Postcolonial nursing education in Trinidad and Tobago

In this article the impact of the developed nations on basic nursing education in Trinidad and Tobago in the postcolonial period is discussed and analyzed. Subsequent to self-government in 1956, the national government, in its efforts to become independent of its reliance on Great Britain, turned to the United States and Canada for technical and financial aid. Consequently, sources such as the World Bank, Inter-American Development Bank, Pan American Health Organization/World Health Organization, and the Canadian International Development Agency were major avenues for the provision of ideas, concepts, and values in health planning and policy making with primary health care endorsed by the government. Nursing education was thus influenced by these industrialized concepts and values. The impact of socioeconomic and nursing events in the Caribbean region coupled with local initiatives taken by the indigenous leadership to improve nursing education resulted in a program that was an amalgamation of British, North American, and indigenous features.

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THE PROVISION of health services in Trinidad and Tobago during the colonial period from 1814 to 1956 was a cause of continuing concern. The early establishment of health care services and nursing care was designed primarily for the English expatriates, and the leadership in the medical and nursing services was recruited from the British Overseas Colonial Services. The focus was on curative care while public health received scant attention. The deplorable economic and social conditions in the 1930s, in which there were high infant mortality rates, tuberculosis, and chronic illness rampant among the plantation and oilfield workers, resulted in social uprisings and a shortage of medical personnel. Consequently, the health services became the subject of a series of Commissions of Enquiries into prevailing conditions over the years. It was within this environment that the foundation of a British apprenticeship system of nursing education was laid.[1]

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While British ideas and values were paramount in the colonial era, with the advent of self-government in 1956 and independence in 1960, the government's economic strategy encouraged investments from North America and loans from the Inter-American Development Bank and World Bank. These were seen as necessary to growth combined with local input and control. This approach facilitated the entry of the United States and Canada in the development of the country, thus bringing North American ideas and values into the entire fabric of the nation to be combined with the inherited British influence. Consequently, in the health care field, there was considerable North American involvement in the development and implementation of the first 10-year national health plan.[2] Similarly, changes in nursing education were greatly influenced by these industrialized ideas.

LAYING THE FOUNDATION

There is record of nurses' training as early as 1898 in Trinidad and Tobago but it was not until 1913 that a curriculum was prepared on lines used in English hospital schools of nursing. Students of the three-year program received lectures by physicians, the matron, and her assistant.[3] Lobbying by the local organized nurses' association led, in the 1940s, to substantial changes in program content and length to improve standards of education. By 1950, transfer of the control of nursing education from expatriates to local leadership occurred with the formation of a Nursing Council and a Bill of Registration for nurses. The practice arena, however, remained in the hands of the expatriates.[1] According to an interview with L. Beckles (January 1986), changes instituted during the colonial period were based on the assessment of local nursing standards by the expatriates; although registration by local personnel made the system autonomous, nursing relied on the British system as a model of excellence and a yardstick by which to measure their programs and to achieve recognition and status through reciprocity.

THE NURSING COUNCIL

From its inception in 1950, the Nursing Council directed its attention toward the improvement of standards and facilities for training in the school of nursing. It relied considerably on the knowledge, expertise, and written documentation of the General Nursing Council of Great Britain and Wales with respect to the education of student nurses in order to improve on deficiencies identified in earlier reports (as noted in an interview with L. Beckles, January 1986). Between 1965 and 1970 there was considerable help under the Canadian Technical Aid Program for mental health nursing, and scholarships were granted to nurses to visit mental hospitals in Canada. The council in executing its mandate continually sought to refine the education and examination procedures and processes for nursing students. For example, a workshop was conducted to assist staff in improving their assessment skills for student practical examinations.[4] The council further introduced a number of curriculum changes. These included discontinuation of the British pattern of the three-month preliminary training school; inclusion of content in obstetrics, psychiatric nursing, and community health; discontinu-

ation of the single-trained mental nurse program; and the introduction of a one-year postbasic psychiatric program for registered nurses.[1] While the Nursing Council, by law, had a large measure of control over the education and practice of nursing, it was obvious that it was not the major agency concerned with nursing education in the postcolonial era. The Nursing Division, Ministry of Health, played a key role in both the education and the practice of nurses.

THE NURSING DIVISION

The health services of Trinidad and Tobago are administered by the Ministry of Health. The ministry is organized into four major divisions: Institutions, Community Services, Epidemiology, and Nursing. The Nursing Division, created in 1966, concurrent with the development of the national health plan, was comprised of a chief nursing officer, the director of nursing education, the director of institutional nursing, and the director of community nursing. The stated objective was "to deliver to individuals, families and groups, a comprehensive care, adequate in quantity, up-to-date in quality and commensurate with the aspirations and resources of the country."[5(p2)]

The division took the initiative, as its first task, to conduct a qualitative and quantitative survey of nursing needs and resources. This project was undertaken in 1966 in collaboration with the Pan American Health Organization/World Health Organization (PAHO/WHO). The purpose was to develop a national plan to meet the increasing health service needs of the country. As a result of the findings, a 10-year plan accompanied by a program for each field of nursing was formulated, including plans for the development of a nursing assistant program.[6] Both British and North American experiences were influential in effecting the introduction of the nursing assistant program in 1968 to strengthen nursing power. Similar action had taken place in the metropolitan countries. In Canada and the United States, practical nurses had been in existence prior to World War II although they did not become licensed to practice in the United States until 1944.[7] In Britain, they were introduced after World War II when shortage of staff was experienced.[8]

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A significant change of a national nature was the notion of salaried students. While students in the colonial period received an allowance, nursing students in the postcolonial era were assured of a decent wage that reflected the government's welfare-oriented policies in its process of decolonization. The government saw itself as the chief employer of the people to ensure their economic and social well-being, and the civil service was seen as a principal decolonizing agent. Consequently, students were considered civil servants and paid a salary.[1]

The Nursing Division took actions that had significant positive effects on the nursing program. Its staff development program, through varied programming, increased the managerial and clinical skills of the nursing staff, many of whom supervised students on the wards. Of greater significance was the

development of a new curriculum, which was an endeavor of major proportions.

CURRICULUM IN THEORY AND PRACTICE

In 1976, nursing educators and the director of nursing education expressed the need for a new curriculum. Several factors precipitated this need. Two regional surveys of the schools of nursing in the Caribbean region were conducted in 1966 and 1968 with technical and financial aid from PAHO/WHO in collaboration with leaders in the region. The criteria used in evaluating the schools were those used by Mussallem in the Canadian survey of nursing education programs with adaptation and modification for use in the area.[9,10] This initiative led to the first North American influence on nursing education and greatly reduced the single British influence. Findings from the surveys revealed a number of shortcomings in the program. Another factor was that the previous curriculum, which identified topics and courses, was limited in scope and geared toward the curative aspects of health care. Furthermore, the changing face of health care demanded that emphasis be placed on the preventive aspects of health care.[11]

An indigenous core curriculum committee was formed to develop a new curriculum using as a basis the Nursing Council's syllabus of subjects for the certificate in general nursing as well as the curriculum guidelines developed by the Regional Nursing Body. This body was established through the initiative of senior nursing personnel from the Commonwealth Caribbean, subsequent to the two surveys of the nursing schools.[1]

International, national, and professional influences also had their impact on the curriculum. On the international scene, the WHO Expert Committee on Community Health, which met in Geneva in 1974 to discuss community services, promoted the concept of primary health care. Its aim was to provide for the basic health needs of individuals at a safe and acceptable level in their own communities. Implementation of this approach required a change in the education of nurses to prepare them to be generalists capable of functioning in any health care setting.[11] Nationally, with the gradual shift in emphasis from curative focus to preventive measures, health care delivery had increased in the homes and community. In 1977, the government of Trinidad and Tobago was among those at the Fourth Special Meeting of Ministers of Health of the Americas that unanimously reaffirmed the right to health care as a prerogative of human beings that entitles them to claim an equitable distribution of opportunities and services to help them attain the highest possible level of physical, mental, and social well-being.[12] Additionally, the government in 1978 was signatory, at the Alma Ata Primary Health Care Conference, to the goal of "Health for All by the Year 2000" with subsequent future construction and expansion of primary health care centers.

Primary health care was viewed as

> the simplest form of health care given by a recognized member of the Ministry of Health. Primary health care is based in health centers and the intersectoral approach is used at the local level. Community participation is encouraged through existing community organizations such as Community Centres and Village Councils.[12(p9)]

In 1986, there were two major general hospitals, one of which is a teaching hospital for the University of the West Indies, several country and district hospitals, three special-

ist hospitals, and a network of 102 health centers throughout both islands.[1]

In the professional sphere, the trends in nursing in industrialized countries increasingly used the nursing process as the instrument through which care was given.[11] Consequently, changes were incorporated in the new curriculum to reflect those international, national, and professional concerns. The committee met between 1976 and 1979 with the assistance of the PAHO/WHO area advisor for nursing education, who guided the development of the curriculum. The existing curriculum could no longer prepare practitioners capable of coping with the tremendous changes in technology and medical science, as it focused on the role of the nurse in caring for ill patients in hospitals, and paid insufficient attention to health promotion and health maintenance. Furthermore, it failed to emphasize the nurse's independent and interdependent functions as a member of the multidisciplinary health team.[12]

One of the first tasks of the committee was to identify the health problems and needs of the population. This involved studying the services and agencies available for meeting health needs; identifying the purpose, philosophy, and organizational structures of the teaching hospitals; identifying the characteristics of students and teachers; and searching the population and health statistics for indicators of morbidity and mortality. These were analyzed using a family-centered and community-oriented approach. Four family groups—beginning, expanding, growing, and contracting—were determined, and four factors—psychosocial, physiologic, environmental, and life style—were used to identify the common health problems affecting the four family groupings. The analysis of health problems identified showed certain vulnerable age groups within these broad groups. These findings revealed that 60% of the population was under 25 years; that in 1976, the infant mortality rate was estimated at 25.5 per 1,000 live births; that in the 15 to 44 age group accidents and suicide were the first and third leading causes of death; and that the major health problems of people over 45 were cardiovascular diseases, diabetes mellitus, and malignant neoplasms. The committee noted that of the vulnerable groups identified many were found in the community and were not receiving adequate care.[11,12]

The new curriculum is different from the previous curriculum in that it is family centered and community oriented and focuses on promotional and preventive aspects of health care. Primary health care strategies such as prevention and control, environmental health, family planning, intersectoral coordination, community participation, and health education are some of the key concepts addressed.[13] Other indigenous features are related to social and health service problems, such as a lack of public utilities and recreational facilities, that affect the population; the concept of work and attitudes toward work; and different cultural factors and beliefs. Particularly outstanding are the many references by Caribbean authors bringing a regional flavor to analysis of issues. To complement the theory, clinical experience in the health care centers throughout the territories are provided for students.

The new curriculum is a thorough and comprehensive document. It outlines in great detail the philosophy of nursing education, its conceptual framework, curriculum objectives, and a list of courses with detailed behavioral objectives.

The curriculum addresses the cultural aspects of the society, thus bringing a distinctly national character to its otherwise metropolitan outlook. A two-pronged approach to nursing education instituted in 1978 is yet another distinctive indigenous feature. It originated as a result of the considerable decline in registered mental health nurses when the one-year postbasic psychiatric program for registered nurses was introduced in 1970 on the recommendations of the nursing survey.[6] The current 3-year curriculum consists of a common core of 18 months, with the final 18 months in either general nursing or mental health nursing. Both avenues lead to registration with the Nursing Council as either a registered nurse or a registered psychiatric nurse. While the validity of this approach, reinstituted in 1978, has been questioned by metropolitan advisors, and is seen as undesirable because psychiatric nursing was advocated as a postbasic program, the current nursing leadership is to be commended for its initiative and persistence, not only in instituting this unique approach to meet the needs of the society, but in doing so despite metropolitan pressure to the contrary.

It would seem that the validity of any programmatic approach would depend on whether or not it is meeting the needs of the particular society. It is inappropriate in developing countries to prolong periods of nursing education based on North American models if other more appropriate models based on cultural needs and differences can be developed. They are worthy of consideration and no less desirable. Furthermore, because these psychiatric nurses are registered with the council, quality of nursing standards can be assured. The area of mental health nursing education is beyond the scope of this article, although it is briefly alluded to within the context of the development of basic nursing education, and is a particularly outstanding indigenous element.

In implementing the new curriculum a few changes were achieved that were congruent with the nursing theory. Students received experiences in a variety of community settings other than the traditional illness-focused hospitals, and the school retained the right to determine the particular setting for groups of students. The greatest stumbling block to implementation, however, lay in the organized system of nursing education where there was a lack of autonomy. The needs of the hospitals still determined the organization of the curriculum to facilitate staffing and thus maintained the inherited British tradition of a block system. The lack in the quality and quantity of instructors and the perpetuation of student supervision by ward staff inevitably led to a gap between the espoused theory of the new curriculum and day-to-day practice.

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Other gaps resulted because the hospital, rather than the school, maintained control of the students' learning experiences, with the result that service needs assumed priority despite a sound theoretic component. Furthermore, the practice area maintained the inherited colonial pattern of administration characterized by a hierarchical and authoritarian structure, added to which was a dearth of well-prepared management personnel at the unit level. As noted in an interview with

M. Julien, RN (February 1986), the trappings of colonial days still held sway, symbolized by the style, pattern, and color of the student uniforms, which were similar to those worn in the preindependence era, and the "standing to attention" at the presence of the matron was still required. The black belt, silver buckle, and "veil" worn by some staff were reminiscent of an era past, and the senior administrative personnel at the Ministry of Health still wore uniforms four out of five working days. Nurses had been subservient for so long in their history in terms of nursing as a profession, in their role as women, and in their colonial heritage that the senior administrative nurses were essentially compliant. According to an interview with T. Taitt, RN (January 1986), a senior nursing administrator in the Ministry stated:

> Uniform is a hang-over from the British. We are not compelled to wear it but the previous Minister of Health (a male, medical doctor) said he liked to see his nurses in uniform. We are still given uniform materials and an allowance for doing so including laundry. If one were given a comparable amount [salary] one may not do so. There are no provisions for "mufty" [ordinary clothes]. On Fridays we wear our ordinary clothes.

Added to these many aspects of the colonial influence, which were predominant in nursing practice, was that of the instructional staff. All the nursing instructors were prepared on British lines whether trained locally or in the United Kingdom. Their postbasic education, acquired by most at the University of the West Indies and by a few at North American universities, provided a possible avenue for tempering the British influence, but because nursing instructors were a scarce commodity they taught the theoretic content rather than the practical. Clinical supervision by them took the form of consultation due to the high teacher–student ratio. Consequently, the direct practical supervision was left to the less qualified clinical instructors and the ward staff. In the community, however, students were supervised by staff with additional public health experience and education. Credit must be given to the senior personnel in the Nursing Division who made valiant efforts in the face of overwhelming odds to ensure that supervisory staff received inservice education.[1]

The sophistication of the curriculum in its North American orientation and its forward-thinking content was a marked contrast to the nursing service area in the hospital that remained essentially as it was in the colonial era, maintaining the inherited pattern of functional nursing and supervision of students by ward staff with insufficient numbers of instructors.

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The economic and political reforms adopted by the national government reflected those of its metropolitan colonists, but despite restrictive conditions, the nursing leadership in the colonial era had achieved registration for nurses to ensure standards of quality in education and practice.

The nursing program in the postcolonial era had undergone major revisions in its theoretic content reflecting metropolitan ideas and values blended with substantial indigenous features, while the practice area retained the inherited colonial tradition with nursing education subservient to nursing service.

By 1986, 30 years after self-government was achieved, nursing education, while it was still an apprenticeship system, had a well-organized, comprehensive nursing cur-

riculum that was used by the schools of nursing to prepare students for entry to the nursing profession. It is to the credit of the local leadership, prior to and since independence, that despite obstacles they were able to develop a national nursing education program that reflected a blend of British, North American, and local influences with a focus on primary health care. This was consistent with the values in the society at large that was eclectic consisting of colonial attitudes, North American values, and indigenous features.

While industrialized countries are considering areas such as midwifery and psychiatric nursing as postbasic programs requiring a foundation in general nursing, one has to exercise prudence when applying these ideas to the developing countries. This is not to deny the desirability of such a goal in the developed nations, but the concept needs to be tempered with common sense, practicality, and caution for the developing countries. In Trinidad and Tobago, with the increasing evidence of mental illness and the concomitant dearth of mental health nurses, the current local model of single-trained psychiatric nurses with a common core of basic nursing education appears to be a viable, realistic model in meeting the needs of the society at this time. The use of psychiatric nurses need not be scoffed at, or seen as providing a lesser quality of care to clients; rather, it could be viewed as more appropriately and realistically meeting the needs of this country. Too often the models used by western societies are taken as paradigms without regard for cultural, social, and economic circumstances of the local situation.

Nursing education in Trinidad and Tobago has accomplished much of which it can be genuinely proud. The current leadership is fortunate to be a part of a new Caribbean society that is emerging, where its own people control the state, where despite social and economic problems, it has maintained a stable political environment and has attained improved standards of living and health. Nursing education has the formidable task ahead of it of constantly ensuring attention to indigenous features in the curriculum, especially in relation to primary health care, preparation of teachers, shortage of human and physical resources, greater control over student learning, and developing political acuity. Still, educators need not suffer from any undue inferiority complex because of these demands. Rather, as Demas has pointed out in relation to the West Indian society,

> [A]ll of this means that the New Caribbean Society must rest on an indigenous and not an imported ideological basis. If we are to create a distinctive society in the Caribbean, we must formulate the intellectual and moral bases of this society in light of our situation, our own history, our own possibilities and our own aspirations. The New Caribbean Man [Woman] must look inward for ideological inspiration.[14(p321)]

Nursing education in Trinidad and Tobago has begun slowly along that path.

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