addressed further in the thesis. The following chapter describes the findings from the late engagers with the reform – Barbados and St. Kitts/Nevis.

Chapter 9

Late Engagers: Barbados and St. Kitts/Nevis

9.1 Nursing education in Barbados

General Nurse training in Barbados is currently conducted through the Barbados Community College (BCC). The BCC is part of a mainly government-funded tertiary education system that also includes a polytechnic, a teachers' training college, and the Cave Hill Campus of the UWI. A number of private institutions, including offshore universities, operate in the system (Ministry of Education and Human Resource Development, 2012).

Nursing education was transferred to the College from the Ministry of Health in 1986, following which the associate degree was awarded up to 2015. In 2015 the BCC, a degree-granting institution, commenced delivering the pre-registration BScN. This is the background against which Barbados' engagement with the CARICOM BScN reform was examined.

9.2 Barbados' empirical findings

The following sections present the findings from six interviews with participants from Barbados. The participants were:

- two former Permanent Secretaries of the Ministry of Health, designated Bureaucrats B and C;

- one former RNB representative, designated Representative E;

- two education administrators, designated Administrators B and C; and

- one nurse educator, designated Nurse Educator C.

Following are the findings.

9.2.1 Why BScN reform in Barbados?

The responses suggested that there were nine reasons behind the reform in Barbados. Identifying two reasons behind the reform Representative E said, "…basically the shortage of nurses and international trends in nurse training." Other responses were similar. Nurse Educator C stated,

> "Financial reasons…it was about maximizing output for governments with minimum input due to governments' financial challenges…. also, the exodus of a lot of nurses from the region …another issue was the standards of practice. The aim was to ensure that our standards would be aligned with global standards."

This comment suggested that containing training costs, nurse emigration and concern about the quality of nursing service were behind the reform. Collectively, the responses suggested that international trends, concern about the quality of nursing service and the emigration of nurses were the top three reasons behind the reform. Table H1 in Appendix H lists the reasons for Barbados' engagement with the reform.

9.2.2 Barbados' reform intentions

The evidence suggested that there were thirteen intentions associated with Barbados' engagement with the reform. The thirteen aspirations attached to the reform in this territory focused on improvements in nursing service, nursing education and nursing's status. In response to the question about "what goals, plans and expectations were attached to the reform" Bureaucrat C stated,

"Primarily to improve the standard of nursing care so that we would be

sure that the patients across the region are treated in a similar manner…

to raise the profile of nursing … for nurses to reach a level of education

where they can essentially function as independent practitioners if the

requisite legislation was put in place…"

Representative E said, "To increase the standard of nursing in the region."

Nurse Educator C responded, "Upgrades to the clinical infrastructure and skill

sets for Barbados." Other responses were similar. These and the other

responses suggested that improving the standard of nursing service, the

competencies of nurses, and the status of nursing were the main intentions

behind the reform. The remainder of the intentions are listed in Table H2 in

Appendix H.

9.2.3 Barbados' BScN reform components

The accounts suggested that the reform process in Barbados was multifaceted.

Components included changes in the delivery of nursing education, changes to the

RENR, infrastructural and curriculum upgrade, and the upgrade of practicing nurses.

The following responses were given to the question "what did the reform encompass?"

Bureaucrat C said, "…it encompassed a serious look at the curriculum and trying to

bring the curriculum to a standard that would see nursing being parallel with similar

professions in the region." Representative E said, "Moving to degree status, upgrading

the clinical areas and upgrading the tutors to be qualified at no less than Masters'

level." Nurse Educator C responded, "The structure of the RENR, the positioning of

nursing academically and clinically – moving everyone to bachelors." Bureaucrat B

responded emphatically that it involved, "Recognition by powers in the region that nursing had a high degree of criticality and was not to be treated like the underdog of the medical profession but that it had to be elevated to a place of equality at the table of health." These responses implied that the reform encompassed not only changes in the delivery of nursing education and upgrades to various inputs into nursing education, by an ideological shift in the region regarding the value of nursing.

Other components highlighted by the responses included the transfer of nursing education from hospitals to tertiary education institutions; revision of the national nursing legislation; continuing education for nurses; and recruitment of staff. The full list of components is presented in Table H3 in Appendix H.

9.2.4 Barbados' BScN policy evolution

Participants were asked how the reform was communicated to their territory and institution, and what guidelines accompanied or followed the reform. The responses suggested that discourse and activity around the pre-registration BScN were underway in Barbados well before 2006. Participants were also asked to describe the actions that their organisation took in relation to the reform, recall the associated timelines and give reasons for the actions. Their responses suggested that the reform process entailed collaboration, lobbying, opposition, disregard, selective attention, and eventual acceptance. As with any reform process, leadership was integral but, the effectiveness of its execution was questionable. The following sections examine the interactions that took place to implement the reform.

9.2.4.1 Communication and guidelines

The evidence suggested that the 2006 decision entered the country through multiple sources and went to multiple recipients using multiple modes. Reportedly, the modes of communication included meetings, minutes, reports, letters, policy papers and discussions. The responses suggested that the communication was both formal and informal, and came from the CARICOM Secretariat, Minister of Health, CNO, PS in the Ministry of Health, and the President of the NNA – who was also President of the Caribbean Nurses' Organisation at the time. Reportedly, the meetings included Ministry of Health meetings, those of the GNC, College Nursing Advisory Committee meetings, Nursing Department and Divisional meetings at the College, and meetings of the NNA's Executive with the Minister of Health. Bureaucrat B recalled,

> "There was very powerful advocacy from the nurses themselves from people like Mrs._____ , who is now Dr._____. It was communicated to Barbados through the COHSOD network…to Cabinet and incorporated in cabinet papers and policy papers... All of the decisions with respect to our nurse training would have been put in Cabinet papers… It was communicated to BCC through meetings and writing to the Principal…"

Bureaucrat C explained, "…from CARICOM the Minister would have to adopt it and bring it back to Barbados. The CNO attends RNB meetings but a decision as important as this one would definitely have to come through the Minister and the Minister would state the policy position…it would have been adopted at the level of the Minister first and then he would have instructed the Permanent Secretary to pursue the policy implementation." Administrator C responded, in part,

"There would simply have been a note to the Ministry. I'm not sure but I suspect it would have come to the Ministry of Health or Education. It was never communicated in an official way. It would be said at meetings either at Advisory Committee or Ministry meeting. It was quite informal. As _____, I don't recall getting an official document that says we should be moving towards a bachelor's."

The responses from Bureaucrat B and Administrator B implied a communication gap between the Ministry of Health and the Division of Health Sciences regarding the reform. To the extent that Bureaucrat B stated that the decision was communicated in writing to the Principal of the College, and Administrator B stated that "no official document" was received, it suggested that there was either a breakdown in communication about the reform between office of the Principal and the Division of Health Sciences, where nursing is delivered; or that the Administrator did not accept the communication received because it was not deemed to be "official". Collectively, the responses suggested that the Minister of Health, the GNC, the Cabinet of Barbados, the Principal of the College, the Senior Tutor of the Division of Health Sciences, and the nurses all received information about the reform.

Additionally, communication was reportedly both bottom-up and top-down. Bureaucrat B clarified the flow of communication between COHSOD and the territories – with special reference to Barbados. He explained,

"…, remember that although we talk about COHSOD down, it's not only COHSOD down, it's from Ministry up to COHSOD too! COHSOD is the aggregation of the Ministries of Health and Education at that level. So, it's not that COHSOD is a supranational institution

that dictates to the Ministry of Health. It is that COHSOD was formed

by these people, and the conclusions that COHSOD comes to are based

on the inputs of the Ministries of Health and the consensus which is

reached at that level… I'm saying that there was an awareness within

the Health Sector in Barbados that this is what we needed to do – to

teach nursing at the degree level… we had general awareness and

agreement. Then when we met at COHSOD there would have been

general agreement at that level and they took it to the Heads of

Government."

This response suggested that Barbados proposed the delivery of the BScN degree

programme at COHSOD and sought consensus at that level for the regional

implementation of the programme. Given that the outcomes of a reform are linked to

how it is communicated (Psacharapoulos, 1989), the impact of this multi-directional

communication strategy will be considered further in the discussion.

The participants' responses regarding implementation guidelines for the 2006 reform

were varied. Some responses suggested that institutional actors either did not know of

any implementation guidelines related to the reform or, lamented that none were given

and had to be developed by the College. Administrator B reported, "There were no

guidelines. We took the initiative to look at the UWI system and the US system. Even

things like nursing standards were never really sent to us." This comment suggested

that the participant held the expectation that implementation guidelines should have

been supplied to the College from an outside source. The bureaucrats and RNB

representative, on the other hand, seemed accepting of the fact that guidelines were

not "supplied" to the College. Representative E even seemed annoyed at the question

on guidelines – as if that was a contentious issue. Regarding the issue of guidelines Bureaucrat C stated simply, "We formulated guidelines locally." In response Representative E retorted,

> "I think the guidelines were in the decision that was taken – the information about the clinical coordinators and all that. But if you know you have to implement a bachelors' programme, the Heads of Government may not give you everything; they may give the policy, but then it is the College to set the guidelines. RNB developed a model curriculum for the BSc. It doesn't mean you have to take it wholesale but at least you have a guide. The model curriculum was out long before Barbados implemented."

This response suggested that broad guidelines were provided, and the expectation was that specific implementation guidelines would be developed locally. The responses of Administrator B and Representative E suggested that there was a difference of opinion regarding whether guidelines were given, and what constituted implementation guidelines. This implied that there was some conflict in the system regarding how the programme should be implemented, and who should lead the implementation. The issue of conflict in the system will be elaborated in the following section because it has implications for the reform's realization.

9.2.4.2 Collaboration, lobbying and conflict

The responses suggested that collaboration started early in the process, back in 2000, when the nursing faculty worked with PAHO to develop the first curriculum for the BScN. Nurse Educator C explained, "There was a decision made a long time ago that Barbados was moving to the BScN in 2000… With the original decision BCC allowed

staff to have time and continuing education in curriculum building…with PAHO." This comment suggested that BCC partnered with PAHO to develop courses for the BSCN programme that was to commence at the College in 2000.

Nurse Educator C continued, "In 2002 BCC moved to the semester system. Between 2004 and 2006 we started to talk of the University College of Barbados and the emphasis was on trying to fit the Department in that structure… I think that at one point there was lack of appreciation for the contribution of the staff and our voices were not being heard." When asked why she thought that things had turned out this way, Nurse Educator C responded, "Change in administration and personal preferences of administrators." These comments suggested that there was a change in administrators for nursing education in the College during the period and, with that change, there was a change in agenda and loss of focus on the BScN.

The responses further suggested that during the period when the College's focus shifted from the BScN, there was a strong lobby from the NNA for the BScN. The reader should note that the President of the NNA at the time was simultaneously a member of the College's nursing faculty and the President of the Caribbean Nurses' Organisation. As such, the individual was the Caribbean Nurses Organisation's RNB Representative and therefore had opportunity to participate in the reform process at the regional, national and institutional levels. Bureaucrat B recalled the process this way,

> "There was very powerful advocacy from the nurses themselves from
>
> people like Mrs. _____, who is now Dr. ____… Between 2002 and
>
> 2004 we had consultations with stakeholders as I mentioned earlier like

> PAHO, etc. The matriculation requirements and qualifications for entry were set after my time in office. Mostly what took place in my time was the consultations… We engaged in consultation because we felt that the quality of decision-making improves when you broaden the circle of involvement… The consultations were either informal or took place through the monthly management meetings of the Ministry. Nursing always figured prominently in that. We had meetings with nursing and the BCC. We had big arguments with Miss _____..."

This response suggested that the President of the NNA led the lobby for the BScN at the national level. It also suggested that there was conflict between the Ministry and the College's newly appointed administrator for nursing education, regarding the BScN programme.

Bureaucrat B's explanation continued,

> "Okay, so there was the COHSOD decision that went to Heads of Government. Then we took that decision to Cabinet. In the Ministry we consulted with the various stakeholders, the planning unit and administrative staff were brought on board with us to meet as a team with BCC. I told Miss _____ that "we are instructing you to deliver this programme because the government and people of Barbados fund the BCC's programmes." I reminded her that this is the policy of the government and so it has to be implemented…if necessary our Minister would have reported to Cabinet on her opposition."

This response indicated that there was strong opposition to the BScN coming from the newly appointed education administrator, to the point that the PS considered that the opposition may have needed to be reported to Cabinet.

Administrator B recalled what took place at the institutional level, in part, this way,

> "Not a whole lot. There were discussions with the GNC and the Barbados Nurses Association (BNA). The BNA was concerned about the delay more than anything else… they were concerned about how long it was taking to get it implemented. In 2009 we had a draft curriculum and discussed it at Advisory Committee. From then on we had set up a few committees in the Department to look at the curriculum and make recommendations on that. There was just backward and forward from then on. We had the internal departmental discussions and that's it really. The process was really very slow…I had personal concerns about what you do with the post-basic programmes that we offer now that you're doing a generic bachelor's. So when you offer a bachelor's, are you going to upgrade them or are you going to keep them at the same level? And that was a discussion that I kept trying to engage in but nobody would take me on…"

This comment suggested that the administrator had concerns regarding the implications of delivering the BScN, and that the interest groups had concerns regarding the delay in delivering the BScN. It also suggested that there were symbolic responses being made with respect to having the curriculum reviewed by numerous committees after it was presented to the Advisory Committee. Collectively, the responses suggested that the College's education administrator opposed the delivery

of the BScN, and that the opposition was allowed to stall the implementation of the programme.

9.2.4.3 Ineffective leadership and policy disregard

Administrator B's response regarding the College's implementation process suggested disregard for the policy at the institutional level. Her comment continued, "…Yes there's discussion…but in terms of saying look this is what we really need to do, I find that's still missing." This comment suggested that this institutional leader was looking for leadership from an external source to guide implementation in the educational institution. When asked what took place at the College in relation to the reform Administrator C said, "Curriculum revision…I'm not sure of other steps." This response and Administrator B's admission of "not a whole lot" happening confirmed that there was some disregard for the reform in the College and suggested an absence of institutional leadership for implementation.

Nursing leadership also appeared problematic. Responses suggested that the focus of nursing leadership was on peripheral activities but little, if any, was applied to guiding implementation of the programme. According to Bureaucrat C, "The Ministry always wanted Council to push the reform forward… spending so much time doing auxiliary exams distracted Council from the reform process." Notably, multiple assignments were given to the GNC. The same participant stated, "The Council was asked to review the legislation and…advise on the curriculum….Continuing education was charged to the CNO and the Council to develop the system to ensure that nursing education remained at a fairly high standard. So those were three major areas." From this response it became evident that the GNC, had three major areas of responsibility with

respect to the reform. Yet, as indicated earlier, Council concentrated much energy on nursing auxiliary examinations at the expense of nursing education reform. This brought into question the feasibility of accomplishing all of these tasks in a timely manner, and the capacity of the Council to execute the given assignments.

In an apparent attempt to allocate blame for the stalling of the reform on the nursing leaders Administrator B stated, "…there was no strong coordinated approach by the nursing profession itself." As if conscious of the allocation of blame, during our one-on-one interview Representative E emphasized, "The College would have to push it. The Ministry of Health can't push that. Nursing education is under education not the Ministry of Health. Health can only recommend." These comments implied that while Representative E saw implementation as the responsibility of the College, Administrator B expected that drive to come from the nursing leaders. Given that the responses suggested that the Nurses Association was lobbying for implementation from 2000 and through the period of impasse, as mentioned by Administrator B, the comment implied that the participant expected the nurses to push even harder to have the BScN implemented.

The reader should be aware that although the participants' responses referred to the GNC, the College's administrators, faculty and the NNA as separate bodies – which they are – the reality is that some of the members of these bodies were also key policy actors in the implementing organisations. For example, the Senior Tutor of the Division and the Head of the Nursing Department, two of the College's administrators, were members of the GNC – which was chaired by the CNO. Interestingly, during the

period when the implementation was stalled, Barbados' CNO was Chairman of the RNB, and Barbados' representative on RNB.

Yet, the evidence suggested that the key positions these actors held did not augur well for implementation on the island. The evidence implied that the absence of strong leadership allowed the conflict to stall the implementation process. Notably, the data didn't indicate the College Principal's contribution to the implementation process. However, the suggestions that a College administrator's opposing viewpoint was allowed to hinder the implementation of this government policy, implied that leadership in the College did not take up the challenge of implementing the policy. The reader should note however, that the College's Principal did not participate in the study. It is possible that the Principal may have held different views on leadership in the reform's implementation, had he been a participant in this study. Nevertheless, from the evidence provided it can be concluded that leadership team members did not attend to the implementation of the reform.

9.2.4.4 Selective attention

 The responses suggested that at least one BCC administrator touted engagement with the reform to procure resources for the College, despite the College's opposition to the reform. Administrator B continued her explanation of the reform process by saying,

> "Honestly, BCC didn't do much to address it … I think legislation would have made it easier to move forward in a planned way….We know that a decision at CARICOM is really a decision in principle and governments still have to enact it. And some governments may say

"yeah we're gonna do it" and others may say "no we're not gonna do

it"."

This explanation implied that the administrator deemed implementation unnecessary until there was evidence of transposition into municipal law – despite the articulation of a ministerial policy. The participant went on to say, "…it was like a mantra…we kept saying all the time that we're moving towards a bachelor's so that they would give us the equipment and staff and facilities that we need…" This comment implied that in negotiations with the Ministries, the College would present delivering the bachelor's programme as a goal in order to secure resources. This further implied that the College was giving selective attention to the policy through making symbolic responses but was not meaningfully advancing towards implementation.

The responses suggested that sometime between 2013 and 2015, the College received a mandate from the government to deliver the BScN programme. When asked to reconstruct what took place in her organisation to realize the reform, Administrator C stated, "Well, we received the directive from the Senior Tutor." In response to the same question, Bureaucrat C stated, "Well, when I took over in 2013 we were just floundering so I kept insisting that we need to move the process along…I mandated that this thing must start." Administrator B stated, "We upgraded to the BScN in 2015."

When asked what enabled the reform in her territory Administrator B stated, "Political pressure on BCC to offer the BScN from the Ministry of Education and the Ministry of Health. They didn't want to be left out because other territories in the region were moving." This response implied that without Ministerial intervention, movement

toward implementation would not have ensued when it did. Collectively, the responses suggested that it was a government mandate, from both the Ministry of Health and the Ministry of Education that pushed the BCC to implement the programme. Notably, when only the Ministry of Health was issuing the directive, the BCC was able to stall implementation. But the coordinated approach between the Ministry of Health and the Ministry of Education - the BCC's parent ministry - resulted in forced acceptance and implementation.

Participants were asked why they thought that the process transpired in the way it did. Bureaucrat B's response suggested that he blamed BCC's ideology about nursing for its opposition to the reform. He stated,

> "…nursing was new to BCC. They felt it was being inflicted on them. I don't think there were many people in there sufficiently knowledgeable about the importance of nursing. They tended to look down on nursing. BCC questioned if the budget would be sufficiently expanded or be compromised because of the inclusion of nursing… nursing unfortunately still resides in the kitchen of that palace… we need to move towards the stage where there is a faculty of nursing with leadership provided by nurses."

Referring to the gradual change in the College's response Bureaucrat C stated, "People had been in charge of areas and programmes for a long time and it was challenging…to give up some power….that was one of the crippling things." Administrator C responded, "I thought the CNO and Council could have been more involved to get agreement from the beginning but I don't know if the College structure allowed for that." In response, Nurse Educator C stated, "The changes in BCC e.g. the

structure, divisional head changes and departmental head changes hampered our progress. The exodus of senior teaching staff also hampered our progress." Administrator B responded, "There was a lack of strategic direction. I think legislation would have made it easier to move forward in a planned way." Representative E did not respond to this question. In fact, Representative E did not respond to any questions after being asked about the impact of the reform guidelines.

The responses suggested that most of the participants saw factors associated with changes in the College, leadership and capacity as influencing the implementation process. The following sections examine more closely the participants' perceptions regarding the factors influencing the reform's realization.

9.2.4.5 Reform enablers

Participants identified ten enablers of the reform. Their responses suggested that interest group participation, political will, policy fit and ideology were the top enablers of the reform. The first three of these were viewed as operating at both the institutional and national levels. Ideology was regarded as enabling the reform at the national level.

Interest group participation was cited seven times as impacting the reform. In this case, this factor related mainly to nurses' actions and the involvement of the NNA. Regarding this factor changing public perception and impacting the reform Bureaucrat B said, "It is only now where nurses are beginning to assert themselves, and where they are doing their training and where people are giving them more voice, that we are coming to a recognition of the importance of nurses…." Administrator B said, "There was a regional push on BCC to offer the BSN…graduates were always asking…."

This comment suggested that the demand that regional nurses placed on the BCC to deliver the BScN enabled the reform's implementation.

Political will was also highlighted as a top enabler, operating at both the national and institutional levels. Administrator B's comment about this in the previous section supported this claim. Additionally, Bureaucrat B explained, "…there was mainly external propulsion because the Ministry leaned on BCC and mandated BCC to offer the Bachelor's degree." These comments illustrated the Government's insistence on implementation, after sustained opposition and disregard by the College.

Policy fit was also regarded as enabling the reform. Administrator B stated that one of the enablers was, "BCC wanting to raise its profile and attract students from across the region." Nurse Educator C said, "We saw offering the BScN as giving the College a competitive edge." These comments suggested that eventually the College's administration perceived that delivering the programme would benefit the institution and this made implementation more acceptable.

National ideology was also regarded as an enabler for the reform. Administrator C stated, "Barbadians are pro education so we always want to ensure our people have a high standard of education." Bureaucrat B said, "There is a propulsion that comes from the expectations of our people. Our people want the best…." Interestingly, although this factor had the fourth highest frequency among the enablers, it also had the fourth highest frequency among the reform constraints. This, and the associated comments, suggested that there was a tension in the national ideology between educational achievement generally, and the educational achievement of nurses. The findings

suggested that this tension constrained the reform by contributing to the implementation delay. Table H4 in Appendix H displays the participants' perceptions of the reform's enablers and the context levels they impacted, but additionally, participants shared what they saw as reform constraints.

9.2.4.6 Reform constraints

Participants identified thirteen factors that hindered the reform. Only one, nationalism, was cited as impacting the regional level. Bureaucrat C, who expressed annoyance at this factor stated,

> "Some countries in the region actually offer a separate registration from the RNB. They have parallel registration systems. Of course the people shouldn't be employed other than in that country…the registration is not valid as a regional registration but it happens. I mean I won't call the name of the country but it is a country that is very prominent and at regional meetings they have made no bones about the fact that they have their own registration. They do RNB exam as well but you can choose not to do it. Or, if you fail that three times or whatever, you still get their local registration. That is one of the challenges you have. So when somebody presents and says I'm a nurse in this country you have to be sure that the person has actually passed the regional exam."

This comment suggested that nationalism permitted the persistent fragmentation of nursing in CARICOM. The comment further suggested that the ideology and the pursuant practices threatened the quality of nursing service in the region. The issue of nationalism and its implications for nursing in CARICOM will be explored further in Chapter 11.

The majority of constraints were cited as impacting both the institutional and national levels of the context. This suggested deficiencies in the system that hindered implementation. History, inadequate capacity, leadership deficiencies and ideology were the top four constraints identified.

History was described as affecting both the national and institutional levels of the context. Regarding this factor Bureaucrat B said,

> "…we started planning for this since 2002 in Barbados, but you know, we have a sort of dynamic inertia. We have the ability to think critically and come up with ideas but implementation is where we fall down and sometimes our tendency is to say what can't be done as opposed to how best and how quickly we can get this done. We are very slow in implementation… Also, in Barbados we are very majoritarian - even if the view is not right the majority must always prevail! And because the majoritarian view in Barbados was that the doctor is the most important person in the health profession that prevailed for the last few hundred years."

This comment suggested that Barbados' history of implementation deficit and the history of doctors' supremacy on the island constrained the reform. The positioning of nursing in the College when it transferred from the Tercentenary School of Nursing in 1986 was also a concern. Bureaucrat B continued,

> "I'm concerned that when nursing moved into BCC it was made a department in Health Sciences. I think in 2016-2017 we should be moving towards making nursing a faculty in the BCC and not a

department… But we missed that opportunity because in the healthcare

sector in Barbados, a lot of what we do is doctor driven… nursing

unfortunately still resides in the kitchen of that palace."

The participant linked doctors' historical influence over nursing education in Barbados

with the position of nursing in the College and to the institution's response to the

reform. Administrator B noted,

"Bachelors' programmes are still new to the institution. I don't think

the institution had or has a whole lot of experience with implementing

bachelor's programmes. So for me, as the person who was responsible

for implementation, I did not have a cohort of persons to support me in

getting this done. And I don't think it's that people didn't want to do it,

it's because they didn't have the experience."

This comment suggested that the College did not have a long enough history

with baccalaureate programmes to facilitate its delivery of the BScN. It further

suggested that the institution did not have sufficient capacity to implement the

programme and raised the question of whether nursing and the BScN

programme were aptly placed in the BCC.

Inadequate capacity was also frequently cited as a hindrance of the reform. In this

instance capacity related to institutional capability. One participant commented, "The

reform did not take place as quickly as one would have expected … at the BCC there

were some quality issues that had to be resolved before Barbados could implement."

This comment suggested that the BCC may not have been the most appropriate

institution in Barbados for delivering the BScN programme. Explaining what she saw

as constraining the reform Nurse Educator C commented, "Changes in administrators

in the Department – we had about five heads in a three year period…then there was a change in the Divisional Head. Also, quite a number of senior educators were lost." These comments suggested that the College's capacity to implement the BScN was compromised by a number of factors. The impact of inadequate capacity will be examined further. But these findings strongly implied that the College may not have been the best institution from which to deliver the BScN programme.

The evidence suggested that leadership deficiencies also constrained the reform in Barbados. The responses implied deficiencies in both nursing and educational leadership. Reportedly, these deficiencies impacted the institutional and national levels of the context. When asked what he would say constrained the reform at the national level Bureaucrat B stated, "The leadership at the level of the Principal and the Health Sciences Division… at BCC we need to have a level of empathetic realization. Our choices for leadership over the years has been a problem… we need leaders who are visionary, good managers, but also implementers…" Bureaucrat C implied the deficiency by saying, "There was a lack of leadership at the operational level." Administrator B stated, "There was no internal drive from BCC…" These comments suggested that the participants perceived leadership deficiencies to have hampered the reform. Participants represented their disappointment at the decisions executed in relation to the reform. However, as previously indicated, the Principal might have given a contrasting account, with attendant reasons, had he participated in the study. Nevertheless, given the participants' concern about leadership in the process, this factor will be explored further in the thesis.

Ideology was cited as having impacted the reform at the national and institutional levels. As stated previously, the institution's ideology about nursing was implicated. But national ideology was similarly implicated. When asked what constrained the reform Bureaucrat B said, "…the legacy of the hierarchy in health where the doctor was always at the top…" Nurse Educator C explained, "…the vision of nurse leaders about the reform was limited. They had a short-sighted approach as to how their institutions could incorporate the reform." These comments suggested that the national ideology about the doctor's position relative to that of the nurse's, and the limited vision of the nurse leaders constrained the reform's implementation. Table H5 in Appendix H provides the full list of constraints identified.

9.2.4.7 Barbados' document findings

The Barbados Nurses Act, 2008, the Barbados Nurses Rules, 2008 and the Barbados Community College Act, 1968 were analysed to triangulate with the interview findings. The analysis revealed that while the College is permitted to prescribe the subjects of instruction, it is the GNC that has the responsibility to approve the curriculum. This implied that the Council and the College needed to collaborate to develop the curriculum. It further suggested that the College should have consulted the Model Curriculum supplied by CARICOM, which was developed by the regional GNCs and nurse educators, to guide its second round of curriculum development towards designing courses for the BScN programme.

The findings also revealed that although the Nurses Act and Rules were revised in 2008, no provision was made for establishing the BScN as the entry to practice qualification. This finding is consistent with the findings from reviewing the nursing

legislation of the previously reported case territories. As stated earlier, this has implications for the permanence of the reform, and so will be discussed further.

The document findings supported the claim that the College could legally grant degrees. This provision was made when the College's Act was amended in 1990. However, the participants' responses suggested that the College did not have sufficient capacity to implement the BScN programme. This implied that the College, although legally permitted to deliver baccalaureate degrees, may not have been the best institution to implement the programme.

It is noteworthy that the UWI has a campus in the territory, and was only consulted briefly regarding curriculum development for the BScN. Furthermore, it is noteworthy that the Government of Barbados pursued delivery of the BScN through the BCC rather than through the UWI – even against strong, protracted opposition from the BCC itself. These findings recalled the issue of the national ideology regarding nursing education that was so strongly articulated by Bureaucrat B. Did the national ideology prevent the local policymakers from considering that the BScN should be delivered through the Cave Hill Campus of the UWI? What prevented, or prevents, the Cave Hill Campus from delivering the BScN in Barbados to service the Barbadian and wider Eastern Caribbean population? These questions will be considered further in the thesis. Forthcoming is the summary of the reform's evolution in Barbados.

9.3 Summary of the BScN reform's evolution in Barbados

The evidence suggested that the CARICOM BScN reform not only entered Barbados through multiple modes and went to multiple recipients; but that Barbados was at least

one of the member states that proposed the policy to COHSOD. The evidence further suggested that there was conflict amongst local policy actors regarding the implementation of the reform on the island, and that this conflict was allowed to persist and delay the implementation process. This finding contrasted sharply with the treatment of conflict by the bureaucratic leadership in the Jamaica reform process and suggested that stronger bureaucratic leadership in this instance may have permitted earlier, or at least smoother, implementation.

The evidence further suggested that interest group participation was the main enabler of the reform in Barbados. However, it seems to be the case that the enablers were countered by an institutional history and inadequate capacity that constrained progress in implementing the programme. Examination of the reform process in Barbados suggested a tension between the society's educational values and its ideology on nursing education – particularly at the College level. The fact that responses indicated minimal involvement of the UWI Cave Hill Campus in the implementation process suggested that the ideology may extend beyond the College to the Cave Hill Campus of the UWI. Again, this finding is in sharp contrast to the involvement of the Mona Campus of the UWI in implementing the reform in Jamaica. The implications of these findings will be explored further in the thesis.

The evidence further suggested that leadership deficiencies in numerous areas hindered implementation of the BScN programme. The responses suggested that the policy was accepted, because of Ministerial intervention, only after an extended period of opposition, disregard and selective attention from the implementing institution. This implied that leadership deficiencies hindered the programme's implementation

significantly. The evidence indicated that the pre-registration BScN finally commenced at the BCC in 2015. Figure 9.1 illustrates the reform's evolution in Barbados, as understood by the researcher.
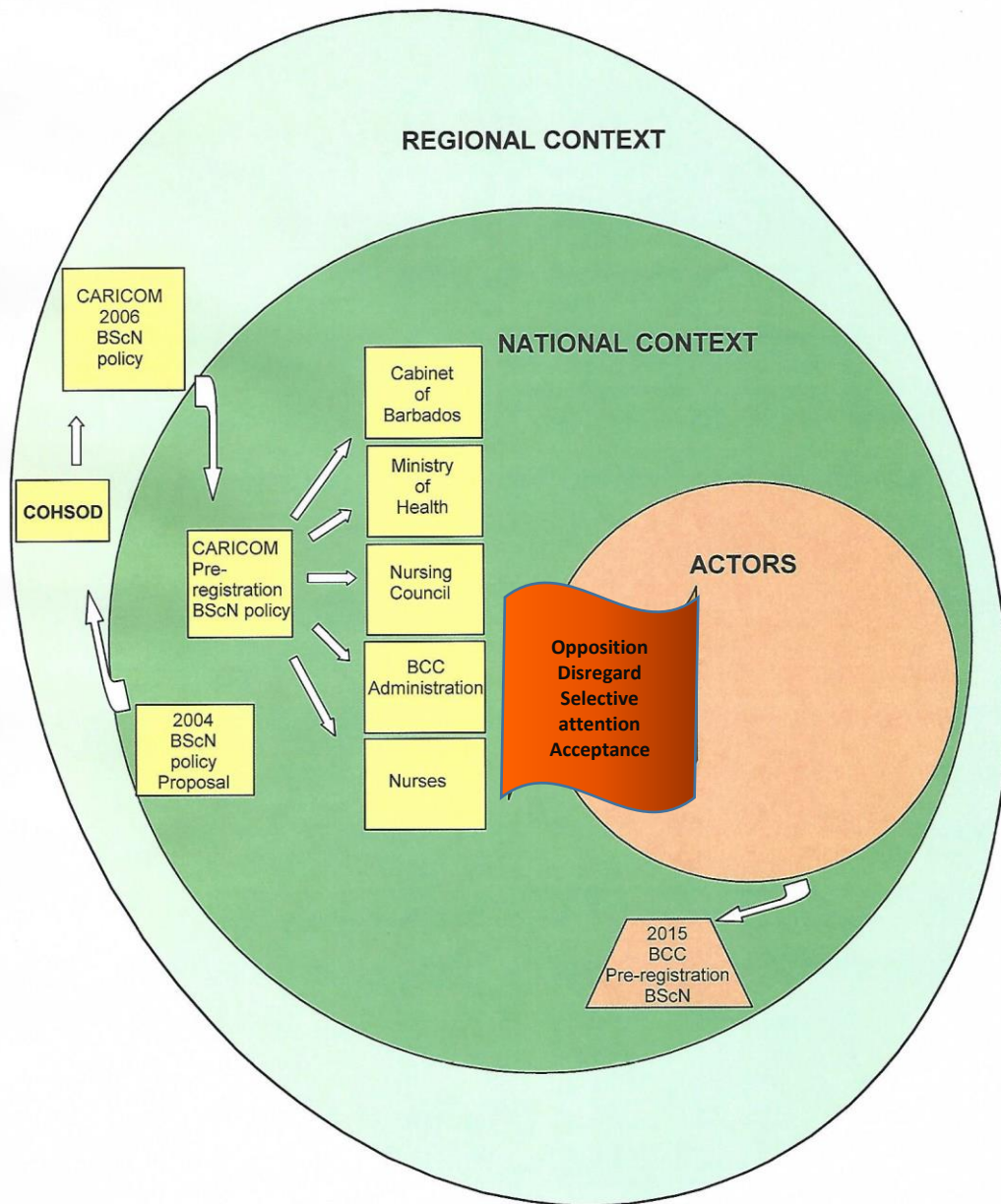
Figure 9.1 Evolution of the BScN Reform in Barbados

9.4 Nursing education in St. Kitts/Nevis

Nursing education in St. Kitts/Nevis is delivered through the Clarence Fitzroy Bryant College (CFBC), the only national tertiary education institution in the twin-island

state. The tertiary education system also encompasses an Extra-Mural Department of the University of the West Indies and a number of offshore universities.

CFBC's management is guided by cabinet decisions and Ministry of Education directives. There is no legislation governing the College's structure and function (Gittens, 2005). The system is challenged to provide its secondary school graduates with access to tertiary education (UNESCO, 2016).

9.5 St. Kitts/Nevis empirical findings

The following sections present the interview and documentary findings from St. Kitts/Nevis. The participants from St. Kitts/Nevis were a former PS in the Ministry of Health, designated Bureaucrat D; and two educational administrators, designated Administrators D and E. One of the educational administrators also represented the territory at the RNB for an extended period and as such, would have been exposed to both national and regional activities and decision-making related to the reform. The other educational administrator also had a background in nursing.

9.5.1 Why BScN reform in St. Kitts/Nevis?

The evidence suggested that the main reason behind the reform in St. Kitts/Nevis was international trends. Of the six reasons identified, only this one was cited more than once. When asked about the main issues prompting the reform Administrator D stated, "I would say wanting to upgrade from offering the Associate degree for so long; wanting to keep abreast of international nursing trends and to move from hospital programmes to tertiary education institutions." This response not only indicated the

desire to attain international parity but it also identified concerns related to nursing education.

Notably, public demand and the government's human resource policy also listed among the prompting issues. In response to the question Bureaucrat D stated, "Public demand. The people demanded more of the health professionals. Also, government's commitment to upward mobility of the health professionals – including the nurses." This comment suggested that public demand and government policy were additional reasons behind the territory's engagement with the reform. Table I1 in Appendix I ranks the reasons cited by participants according to their response frequencies.

9.5.2 Reform intentions

Participants were asked to identify the goals, plans and expectations that were attached to the reform. Of the eight intentions given, improved quality of nursing service and improved competencies of beginning level RNs were the most frequently mentioned. The remaining intentions included the harmonization of CARICOM nursing, international parity, regional reciprocity, along with postgraduate education, career advancement and increased remuneration for nurses.

In response to this question Bureaucrat D stated, "To provide advancement for nurses and improve the quality of care for our public." Administrator D explained,

> "I believe to meet international standards and keep up with international trends. In addition the BScN would offer the graduate supervisory, administrative and leadership skills. It could be a good springboard for graduate studies, it could offer them opportunity for

negotiation in terms of salary. So the graduate coming from a BScN as

opposed to the associate degree, their options and opportunities for

graduate studies would be better and the patient would get a more

skilled nurse to take care of them so patient care would be better."

Administrator E explained her views of the intentions as, "To deliver a generic

BSc programme based on the recommendation of the RNB and COHSOD to

meet the standards and align with other institutions. In addition, to prepare

graduates with higher education who can meet the needs of an evolving society

and health sector. To enhance the quality of care. Also, to build national human

capacity and regional human capacity through reciprocity." These views

resonated with the views of Jamaica's participants, and echoed similar national

and regional considerations. Table I2 in Appendix I shows the list of intentions

and their response frequencies.

9.5.3 Components of the reform in St. Kitts/Nevis

The responses suggested that, as in the other territories, the BScN reform's

implementation was multifaceted in St. Kitts/Nevis. Similar components to those

listed for the other territories were listed by this state's participants.

Regarding what the reform encompassed Administrator D explained,

"…they conducted a series of meetings to upgrade the blueprint and

the curriculum… they had several workshops. I remember going to one

that was hosted by the same Syringa…so a series of workshops …we

were reviewing the blueprint, reviewing the standards for nursing

education, upgrading the curriculum to allow a BScN programme,

reviewing all the documents supporting the examination – the CARICOM guidelines for examination, the administrative manual and so on…."

This comment suggested that the process involved an upgrade of CARICOM's nursing education standards and curriculum upgrade – among other components. Administrator E responded by saying, ""It involved harmonizing the curricula, upgrading from ninety credits …The faculty were sensitized and three went off to pursue Masters. There was also aggressive advertising of the BScN programme. We invested substantially in the skills lab. So it was mainly resources, faculty upgrade and marketing." This comment suggested that harmonizing nursing education, faculty training, and changes in the delivery of nursing education were part of the reform. Bureaucrat D stated, "... The students who were already nurses who pursued the 2year upgrade programme were paid 80% of their salary. There was reduced tuition for CARICOM nationals and an immediate transfer to a higher pay scale upon graduation, with a 5year bond." This comment suggested that the reform encompassed the upgrade of practicing nurses, a salary increase for BScN qualified nurses, and a mechanism for retaining graduates. Table I3 in Appendix I lists the components of the reform identified by participants from St. Kitts/Nevis.

9.5.4 Evolution of the BScN reform in St. Kitts/Nevis'

Participants were asked to describe the actions their organisations took in relation to the reform and give the associated timelines. The responses suggested that partnerships, lobbying, and championing were key interactions in the implementation process.

9.5.4.1 Communication and lobbying

Responses suggested that the regional decision entered this territory via multiple routes, from around 2003, and was disseminated widely in the system. Reportedly, the CNO informed the Nursing Council of the RNB agenda and regularly updated the Council on regional progress with the policy. Responses suggested that around 2009, the territory started to actively engage with the reform. Administrator E explained,

> "Firstly we had that review of our curriculum around 2009-2010. Then the proposal was written in 2011. The taskforce was formed between 2012 and 2013. Then the UWI consultation for the franchise was early in 2013 and an original implementation date was set for September 2013. However, that date was revised."

This response implied that activities toward implementation spanned the period 2009 to 2013.

Administrator D explained the communication about the reform this way,

> "We were represented at the RNB meetings by the PNO and we were kept informed by her what RNB was doing ... She would report to the Council at meetings.... so we were kept informed of what RNB was saying… and what we needed to do… I think she wrote a report to the PS of the Ministry on her return and by extension Minister. She would always report to them and so the Ministry was always well aware of what was happening at RNB level."

Administrator E said, "The message was brought back…to the Council through word of mouth and reports from RNB. I sit on Council so I was in the position to hear and be able to sell the initiative in the College to the Board of Trustees and the

Administration. Mrs. ____ and the PNO would have been advocating with the Ministries and with the College Administration as well." These comments suggested that communication about the reform to the GNC started early during the recent RNB discourse on the reform and was frequent. They also suggested that members of the Council fed the information back to their organisations. These findings implied that as information was being shared with the GNC, the members were disseminating it to their organisations. Reportedly, during dissemination, the CNO and the College's representatives on the Council were championing the reform to their Ministries and CFBC.

9.5.4.2 Championing and leadership for the reform

The responses suggested that championing of the reform and leadership in the process were provided by the PNO and the Dean of College's Health Sciences Division. When asked why she thought the proceedings turned out the way they did Administrator E said, "It was advanced by key persons in strategic positions. The Dean's resolve and perseverance also influenced the process significantly." Administrator D explained,

> "She [the PNO] would come back from the [RNB] meeting and she
> would have the whole itinerary that they had, all the decisions,
> resolutions and so on, then we would have discussion on the issues. She
> would always report and so the Ministry was always well aware of what
> was happening at RNB level…It came home forcefully because of her
> passion…We kept encountering reports at Council meetings and we
> were given a copy of the main recommendations from RNB. She would
> write to each of us representatives on the Council and tell us what we

> were expected to do to push the agenda forward. We were never left
>
> out of the loop."

In response to the question Bureaucrat D said, "We conducted sensitization and this was led by the PNO." These accounts suggested that leadership for the reform was exercised strongly by the CNO at the national level and by the Dean of Health Sciences at the institutional level. This implied that there was a unity of purpose between these two principal actors that facilitated the realization of the reform.

The responses also suggested that the principals behind the reform had support from the College's administration and the government, after a period of ambivalence initially. The six year period between the discourse's entrance into the system, and the College's movement towards implementation, along with the reports that the College acted on the reform only after they perceived it as beneficial to their accreditation agenda, suggested that there was ambivalence in the system regarding the reform. Administrator D explained, "The College itself was in the process of examining its own processes towards getting accreditation…that was the main driving force… and I don't think we let up on the pressures we put on them. Because we too as a department wanted to grow. And they saw that I was trying from 2009…I was like a tractor moving nursing forward. I must say I had the full support of both Presidents…The support was there…" Administrator E said, "The Ministries supported it; especially the Ministry of Education – they invested significantly in it." The foregoing responses suggested that the support of the College's administration, the Ministry of Health, and the Ministry of Education facilitated realization of the reform, but only after a period of sustained lobbying by the Dean of Health Sciences.

9.5.4.3 Partnerships

The responses suggested that implementers also formed partnerships to advance the implementation process. Explaining how the College implemented the reform, Administrator D stated, "…we said while the College is getting prepared for accreditation we would franchise; and so we franchised with the University of the West Indies Mona…" This comment implied that because the College did not have the capacity to deliver a BScN programme that would be recognised, the administration decided to partner with the UWI to realize the reform.

The evidence also suggested that the Dean of Health Sciences also partnered, informally, with members of the GNC of Jamaica to lobby the College's administration for the required resources. Administrator D recollected,

> "When they were doing the rounds and inspection, some of the Members of the Board were on the rounds with me. I insisted that they come to hear what they're saying because sometimes when you hear for yourself…Mrs. ____ was the Chairman of the Council and she was very emphatic that we need these things if we're going to be offering a BSN…I think the Deputy Chairman bought into what she was saying."

Beyond partnership in the process, this comment also signalled the support that implementing partners provided to the principals to realize the reform.

Notably the College also formed a taskforce to lead the implementation. Administrator D explained, "The BScN taskforce was very critical to getting the reform going because it was a team directly responsible. I would advise any institution to set up such a team and get the support and buy-in from the administrators to facilitate the

implementation." These comments suggested that formal and informal partnerships were formed between various groups to advance implementation of the reform. These interactions will be discussed further in the comparative section of the chapter.

9.5.4.4 Enablers

The evidence suggested that the primary enablers of the reform in this territory were support and policy fit. These were reported to have impacted both the national and institutional contexts. Regarding support one participant stated, "…I had the full support of the College…they were saying "let's start with Nursing seeing that it is already on that track; let's get it moving up"… support was there… and the mood of getting the College accredited." This comment pointed not only to the support given but also indicated that the College viewed the reform as helpful to its accreditation efforts. The policy's fit with the College's agenda was further emphasized by the response, "The College itself was in the process of examining its own processes towards getting accreditation and so the types of programmes you offered, the levels and qualifications of staff, the facilities and all of that would matter to become accredited… that was the main driving force…."

Administrator E's comment regarding the support provided by the Ministries of Health and Education substantiated the claim that support was a key enabler of the reform. Bureaucrat E's response that "It was the right time for the institution to move to the next level", suggested that the policy fit with the context at the time the principals were advocating its implementation. Table I4 in Appendix I illustrates the factors perceived to have enabled the reform and the context levels they impacted.

9.5.4.5 Constraints

Participants cited only three factors as constraining the reform. These factors were limited finances, inadequate capacity and communication challenges. Limited finances reportedly impacted both the national and institutional contexts. Inadequate capacity and communication challenges were each cited once and were viewed as impacting the institutional context. Regarding limited finances Administrator D said, "Finance is always a problem. We could have done more and even reached further if you will but finance I would say is one of the greatest challenges." Bureaucrat E remarked, "Budgetary cuts [was a constraint]. We're under IMF watch because we have a high debt to GDP ratio."

In response to what constrained the reform Bureaucrat E also said, "The initial qualifications of our lecturers and the numbers." This comment suggested that the College did not have adequate capacity to deliver the BScN because of insufficient faculty complement and qualifications.

Communication challenges between the UWI and CFBC were regarded as constraining *not* the initial implementation of the BScN programme but its continued delivery. It should be noted that continued communication between the UWI and CFBC is essential to facilitate effective delivery of the franchised UWI programme through CFBC. But Administrator D noted, "The franchise is too limiting and there are communication challenges to feeder programmes like ours." This comment suggested that after the franchise arrangement was operational, the communication between the partner institutions became compromised, posing a threat to the continuation of the programme.

9.5.4.6 Document findings

The reader should note that no documents relating to the reform's implementation in St. Kitts/Nevis were retrieved. Efforts to retrieve the territory's nursing legislation also proved futile. The study therefore relied on the interview findings to construct a picture of the reform's evolution in St. Kitts/Nevis.

9.6 Summary of the St. Kitts/Nevis findings

The evidence suggested that the RNB BScN discourse entered St. Kitts/Nevis before the 2006 decision was made, and that it was disseminated widely in the system. Reportedly, curriculum revision towards a BScN programme commenced in 2009, around the time that the College became interested in accreditation. The responses suggested that the College's administration perceived the developments associated with preparing for the BScN programme to be beneficial towards their accreditation goal. Consequently, after some apprehension, because the policy fit with the institution's new agenda, it was finally accepted by the College's administration.

To realize the reform, according to the participants' accounts, the CFBC partnered with the UWI, Mona Campus to deliver a franchised programme. Reportedly, championing, partnerships and lobbying were key interactions in the implementation process. The evidence suggested that the process was enabled by support and the policy's fit with the CFBC's agenda. However, reports suggested that the process was simultaneously constrained by financial limitations and inadequate institutional capacity.

The few constraints versus the plethora of enablers associated with the reform process suggested that, once the decision was made to implement, the system was highly facilitative of the reform. The evidence suggested that by 2014, the system was delivering the UWI pre-registration BScN degree programme through a franchise arrangement with the Mona Campus. However, there was no evidence to suggest that legislation was developed to establish the BScN as the entry level qualification for nursing. Figure 9.2 depicts the researcher's understanding of the reform's evolution in St. Kitts/Nevis.
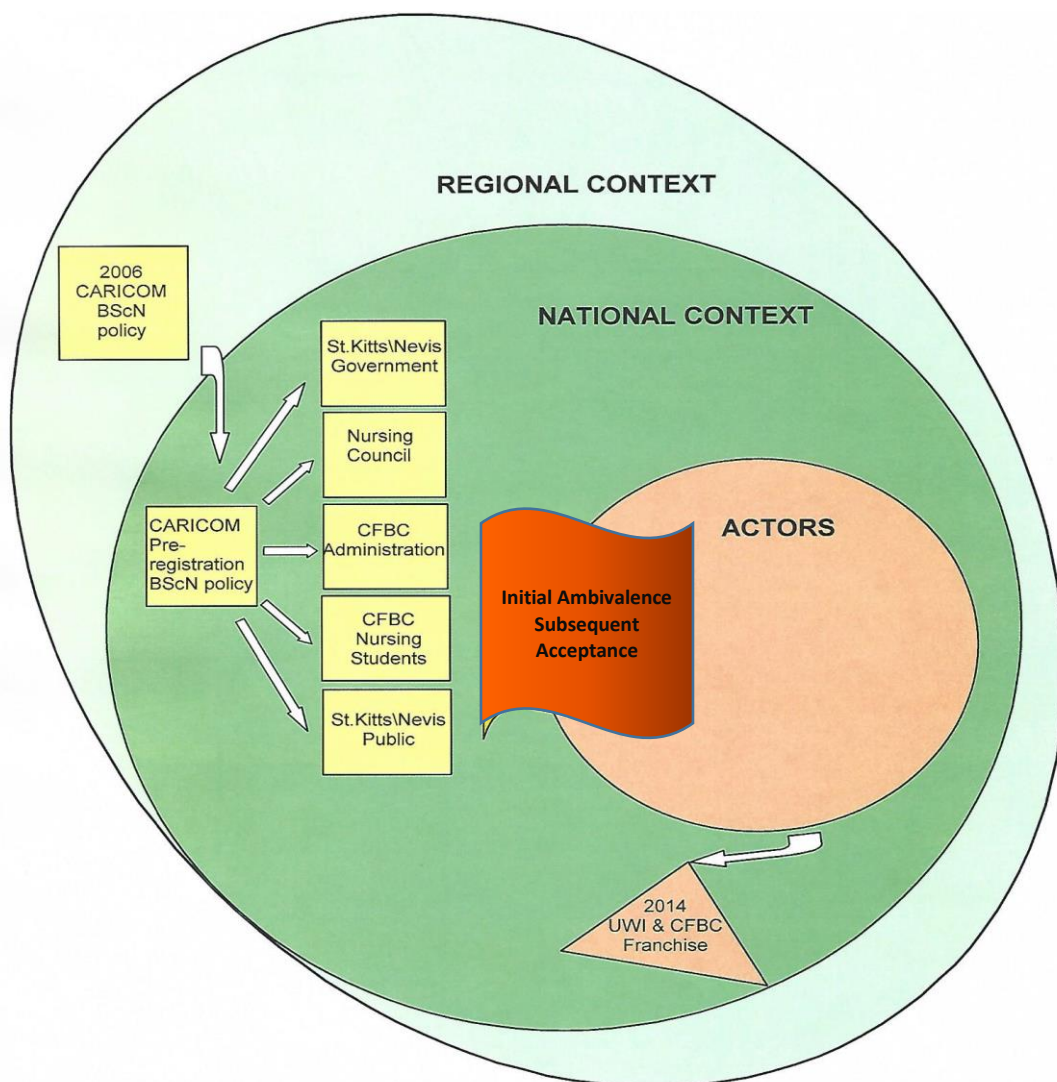
Figure 9.2: St. Kitts/Nevis' BScN Evolution

9.7 Comparison of Barbados' and St. Kitts/Nevis' reform processes

The evidence suggested that similar drivers led to Barbados' and St. Kitts/Nevis' engagement with the BScN reform. These reasons and intentions were similar, to an extent, to those of Jamaica and The Bahamas. However, despite the similarities in reasons and intentions, and time of engagement, Barbados and St. Kitts/Nevis engaged differently with the reform process and had different outcomes. The evidence also suggested that similar enablers and constraints operated in both systems. Interestingly though, the evidence also suggested that Barbados' engagement with the reform was further impeded by its system's ideology about nursing.

The evidence further suggested that the St. Kitts/Nevis system, after a period of ambivalence, accepted the reform and employed a collaborative approach to implementation. Conversely, Barbados' system opposed the reform for approximately nine years, and only moved to implement after being forced to do so by Ministerial mandate from two Government Ministries. Yet, from the evidence available, neither system had made provision for the BScN as entry level qualification for nursing practice in their legislation.

The analysis revealed that both systems were challenged by inadequate capacity for implementation. However, whereas St. Kitts/Nevis engaged the support of partners, including the UWI, to facilitate implementation, Barbados' system engaged in opposition, disregard and selective attention. The evidence suggested that rather than acknowledge the deficiencies and form partnerships to overcome them, the implementing institution in Barbados engaged in avoidance tactics. Notably, based on the responses, it appears to be the case that support would have been available from

the government for early implementation. Given the fact that the Cave Hill Campus of the University of the West Indies is located in the territory, it is reasonable to conclude that, as exemplified by CFBC, the BCC could have sought support from the UWI as well.

As it stands, Barbados' engagement has resulted in a baccalaureate degree being delivered through the BCC, with questions looming regarding the College's capacity to deliver the programme. On the other hand, CFBC, St. Kitts/Nevis' state community college, is delivering the UWI's degree through a franchise arrangement. Both systems have implemented the degree programme, but one with questions of quality compromise looming. Yet the evidence suggests that neither system has legislated that the entry to practice qualification for nursing is the BScN degree.

Chapter 10

Dilatory Engagers: Grenada and Antigua/Barbuda

This chapter compares Grenada's and Antigua/Barbuda's engagement with the CARICOM BScN reform. These two countries have not yet implemented the BScN programme. The initial portion of the chapter describes Grenada's reform engagement. This is followed by a description of Antigua/Barbuda's engagement and a comparison of the two countries' reform evolution patterns. The factors influencing the reform's trajectory in the territories are also compared. The chapter begins with a description of Grenada's nursing education context.

10.1 Nursing education in Grenada

Nursing education in Grenada is delivered through two tertiary education institutions (TEIs). The T. A. Marryshow Community College (TAMCC) delivers training in Midwifery and training for nursing assistants. Graduates of these programmes are awarded certificates.

The St. George's University (SGU) is a private institution that, in agreement with the Government of Grenada, took over the general nursing programme from TAMCC in January 2016. The programme is a three year programme from which graduates are expected to graduate with an associate degree in nursing.

10.2 Grenada's empirical findings

The following sections describe the findings of four interviews with participants from Grenada, regarding that territory's engagement with the 2006 CARICOM BScN reform. Interviewees from Grenada were:

- an RNB representative, Representative F;

- one former Minister of Health, Bureaucrat E and;

- two nursing education administrators, Administrators F and G.

The interview findings are followed by the documentary analysis findings. The first section addresses the drivers of the reform in the territory.

10.2.1 Why BScN reform in Grenada?

Participants were asked about the reasons behind and intentions for the reform to elicit the reform drivers in their countries. When questioned about the reasons, the participants' responses suggested that Grenada's policy actors were primarily concerned about the quality of nursing service on the island and the migration of nurses from the region. Other concerns raised were:

- concern about the quality of nursing education;

- parity with international territories;

- the changing regional demographics and;

- the movement of nursing schools into educational institutions.

Responses suggested that the policymakers' primary intention was to change the way nursing education is delivered in the territory. Five responses signalled this intention. Associated changes included transferring nursing education to TEIs, delivering the BScN locally, and interdisciplinary training for student nurses. Representative F stated,

> "Really the drivers were the strong movement towards tertiary education in the Caribbean … and the managed migration project developed in 2001 in Jamaica…We also wanted to improve the quality

of care given to patients and for all the nursing schools to have the same

basic minimum standards. RNB was calling on governments to

improve the standard of education in the region…to have all the

schools move into the mainstream of education by 2011…We wanted

governments to support the transfer process and invest in it and scale

up. We expected improved patient care outcomes with increased

qualification…that our nurses would have the competencies to care for

the shifting demographics in the region and be able to meet consumer

expectations. We also hoped to retain our nurses in the region."

This response and the identification of other nursing education related changes,

by other participants, illustrated the significance of this intention in Grenada's

context.

Participants also indicated that their territory sought to implement this regional nursing

education reform to comply with improving the quality of nursing service and nursing

education in the region. Both of these goals were cited three times by the four

participants and, as will be revealed later, were shared by other territories involved in

the study.

The retention of nurses in the region was cited by two participants as one objective

that their territory had for engaging with the reform. Addressing the issue of retention,

Administrator F stated, "It was felt that if as a region, we can improve the standard of

nursing education from the certificate level to the BScN, this would help to retain

nurses." This was congruent with the perspectives of participants from other

territories, and connected the reform to addressing the emigration of nurses from the region.

Apart from those intentions already mentioned, the Grenada participants associated three additional aspirations with their country's involvement with this reform. These were the improved status of nursing; the harmonization of nursing in CARICOM; and government investment in nursing education.

The improvement of nursing's status and its harmonization in the region are intentions that have been identified by participants from other territories as well. However, it is interesting that government investment was identified as an objective of the reform in Grenada rather than as one of its components. One of the two participants who cited this intention elaborated on this point by saying, "Governments would invest in nursing education by training nurse educators at the Master's degree level or higher, to effectively deliver the curriculum." Articulation of this objective indicated that such investment would either be outside of the norm or so critical to the reform's success that it had to be highlighted. The fact that this intention was mentioned by two of the four participants suggested that it was not regarded as an intention by the other participants. However, its emergence in the data cannot be dismissed as insignificant. The extent of its significance will be explored further in the analysis. The section following describes the character of the reform on the island.

10.2.2 BScN components in Grenada

Although the BScN is not yet being delivered in Grenada, the reform's facets were outlined by the interviewees. Responses indicated that participants perceived the reform to encompass:

- faculty training;

- changes in the delivery of nursing education;

- infrastructural upgrade;

- transferring nursing education from hospitals to TEIs and;

- implementing the regional managed migration strategy.

Faculty training was the component most frequently identified by participants. The responses suggested that participants perceived this training as upgrading faculty to master's and doctoral levels. Given the citation of government investment in nursing as an intention associated with the reform, I sought to ascertain whether such investment was made for faculty training. However, it was not revealed whether Grenada's government had invested any money or time in this facet of the reform.

The reader may recall that changes in the delivery of nursing education was the primary intention participants associated with Grenada's engagement with the reform. However, responses regarding the reform's components also depicted it as a facet of the reform. These changes included moving from the apprenticeship model of training to full student status in TEIs, for nursing students; and delivering the BScN locally. These two changes were consistent with the RNB reform agenda and with the territory's reported intentions.

Although infrastructural upgrade was cited as a component by two participants, it must be noted that one of these viewed this component as a facet of the regional reform picture − not Grenada's specifically. Interestingly, the responses that referred to upgrades in Grenada related specifically to upgrades done under the apprenticeship system. Consequently, neither response actually provided evidence that infrastructural upgrades were undertaken in Grenada to facilitate the reform. However, their responses suggested that the participants viewed this change as a component of the reform.

The participants cited the transfer of nursing education from hospitals to TEIs as a facet of the reform. Their responses suggested that steps were already taken in the system. Administrator F stated, "The Grenada School of Nursing was transferred to TAMCC in 2008 … In January 2016 the Government transferred the General Nursing programme to SGU." This comment suggested that Grenada's nursing education had already been transferred to the TEIs. This was consistent with the RNB agenda. Moving nursing education into TEIs demonstrated the Grenada policymakers' commitment to harmonize nursing in Grenada with nursing in CARICOM, and change how nursing education is delivered there.

The final component identified was implementation of the regional managed migration strategy. Only one participant presented implementation of this strategy as a facet of the BScN reform. While the participant did not explain this strategy's inclusion as a component of the reform, and while another perspective may cast the BScN reform as a component of the managed migration strategy, inclusion of the

strategy in the responses indicated a connection between the two policies. This connection will be addressed further in the concluding chapters.

One component that was glaringly absent from the Grenada reform process was legislation change. According to CARICOM's governance procedures, decisions must be transposed into municipal law to be binding on a member state. The omission of legislation change from among the facets of the reform suggested a lack lustre approach to reforming nursing education in the system. If Grenada's intention is to establish and maintain changes to the delivery of nursing education that are consistent with the CARICOM BScN policy, those changes would require the support of legislation for formalization. The impact of this deficit will be examined further in the analysis. From identifying the reform's components, participants proceeded to describing what had occurred in Grenada, so far, in relation to the reform.

10.2.3 Grenada's reform engagement

The following sections outline the interactions that took place in relation to Grenada's engagement with the 2006 CARICOM BScN reform, so far. Key developments in the process are addressed.

10.2.3.1 Communication

Participants were asked to explain how the 2006 CARICOM decision was communicated to Grenada and its training institutions. Their responses suggested that the idea of delivering the BScN entered Grenada before the 2006 decision.

Reportedly, in the early 2000s there was discussion of transferring nursing education from the hospital to the community college and of delivering the BScN. Additionally, SGU had delivered a BScN programme up to 2013, at which time it had to be suspended due to undersubscription. Representative F stated, "There was a cabinet decision in 2005 to move nursing education into the Ministry of Education and ever since then there was discussion about moving to the Bachelors." Additionally, Administrator G explained, "SGU offered the BSN programme previously but that programme was closed in January 2013 … We were in some competition with the local College because traditionally nurses sought to go to TAMCC. It therefore became financially untenable to run the SGU programme. But as soon as they closed they started looking to reopen it." These comments implied that Grenada had a history of delivering BScN education through the offshore university, and that the government was looking to upgrade the nursing education system.

The 2006 CARICOM decision entered the territory through multiple modes. Responses indicated that it was conveyed through GNC meetings, RNB reports, conversations and at least one letter. When asked about the communication methods Administrator F stated, "Primarily through meetings and reports from RNB meetings." Administrator G responded, "It was said in discussion with me." These comments suggested that the decision was communicated to policymakers in the territory by multiple methods. The investigation also revealed that a letter was sent to the Chancellor of SGU by the Minister of Health in 2015, regarding delivery of the BScN. The letter was analysed along with other documents for evidence in this study.

Reportedly, COHSOD conveyed the decision to the Minister of Health through the report of its fourteenth meeting. The CNO was officially informed of COHSOD's decision through the RNB report and through correspondence from the Chairperson of RNB. The CNO in turn reported to the Minister of Health.

Responses further indicated that the GNC was informed through meetings and verbal reports from the CNO between 2006 and 2007. Previous comment suggested that one administrator at SGU was also informed during a conversation with a Ministry of Health official.

Although there were multiple modes of communication, one participant indicated that while in leadership in the NNA, she had not heard about the reform through local discussion or direct communication from official sources on the island. Rather, it was discovered through external affiliations. This indicated a lack of communication to a key interest group on the island. Bureaucrat E emphasized, "I read about it. I heard about it through a little grouping we have in ICN…and documents I sourced…." This response was different from those given by the nursing education administrators and the regional actor. It was therefore inferred that the reform decision was communicated to the training institutions but not to the NNA.

Such a communication gap could threaten the outcome of the reform on the island. While direct communication with the institutions intended to implement the reform is critical, communication with interest groups is equally crucial. This communication deficiency could have constrained the demonstration of support for the reform on the island. Its impact will be examined further in the analysis.

10.2.3.2 "Sense-making"

Participants who reported that they had received official communication about the reform indicated that, from that communication, they understood that the region had taken the decision to transfer the schools of nursing into colleges and universities by 2005. Furthermore, it was understood that by 2010, the entry qualification for practice would have been the BScN. This, however, was not the case for the participant who had heard of the reform from external sources. Given the role that the NNA would be expected to play in supporting the reform, this was a cause for concern. In explaining her understanding of the reform the participant said,

> "What I gathered was that it was a phased thing…each country had to
>
> do its own internal analysis and look at the timing in terms of how they
>
> would transition…from Ministries of Health to Ministries of
>
> Education…it wasn't something that would just happen overnight…
>
> each country would go out there and use its own internal mechanisms
>
> as a process for transitioning. It wasn't a one glove fit all…but we all
>
> needed to do that in country."

The understanding expressed in this comment was congruent with CARICOM's expectations – as will be shown later. However, the comment also indicated that participant did not understand the reform to have an implementation deadline – a situation that was potentially problematic because the participant's role evolved to be pivotal in advancing the reform. The difference in interpretation amongst the actors suggested a fragmented approach to the reform – which could result in unintended outcomes.

Interviewees' descriptions of what transpired in their territory regarding the BScN policy, so far, indicated that stakeholder collaboration, lobbying and reframing were some of the socio-political processes involved in the engagement. It was reported that between 2012 and 2013 the Ministry of Health and SGU engaged in discussions regarding the delivery of the BScN. Indications were that the GNC also had engaged in discussion with SGU, through the University's nursing education administrators, regarding the curriculum's development and approval processes. These occurrences suggested that the actors engaged in stakeholder collaboration to effect implementation of the BScN programme. However, strikingly absent from this collaboration was the national NNA.

10.2.3.3 Collaboration

The NNA's absence from the collaborative process was confirmed by Administrator F who stated, "…The Nurses Association should be lobbying the government to invest in nursing education." This suggested that the association was not advocating for government investment in nursing education in Grenada. But, no reasons were proposed by this participant for the association's lack of involvement. However, Bureaucrat E's comment suggested that no communication went to the NNA about the reform. This could have accounted for the association's non-involvement.

Responses also indicated that the GNC had lobbied for implementation of the BScN reform. This claim was supported by Administrator G's comment that, "…the GNC's insistence that the BSN is what they wanted led me to be creative…." This lobbying role should have been shared with the NNA. If collaboration with the NNA is not fostered, that deficiency could hamper the implementation process on the island.

Responses suggested that the Government engaged SGU to deliver the BScN programme. However, they also suggested that SGU's investors had a different objective. Administrator G remarked,

> "Our investors thought the BSN would be too expensive because they thought it had to be done in 4 years…I think the move from TAMCC to SGU came about because it was not financially sustainable for the government…it's probably a marriage of convenience between government and SGU…. SGU is already accredited by Grenada's accreditation board...The agreement is not to charge the nursing students because they wouldn't be able to afford it."

Reportedly, in attempting to bridge the gap between the Government's and SGU's investors' objectives, an innovative approach to implementing the BScN was crafted by SGU's nursing education administrators. Reportedly, they reframed the curriculum for the nursing programme to make it equally appealing to two groups of stakeholders with divergent views.

Along with a consultant, the administrators developed a curriculum that reflected the standards of the CARICOM 2011 Model BScN curriculum for the SGU associate degree programme. When the curriculum was presented to the University's administration it received approval to be delivered as the ASDN programme. The same curriculum received the GNC's approval for delivery of the BScN programme at the earliest opportunity. Administrator G explained,

> "When it was presented…that SGU would be offering the associate degree, there was dissent by the faculty because SGU does not offer

associate degrees. My colleagues felt that the standard of the University was being lowered…But my own professional loyalty and the GNC's insistence that the BScN is what they wanted led me to be creative – to develop a BScN curriculum for the associate degree. I saw this as a good compromise. Now I hope to just get a programme name change."

The comment suggested an attempt to meet the demands of the Government and the University's investors – two policymaker groups whose decisions would significantly steer the implementation process, and influence the reform's outcomes. This implied therefore, that as the principals in the reform process, Grenada's nurses should unite to secure the intentions that have been established for the territories' engagement with the reform. Unfortunately, the time allotted for this study did not permit ascertaining whether delivery of the BScN programme from SGU has received the University investors' approval to date.

10.2.3.4 Acceptance with apprehension

While the responses suggested a general acceptance of the reform in Grenada, some also indicated that the College's nursing faculty was experiencing some anxiety. Administrator F explained,

"The transfer had some teething problems, but the College was trying to meet the requirement…they were improving the library…bought a few manikins for teaching and learning... moved from a certificate to an associate degree. But the issues surrounding the nurse educators have not been addressed - especially now with the transfer of the general nursing programme to SGU."

This response suggested that the rapid transfer of the general nursing programme through three institutions, resulted in uncertainty about the faculty's tenure. The faculty was concerned. Responses implied that their concern was compounded by the fact that before their employment issues were finalized with the College, the main nursing programme was transferred to the private university.

Another respondent explained her perspective on the transfer to SGU and the nursing faculty situation this way,

> "… That to me has its pluses as well as…some minuses. And the pluses I think will outweigh the minuses...SGU has the clinical space and the capacity... I mean they're right on the nose with all of those kinds of equipment and support things that you would need to run a programme like that. The library facilities, all of these things. The faculty…there will be concerns… people have security of tenure for their services and so on. So I think that is something for both the trade union movement and the government to sit with SGU to look at."

The response suggested that, in comparison with the College, SGU possessed the capacity for delivering the BScN and so, was more appropriate for implementing this aspect of the reform. However, it also confirmed that there were concerns about the tenure of the College's nursing faculty and suggested that this associated issue should be addressed by the Government, the trade unions and SGU going forward.

10.2.3.5 Reform enablers

Participants were asked to identify the factors that they thought enabled the reform in Grenada. Leadership and capacity were most frequently cited. In response to what she considered to have enabled the reform Administrator G stated, "The CNO's positivity…also, how I managed the change." Two out of the other three participants agreed that leadership facilitated the reform. But the other interviewee had a different perspective of the issue. This will be examined later.

Capacity was cited three times as enabling the reform but its influence was associated with the institutional and national levels of the context. Administrator F's comment interpreted as referring to capacity was, "The nurse educators are properly trained. Also…the GNC and its regulations…TAMCC already offers degrees in other areas." Another comment related to this factor was, "SGU has far more resources than TAMCC to facilitate the BScN… content experts already on staff and therefore, don't need to hire staff in nursing for support courses." These comments relayed what the participants viewed as demonstrating TAMCC's and SGU's capacities for delivering the BScN; and the system's capacity for governing nurse training. They however also highlighted the differences in capacity between the two institutions, and the latter hints at what may be a problem for the College's nursing faculty who hope to be considered for employment at the University.

The remaining seven enablers were each cited once as impacting the reform. Six of these were reported as impacting the national context. Among them was ideology. Bureaucrat E's comment interpreted as indicating this factor's influence was,

> "I think if we strongly pursue that arrangement with SGU, psychologically because our people tend to value what is not ours, they would tow the line if they are a part of the faculty of SGU as against being members of the faculty of TAMCC; and maybe people would see the seriousness of what has to happen and it might move quicker under SGU as opposed to under the state institution TAMCC."

Table J4 in Appendix J illustrates the factors reported to have enabled the reform by Grenada's participants and the context levels they impacted.

10.2.3.6 Constraints

In addition to identifying what they perceived as enabling the reform, participants expressed what they thought constrained it. Seven factors were distilled from their responses. Interestingly, inadequate capacity, nursing leadership deficiencies and lack of interest group participation emerged as the main constraints to the reform in this territory. The identification of these factors as constraints and the citation of their reversals as the key enablers of the reform, pointed to inconsistency in the system.

Inadequate capacity emerged as the main constraint to the reform in Grenada. However, nursing leadership deficiencies was similarly implicated. Bureaucrat E commented,

> "…As we speak I don't think that the College itself is adequately prepared to deliver the programme at the level of the bachelor's…For anything to succeed you need a champion. When I say a champion I mean somebody that eats, sleep, drink and breathe that process…and there isn't a champion for nurses and the voice of nurses at the moment.

> I don't know how vocal nurses are in terms of their professional organisation."

Championing was interpreted as one aspect of nursing leadership, and the College's readiness to deliver the programme was taken to indicate its capacity. The comment was therefore interpreted as conveying deficiencies in capacity and nursing leadership as constraints to the reform. Comments by other participants concurred with this participant's perspective.

Previous comments alluded to a lack of interest group participation as constraining the reform. This factor was cited three times by participants as a constraint. Therefore, along with leadership deficiencies and inadequate capacity, it was one of the top three constraints identified. Table J5 in Appendix J   illustrates the factors perceived as constraints to the reform by Grenada's participants. The following section reports the findings from the documents analysed to triangulate with the interviewee findings.

10.2.3.7 Grenada's document findings

Four documents were analysed in relation to the reform in Grenada. Three of these were legislative documents and one was a letter. The three legislative documents related to the governance of nursing in Grenada. These were the Nurses and Midwives Act, the Nurses (Training and Examination) Rules, and the Nurses (Registration) Rules. The letter analysed was the formal communication between the Ministry of Health and SGU about plans for nursing education delivery in Grenada.

The findings from the letter suggested that, by early 2015, talks between the Ministry and SGU had resumed. In October 2015, official communication was sent to SGU

regarding Cabinet's decisions on the delivery of nursing education in Grenada. The decisions were that the associate degree and Bachelor's degree programmes would be undertaken by SGU while the other nursing programmes would remain at the community college. It was further stated that Cabinet had decided that the associate degree programme which would start at SGU in 2016 would move to a full baccalaureate degree on or before completion of the first batch of students who would have commenced the programme.

It must be noted, that while the Government of Grenada expected the associate degree programme to transition into a baccalaureate programme within a specified period, participants' responses indicated that the University's investors had not yet bought into that idea. The outcome of this difference in perspectives is yet to be revealed because no resolution had been reached up to the time of conducting the study.

The review of the legislation gave insight into the powers of the Grenada GNC and the extent of nursing education reform in the territory. It was noted that although changes were made with respect to the institutions from which nursing education is delivered in the territory and the types of qualifications awarded, the concomitant changes in the nursing legislation had not been made.

The Nurses and Midwives Act, revised in 2003, indicated that the Council is responsible for advising the Minister on nursing matters. The Council is also to verify the qualifications of nurses trained overseas who want to be registered in Grenada, and prescribe the qualifications for nurse educators. Additionally, the GNC is expected to certify nursing schools in Grenada and prescribe continuing professional education for

nurses. The Council was charged generally to ensure maintenance of the standards in nursing in Grenada (Government of Grenada, 2003).

Analysis of the Training and Examination Rules revealed that the Council has prescribed the basic curriculum for general nursing programmes to be delivered in the country. However, these rules appeared not to have been revised since 1954 and did not specify baccalaureate training as the entry level qualification for nursing practice in Grenada. It can therefore be concluded that although the Government of Grenada was taking steps to deliver a BScN programme on island, it was not yet sufficiently committed to the reform to make the necessary legislative amendments.

Examination of the Nurses (Registration) Rules substantiated the conclusion regarding the Government's lukewarm commitment to the reform. Moreover, it suggested the legislature's neglect of nursing from the 1960s to the present. The rules, which appeared not to have been revised since1955, indicated that a candidate only needed a certificate to be registered as a nurse in Grenada. The findings from these documents were combined with those from the interviews to give insight into the evolution of the reform in Grenada.

10.3 Summary of Grenada's engagement to date

The evidence suggested that the BScN reform is still unfolding in Grenada. The responses suggested that stakeholder collaboration and curriculum development were key interactions in the process so far. They also suggested that general nurse training had transitioned from hospital training to the College and then to a university as an associate degree programme. Up to the time of writing this report, general nurse

training on the island was at the level of an associate degree in a private university, through an agreement between the Government and the St. George's University. Figure 10.1 illustrates the researcher's understanding of Grenada's engagement with the reform to date.
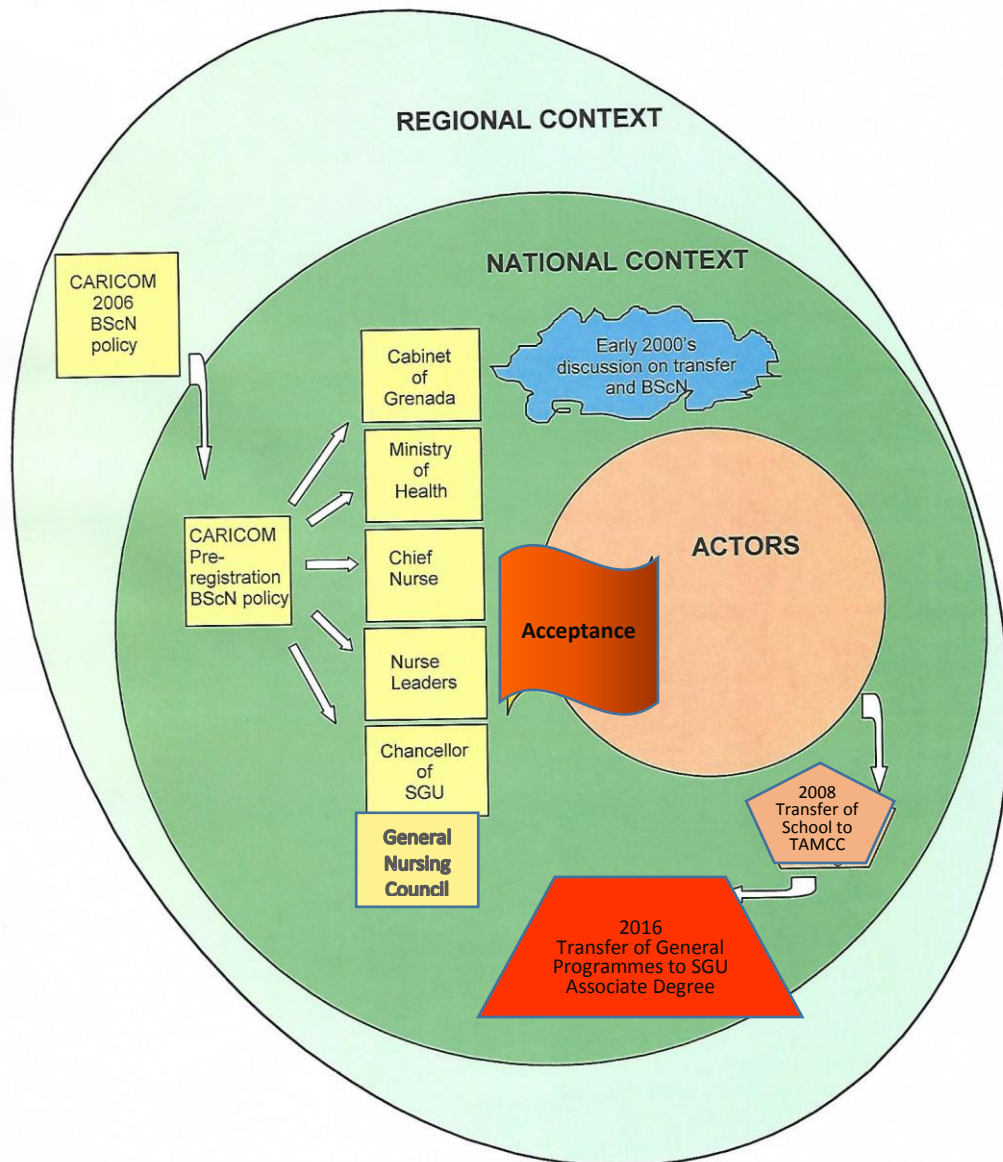
Figure 10.1: Grenada's BScN reform evolution

10.4 Nursing education in Antigua/Barbuda

Nursing education in this territory is delivered through the Antigua State College (ASC). The College is part of a tertiary education system that also includes universities and technical institutes. Reportedly, nursing education transferred to the College in 2000. The College delivers certificate, diploma, associate degree and baccalaureate programmes. Graduates of the general nursing programme are awarded a diploma (Antigua State College, 2017).

The territory has an Extra-Mural Centre of the UWI located on Antigua. Also present are the University of Health Sciences, Antigua and the American University of Antigua and Barbuda College of Medicine, private offshore universities. The institutes in the system are the Antigua and Barbuda Hospitality Institute, the Antigua and Barbuda Institute of Technology (ABIIT) and the Antigua and Barbuda Institute of Continuing Education (ABICE) (Roberts, 2006 and CIA, 2017).

10.4.1 Antigua/Barbuda's empirical findings

The following sections present the findings from four interviews and document analysis on Antigua/Barbuda's engagement with the BScN reform. The interview participants from this territory were a former PS in the Ministry of Health, Bureaucrat F; a former RNB representative, Representative G; and a nursing education administrator, Administrator H.

10.4.1.1 Reasons behind the reform in Antigua/Barbuda

Responses suggested that four issues lay behind this territory's engagement with the reform. The issues were international trends, the movement of nursing schools into

educational institutions, concern about the quality of nursing service, and concern about the quality of nursing education. These issues mirrored those identified by participants in the other territories. Notably, none of them was unique to Antigua/Barbuda.

10.4.1.2 Reform intentions

Intentions cited were also similar to those of the other territories in the study. The responses suggested that the participants perceived the reform as intending changes in the delivery of nursing education, and that those changes would standardize nursing education in CARICOM. The changes identified were delivering the BScN locally and ending the diploma level training. However, none of the intentions reflected changes unique to Antigua/Barbuda's nursing education system. This implied that the system had not yet sufficiently engaged with the reform to have vested interests in the outcomes of the process.

10.4.1.3 Reform Components

When the participants articulated their views on the components of the reform, their responses suggested that they viewed it as encompassing changes in the delivery of nursing education, reciprocity amongst nurses in CARICOM, infrastructural upgrade, faculty upgrade/recruitment, and the harmonization of nursing education in CARICOM. Categorised under changes in the delivery of nursing education were discontinuing the diploma level training, delivering the BScN locally and extending the length of the general nursing programme. These expected changes were consistent with the intentions identified. This implied that the major change anticipated in the system was a change from the diploma to the BScN programme. But, it further implied

that other changes were required to support this major programme change. The participants' responses suggested acknowledgement that infrastructural and faculty qualifications upgrades were necessary. Table K2 in Appendix K lists the components of the reform, as perceived by Antigua/Barbuda's participants.

10.4.1.4 BScN reform engagement

The evidence suggested that the territory's engagement with the reform so far entailed collaboration, contestation, compromise, apprehension, disregard and, acceptance. The following sections examine these interactions and responses in the process.

10.4.1.5 Multi-directional communication and nursing leadership

The responses suggested that the BScN decision was communicated to the Ministry of Health via the CNO, and then to the Principal of ASC and the Principal Tutor of its School of Nursing via a letter from the PS. Reportedly, the CNO also communicated the decision to the nursing faculty via meetings. Administrator H recalled the communication this way, "By word of mouth at a meeting. The CNO told us at a Council meeting. Most of the CNOs are Chairs of Council…In Antigua, this happened around 2006-2007." Bureaucrat F recalled, "I'm not sure about to Antigua but it would have been communicated to the school verbally and in writing. The CNO would have spoken to the faculty and I sent a letter to the Principal Tutor of the school and copied it to the Principal of the Antigua State College because our School of Nursing comes under the umbrella of the Antigua State College." When asked how the decision was communicated to member states Representative G stated, "Through the RNB members." This response implied that the CNO, who was Antigua's representative on RNB also communicated the decision to that territory. Collectively, these responses

implied that the CNO was the main conduit through which the decision flowed into Antigua's nursing education system. They also suggested that official communication was sent to the College about the reform from the Ministry of Health. But the CNO was also reported to have led engagement with the reform, even before the decision was made at COHSOD.

Speaking of the origin of the decision, Bureaucrat F recalled, "It came out of consultation...out of an RNB meeting attended by _____ who was our CNO and Chairman of RNB at the time. The nurse leaders put forward the recommendations to us and we forwarded them. They consulted with us, we all had discussion. It was not thrust on us. We came up with something agreeable to all parties eventually at national level and then sent forward to COHSOD. There was bottom-up discussion." This response suggested that Antigua/Barbuda, like Barbados and Jamaica, had proposed the BScN policy to COHSOD after consultation between its national nurse leaders and the bureaucrats in the Ministry of Health. This implied that communication regarding the reform was both bottom-up and top-down in this system.

10.4.1.6 Collaboration, contestation and compromise

Bureaucrat F recalled his Ministry's engagement with the reform this way,

> "In late 2014 we were trying to get UTech, an accredited degree-granting institution, to offer the degree for us…Some persons had concerns about whether our present faculty had the requisite qualification. Our concerns were quality-related. We were looking for short to medium term solutions. The long term aim was to get our institution to offer the degree. We were also looking for one of the

offshore institutions to offer the training but there were strong concerns

coming from the Nurses Association about this option."

This comment suggested that, acknowledging their College's inadequate capacity to deliver the baccalaureate programme, the Government was seeking assistance from one of the offshore universities to facilitate delivery of the programme. However, the direction was changed to partnering with UTech after interest group opposition. Bureaucrat F recalled, "We had discussion with our technicians again and consensus that we would approach UTech about the franchise. So in 2014 we started to look at an agreement with UTech but then we started to look at elections shortly afterward." This comment suggested that approaching UTech for the partnership was a compromise.

Notably, the CNO had also intervened in the situation to advise the Minister on the issue and abate the conflict of ideas. Representative G recalled, "When I was PNO I suggested to the Minister to take the money the government would pay these offshore schools to deliver BScN programmes and use it to improve the infrastructure and make the national institution a degree-granting institution." Administrator H noted, "We tried to get the College on Board for some time. Only after their decision to move to the University College did they start to show interest. There is a Government mandate so they now see nursing as helping them to jump to meet this mandate." These comments suggested that there was a shift in direction regarding the College's engagement after intervention by the CNO and a subsequent mandate by the government. While not suggesting that the shift was a direct result of the CNO's advice, the responses do suggest that the nurse leader influenced the bureaucratic decision-making in the system. The responses further suggested that although

advances were being made at the national level, there was some apprehension and disregard for the policy at the institutional level.

10.4.1.7 Apprehension and disregard with subsequent acceptance

Bureaucrat F's comment that "some persons had concerns…" and Administrator H's comment about the College's response suggested that there was some apprehension in the system regarding engaging with the reform. Administrator G recalled ASC's engagement with the reform this way,

> "For a while the College wasn't moving on the idea but now they want to go to University College, the School of Nursing is their flagship…the College is excited. It's trying to develop a University College of Antigua and the School of Nursing would be the highlight. So there's now a synergy between nursing's goals and the College's goals. The Principal Tutor is now asked to sit on the University Planning Committee… We had the BScN curriculum developed by Dr. Reid but the College doesn't have degree-granting status…actually the tutors started to revise the Curriculum before the consultant. Then we collaborated with the consultant for the curriculum upgrade and we now need to put our clinical guidelines together."

These comments suggested that after disregarding the policy for some time, the College only began to engage with the reform after an agenda was set for it to upgrade to a University College. This finding was similar to what had transpired in The Bahamas and in St. Kitts/ Nevis. It was also similar to what transpired with the Barbados Community College, with respect to moving on the reform only after Ministerial intervention. This implies that, to an extent, the advancement of nursing

education in CARICOM, is dependent upon the willingness of the tertiary level institutions to permit its development. But, although nursing education has been placed in the state colleges as a means of integrating it into the tertiary education system, from the evidence it appears to be the case that the colleges do not have the capacity to accommodate the developments taking place in nursing education. This finding will be addressed in the synthesis chapter.

Administrator G continued her explanation of the process by saying, "…we are discussing with Mona Campus and exploring how we can link with them by some type of articulation agreement so that our graduates would be awarded a UWI degree…We trained our nurse educators to Masters level and we're trying to meet the…requirement of having a Simulation Learning Centre." From this response it appears to be the case that the College has accepted the reform and are working towards implementation. However, the response suggested that the process is still at the discussion stage with a potential partner institution.

10.4.1.8 Reform enablers

Participants were asked what factors they thought enabled or constrained the reform in their territory. The responses suggested that commitment and support were the key enablers of the reform in this territory. Identifying the enablers Bureaucrat F said, "We had a strong and knowledgeable CNO who understood the whole dynamics of nursing…They [the College administrators] were satisfied that the level of training and structure of the programme that the students are currently engaged in would enable them to qualify, with a few more credits, to enter the degree programme." This

comment suggested that leadership and the College administration's support enabled the engagement to reach the stage it has.

Administrator H elucidated her views on the issue this way,

> "The nurses' interest in upgrading to BScN. The new entrants to the profession are being paid higher with the BScN. The facilitation it gives to reciprocity and the Ministerial pronouncements also help it along. All you get is pronouncements at the Ministerial level though. Nothing more forthcoming from that level. We tried to get the College on Board for some time. Only after their decision to move to the University College did they start to show interest."

This comment suggested that the demand for the programme, and government support – including supporting policy, facilitated progress in engagement with the reform.

Representative G expressed her view on the enablers as, "Self-motivation of the nurse educators. We have a group of highly motivated nurse educators here. They have a higher level of professional understanding and camaraderie. I think that's mainly it." This comment suggested that the participant viewed the faculty's commitment as the key enabler of the reform at the national level.

When asked about what enabled the reform at the regional level, Representative G stated, "The technical assistance from CARICOM and PAHO. Also the desire by the CNOs to see the process through and raise the standard – there is generally high motivation among the CNOs." This comment implied that the commitment of the nurse leaders and the support they received from CARICOM and PAHO enabled

progress with the reform at the regional level. Table K3 in Appendix K illustrates the factors participants cited as enabling the reform and the context levels they were perceived to have impacted.

10.4.1.9 Reform constraints

Participants also expressed their views on what constrained the reform. Their responses suggested that ideology and inadequate support, among other factors, constrained progress with the reform. Administrator H stated, "…there was not much political will … also, there was a reluctance on the College's part to spend money on nursing. Our school was under the Ministry of Health and then seconded to the Ministry of Education. So, there was reluctance to spend money on the school of nursing because there was the perception that the Ministry of Health should be financing the school." This comment suggested that insufficient financial support from the government, the College's ideas about who should finance nursing education, and its focus on cost avoidance helped to constrain the reform.

Bureaucrat F expressed his views about the constraints this way, "Government's financial commitment. Allocation of funds is the challenge. You may get verbal support but allocation of funds may be a different matter...The lab and other facilities need upgrading for Nursing and Pharmacy. We're seeking funding for this. Also, we need more staff to drive the programme and we need to upgrade our staff's qualifications." This comment suggested that insufficient government support, inadequate capacity and financial insufficiency all constrained the reform. But Representative G had stronger views on the issue.

In relation to the constraints, Representative G stated emphatically,

> "The territorial nature of nurse leaders limits advancement of the profession. Wherever we go in the region it's the same. There is this distorted conceptualization of the nursing field by nurses and others. Everybody, including *them* doctors, want to run nursing. The exclusion of nurses from health meetings unless there are matters directly related to nurses helped to constrain it. Nurses are not consulted at high policy levels you know. When you see the Minister going to high level international and regional health meetings he taking the CMO and leaving the CNO at home. But who make up the largest chunk of the health workforce? The nurses. It is the nurses who will make these policies work or go bust. So who should be invited to get their full participation? But no, they exclude the nurses."

This comment suggested that ideology acts as a strong hindrance to nursing reforms in the CARICOM region. Ideology in this instance pertained to the parochial nature of some nurses, and the conceptualization of nursing that elite policy-makers hold. The comment also suggested that the exclusion of nurses from policy meetings similarly hinders the advancement of the profession and the success of health policies. These comments were similar to comments made by participants from other territories and so the issue of ideology will be addressed further in the synthesis chapter. Table K4 in Appendix K illustrates the factors deemed to have constrained the reform and the context levels they were perceived to have impacted.

10.4.2 Document findings

To triangulate with the interview findings, the Antigua and Barbuda Nurses Act, 1954 was also analysed. The key findings from this document were firstly that, like the other territories, the GNC in this state had responsibility to regulate the training and entry into the profession. Secondly, it was found that the legislation was not revised in recent times and had made no provision for the BScN to be established as the entry to practice qualification in the territory. The implication of this pattern will be examined further in the chapter following.

10.5 Summary of Antigua/Barbuda's reform process, to date

The evidence suggested that the 2006 decision entered Antigua/Barbuda through communication from the CNO and was disseminated to key actors in the system. But the evidence further suggested that beyond this, Antigua actually contributed to the regional decision by proposing the policy at COHSOD, along with Barbados and Jamaica, after lobbying by the CNO and discussions between the nurse leaders and the Ministry of Health officials.

The evidence also suggested that there was apprehension about the reform in the system initially. Reportedly, this apprehension was at the national level and the institutional level. The responses suggested that the Government's apprehension was due to the College's inadequate capacity to deliver the BScN programme. They further suggested that the College's apprehension was due to their reluctance to invest money into the Nursing Department due to the administration's ideation about who was responsible for nursing education. Moreover, the responses suggested that not only was the College apprehensive about the change, but that the institution disregarded the

policy for at least seven years before it began meaningful engagement; and that engagement came only after Ministerial mandate for the College to upgrade to a University College.

The evidence suggested that to overcome the College's deficient capacity, the nursing faculty had been trained to Master's level. The evidence further suggested that the system is currently negotiating with a regional partner, the UWI, to franchise and deliver the UWI degree. But the evidence also suggested that despite these strides towards implementation, no legislative changes have been made to establish the BScN as the entry to practice qualification for nursing in the territory. This finding implies that although the programme may be taught in Antigua/Barbuda, that development may not be permanent, as the institution would not be obligated to continue the programme. This finding is consistent with what transpired in other territories, and will therefore be examined further in the next chapter. Figure 10.2 illustrates Antigua/Barbuda's engagement with the reform to date, as understood by the researcher.
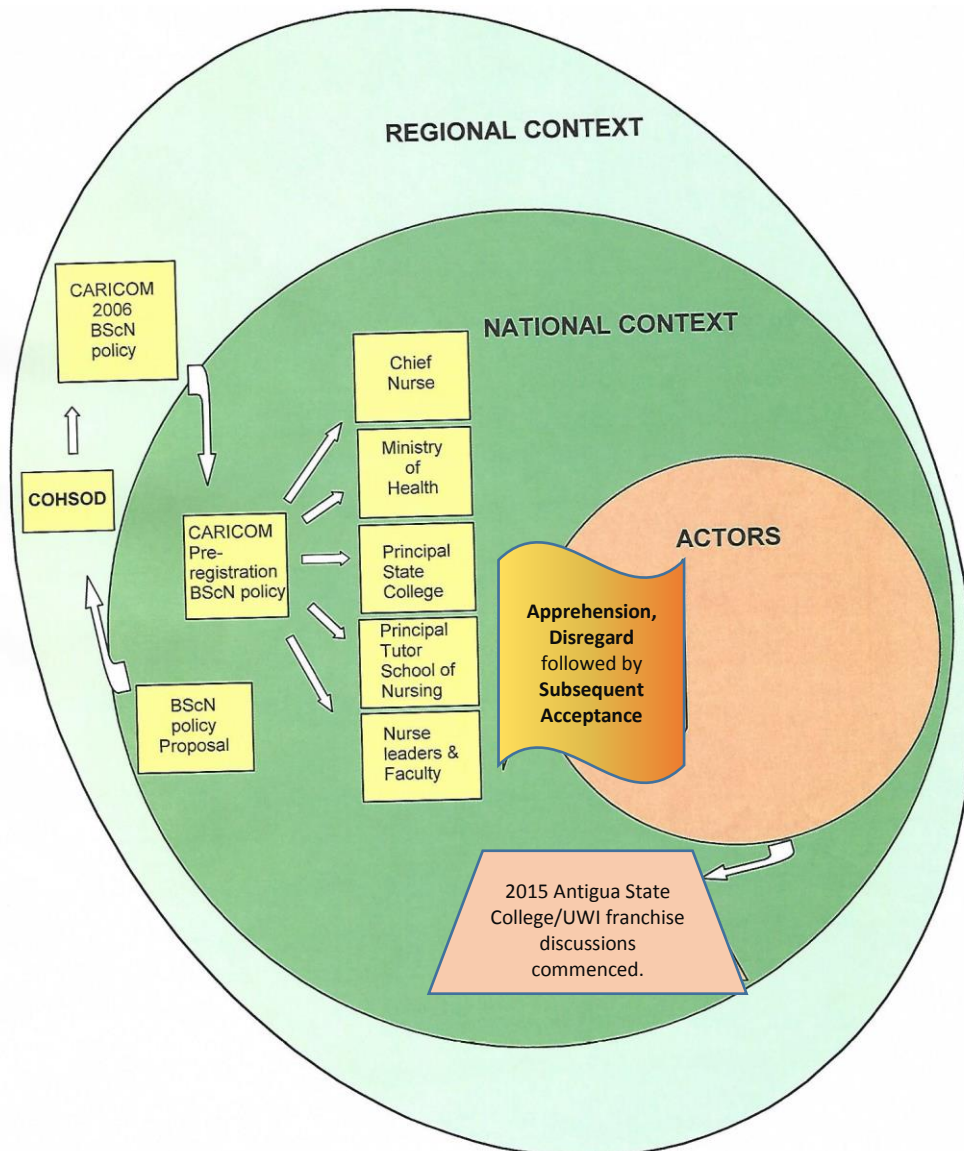
Figure 10.2: Evolution of the BScN Reform in Antigua/Barbuda

10.6 Comparison of Grenada's and Antigua/Barbuda's engagement processes

The evidence suggested that in both cases the 2006 CARICOM decision was widely disseminated in the system. However, in the case of Grenada, no communication went to the NNA. Despite this omission, the accounts suggested that between 2008 and 2016 major strides were taken toward advancing general nursing education in the system from the hospital-based apprenticeship system to university level education.

This suggested a general acceptance in the system for the reform and, up to the time of writing, general nurse training was being delivered at St. George's University as an associate degree, with a BScN curriculum prepared. Reportedly, the system was merely awaiting the SGU's investors' permission to deliver the degree programme an award the commensurate qualification.

On the other hand, progress in Antigua appeared not to be as swift. The accounts suggested that the College disregarded the policy for an extended period, despite communication from the Ministry of Health. Moreover, the College did not engage with the reform until it received a Government mandate to upgrade its operations, and finally saw the reform as enabling its new agenda. Despite Antigua/Barbuda's nursing education residing in the College well before Grenada's, the positioning of nurse training in the College system seemed not to offer any advantage to implementation of the BScN programme. In fact, from the evidence it appears that, positioning nursing education in the College actually permitted the institution to stall the advancement of the reform. This finding is consistent with the accounts given of The Bahamas', Barbados', and St. Kitts/Nevis' state colleges' responses to the BScN reform. It therefore implies that positioning nursing education in community colleges may not be beneficial to advancement of the field of study. It suggests that because nursing is advancing to a degree level discipline, policy-makers should seek to have it integrated into universities, as these institutions already have the capacity to deliver multidisciplinary baccalaureate education.

The findings also suggested that if the commitment of Antigua/Barbuda's nursing faculty and the strong support of the Government were absent, the reform process may

not have advanced to the current stage of discussions with a partner university. Moreover, it suggested that the College's ideology regarding nursing education militated strongly against baccalaureate level education for nurses. This further suggested that the College may not have been the best tertiary level institution for nursing education.

Conversely, despite Grenada's constraints of inadequate capacity, nursing leadership deficiencies, and lack of interest group participation, that system was able to progress to the same point as Antigua's in a shorter timeframe. Furthermore, the system also made the major advancement of transferring nursing education to the TEIs during that period. Nursing education was transferred from the hospital to the College in 2008. But by 2016, the discipline was already in SGU and ready to be delivered as a BScN - again. This contrast highlights the strong hindrance that an unfavourable ideology can have on an educational reform. It also highlights the capacity differences between universities and colleges for baccalaureate nursing education. The following chapter synthesizes the findings from the case units and explores the implications of the implementation pattern for the future coverage and coherence of nursing provision in the region.

Chapter 11

Synthesis and Implications of the Findings

This chapter synthesizes the evidence to provide a regional picture of the reform. The picture presented only approximates reality because it has been developed from the perceptions of policy actors who operate in a sample of CARICOM territories. The sample was not deemed representative of all of CARICOM. Indeed, the sample was not chosen for representativeness but was selected to provide an in-depth understanding of how the reform unfolded in the selected territories. Nevertheless, the details provided by these participants who performed key roles in the formulation and implementation processes associated with this reform, revealed substantial information about its evolution in the system. The information is presented as responses to the research questions.

11.1 What were the reasons for the 2006 CARICOM BScN reform?

The findings suggested that the 2006 decision was part of a larger 1970s RNB agenda. The evidence further suggested that as early as 1972-1975, RNB had decided that nursing education should be transferred to tertiary education institutions and the intention from then was to make the BScN the entry requirement for practice. This does not suggest, however, that the movement of nursing into TEIs and the delivery of the BScN degree programme emanated from within CARICOM. The literature suggests that as early as 1901, the transfer of nursing education to universities, for baccalaureate education, was on the ICN's agenda (Scheckel, 2009). Given CARICOM nursing's involvement in the ICN, and given the region's propensity for policy transfer, it is plausible that the 1970s RNB agenda was really an adoption of ICN's international nursing agenda. Reportedly, member states moved at different

rates to transfer nursing education into TEIs and this uneven movement stalled progression of the RNB BScN agenda.

The evidence further suggested that recent circumstances in the region stimulated the resurgence of the RNB objective to make the BScN the entry level qualification for nursing in the region. These circumstances were, the:

- emigration of nurses from the region, seeking higher education and other opportunities;

- concern about the quality of care, that resulted from the emigration of experienced nurses in the late 1990s and early 2000s; and

- the varied standards in CARICOM nursing education.

From the evidence it is safe to conclude that the old agenda of establishing the BScN as the minimum qualification for practice was therefore reintroduced as a solution to these problems.

11.2 What was encompassed by the reform?

The evidence suggested that the reform encompassed:

- the transfer of nursing education from hospitals to TEIs;

- the delivery of the pre-registration BScN degree programme throughout the region;

- the upgrade of practicing nurses;

- revision of the CARICOM standards for nursing education;

- programme accreditation; and

- the revision of the territories' nursing legislation to establish the BScN as the entry to practice qualification for nursing.

Additionally, the evidence suggested that the reform encompassed all other changes necessary to deliver the pre-registration BScN degree programme locally. Therefore the territories had to make country-specific changes to implement the reform. Some of these changes were faculty training and/or recruitment, infrastructural upgrade, and curriculum development.

What goals, plans or expectations (intentions) were attached to the reform?

The responses suggested that regional and national intentions were attached to the reform. In some cases, the reform was used as a vehicle to facilitate development of the country's tertiary education system. In others, it was viewed as developing nursing education to attain regional and international parity. From the evidence it would be safe to conclude that the regional intentions associated with the reform were to:

- change how nursing education is delivered in CARICOM;
- harmonize the standards of nursing education in the region;
- improve the quality of nursing education in CARICOM;
- enhance the quality of nursing service by improving the competencies of graduates;
- improve the status of the nursing profession;
- promote regional reciprocity in nursing;
- retain nurses in the region by offering the educational opportunities they sought in destination countries;
- give nurses parity with other health professionals and;
- facilitate postgraduate education for nurses.

11.3 What factors promoted or inhibited the realization of this policy?

The evidence suggested that, in the main, the same factors operated in all of the territories to promote the delivery of the BScN degree programme. Only seven of the twenty enablers cited appeared to be country-specific. The factors that appeared to be specific to the country contexts were:

- leadership networks,

- history,

- community need,

- public demand,

- communication pattern,

- reform championing,

- applicant readiness, and

- interest in nurse migration.

The responses suggested that, at the regional level, the reform was enabled by:

- support,

- leadership,

- stakeholder collaboration,

- capacity,

- commitment, and

- political will.

These factors were reported to have enabled the reform at some national and institutional levels of the context as well. In addition to these, other factors were cited as impacting the national and institutional levels to effect implementation of the programme. These factors were:

- financing,

- policy fit,

- ideology,

- supporting policy,

- the demand for nurses and,

- interest group participation.

But besides the enabling factors, participants also identified those factors that they perceived as hindering the reform.

The evidence suggested that the factors participants perceived as the greatest constraints to the reform were inadequate capacity and nursing leadership deficiencies. Both of these were reported to have operated at the regional level by participants from three out of the six territories. These were followed by financial insufficiency and conflict, which were reported to be operating at the regional level by participants from two out of the six territories.

In examining the constraints operating at the national and institutional levels, it was revealed that inadequate capacity was implicated as constraining the reform in all instances except in The Bahamas. More specifically, it impacted all of the Colleges that engaged with the reform. This implies that the community colleges lacked the capacity to implement the BScN degree programme without assistance, under the prevailing circumstances.

Of particular concern is the capacity of the BCC to independently deliver the BScN programme and award the degree. Of all the participants, those from Barbados cited

the most constraints, and most of these were reported to be operating at the institutional level. This not only suggested that the institution does not have the capacity to deliver the programme independently; it also implies that its already inadequate capacity is further compromised by a plethora of other constraints at the institutional level that militate against realization of the reform. This raises the question of whether there is yet room for a partnership between the BCC and UWI to deliver a creditable BScN degree programme to students in Barbados and the OECS.

As a constraint, leadership deficiencies were reported to have impacted all territories except St. Kitts/Nevis. In fact, St. Kitts/Nevis' participants listed only three constraints – financial insufficiency, inadequate capacity, and communication challenges (in the post-implementation phase). Leadership deficiencies, in some cases, referred to shortcomings in nursing leadership. In other cases it referred to educational leadership. Yet in other cases it referred to deficits in the exercise of leadership by both educational and nurse leaders. St. Kitts/Nevis' exception may be a result of the fact that its reform champion was the lead institutional implementer and the territory's RNB representative. Consequently, there were no intermediaries to distort the reform message, and the champion was able to lead the collaboration to roll out the programme's implementation. The findings suggested that St. Kitts/Nevis' reform champion/lead implementer had strong support from the Government and the CFBC's administration, once they saw that the policy fit with their institutional agenda. Therefore, from the evidence, it appears to be the case that in this reform episode there was little opportunity for this RNB representative's leadership skill to be rigorously tested, in the area of conflict resolution.

Financial insufficiency was reported to be operating in all of the territories except Grenada, whose participants - along with those from Antigua/Barbuda and Barbados – cited cost avoidance as a constraint. It should be noted however, that the reform's implementation is incomplete in Grenada and Antigua/Barbuda, so it is yet to be seen if financial insufficiency impacts its realization. Moreover, although Barbados' participants did not cite financial insufficiency as a constraint, they did report that financial limitations hindered the reform's realization. These findings suggest that financial insufficiency was deemed to have a significant impact on the reform; although it was not regarded as the main hindrance to the reform's implementation.

The emigration of nurses was reported to have constrained the reform in the region but the only participants who reported that it impacted the national and institutional contexts were those from Jamaica. This was consistent with Jamaica's history of migration. Notably, although other territories' participants cited emigration as a feature of their national contexts, they did not cite it as a constraint. However, in Jamaica, it was deemed to have depleted the complement of experienced nurses available for students' clinical supervision, and to fill faculty positions.

Conflict was also implicated as hindering the reform at the regional level, by the RNB representatives from Jamaica and Antigua. This factor was also considered to have acted as a constraint at the national and institutional levels in three of the six territories. Notably, Grenada and Antigua, which have not yet implemented the BScN programme did not identify conflict as a constraint. Since the policy implementation literature associates conflict with interest group participation, and since the findings suggested that interest group participation heightened during the institutional implementation

phase, the impact of conflict in these two territories' reform processes may not be fully evident. As such, for an assessment of conflict's impact on Grenada's and Antigua/Barbuda's reform processes, the programme implementation phase would have to be investigated to derive a more accurate picture of this factor's impact.

Political will was identified as a regional constraint by one participant from The Bahamas. Notably, political interference was deemed by another participant to have constrained the reform at the institutional level in this territory. This suggests that the reform efforts in The Bahamas had little political support. This claim is further substantiated by the finding that the conflict over revising the degree programme in that territory was allowed to continue for approximately four years without any leadership intervention, and the finding that the revision was only facilitated after the territory set an agenda to upgrade its College to a University. Most other territories reported that political support for the reform was strong. Although some stressed that it was only in the form of pronouncements – not monetary contributions.

Nationalism was cited by one participant as a constraint that operated at the regional level. The participant who cited this constraint explained that nationalism facilitated the persistent fragmentation of nursing education in CARICOM. In the main, this perspective was supported by the findings of the study. The findings suggested that while member states had taken some steps to deliver the degree programme locally, they did not go all the way with implementation. The territories did not transpose the CARICOM decision into their municipal law. This step is required by CARICOM governance procedures for CARICOM decisions to take full effect in member states. Its omission implies an attempt by the territories to exercise control over the extent to

which they engage with this regional decision. This finding is consistent with O'Brien's (2011) view on CARICOM policy implementation. O'Brien advanced that the 'implementation gap' in CARICOM policy is a result of the "fragmented ideological consensus that had previously existed between the leaders…" (O'Brien, 2011). This finding again raises the issue of ideological tensions in the system, and their impact on the reform's implementation.

Participants from three of the six territories identified ideology as a constraint on the reform. Notably, these countries were Barbados, a late engager, and Antigua and Grenada, the two dilatory engagers. Interestingly, it was not reported to have hindered implementation in the early engagers, and was not reported to have affected the reform's roll out in St. Kitts/Nevis – the territory in which the lead implementer had substantial influence. These findings suggest that ideology contributed to the delay in implementation. But ideology was also cited as having an enabling effect on the reform.

In St. Kitts/ Nevis, the institutional ideology reportedly favoured the reform. No mention was made of the national ideology in that territory. The participants from Barbados cited ideology as a constraint operating at the institutional and national levels of the context, but also cited it as an enabler operating at the national level. Grenada's respondents cited this factor as operating as both an enabler and a constraint at the national level. These findings suggest that ideological tensions exist in CARICOM's nursing education system that simultaneously supported and militated against the BScN reform. Some of these tensions will be examined later in the chapter.

11.4 How, and to what extent, was the 2006 CARICOM BScN decision implemented in member states?

The evidence suggests that some of the territories have partially implemented the reform while others are preparing to do so. But the evidence further suggests that none of the selected territories have established the BScN degree as the entry to practice qualification for nursing, as they have not enacted the requisite legislation to formalize the decision in each member state.

Reportedly, all of the territories engaged in stakeholder collaboration to plan for implementation, and most formed partnerships to overcome inadequate capacity. Additionally, it appears to be the case that, most territories engaged in country-specific activities to enhance institutional capacity to deliver the pre-registration BScN degree programme.

All of the territories sought to deliver pre-registration BScN programmes locally – either through their state colleges, or through universities. The findings indicated that in Jamaica, the pre-registration BScN degree was rolled out to the national university and the community colleges. The evidence further suggests that it is currently delivered through the national and regional universities; and that the state colleges deliver the UWI BScN degree through franchise arrangements.

Reportedly, The Bahamas revised its BScN programme in early 2016 and continued delivering the programme through the College of The Bahamas. In November 2016, the College upgraded to the University of The Bahamas. Therefore, the pre-registration BScN degree in that territory is now a university degree.

The evidence suggested that, in St. Kitts/Nevis, the CFBC formed a partnership with UWI to deliver the UWI BScN programme on franchise. It was also revealed that Antigua/Barbuda is negotiating a partnership with the UWI for a similar arrangement. Based on the evidence, to date Grenada's general nursing programme is still an associate degree programme. However, the evidence suggests that Grenada has made significant strides in developing nursing education in the last eight years. The general nursing programme was transferred from the hospital to the community college in 2008, and from the College to the St. George's University in 2016. The programme transferred to SGU as an associate degree programme and is currently awaiting clearance from the university's investors for the BScN programme to commence.

The findings further suggested that Barbados was the only territory amongst the six that was delivering its BScN programme through its community college *and* awarding the degree from the College. Notably, the evidence also suggested that none of the colleges in the study had sufficient capacity to deliver the BScN programme without the assistance of partners. This therefore raises concern regarding the value of the BScN degree currently being awarded by the BCC.

Notably, none of the territories had revised their legislation to the extent that establishes the BScN as the entry level qualification for nursing practice in the country. While all the territories had made steps toward delivering the pre-registration BScN locally, the evidence suggested that none of them had revised their national nursing legislation to give effect to this CARICOM decision. Given CARICOM'S governance procedures, enacting the requisite legislation is a necessary step to formalize such decisions in member territories. Omitting this step suggests an attempt to limit this

CARICOM decision's authority in the territories. This implies a nationalistic perspective militating against a regional agenda.

11.5 What are the implications of this implementation pattern for the future coverage and coherence of nursing provision in CARICOM?

The findings suggest an uneven implementation of a reform that has been only partially adopted by the member states. This pattern of adoption and implementation threatens the region's quality of nursing education and nursing service by not guaranteeing a common minimum standard of nursing education and nursing care in the region. Moreover, the failure to expand the delivery of baccalaureate nursing education in the region leaves CARICOM at risk for continual migration of nurses seeking educational and other opportunities in destination countries. The continued depletion of the region's nurses compromises its ability to deliver healthcare to its population, and achieve quality healthcare for all by 2030.

Beyond the threats to healthcare provision, the implementation pattern threatens the harmonization of nursing education and the attainment of reciprocity in CARICOM nursing. The ability to share nursing manpower of comparable cognitive and psychomotor capabilities would strengthen CARICOM's resilience in the area of health human resource management. It would also facilitate CARICOM's functional cooperation agenda. But the current adoption and implementation pattern of the CARICOM BScN reform does not portend to these benefits in the short term.

The implementation pattern not only impedes the union's harmonization and reciprocity agenda, it prevents the region from effectively addressing the challenges it

faces with NCDs. The under-preparation and, in some cases, ill-preparation of the region's nurses, hinders them from developing the skills to make the clinical and management decisions necessary to combat the region's health challenges. The 2009 World Bank data on the inadequate complement and ineffective training of nurses in the region suggests a link between the fragmented delivery of nursing education and the inadequate capacity to deliver quality nursing service. The fragmented delivery of nursing education therefore demands urgent redress. Beyond exposing the uneven implementation pattern and the danger to healthcare in CARICOM, the findings also revealed tensions in the system.

11.6 Tensions in the system

While the interactions to implement a reform cannot be ignored, equally important are the values that drive those interactions at each stage of its evolution. The evidence suggests that while policymakers may agree in principle on a reform initiative, their underlying values function to either promote or hinder the reform's realization and will shape its outcomes. During the interviews, the nurses who participated in this study presented as having an interest in harmonizing CARICOM nursing education. But the findings of the study suggested that there are some underlying values tensions that are delaying attainment of this target.

The finding regarding the territories' failure to enact the supporting legislation and give full effect to the 2006 CARICOM BScN degree policy implied a tension in the system between regionalism and nationalism. It suggested that while territories may be willing to engage with this CARICOM reform, to a point, they are unwilling to fully commit to the CARICOM direction. This threatens the achievement of

harmonization. This finding is consistent with Hall and Blake's (1977) viewpoint that CARICOM's decision-making mechanisms perpetuate nationalism and variation in policy implementation. If territories are not obligated to comply with CARICOM agreements, then they are not obligated to provide nursing education of an agreed minimum standard at an agreed minimum level. Therefore, there can be no guarantee of comparable quality nursing education and, by extension, comparable quality nursing service in the region. Consequently, the tension between nationalism and regionalism threatens more than the harmonization of nursing education, it threatens the quality of care that the Caribbean population would receive from its nurses and hinders the objective of regional reciprocity in nursing.

The evidence also suggests that the varying levels of implementation capacity in the member states creates a tension in the system. Capacity in this instance related to the leadership capabilities in higher education and nursing; higher education and clinical placement facilities; human resource capacity; and available finances. The responses suggested that capacity was an enabler of the reform while its inverse, inadequate capacity, was the main constraint. This vacillation by participants regarding the system's level of capacity to implement the reform suggested uncertainty in relation to the territories' ability to deliver the degree programme. Yet, the region aims for international parity in nursing education. This implies a tension between capacity and ambition in CARICOM's nursing education system; and it further implies that for the system to achieve this ambition, it should strategically utilize its partnerships to overcome its capacity deficiencies.

Participants' responses also suggested that a tension exists between parochialism and liberalism in the system. They suggested that while CARICOM nursing had committed to the BScN degree agenda some nurse leaders in the system – due to a narrow outlook - were engaging with the reform in ways that undermined the agenda. These tactics included withholding information, obstructing changes, and disregarding the policy. The accounts of participants from Antigua/Barbuda, Grenada, Barbados and Jamaica implicated this factor as hindering the progress of nursing's agenda in the region.

It is plausible that if these tensions remain unchecked they can stagnate the system's nursing education agenda. Therefore I advance that CARICOM nursing needs to clarify and reflect on its values in order to define itself and chart its path. Additionally, its nurses need to develop the skills that would empower them to drive the profession's agenda in their home territories. This study's illumination of some of the tensions impacting CARICOM nursing is an initial step in this process.

11.7 Avenues for reform acceptance

But, beyond the tensions and the extent of implementation, the findings also suggested that expanding the implementation of the regional policy at the state level may be facilitated through deploying reform champions, enhancing member states' capacity, and increasing reform enablers. They suggest that deployment of reform champions to strategic positions in the territories to guide the discourse and shape ideology, would promote acceptance, and help to drive implementation of the regional policy at the national level. They further suggest that enhancing the member states' capacity in the areas of infrastructure, financing, human resources and leadership capacity would also

facilitate regional reform implementation. Specifically, they imply that realizing CARICOM nursing policy intentions in member states requires significant strengthening of nursing leadership in the region and strategic collaboration amongst major players. In addition, increasing enablers like government support, interest group participation, multimodal, multidirectional communication, and commitment to the reform agenda would similarly promote the realization of regional reforms in local spaces. The chapter following concludes the thesis and advances the researcher's argument.

Chapter 12

Conclusion

This final chapter reflects on the overall conduct and implications of the study. It begins by relating the findings to the literature that informed the conceptual framework, and continues by relating them to the framework itself. The chapter then situates the study in the wider Caribbean policy research field, and culminates by advancing a way forward for the expansion of the 2006 CARICOM BScN reform.

12. 1 Congruence with the literature

The research findings generally support the literature on Caribbean policy-making and policy implementation. They corroborated Jones and Schoburgh's (2004) view that the Caribbean's policy-making tends to be overambitious. Moreover, while they did not confirm that the reform was a function of policy transfer, they did not rule out this claim either – to the extent that they suggested the territories' engagement with the reform was partially stimulated by international trends in nursing. They also support Garn's (1999) point that local capacity and will are factors that most critically affect the outcomes of the implementation process.

Beyond supporting the literature on Caribbean policy-making, the findings shed further light on CARICOM policy-making by revealing some of the factors that promoted and inhibited this regional policy's implementation in local spaces. They also illuminated some of the tensions in the region's policy system.

The evidence supported the literature on communication and discourse in policy-making (Yanow, 1993; Ball, 2013; Canary, 2010; and Johnson and Chrispeels, 2010).

It suggested that multimodal, multidirectional communication promoted realization of the reform. According to the accounts, this form of communication was exemplified in Jamaica's engagement with the reform, and the outcome was expansion of the BScN degree throughout the country's tertiary education system. The accounts of Barbados' and St. Kitts/Nevis' engagement suggested that communication challenges constrained the reform in those territories – the late engagers. The participants' recollection of these reform episodes suggested a protracted implementation delay. This further suggested that widespread, multimodal communication promotes reform implementation. Moreover, these findings also imply that limited communication can hinder a reform's progress.

The view of Bacharach and Lawler, on influence and networks, as cited in Bell and Stevenson, 2006 was also supported by the findings. The accounts supported the view that the extent of leadership influence and the support of leadership networks help to promote reform implementation. The participants' recollection of the reform events in Jamaica, The Bahamas, and St. Kitts/Nevis substantiate this viewpoint, to the extent that they provide specific examples of how influential actors were able to shape the policy process.

Bell and Stevenson's (2006) view of conflict and power in policy-making was also supported by the findings. The tendency for conflict to delay policy implementation was illustrated in the accounts of The Bahamas' and Barbados' engagement with the reform, where personal conflicts and professional discord and power struggles appeared to have constrained the reform. However, the control that effective use of power can exert on conflict, to promote a reform agenda, was demonstrated in the

exercise of bureaucratic leadership, as conveyed in the accounts from Jamaica's participants. Beyond supporting the literature, the evidence also supported the claims in the Policy Evolution Model.

12.2 Congruence with the Policy Evolution Model

The evidence supports the PEM's claim that the interaction amongst policy, actors and contextual characteristics in a policy system shapes a reform's outcomes. It also supports the claim that the same policy will have different outcomes in different contexts because of contextual variations in these characteristics. The finding that each territory's engagement with the reform yielded a slightly different outcome substantiates this claim.

The reader may recall that territories like Jamaica and St. Kitts/Nevis partnered to deliver the pre-registration BScN on franchise through their community colleges. From the evidence, Jamaica and The Bahamas are also delivering the degree through their national universities, while Barbados is delivering and awarding the BScN from its community college. The findings also suggest that Grenada is currently delivering a BScN degree programme through a private university – SGU - and is awarding the graduates an associate degree. The findings also suggest that SGU is awaiting permission from its investors to award the BScN degree.   With respect to Antigua/Barbuda, the findings indicate that this territory is still to implement the BScN degree programme. These different outcomes imply that for CARICOM reforms to be realized as intended in local spaces, policymakers should manipulate the system's characteristics to promote interactions that are favourable to the reform agenda. If necessary, the policy should be tailored to fit the context. But the evidence suggests

that it should be disseminated widely, using multiple communication modes, to promote acceptance. The evidence also suggests that the context should be fortified with the resources needed for policy implementation and that policy actors should be empowered, engaged and strategically deployed to facilitate policy acceptance and implementation.

12.3 Reflections on the study and projections for further research

The data derived from this study largely accomplished the research aim in that they provided a picture of the reform's evolution in the selected states, although they did not definitively ascertain whether the reform was a transferred policy or whether it originated in the system. However, the findings strongly suggested that it could have been transferred. Beyond accomplishing the aim, the study also illuminated some of the tensions in CARICOM's nursing education policy system. Had time permitted, deeper analysis may have yielded an even clearer picture of the reform's evolution. Nevertheless, the study adds to extant knowledge about policy-making in CARICOM's nursing education policy system.

 The study represents, for the researcher, the beginning of an evolving research agenda in the areas of Caribbean nursing and higher education policy. The findings suggest that further research is needed to provide a deeper understanding of the region's nursing education system, through empirical investigation. This study's data diverged into directions which suggest that further investigation into the influential factors, the regional policy formulation process, and the policy's outcomes is warranted.

The findings suggested that the effect of specific factors like leadership, ideology, political interference and nurse emigration on the reform's implementation would be worthy of further investigation. The evidence also suggested that it may be worthwhile investigating the process through which the policy was formulated, to ascertain whether it was an exercise of policy transfer or a decision originating with the RNB.

The research findings suggested that empirical investigation into the quality of the BScN programmes in the region is warranted, given the capacity constraints reported to be operating in the implementing states. These areas provide pathways through which a research agenda in Caribbean higher education policy analysis may be pursued.

12.4 The Way forward for the BScN reform in CARICOM

As it stands therefore, the evidence suggests that the reform has only been implemented partially; given that the requisite legislative changes have not been made, and given that there are still territories that deliver nursing education which have not reached the point of delivering the pre-registration BScN degree programme. According to CARICOM's governance procedures, agreements by organs of the Community must be entered into a member state's municipal law in order to take full effect in that state. So far, none of the territories have taken this step, and therefore have not demonstrated full acceptance of the reform. This threatens the permanence of the reform and, by extension, the attainment of the region's broader health, human resources development and political agendas.

The evidence also suggests that roll out of the BScN degree programme in the region is uneven. Furthermore, it appears to be the case that concerns regarding the quality

of the BScN programmes currently being delivered are warranted, given that only one of the selected territories listed accreditation as a component of the reform process, and given that all of the implementing community colleges were deemed not to have sufficient capacity to deliver the BScN programme. If it is the case that the quality of nursing education is below accepted standards, this threatens the quality of nursing care that would be delivered in CARICOM territories. The quality of nursing care and nursing education in the region are further threatened by the uneven implementation pattern, because such a pattern perpetuates fragmentation and varying standards in the delivery of nursing education in the region.

Therefore, to address these shortcomings and minimize their threats to the system there is need for a number of steps to be taken. Firstly, there needs to be legislation reform to formalize the BScN degree as the entry to practice qualification for nursing in CARICOM territories. Secondly, an assessment of the quality of the BScN degree programmes being delivered in the region must be undertaken in the short term. Thirdly, these degree programmes should be accredited, where feasible, to assure all concerned of the quality and continuous quality improvement of such programmes. Lastly, the territories' capacity to deliver baccalaureate nursing education must be enhanced. The accomplishment of these outcomes would require action from a number of stakeholders in the system. Specifically, these stakeholders are the RNB, the NNAs, the Nursing Councils, the wider nursing fraternity, the relevant government ministries, the national legislatures and CARICOM's partner organisations.

To encourage the full adoption of the reform in CARICOM territories the RNB, in keeping with the 2006 decision, must facilitate the consultation amongst the relevant

stakeholders to set the timeframe for formalizing the BScN degree as the entry to practice qualification for nursing in the region. The Chief Nurses, who are the territories' RNB representatives, also need to communicate the policy widely to all concerned in their territories so as to promote its uptake. The methods of communication should be varied to accommodate diverse audiences. Methods such as mass media programmes, meetings, workshops and social media should be employed.

Additionally, the Chief Nurses must urgently initiate the revision of their national nursing legislation to reflect the BScN degree as the entry to practice qualification for the profession. They must enlist the support of the NNAs, Nursing Councils and other partners to strengthen their push for this legislation change. The results of the Aiken et al (2003) study and of this study provide empirical evidence to support their propositions when negotiating for legislation reform with Permanent Secretaries, Ministers, and other stakeholders. Writing into municipal law the BScN degree as the entry to practice qualification would be a significant step towards harmonizing nursing education in the region and would support the CARICOM functional cooperation agenda. It is imperative therefore, that the Chief Nurses urgently champion and lead the review of their nursing legislation to include therein the BScN as the entry to practice qualification for the profession.

Assessment of the BScN degree programmes being delivered in the region, and situational analyses into states yet to implement the reform must be conducted, in the short term, to determine the way forward for the programmes' improvement and for expansion of the reform. Chief Nurses, Nursing Councils and the NNAs should collaborate to formulate the grant proposals to fund these studies and identify suitable

analysts to conduct the investigations. The support of partner organisations like WHO/PAHO and the UWI should be enlisted in these activities to leverage their expertise and their resource networks.

Programme accreditation is necessary to ensure that all BScN degree programmes being delivered in CARICOM conform to an accepted minimum standard; and the member states' capacity to deliver legitimate BScN degrees programmes must be enhanced. Given that CAAM-HP, the regional authority for accrediting nursing education programmes in CARICOM, only accredits university level baccalaureate nursing programmes, I argue that the universities in the region must participate in the delivery of these programmes to meet their quality assurance requirements and contribute to CARICOM's human resources development needs.

The expansion of the BScN programme's delivery in the region would increase CARICOM nationals' access to the programme and promote its establishment as the minimum qualification for entry to the profession. These changes would support the production of nurses with the requisite critical thinking and psychomotor skills to improve the quality of nursing service in the region. It is therefore incumbent upon the nursing fraternity in CARICOM to lobby for the adoption of the policy by their governments.

But given the member states' capacity challenges, increased access to legitimate BScN programmes cannot be achieved without the assistance of key partner organisations. It is therefore imperative that the UWI – its Cave Hill Campus in particular – and

WHO/PAHO provide stronger support to the territories for full implementation of the policy.

The evidence suggested that the support of partner organisations promoted implementation of the BScN in the case territories. The evidence further suggested that where that support was limited/lacking, implementation of the reform was compromised. Moreover, the limited leadership and technical capacity of some CARICOM member states constrained their ability to deliver quality baccalaureate nursing education. Given this evidence, it can be concluded that stronger support from partner organisations like WHO/PAHO and the UWI would promote the implementation of the reform in member states. The delivery of quality BScN degree programmes in CARICOM therefore necessitates the involvement of WHO/PAHO and *all* UWI campuses to support its effective implementation throughout the region.

The reader may recall that of the three UWI campuses, only the Cave Hill Campus, located in Barbados, does not deliver nursing education. The reader may also recall that this campus services Barbados and the OECS, and therefore, in effect, its non-involvement in nursing education deprives its constituents of access to baccalaureate nursing education that may be accredited by CAAM-HP. Given that CAAM-HP only accredits university baccalaureate programmes, and given the Cave Hill Campus' espoused mission, I argue that it is incumbent upon the UWI Cave Hill Campus to deliver the pre-registration BScN degree programme as a matter of urgency. If the Campus fails to do so, an unjust status quo would be perpetuated. Moreover, the inaction would oppose aspects of the Campus' espoused mission, and run counter to the 2006 CARICOM BScN decision and the UWI's role in that policy-making process.

The UWI Cave Hill campus' delivery of the BScN programme would be a strategic step towards meeting the human resource development needs of the campus' sub-regional market. The programme's delivery may be executed by the campus independently or in partnership with the sub-region's community colleges. But if the campus remains uninvolved in the delivery of this degree programme it would be reneging on its commitment to increase access to higher education to the underserved residents of the Caribbean and it would perpetuate the situation of compromised nursing education and nursing service in the region, as articulated by the World Bank (2009).

The Cave Hill Campus' non-involvement in nursing education also delays the attainment of reciprocity in CARICOM nursing and the CARICOM objective of functional cooperation in services. Cave Hill's delivery of the BScN programme would expand the campus' offerings to its target market; provide the residents of Barbados and the OECS with equitable access to a legitimate pre-registration BScN programme; reduce the shortage of nurses in CARICOM; facilitate the development of nursing manpower that possess the technical and cognitive skills necessary to combat the region's healthcare challenges; and promote functional cooperation in CARICOM.

While it may be argued that preparing nurses at the baccalaureate level risks further migration and may compound the region's nursing shortage, I contend that this loss can be controlled by fully implementing the region's Managed Migration Strategy developed in 2001 (Salmon et. al, 2007). Furthermore, if the under-preparation and shortage of nurses in the Caribbean are allowed to persist, the region could face a

significant health human resources crisis because it risks further loss of nurses who would emigrate in search of higher education and better living and working conditions. Furthermore, while delivering the online BScN may seem a workable compromise, for some, policymakers must be reminded that nursing is a practical discipline and the clinical competencies a student develops cannot be guaranteed through distance modalities. The campus must therefore provide access to face-to-face undergraduate and graduate nursing education to prepare nurses with the requisite skills for beginning level and advanced nursing practice roles.

But apart from the measures that need to be implemented by the UWI Cave Hill Campus, WHO/PAHO - the other partner organisation on RNB – also needs to significantly strengthen its support for the roll out of this reform in the region. Given that WHO/PAHO was instrumental in adopting this policy at the RNB level, and given that the current implementation pattern of the reform threatens the achievement of WHO/PAHO's objective of universal access to quality healthcare, in CARICOM; and given that the BScN reform is intended to improve the quality of nursing service in the region; I advance that it is incumbent on WHO/PAHO to provide stronger support for the reform's implementation in CARICOM. This support should take the form of technical support to help the territories conduct situational analyses and develop implementation guidelines.

Additionally, given the critical role that the Chief Nurses must play in promoting the adoption of this reform; and given that the findings suggest that deficiencies in nursing leadership have constrained its implementation, there is need for WHO/PAHO to facilitate the enhancement of the region's implementation capacity through facilitating

the development of the regional nurse leaders' leadership skills, and facilitating other capacity building initiatives. Leadership workshops, internships for nurse leaders and advanced practice nurses, and facilitating partnerships between Caribbean health service and tertiary education organisations, with international centres of excellence in related fields would significantly assist with capacity building for the full implementation of this policy. Moreover, the organisation must assist with monitoring the reform's implementation in the region and provide feedback to the CARICOM Secretariat, through RNB, to inform further implementation.

In summation, given all that has been articulated regarding the way forward for the CARICOM 2006 BScN reform, it is clear that its formalization and expansion require a collaborative approach by stakeholders. In some instances it will require coalition-building, persistent lobbying and skilful negotiation to overcome resistance to change, and accomplish key outcomes like legislation change. The nurses in the region must demonstrate ownership of this reform by engaging in activities to promote its full adoption in their territories. Specifically, the Chief Nurses must champion the full adoption of the reform and the necessary legislation reform. The Nursing Councils and NNAs must partner with the Chief Nurses to support the implementation of the policy in their territories. Beyond these, the UWI Cave Hill Campus and WHO/PAHO must provide strong support for the policy's implementation to facilitate development of the region's health human resources and facilitate its attainment of universal access to quality health care. So what are the critical actions to be taken at this juncture? They are:

- a regional stakeholders' consultation to set the implementation deadline;

- national nursing legislation change;

- multimodal, multidirectional communication of the policy to constituents;

- UWI Cave Hill's participation in delivery of the pre-registration BScN programme;

- leadership training for Chief Nurses;

- assessment and improvement of the quality of existing pre-registration BScN programmes;

- situational analyses to determine the capacity-building measures necessary to equip the remaining territories to implement the policy and;

- CAAM-HP accreditation of all pre-registration BScN programmes in the region.

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APPENDIX A

POLICY-MAKING FOR NURSE EDUCATION IN THE CARIBBEAN REGION: THE CASE OF THE BACHELOR OF SCIENCE DEGREE IN NURSING

INFORMATION SHEET

Researcher and Research Aim

My name is Andrea Brathwaite and I am undertaking research for the degree of Doctor of Education at the University of Sheffield in the United Kingdom. I am interested in understanding the genesis of the 2006 CARICOM decision that the Bachelor of Science in Nursing degree should be the minimum requirement for Registered Nurses in the English-speaking territories, and how this policy unfolded in different territories.

Method

I will conduct documentary and interview studies in order to understand what range of developments took place in selected territories following the 2006 decision. The study will be conducted in three stages:

- Stage 1 will involve a desk review of background data about nurse education in the Caribbean, the 2006 Bachelor of Science in Nursing degree policy decision, and the input of the Council for Human and Social Development and the Regional Nursing Body.

- Stage 2 will consist of documents review and interviews with key informants to determine the occurrences in each territory in relation to undergraduate nurse education after the 2006 decision. The interviews will ask about what developments took place, when and why they took place.

- Stage 3 will involve analysis of the data collected, synthesis of the findings, and presentation of conclusions and recommendations.

Contact Details

The researcher may be contacted via email at edp11afb@sheffield.ac.uk. I may also be contacted via telephone at 1-246-416-9419 (home) or 1-246-247-7779 (mobile).

My research supervisor is Professor Gareth Parry and he may be contacted via email at g.w.parry@sheffield.ac.uk or via telephone at (+44) (0) 114 222 8101.

THANKS FOR YOUR ASSISTANCE WITH THIS PROJECT!

APPENDIX B

PARTICIPANT INVITATION LETTER

ANDREA F. BRATHWAITE M. Ed (Admin) U.W.I
No. 54 Serenity Drive Ocean City, St. Philip
Telephone: 1-246-416-9419 (H) or 1-246-247-7779 (C)
E-mail: edp11afb@sheffield.ac.uk

July 1ˢᵗ, 2016

Dear Sir/Madam,

Re: Policy-making for nurse education in the Caribbean region:
the case of the Bachelor of Science degree in Nursing

Thank you for your interest in participating in the above captioned research study. The study focuses on the Caribbean Community's (CARICOM) policy decision that the Bachelor of Science in nursing degree should be the minimum qualification for Registered Nurses in its English-speaking territories. You have been asked to participate because it is believed that by virtue of your professional role you would have some integral involvement in establishing this reform.

As a participant in this study, you would be asked to participate in at least one interview conducted by the researcher. Your interview should last approximately 1-1 ½ hours and will be recorded. The interview is necessary to enable the researcher to understand the policy process from your perspective.

Please be assured that this research is being conducted under the strict ethical requirements of the University of Sheffield's School of Education. Your personal information will be confidential and your responses will be anonymised at all stages.

All email and other recorded files of your communication with the researcher will be held in strictest confidence. They will be stored for the period that allows completion, submission and any necessary revision of the thesis document. Upon completion of the research requirements, the records will be deleted.

Your participation in the study is voluntary and you are free to withdraw at any time without having to give a reason. I do hope you will find it possible to participate. Every response is important to the success of the study. I would be happy to answer any questions you may have and may be contacted at the telephone numbers and email address above. Thank you for your cooperation.

Yours faithfully,

Andrea F. Brathwaite
Doctoral Research Student
University of Sheffield

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APPENDIX C
CONSENT FORM

Title of Project: Policy-making for nurse education in the Caribbean region: the case
of the Bachelor of Science degree in Nursing

Name of Researcher: Andrea F. Brathwaite

Participant Identification Number:

Instructions: For each statement below place a tick in the box next to it, if you
    agree.

1. I confirm that I have read and understand the information sheet 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. The researcher may be contacted by telephone at the number
1-246-247-7779.

3. I understand that my responses will be anonymised at all stages. I give permission for
the research supervisor to have access to my anonymised responses.

4. I agree to take part in the above research project.

_____ _____ _____
Name of Participant   Date   Signature

_____ _____ _____
Researcher   Date   Signature

THANKS FOR CONSENTING TO PARTICIPATE IN THIS STUDY!

APPENDIX D

SCHOOL OF EDUCATION
FACULTY OF SOCIAL SCIENCES
UNIVERSITY OF SHEFFIELD

POLICY-MAKING FOR NURSE EDUCATION IN THE CARIBBEAN
REGION: THE CASE OF THE BACHELOR OF SCIENCE DEGREE IN
NURSING

NATIONAL AND INSTITUTIONAL ACTORS' PRE-INTERVIEW
QUESTIONS

ID. NO.:
Thank you very much for agreeing to be interviewed for my Doctoral research.
These are the questions I would like to cover in the interview. I've sent them in
advance so that you have a chance to think about them and, if necessary, to access
information or consult with your colleagues. I look forward to talking with you.

1. What was encompassed by the 2006 BScN reform?

2. What is your understanding of the plans, goals or expectations that are attached to the reform?

3. How was the decision communicated to your territory?

4. What did you understand by the decision?

5. Was the communication about the reform accompanied or followed by guidelines?

6. If there were guidelines, how did they assist with achieving the plans, goals or expectations of the reform?

7. What happened in nurse education in your territory after the decision was made?

8. How did your organisation address this reform?

9. What were the main factors that influenced how your organisation addressed this reform?

10. Who else would have details about this reform?

Thanks for taking the time to consider these questions.

APPENDIX E

SCHOOL OF EDUCATION
FACULTY OF SOCIAL SCIENCES
UNIVERSITY OF SHEFFIELD

POLICY-MAKING FOR NURSE EDUCATION IN THE CARIBBEAN REGION: THE CASE OF THE BACHELOR OF SCIENCE DEGREE IN NURSING

NATIONAL AND INSTITUTIONAL ACTORS' INTERVIEW PROTOCOL

ID. NO.:

Thanks again for agreeing to participate in this interview and for signing the consent form.   You will have seen the INFORMATION SHEET on my research and the range of questions we shall consider.

1. How is undergraduate nursing education delivered in your territory currently?

2. What were the reasons for the 2006 reform?

3. What was encompassed by this reform?

4. What plans, goals or expectations were attached to this reform?

5. What happened in your territory in relation to the reform?

6. Reconstruct for me how these things occurred.

7. Why do you think things unfolded in this way?

8. What else can you tell me that would help me to understand the process of establishing this reform?

9. Who else would be able to help me understand the process?

Thanks for answering my questions. Your input is certainly appreciated.

APPENDIX F
JAMAICA'S INTERVIEW FINDINGS

Table F1: Reasons for the BScN reform in Jamaica

Rank	Issue	Frequency of Response
1	Concern about the quality of nursing education	8
2	International trends	5
2	Concern about the quality of nursing service	5
2	Concern about the status of the nursing profession	5
5	Poor remuneration	4
5	Goal of regional reciprocity in nursing	4
7	Outward migration of nurses	2
8	Concern about the cost of training nurses	1

Table F2: Jamaica's reform intentions

Rank	Intention	Frequency of Occurrence
1	Changes in nursing education delivery	7
2	Improved quality of nursing service	4
3	Improved quality of nursing education	3
4	Improved competencies of beginning level RNs	2
4	Facilitate postgraduate education for nurses	2
6	Harmonization of nursing education in CARICOM	1
6	Regional reciprocity in nursing	1
6	Improved status of nursing	1
6	Increased salaries for nurses	1

Table F3: Components of the BScN reform in Jamaica

Components	Frequency of response
a) Changes in the delivery of nursing education	5
b) Curriculum upgrade	4
c) Transfer of nursing education from hospitals to TEIs	3
d) Accreditation	3
e) Common registration examination	3
f) Faculty training	3
g) Nursing Council's approval of curricula	2
h) Upgrade of practicing nurses	2
i) Revision of national nursing legislation	1
j) Recruitment of staff	1
k) Stakeholder support	1
l) Changes in nursing faculty role	1

Table F4: Factors enabling the reform in Jamaica

Enabling Factors	Context Level Impacted			Frequency of Response
	I	N	R	
1. Support	*	*	*	9
2. Leadership	*	*	*	8
3. Collaboration	*	*	*	6
4. Networks	*	*		6
5. Capacity	*	*	*	5
6. Interest group participation	*	*		3
7. Policy fit	*	*		3
8. Financing	*			2
9. History	*			2
10. Community need	*			1

KEY: I = Institutional   N = National   R = Regional

Table F5: Jamaica's reform constraints

Constraints	Context Level Affected			Frequency of Response
	I	**N**	**R**	
1. Inadequate capacity	*	*	*	7
2. Limited support	*	*	*	5
3. Outward migration of nurses	*	*	*	4
4. Conflict		*	*	4
5. Applicant deficiencies	*	*		3
6. Lack of commitment	*	*		2
7. Nursing leadership deficiencies			*	2

KEY: I = Institutional   N = National   R = Regional

APPENDIX G
BAHAMAS INTERVIEW FINDINGS

Table G1: Reasons behind the reform

Rank	Issue	Frequency of Response
1	Concern about the quality of nursing service	2
1	International trends	2
1	Emigration of nurses	2
4	Nurses' demand for BScN	1
4	Concern about the quality of nursing education	1
4	Concern about the status of the nursing profession	1

Table G2: Reform intentions, Bahamian perspectives

Intention	Frequency of Occurrence
a) Changes in nursing education delivery	1
b) Improved quality of nursing service	1
c) Improved competencies of beginning level RNs	1
d) Improved status of nursing	1
e) Retention of nurses	1
f) Upgrade of practising nurses	1
g) Inter-professional collaboration	1
h) Parity with international nursing education	1
i) College upgrade to a university	1

Table G3: Bahamas reform enablers

Rank	Enabling Factors	Context Level Affected			Frequency of Response
		I	N	R	
1	Nursing leadership	*	*	*	6
2	Capacity	*	*	*	4
3	Commitment		*	*	3
3	History		*	*	3
5	Policy fit	*	*		2
5	Support		*		2
7	Interest group participation		*		1

KEY: I = Institutional   N = National   R = Regional

Table G4: Reform constraints - the Bahamas experience

Rank	Constraints	Context Level Affected			Frequency of Response
		I	N	R	
1	Communication challenges	*	*		3
2	Faculty overload	*	*		2
2	Applicant deficiencies	*	*		2
2	Inadequate capacity			*	2
2	Lack of support			*	2
6	Resistance	*			1
6	Conflict	*			1
6	Ideology	*			1
6	Political interference		*		1
6	College requirements		*		1
6	Absence of political will			*	1
6	Nursing leadership deficiency			*	1

KEY: I = Institutional   N = National   R = Regional

APPENDIX H
BARBADOS INTERVIEW FINDINGS

Table H1: Reasons behind the reform

Rank	Reason	Frequency of Response
1	International trends	3
2	Concern about the quality of nursing service	2
2	Emigration of nurses	2
4	Concern about the status of the nursing profession	1
4	Concern about the quality of nursing education	1
4	Government human resource policy	1
4	Varying standards of nursing in CARICOM	1
4	Former RNB members' vision	1
4	WHO recommendation	1
4	Cost of administering the RENR	1
4	Poor remuneration of nurses	1
4	Don't know	1

Table H2: Reform intentions, Barbadian perspectives

Rank	Intention	Frequency of Occurrence
1	Improved quality of nursing service	5
1	Improved status of nursing	5
3	Improved competencies of beginning level RNs	4
4	Harmonization of nursing in CARICOM	2
4	Postgraduate education for nurses	2
4	Regional reciprocity in nursing	2
4	Train nurses for export	2
8	Upgrade of practicing nurses	1
8	Infrastructural upgrade	1
8	Retention of nurses in the region	1
8	Career advancement for nurses	1
8	Increase public confidence in nurses	1
8	Increase nurses' confidence	1

Table H3: Components of the Reform in Barbados

Components	Frequency of response
a) Changes in the delivery of nursing education	4
b) Upgrade of faculty qualifications	3
c) Changes to the RENR	3
d) Elevation of nursing's status	3
e) Infrastructural upgrade	2
f) Curriculum upgrade	2
g) Enhancing nursing service	2
h) Transfer of nursing education from hospitals to TEIs	2
i) Revision of national nursing legislation	2
j) Recruitment of staff	1
k) Upgrade of practicing nurses	1
l) Continuing education for nurses	1

Table H4: Reform enablers in Barbados

Enabling Factors	Context Level Affected			Frequency of Response
	I	N	R	
1. Interest group participation	*	*		7
2. Political will	*	*		6
3. Policy fit	*	*		6
4. Ideology		*		6
5. Public demand	*	*		4
6. Leadership		*		3
7. Will/Commitment	*		*	3
8. Financing		*		1
9. Heightened interest in nurse migration		*		1
10. History	*			1

KEY: I = Institutional   N = National   R = Regional

Table H5: Barbados' Reform Constraints

Constraints	Context Level Affected			Frequency of Response
	I	**N**	**R**	
1. History	*	*		10
2. Inadequate capacity	*	*		9
3. Leadership deficiencies	*	*		7
4. Ideology	*	*		4
5. Limited finances	*	*		4
6. Resistance	*	*		3
7. Lack of commitment	*	*		3
8. Conflict	*	*		3
9. Communication challenges	*	*		3
10. Ineffective resource management	*			2
11. Absence of post-basic BScN programme		*		1
12. Cost avoidance	*			1
13. Nationalism			*	1

KEY: I = Institutional   N = National   R = Regional

APPENDIX I
ST. KITTS/NEVIS INTERVIEW FINDINGS

Table I1: Reasons behind the reform in St. Kitts/Nevis

Rank	Issue	Frequency of Response
1	International trends	2
2	Concern about the quality of nursing service	1
2	Concern about the quality of nursing education	1
2	Concern about the status of the nursing profession	1
2	Government human resource policy	1
2	Public demand	1

Table I2: St. Kitts/Nevis' Reform Intentions

Rank	Intention	Frequency of Occurrence
1	Improved quality of nursing service	2
1	Improved competencies of beginning level RNs	2
3	Harmonization of nursing in CARICOM	1
3	Attain international parity	1
3	Regional reciprocity in nursing	1
3	Postgraduate education for nurses	1
3	Career advancement for nurses	1
3	Increased salaries for nurses	1

Table I3: Components of the BScN reform in St. Kitts/Nevis

Components	Frequency of response
a) Changes in the delivery of nursing education	2
b) Curriculum upgrade	2
c) Harmonization of CARICOM nursing education	2
d) Changes to the RENR	2
e) Infrastructural upgrade	2
f) Upgrade of practicing nurses	1
g) Faculty training	1
h) Accreditation	1
i) Upgrade of CARICOM nursing education standards	1
j) Mechanism for retaining graduates	1
k) Salary increase for nurses	1
l) Legislation change	1

Table I4: Reform Enablers in St. Kitts/Nevis

Enabling Factors	Context Level Affected			Frequency of Response
	I	**N**	**R**	
1. Support	*	*		4
2. Policy fit	*	*		3
3. Interest group participation		*		2
4. Financing	*			2
5. Stakeholder collaboration	*			2
6. Communication	*			1
7. Championship	*			1
8. Ideology	*			1
9. Supporting policy		*		1
10. Demand for nurses		*		1

KEY: I = Institutional   N = National   R = Regional

APPENDIX J
GRENADA INTERVIEW FINDINGS

Table J1: Reasons behind the reform

Rank	Reason	Frequency of Response
1	Concern about the quality of nursing service	2
1	Emigration of nurses	2
3	Concern about the quality of nursing education	1
3	International trends	1
3	Transfer of nursing education from hospitals to TEIs	1
3	Demographic changes	1

Table J2: Grenada's reform intentions

Rank	Intention	Frequency of Occurrence
1	Changes in nursing education delivery	5
2	Improved quality of nursing service	3
2	Improved quality of nursing education	3
4	Retention of nurses	2
5	Improved status of nursing	1
5	Harmonization of nursing education in CARICOM	1
5	Government investment in nursing education	1

Table J3: Components of the BScN reform in Grenada

Components	Frequency of response
m) Faculty training	3
n) Changes in the delivery of nursing education	2
o) Infrastructural upgrade	2
p) Transfer of nursing education from hospitals to TEIs	2
q) Implementation of the regional managed migration strategy	1

Table J4: Factors enabling the reform in Grenada

Enabling Factors	Context Level Impacted			Frequency of Response
	I	N	R	
1. Leadership	*	*	*	3
2. Capacity	*	*		3
3. Interest group participation		*		1
4. Public demand		*		1
5. Stakeholder collaboration		*		1
6. Political will		*		1
7. Financing		*		1
8. Ideology		*		1
9. Commitment			*	1

KEY: I = Institutional   N = National   R = Regional

Table J5: Grenada's reform constraints

Constraints	Context Level Affected			Frequency of Response
	I	N	R	
1. Inadequate capacity	*		*	3
2. Nursing leadership deficiencies		*		3
3. Lack of interest group participation		*		3
4. Cost avoidance	*	*		2
5. Inadequate support		*		2
6. Ideology		*		2
7. Absence of guidelines		*		1

KEY: I = Institutional   N = National   R = Regional

APPENDIX K
ANTIGUA INTERVIEW FINDINGS

Table K1: Reasons behind the reform

Reason	Frequency of Response
Concern about the quality of nursing service	1
Concern about the quality of nursing education	1
International trends	1
Transfer of nursing education from hospitals to TEIs	1

Table K2: Components of the BScN reform in Antigua

Components	Frequency of response
r) Changes in the delivery of nursing education	4
s) Regional reciprocity in nursing	2
t) Infrastructural upgrade	1
u) Faculty upgrade/recruitment	1
v) Harmonization of nursing education in CARICOM	1

Table K3: Factors enabling the reform in Antigua

Enabling Factors	Context Level Impacted			Frequency of Response
	I	N	R	
1. Commitment	*	*	*	3
2. Support		*	*	2
3. Supporting policy	*	*		1
4. Nursing leadership		*		1
5. Public demand		*		1
6. Policy fit	*			1
7. Capacity	*			1
8. Applicant readiness	*			1

KEY: I = Institutional   N = National   R = Regional

Table K4: Antigua's reform constraints

Constraints	Context Level Affected			Frequency of Response
	I	N	R	
1. Ideology		*	*	4
2. Inadequate support		*	*	2
3. Nursing leadership deficiencies		*	*	2
4. Financial insufficiency		*		1
5. Inadequate capacity	*			1
6. Policy disregard	*			1
7. Cost avoidance	*			1
8. Conflict			*	1

KEY: I = Institutional   N = National   R = Regional

APPENDIX L
DOCUMENT ANALYSIS WORKSHEET TEMPLATE

DOCUMENT TYPE:

CATEGORY:
(Primary or Secondary)

UNIQUE CHARACTERISTICS:

DOCUMENT TITLE:

AUTHOR AND DATE:

INTENDED AUDIENCE:

RELEVANCE TO RESEARCH:

SUMMARY OF THE MAIN POINTS:

RELATED THEMES	EVIDENCE QUOTE