Implementation Gaps of a Health and Family Life Programme: a Case Study of a Caribbean Island

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Abstract
Governments attempt to deal with life skills issues through introduction of skills programme in school with a purpose to assist the young adults to make appropriate choices in life. This is the situation in the Caribbean where similar programmes have been introduced under different names. This study is an attempt to document the implementation gaps following the introduction of a life skills programme in a Caribbean Island. A qualitative case study approach was undertaken to unearth the experiences of key informants to the Health and Family Life programme in the Caribbean state using the Active Implementation Framework (AIF). Gaps were identified and arranged in themes under the (a) Usable intervention, (b) Implementation stages, (c) Implementation drivers and (d) Implementation teams as postulated by the AIF. The pertinent findings were discussed and placed in context with literature. Also the implications of the findings as they relate to other subjects e.g. social studies, need for the ‘buying in’ concept, administrative concerns and need for support from all were discussed. This study has implications for the CARICOM states. If there are implementation issues in Trinidad and Tobago, irrespective of the infrastructures in place for the programme, it calls for a careful and determined follow through with the dictates of the AIF to derive the benefits of a well-reasoned programme such as the Health and Family Life Education programme of Trinidad and Tobago.

Keywords: Caribbean, School health & Life skills Programme, Programme implementation & Evaluation

Introduction
The issue of maintaining good health has become crucial in the society, as it is said: “a healthy nation is a wealthy nation”. Crimes, violence, poor academic performance, suicide, ill-health, school drop-out, sexually transmitted diseases, teen pregnancy, social vices among others have been linked to poor health habits people engaged while young and lack of skills to deal with life challenges. Schools have been identified as a place where children and young adults can be taught healthy life styles and also a place to reach a large number of persons. Health and Family Life Education (HFLE) is a school health programme designed to be taught as subject in schools using a life-skill approach. It is a programme targeted to empower students with healthy life skills, skills that will enable them to be healthy, productive and responsible citizens. HFLE is a means of establishing health promoting schools in the Caribbean Community (CARICOM) states, as well as schools that will help to develop healthy life skills in students.
The study investigated HFLE implementation in Trinidad and Tobago by exploring its implementation gaps using the Active Implementation Framework (AIF). In order to understand the research issue, literature was reviewed under school health programme and the AIF. Data was collected from three key informants and result from it was presented and recommendations were made. Drake, Graham, Fuller & Jenkins (2009) define Health and Family Life Education (HFLE) as a skill-based approach to education that seeks to enhance the development of healthy living, social and emotional skills in children and young people. Health and family life education is a type of education that is geared towards providing children with knowledge and life skills that will enable them to live healthy and make good decisions about life and be productive citizens.

Health education is an important part of school health programs; according to Page and Page (2011), it is targeted at changing the individual’s health behaviour; it provides students with the knowledge and skills they need to become healthy, successful learners, responsible and productive adults. Health Education program is beneficial to students in the sense that it will help reduce teenage pregnancy, delay the early initiation of sex, and reduce the spread of sexually transmitted diseases. Also, Page and Page (2011) indicated that two-thirds of death among those older than 25 years is as a result of cardiovascular diseases and cancer; some of these diseases are the result of unhealthy behaviours such as poor diet, cigarette smoking and lack of physical activities that are established early in life; hence it is crucial to address the issues of health early in life.

Schools are seen as powerful agents in the promotion of good health among students through the curriculum and everyday practices; schools reach a larger population for many years (Naidoo & Wills, 2011). Marks (2012) suggested that if schools fail to provide students with the knowledge and skills they need to negotiate healthy environment and critically analyse health information, students may experience heightened health challenges, both while at school and later in life. School health programme encourages the health and well-being of students and staff, it involves parents, families and communities in health promotion, involves student participation and empowerment, integrates into the school’s on-going activities and provides a safe and supportive environment (Naidoo & Wills, 2011).

Research have shown that schools can help students achieve good health, although school needs good health programmes, support, collaboration from families, communities and government in order to make advancement in students’ health (Report of a WHO Expert Committee on Comprehensive School Health Education and Promotion, 1997). In addition studies conducted on the effectiveness of school health programmes in schools showed that lack of administrative support, policy awareness, skills and knowledge contributed to its non-implementation (Cholevas & Loucaide, 2011; Ademokun, Osungbade & Obembe, 2014). On the other hand, Samdal & Rowling (2013), Kam, Greenberg & Walls (2003) are of the view that that schools with strong administrative, leadership and support is more likely to succeed in implementing health programmes.

Life skill is an approach to the delivery of HFLE. Life skills are defined by Page and Page (2011) as abilities and behaviour that help individuals to deal effectively with the challenges and demands of everyday life. The development of life skills in young people helps them acquire personal skills that have positive impact on their lives; it helps to protect them from unhealthy lifestyles and health threats. Life skills should not only be based on knowledge but also on practical life skills such as decision making, communication, building self-esteem, negotiation and assertiveness skills (Naidoo & Wills, 2011). McKenzie, Neiger & Thackery (2009) expressed that successful implementation of school health programmes start from planning, from exploring the need for the programme to methods of delivery.

One group of authors identified 3 key groups of life skills which are: social and interpersonal skills (such as communication, refusal skills, assertiveness, and empathy); Cognitive skills (like decision making, critical thinking and self-evaluation); and Emotional coping skills (such as stress Management skills (Mangrulkar, Whitman & Posner, 2001). Life skills help an individual to be resilient and practice healthy life styles. Life skills can be taught effectively by using participatory
approach or interactive teaching strategies like open discussion, role playing, games, group discussion and small group activities such as cooperative and collaborative learning. Life skills foster the development of a holistic child.

Countries with School Health Programmes

Centres for Disease Control (CDC) in its efforts to promote healthy living among students and improve students’ health, supports and funds school health programs. CDC is an agency that supports and promotes overall public health; its works include but not limited to health education, health promotion, ill-health prevention and other school health preparedness activities in the United States (Center for Disease Control, 2015). CDC’s Coordinated School Health (CSH) Program which began in 1980’s is one those projects that integrate health promoting practices in the school curriculum. CSH program is an integrated set of sequentially planned activities and services geared towards enhancing the emotional, educational, physical and social development of students. CSH program also supports and involves families. It is coordinated by a multidisciplinary team and accounts program’s effectiveness and quality to the community. It is a strategy to improve students’ learning and health. The CSH model has eight interactive components which are healthy school environment, health education, health services, family/community involvement, health promotion for staff, counselling/psychology and social services, nutrition services and physical education (Fogden, 2006).

CDC also recommends that schools should do an assessment using the school health index before implementing CSH program. Furthermore Weare (2000) opined that the features of whole school approach include positive staff-pupil relationships, staff development and education, starting the program early with the youngest children, having a long-term commitment to the programme, team work; active involvement of parents, government and the local community; this strategy has been proven to be successful in making long-term changes to students’ behaviours in countries like US and Europe. Similarly, Marks (2012) identified collaboration between researchers, parents, policy makers, educators, and school administrators as a strategy to the effective implementation of school health programs; working together with these stakeholders can assist in identifying the health literacy skills necessary to their communities and community members and what can be taught through the educational system. He also proposed that integrating health related topics into other subject is another strategy for implementing school health program.

In Chile, a school health program called Skills for Life (SFL) was developed in Chile and it is to be taught at schools. A study done by Javier…et.al (2015) shows SLF is a successful health program in that it helps the “at risks” students improve in behaviour and academics. This program also helps students to develop social skills. Page & Page (2011) articulated an effective health education curriculum uses strategies designed to personalize information and engage students, provides age-appropriate and developmentally appropriate information, learning strategies, teaching methods and materials, provides adequate time for instruction and learning, provides opportunities to reinforce skills and positive health behaviours, and includes teacher information and plans for professional development and training that enhance effectiveness and student learning.

The Uk government in her National School Curriculum has a program called Personal, Social, Health and Economic (PSHE) Education. This program has been in existence since 2000 and was designed to help equip children with practical skills, knowledge, attitudes and understanding that will enable to live healthy, be productive and responsible citizens; this program was designed to make young people to be in charge of their lives; and the schools’ role is to help young ones develop self-awareness and self-esteem (Naidoo & Wills, 2011; Page & Page, 2011& Weare, 2000). PSHE is taught under these three themes: Relationships, Living in a wider world, and Health and Well-being. PSHE topics are: sex and relationship education, personal health, citizenship, bullying, careers, personal finances, family and relationships, alcohol, smoking and drugs. Changes have been made to PSHE to include other aspects of skill development like emotional literacy and behavioural skills. A lot of studies have been conducted to assess the effectiveness of the program’s implementation. Results showed that due to lack of training for teachers in PSHE and mixed messages from the government as to the necessity
of PSHE within the curriculum that PSHE is not mandatory but it is strongly encouraged, PSHE implementation has been patchy. The program was revised based on findings from the studies (Naidoo & Wills, 2011).

In St. Lucia, a Caribbean Island state, a family life education/guidance and counselling curriculum was developed in 1989, by the ministry of education and its implementation started in 1991 in primary and secondary schools. This curriculum later evolved into HFLE curriculum in 1997. In St. Lucia, HFLE is an examinable subject for the Common Entrance Examination. Initially at primary schools, there were challenges of mastering the methodologies for teaching HFLE. Also, some stakeholders from the Roman Catholic schools objected to the teaching of HFLE at their schools. This was later resolved, with directives from the Ministry of Education; the catholic schools subsequently started implementing HFLE (Rampersad, 2008).Grenada, also started with the teaching of Family Life Education in 1988 to infants, juniors and seniors in all primary schools. They started the implementation of HFLE in 1994. Now, it is an in-school and out-school youth programme. As an out-school programme, it is taught at health centres, prisons and community centres to help those perceived as “at risks” like school drop-outs and young persons in foster care. The in-school youth programme was taught at secondary schools by organizations like NGOs. Primary and Secondary school teachers were trained on the implementation of HFLE. These trained teachers became subject leaders in their respective schools. There are hindrances to successful implementation of HFLE in Grenada which are: less priority was given to HFLE curriculum and this impacted on time-tableing arrangements, teachers lack of confidence to teach HFLE and their lack of commitment to the subject, lack of training to deal with sensitive issues such as sexuality; teachers discomfort to teach lifestyles which are in conflict with their own life styles and beliefs, and health behaviours; low number of HFLE teachers; and slow process of training and retraining teachers (Rampersad, 2008). According to Mckenzie, Neiger & Thackery, (2009), training builds understanding, commitment and skills to enable teachers effectively teach the curriculum.

Health and Family Life Education in Trinidad and Tobago
HFLE is introduced to help students cope with life challenges and live healthy lifestyles. In essence, HFLE enhances positive development of the social, physical, emotional and mental health[Ministry of Education,( MOE) Trinidad and Tobago, 2006]. The rationale behind HFLE in Trinidad and Tobago is to empower the children and youth with the necessary life skills to overcome social ills and health issues such as teenage pregnancy, poverty, substance abuse, violence, HIV/AIDS, life styles related diseases and live healthy lives (MOE, 2006). According to King (2002), health education makes a significant contribution in promoting health lifestyles if started early in life and it is continually reinforced as the child moves through adolescence into adulthood.

The life skills approach to the HFLE curriculum was developed on the basis of these theoretical underpinnings: child and adolescent development, problem solving, social learning, problem behaviour, social influence, cognitive problem solving, multiple intelligence, risk and resiliency (MOE 2006). Constantine, Stueve & O’Donnell (2009) articulated that teachers’ limited experience and skills with life skills approach to HFLE is negatively impacting on its delivery at schools. The HFLE Curriculum has four thematic areas and these four themes cover the overarching theme of HFLE which is on Health and Wellness. The issues outlined were in accordance with the four thematic areas mandated by the United Nations Children’s Emergency Fund (UNICEF) and CARICOM secretariat. The four thematic areas are:

- Self and Interpersonal Relationships
- Sexuality and Sexual Health
- Eating and Fitness
- Managing the Environment

There was an informal interview with some primary and secondary teachers on the issue of HFLE implementation. Some of the teachers indicated that they do not implement HFLE that they use the period for HFLE to teach other examinable subjects. Some teachers stated that although they teach
HFLE but not so much as it was designed. Furthermore, the informal interview which was conducted to ascertain the extent of HFLE implementation indicated that some teachers are of the view that the teaching of HFLE is for Social Studies teachers; although some indicated that HFLE was meant to be infused into subjects at the secondary level.

Morrissey (2005) opined that after many years of introducing HFLE, there was little to show that it is being implemented at schools. Despite commitments and support by the CARICOM Secretariat and UNICEF which resulted in the development of new curriculum framework and prototype lessons for the four themes of HFLE, Constantine, Stueve, O’Donell, Agronick & Vince-Whiteman (2009) & Morrissey (2005) indicated that there are challenges facing the successful implementation of HFLE, and Mohammadi, Rowling & Nutbeam (2010) stated that any challenges faced during programme implementation should be addressed so as to progress its proper implementation. The Vice-President of National Parents Teachers’ Association (NPTA) has advocated the teaching of HFLE curriculum as a separate subject from nursery to secondary schools in Trinidad and Tobago. She also explained that teachers have problems implementing HFLE. Furthermore, she made a call for stakeholders to support the implementation of HFLE curriculum in all schools in Trinidad and Tobago, because of the many violence, teenage pregnancy, sexual transmitted diseases and exploitation among youths in Trinidad and Tobago (Guardian Newspaper, 2011).

In Trinidad and Tobago, anecdotal evidence suggest despite the fact that HFLE has been introduced over a decade, it is not being implemented as stipulated, that is, using a thematic approach. Also, UNICEF (2010) stated that there little to show that HFLE is implemented in Trinidad and Tobago as it yet to yield positive outcomes. It has been observed that some schools have not even attempted to implement HFLE; as a consequence students may not be benefiting from the program. Hence, there is a need to research and evaluate HFLE programme implementation in schools.

Active Implementation Frameworks
The proposed implementation framework against which the implementation of HFLE Curriculum in Trinidad and Tobago will be assessed for this study is the Active Implementation Frameworks (AIF). AIF will be applied in this study in order to identify HFLE implementation gaps. AIF is an implementation framework developed by the US National Implementation Research Network (NIRN) in 2005. NIRN developed AIF based on conducted research and identified what contributes to obtaining results and improvement of services and products in education and other disciplines (Bertram, 2014). AIF prescribes strategies for successful implementation of programs that help to close implementation gaps and challenges. It was designed to help understand why and how implementation succeeds or fails; and to address barriers to successful implementation. Nilsen (2015) stated that AIF is a determinant framework; it determines factors which act as hindrances (Implementation gap and challenges) to successful implementation as well as facilitating factors (independent variables) that have impacts on implementation outcomes (dependant variables). AIF has five overarching frameworks which are: Usable Intervention, Implementation Stages, Implementation Drivers, Implementation Teams, implementation drivers and Improvement cycles (National Implementation Research Network, 2015). Metz, Bartley, Ball, Wilson, Naom & Redmond (2015) articulated that AIF is a favourable framework for enhancing high fidelity implementation of research-based innovations.

Usable Interventions: It is advocated that for a program to be effectively implemented, there must be need for it, and clarity about the program. The implementers should have a clear understanding of what the program is for; that is the goals, objectives and also practical performance assessment of the program are to be clear to the implementers. Also, there must be clear values and philosophies guiding the program. Also, for effective implementation of any program, it has to be learner-able, teachable and practicable (National Implementation Research Network (NIRN), 2015).
Implementation Stages: The AIF suggests that implementation of program is done in stages; it is a process that is recursive. This process entails taking several decisions, actions and corrections where applicable. According to Panzano and Roth (2006), it takes about 2 to 3 years to effectively implement a well-structured program. The implementation stage has 4 functional stages; these stages are exploration, installation, initial implementation and full implementation stages. Activities in these stages overlap, any stage does not need to end before another stage is started and at any point any stage can be revisited to make some changes if the need arises. The exploration stage involves assessing the needs of the students the program is meant for, which is if the program meets the need of the students, schools and the society. This stage also entails getting stakeholders involved, examining potential barriers to implementation and implementation teams formed. The installation stage involves practical activities that will assist in the successful implementation of the program. These practical activities are: Developing communication pathways, making sure that both human and financial resources are put in place, finding physical place where necessary, ensuring that facilities to support the program are installed and training the implementers of the program. Initial Implementation stage involves paying special attention to coaching, attention to continuous improvement and rapid cycle problem solving and using decision support data systems. Coaching here entails intensive coaching for implementers to help them overcome any challenges they encounter. The support data system is to be used to assess implementation, identify any problems and make informed decisions. The next stage is the full implementation stage; this is when teachers now implement the program at their schools and outcomes are achieved. At this stage, there are support, infrastructure and resources to support teachers. In addition to the four functional implementation stages above, AIF advocates that there should be sustainability of finance and infrastructure at every stage of implementation. The implementation infrastructure should be reliable and effective (NIRN, 2015).

Implementation Drivers: The three implementation drivers stated in the AIF are competency, organization and leadership drivers. The competency drivers are those activities put in place to improve and sustain implementers’ ability to implement the program and students benefit from the program. Competency drivers include selection, coaching, training and performance assessment. Organization drivers are used intentionally to develop the infrastructures and support needed to establish hospitable environment for new programs. These supports are decision-support data systems, facilitative administration and system interventions. The collected data are used to make informed decisions concerning the program. Facilitative administration entails administrators using a wide range of data to support effective implementation of the program. Administrators work with the data to identify and address any challenges facing the program. They develop and adjust policies; hence they work towards achieving the expected outcomes of the program. System intervention involved working with external bodies outside the school to ensure that the program is implemented. There may be challenges or issues that cannot be dealt with at school or district levels, such issues can be referred to external body like the ministry of education. Leadership drivers entail the vital roles leaders play to ensure successful implementation of a program. All the three implementation drivers are integrated, and they complement each other in the implementation of programs. They also compensate each other like if some teachers are not knowledgeable in the use of data, training workshops can compensate for that by training those teachers on how data are used.

Implementation Teams: The AIF postulates that implementation teams are the ones who work to ensure efficient implementation of programs. The implementation teams identified are: State Implementation Team, Regional Implementation Team, District Implementation Team and Building Implementation Team. The implementation teams build an internal support structure that cut across all the stages of implementation. They make sure that things like implementation infrastructures and resources are put in place. Each implementation team is given specific roles which are clearly defined. They also work hand-in-hand, building linkages with external systems; they assess and report on fidelity and outcomes (NIRN, 2005).
Improvement Cycles: Improvement cycles enhance the effective implementation of programs; it is used by the implementation teams to support the implementation of programs and achieve expected outcomes. Improvement cycles are based on PDSA that is Plan-Do-Study-Act and Policy-Practice Communication cycles. Implementation teams use the improvement cycles to identify barriers or challenges implementers of programs may be facing; and they work to alleviate those barriers. In the four phases of PDSA cycles, in the ‘plan’ phase, challenges facing implementations are identified using data where possible and plans are specified to move the program forward. In the ‘Do’ phase, the specified plans are carried out to address the identified barriers. While at the Study phase, the program ‘progress’ is tracked and assessed using the identified measures at the planning phase while at the ‘Act’ phase; changes are made to the next iteration of the plan to help improve implementation. Policy-Practice Communication (PPC) Cycle is used by the implementation teams to connect policy to practice. Good policy informs practice; on the other hand, practice can be used to inform policy. In PPC, the implementation team gives feedback on practice to policy makers, so they have the duty to develop, promote and negotiate mechanisms to communicate intended and unintended impact at the practice level. Table 1 explains the components of the five frameworks of the AIF.

Table 1: Elements of AIF

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<tr>
<td>Clarity</td>
<td>Exploration Stage:</td>
<td>Competency Driver</td>
<td>Implementation Teams</td>
<td>- Identify barriers</td>
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<tr>
<td>- Goals</td>
<td>- Needs of students, school &amp; society</td>
<td>- Sustainability of training &amp; performance assessment</td>
<td>- State</td>
<td>- Improve programme based on specific plan</td>
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<td>- Objectives</td>
<td>- Consultation with stakeholders</td>
<td>Organization Driver:</td>
<td>- District</td>
<td>Plan-Do-Study-Act Cycle</td>
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<td>- Assessment</td>
<td>- Involvement of stakeholders</td>
<td>- Support from organization:</td>
<td>- School</td>
<td>Policy-Practice Communication Cycle</td>
</tr>
<tr>
<td>Clear Policies</td>
<td>- Implementation Teams Formed</td>
<td>- Facilitative administration</td>
<td>- Specific roles</td>
<td>- Used by implementation teams</td>
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<td>Clear Values</td>
<td>- Potential barriers examined</td>
<td>Decision support data system</td>
<td>- Coordination</td>
<td>- Track &amp; assess programme’s progress</td>
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<td>Clear Philosophies</td>
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<td>- Support from External bodies, NGOs</td>
<td>- Supervision</td>
<td>- Changes made to improve programme.</td>
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<td>Learnable</td>
<td>Installation Stage:</td>
<td>Leadership Drivers:</td>
<td>- Providing infrastructures &amp; resources.</td>
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<td>Practicable</td>
<td>- Communication</td>
<td>- Leadership roles</td>
<td>- Increases “buy-in”</td>
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<td>Teachable</td>
<td>- Initial Training, provisions of resources &amp; facilities</td>
<td>- Leadership characteristics/qualities Teacher characteristics.</td>
<td>- Aligns policy, procedures and guidelines with implementation.</td>
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<td>Benefits</td>
<td>- Support data system to assess implementation and identify problems.</td>
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<td>Making it Happen.</td>
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<td>Full Implementation:</td>
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<td></td>
<td>- Implementation outcomes achieved Sustainability of finance and infrastructures.</td>
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Purpose
The purpose of this study is to explore the implementation gaps and challenges of a life skills Health and Family Life Education Programme by applying an Active Implementation Frameworks (AIF).

Methodology

Research Design: This project is a qualitative case study. Qualitative method was used so as to understand the research through the experiences and meaning people ascribed to the research issue and also gather a rich data on it. According to Creswell (2007) researchers make sense of a phenomenon through the meanings people bring to it. In this study, the experiences of persons regarding HFLE implementation are crucial in understanding its implementation gaps. Furthermore, Creswell (2012) explained that problems are explored and described in detail in qualitative study; hence the AIF was applied to explore HFLE implementation gaps in details. Qualitative study examines a phenomenon through an approach; Case study will be the approach to this study. Case study is an in-depth exploration or detailed study of a particular case or cases. The case can be individuals or events; in essence, it is geared toward understanding a group of people, an individual or a particular event (Litchman, 2009; Creswell, 2007). HFLE is a programme that is implemented in the CARICOM member states but for this study, the case of HFLE implementation in Trinidad and Tobago was explored.

Sampling Procedure: Three key informants were purposefully selected for the study. The selected participants were chosen because they have ample experience and knowledge with HFLE implementation, hence purposeful sampling method was employed for the study. Purposeful sampling is used based on the assumptions that the investigators want to discover and understand a phenomenon and therefore selects the sample that will give the wanted information (Merriam, 2009). One of the key informants was deeply involved with HFLE development at the CARICOM level and was involved with the training of teachers for HFLE delivery. Also one of the participants is currently involved with the training of teachers for HFLE delivery and the other key informant is a teacher that was among the team that developed HFLE Secondary Curriculum.

Data Collection Methods: Data was collected through a face to face, semi-structured interview. Creswell (2007) stated that in qualitative study, data is collected through multiple source among which is an in-depth interview and interview is used to get an understanding to experiences and meanings regarding the research problem. The semi-structured interview gave room for probing during the interview. Open-ended questions were used so as to allow the participants to elaborate their experience on with HFLE implementation. Some of data were also collected through phone calls and emails.

Data Analysis Methods: Data was analyzed through a Thematic Analysis method. The responses from the interview were transcribed in a word document. The transcribed data along with the printed copy of the data gotten through email were read severally, after which codes and categories were formed from them. Themes were derived from the categories and placed under the four frameworks of AIF. The results from the data were presented in a narrative form.

Results
This project was conducted to explore the implementation gaps of a life skills approach school health programme, HFLE. In order to explore its implementation gaps, data was sought through face to face interview with three key informants over a period of one month.

The results are based on codes and categories formed from the transcribed responses of the three key informants. The categories were marched against the AIF and themes formed under the AIF different implementation frameworks. AIF formed the broad themes while the categories are the sub-themes.
Research Question: What implementation gaps can be identified in HFLE implementation using the Active Implementation Frameworks?

These themes were formed under these four AIF: Usable Intervention, Implementation Stage, Implementation Drivers and Implementation Teams.

**Usable Intervention:** Clarity, Examination and Information Gaps were categories formed under the theme on Usable Intervention.

**Clarity Gap:** Responses from the interview indicated that there are clarity issues with HFLE implementation; clarity issues on the intended outcomes and purpose of the programme and on how to deliver the programme. There was misconception that HFLE is under social studies and Social Studies were selected to teach the subject at some schools. Participant A stated:

> The thing with HFLE in Trinidad and Tobago is that it was linked to Social Studies, Therefore they brought Social Studies facilitators to monitor and oversee the programme.

Also, as a result of this misconception, the Social Studies facilitators were not teaching HFLE using a life skills approach: Again Participant A said:

> …so they came with the mind set on how they did their work in Social Studies that is they were looking at knowledge acquisition rather than the skills competency and that was a major issue.

Further on Clarity gap, Participant A explained:

> There was an issue of whether HFLE should be taught as a single subject or infused because when the government of Trinidad and Tobago rolled out the curriculum, it was intended to be taught as a single subject and teachers are free to infuse as they thought or sought.

**Information Gap:** The participants also explained that teachers do not have sufficient information on HFLE programme. Participant B expressed:

> Teachers do not have enough information about the programme; the Ministry of Education is not forth coming when it comes to educating teachers on what to do.

**Examination Gap:** HFLE is not an examinable subject, whether internally or externally. Hence, principals and teachers do not see the need for the programme. Participant A said:

> …it is not on the front burner, principal and teachers do not see it as important because it is not tested, there is no examination.

Similarly, Participant 2 declared:

> The way they see it as not being important; as you see in the Primary school, they focus on subjects that are assessed for SEA examination and so on and not on anything that does not have impact on SEA.

The lack of examination on HFLE has a negative impact on HFLE successful delivery. There is this perception by key implementers that since HFLE subject is not tested, it is not relevant.

**Implementation Stages**

Implementation stage theme was formed from the categories of Competency, Training and Timetabling Gaps.

**Competency Gap:** The Social Studies teachers lacked the skills to implement HFLE subject because HFLE is not their subject area. Participant A expressed:
These are Social Studies teachers who have been trained in their subject area, so they lack the skills to efficiently implement HFLE at their schools.

Training Gaps: Training is another missing factor in HFLE’s implementation; although there were trainings at various levels but the participants are of the view that those training are not enough.

As Participant C said:

Teachers’ lack of confidence with teaching HFLE is due to lack of adequate training.

Participant A stated:

Training was always done at the beginning at CARICOM level and so governments would be invited to send representatives of their countries and they did what was called “train the trainer workshops”. And those people who are supposed to be like HFLE coordinators are supposed to come back to countries and do workshops to train people but this was happening in countries except in Trinidad and Tobago.

In addition, it was explained that there should be teachers specifically trained to teach HFLE subject, as Participant C explained:

We don’t have teachers trained as HFLE teachers…Trinidad and Tobago at that time was behind countries like Jamaica and Barbados who were way a head reimplementation since they had already implemented the training of teachers as HFLE teachers in their Teacher Training Program.

Timetabling Gap: Timetabling issue according of the participants is a problem in HFLE’s implementation, this was indicated when Participant A said:

As for the school timetable, they should have made sure that at least once a week HFLE was timetabled, that it was part of the curriculum.

HFLE in some schools is not timetable like other subjects. There is no time assigned to the teaching of HFLE in some schools.

Implementation Drivers
The Implementation Drivers theme was derived from these categories: Administration Gap, Continuous Training Gap, and Monitoring and Evaluation Gap.

Administration Gap: Administration gap was observed both at school and government levels. Participant A stated:

But the point is, why Trinidad and Tobago is lagging behind. And it is lack of political-will, lack of planning…lack of principals buying-in.

Similarly, Participant C expressed:

There is lack of guidance from the Ministry of Education.

Also, Participant C articulated:

Training took place over a period of time…but it was sporadic and not sustained and was susceptible to changes which would have occurred as governments changed and policies changed.
There is also administration gap as a result of lack of instruction and information as what implementers of HFLE should do.

It was also noted that sometimes, principals’ roles are not helping HFLE implementation. Some of the principals do not attach great importance to the teaching of the subject, as they assign teachers to teach other subjects after their training, this was indicated when Participant A stated:

“So from that time teachers were given the orientation, they have to go back to their schools and principals were supposed to make sure that when they were doing the timetabling they put these people first to run the program. But, very often when they went back school, d principal would have reallocated them depending on the perceived needs at that time where they thought the teacher would be best be redeployed in the school. And sometimes, even after the training, the teachers were not able to use the skills back into the school.”

As a result of this administration gap, teachers do not practice what they have learnt from the trainings. Also, change in government is affecting teacher training, as new government administration sometimes makes changes to policies.

Continuous Training Gap: The participants indicated that teachers’ training was not sustained. Participant C expressed:

“Training took place over a period of time…but it was sporadic and not sustained.”

Also, another participant stated that there was a large scale training initially but this was not sustained. Participant A said:

“…so it was done throughout and to the best of my knowledge we have not had that large scale training again.”

Monitoring and Evaluation Gap: Data collected shows that there is monitoring and evaluation gap in the implementation of HFLE, Participant A has this to say:

“I cannot tell you that there was any serious monitoring of HFLE because as I said these were social studies facilitators as they just had slash HFLE tagged on to it. So there swamped because they had to monitor their social studies areas as well as HFLE and I think always HFLE was just sliding.”

This gap was associated with not having specific teachers for HFLE to facilitate its teaching. There was no real monitoring of HFLE, as it became workload for Social Studies teachers appointed to teach HFLE.

Also, Participant A expressed:

“HFLE is lagging behind; the Ministry is not monitoring or evaluating it.”

Furthermore, it is of the view of the participants that HFLE lacks monitoring and evaluation at the Ministerial level.

Implementation Teams
Coordination Gap: The participants explained that there are no implementation teams formed to coordinate the running of the HFLE programme. Participant A said:

“…there were no implementation teams, not to my knowledge.”

In addition, Participant A stated:
And the policy would have explained about the national coordinators, and a coordinator at every school and those kinds of things that were supposed to happen and never happened.

Forming coordinators at national and school levels was part of the initial structure meant to be in place for HFLE implementation as these coordinators can function as implementation teams.

Discussion of Findings
This section of the study will explain in details results gotten from the transcribed interview. The findings of this study will discussed based on AIF and other literatures discussed previously in the study; and also be discussed under the two research questions.

Usable Intervention: The AIF proposes that for programmes to be implemented effectively there should be clarity on the goals, objectives, benefits and practical assessment of the programme. It further stated that there should be sufficient information about the programme and implementers should be aware of them. Result from the study indicated that HFLE is linked to Social Studies in some schools, and this has created gap in HFLE’s implementation, hence, implementers are not certain on how to teach and monitor the programme. Again, the subject is taught in some school for knowledge acquisition rather skill acquisition; this can be attributed to non-clarity and information about HFLE to teachers. Fullan (2007), Naidoo & Wills (2011) opined that clarity on programme implementation whether on policy, goals, method of delivery, objectives and philosophies is very crucial, as implementers need to know what the programme is about and have knowledge on how to implement it. Examining students on HFLE will enhance teachers’ dedication, interest and motivation in the subject delivery. Clarity on practical assessment of the programme will enable administrators to ensure that HFLE is being assessed and that students are assessed on it; and one of the ways this can be done is by scheduling HFLE examination for students. Practical assessment is one of the ways to evaluate programmes and evaluation helps to improve programme’s delivery so as to yield results.

This finding also suggests that schools are not sure on how to go about the delivery of the programme, whether to infuse it into other subjects or teach it as a single subject; this is similar to findings in a study on HFLE that indicated that teachers have problem obtaining information regarding HFLE subject content and delivery (Phyllis, 2012). Therefore, it will be crucial if HFLE forms an examinable part of school curriculum while the benefits and mode of delivery of the programme are appropriately communicated to the implementers.

Implementation Stages: Result from the study found that Social Studies becoming HFLE facilitators created a competency gap, because it seemed they do not know exactly what to teach or monitor. The Social Studies became overwhelmed or swamped by the extra duties assigned to them.

AIF speaks to initial training of implementers as among the different factors of ensuring successful programme’s implementation. At the second framework which is called the implementation stage, implementers receive training on how to implement and also are given training on how to overcome challenges that they may encounter during implementation. Initial training takes place during the installation stage so as to equip teachers with the needed skills for delivery and build their confidence. This result shows that teachers are not confident to teach HFLE as a result of insufficient training. Training gaps in HFLE implementation is hampering on the effective and efficient delivery of the subject, like result from a study done by Rampersad (2008) found that inadequate training is hampering the effective delivery of HFLE in some CARICOM countries. In addition, this result is similar to result from a study that indicated inadequate skills and experience with life skills approach to HFLE as an inhibiting factor to HFLE implementation (Constantine et.al, 2009). Initial training according to AIF is very necessary and it comes before full implementation so as to adequately prepare the implementers. AIF suggests that teachers are meant to be trained first and equipped with the needed skills, in order for them to get to the full implementation stage, where they now teach HFLE to students.
HFLE is not timetabled in many schools and this supposed to be taken into consideration at the implementation stage of AIF, as Naidoo & Wills (2011) indicated that an effective Health Education subject should have adequate time for instruction. This speaks to what AIF proposed in the second framework at exploration stage, where all the needed resources and facilities are to be put in place in readiness for full implementation. This suggests that giving specific periods for HFLE subject in schools can enhance its proper delivery in schools that is timetabling HFLE as it is with other subjects; and this can as well help in its monitoring, evaluation and assessment. The issue of not timetabling HFLE also implies that the teaching HFLE is left at discretion of the administration and teachers and somehow is not mandatory in schools. This further indicates the low level of importance placed on HFLE. We surmise that better result will come out of the programme if HFLE is part of the timetable, and infused in subjects from form four to six. Also, large scale training for all teachers involved in the form of “training the trainers” as a way of reaching out to the large population of teachers to be involved in the programme.

Implementation Drivers: It was advocated in Framework three of the AIF that implementation drivers are core components that enhance successful programme implementation. Result from the study shows that HFLE programme lacks political will and government support, mainly as change in government comes with change in policy. Ministry of Education as an organization driver is meant to put facilities and structures to help implementers and ensures that previous good policies are maintained and implemented despite any change in government. Also at school, administrators are in position to support HFLE implementation by providing the needed support and infrastructure to teachers. The relevance attached to HFLE can be seen by the level of support given to the implementation of HFLE by administrators. Administrative support is crucial to the implementation of HFLE because it will facilitate its effective delivery. A programme that is given less priority may not be implemented with fidelity. Findings from this study shows that leadership roles such as their support will positively impact on HFLE implementation; this result concurred with the report a WHO Expert Committee on Comprehensive School Health Education and Promotion (1997) that articulated for school health programmes to be effectively implemented, it needs support from the administrators. In addition, finding from a study done by Ademokun et.al (2014) found that lack of government support attributed to non- implementation of a school health programme.

The study found that regular teacher training is needed for the successful delivery of HFLE. Teachers need to be trained continuously; training for implementers is to be sustained for effective delivery of HFLE. New teachers come into the education sector yearly as teachers retired; these new teachers need the skills to teach HFLE. In addition, AIF proposes that for programmes to be successful there should be sustained monitoring and evaluation on programme to ascertain how the programme is going. In HFLE programme, it appears from the findings that there is no serious monitoring and evaluation for it both at the Ministry of Education and Schools; and this is a major missing factor in HFLE implementation. As a result, we recommend that teachers should not only be specifically trained in the HFLE but follow-up exercises be instituted in the form of continue education activities on the HFLE programmes.

Implementation Teams: This also another missing factor in the implementation of HFLE, as identified in the AIF. The implementation teams as described in the AIF ensure that the needed infrastructures, human and material resources are provided and effectively used to support the programme. Implementation teams work to increase “buying-in” and enhancing sustainability; they as well build linkages with external bodies and help in ensuring that the programme’s policy, guidelines and procedures are aligned with implementation. Each implementation team is given specific roles and responsibilities that will promote the implementation of a particular programme. Implementation teams can be formed at the state, regional, district and schools levels. Forming implementation teams for the implementation of programmes has been explained in AIF to be very important in ensuring effective implementation of programmes. Result from the study suggest that there is no organized coordination or implementation teams for HFLE, giving specific roles to the formed HFLE...
implementation teams or coordinators is one way of ensuring that HFLE is implemented with high fidelity. Each implementation team works towards accomplishing their given tasks, they work towards sustaining programme’s implementation. Implementation Team “make it happen”, they provide internal structure; the activities of implementation team give room for more efficient and higher equality implementation. HFLE implementation teams at the national, district and school levels will help in coordinating and facilitating the different activities that go into HFLE implementation. Implementation team works with PDSA and PPC cycles as described in the Improvement cycle of AIF. Improvement cycles are used to identify implementation barriers. We therefore recommend that implementation teams or coordinators should be formed for HFLE implementation, and providing them with specific duties among which will be using the improvement cycles to improve implementation.

Conclusion
This qualitative case study explored life skills approach to HFLE, its implementation gaps by applying an AIF. HFLE is a school health programme introduced in the CARICOM states, of which Trinidad and Tobago is a member. This project looked at factors that positively and negatively impact on school health programmes implementation. It was noted in the study that there are implementation gaps in the implementation of HFLE in Trinidad and Tobago; despite having put some structures into place, HFLE in Trinidad and Tobago still has implementation issues. To answer the research question, three key informants were interviewed to elicit their experiences and views on HFLE. Data collected from participants was coded to from categories and themes under the five frameworks of AIF. The data collected from the study was marched against the AIF. Although participants in the study indicated that there have been training for teachers, results from the study suggest that these trainings are not enough. Furthermore, findings from the study show the need for “buying-in” from the leaders and ensuring that implementers are well informed about the programme. From the results, it appears that to improve the implementation of HFLE and achieve results in Trinidad and Tobago, application of AIF should start from the first framework; the whole process should be revisited and align with the five frameworks of AIF, beginning from Usable Intervention to Improvement Cycles. Also, from the findings, it appears that implementation gap at any stage of AIF can negatively affect other stages of implementation. In some cases, implementation gaps can lead to implementation challenges; such as training gap can cause teaching challenge. Finally, it can be said that strategies to effective implementation of HFLE cut across the five frameworks of AIF.

References


