Internationalizing Nursing Education in Central Java, Indonesia: 
A Postcolonial Ethnography

Robyn L. Aitken

RN, B. Ed. Studies, M. Ed. Studies

Submitted in total fulfilment of the requirements
of the degree of Doctor of Philosophy

November, 2008

School of Nursing and Social Work
Faculty of Medicine, Dentistry and Health Sciences
The University of Melbourne
Abstract

Using a postcolonial ethnographic study, this thesis explores the tensions of why Indonesian nurses both desired and rejected western expertise and compliance with international standards for nursing education and practice. The dominant understanding of such ambivalence is that while all nurses accept the need for universal competencies for the contemporary, internationally mobile nurse, non-western nurses are prevented from achieving some of these competencies by virtue of inherent cultural differences from their western nursing counterparts. Drawing on postcolonial theory, this thesis deconstructs such notions of culture and difference as colonial constructions and identifies the hegemonic nature of western nursing. It deconstructs the image of the contemporary, internationally mobile nurse as historically situated and discursively constructed. It unsettles the dominant understanding of what nursing is, what nursing should be, and questions the exclusive conditions of entry into nursing as a globalized profession.

Based on the need to escape dominant understandings, ethnographic techniques of observation, individual and group interviews, documentary analysis, and reflective journaling were used to explore how both local and global influences on nursing impacted on achieving international standards within everyday circumstances. Data were analyzed using key postcolonial themes including orientalism, subalterneity, ambivalence, mimicry and hybridity. Assumptions of difference influenced perceptions and judgments about the quality of Indonesian nursing education and practice. Incongruence existed between what is said and documented about nursing and actual nursing practices in Indonesia. This finding represented both passive and powerful subaltern resistance to western models. Partial resistance to western models of nursing, practice and education helped to open up hybrid spaces in which cultural differences could operate.

Western models of nursing practice and education underpinning the agenda for global consistency of nursing are not universally applicable. Instead, it is a colonial assumption that all nurses should be the same regardless of the context in which they practice. This thesis shows that despite the apparent necessity for western
The findings suggest that ambivalence arises when being ‘internationally recognized’ means accepting the dominant western hegemony of nursing but rejecting locally situated meanings and practices. I propose that this ambivalence creates a hybrid space to improve Indonesian nursing and challenge the universality of western standards for nursing education and practice. I also propose that ambivalence creates a space for reconceptualizing the role of western experts in non-western settings. In this re-conceptualized role, expertise is not defined by its western foundations. Instead, expertise is defined by an ability to facilitate content knowledge that can be accepted, rejected, or incorporated into hybrid solutions.
Declaration of Authorship

This is to certify that:

i. The thesis comprises only my original work towards the PhD except where indicated;

ii. Due acknowledgement has been made in the text to all other material used;

iii. The thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signature: Date:

[Signature]

20/10/08
Acknowledgments

This list of acknowledgments has been included in recognition and appreciation of those who in their different ways played a part in my completion of this research.

I wish to thank Professor Judith Parker, Professor Sioban Nelson, Professor Elizabeth Manias and Professor Lesley Barclay. In this order, each of these academics has supervised my work. Each has contributed specific expertise, and in line with my commitment to this thesis as a postcolonial project, have contributed to the multiple perspectives that I have explored.

To the participants in this research I say: *Terima kasih banyak, temangku; Sampai Jumpah Lagi* [Thank you very much my friends; until we meet again]. The path we walked together in the Central Java Sister School Program (CJSSP) was not easy. It was your simultaneous desire for and resistance to collaboration that prompted this research, and opened my eyes to possibilities that I would otherwise never have considered.

To my husband Peter, I say: *Selasai* [It is done]. Whilst you may have thought otherwise, your simultaneous frustration with my thoughts being elsewhere and desire for me to succeed was the greatest motivation to complete this work. To my daughters Georga and Tess, I now say *Sudah* [already done]. No more will I say: *belum* [not yet] or *nanti* [later].
# Table of Contents

## Chapter 1: Montage

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>A Collaborative Space</td>
<td>1</td>
</tr>
<tr>
<td>DIII Nursing Education</td>
<td>2</td>
</tr>
<tr>
<td>A Space Where Local and Global Agendas Meet</td>
<td>4</td>
</tr>
<tr>
<td>International Standards for Nursing Practice</td>
<td>7</td>
</tr>
<tr>
<td>The Competency Requirements of the Contemporary Internationally Mobile Nurse</td>
<td>8</td>
</tr>
<tr>
<td>International Standards for Nursing Education</td>
<td>9</td>
</tr>
<tr>
<td>The Space for Western Intervention in Non-western Nursing Education</td>
<td>10</td>
</tr>
<tr>
<td>The Space for Research</td>
<td>11</td>
</tr>
<tr>
<td>The Place Where the Research Question Evolved</td>
<td>13</td>
</tr>
<tr>
<td>Defining Terminology</td>
<td>15</td>
</tr>
<tr>
<td>A Conceptual Space</td>
<td>17</td>
</tr>
<tr>
<td>Placing the Montage in Context</td>
<td>20</td>
</tr>
</tbody>
</table>

## Chapter 2: A View from the Centre

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>23</td>
</tr>
<tr>
<td>Perspectives on the Application of Universal Competencies to Internationalize Non-western Nursing</td>
<td>24</td>
</tr>
<tr>
<td>Achieving Professional Values and Attitudes</td>
<td>24</td>
</tr>
<tr>
<td>The Autonomous Professional Nurse</td>
<td>24</td>
</tr>
<tr>
<td>The Nurse as a Member of a Scientific Discipline</td>
<td>28</td>
</tr>
<tr>
<td>Implementing Teaching and Learning Methodologies that Encourage, Critical Thinking, Problem Solving, and Student Participation</td>
<td>31</td>
</tr>
<tr>
<td>The Capacity of Non-western Nurses to Acquire Critical Thinking, Problem Solving Skills</td>
<td>32</td>
</tr>
<tr>
<td>The Capacity of Non-western Nurses to Teach Critical Thinking, Problem Solving Skills</td>
<td>36</td>
</tr>
<tr>
<td>Achieving Concordance between the Theoretical and Practical Components of the Entry-to-Practice Nursing Education</td>
<td>40</td>
</tr>
<tr>
<td>Implications of the Literature Review for this Thesis</td>
<td>44</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>The Hegemonic Construction of a Single Western Derived Definition of the</td>
<td></td>
</tr>
<tr>
<td>Contemporary, Internationally Mobile Nurse</td>
<td>44</td>
</tr>
<tr>
<td>Dominant Understandings of Culture</td>
<td>46</td>
</tr>
<tr>
<td>A Space for a Different Approach to Researching Internationalization of DIII Nursing Education</td>
<td>48</td>
</tr>
<tr>
<td>Conclusion</td>
<td>49</td>
</tr>
<tr>
<td>Chapter 3: An Alternative Landscape</td>
<td>51</td>
</tr>
<tr>
<td>Introduction</td>
<td>51</td>
</tr>
<tr>
<td>Postcolonial Theory</td>
<td>51</td>
</tr>
<tr>
<td>Positioning the Compatibility between Contemporary Postcolonial Scholarship and this Thesis</td>
<td>53</td>
</tr>
<tr>
<td>Colonization</td>
<td>54</td>
</tr>
<tr>
<td>Colonial Trade Monopolies, Occupation of Indonesia and Subjugation of</td>
<td>55</td>
</tr>
<tr>
<td>Indonesian People</td>
<td></td>
</tr>
<tr>
<td>Inferiorization Justified Subjugation of Indonesian People</td>
<td>55</td>
</tr>
<tr>
<td>Europeanization, Liberalization and Civilization of the Indonesian Colonial Subject</td>
<td>56</td>
</tr>
<tr>
<td>The Discourse of Development</td>
<td>57</td>
</tr>
<tr>
<td>Neocolonial Economic Subjugation of Indonesia and the CJSSP</td>
<td>59</td>
</tr>
<tr>
<td>Neocolonial Occupation and Liberalization of Indonesia and the CJSSP</td>
<td>60</td>
</tr>
<tr>
<td>Discourses of Development and the CJSSP</td>
<td>61</td>
</tr>
<tr>
<td>Orientalism (Edward Said)</td>
<td>63</td>
</tr>
<tr>
<td>Hegemonic Colonial Discourses</td>
<td>63</td>
</tr>
<tr>
<td>The Stereotypical Oriental</td>
<td>66</td>
</tr>
<tr>
<td>Manifest and Latent Oriental</td>
<td>68</td>
</tr>
<tr>
<td>The Orientalist Discourse of Culture</td>
<td>69</td>
</tr>
<tr>
<td>Orientalism as a Fabricated Construct</td>
<td>71</td>
</tr>
<tr>
<td>Enduring Unequal Power Relations between East and West</td>
<td>71</td>
</tr>
<tr>
<td>The Subaltern ‘other’ (Gayatra Spivak)</td>
<td>73</td>
</tr>
<tr>
<td>Subalternity</td>
<td>73</td>
</tr>
<tr>
<td>Marginality and Centrality</td>
<td>74</td>
</tr>
<tr>
<td>The Silence of the Subaltern</td>
<td>75</td>
</tr>
<tr>
<td>Passive and Powerful Subaltern Voices</td>
<td>76</td>
</tr>
</tbody>
</table>
Exploring Subaltern Heterogeneity ................................................................. 77
Psychological Colonialism (Homi Bhabha) ....................................................... 80
Mimicry ............................................................................................................. 80
Ambivalence and Mockery ............................................................................. 81
Hybridity .......................................................................................................... 84
Conclusion ....................................................................................................... 85

Chapter 4: Mapping the Territory .................................................................. 87
Introduction ..................................................................................................... 87
Ethnography as Methodology ......................................................................... 87
Tensions between Ethnography as Methodology for the Thesis and
Postcolonialism ............................................................................................... 88
Postcolonial Ethnography as a Postmodern Construct .................................... 90
Disputing notions of discovering truth ............................................................ 91
Rejecting the notion of researcher objectivity ................................................ 92
Reflexivity ......................................................................................................... 94
Giving voice to the research subject ............................................................... 96
The Fieldwork of this Thesis ......................................................................... 97
Research Preparation: Learning About Indonesia and Learning Bahasa
Indonesian ....................................................................................................... 97
Research Sites ................................................................................................. 99
Gaining Access to the Research Sites ............................................................ 101
Recruitment Procedures ............................................................................... 102
Recruiting Dosen, AKPER Directors, and Kepala Bangksa participants ...... 103
Recruiting Clinical Instructor participants .................................................... 104
Recruiting Ministry Officer participants ....................................................... 105
Recruiting student participants ..................................................................... 106
Participant Characteristics ............................................................................ 107
Bi-lingual Secretary participants ................................................................. 109
Data Collection .............................................................................................. 112
Participant Observation .................................................................................. 114
Focus groups .................................................................................................. 116
Conducting the focus groups ....................................................................... 118
The focus group guide and moderating the discussion ................................. 119
Composition of the groups ................................................................. 120
Size and number of focus groups .................................................. 121
Individual (Key Informant) Interviews ......................................... 121
Unsolicited interviews ................................................................. 122
Solicited interviews ..................................................................... 123
The Rashomon interviewing technique ........................................ 124
Using the Rashomon technique in this thesis .............................. 124
Secondary Data Sources ............................................................... 126
Documenting and Recording Data ............................................... 126
Field Notes ................................................................................. 126
Reflexive Journaling ................................................................. 127
Audiotaped Records .................................................................. 129
Ethics Approval .......................................................................... 130
Ethical Compliance .................................................................... 133
Data Analysis ............................................................................ 133
Cyclic Data Collection and Data Analysis .................................... 134
Documenting analysis during data collection .............................. 134
Data analysis following completion of data collection ................ 135
Reporting the data ..................................................................... 135
Credibility .................................................................................. 137
Conclusion .................................................................................. 140

Chapter 5: Representations of ‘otherness’ ................................... 141
Introduction ................................................................................. 141
Images of Eastern Inferiority and Western Scientific Superiority ...... 141
Inferior Equipment as a Defining Feature of Poor Practice ............ 143
Superior Intellectual Processes Define Western Practice ................ 145
Technology Defines Difference ................................................... 149
Images of Eastern Irrationality versus Western Logic .................... 149
Logic is Missing from Decision Making ...................................... 151
Absence of Shared Rationality ...................................................... 155
Searching for Rationality .............................................................. 155
Undeveloped and Requiring Development ................................... 158
Pre-Conceptions of the Need for Development ............................ 160
Developing the practical field .................................................................162
Developing improved medication management.................................164
Deconstructing the development activity ...........................................164
Sustaining Development .....................................................................166
Colonial Occupation of Foreign Territories ........................................170
Unequal Distribution of Responsibility ..............................................171
Reversion to Mystic Wisdom of the East ...........................................171
Laziness as an Obstacle to Developing Improved Infection Control Teaching in the Laboratory .................................................................174
Reversion to Uncivilized Immoral Behavior .....................................177
Developing Improved Oxygen Administration Practices .....................182
Uncivilized Attitudes Towards Life and Death ....................................183
Orientalist Discourse Denies the Space for an Alternative Image of Indonesian Nursing .................................................................185
An ‘other’ Image of Indonesian Nursing ..........................................187

Chapter 6: Deconstructing ‘other’ voices ..............................................189
Introduction ..........................................................................................189
Appropriation of Dominant Discourses ..........................................189
The Master/Slave Narrative ..............................................................195
Resistance to the Master/Slave Narrative ......................................198
Reversing the Master/Slave Narrative ...........................................201
Heterogeneity within the Subaltern Group ......................................203
Conclusion ..........................................................................................205

Chapter 7: Looking in the Mirror .........................................................207
Introduction ..........................................................................................207
Ambivalence .......................................................................................207
Mimicry ...............................................................................................208
Reproducing a copy of the colonizer to guard against interference ......208
Indonesian nurses’ resist subordination by adopting the behavior of the colonizer on their own terms .......................................................211
An image that is at the same time consensual and conflicting ..........212
A resemblance that is almost the same, but not quite .......................214
Mockery .................................................................................................................. 218
Mockery decenters western authority ................................................................. 221

Hybridity .................................................................................................................. 223
A Hybrid Model of Western Expertise that is Acceptable to the Colonized...... 227
A Hybrid Model of Western Expertise that is Acceptable to the Colonizer...... 229

Hybrid Models for Indonesian Nursing ............................................................... 230
A Hybrid Model for Evidence Based Practice .................................................. 231
A Hybrid Model of Encouraging Critical Thinking Skills ............................... 235
A Hybrid Model for Closing the Gap between Theory and Practice .............. 243

Conclusion ............................................................................................................. 247

Chapter 8: A View from a New Place ................................................................. 249

Introduction ......................................................................................................... 249
Desirability of Compliance with International Standards for Nursing in Indonesian
Entry-To-Practice Nursing Education ................................................................. 250

Indonesian Nurses Desire for Compliance with International Standards Reflects
the Hegemonic Influence of Western Nursing ................................................... 251
The Influence of Colonial Discourses on the Desire to Comply with International
Standards Underpinning Entry-To-Practice Nursing Education ...................... 253

The colonial discourse of assimilation and membership of nursing as a global
profession ............................................................................................................. 254
The neocolonial discourse of development and the potentially colonizing
endeavor of western intervention into non-western nursing education ...... 256

International Standards Define the Margins and Center of Nursing ............ 258
Discourses of Western Exclusivity within Nursing Defines the Desirability of
Western Expertise .................................................................................................. 259
Contextualizing Indonesian Resistance to Western Expertise and Compliance with
International Standards for Nursing ................................................................. 261

New Understandings of the Impact of Physical Occupation on the
Internationalization of Non-western Nursing .................................................. 264
Static Definitions of Culture Deny Complexities of Historical and Contextual
Spaces Where Nursing Takes Place ................................................................... 265
Ambivalence Opens Up a Potential Space for Improving Indonesian Entry-to-
Practice Nursing Education ............................................................................... 268
A New Perspective on Improving Entry-to-Practice Nursing Education in the Context of Globalization.................................................................273

Opportunities for Hybridity to Improve Entry-to-Practice Nursing Education in Non-western Settings.................................................................273

Opportunities for Hybridity to Improve Entry-To-Practice Nursing Education in western Settings.................................................................276

Re-Conceptualizing the Contribution that Western Nursing Experts Can Make to Non-western Nursing ........................................................................277

Strengths of the Thesis ........................................................................280

Limitations of the Thesis .....................................................................283

Conclusion .........................................................................................285

References .........................................................................................287

Appendices .........................................................................................

Appendix 1: Central Java Sister School Program (CJSSP) Terms of Reference...315

Appendix 2: The Concordance between CJSSP Terms of Reference and International Standards for Nursing ...............................................................323

Appendix 3: Permission for Access to Research Sites and Research Participants 333

Appendix 4: Plain Language Statement – Short Version .........................334

Appendix 5: Plain Language Statement – Long Version ..........................336

Appendix 6: Consent Form – Short Version ............................................339

Appendix 7: Consent Form – Long Version ............................................340

Appendix 8: Verification of Translation Form .........................................342

Appendix 9: Advertisement for Student Focus Group ..............................343

Appendix 10: Questionnaire for Dosen Participants ................................344

Appendix 11: Questionnaire – Clinical Participants ................................346

Appendix 12: Questionnaire – Ministry Officer Participants ..................348

Appendix 13: Questionnaire – Student Participants ...............................350

Appendix 14: Questionnaire Pilot Feedback Form ..................................352

Appendix 15: Schedule of Participant Observations ...............................354

Appendix 16: Schedule of Focus Groups ..............................................358

Appendix 17: Focus Group Guide – Dosen Participants ..........................360

Appendix 18: Focus Group Guide – Dosen Participants ..........................362
Appendix 19: Focus Group Guide – Clinician Participants ........................................365
Appendix 20: Focus Group Guide – Student Participants ........................................367
Appendix 21: Focus Group Guide – Pilot Feedback Sheet ......................................369
Appendix 22: Schedule of Individual (Key Informant) Interviews ..........................371
Appendix 23: Central Java Sister School Program Reports ........................................375
Appendix 24: Ethical Approval ..................................................................................378
Appendix 25: Explanatory Statement Accompanying Ethics Submission ..............379
Appendix 26: Variation to Ethical Approval .................................................................380
Appendix 27: A Postcolonial Compass for Interrogating the Data ..........................381
Appendix 28: Data Codes .........................................................................................384
Appendix 29: Research Outputs ..............................................................................388
Chapter 1

Montage

Introduction

This thesis explores the tensions between promoting global consistency and respecting local uniqueness in nursing education and nursing practice. It does so by using a postcolonial ethnography to examine my experience as an Australian ‘western expert’ involved in an International Bank for Reconstruction and Development (World Bank) funded project in the non-western setting of Central Java, Indonesia. This introductory chapter is entitled ‘Montage’. ‘Montage’ is a word that appears in postcolonial critiques and refers to “the technique of making a picture or film by putting together pieces from other pictures or films” (Soanes, Waite & Hawker, 2001, p. 836). Accordingly, in this introductory chapter I provide an overview of the thesis as a journey through both a theoretical space and physical place.

While the term ‘montage’ does not necessarily suggest an ordered piece of work, I have attempted to put the pieces together in such a way that leads the reader through various ‘pictures’ to introduce the research questions in a logical fashion. In doing so, I particularly highlight the tensions between myself and the Indonesian participants that led to this thesis exploring the specific paradox of Indonesian nursing’s simultaneous desire for and rejection of western expertise and compliance with international standards for nursing. The choice of postcolonial theory as a framework for this thesis is also described. The chapter concludes with an introduction to the overall structure of the thesis.

A Collaborative Space

In early 2002, the International Bank for Reconstruction and Development (IBRD) issued internationally competitive tenders for three Sister School Programs to be implemented in the Indonesian provinces of Jawa Tengah (Central Java), Kalimantan Tengah (Central Kalimantan) and Selatan Sulawesi (South Sulawesi). These tenders sought applications from international educational institutions to engage in
contractual relationships with *Dinas Kesehaten (Dinkes)* (Provincial Ministries of Health) in each of the provinces in which the Sister School Programs (SSP) would operate. In mid 2002, the Australian university where I was employed as a Senior Lecturer won the tender for the Central Java Sister School Program (CJSSP).

The SSPs were one component of a broad program of IBRD loan-funded projects that were auspiced under the umbrella of the ‘World Bank Indonesia, Fifth Health Project (HPV): Improving the Efficiency and Quality of Provincial Health Services’ (World Bank, 1998). The HPV focused on human resource development for the Indonesia health sector with the ultimate aim of improving the health of the poor and disadvantaged (IBRD, 2001). This aim was to be achieved through four objectives: “improved efficiencies in the utilization of health professionals; more equitable distribution of these personnel; improved quality of health professional practices; and increased skills of health professionals” (IBRD, 2001, p.1). With the explicit aims of reforming Diploma III (DIII) entry-to-practice nursing and midwifery education, the SSPs were designed to address the last two of these objectives.

**DIII Nursing Education**

DIII nursing education is a nationally mandated six-semester program (Pusat Pendidikan Edukasi dan Kebudaya, Directorate Jenderal Tinggi Edukasi, 1999a) for high school graduates. The DIII curriculum was introduced in 2000 as part of Indonesian government policy to increase both the quantity and quality of nurses entering the Indonesian health care workforce (Departmen Kesehaten R.I (DepKes), 2003; Sugiharto, 2005). At this time Indonesia was ranked amongst the poorest performing countries when benchmarked against international health and welfare indices (Fukuda-Parr, Birdsall, Sachs, Bonacito & Boudard, et al., 2003; WHO, 2004a). While poverty was at the heart of such poor performance (Watkins, Fu, Fuentes, Ghosh, & Giamberardini, et al., 2005), government intervention into nursing education was also seen as making an essential contribution to improving health outcomes (Nursing & Midwifery Working Group, Ministry of Health (NMWG-MOH), 1998).
Although there were a small number of degree-level nursing programs conducted in Indonesia, University education was beyond the reach of the majority of Indonesians (Fukuda-Parr et al., 2003). Therefore, the majority of nurses entering the Indonesian workforce graduated from *Sekolah Perawatan Kesehatan (SPK)* (School Health Nursing) training. The SPK program incorporated nursing training alongside the general education content in the last two years of high school (NMWG-MOH, 1998). However, in 1999 SPK training did not contribute the number of nurses, or the quality of practitioners considered necessary to improve Indonesia’s performance against international benchmarks such as the Millennium Development Goals (Hennessy, 2001). As a result, government legislation was passed to establish both government and private *Akademi Keperawatan* (AKPER) where diploma level entry-to-practice nursing education could be conducted (Wea, 2000). While permitting private providers to establish AKPER promised to increase the number of graduates from entry-to-practice programs, of critical importance was that legislation was also passed to replace SPK training with DIII education as the minimum qualification required for practice as a nurse or midwife in Indonesia (Pusat Pendidikan Educati dan Kebudaya, Directorate Jenderal Tinggi Educati, 1999b). Replacing SPK training with diploma level education was seen as a critically important step to professionalize Indonesian nursing and improve the quality of the nursing workforce (Directorate of Nursing and Technical Medics, Directorate General Medical Care, WHO SEARO & Ministry of Health Indonesia (DONMT-WHO), 2002).

In contrast to SPK training, the DIII curriculum incorporated a greater focus on the scientific underpinnings of nursing and aimed to provide graduates with a more in depth knowledge of the theoretical underpinnings of nursing practice. There was also an increase in the time students were allocated to engage in supervised learning experiences within the clinical setting. Prior to the introduction of the DIII, Indonesian nurses were predominantly described as a ‘sub-professional’ workforce (IBRD, 2001), occupying a low status as ‘doctor’s helpers’ (Shields & Hartarti, 2003). The ‘Nursing Process’ with its four steps of assessment, planning, intervention and evaluation (Doenges, Moorhouse & Murr, 2006) appears as an integrating theme within the curriculum to specifically support Indonesian nursing’s transition from sub-professional to professional status (Pusat Pendidikan Educati dan Kebudaya, Directorate Jenderal Tinggi Educati, 1999a).
The reforms included in the three SSPs aimed at further supporting this transition. Specific goals described in the CJSSP Terms of Reference (IBRD, 2001; Appendix 1) involved introducing a competency based curriculum, improving teaching and learning methodologies used within the Diploma III program, developing the practice field and implementing internationally benchmarked educational management systems. These goals also responded to areas within both the theoretical and practical components of the DIII curriculum that needed urgent attention in order for Indonesian nurses to gain recognition within the context of a globalized nursing profession (DONMT-WHO, 2002; Hennessy, 2003; Sadana, Smith & McMahan, 1998).

**A Space Where Local and Global Agendas Meet**

From within Indonesian nursing there was a desire to elevate the status of nurses to be in line with the professional standing of international nursing colleagues (Shields & Hartarti, 2003). To this end, *Persatuan Parawat Nasional Indonesia (PPNI)* (the National Indonesian Nursing Association) sought membership with the International Council of Nurses (ICN). The ICN represents the regulatory bodies, professional associations and nursing unions of more than 129 countries worldwide (ICN, 2003) and provides guidelines such as the ‘Framework of Competencies for the Generalist Nurse’ (ICN, 2003), for those countries seeking membership. Therefore, ensuring that the newly introduced DIII curriculum facilitated compliance with these ICN competencies was of particular importance to PPNI. As a result, PPNI members wholeheartedly supported the SSP objective to improve the quality of entry-to-practice education.

In Central Java, where membership of PPNI was strong, local members were represented as key stakeholders on the committee that designed the Terms of Reference for the CJSSP (IBRD, 2001). These PPNI members significantly influenced the formulation of the outcome indicators of the CJSSP, ensuring that they closely aligned with the national nursing association’s desire to ‘professionalize’ Indonesian nursing. As a result, the specific strategy of “Competency based curriculum development” (IBRD, 2001, p. 5) provided a framework within the Terms of Reference to measure the outcomes of CJSSP activities against the competencies
that define the contemporary, internationally mobile nurse. Importantly, not only did these competencies attempt to define the nature and practice of nursing but they were also intended for use in underpinning nursing curricula that would prepare nurses for international mobility (ICN, 2003). This focus was also particularly important for Indonesian nursing as the national workforce planning agenda exerted significant pressure on the PPNI to professionalize nursing as a way to create opportunities for greater international mobility for nurses (Wea, 2000).

In the context of increasing foreign debt following Krismon (the Asian Financial Crisis), Pusgunakes (the Indonesian Department of Manpower and Transmigration) set a target of facilitating the placement of 2,350,000 workers abroad (Lanjouw, Pradhan, Saadah, Sayed, & Sparrow, 2001). This figure is considerably higher than the 662,460 new domestic employment opportunities it hoped to create (International Labor Organization (ILO), 2005). To this end, actively facilitating the export of skilled health workers was included in Pusgunakes’ strategic plan for 2001 – 2004 (Wea, 2000).

Exporting nurses had been particularly successful in reducing domestic unemployment in various parts of Asia and generating foreign income in the form of remittances to Indonesia’s neighboring countries (Alburo & Abella, 2002; Brown & Connell, 2006; Buchan & Calman, 2004). For example, the government of the Philippines has had a policy that actively encourages migration by training nurses specifically for the international market since the mid 1970s (Hawthorne, 2001; Ortin, 1990; Perrin, Hagopian, Sales & Huang, 2007). It is now the leading source country for nurses employed overseas (Aiken, Buchan, Sochalski, Nichols & Powell, 2004; Buchan, Kingma & Lorenzo, 2005; Lorenzo, Galvez-Tan, Icamina & Javier, 2007). In 2003, 85 percent of employed Philippino nurses were working internationally (Perrin et al., 2007) and contributing $US 7.6 billion back to the Philippino economy (Pacquiao, 2004).

When the Terms of Reference for the CJSSP (IBRD, 2001) were formulated Pusgunakes believed that the recent government interventions into improving entry-to-practice nursing placed Indonesia in a position to emulate the success of the Philippines (Wea, 2000). By 2002, the introduction of private education providers had
produced an on-paper nursing surplus of 16,670 graduates per year (Departmen Kesehaten (DepKes) RI, 2002). With health spending at only 3% of the total development budget (or 1.8% of Gross Domestic Product (GDP) (Lanjouw et al., 2001), the resulting zero growth in government employment meant that working prospects for graduates were thought to be as low as 10% in some regions (DepKes RI, 2002). Accordingly, Pusgunakes required the Indonesian Department Kesehaten (DepKes) (National Ministry of Health) to incorporate initiatives for exporting surplus nurses in the strategic planning for health for the years 2000 to 2010 (Wea, 2000).

However, for exporting nurses to be a viable option, having a surplus is not the only determinant for success. Three other important conditions need to be met. Firstly, there needs to be a market; secondly, there needs to be a willing workforce to export; and thirdly, the quality of the willing workforce needs to meet the demands of the destination country (Aitken, 2006). There is ample evidence that a market is available for non-western nursing graduates in the United Kingdom, the United States, and Canada (Pittman, Aiken & Buchan, 2007). Moreover, in the current global political climate, Indonesia with its predominantly Muslim nursing graduates may be particularly attractive to the Arab states as a source country (Aboul-Enein, 2002; Trossman, 2007). Similarly, the generic ‘push factors’ for migration including poor employment prospects, low standards of living and high risks of occupationally acquired infectious diseases (Bloice & Hallinan, 2007; ICN, 2006; Perrin et al., 2007; Thupayagale-Tshweneagae, 2007), all exist in Indonesia (WHO 2004b). However, the driving forces leading to the surplus of nurses and the possibility of government assisted migration (which is a significant “push” factor) do not bode well for Indonesian graduates being of the required quality for export (Hawthorne, 2001).

While the goal of improving the number of nurses has been overwhelmingly achieved, this has been to the detriment of improving the quality of graduates and the health system within which they practice (Hennessy, 2001).

The most significant deficit in terms of preparation for practice was reported to be the failure of the existing education system to achieve a minimum standard of clinical competence (DONMT-WHO, 2002; Hennessy, 2003; Rahim-Hillan, 2002). This deficit is readily apparent when compared to international benchmarks such as the ‘ICN Framework of Competencies for the Generalist Nurse’ (ICN, 2003) (Aitken,
compliance with which PPNI had already identified as critical for improving the professional standing of Indonesian nursing. Accordingly, the desire to ‘professionalize’ Indonesian nursing and gain international recognition for Indonesian nurses on the part of both the nurses themselves and a number of government departments influenced the formulation of the CJSSP Terms of Reference (IBRD, 2001). The CJSSP initiatives to reform the DIII curriculum were therefore underpinned by a coalescence of local and global driving forces. Together, these forces mandated Indonesian nurses’ compliance with international standards for nursing practice and education.

**International Standards for Nursing Practice**

International standards for nursing are a set of competencies that define the minimum standard of practice for the contemporary nurse. Competency refers to the ability to perform a task in a way that complies with identified performance outcomes (Gonczi, 1994; Gurvis & Grey, 1995). Performance outcomes relating to the task of being an internationally mobile nurse are defined by the International Council of Nurses (ICN) as including a range of cognitive, technical, psychomotor and interpersonal skills underpinned by knowledge, understanding and judgment (ICN, 2003). Competency in performing the task of being a contemporary internationally mobile nurse is also to be measured against performance outcomes relating to specified personal attributes and attitudes (see for example, Australian Nursing Council Inc. (ANCI), 2002; Benner, Tanner & Chesla, 1996; Del Bueno, Weeks & Brown- Stewart, 1987; Girot, 1993; Watkins, 2000). Standards of competency applicable to the point of entry-to-practice into nursing (i.e. following completion of the DIII program) are embodied in the ‘ICN Framework of Competencies for the Generalist Nurse’ (ICN, 2003).

The status of these ICN competencies as ‘international’ is attributed to three important factors. Firstly, they are promulgated by the ICN as internationally applicable (ICN, 2003) and as essential for supporting global consistency of nursing practice (Thompson, 2002). Secondly, they are endorsed as internationally relevant in the peer reviewed international nursing literature (Bieski, 2007). Finally, these competencies are incorporated in legislation that regulates entrance into nursing as a profession in countries that are members of the ICN and countries that seek membership of the ICN.
(for example, ANCI, 2002; Canadian Nurses Association (CNA), 2005). Such legislation not only mandates that local nurses practice in a specific way, but by regulating entrance to practice, this legislation also determines international mobility. That is, nurses are only deemed fit for practice in countries that adopt these competencies, when they can demonstrate compliance with the same (Hancock, 2004; Hawthorne, 2001).

The Competency Requirements of the Contemporary Internationally Mobile Nurse

The dominant nursing literature suggests that contemporary, internationally mobile nurses graduate from educational programs that equip them with a set of competencies that support global consistency of nursing practice. According to this literature, the contemporary, internationally mobile nurse should graduate from initial (entry-to-practice) nursing education in possession of a sound, scientific knowledge base and technical competence to provide ‘hands on’ preventative and curative care (Ketefian & Redman, 1997). The contemporary, internationally mobile nurse should be able to provide such care for individuals in a wide range of health care settings and use a wide range of technology (Watkins, 2000). The literature described such a contemporary, internationally mobile nurse as an autonomous professional (Benefield, Clifford, Cox, Hagenow, Hastings et al., 2000; Mawn & Reece, 2000).

The autonomous professional nurse is further defined in the literature by locating nursing as a rational scientific discipline that is informed by politically neutral, impartial knowledge development using objective reasoning and research techniques (Gustafson, 2005; Leighton, 2005; Puzan, 2003). Accordingly, the literature places an emphasis on evidence-based nursing care and denounces clinical practice based on tradition, ritual and intuition (see for example: Duffy, Foster, Kuiper, Long & Robison, 1995; Gerish & Clayton, 1998; Parse, 1992 & 1999).

Moreover, critical thinking and problem solving skills are essential for the type of rational clinical decision making that autonomous scientifically prepared professional nurses should engage in to support their technical proficiency (Alderman, 2001). According to the literature, the contemporary internationally mobile nurse relies upon critical thinking and problem solving skills to implement the nursing process (Clark &
Lang, 1992), which provides a ‘professional’, rational, evidence-based, systematic approach to clinical practice (Doenges et al., 2006).

By comparing the CJSSP Terms of Reference (IBRD, 2001) with this literature (Appendix 2), it became clear that it was with these attributes in mind that the Indonesians embarked upon the task of improving DIII nursing and midwifery education.

**International Standards for Nursing Education**

The goal of nursing education that prepares nurses’ for entry-to-practice is to produce graduates who comply with international standards for nursing practice. Therefore, international standards for nursing that define the minimum standard of practice for the contemporary, internationally mobile nurse also define minimum standards for entry-to-practice nursing education. A key pre-requisite to producing graduates who possess the attributes of the contemporary, internationally mobile nurse is an educational system that demonstrates concordance between the scientific basis for nursing and the clinical practice of nursing (see for example, Gillespie & McFettridge, 2006; LeStorti, Cullen, Hanzlik, Michiels, Piano et al., 1999).

The literature describes standards for nursing education programs designed to promote concordance between the theoretical and practical components of nursing education (Nursing & Midwifery Council of the United Kingdom, 2000; Nursing Council of New Zealand, 2005). These standards relate to four areas: clinical credibility of teaching staff, collaborative relationships between nursing education and clinical services, practical learning experiences for students, and effective clinical teaching (Gillespie & McFettridge, 2006). Prior to this thesis, the existence of deficits in each of these areas in Indonesian entry-to-practice nursing education had been identified (Aitken & Seibold, 2003; Hennessy, 2001; Rahim-Hillan, 2002). Therefore, it made sense that there was a high concordance between these four standards and the CJSSP Terms of Reference (IBRD, 2001) and that these standards for entry-to-practice nursing education underpinned the activities of the CJSSP designed to improve the DIII program (Appendix 2). It also made sense that the Indonesians chose to do this by establishing the ‘Sister School’ relationship with a “well-qualified,
prestigious overseas teaching institution” (IBRD, 2001, p.1), whose program espoused to comply with these standards and whose graduates were recognized internationally as possessing the qualities of the contemporary, internationally mobile nurse.

The Space for Western Intervention in Non-western Nursing Education

Historically, many non-western nursing education systems have been developed based on western models (Meleis, 1980). In the nineteenth and early twentieth century, the activities of western missionaries and colonial administrators led to the first formal nursing schools being established in many non-western countries, including Indonesia (Griscti, Jacono & Jacono, 2005; Lee, 2005; Shields & Hartarti, 2003; Xu, Davis, Clements, & Xu, 2002). Whilst the post World War II era saw the demise of colonial empires, it also saw a rising American influence. During this time many non-western countries used or adapted western nursing curricula for both initial and postgraduate preparation of nurses (Hisama, 2001; Ketefian & Redman, 1997; Xu, Xu, Sun, & Zhang, 2001).

In the present day, nursing leaders from non-western countries travel to western countries to be educated by western nursing scholars. In turn, western nursing scholars are employed to teach in non-western nursing schools, lead non-western nursing schools, and reform their curricula (Davis, 1999; Lash, Lusk & Nelson, 2000; McAuliffe & Cohen, 2005). Like the CJSSP, these western interventions into non-western nursing have predominantly been based upon the counterpart model (DeSantis, 1987, 1995). In this model, the engagement commences with local participants in a dependant relationship with western experts. In optimal situations this relationship changes over the duration of the engagement. Ideally, the knowledge and skills imparted by western experts should result in local participants taking over responsibility for achieving their own goals. Such engagements, as in the case of the CJSSP, have often occurred with the assistance of international organizations (Jayasekara & Schultz, 2006). Collaborative projects funded by western governments and western educational institutions are relatively common (Conway, Little, & McMillan, 2002).
However, whilst western systems of nursing education appear to successfully produce western graduates who meet the competency requirements of the contemporary, internationally mobile nurse (Aitken, Faulkner, Bucknall & Parker, 2001; Ben-Zur, Yagil & Spitzer, 1999), the same cannot be said when these systems are applied in non-western countries. Instead, despite the powerful influence of western nursing scholarship over development of education and practice in non-western nursing settings, many authors have concluded that nursing education in non-western countries continues to have reduced capacity to produce graduates who achieve these competencies (Bieski, 2007; ICN, 2005; United Nations, 2006). Given these findings, my involvement as a western nursing education expert in a program designed to reform non-western nursing in Central Java Indonesia represented a unique opportunity. It enabled me to research non-western nurses’ ability to comply with international competencies and provided a case study of the applicability and acceptability of western expertise in leading such an initiative.

The Space for Research

As the in-country team leader, I was assigned the task of implementing the activities of the CJSSP. Initially this involved short trips from Australia to Indonesia to facilitate workshops, consolidation activities and ‘on-the-job’ training with select CJSSP participants. During these trips I also attended the Joint Coordination Committee meetings that included the key Australian and Indonesian personnel responsible for overseeing the implementation of the CJSSP. Six months into the CJSSP the Indonesian members of this committee determined that a sustained in-country presence by the Australian technical consultants was necessary in order to fulfil the terms of the CJSSP contract. As a result, I was required to re-locate to Central Java for the remainder of the 15-month contract. I therefore became embedded in the natural setting of a project designed to improve non-western nurses’ compliance with international standards for nursing. This embedding promised to provide a unique opportunity for me to participate: “overtly or covertly, in people’s daily lives for an extended period of time, watching what happens, listening to what is said, asking questions, in fact collecting whatever data are available to throw light on the issues with which he or she is concerned” (Hammersley & Atkinson, 1983, p. 2).
Research to date had not examined the transferability of expertise or the applicability or acceptability of international standards for nursing in non-western settings from within everyday experiences during activities designed to internationalize non-western nursing. Instead, the literature described competency outcomes that were either reported or observed after an intervention had taken place. For example, Xu et al. (2001) reviewed published studies to assess the pedagogical and institutional effects of American interventions into Chinese nursing education since 1949. Stockhausen and Kawashima (2003) used focus groups to reveal the way in which Japanese students responded to the introduction of an Australian Bachelor of Nursing degree conducted in Japan for Japanese nurses upgrading their local qualifications to an internationally recognized qualification.

While there was some research about the efficacy of preparing Indonesian nurses for beginning nursing practice in Indonesia (for example, Rahim-Hillan, 2002), there was no published research that related to Indonesian nurses’ compliance with international standards for practice. Therefore, I sought to undertake an ethnography using the techniques of participant observation, documentary analysis, key informant interviews and focus groups. Participants in the research would be Ministry Officers (DinKes and DepKes), Dosen (nurse teachers), clinicians and students. All participants would be involved in the implementation of the CJSSP and DIII program in one or more of the six Ministry of Health owned and administered AKPER and associated clinical institutions in Central Java, Indonesia.

The significance of the thesis is threefold. It aims to provide empirical data about the efficacy of existing educational preparation of nurses in the specific context of Central Java Indonesia. It assesses the outcomes of activities designed to reform educational practices and their contribution to improved professional preparation of nurses in Central Java, Indonesia. Finally, in an age where nursing has become a global profession and there is the desire to participate in a global workforce, I propose that this research benefits Indonesian nursing, and the profession as a whole. That is, this thesis makes a significant contribution, not only in understanding Indonesian nursing, but in understanding the complexities of applying international standards for nursing across diverse contexts.
The Place Where the Research Question Evolved

A visit to the research site prior to the commencement of this thesis was the catalyst for developing the research questions that would subsequently guide my research. During this visit, which informed contractual negotiations relating to the CJSSP, I recognized that I held implicit assumptions about the CJSSP that I had overlooked prior to my first exposure to the local context. Exploring issues relating to these assumptions focused my research.

As I was aware of the limited success of western interventions into non-western nursing, my first assumption was that the focus of this thesis would be on exploring the areas of incompatibility between Indonesian nursing and international standards and then assessing the efficacy of different strategies used in the CJSSP to overcome this difference. I had assumed that these incompatibilities would be identified by the Australian technical consultants, who would also determine the nature of the activities designed to internationalize the DIII program. However, during the contractual negotiations it became very clear to me that this assumption was flawed and that such research would not be possible. The Indonesian nurses and Ministry Officers participating in the CJSSP strongly indicated that while internationalization of DIII nursing was highly desirable, it was their role to consider what was compatible and incompatible with the activities of the CJSSP. They would decide how compliance with international standards was to be achieved. In addition, they would decide which initiatives would be implemented and would apply, resist or reject specific interventions based on how compatible these were with locally situated standards for education and practice. Therefore, a research question that explored the decisions made by Indonesian nurses about the desirability and applicability of international standards was much more appropriate to understanding the complexity of applying international standards to the DIII program than exploring this phenomenon from the perspective of the Australian consultants.

The fact that the Indonesian nurses and Ministry Officers participating in these negotiations had deliberately chosen the submission from a western University as the successful tender, led me to assume that western expertise was highly valued. This assumption was also consistent with my knowledge of the high levels of participation
of western nursing scholars in reforming the curricula of non-western nursing programs. I also assumed that the ‘sister’ like relationship espoused in the CJSSP Terms of Reference (IBRD, 2001) represented a collaborative partnership between the Indonesian and Australian participants in the CJSSP. However, my participation in the contractual negotiations revealed that the partnership would not be equal. The decision making responsibilities as defined during these negotiations established a hierarchy that placed Indonesian participants responsible for directing activities and the Australian consultants as responsible for doing the work. In addition, far from my expertise being unquestioningly accepted, my position as the knowledgeable expert related only to the description of my contractual responsibilities. I was to bring western expertise to the CJSSP, but the relevance of the expertise that I brought to my role was to be decided by the Indonesian participants. Accordingly, a research question that explored the decisions made by Indonesian nurses about the desirability and applicability of my western expertise was appropriate to understanding why western intervention into non-western nursing programs is of limited success.

A final assumption that I held about the activities of the CJSSP, but had been overlooked prior to my first visit to the research site related to the relationship between the local context within which the DIII took place and the graduates it produced. I had assumed that by internationalizing an entry-to-practice program using international standards for nursing, the reformed program could produce graduates who comply with a single set of competencies regardless of the setting in which nursing takes place. However, my first visit to the research site revealed how vastly different the local context of Indonesian nursing practice was compared to the western practice settings from which the competencies originated. This discrepancy had not been explored in previous research. I therefore considered that it was important to understand how the social, historical and political context in which nursing takes place influenced the competencies that students could acquire prior to graduation from the DIII.

These concerns underpinned my choice of postcolonial ethnography as a research method and mandated the consideration of local uniqueness as a guiding principle for formulating the research questions of this thesis. My initial conceptualization of the research endeavor therefore, was refined to propose research questions that reflected
both the realizations described above and my desire to understand the complex interplay between local uniqueness and global consistency. The primary research question that guides this thesis is:

Why is western expertise and compliance with international standards for nursing considered by Indonesian nurses to be highly desirable on the one hand, but on the other hand resisted, rejected and of questionable applicability?

Two sub-questions that are considered during the research journey include:
- How does the local context within which nursing education and practice are situated influence the acceptance and applicability of international standards for nursing in the specific setting of Central Java, Indonesia?
- How transferable is western expertise based on notions of global consistency and international standards for nursing to the unique setting of Ministry of Health Nursing academies in Central Java, Indonesia?

The next section of this chapter defines some of words included in the research questions and explains how I have used and understood specific terminology within this thesis.

**Defining Terminology**

The following terminology is used throughout this thesis. It has been defined from the literature and represents my interpretations of a number of possible meanings.

**Globalization**

Robertson refers to globalization as “the compression of the world and intensification of consciousness of the world as a whole” (1992, p.8). In this thesis I recognize that such compression of the world has occurred secondary to technological and economic processes that transcend national borders and so effect changes to the nature of human interactions across the social, cultural, political, and professional spheres of human existence (Held, McGrew, Goldblatt & Perraton, 1999). I also acknowledge that the driving force behind globalization is the effective erasure of national boundaries for economic purposes. Of importance to this thesis, globalization particularly refers to
“global economic integration of many formerly national economies into one global economy, mainly by free trade and free capital mobility, but also by easy or uncontrolled migration” (Daly, 1999, p.1)

**Internationalization**

Despite having different meanings, the terms internationalization and globalization are often used interchangeably (Daly, 1999). In this thesis I have distinguished internationalization from globalization by defining internationalization as the response to the flow of technology, economy, knowledge, people, values and ideas that arises from globalization (Parker & McMillan, 2007). In nursing internationalization is generally taken to mean the reorganization of the way that nursing is regulated and practiced, and the way that educational programs for nurses are developed and delivered (Seloilwe, 2005). There is an agenda for global consistency so that nurses speak a global language (Coenen & Pesuit, 2002), local nursing education programs become more universally applicable (Seloilwe, 2005), and prepare nurses with core attributes (ICN, 2003).

**Entry-to-practice Nursing Education**

The term ‘entry-to-practice’ nursing education is used in this thesis to refer to education that leads to the initial qualification required for a nurse to meet legislative requirements to enter into practice. This term has been chosen rather than the terms ‘undergraduate’ or ‘pre-registration’ because globally there is great variation in both the level of academic qualifications and the licensing requirements for entry into nursing practice. For example, Indonesia does not have a system of nurse registration. Instead, DinKes issues a license for nurses who graduate from SPK (prior to 2000), DIII, and degree courses to practice in health institutions within designated areas of Indonesia. Therefore, using the term ‘entry-to-practice’ nursing education is inclusive of all possible levels of qualification and legislative requirements that lead to eligibility to practice as a nurse.
**International Standards for Nursing**

The term 'international standards for nursing' that is included in the primary research question and appears throughout the body of this thesis refers to international standards for both nursing practice and nursing education. As has been described in this chapter, standards for nursing practice and nursing education are inextricably linked through the concept of producing graduates who comply with the competency requirements of the contemporary, internationally mobile nurse.

The following terms are used in the research questions and throughout the body of this thesis. They have been defined according to the Oxford Dictionary and Thesaurus (Soanes et al., 2001).

**Desire and desirable**

To desire is to want, or wish for something to happen. Something is desirable when it is wished for as being attractive, useful or necessary.

**Compliance/ comply with**

To comply is to act in accordance with or meet specified rules or standards.

**Reject**

To reject is to dismiss as inadequate or faulty, or to refuse to consider or agree to.

**Applicable/applicability**

Applicable is the word that describes something that is relevant or appropriate.

**Expert/Expertise**

An expert is a person who is considered to be very knowledgeable about or skilful in a particular area. Expertise refers to having or involving such knowledge or skill.

**A Conceptual Space**

A review of the literature normally identifies gaps in existing research and assists with refining the research question. In this thesis, reviewing the literature confirmed that little research has been undertaken with a focus on questioning the legitimacy of
universally accepting a particular image of the nurse and compliance with the competencies that define this contemporary, internationally mobile professional. Instead, the literature focused on enunciating non-western nursing’s difference from western nursing and non-western nurses’ reduced capacity to educate nurses to comply with the competencies attributed to the contemporary, internationally mobile nurse. Such a reduced capacity was almost exclusively attributed to a dissonance between the culture within which nursing in non-western settings takes place and the western culture from which the competency requirements for the contemporary, internationally mobile nurse were derived (Jayasekara & Schultz, 2006; Upvall, Rehmatullah, Hashwani, Khan, Husain et al., 1999). Accordingly, the literature confirmed that questioning the tension between the simultaneous desire for and rejection of the western derived image of nursing and international standards for nursing education and practice on the part of non-western nurses would make an important contribution to the existing body of knowledge.

The literature also highlighted that existing research was founded on defining western and non-western nursing from a particular ideological position. Positioning western nursing as the benchmark against which all nursing is measured placed western nursing at the Center of the discipline and marginalized non-western nursing (Meleis & Im, 1999). Classifying incompatibilities between western and non-western nursing according to a set of static attributes that define people according to their ‘different’ ways of thinking and ways of behaving (Culley, 1996; Meleis, Isenberg, Koerner, Lacey & Stern, 1995; Swendson & Windsor, 1996) is consistent with definitions of culture derived from the discourses of liberalism and humanism that underpinned colonization (Duffy, 2001; Gustafson, 2005). For me this positioning meant that the dominant literature left no place for alternative understandings of nursing in non-western settings. It left no space for reconciling the local and global agenda of the CJSSP: the former would always take second place to the latter. It also did not take into account the historical, political, social and economic influences on behavior. Nor did it address my subsidiary questions about the influence of local context upon Indonesian nursing and the applicability and acceptability of western expertise across diverse settings.
Conceptually underpinned by postmodern theory, postcolonial theory creates a space for examining and developing an alternative understanding of these circumstances. Postcolonial theory appeared appropriate as a conceptual framework for this thesis for two main reasons. Firstly, Indonesia is a once-colonized nation, gaining independence from the Dutch in 1949 after 300 years of European colonization (Ministry of Foreign Affairs: Indonesia, 2001; Ricklefs, 1993). Colonization from within the region by Vietnamese, Chinese, Indian and Arab traders and Muslim holy men had also occurred since the first century (Cribb, 2000; Grant, 1964). Secondly, low levels of participation in the global workforce and perceived deficits when measured against international standards potentially positioned Indonesian nurses on the margins of the profession. Therefore, the explicit focus on reforming Indonesian institutions through a partnership with an institution from nursing’s western Center, and a sustained in-country western presence the CJSSP potentially represented a form of neo-colonial occupation (McLeod, 2000). As Quayson (2000) explains, postcolonialism involves:

A studied engagement with the experience of colonialism and its past and present effects, both at the local level of ex-colonial societies as well as at the level of more general global developments thought to be the after-effects of empire (Quayson, 2000, p. 2).

In this thesis postcolonial theory provided a way to take into account present day colonization that constructs dominant and marginalized positions within nursing. Postcolonial theory provided me with a way to pay particular attention to unpicking the dynamic perspectives of Indonesian nurses and my own changing interpretations of the desirability and transferability of western expertise and international standards for nursing.

The work of three postcolonial scholars informed this thesis as a postcolonial endeavor. Edward Said (1972, 1975, 1978, 1988, 1993), provided a theoretical basis for examining perceptions of difference as ‘otherness’ and deconstructing the construction of Indonesian nursing as inferior, irrational and even unethical. Guyatra Spivak’s work (1988a, 1988b, 1990, 1992, 1993) on deconstructing narratives according to their dominant (central) and subjugated (marginal) components also provided a way to re-conceptualize the ‘other’. Spivak proposed that whilst
marginalized people are positioned as subjects of inferior (subaltern) rank they can respond to globalization with either passive or powerful resistance. Exploring the positioning of Indonesian nurses as both passive and powerful subalterns provided a way for me to understand the paradoxes of Indonesian nursing embracing the discourses that underpin the image of the contemporary, internationally mobile nurse, yet rejecting the adoption of these attributes within the local context. The work of Homi Bhabha (1983, 1990, 1994, 1997) provided further guidance for unpicking such ambivalence. In particular, Bhabha’s work provided a theoretical basis for both identifying and analyzing the situation where Indonesian nurses requested western solutions for Indonesian nursing, but at the same time asserted a powerful resistance to the western knowledge that I brought to the CJSSP.

**Placing the Montage in Context**

Adopting a postcolonial approach means a number of things for the presentation and structure of this thesis. Although I re-located to Indonesia, my geographical, historical, political, economic and social background remained Australian. Therefore, I have to acknowledge that the data presented and the analysis of that data constitutes a representation of the situation as interpreted through my own particular position. Similarly, I write in the first person when acknowledging my voice within the text. In line with postcolonial conventions, I also refer to Indonesian terms first within the text, bracketing the English translations. The following translations and abbreviations are those that I used to understand the meaning of Indonesian words that are used frequently within this thesis.

*Dosen*  
Singular and plural for Nurse Teacher(s)

*Departmen Kesehaten (DepKes)*  
National Ministry of Health

*Dinas Kesehaten (DinKes)*  
Provincial Ministry of Health

*Academi Keperawatan (AKPER)*  
Nursing Academy

*Ibu*  
Form of address for adult female

*Kepala Bangksa*  
Singular and plural for Head Nurse(s)
Using this approach however, has created the appearance of a textual anomaly in the thesis. The Sister School Program (SSP) operated in three provinces. I have used the term Central Java Sister School Program (CJSSP) extensively throughout this thesis to denote the activities that occurred in Central Java. However, during the on-the-ground activities of the CJSSP and the data collection activities of this thesis, the CJSSP was predominantly referred to by both the research participants and me as the SSP. Therefore, within the data excerpts, the term SSP in fact refers to the CJSSP.

Importantly, to acknowledge the contextually embedded nature of language (Temple, 1997) I have also observed some Central Javanese grammatical conventions. For example, the terms Dosen, Clinical Instructor and Ministry Officer are always capitalized in written materials to afford respect to persons occupying these positions. I have observed this convention in the thesis. In contrast, I have also adopted the postcolonial convention of de-capitalization of the words western, eastern, postcolonial, postmodern, poststructural and ‘other’.

The chapters, while following a traditional progression of an introduction, methodology, findings, and discussion have been named to reflect a ‘spatial’ theme that compares and contrasts the situated nature of knowledge from the center and the
margins. Chapter 2 presents a review of the literature review. However, the title ‘A view from the Center’ identifies the knowledge presented in this chapter as the ‘authority’ of western nursing. My critique of the exclusive hegemonies underpinning this literature leads into Chapter 3 where I propose postcolonial theory as an alternative way of generating knowledge, and explain how it is specifically appropriate as a conceptual framework for this thesis.

Chapter 4 (Mapping the territory) describes the plan for, conduct of, and participants in this research. It also describes the key elements of ethnography, comparing and contrasting positivist and postmodern influences on this method to defend it as compatible with this thesis as a postcolonial project. Chapters 5 (‘Representations of otherness’), 6 (‘Deconstructing ‘other’ voices’) and 7 (‘Looking in the mirror’) present the results of interrogating the data drawing upon the work of Said, Spivak and Bhabha respectively. Each chapter provides a different perspective on the data. It juxtaposes different interpretations of some data sets and highlights how the image of nursing is constructed, how western hegemonies influence these constructions, how cross-cultural encounters are contextually embedded, the existence of multiple versions of reality, and the partiality of truth. Chapter 8 (A view from a new place) compares and contrasts the postcolonial understandings generated by this thesis to dominant understandings about internationalizing nursing education and practice.
Chapter 2

A View from the Centre

Introduction

This chapter reviews the literature relevant to the research questions of this thesis. In Chapter 1 it was noted that there was a concordance between key elements of the CJSSP Terms of Reference (IBRD, 2001) and the specific competencies for the contemporary, internationally mobile nurse that underpinned international standards for nursing practice and education (Appendix 2). The inclusion of specific activities and outcome indicators in the CJSSP Terms of Reference also attested to an understanding of where Indonesian nursing (and specifically the DIII program) failed to meet these competency based standards. However, despite an assumption that the CJSSP Terms of Reference constituted an expression of the desire to address these deficits, as implementation of the work plan commenced the Indonesian participants’ demonstrated resistance to, and rejection of, some of the key activities initiated by the Australian technical consultants. This resistance suggested that there was an incompatibility between the Indonesian partner’s desire to comply with international standards for nursing and the reality of doing so in the local situation.

Therefore, to inform the work of this thesis, it was important to know what research had been conducted on contextual factors that influenced the universal applicability of standards designed to achieve global consistency in nursing practice and education. This body of work is presented and critiqued in terms of the view it presents on achieving global consistency across western and non-western nursing contexts. The role of western scholarship in achieving such consistency is also critiqued. Finally, the gaps in nursing knowledge uncovered through this critique and the potential contribution of the thesis in developing new knowledge are examined.

In order to acknowledge the pervasive influence of dominant ways of thinking on the potential for implementing global standards and competencies to the local context of Indonesian nursing, this chapter is entitled ‘A view from the centre’. The literature
that provides an alternative view to inform the work of this thesis is presented in Chapter 4.

**Perspectives on the Application of Universal Competencies to Internationalize Non-western Nursing**

Three themes emerged in the literature relating to compatibility between non-western nursing and international competencies proposed as outcomes of nursing education programs, which are designed to produce graduates fit for entry into the practice of nursing as a professional, scientific discipline. The first theme related to the perceived likelihood of graduates from non-western nursing programs achieving professional values and attitudes consistent with membership of a professional, scientific discipline. The second theme related to the perceived capacity for non-western nurses and nursing students to acquire critical thinking and problem solving skills and their capacity to engage in student-centered learning. The third theme related to the perceived ability of non-western nursing programs to achieve concordance between the theoretical and practical components of nursing curricula.

**Achieving Professional Values and Attitudes**

Two sub-themes emerged in the literature in relation to graduates from non-western nursing programs achieving professional values and attitudes consistent with membership of a professional, scientific discipline. The first sub-theme related to the concept of individual autonomy and the second related to incorporating scientific evidence into clinical practice.

**The Autonomous Professional Nurse**

In a commentary exploring ethical issues associated with the global influence of American nursing, Davis (1999) proposed that the characteristics of a nurse as an autonomous professional (such as accountability and responsibility for individual professional judgment, actions, and recognizing limits of one’s own competence) were underpinned by the value of individual autonomy. Davis examined the degree to which Japanese nursing conformed to this concept of the professional nurse and
concluded that the value of individual autonomy was not transferable to the Japanese situation. According to Davis, Japanese nurses had resisted the lengthy influence of American nursing scholarship to instead continue to practice according to the concepts of *amae* (social cohesion and mutual dependency) and *dantai* (the individual as a part of the larger whole), which are the predominant cultural values in Japan (Yamashita, 1998).

Davis’ (1999) observations could be criticized as a western perception of Japanese nursing. However, her conclusions are also supported by the work of Hisama (2000, 2001). Hisama is a Japanese nursing scholar who explored the cultural influence on nursing scholarship and education and the acceptance of nursing theory from her own, non-western perspective. In her two opinion papers, Hisama confirmed that the western concept of individualism is rejected by Japanese nurses in preference for traditional collectivist values.

A commentary by Chinese scholars, Kao, Reeder, Hsu and Cheng (2006) reporting on the Chinese view of the western nursing paradigm reported a similar perspective. These scholars concluded that the cultural values of collectivism that dominated Chinese life and therefore Chinese nursing were incompatible with western values of individual autonomy. The legitimacy of the opinions of Davis (1999), Hisama (2001) and Kao et al. (2006) are strengthened by research by Pang, Sawada, Konishi, Olsen, Yu et al. (2003).

Using a survey design, Pang et al. (2003) linked the principles of autonomy to ethical decision making to understand the perceptions of ethical role responsibilities relevant to nursing practice in three different cultural settings. In total they surveyed 1243 nurses, who resided in China (n = 413), Japan (n = 667) and the USA (n=163) using the previously validated Role Responsibilities Questionnaire. Their findings supported the view that in contrast to the American situation, the concept of autonomy is in direct conflict with traditional non-western values in both China and Japan. Pang et al. also concluded that the dominance of collectivism meant that both Japanese and Chinese nurses’ perceptions of their ethical role responsibilities and nursing practice were oriented to the social expectation of their role and the norms that govern membership of the nursing ‘group’.
In a monograph entitled: ‘The development of the Japanese nursing profession: Adopting and adapting western influences’, Takahashi (2004) explained how such orientation influenced Japanese nursing. Takahashi reported that history revealed that when nursing practices or values challenged Japanese group consciousness, they were rejected as incompatible. Pang et al. (2003) contrasted such collectivism with the responses from American nurses whose perceptions of their roles reflected the western values of individualism and promoted self-reliance and self determination as individual nurses. Accordingly, they concluded that conflict between autonomy and collectivism reflected cultural incompatibility and therefore posed a problem for the transferability of the concepts relating to professional nursing practice from western to non-western cultures.

Whilst one of the Indicators of Achievement of the CJSSP was to “improve professional attitudes and values” (IBRD, 2001, p. 4), my knowledge of Indonesian culture suggested that Indonesian nurses also shared similar barriers to achieving autonomy. The reasons that Indonesian nurses had not achieved professional autonomy prior to the CJSSP may have been consistent with the literature relating to Japanese and Chinese nursing. For example, the Pancasila constitutes the underpinning philosophy of the DIII curriculum. Pancasila includes five elements, one of which describes democracy in terms of the traditional decision making process of musyawarah-mufakat (consensus). On the other hand, Indonesia’s colonial history suggests that the Indonesian approach to foreign influences results in cultural syncretization. Therefore, there is less likelihood that a cultural incompatibility between individualism and collectivism would act as a barrier to Indonesian nurses achieving competency according to the ICN definition of professional practice.

Moreover, there is evidence to indicate that when attempts to professionalize non-western nursing are associated with collaborative initiatives such as the CJSSP, there is greater acceptance of western ideologies. For example, Zhaomin Xu and colleagues (2001) claimed that Chinese nursing has significantly moved towards a western model of nursing, to the exclusion of a Chinese model for nursing science. These authors examined the globalization of tertiary nursing education in post-Mao China. They completed a systematic review of published studies. However, the systematic review that they conducted simply described the type of western initiatives that have occurred.
in Chinese nursing education both before and after 1949 and the changes that have been cited as relating to these interventions.

The work that Xu et al. (2001) examined appeared in both English language and Chinese nursing literature. They supplemented their investigation with unpublished documents and discussions with senior Chinese nurse academics. Xu et al. (2001) reported that the literature demonstrated positive outcomes from western interventions into Chinese nursing. They cited the implementation of the nursing process to guide a systematic approach to holistic nursing as one such positive outcome. Another positive outcome was the incorporation of humanities and social sciences content within the nursing curriculum and the use of a human needs model to guide the nursing curriculum. They reported that using the nursing process and the human needs models was an improvement on the use of the traditional biomedical model that structured content according to body systems and life stages. In China, teaching and learning styles had, and are continuing to change to replace traditional rote learning by passive recipients, and instead cultivate greater critical thinking and participative learning. This movement away from traditional teaching and learning was also interpreted by Xu et al. as a positive outcome of western interventions into Chinese nursing education. Xu et al. therefore concluded that globalization has, and continues to be one of the major forces underpinning both Chinese nursing education and Chinese nursing.

However, Xu et al. (2001) also raised the concern that globalization in nursing was a one-way process. They presented three case studies of collaboration between Chinese nurses and American or Canadian nursing academics to support their finding of a one-sided flow of expertise from western to non-western nursing. The case studies included: a Canadian International Development Agency funded linkage project between the University of Ottawa (UO) and Tianjin Medical University (TMU); the Project Hope/Yale University funded nurse instructor preparation program (NIPP) in Shaanxi Province China; and the Community-Based International Learning Programs China Project between the University of Michigan and Beijing Medical University. Of significance to this thesis is that the case studies reported by Xu et al. focused on developing the skills of teaching staff, incorporating student-centered teaching processes in the curriculum and improving students’ clinical experiences. The
initiatives explained in the case studies were similar to the activities of the CJSSP. In addition, the approaches used in these initiatives were similar to the approach used in the CJSSP. They were founded on the counterpart model and incorporated workshops conducted by western experts, staff and student exchanges and short term visits by western nursing scholars. Xu et al.’s findings therefore, were initially encouraging in respect to overcoming cultural barriers to Indonesian nurses achieving the goal of professional autonomy.

The Nurse as a Member of a Scientific Discipline

Another factor described in the literature as limiting nursing autonomy in non-western settings is the dominance of medicine and the perceived subservient position of nursing (Pang, Wong, Wang, Zhang, Chan et al., 2004; Upvall et al., 1999; Xu et al., 2001). This perceived subservience is not an exclusively non-western factor (see for example, Rolfe & Cutcliffe, 2005). However, the literature identifies the culturally defined role of the non-western nurse as a particular barrier to incorporating evidence based practice into nursing curricula in non-western settings. This is seen as a significant failure to comply with one of the defining features of nursing as a scientific profession (Hicks & Hennessy, 1997). For example, Upvall et al. (1999) conducted focus groups with 20 faculty, 4 clinical staff, and 21 students involved in the first Bachelor of Science in Nursing (BScN) program conducted in Pakistan. The BScN was introduced as a post-graduate degree, articulating with the entry-to-practice diploma level course. The authors described that the incorporation of evidence-based principles of practice into the BScN was one of the features of degree level education that distinguished it from the diploma level program. As such, it was anticipated that the introduction of the BScN would contribute to the development of nursing as a profession in Pakistan. The purpose of Upvall et al.’s research was to evaluate whether the BScN was implemented as intended and whether it achieved the anticipated outcomes. In particular, they were interested in whether the introduction of bachelor level education changed the focus of nursing education from producing graduates who followed doctors’ orders to graduates who engaged in autonomous evidence-based nursing practice.
Whilst students reported enhanced knowledge from the theoretical component of the program, Upvall et al. (1999) found that all three groups represented in the study reported that the focus in the practical component was no different to the Diploma program. That is, just like the Diploma students, students in the BScN program were expected to engage in tasks as directed by the physicians and were unable, and not expected to, engage in evidence based decision making. Whilst this was only a small study, and related to one clinical setting only, the qualitative data were consistent across all stakeholder groups.

Although the work of the CJSSP was to strengthen an existing diploma level program rather than introduce a degree level program, the research by Upvall et al. (1999) is useful for informing this thesis. Indonesian nursing and Pakistani nursing not only share a focus on professionalizing nursing through educating students about a scientific basis for practice, but, they also involve a similar ‘cultural milieu’ (Upvall, Kanji, Jaffer, Khowaja, Barolia et al., 2002). According to commentary from Shields and Hartarti (2003), the cultural milieu of nursing practice in Indonesia, like Pakistan, positions nurses as ‘servants’ to physicians. Accordingly, it was likely that similar barriers to those reported by Upvall et al. (1999) could influence the success of CJSSP activities designed to introduce curricula and practice development initiatives that aimed to enhance evidence based practice in Indonesia.

Another research paper by Samantha Pang and her colleagues (Pang et al., 2004) provided further evidence of a link between the culturally embedded perceptions of the role of the nurse and transferability of western notions of the profession as a scientific discipline. Pang et al. used a previously validated mixed methods research approach called Van Kaam’s controlled explication. This approach involved the collection of 254 written accounts of Chinese nurses’ lived experiences, which were analyzed to identify common themes. These themes then formed the basis for two close-ended questionnaires. Together, the qualitative and quantitative data provided a definition of nursing articulated in Chinese. The process was rigorous and the researchers used factor analysis to describe agreement with both positive and negative characteristics of Chinese nursing. There was high agreement that nurses wanted to be professional practitioners, but also high agreement that workplace conditions reinforced the traditional view of nurses as handmaidens to physicians. Of particular
relevance to this thesis is that while Chinese nurses used terms such as ‘nursing diagnosis’ and ‘nursing process’ to describe their activities, they used these terms to describe tasks rather than provide a logical approach to clinical decision making. Pang et al. concluded that shared definitions between Chinese and western nursing belied the vastly different epistemic concerns, philosophies and ideologies of the east and west. For example, the term ‘zhi’ was used by Chinese nurses to refer to ways of approaching decision making.

Whilst direct translation may define zhi as ways of knowing, Pang et al. (2004) described that it is not the same as the western concept of knowing through objectivity and scientific or systematic studies. Instead, they described that in China it refers to ways of understanding that include creativity, knowledge, philosophy and subjectivity. Similarly, the Chinese definition of nursing also included responding to a patient’s “dynamic health status” (Pang et al., 2004, p. 668). This definition however, was not based on the interplay between the natural and humanistic environments of individuals as described by western nursing theorists such as Rogers (1970), Watson (1985) and Roy (1999). Instead, it was based on the theory of systematic correspondence, which as the theoretical foundation of traditional Chinese medicine, describes a constant tension between the natural environment and relational dynamics between people.

Of importance to this thesis is that Pang et al. (2004) did not examine the implications of this reported incompatibility between western and non-western philosophies and ideologies on the concept of universal competencies for nursing. Other authors (including Hisama, 2000, 2001; Kao et al., 2006; Takahashi, 2004; Upvall et al., 1999) who explored the transferability of the attributes of the contemporary ‘Professional nurse’ to non-western nursing did not examine this issue either. Whilst these authors acknowledged the influence of western ideologies on the attributes associated with the contemporary ‘Professional nurse’, excepting for Davis (1999) and Xu et al. (2001), they simply acknowledged this phenomenon.

Davis (1999) and Xu et al. (2001), however, questioned the one-way transfer of nursing knowledge and encouraged Asian nursing scholars to contribute to western knowledge about nursing. Davis (1999) suggested that non-western nurses have a
responsibility to reduce the global influence of American nursing. She indicated that they should contribute to both western and non-western nursing by questioning western ethics of care and principles of individualism espoused in western models for biomedical ethics.

Xu et al. (2001) suggested that Asian nursing scholars could contribute to both Asian and western nursing by developing an “integrated nursing science” (p. 185). Such an ‘integrated nursing science’, they described, consisted of a blend of traditional Chinese medicine and western medicine that could be applied globally and used to change the face of nursing internationally. However, even though Davis (1999) and Xu et al. acknowledged the dominance of western concepts of nursing, their work did not sufficiently fill the gaps left by other researchers.

Davis (1999) and Xu et al. (2001) did not apply their findings to critique the assumption that western standards were the benchmark against which nursing practice and education in non-western settings were measured. Nor did any literature relating to non-western nurses achieving the professional values and attitudes of the contemporary nurse provide insight into the ramifications of the differences between western and non-western nursing practice and education on international mobility. The influence of the socio-economic, political and historical context in which nursing took place was also overlooked as a factor contributing to the nature of, or concepts associated with nursing in non-western settings. Instead, there was an assumption that cultural factors explained the context in which both non-western and western nursing took place. Similar gaps in knowledge about the applicability and acceptability of western standards for nursing practice and education appear in the literature relating to the critical thinking and problem solving capacities of nurses in non-western settings. This literature is described in the next section of this chapter.

**Implementing Teaching and Learning Methodologies that Encourage, Critical Thinking, Problem Solving, and Student Participation**

Two sub-themes emerged in the literature in relation to compatibility between non-western nursing and the proposed standards for entry-to-practice nursing education that support global consistency in nursing practice and education. The first sub-theme
related to the capacity for non-western nurses and nursing students to acquire critical thinking and problem solving competencies required by the contemporary, internationally mobile nurse. The second sub-theme related to the capacity for non-western nurse teachers to facilitate such skill acquisition.

The Capacity of Non-western Nurses to Acquire Critical Thinking, Problem Solving Skills

Although critical thinking has been emphasized as a particularly important attribute of the contemporary, internationally mobile nurse, of particular interest to this thesis is that it is also reported to be difficult to achieve in Asian countries (see for example, Khoo, 2000, 2003; Melles, 2004). Many nursing scholars have drawn attention to how such difficulties are encountered in nursing education in non-western settings. Of particular interest for this thesis are papers that describe difficulties in acquiring critical thinking skills in the context of wanting to acquire these skills in order to ‘professionalize’ or ‘internationalize’ nursing. Such difficulties are described by Saksomboon, McMillan and Cholowski (2002), Pimparyon, Roff, McAuleer, Poonchai and Pemba (2000), and Shin, Lee, Ha and Kim (2006).

According to Saksomboon et al. (2002), Thai nursing students experienced difficulties in acquiring critical thinking skills, despite a desire to do so. These authors analyzed data from three different sources to examine the outcomes of implementing a new curriculum. The new curriculum was specifically designed to comply with global trends for nursing education. They administered surveys (incorporating open and closed questions), and conducted semi-structured interviews and a stakeholder workshop. An unspecified number of student nurses, newly graduated nurses and nurse practitioners participated in their study. Saksomboon et al.’s findings largely related to the clinical component of the curriculum. Their work paralleled that conducted by Pimparyon et al. (2000), who evaluated the critical thinking skills of students engaged in the academic program. Both papers described how Thai nurses continued to rely heavily on rote learning and did not engage in critical thinking. Saksomboon et al. concluded that these findings illustrated a conflict between an educational program that was designed to respond to global trends in education and a
uniquely Thai culture of non-confrontation. They referred to this conflict as created by the presence of, and need to deal with “competing ideologies” (p. 647). Saksomboon et al. (2002) described two particular examples of ‘competing ideologies’. The first example was an inconsistency between the curriculum as it was conceptualized (the written curriculum) and the curriculum as it was implemented (the taught curriculum). Whilst the written curriculum was intended to promote critical thinking through a focus on learning processes, the way that the curriculum was taught emphasized content. Such a focus on content left little time or opportunity for students to engage in critical analysis of concepts and so perpetuated the traditional approach of rote learning. The second example was an inconsistency between the desire for encouraging critical thinking and questioning in the clinical setting and the desire to observe traditional Thai manners relating to engagements between students and teachers. According to Saksomboon et al., the participants in their study rejected students’ questioning clinical practices in preference for students respecting teachers and clinical staff older than themselves. Thai students and clinical nurses also condoned avoiding questioning if it was likely to result in confrontation between the person asking the question and the person responsible for answering.

Of importance to this thesis is that my previous academic work teaching Indonesian nurses confirmed a similar reluctance to include questioning as a learning technique. Despite my endeavors to encourage critical analysis, Indonesian nursing students enrolled in the Masters degree program at the Australian University where I worked, seldom questioned my authority over knowledge as the teacher. Similarly, when I introduced controversial topics in classroom discussions they not only engaged in limited interaction with me, but rarely explored each other’s opinions.

Also of importance to this thesis is that while Saksomboon et al. (2002) indicated their work demonstrated the presence of, and need to deal with ‘competing ideologies’ they did not suggest how these tensions could be resolved. Burnard and Naiyapatana (2004), who also reported on similar tensions within Thai nursing, suggested that conflict between observing traditional manners and wanting to engage in critical thinking was inevitable. Burnard and Naiyapatana conducted an ethnographic study of communication. Their aim was to explore how cultural issues impinged on the ways that Thai clinical nurses and nurse educators communicated
during everyday practice within both the clinical and academic components of a Thai nursing program. They gathered data from observations, conversations and interviews with 14 participants. They did not identify whether the program was an entry-to-practice program. However, they did identify ‘being critical’ as “a ‘Western’ activity and not, necessarily, a South East Asian one” (Burnard & Naiyapatana, 2004, p. 756). Like Saksomboon et al. (2002) they did not suggest how this situation could be resolved. Instead, they proposed that it was expected that all nurses in all countries are expected to defend cultural norms. As a result they inferred that Thai nurses should continue to observe traditional manners and resist complying with inappropriate nursing ideas that are wrongly perceived to be ‘universal’.

A descriptive survey study by Shin et al. (2006) includes data that reflect a similar situation within the Korean setting with regard to competing cultural ideologies. However, in contrast to Burnard and Naiyapatana (2004), Shin et al. suggested that Korean nurses should abandon their Korean dispositions and instead embrace the western driven trend to encourage critical thinking within nursing education. Shin et al. surveyed 60 Baccalaureate-level nursing students over a three-year period. They translated an English version of the Californian Critical Thinking Disposition Inventory (Facione, Facione & Giancarlo, 1994) into Korean to measure student nurses’ dispositions towards critical thinking. They did this to specifically assess the efficacy of new types of educational strategies introduced in Korea. These strategies were designed to improve the critical thinking dispositions of these students.

A significant concern relating to their research, however, was that the authors did not specify the nature of the new educational strategies. They did report that the techniques constituted a significant move away from the predominant teaching style in Korean nursing education. As in Thailand, this style consisted of teachers presenting straightforward facts for students to memorize and repeat. The overall results were reported as encouraging, but the subscale scores indicated persistently weak critical thinking dispositions. Students particularly demonstrated low scores in their ability to systematically approach problems, self-confidence in their ability to reason, and the ability to recognize that problems may have more than one solution. The researchers did not believe these results reflected the intellectual capacity of the students, but instead attributed the results to the influence of cultural norms. These
A number of issues that are of particular importance to this thesis arise from Shin et al.’s paper (2006). Shin et al. described critical thinking as a western driven, world wide trend that Korean nursing should embrace in recognition of a desire for compliance with international standards for nursing practice and education. At the same time, they acknowledged that Korea had strong cultural characteristics and values that influence nursing education and the working environment of nursing in ways that was quite different from those in the west. However, these researchers were ambivalent about what their results meant in terms of promoting critical thinking amongst nursing students. On the one hand, they saw Korean culture as the major obstacle for preventing the transferability of highly desirable western educational methods. On the other hand, Shin et al. recommended that further research should be conducted to assist Korean nurse teachers to develop teaching strategies that are customized to Korean culture. Accordingly, a particular deficit in their research was the authors’ omission of discussion about the tension between these two positions.

Shin et al.’s (2006) research also identified that students’ learning styles were well established by the time they entered nursing. This is of importance to this thesis as the general education system in Indonesia is similar to the teacher-centered methods used in Korea (Rahim-Hillan, 2002). Similarly, the CJSSP goal of introducing new teaching and learning methodologies in the DIII program was to be realized in a nursing education system that was heavily reliant on teacher-centered, didactic lectures and rote learning (Cooke, 2003). Therefore, exploring the relationship between failure of uptake of critical thinking skills by Korean nursing students and the implications this had on further development of Korean nursing were particularly important to answering my questions about the universality of competencies. Moreover, until my participation in the CJSSP, I had assumed that these competencies were universally desirable and universally applicable. Therefore the type of ambivalence that these authors displayed was similar to my own experiences.
In addition, while both Shin et al. (2006) and Saksomboon et al. (2002) explored the impact of implementing teacher-centered learning on nursing students’ critical thinking skills, neither examined the nurse teacher’s responses to this change in pedagogy. Nor did they examine the nurse teacher’s competencies in these new approaches. As the CJSSP activities to improve DIII students’ critical thinking skills revolved around changing the teaching patterns of Dosen and Clinical Instructors, responses of teaching staff was important to understand. The next section of this chapter examines literature that explores this issue.

The Capacity of Non-western Nurses to Teach Critical Thinking, Problem Solving Skills

For critical thinking skills to be acquired, both the student and the teacher need to be committed to a learner-centered approach (Beitz & Wieland, 2005). Research describing nurse teaching in non-western countries reveals that cultural values significantly inhibit the ability of teachers to implement student-centered learning and foster critical thinking skills of nursing students. Two papers by Li-Ling Hsu (2006, 2007) particularly highlight this skill deficit on the part of Taiwanese academics when performing the role of clinical nurse educators. Although it is not stated in either paper, Hsu appeared to be reporting on two different elements of the same study. In both papers, she reported on her observations of the activities of 10 Master’s degree prepared Taiwanese clinical nurse educators engaged in teaching students during their first clinical placement within a two year entry-to-practice nursing program. In her 2006 paper, Hsu reported findings based on observing clinical nurse educators’ interactions with students while providing instructions about clinical work. Hsu kept field notes and shared copies of both transcriptions and analysis of observations with the participants to clarify tentative findings. In her 2007 paper, Hsu reported findings based on observing clinical nurse educators’ interactions with students during their end-of-day conference while on clinical placement. In this later study, Hsu was joined by another observer and interrater reliability was established between the two researchers.

In both papers Hsu (2006, 2007) reported that Taiwanese clinical nurse educators demonstrated teaching styles that were inconsistent with behavioral and instructional
strategies for learner-centered teaching. Instead, in both studies she observed behaviors that were compatible with assumptions that the teacher knows everything and is smarter than the students whose task is to follow instructions and not question the teacher’s knowledge. Hsu found that it was difficult for clinical nurse educators themselves to admit to not knowing answers and so there was also great reluctance to model problem solving behaviors by engaging in information searching alongside students. Hsu concluded that such behaviors reflected culturally appropriate behavior for persons of Chinese origin. She noted that it was particularly common for Taiwanese clinical nurse educators to follow the Chinese saying that states “[an] excellent student is trained by a strict master” (Hsu, 2006, p. 626; Hsu, 2007, p.1532).

Hsu’s work (2006, 2007) is of significance to this thesis on a number of levels. Other studies (such as Upvall et al., 1999; Xu et al., 2002) have identified low levels of inclusion of critical thinking activities within non-western nursing curricula and have identified this situation as reflective of low relevance of critical thinking attributes to nursing in Asian cultures. These studies have also proposed a causal relationship based on opinions, survey and interview data. Hsu’s studies (2006, 2007) are unique in that she observed the actual behavior of nurse teachers implementing a curriculum that deliberately attempted to acknowledge the importance of critical thinking to nursing practice within an Asian culture. The CJSSP Terms of Reference(IBRD, 2001) indicated a similar desire for critical thinking skills to be an outcome of the DIII curriculum. Therefore, the findings of Hsu’s studies were important to understanding potential factors that would limit the success of CJSSP activities designed to change teaching strategies used by Dosen and Clinical Instructors.

Additionally, while Hsu (2006, 2007) inferred that there were benefits of seeing first hand what teachers did, rather than hearing reports of their techniques, she also recommended that interviewing teachers would be useful for supplementing observation to “get a more complete picture” (Hsu, 2006, p. 627). As I planned to use an ethnographic technique for this thesis, the information Hsu presented about how she conducted both studies and her insights into the advantages and disadvantages of observational techniques were important. Together with the observational work of Burnard and Naiyapatana (2004), Hsu confirmed that observational methods were
acceptable to non-western nurse teachers, but there were also benefits in following observations with interviews and asking participants to clarify tentative findings.

Also of importance to this thesis is that like some Dosen participating in the CJSSP, some of Hsu’s (2006, 2007) nurse educator participants held master’s degrees in nursing from western countries (including Australia). Unfortunately, Hsu did not report any analysis of differences between Taiwanese educated and overseas educated nurse educators. Of significance, however, was that the both Hsu’s Taiwanese nurse educators and the Indonesian Dosen participating in the CJSSP were considered to be ‘good teachers’. Research by de Guzman, Ormita, Palad, Panganiban, Pestano and Pristin (2007) is important in informing this thesis about the ramifications of Dosen participating in the CJSSP being endowed with such a positive image. de Guzman et al. interviewed 22 senior nursing students enrolled in a four year entry-to-practice Baccalaureate degree conducted at the first University to offer this qualification in the Philippines.

Thematic analysis by de Guzman et al. (2007) identified three conceptual themes: ‘Credibility as an image building activity’; ‘Credibility as a work in progress’; and ‘Credibility as an influencing agent’. Perceived as an image building activity, credibility meant that the students had greater respect for their teachers if they could see them doing what they taught. Image building in turn influenced the notion of credibility as ‘a work in progress’. de Guzman et al. found that students perceived teachers to constantly define themselves as credible in terms of physical appearance, consistency between knowledge and skills and attitudes towards students. This perception meant that teachers who worked hard were respected for their ability to instill in students a fear to also work hard. Similarly, credibility as ‘an influencing agent’ meant that if teachers work hard, they instill a fear in students of not doing their best. For example, one student said: “It is I think an embarrassment to the student if he does not perform well if his Clinical Instructor (CI) is excellent” (de Guzman et al., 2007, p. 532).

Therefore, the distance between teachers and students that Hsu (2006, 2007) found in Taiwan was also reported to be culturally acceptable in the Philippines. Moreover, in contrast to the western literature on this topic, such distance was considered to be an
attribute of a good teacher rather than detrimental to learning. In fact, de Guzman et al. (2007) suggested that the credibility of teachers would be undermined if they did not behave in this way. Together, de Guzman et al.’s insights and Hsu’s findings therefore suggested that Dosen and Clinical Instructors participating in the CJSSP would need to put aside their culturally defined concepts of themselves if they were to successfully adopt learner-centered approaches. Hsu reported that this casting aside would be particularly difficult and her opinion is supported by research by Stockhausen and Kawashima (2003).

Stockhausen and Kawashima (2003) reported on focus groups with 29 Japanese nursing students enrolled in an Australian Bachelor of Nursing degree to upgrade their initial Japanese entry-to-practice Diploma level qualifications. The aim of the study was to describe Japanese students’ perceptions of their learning experiences while participating in this joint initiative between the nursing school of an Australian University (GU) and a Japanese Research Institute (Nissoken). While undertaking the GU-Nikkosen program, the Japanese nursing students engaged in a Problem Based Learning curriculum through self-directed study using distance education materials. These materials were prepared by Australian nursing academics and translated into Japanese. The students were also supported during their studies by Japanese nurses who were employed as in-country learning facilitators. Although they did not identify the qualifications of the facilitators, Stockhausen and Kawashima referred to them as nurse teachers.

Based on the focus groups with students, Stokhausen and Kawashima (2003) found that Japanese nurse teachers were unable to escape deep-seated cultural constructs of learned, shared and inherited values that perpetuated their traditional practice. The researchers described that Japanese nurse teachers were unable to change because these practices determined their membership of a specific group within Japanese society. According to the students, this meant that nurse teachers were unable to use instructional methods that were compatible with the Problem Based Learning curriculum. For example, Stockhausen and Kawashima found that despite enthusiastically engaging in problem-based learning activities, students were dissatisfied with the outcomes. The students felt that their Japanese teachers’
adherence to traditional teacher-centered techniques undermined their attempts to engage in problem-based learning and develop responsibility for their own learning.

As the Nissoken project, like the CJSSP, was a partnership between Australian and non-western educational institutions that focused on upgrading non-western nursing qualifications to international standards, these findings are particularly significant for informing this thesis. Stockhausen and Kawashima’s (2003) findings, together with the work of Hsu (2006, 2007) and de Guzman et al. (2007) imply that a shift in cultural values of nurse teachers is necessary for successfully implementing western based student-centered learning techniques and fostering critical thinking skills amongst non-western students. While Stockhausen and Kawashima suggested it was important to educate Japanese nurse teachers to reflect on their traditional teaching methods and develop new skills to empower Japanese students’ learning skills, Hsu was skeptical of the success of this solution. Hsu’s skepticism was based on a perceived absence of a lifelong learning habit on the part of teachers from Asian cultures.

On the other hand, a commentary by Lu (1993), which confirmed this cultural attribute, does offer some hope. In Lu’s opinion, the same cultural values that limit individual autonomy and define a person’s social position within a hierarchical Asian society also mean that while teachers would not voluntarily change their practices, they would change traditional behaviors if government policy is established. The literature relating to the cultural influence of hierarchical structure specifically relating to student supervision within the practical field is explored in the next section of this chapter.

**Achieving Concordance between the Theoretical and Practical Components of the Entry-to-Practice Nursing Education**

The clinical credibility of nurse teachers is particularly important for closing the gap between the theoretical and clinical components of nursing education. The ability to close this theory-practice gap is vital in preparing nurses for contemporary practice and international mobility (Gillespie & McFetridge, 2006). Two papers that explored poor compliance with these standards in non-western countries were relevant to this
thesis. Lu (1993) and Upvall et al. (2002) described low levels of clinical competence amongst non-western nurse teachers who supervised the clinical component of entry-to-practice education in China and Pakistan respectively. The teachers they referred to were employed by the nursing schools, and were not practicing clinical nurses. Such competency deficits were attributed to a culture of separation between academic institutions and the clinical service institutions, which is reinforced by hierarchical structures that dominate the cultural milieu in which nursing takes place (Lu, 1993; Upvall et al., 2002; Shields & Hartati, 2003; Perrin et al., 2007). This finding is important for this thesis because such a culture of separation in Indonesian nursing had led to, and was reinforced by academic faculty having little understanding of the clinical setting (Shields & Hartarti, 2003).

Lu (1993) and Upvall et al. (2002) explained how a higher status afforded to academics compared to clinical staff in China and Pakistan respectively meant that both academic staff and clinical staff were reluctant to cross the cultural barriers that such status differential creates. In her opinion paper, Lu used Benner’s (1984) model of competence to explain that Chinese academic faculty were regarded by the Chinese nursing profession as experts in delivering the theoretical component of nurse education. However, if they were to engage in clinical practice they would be perceived to use a lower level of knowledge that would result in a fall in status. Lu suggested that neither the academic nor clinician would be comfortable with such a change to the existing hierarchy.

Upvall and colleagues (2002) supported Lu’s (1993) theorizing with qualitative research findings. They conducted 15 focus groups with 37 academic faculty, 42 senior nursing staff and 48 students involved in entry-to-practice education at five hospital nursing schools in Karachi, Pakistan. According to Upvall et al. (2002) these focus groups revealed that the distinct boundaries and hierarchies that characterized the cultural milieu of nursing education in Pakistan raised significant barriers to implementing faculty practice. According to the student participants, academic faculty were considered to be beyond everyday care-giving levels of clinical nurses. Traditional beliefs of demonstrating respect to someone of a higher status meant that it was both unacceptable for academic faculty to work at the same level as clinical nurses and unacceptable for academic faculty to admit they have more to learn.
Responses from academic faculty revealed that the possibility of being challenged by engaging in clinical practice would incur a risk of moving to a lower position in the nursing hierarchy and result in loss of respect from students, clinicians and other academic staff. Clinician participants were particularly concerned that they would not be able to teach the ‘superior’ academic faculty anything that they did not know already, and if they could, then the academic faculty should not be teaching in the academic program. As the thought of crossing these hierarchical boundaries generated similar responses from students, academic faculty and clinical staff, the findings of this research are particular important. Given the perceived hierarchical nature of Indonesian society (Ricklefs, 1993) and nursing (Sahar, Courtney & Edwards, 2003) these findings have relevance to this thesis.

This division between the academic and clinical components of entry-to-practice nursing curricula and how it positioned faculty and clinicians within the hierarchy of the nursing profession was a particular theme within the literature reviewed. Hsu (2006) and Upvall et al. (2002) both described that clinicians were expected to focus on teaching technical skills and training students to be task-orientated rather than developing clinical judgment skills and problem solving abilities of their students. Research by Yu Xu and colleagues (2002) confirmed the importance of this focus on task based competencies in Chinese nursing education.

Xu et al. (2002) surveyed 11 Deans or Directors of Baccalaureate nursing programs in China to assess the universality of an American model for entry-to-practice nursing education. These researchers examined the relevance of the American Association of Colleges of Nursing guidelines for baccalaureate education (AACN, 1998) to Chinese nursing education. They extracted 21 key concepts from the AACN essential components of professional nursing education, translated them into Chinese and asked the participants to rank them according to importance, cultural relevance and extent of exposure in their current curriculum. They also asked an open-ended question to elicit data about other concepts the participants considered important for inclusion in Baccalaureate nursing education. Of the 21 concepts extracted from the AACN, the researchers found that ‘technical skills’ and ‘illness and disease management as directed by medical staff’ were considered to be the competencies that were most important and most culturally relevant and paid most attention to Chinese entry-to-
practice education. In contrast, the competencies that equipped the nurse to be the ‘designer/manager/and coordinator of care’ were found to be the least compatible with Chinese culture.

Xu et al. (2002) related this incompatibility between the AACN competencies and Chinese nursing to the different ideologies that underpinned nursing in each cultural context. They described that the dominant ideology of autonomy underpins the construction of the western nurse and so is compatible with the nurse as a competent ‘designer/manager/and coordinator of care’. On the other hand, they attributed the selection and omission of critical competencies for Chinese nurses to their role as subservient to medical staff and their status within Chinese society as lacking in their own independent nursing identity. These researchers claimed that this role is underpinned by the ideology of collectivism that dominates Chinese culture and so constructs Chinese nurses.

Despite the fact that their sample (n=11) was small and represented only 50% of the Deans/Directors of Chinese nursing programs, Xu et al.’s (2002) analysis of their data was comprehensive. They showed particular concurrence between the closed and open-ended questions, with participants confirming high ranking competencies by commenting that the same competencies were considered most important for inclusion in Chinese nursing education. However, one of the weaknesses of Xu et al.’s work was the incongruence between some of their concluding remarks.

On the one hand these researchers suggested that the majority of the competencies in the AACN Essentials have global relevance. On the other hand, the competencies that they listed as either requiring culturally specific adaptation or defying transferability across cultures represented a significant number of the concepts that define western nursing. For example, concepts relating to professional values, core knowledge, and role development competencies were placed in this latter group. This left a minimum number of shared concepts that largely related to the technical elements of nursing. Paradoxically, Xu et al. themselves acknowledged that these technical elements are consistently ranked as low order competencies within contemporary, evidence based western nursing curricula. That is when technical skills are carried out without the accompanying higher order skills of scientific reasoning, they reflect behaviors
associated with task-oriented vocational education and sub-professional nursing (Upvall et al 2002). Therefore, shared valuing of technical proficiency does not confirm global relevance of practice informed by theory or the importance of congruence between theoretical and practical elements of entry-to-practice nursing education.

**Implications of the Literature Review for this Thesis**

The implications of the literature review for this thesis centre around three interrelated themes regarding the dominant ways of thinking that underpin existing understandings about international standards for nursing applied to nursing practice and education in non-western settings. The first theme is that a gap in current understandings about the tension between global consistency and local uniqueness in nursing exists by virtue of what is not said. Nursing scholars have generally not acknowledged the hegemonic construction of a single western derived definition of the contemporary, internationally mobile nurse. The second theme relating to the limitations of current knowledge is based on nursing scholars’ reliance on the dominant construction of culture to inform their work relating to the adoption and rejection of international standards for nursing in non-western settings. Such reliance both denies the contextual influences on nursing practice and education and prevents a way forward for improving outcomes of western intervention into nursing education in non-western settings. The third theme involves an over-reliance on research methods to investigate the tensions between global consistency and local uniqueness that are consistent with a single image of the contemporary, internationally mobile nurse. These three themes and the implications of each on limiting current understandings of nursing practice and education in non-western settings are now described.

**The Hegemonic Construction of a Single Western Derived Definition of the Contemporary, Internationally Mobile Nurse**

The hegemony of western nursing is the pervasive power of dominant western nurses over non-western nursing practice and education. According to Davis (1999), Burnard and Naiyapatana (2004), Zhaomin Xu et al. (2001), and Yu Xu and Zhang (2005),
western nurses are able to convince non-western nurses to willingly submit to the homogenizing endeavor of applying a single western derived image for nursing to unique non-western settings. Consistent with the notion of hegemony, non-western nurses do comply because western nurses convince them that global consistency in nursing is in the interests of all nurses (Holmes, Murray, Perron & Rail, 2006; Holt, Barrett, Clarke & Monks, 2000). Similarly, as a hegemonic construction, the image of the contemporary, internationally mobile nurse exists as a subtle form of social control (Leighton, 2005). The content of this chapter has revealed that such control is exerted by the image of the contemporary, internationally mobile nurse appearing as the dominant standard for nursing in the international nursing literature. It has also revealed that the power of western nurses over non-western nurses is reinforced by the western derived contemporary image of the nurse being embedded in legislation that regulates international mobility. Moreover, the western hegemonic nature of the image of the contemporary, internationally mobile nurse has been revealed as perpetuated through entry-to-practice nursing education that is competency based.

The chapter has also revealed that the competencies that underpin the image of the contemporary, internationally mobile nurse are influenced by discourses, or ways of thinking derived from western ideologies of liberalism and humanism. Importantly for this thesis, as is described in Chapter 3, the dominant ways of viewing the world during the colonial era now persist in the contemporary globalized world (Holt et al., 2000). For example, Davis (1999) revealed that the image of the contemporary, internationally mobile nurse as autonomous is underpinned by discourses of individualism and humanism. In the literature reviewed in this chapter such discourses emphasized assumptions that the contemporary, internationally mobile nurse is an individual who is rational and freely choosing. Similarly, this literature suggested that western nurses who do not comply with this image are excluded from the benefits of full membership of the international community of nurses. Such dominance and exclusivity supports Davis’s (1999) proposition that the image of the contemporary, internationally mobile nurse is a western hegemonic construction.

Nursing as a scientific discipline can also be deconstructed as underpinned by these same liberalist discourses that emphasize rationality (Browne, 2001). For example, as a member of a scientific discipline, the contemporary, internationally mobile nurse is
required to implement nursing care using the logical nursing process. As the nursing process (Doenges & Moorhouse, 2003; Doenges, et al. 2006) is founded on rational decisions based on impartial scientific evidence, it complies with the discourse of evidence based practice. The notions of value neutral, scientific objectivism that underpin the discourse of evidence based practice is particularly rooted in the liberal and humanist ideologies that position objective scientific knowledge as the only legitimate form of knowledge (Holmes et al., 2006; Holt et al., 2000). The legitimacy of such knowledge to the exclusion of all other potentially valuable forms of knowledge is proposed to benefit all nurses. When nursing as a scientific discipline is deconstructed in this way, Davis’s (1999) proposition that the image of the contemporary, internationally mobile nurse is a western hegemonic construction is supported.

**Dominant Understandings of Culture**

The literature described in this chapter predominantly puts forward the view that non-western nurses need to set aside cultural attributes that conflict with western defined competencies in order to comply with the image of the contemporary, internationally mobile nurse. The dominant western view of ‘culture’ is that it explains the presence of commonly-held general beliefs and values that define what is right and wrong for a homogenous group of people (Gustafson, 2005). These shared cultural attributes are transmitted from generation to generation through socialization (Leininger, 1978) as a static, enduring and timeless entity (Dorazio-Migliore, Migliore & Anderson, 2005; Mohammed, 2006). However, this dominant concept of culture, and therefore the notion of cultural incompatibility between western and non-western nursing has also been positioned as a western hegemonic construction (Bruni, 1988).

Whilst the literature focused on enunciating non-western nurses’ difference from western nurses, some authors have suggested a way forward to resolve the tension between such difference and the desire for non-western nursing to comply with the western derived image of nursing and international standards for nursing education and practice. Yu Xu et al. (2002) indicated that assimilation was the solution. They believed that it was simply a matter of time, and the more exposure a culture had to western driven globalization, the less cultural conflict would arise. Other nurses
writing about collaborative (counterpart type) projects instead suggested that it was imperative for participants to develop an awareness of cross-cultural issues when western experts influenced nursing in non-western countries (for example: Jayasekara & Schultz, 2006; Stockhausen & Kawashima, 2003; Xu et al., 2001). Developing awareness simply represented becoming more knowledgeable about the non-western culture to determine how transplanting western concepts may impact on non-western nursing. As such, this strategy represented a discourse of inertia (Dorazio-Migliore, et al., 2005). Culture was assumed to be a static, enduring and timeless entity (Mohammed, 2006).

Such an understanding of culture denies the historical, political, social and economic influences on behavior, and did not address my questions about the influence of context upon Indonesian nursing and the applicability and acceptability of western expertise across diverse settings. The literature was therefore consistent with dominant western discourses that, without naming it as such, position western behavior as the cultural norm. In the context of an agenda for global consistency in nursing, this literature positioned western nursing as the benchmark against which to marginalize nurses who are categorized as different. The literature reinforced a fixed hegemonic representation of nursing that arises from the western centre of nursing. In doing so, it upheld the position of structural advantage experienced by western nurses who set the agenda for global consistency in nursing, positioning white-dominant culture as the unspoken and centered norm (Blackford 2003; Mohammed, 2006; Reimer-Kirkham & Anderson, 2002).

At the same time this literature denied the possibility of using knowledge about lack of transferability of western education and practices to create a space for an alternative construction of nursing. The fact that the literature does not create a space for proposing alternatives is consistent with Meleis and Im’s (1999) proposition that intolerance of diversity within nursing leads to an absence of knowledge that is outside the dominant centre of power and discourse. Therefore, this review identifies that research to develop new knowledge that would not marginalize difference is necessary to illuminate the complexities of being a western expert and introducing western standards for nursing to internationalize the non-western DIII program.
Meleis and Im (1999) proposed that a way to challenge global consistency of nursing practice and education is to deconstruct the historical, political and contextual factors that impact on understandings of cultural diversity. They suggested that this approach would provide a way to resist the nursing scholarship that has created a mould against which others are judged and populations are stereotyped. Similarly, Mohammed’s (2006) writing encouraged me to move away from fixed understandings of culture towards “understanding culture as more fluid and complex, historically situated and discursively constructed” (p. 98). Applied to this thesis, this meant disregarding the notion that the meanings and values, traditions and practices that take place within Indonesian nursing are fixed, but instead are the embodied understandings and responses to dynamic situations that are determined by historical conditions and relationships unique to Indonesian nursing (Hall, 1999).

**A Space for a Different Approach to Researching Internationalization of DIII Nursing Education**

The existing research that examines the tension between global consistency and local uniqueness in nursing not only paid little attention to these contextual issues, but also rarely embraced research methods likely to assist in doing so. Instead, the existing research predominantly explored the applicability and rejection of international standards for nursing using techniques that focused on gathering objective scientific data. For example, many of the studies involved the use of a survey technique. In turn, the empirical evidence that was gathered reported behaviors as static moments in time and ignored potential historical influences on the acceptability and applicability of western derived competencies. The research conducted by de Guzman et al. (2007) explored the characteristics of ‘good’ Philippino nurse teachers. However, they overlooked the historical conditions that have decimated the local Philippino workforce and have left behind nurses and other professionals with lower skill levels than their migrating counterparts (Alburo and Abella, 2002; Daly & Lumley, 2005; Kingma, 2001).

Similarly, the influence of a researcher’s view of the culture to which the research participant belonged has seldom been acknowledged. Whilst the researcher’s status as a western nurse was sometimes acknowledged, his or her membership of the
dominant group within nursing and how this potentially influenced research findings was neither acknowledged nor explored. In line with Puzan’s (2003) observations about normalizing nursing as a white, western construct, the scientific discourse associated with the image of the contemporary, internationally mobile nurse also served to reinforce the validity of research techniques that excluded the potential of including the voices of non-western nurses within research.

Few researchers used qualitative research techniques to uncover understandings located outside (or on the margins) of the dominant western hegemonic construction of the contemporary, internationally mobile nurse (Racine, 2003). The work by Pang et al. (2004) who explored Chinese nurses’ definitions of nursing was the only study that attempted to gain insight and report on how non-western nurses’ perceived themselves as uniquely non-western. Pang and her colleagues were unique in this respect. In contrast, the other papers reviewed in this chapter (see for example, Hsu, 2006, 2007; Xu et al., 2002), examined non-western nurses’ behaviors as measured according to the western benchmark of international standards for nursing practice and education. This trend was evident in research using both qualitative and quantitative methods carried out by both western and non-western investigators.

Finally, past researchers have not been informed by everyday experiences within activities designed to internationalize non-western nursing. Instead, they described competency outcomes that were either reported or observed after an intervention had taken place. Alternatively, they explored perceptions, rather than actual occurrences of the influence of western scholarship upon non-western nursing. As a result, aside from acknowledging the pervasive influence of western nursing scholarship on non-western nursing, there is no literature that specifically describes the role of the western expert in achieving in global consistency of nursing practice and education.

**Conclusion**

This chapter has examined the literature that describes the capacity of non-western nurses’ to comply with the competencies upon which international standards for nursing practice and education are based. It has found that the knowledge that currently exists about internationalizing non-western nursing education is aligned
with dominant western discourses that construct nursing itself and deny alternative ways of thinking. Therefore, gaps exist in current understandings of the transferability of western expertise and the desirability, acceptability and applicability of international standards for nursing to Indonesian DIII nursing education. Accordingly, this thesis adopts a conceptual and methodological approach that attempts to address the gaps in the current knowledge.

This thesis sought to avoid replicating previous research where the dominant concept of culture has reinforced the unequal power relationships and structural inequities between western and non-western nursing. It also sought to avoid replicating previous research where the dominant understanding of culture has denied the influence of the historical, political, economic and social context on non-western nursing. This thesis aimed to provide new insights into both the transferability of competency standards for the contemporary, internationally mobile nurse and the western expertise associated with internationalization of non-western nursing. The next chapter describes postcolonial theory and its specific application to guiding both the conceptual and methodological work of this thesis to achieve these aims.
Chapter 3

An Alternative Landscape

Introduction

This chapter describes postcolonial theory and how specific elements of postcolonial scholarship are applied as a theoretical framework to the thesis. It also includes a description of the process of colonization to historically situate the application of postcolonial theory to research in the once colonized context of Indonesia. The title ‘An alternative landscape’ refers to how the deconstructive nature of postcolonial theory opens up ways of seeing and conceptualizing nursing that are an alternative to the knowledge presented in the literature review. It also refers to the potential for an alternative understanding of the hegemonic discourses that underpin international standards for nursing; an alternative way of conceptualizing transferability of western expertise; and an alternative way of deconstructing Indonesian nursing in response to the specific intervention of the CJSSP.

Postcolonial Theory

In this section I describe the historical and conceptual components of postcolonial theory. In recognition of the tension between the time specific post-colonial era and postcolonial constructs as an enduring, timeless phenomenon (Ashcroft, Griffiths & Tiffin, 2000), I have chosen to distinguish between these two perspectives following John McLeod’s (2000) recommended nomenclature. In this thesis, the hyphenated term ‘post-colonial’ is used to denote reference to a particular historical period. The non-hyphenated ‘postcolonial’ is used to describe the historically situated forms of representation, practices and values that range across both the past and the present (McLeod, 2000). Similarly, to avoid additional confusion I use the term ‘once-colonized’ to refer to a country, nation or people with a history of colonialism, rather than using the terms postcolonial or post-colonial. The exceptions to these distinctions are when I am quoting the work of others whereby I preserve the nomenclature used in the source publication.
The term ‘post-colonial’ was first used by historians who described the effects of colonization on ‘Third World’ cultures and societies at the point of their independence from ‘First World’ colonial rule in the period of major geo-political change ‘post’ World War II (Ashcroft et al., 2000). As such, the term post-colonial defined a specific chronological period in history. In the 1970s, the term post-colonial was adopted by literary critics who explored the discursive operations of European imperialism during the colonial period (Ashcroft et al., 2000). The literary critics particularly challenged the colonial representations of once colonized people and uncovered the disempowering effects of colonialism. As a result, their work became known as post-colonial literary critique (McLeod, 2000).

Although post-colonial literary critique still forms a large part of contemporary postcolonial scholarly activities, the literary critics are now joined by critical cultural scholars, sociologists, political scientists and a small group of nursing scholars (Reimer-Kirkham & Anderson, 2002). Beginning with the publication of Orientalism, (Said, 1978), Edward Said pioneered a form of scholarship that broadened the focus of critique beyond texts that described the historical positioning of once colonized people and nations to become a diverse field of study referred to as postcolonialism (Browne, Smye and Varcoe, 2005; McLeod, 2000). In Orientalism, Said (1978) named the divisive practice of ‘othering’ as responsible for defining the relationship between the colonized and the colonizer.

Drawing on concepts of power and domination developed by Antonio Gramsci (1991) and Michel Foucault (1980, 1982), Said uncovered pervasive acceptance of binary inferior/superior constructions of the colonized and colonizer respectively (Said, 1993). Said was followed by Homi Bhabha (1983) and Gayatri Chakravorty Spivak (1988a) who drew attention to synergies between postcolonial critique and other critical theories. They encouraged its use in combination with the insights of feminism, philosophy, psychology, and political science. Bhabha and Spivak built on Said’s concept of ‘othering’ as a passive response to colonization to present a contrasting view that it was possible to read colonial discourses ‘against the grain’ and so uncover sites of resistance to colonization. To do this, they examined colonized people’s reactions to colonization by uncovering responses that ranged from passive resistance through apparent acceptance of colonial domination to
powerful resistance through overt rejection of colonial subjugation. Together, Said, Spivak, and Bhabha (often referred to as the Triumvirate of postcolonial theory) transformed post-colonial critique into a theoretical framework and established postcolonialism as a field of study in its own right (McLeod, 2000).

The unique contributions to postcolonial theory made by each of these postcolonial scholars are discussed later in this chapter. Before doing so however, it is important to identify some broad aspects of compatibility between this thesis and postcolonial theory as it is used in contemporary scholarship and the relationship between postcolonial theory, colonization and this thesis.

**Positioning the Compatibility between Contemporary Postcolonial Scholarship and this Thesis**

As a field of study, postcolonialism is currently used to provide a theoretical framework to examine not just the colonialism of the past, but also to position present day globalization, capitalism and the white, male domination of society as forms of postcolonial imperialism (Browne et al., 2005; Dorazio-Migliore et al., 2005; McLeod, 2000; Quayson, 2000). Postcolonial theories have been utilized by nursing scholars for their value in guiding critical analysis of inequities in healthcare delivery and the impact on globalization of healthcare (see for example, Anderson, 2000a; Lynam & Cowley, 2007; Sherwood & Edwards, 2006). They have also been employed to uncover the influence of dominant discourses in healthcare and nursing (Racine, 2003; Reimer-Kirkham, Baumbusch, Schultz & Anderson, 2007). Postcolonial ethnographic techniques are increasingly being used to understand diversity in nursing practice, to value knowledge produced by marginalized groups within nursing, and to direct nursing research with, rather than on, marginalized peoples (for example, Anderson, 2000b; Anderson, Perry, Blue, Browne, Henderson et al., 2003; Blackford, 2003; Browne, 2007; Browne, Johnson, Bottorff, Grewal & Hilton, 2002; Mohammed, 2006; Meleis & Im, 1999).

Therefore, while there is an undeniable historical component of postcolonial theory, the ‘post’ in postcolonialism does not signify a historical period delineated as ‘after’ colonialism’. Instead, the use of ‘post’ in postcolonialism refers to a conceptual shift
in thinking that moves beyond the legacy of colonial science, colonial social control and the inequitable distribution of power that persists despite the demise of 19th Century colonialism (Quayson, 2000). Accordingly, to adopt a ‘post’ colonial position for this thesis means moving beyond the colonial conceptualizations of race, culture and western science as the unique sources of knowledge production in nursing. Adopting a postcolonial perspective provides a way of exploring how Indonesian nursing is constructed by the colonial discourses of racial and cultural difference. It also provides a way of deconstructing how the image of nursing as a scientific discipline influences classification of practices within Indonesian entry-to-practice nursing education as inferior to western nursing education. By using postcolonial theory the activities of the CJSSP designed to reform Diploma III (DIII) nursing education can be interrogated to uncover how Indonesian nursing is judged against the western derived image of the contemporary, internationally mobile nurse. Postcolonial theory also enables interrogation of the interactions between myself (as the western expert) and the Indonesian participants in the CJSSP to uncover the hegemonic nature of western nursing that represents what Quayson (2000) refers to as “the after-effect of empire” (p. 2).

The next section of this chapter explores the historical and conceptual nature of 19th Century colonization. Such an exploration is important in order to understand the underpinning social, economic and political forces of modernity that are challenged by postcolonial theory. By contextualizing the characteristics of colonization to the specific setting of Indonesia, the compatibility between postcolonial theory and this thesis is also situated.

Colonization

With its roots in the hegemonic discourses of modernity and capitalism (Caldwell & Utrecht, 1979), European colonization in the post Renaissance period of ‘enlightenment’ is believed to be sufficiently specialized and historically specific to be a distinct political ideology (Ashcroft et al., 2000). In Indonesia, the progression of European colonization was characterized by three phases that are particularly important to the compatibility between postcolonial theory and this thesis. These phases were: trade monopolies, occupation and subjugation; inferiorization; and
finally Europeanization, liberalization and civilization of the colonial subject (Ashcroft et al., 2000).

Colonial Trade Monopolies, Occupation of Indonesia and Subjugation of Indonesian People

Control over trading Indonesian spice, rice, coffee and wood by the Portuguese, the Dutch and very briefly, the English coincided with the periods of dominance of these respective nations as both colonial forces and as the dominant power at home in Europe (Ricklefs, 1993; Kingsbury, 1998). Importantly, maintenance of trade monopolies was heavily reliant on European occupation of the foreign territory (Ashcroft et al., 2000). In Indonesia, occupation was necessary to prevent access and subsequent takeover from a European force with greater power, and to ensure that the rulers of Central Java, who consistently reneged on hard won trade agreements, submitted to European authority (Cribb, 2000). It was no surprise, however, that an occupying force was required to maintain these ‘agreements’ as they were heavily weighted against the benefit of the Indonesian people (Ricklefs, 1993). These typically unequal relationships between people subjected to colonization (subject peoples) in the peripheral territories and the representatives of imperial power at the center (dominant peoples) were justified by the imperial discourses of cultural dominance (Said, 1993). According to such discourses, the Europeans as superior people had an inalienable right to exploit the material and human resources of inferior foreign territories for the benefit of the superior populace ‘at home’ (Young, 2003).

Inferiorization Justified Subjugation of Indonesian People

It was no accident that Indonesians were positioned by the European colonial traders as the inferior party in the unequal exchanges that took place between these so-called trading partners. The concurrent development of the capitalist system of economic exchange and the expansion of territorial power were both underpinned by liberal, humanistic ideas that privileged the rights of rational individuals to achieve their full potential (Browne, 2001; Mulholland, 1995). The fact that competition in the market place was unequal was attributed to the inferior characteristics of colonized Indonesians compared to ‘superior’ Europeans. The disadvantages imposed on
colonized Indonesians were not viewed by European colonizers as transgressions of Indonesian’s individual rights. Instead, the relationship between the colonized and the colonizer was legitimized by a constructed hierarchy of difference that justified unfair and inequitable exchanges of an economic, cultural or social nature (Ashcroft et al., 2000).

Initial European perceptions of inferiority of Indonesian peoples were based on their unfamiliar culture including Islamic religious practices, traditions, and complex systems of social organization. These perceptions were ‘scientifically’ supported when Charles Darwin’s theory of mankind’s evolution proved a genetically predetermined inferiority of the colored inhabitants of foreign territories (Said, 1993). Darwin’s concept of ‘race’ naturalized the state of inferiority so that subjection of colonial people was not just a matter of profit, but instead conformed to a natural order. The natural order of superiority in the center and inferiority on the margins justified the pursuit of markets in the ‘new world’ as part of the evolutionary process that ensured the survival of the fittest (Ashcroft et al., 2000; Swendson & Windsor, 1996).

**Europeization, Liberalization and Civilization of the Indonesian Colonial Subject**

Membership of primitive races, considered to be not yet adequately evolved also rendered Indonesian colonial subjects in need of civilizing (Swendson & Windsor, 1996). This pattern of domination, which occurred in the early years of the twentieth century, represented transplantation of the imperial civilization into the peripheral territories. Indigenous languages were replaced with the language of the colonizer, indigenous peoples were displaced, and social services were organized (Young, 2003). For example, in the early twentieth century Indonesian Schools were established to teach in the Dutch language. Translocation (from one area of the archipelago to another) was also implemented on the pretext to meet labor force demands. However, translocation was underpinned by the need to break up and ‘civilize’ indigenous social and political structures that threatened Dutch rule (Philpott, 2000). Social and health services, such as hospitals, were implemented under the auspices of rectifying the injustices of colonial rule in Indonesia. Vocational education to support the creation of an indigenous administrative class commenced.
Dutch led schools to train Indonesian nurses, midwives and doctors were established to replace traditional medicine and witchcraft (Ricklefs, 1993).

In the early twentieth century Dutch interventions to improve the welfare of Indonesian peoples subject to Dutch imperialist rule were therefore purported to reflect a new era of social responsibility. Colonization in this form was legitimized as a civilizing process. However, underneath such virtuous representations these civilizing processes continued to support the economic agenda of colonization (Philpott, 2000). In the words of Ashcroft et al. (2000), the civilization of the inferior races justified the continuing process of colonialism and provided a smokescreen to “hide the fact that these territories were the displaced sites of the increasingly violent struggles for markets and raw materials by the industrialized nations of the west” (p. 47). Indonesian civilization, therefore, occurred under the guise of ‘development’: a powerful discourse that persists into the present day and is linked implicitly to globalization (Parpart, 1995; Swendson & Windsor, 1996).

**The Discourse of Development**

The discourse of development belongs to a classification system that was prompted by the emergence of socialist nations post World War II. This system divided the world into industrialized and non-industrialized nations according to their stage of technological and economic development and political organization (Pletsch, 1981). The principal industrialized countries with developed free market economies, democratic governments and advanced technological status included: the United States; the United Kingdom; the nations of Western Europe; Japan; Canada; Australia; and New Zealand. These countries were classified as ‘First World’ nations and enjoyed such an advanced status by virtue of a reliance on scientific processes and utilitarian thinking rather than traditional ideologies. ‘Second World’ nations included Russia and Eastern Europe. They were industrialized and technologically advanced countries with an economy referred to as ‘planned’ (as distinct from the free market). However, as they were governed by socialist regimes that limited free access to science, these Second World countries were not considered as advanced as First World nations.
Indonesia was, and still is, classified as a ‘Third World’ nation. The Third World is considered to consist of ‘developing’ nations. The nations belonging to the Third World are characterized by undeveloped economies reliant on small-scale agriculture and industry. Membership of the Third World included: Africa, Asia, Latin America and Oceania. Nations belonging to this geographical grouping were considered to be technologically undeveloped as a consequence of a traditional mentality prohibiting the possibility of utilitarian and scientific thinking (Mignolo, 2000). Of particular significance is that most developing nations are also newly independent, once colonized states, and are the primary target for activities associated with globalization (Robertson, 1992).

The term globalization is a concept that refers to “the compression of the world and intensification of consciousness of the world as a whole” (Robertson, 1992, p. 8). The dominant view is that through such compression of the world, globalization provides a way of dispensing technological progress and scientific advances from the developed world to under-developed poverty stricken Third World countries and so initiate a shared global prosperity (Anderson, 2000). Critics of globalization (for example: Ahmad, 1993; Bourdieu, 1998; Gill, 1995; Easterly, 2006; Shiva, 1989) however, argue that the hegemonic discourses of development, capitalism, individual freedom, global consistency and cultural convergence that underpin this view are used instead to hide the unequal distribution of benefits of globalization. The benefits of globalization are very often the accumulation of a large amount of wealth by a minority at the expense of poverty for many (Anderson, 2000a). As such, globalization is widely referred to as neo-colonial globalization.

Neo-colonialism literally means ‘new colonialism’. However used as an adjective of globalization, neo-colonialism refers to the form of control exerted over once colonized Third World countries by First World powers who work to establish a global capitalist economy (Ashcroft et al., 2000). Critics of neocolonial globalization also argue that the combination of liberalist ideological foundations, a development mission and the communication technology that ensures occupation across the barriers of physical distance represents psychological colonization (Browne et al., 2005). Such psychological colonization renders twenty-first century neocolonial globalization a
more insidious form of control that is harder to resist than the overt colonizing processes used in the nineteenth and twentieth centuries (Bhabha, 1994).

The colonial processes of economic subjugation, occupation, inferiorization, and liberalization and the accompanying discourses of civilization and development persist into present day neocolonial globalization (McLeod, 2000). They particularly influenced the relationship between the Indonesian and Australian participants in the CJSSP. This persistence underpins the compatibility between the purpose of this thesis and postcolonial theory as an analytical framework.

**Neocolonial Economic Subjugation of Indonesia and the CJSSP**

A postcolonial approach to this thesis recognizes Indonesia as both a once colonized nation and as a country experiencing continued economic subjugation by western powers. This subjugation of Indonesian people persists by virtue of Indonesia’s position as a ‘developing’ country in the neocolonial globalized world. Positioned in such a way, Indonesia experiences frequent incursions by western countries under the auspices of global development aid and globalization interventions (Philpott, 2000). Viewed from a postcolonial perspective, the CJSSP constituted such an incursion. It was financially supported by development funds from the International Bank for Reconstruction and Development (IBRD).

The IBRD is the lending institution of the World Bank and part of the economic division of the global organization of the United Nations (Shiva, 1989). The funds loaned to the Central Java Ministry of Health were part of a national health system development strategy that complied with the requirements of even broader international funding: the International Monetary Fund (IMF) ‘rescue package’ (Knowles, 2005; World Bank, 2003). This ‘rescue package’ aimed to support Indonesia following the local political instability of Reformasi (a change of government associated with civil unrest and military intervention) and the regional instability caused by Krismon (the Asian financial crisis). Such assistance was particularly necessary given the economic conditions that characterized Indonesia’s emergence from Dutch colonial rule as the independent Republic of Indonesia (Philpott, 2000). Therefore, from a postcolonial perspective, the CJSSP can be
conceptualized as a form of development ‘assistance’ from the contemporary center of civilization, which specifically required compliance at the peripheries with global economic agendas.

The policies linked to these agendas have been likened to the previous colonial subjugation of Indonesia (Caldwell & Utrecht, 1979; Malik, 1980). As these policies include the imposition of tax structures, decentralization of government, elimination of foreign exchange controls and encouragement of private foreign investment, they represent the colonizing capacity of globalization (Anderson, 2000a; Marzolf, 2002). Despite the overt mission of ‘development’, compliance with these policies, as in imperial colonization, occurs at the expense of local investment in education, health and housing (Isla, 1993). Accordingly, viewed through a postcolonial lens, such ‘assistance’ appears to differ very little from the colonial incursions and subsequent ‘agreements’ during Dutch colonialism.

**Neocolonial Occupation and Liberalization of Indonesia and the CJSSP**

Recalling the hallmarks of colonization, the CJSSP can also be considered to resemble a colonial incursion in other ways. It involved a continued presence by the western experts (occupation) who were charged with the brief of ‘internationalizing’ the DIII nursing curriculum. The internationalizing process also involved liberalizing existing Indonesian nursing education practices and clinical competencies. In this case liberalization meant replacing the existing practices with a competency based system of nursing education that complied with global standards designed to produce a practitioner able to make superior clinical judgments based on objective, scientific evidence (IBRD, 2001).

In Chapter 2, it was identified that the Terms of Reference for the CJSSP (IBRD, 2001) and the work plan used to guide the activities of the Australian technical consultants were consistent with the hegemony of western nursing that constructs the contemporary, internationally mobile nurse according to a particular image. This image was underpinned by the discourses of nursing as a scientific profession and nurses as autonomous, rational, professionals. The image also considers western nursing as the benchmark against which nursing education in non-western situations
is measured. By subscribing to this image and the mandate for greater international consistency of nursing education and practice, the CJSSP was therefore underpinned by the same liberal ideologies that were associated with colonization. Parallels can therefore also be drawn between the activities of the Australian technical consultants and me as ‘western experts’ and the civilizing ‘development’ mission of colonization.

**Discourses of Development and the CJSSP**

Given the parallels between liberalization and the post-colonial civilizing processes that are legitimized by the neocolonial discourse of development, the CJSSP may be conceptualized as a development activity. The CJSSP aim of reforming Indonesian nursing education to comply with the standards applied to western nursing is particularly consistent with the discourse of western (First World) development of non-western, Third World peoples. Therefore, if the CJSSP is constructed as a development activity, the work of Said (1972, 1975, 1978, 1988, 1993), Spivak (1988a, 1988b, 1990, 1992, 1993) and Bhabha, (1983, 1990, 1994, 1997) is appropriate for exploring how Indonesian nurses and I (as the western expert) constructed Indonesian nursing as requiring development during both the formulation and implementation of the CJSSP. For example, if the CJSSP is conceptualized as a development activity, then it is also reasonable to expect that responses to the CJSSP activities from the Indonesian participants would be influenced by past and more recent histories of colonial incursions. Postcolonialism therefore, is an appropriate way of understanding the apparently incongruent simultaneous desire for development and rejection of development as a reflection of Indonesian nurses’ once colonized position.

Spivak’s (1988a) theory of passive subalternity is appropriate for understanding how Indonesia’s history of colonial incursions may influence the Indonesian nurses’ adoption of western Orientalist assumptions about their own development needs (as expressed in the subverted voice of the subaltern). Her theory of powerful subalternity and Bhabha’s (1994) notion of mimicry (both described in the next section) are also appropriate for probing the response of rejecting Orientalist assumptions. Without this theoretical perspective, such resistance to colonization may
otherwise remain hidden underneath appearances of acceptance of development (Young, 1995).

Bhabha’s application of the psychological term ‘ambivalence’ (Bhabha, 1994) is also appropriate to understanding how the interactions between Indonesian nurses and me within the CJSSP are influenced by Indonesia’s once colonized status. Bhabha appropriated the term ambivalence to describe how both the colonized and colonizers at the same time want and reject complete colonization. Ambivalence as a postcolonial construct is particularly useful for providing insights into how a history of colonization can influence resistance to development by Indonesian nurses when they themselves initiated the request for reform of the DIII program. Accordingly, using this aspect of postcolonial theory is compatible with answering the research question: Why is western expertise and compliance with international standards for nursing considered by Indonesian nurses to be highly desirable on the one hand, but on the other hand resisted, rejected and of questionable applicability?

Bhabha’s (1994) theory of ambivalence also provides insights into how persistent colonial stereotypes can influence the type of development activities that were considered applicable or successful in the specific setting of DIII nursing education by either the Indonesian nurses or myself. Therefore, using this aspect of postcolonial theory is consistent with answering the sub-questions that guided this thesis: How does the local context influence the acceptance and applicability of international standards for nursing to Diploma III (entry to practice) nursing education in Central Java, Indonesia? And: How transferable is western expertise based on notions of global consistency and international standards for nursing to the unique setting of Ministry of Health Nursing academies in Central Java, Indonesia?

In summary, it is clear that when Indonesia’s history of colonization and the “after-effects of empire” (Quayson, 2000, p. 2) are examined from a postcolonial perspective there are specific elements of postcolonial theory that have particular compatibility with this thesis that examines present day internationalization of the DIII nursing curriculum. The next section of this chapter provides a comprehensive description of my interpretation of the key elements of Said’s, Bhabha’s and Spivak’s scholarly contributions to postcolonial theory that are used in this thesis. These key
elements in turn, both guide the conduct of the research and comprise the theoretical framework that is used to interrogate the data. Used in this way, postcolonial theory enables me to challenge the underpinning social, economic and political forces of colonization and its consequences in relation to the CJSSP. This endeavor is consistent with the gaps in knowledge that informs nursing as a global profession and the limits to my own understanding that I identified in chapters 1 and 2. That is, there is a need for research that escapes the dominant ways of constructing non-western nursing and that generates a new understanding of the application of international standards to entry-to-practice nursing education in the unique non-western setting of Central Java, Indonesia.

**Orientalism (Edward Said)**

As described in the earlier section of this chapter that provides an overview of postcolonialism, the work of Edward Said (1972, 1975, 1978, 1988, 1993) constituted a turning point in broadening the focus of postcolonial studies beyond examining texts that described the historical positioning of once colonized people and nations. Instead, Said examined colonial discourses to expose the hegemonic nature of colonization.

**Hegemonic Colonial Discourses**

Hegemony originated as a term referring to the dominance of one state within a federation (Ashcroft & Ahluwalia, 2001). Said (1978) adopted the broader understanding of hegemony as the concept of dominance by consent, which originated from the work of Antonio Gramsci (1991) in the 1930s. Gramsci developed this understanding of power relationships within society by investigating the success of the ruling classes in promoting their own interests. According to Gramsci, the phenomenon of dominance by consent is the situation whereby the ruling class convinces all ‘other’ peoples that their own interests serve a common good. That is, the ruling class becomes the dominant group by influencing people to think that by pursuing their own interests, the activities of the dominant group are to the benefit of everyone (Ashcroft et al., 2000).
Hegemony is therefore sustained through subtle social processes of control that influence how people think about themselves, others and the world around them. These processes include biased forms of education, selective media reporting and loaded social policies (Leighton, 2005). Hegemony is justified or subconsciously reproduced within society by being woven through the everyday fabric of life. It appears in spoken interaction, written texts, and visual media. The coherent groups of statements that reinforce hegemonic relationships appear as a “set of meanings, metaphors, representations, images, stories, statements, and so on that in some way together produce a particular version of events” (Burr, 1995, p. 48). These statements are hegemonic or dominant discourses (Ashcroft et al., 2000). In *Orientalism* Said (1978) drew upon the work of Foucault (1980, 1982) to attribute the hegemonic nature of colonization to colonial discourses that operated as an instrument of power, sustaining a system within which particular knowledge legitimized the power of the colonizer over the colonized (Ashcroft et al., 2000).

According to Foucault (1980, 1982), discourses are a system of statements that construct the knowledge through which we come to understand the world. This understanding in turn affects how we think, act and participate in the world (Cheek & Porter, 1997). Dominant discourses legitimize particular meanings, representations and knowledge to reproduce and sustain relationships of power within society (Chenowethm, Jeon, Goff, & Burke, 2006; Weedon, 1987). Powers (2002) describes that a discourse becomes dominant by gathering membership, influence, power and momentum. The relationship between dominant discourses and hegemony is succinctly articulated by Powers (2002):

> When a discourse gathers membership, influence, power and momentum, seeking hegemony, creating definitions, highlighting differences between itself and other competing discourses, it seeks to discredit and suppress other discourses in the interests of solidifying ideology that constitutes meaning. A dominant discourse, convinced of the ‘rightness’ of the ideology seeks to exclude other viewpoints in an effort to accrue power/knowledge by citing benefit to some social group. (Powers, 2002, p. 952)
According to Said (1978) colonial discourses obscured, and continue to obscure, the underlying political and material aims of colonization. The political and material aims of colonization were in turn underpinned by discourses that are derived from western ideologies of liberalism and humanism (Ashcroft et al., 2000). Liberalism and humanism are a collection of philosophical, political and economic doctrines that emerged during the late eighteenth Century intellectual climate of the Enlightenment and characterize the transition from the medieval to the modern, imperialist era (Love, 1998; Weedon, 1997). They are grounded on the rejection of the omnipresence of a supreme being and invest authority in scientific explanations provided by individuals rather than the religious traditions and authority of the state (Tanesini, 1999).

Individualism particularly incorporates notions of abstract, freely choosing individuals who exist in an essentially equitable society (Browne, 2001). Humanism builds on the notion of the individual at the center of society. It defines the essence of humanity to position the individual as a universally rational being with the capacity for self-determination. Free choice and self-determination are facilitated by the individual using scientific method to determine truth from observable evidence. Similarly, knowledge of right and wrong does not stem from transcendental truths, but instead is based on the best understanding of one’s individual and joint interests (Mulholland, 1995).

When Said (1978) named the divisive practice of ‘othering’ as responsible for defining the relationship between the colonized and the colonizer, he did so based on a deconstruction of how the discourses of liberalism and humanism underpinned the knowledge through which the Orient came to be known. He specifically deconstructed how the Orientalists (the anthropologists employed by the colonial governments to study the Orient) discovered, described and explained the activities, beliefs, and patterns of behavior of the Oriental inhabitants of foreign territories (Said, 1993). By examining the relations of power that underpinned colonial assumptions of difference, Said identified how the Orientalists constructed the colonized subject as inferior to the dominant colonizer (McLeod, 2000).

According to Said (1978), as European rule encroached on the Orient during the 19th Century there was a need for the colonial administration to know about the people who inhabited the territories they were systematically accumulating. The colonial
administration particularly needed to know what threat such people posed to their imperialist agenda and in turn what armies and bureaucracies would need to do in order to subdue the Oriental population. The knowledge produced was expressed as a specific stereotype of Eastern and Islamic culture that was influenced greatly by the prevailing positivist views of the world at the time. The stereotype was based on objective scientific investigation by ‘outsider’ anthropologists (generally commissioned by the colonizing government). These Orientalist anthropologists were influenced by humanist theories about the history of mankind and civilization. Consequently, they entered the field looking for evidence of a binary order of ‘civilized’ and ‘uncivilized’. As “rational men of science” (Said, 1978, p. 20), the Orientalist anthropologists became the legitimized authority in this area. As such, they were the exclusive source of information about the Oriental territories. They were the repositories of knowledge of and for the inhabitants of the lands that were the object of colonial accumulation. In order to support the case for subjugation, the Oriental was by necessity portrayed by the Orientalists as a stereotypical antithesis of the Occidental (or westerner).

The Stereotypical Oriental

The stereotypical Oriental without the advantages of European progress in science and culture was, albeit unwittingly, backward in contrast to his Occidental counterparts. Without the rationalism, objectivity and logic imparted by western science, Oriental behavior (and particularly Muslim Oriental behavior) was based instead upon ‘mystic wisdom of the East’. The term ‘mystic wisdom’ was used by the Orientalists to explain knowledge that appeared to have no western scientific basis. ‘Mystic wisdom’ included Oriental spiritual customs, indigenous (local) knowledge systems, ritual, tradition, ‘magic’ or any other belief or driving force for behavior that was unexplainable using western logic (Said, 1978).

According to the Orientalists, the 19th Century stereotypical Oriental was prone to making decisions based on intuition, subjectivity and romanticism and so was also particularly unlike the Occidental male. From their powerful position as members of the dominant gender the exclusively male Orientalists drew upon the male-female binarism to feminize the Oriental male and further establish his inferior status. Not
that absence of masculine rationality was the sole biological founded indicator of inferiority. With the emergence of Darwinism the Orientalists were provided with a scientifically valid explanation for the racial inequalities of advanced and backward bestowed upon Occidentals and Orientals respectively. Legitimated by a rational scientific theory, indigenous peoples could be marginalized as ‘undeveloped’ and so the natural inhabitants of the colonial territories could be subjugated through imperialist administration (Mignolo, 2000). Somewhat paradoxical to the renaissance notions of individual freedom, such a view from the center, meant that the oriental ‘noble savages’ on the peripheries was untouched by the emancipating forces of rationality (Rousseau, 1762/1984). Instead, the Oriental required ‘development’.

Said (1993) highlighted that an equally potent indicator of the uncivilized nature of the Orient was the Orientalist observation that Orientals failed to observe the moral codes upon which civilized Christian western society was based. On the one hand ‘science’ endeavored to replace Christian supernaturalism with its objective analysis of the natural world, but on the other hand Christianity remained the guiding force in determining notions of right and wrong when examining behavior. Therefore, not only was Oriental behavior stereotyped by the Orientalists as ‘backward’, but it was also frequently typecast as ‘sinful’ and in need of salvation. Orientalists described the Oriental as prone to various transgressions, particularly the sins of laziness, cowardliness, and untrustworthiness.

In addition, according to Said (1972, 1975, 1978, 1988, 1993), the Orientalists positioned the Oriental as not just ‘different’, but as ‘strangely’ different, extraordinary and abnormal. This difference gave rise to a dubious morality on the part of Oriental peoples who were considered by the Orientalists to demonstrate a readiness to engage in pursuits born of violence and lust. Added to this dubious morality was the feminine depiction of the Orient. This feminization not only emasculated the Oriental male, but also exoticized the Oriental female. Both of these images were considered to be in contrast with the moral codes and gender roles ascribed by Christianity. As a result, the Orient was a place that not only required Western development but required occupation by civilized westerners.
According to the Orientalists, the Orientals were culturally and biologically inferior, incapable of transforming themselves, in need of redemption and a problem to be solved. The Oriental was thereby linked to powerless identities in western society such as the insane, women, the faithless and the poor (Said, 1972, 1993). Accordingly to Said, the stereotypical Oriental was therefore positioned by the Orientalists as a member of a subject race. Said uses the term ‘subject’ race to refer to the relations of power that underpinned Orientalists perceptions about colonized people’s human identity and colonized people’s subjective consciousness of their own identity.

Drawing on the work of Foucault (for example, Foucault 1982), Said (1993) explained that the discursive processes used by the Orientalists constructed Oriental peoples as subject to colonial domination. As a subject race not only were Orientals positioned as in need of colonial subjugation but, in response to the hegemonic nature of Orientalist discourses, the Orientals themselves appeared to welcome being subjected (Ashcroft et al., 2000).

The systematic construction of this stereotype and its persistence into the present day is what Said (1978) referred to as Orientalism. By virtue of colonial subjugation and now post-colonial globalization the Orient no longer exists as a place outside western influence. However, Said argued that this does not mean that the colonial stereotypes have been put aside. The Orient has neither become part of mainstream western culture, nor have its peoples gained an equal footing with the mainstream population of western nations. Instead, Said referred to the pervasive influence of the 19th Century Oriental stereotypes as latent Orientalism and contrasts this to manifest Orientalism.

**Manifest and Latent Orientalism**

*Latent* Orientalism represents unanimity, stability and durability of the unequal binary typologies of advanced/backward and dominant/subject that have survived the demise of colonialism to be carried forward into the globalized era (Said 1978). *Manifest* Orientalism is the present day stated views about Oriental society, languages, literatures, history, and sociology that are generated by latent Orientalism and are underpinned by untouchable certainties about what the Orient is (Sered, 1996). An example of the interaction between manifest and latent Orientalism that is pertinent to
this thesis is the notion of Transcultural Nursing. A commitment to the ideals of Transcultural Nursing underpins the approach used for many western interventions into non-western nursing education (DeSantis, 1988; Jayasekara & Schultz, 2006; Xu et al., 2001) and is an example of Manifest Orientalism. Leininger (1978) described Transcultural Nursing as:

An area of nursing which focuses upon the comparative study and analysis of different cultures and sub-cultures with respect to nursing and health-illness practices, beliefs and values, with the goal of generating scientific and humanistic knowledge, and of using this knowledge to provide culture-specific and culture-universal nursing care practices (Leininger, 1978, p. 33).

Transcultural Nursing underpins the present day view in nursing that cultural differences need to be scientifically understood (Leininger, 1978). Such understanding is deemed necessary in order to ensure that western nurses institute equitable relations between themselves, the healthcare and educational systems and their non-western patients and colleagues who are from countries included in the colonial ‘Orient’ (Vydelingum, 2006; Xu et al., 2001). However, whilst Transcultural Nursing features in the dominant western literature as a counter discourse to the colonial discourse of racism, nursing scholars (for example Bruni, 1988) deconstruct Transcultural Nursing to identify its latent Orientalist underpinnings. In particular, critics of Transcultural Nursing maintain that it reinforces the notion of cultural understanding as a process of differentiation of self from the ‘other’ (see for example Duffy, 2001; Mulholland, 1995; Swendson & Windsor, 1996). This is the same process that Said (1978, 1993) referred to as ‘othering’, which therefore positions Transcultural Nursing as deeply embedded in the Orientalist discourse of culture (Duffy, 2001).

The Orientalist Discourse of Culture

In Orientalism, Said (1978) deconstructed Orientalist writings to reveal an emphasis upon the question: ‘how are they different from us?’ As described earlier, Said proposed that answering this question led to a stereotypical image of the Oriental constructed according to the enlightenment binary oppositions of normal/abnormal, good/evil, right/wrong and self/other. In addition, he proposed that by constructing
others in this way, the Orientalists invented and legitimized the scientific study of culture that persists into the present day. At the same time as giving emphasis to the unique, the exotic and the unusual, the Orientalists founded culture as a ‘factual’, biologically determined, static entity. Importantly, as such an entity, culture could be, and still is, used to essentialize and categorize groups of people sharing a geographical location and physical and behavioral traits (Ahmad, 1996; Anderson 2000b).

Constructed in this way, culture positioned, and continues to position, Oriental peoples as an oppositional, marginalized ‘other’ in comparison to the normalized Occident (westerner) located at the center of civilization. Importantly for this thesis, this is the same construction of culture that dominated the literature relating to the ability of non-western nurses to comply with the competencies of the contemporary, internationally mobile nurse. Accordingly, Said’s Orientalism (1978) provides a way of identifying ‘othering’, rather than cultural difference as an explanation for Indonesian nursing education and practice being essentialized and classified as inferior to western nursing education and practice.

Once ‘othering’ has been identified, the stereotypes that underpin such essentialist classifications of Indonesian nursing can in turn be deconstructed as a reflection of unequal binary typologies that have survived the demise of colonialism. In the context of this thesis, examining the data to determine how these binaries have been carried forward into the era of globalization is compatible with my desire to develop a different understanding about how Indonesian nurses reacted to my western expertise and efforts to internationalize DIII nursing education. Moreover, deconstructing the interactions between myself and the Indonesian participants in the CJSSP as influenced by enduring colonial stereotypes is compatible with the commitment of this thesis to exposing and possibly resisting the influence of dominant discourses on perceptions about Indonesian nurses’ responses to the western initiatives of the CJSSP. It is also compatible with a commitment to expose how dominant discourses shape Indonesian nurses perceptions about themselves, their desire for western expertise and the applicability and achievability of internationalizing Indonesian entry to practice nursing education.
Orientalism as a Fabricated Construct

Also of importance to this thesis is that the survival of Orientalist derived stereotypes and the subsequent understanding of culture are explained to a large degree by the constructed nature of colonial stereotypes and their oppositional identity to a western identity that embodies qualities reflective of those occupying a place at the center of civilization. McLeod (2000) explained: “Orientalism is first and foremost a fabricated construct, a series of images that come to stand as the Orient’s reality for those in the West” (p. 41). As such the Oriental stereotype is a western representation of ‘otherness’. The Orient is not just ‘different’: it is all that the west is not. Therefore, at the same time that Orientalism creates an identity for the Oriental it defines the west as its contrasting reality. The west comes to know itself by knowing what it is not. Importantly, acknowledging the importance of the oppositional identity means that in this thesis, the constructed image of Indonesian nursing is examined not only in terms of how it renders Indonesian nurses as inferior, but also in terms of how it defines the superiority of western nursing education and my own western expertise.

Enduring Unequal Power Relations between East and West

Said (1993) maintained that latent Orientalism is an enduring feature of western civilization and is just as necessary to maintain order in a globalized world as it was in the colonial world. Progress and value are judged in terms of, and in comparison to the west, so the Orient is always the ‘other’, the conquerable and the inferior (Said, 1993). By constructing Orientals as inferior and strangely exotic, the Orientalists also constructed enduring unequal power relationships between east and west (Said, 1993). The constructions of Oriental inferiority and Occidental superiority provided the western imperialist powers with the justification for subjugating Orientals during the colonial era (Said, 1978). According to Said (1993) these oppositional images created enduring stereotypes that define the unequal power relationships between the east and west that have persisted beyond the demise of 19th Century colonization.

The persistence of such power relationships is important for this thesis. It may assist in identifying how during the CJSSP both the Indonesian nurses and I, participating in the CJSSP, constructed the ability of Indonesian nurses to comply with international standards for nursing within DIII entry-to-practice education. Based on Said’s work
(1972, 1975, 1978, 1988, 1993), these constructions are likely to be influenced by the persistence of unequal power relationships between east and west that are reflected in the regional relationships between Australia and Indonesia. For example, in his article: ‘Fear of the Dark: Indonesia and the Australian National Imagination’, Simon Philpott (2001) proposed that fear of Asia is integral to white Australian identity. He described how much of the Australian literature and public commentary deliberately stresses fundamental differences between westerners and Indonesians. Philpott proposed that the images and metaphors used to contrast Australian and Indonesian society reflect an enduringly negative view of Indonesia. Grant’s ‘Indonesia’ (Grant, 1964) provides an early example of the typical commentary that persists into the present day. It demonstrates how easily the contrast between Australia and Indonesia provides a vehicle for an enduring inequality between the two countries.

Australia and Indonesia are as diverse a pair of neighbours as it is possible to find. One is a large, flat continent, thinly populated with Caucasians professing Christianity and capitalism, essentially materialist, rational and scientific in outlook, instinctively part of the western world. The ‘other’ is an archipelago of mountainous islands, populated with Asians professing Islam and socialism, essentially mystic and irrational, instinctively opposed to western values (Grant, 1964, p.151).

Grant was a former Australian diplomat posted to Indonesia and based on such a description, it is not surprising that the foreign policy of successive Australian Government’s has seen the Australian-Indonesian relationship as an unequal partnership (Chalk, 2005). Indonesia has particularly been stereotyped as the inferior partner in human resource development projects sponsored by the Australian government. For example, the 2005 Statement to the Australian Parliament setting out the strategic direction of Australian aid to Indonesia (AusAID, 2005) described Australia as the mature partner committed to helping Indonesia progress towards achieving international development goals. Therefore, it follows that Orientalism is an appropriate conceptual tool to examine the contribution of perceptions of inequality and inferiority to my work as an Australian expert advising Indonesian nurses about internationalizing entry-to-practice nursing education.
In summary, Said identified the liberal discourses of modernism such as scientific truth, universality and humanism as underlying the constructed inferiority of the colonized ‘other’ (McLeod, 2000; Said, 1993). He also introduced the concept of unequal power relations influencing interactions between the colonizer (who occupied a powerful position at the center of modern civilization) and the colonized (who occupied a subject position on the margins of modernity). In doing so, Said (1972, 1975, 1978, 1988, 1993) situated postcolonial theory as a conceptual partner to the theoretical fields of postmodernism and poststructuralism and paved the way for the next generation of postcolonial theorists.

The Subaltern ‘other’ (Gayatra Spivak)

The work of Gayatra Spivak (1988a, 1988b, 1990, 1992, 1993) expands on the ‘subject’ characteristics of the ‘other’. She also further developed the concept of the center and the margins that describe the contrasting positions of the Orient and the west, and how these distinctions are used to classify the value of knowledge. The following descriptions of the concepts of subalterneity, marginality and centrality, which are central tenets of this thesis, are drawn from my interpretations of Spivak’s work.

Subalterneity

Whilst Said (1972, 1975, 1978, 1988, 1993) explored colonization from the perspective of imperial dominance, Spivak (1998a, 1988b, 1990) followed in the footsteps of earlier work by Fanon (1952/1967) to explore colonization from within the position of subjugation. Central to Spivak’s particular application of postcolonial analysis is her use of the term ‘subaltern’, a military term that describes inferior rank. She used the term subaltern to describe the positioning of the marginalized ‘other’ as not just defined by difference, but also defined by power relationships that position the colonized subject as inferior. The term subaltern is now widely used in postcolonial literature to refer to the subjugated ‘other’.

The concepts of ‘subalterneity’ and ‘subaltern knowledge’ refer to alternative knowledge derived from a group defined by its difference from the elite (Ashcroft et
al., 2000; Guha, 1982; McLeod, 2000). Of importance to this thesis is that a postcolonial approach to researching once colonized peoples emphasizes the inclusion of subaltern knowledge as a means of challenging dominant hegemonies and developing new perspectives on cross cultural engagements between western and non-western peoples (Browne et al., 2005). This is an important gap in current nursing research that was identified in Chapter 2. Importantly, the past and present colonization of Indonesia that was described under the section of this chapter entitled ‘Colonization’ provides an opportunity for this thesis to address this gap in existing knowledge by drawing upon Spivak’s concept of subalterneity.

The historical and contemporary context in which the CJSSP was embedded means that Indonesian nurses may be positioned as subjugated, ‘subaltern’ others in relation to the Australian nurses who acted as technical consultants to ‘develop’ DIII nursing education. The concepts of subalterneity and subaltern knowledge are therefore compatible with examining the questions of desirability, applicability and transferability of western expertise and international standards for nursing from the perspective of Indonesian nurses. To include knowledge developed from a subaltern perspective is one of the aims of this thesis and specifically prompted the formulation of the research question: Why is western expertise and compliance with international standards for nursing considered by Indonesian nurses to be highly desirable on the one hand, but on the other hand resisted, rejected and of questionable applicability?

**Marginality and Centrality**

The notion of the central and marginal contributions to knowledge is a fundamental component of postcolonial theory. Said (1993) described how the Orientalists marginalized the colonial subject by relegating peoples of particular race, religion and cultural grouping to the inferior status of ‘other’. According to Said, this marginalization also meant that the value of the knowledge belonging to the ‘other’ was denied. It was classified as irrational, unscientific and founded on superstition. Both the knowledge and the subject were relegated to the margins of influence under colonial rule.
Central and marginal contributions to knowledge are of particular importance to this thesis for generating an understanding of how subaltern knowledge both adopts and challenges assumptions of universality associated with dominant narratives. The concept of central and marginal knowledge and the tension between the two in relation to postcolonialism arises from the critique of the discourse of imperialism, the dominant narrative underpinning colonial expansion. Imperialism constructs a binary that affirms the west in a position at the center of world history and marginalizes the colonial subject into a position on the periphery where access to power is limited. In such a position, marginalized colonial subjects suffer various forms of exclusion and oppression that serve to endorse and perpetuate the structure that established their initial distance from the center (Ashcroft et al., 2000).

According to Spivak (1988a), the ‘subaltern’ is constructed by a lowly position on the margins of the structures of imperial power layered over the top of essential ‘otherness’. Spivak explored the ‘other’ from within the position of a marginalized subject as constructed according to this position of ‘inferior rank’. In particular, Spivak has examined the position of subaltern knowledge in terms of what is not said: the silences that represent marginal knowledge that has been rejected (Spivak, 1988a, 1988b, 1990).

**The Silence of the Subaltern**

When colonial narratives of western superiority are deconstructed according to the binary of center and marginal, both western knowledge and the alternative marginal knowledge that surrounds this center, can be seen to be contributing to the definition of truth (Mignolo, 2000). The difference is that the knowledge from the center contributes to the truth by being given voice, while the knowledge from the margins that does not appear in the definition of truth, has contributed by being rejected. This is similar to Said’s theory that the west only defines itself by knowing what it is not (Said, 1993).

According to Spivak (1998a, 1988b, 1990, 1993), such treatment serves to endorse and perpetuate the knowledge generated at the center as universal while at the same time classifying the knowledge generated on the peripheries as specific. Silencing the
voice of the colonized subject both reinforces the subaltern position of the ‘other’, and
denies that there can be any possibility of similarity between the center and the
margins. Spivak (1990) has suggested, however, that the dominance of the center can
be disrupted by deconstructing discourses to uncover the silent knowledge and so
separate ‘truth’ into its central and marginal components. Once separate, the
components can be evaluated in their own right (rather than constantly defined by
each other) to reveal similarities and then reconstructed to create alternative
knowledge that belongs to neither the center nor the periphery.

**Passive and Powerful Subaltern Voices**

Deconstructing the silences relating to subalternity and difference is by far the most
common way of incorporating the contribution of subaltern experiences within
nursing research and developing a new understanding of cross-cultural encounters
within a postcolonial framework. For example Anderson (2000b), Meleis and Im
(1999) and Racine (2003) are nursing scholars who used this approach. A less
common way of deconstructing subaltern narratives is to concentrate on uncovering
the meanings that are given voice by the subaltern. That is, deconstructing what the
subaltern says in terms of the relationship between this spoken narrative (as compared
to the unspoken silence) and the dominant narrative. In what is often considered a
ground breaking turn in subaltern studies (Said, 1988), Spivak (1988a) questioned
whether the voice of the subaltern does indeed represent the subaltern. If the subaltern
is speaking from the subject position that he/she occupies within the dominant
discourse, then the danger is that the subaltern voice is not differentiated from the
dominant narrative. This is a passive subaltern voice and indeed Spivak’s conclusion
that the subaltern cannot speak (Spivak, 1988a) is often interpreted to mean that the
subjugated, marginalized ‘other’ cannot voice resistance to, or rejection of, the
dominant discourse. As such, the subaltern narrative does not challenge the dominant
discourse, but instead perpetuates the oppression of the subaltern as the ‘other’
(Griffiths, 1997).

also highlighted that the interdependence of subaltern and dominant narratives can
create a space for a resistant voice as well as a passive subaltern voice. Ashcroft et al.
proposed that Spivak argued that if the subaltern is speaking within the dominant discourse, then as Bhabha’s (1994, 1998) concept of mimicry suggests, the subaltern can appropriate the voice of the elite in order to be heard. Doing so, the subaltern uses the voice of the dominant narrative but in such a way that he/she becomes powerful rather than being subverted and can appropriate power that previously resided with the dominant center (Mignolo, 2000). In fact, Sharpe (1989) argued that subalterns who resist the colonial narrative can only do so from within the dominant narrative that they are opposing. That is, the subaltern cannot resist colonization by passively withdrawing from it, but instead must actively embrace the elements of colonization that will assist resisting the colonizer. For example, Indonesian history demonstrates that the independence movement was not successful when its leaders ignored Dutch imperialist sovereignty and attempted to unite the indigenous people using narratives about Javanese entitlements to self governance. However, the Indonesian revolutionaries: Sukarno and Hatta changed this situation by drawing on their Dutch education, speaking from their positions within the Dutch administration and capitalizing upon Dutch attempts to form a single indigenous nation to govern. They appropriated the Dutch discourse of an ‘imagined community’ of Indonesians, but used it not as it was intended (to unite Indonesians under Dutch rule) but instead to unite indigenous Indonesians against Dutch rule (Anderson, 1983; Hoey, 2003).

**Exploring Subaltern Heterogeneity**

By arguing that within the position of inferiority the subaltern exists as both a subverted, silenced voice and a powerful, resistant voice, Spivak (1988a) also rejected the homogeneity of subservient groups. Identifying heterogeneity within Indonesian nurses’ responses to the CJSSP and the position from where the Indonesian ‘subaltern’ is speaking are particularly important analytical tools for this thesis. The similarities between the goals and outcome indicators within the CJSSP Terms of Reference (IBRD, 2001) and the attributes of the contemporary, internationally mobile nurse that appear in the western literature is highlighted in Appendix 2. However, one of the prompts for undertaking this thesis was that despite an apparently singular voice of acquiescence to CJSSP aims, there were different reactions to the implementation activities of the CJSSP. Therefore, Spivak’s (1988a) notion of heterogeneity of the subaltern group is particularly compatible with the
research question that explores Indonesian nurses’ simultaneous desire for and rejection of international standards applied to Indonesian entry-to-practice nursing education.

Examining the data to identify either passive acceptance of, or powerful resistance to the hegemonic influence of western nursing as heterogeneous responses to the CJSSP activities is also compatible with exploring the influence of local context upon application of international standards to the DIII program. According to Spivak (1988a), heterogeneity within the subaltern group arises from local power relationships between members of subject peoples that exist both independently of and are dependant on the colonizer’s influence. That is, power relationships within the subaltern group that were present prior to colonization continue to exist and influence passive or powerful responses to colonization. At the same time, in consideration of the dynamic nature of power relationships, colonial interference also changes these existing relationships. Groups that were once powerful may be deliberately subverted and other groups may rise to fill their place.

In the context of the CJSSP, it was possible that initiatives designed to internationalize the DIII curriculum were responded to differently by members of a group with existing power that was threatened and members of a group whose status would be elevated by compliance with CJSSP initiatives. Therefore, in this thesis, exploring how nurses who occupy different positions within the DIII program accepted and rejected CJSSP initiatives is particularly compatible with answering both the question of desirability and rejection of internationalization and the influence of the local context on the applicability and acceptability of international standards for nursing.

Moreover, if local power relations that influence compliance with or rejection of internationalizing activities are also influenced by me as a representative of western colonization, then there is another element of compatibility between Spivak’s work and this thesis. Looking for passive and powerful subaltern voices during interactions between myself as the western expert and the Indonesian nurses participating in the CJSSP would also be of use in providing an alternative way to answer the question of the transferability of western expertise. That is, it would contextualize responses to
my expertise that may be overlooked by using dominant culturalist approaches to data analysis. By acknowledging the influence of context-specific responses, postcolonial theory provides a way for me to avoid perpetuating current understandings about lack of transferability of western expertise. By deconstructing interactions between myself and the Indonesian nurses, I could avoid attributing a lack of transferability of my expertise to a static incompatibility between the western culture where my expertise was derived, and the Indonesian culture where it was to be implemented (Gustafson, 2007).

In summary, Spivak’s work (1988a, 1988b, 1990, 1992, 1993) contributes to this thesis by providing insights into the heterogeneity of the ‘other’ and the subaltern knowledge that is subsequently developed from within the experience of colonization. In contrast to Said’s concepts involving the singular, marginalized and subject ‘other’ (1972, 1975, 1978, 1988, 1993), Spivak described the emergence of an alternative, powerful postcolonial subaltern. Spivak’s powerful subaltern can resist colonization by using the knowledge derived from colonial subjugation to manipulate the center from the margins. This resistance is enacted in such a way that turns the table on the master-slave relationship. It is therefore particularly useful in exploring how as the western expert, my expertise was limited in the specific context of reforming DIII entry-to-practice nursing education. Moreover, the tension between the apparent ‘sameness’ and ‘difference’ from the colonizer that is embodied in Spivak’s heterogeneous subaltern is similar to the Indonesian nurses’ simultaneous desire for, and rejection of ‘sameness’. Yet, they also expressed resistance to internationalization.

Bhabha, the third postcolonial theorist whose work I have drawn upon to inform this thesis, proposed that such tensions between ‘sameness’ and ‘difference’ create an anxiety that runs as an undercurrent to colonial power (Bhabha, 1990). Bhabha explored this ‘anxious’ relationship as a response to psychological colonialism. The concept of psychological colonialism and the contributions of Bhabha’s concepts of mimicry, ambivalence and hybridity (Bhabha, 1983, 1990, 1994, 1997) to postcolonial theory and to this thesis are described in the next section of this chapter.
**Psychological Colonialism (Homi Bhabha)**

Bhabha (1994) proposed two phases of colonization: physical and psychological. As the name suggests, the first phase of colonization focused on the physical conquest of foreign territories. During this phase, the Orientalist stereotypes that Said (1972, 1975, 1978, 1988, 1993) described provided the justification for both physical occupation of foreign territories and subjection of foreign peoples. According to Bhabha (1994) these stereotypes were subsequently used by the imperial rationalists, modernists and liberals to legitimize the psychological phase of colonization. This phase has been described as the more insidious conquest and occupation of minds, selves and cultures (Gandhi, 1999). Bhabha also proposed that this second psychological phase of colonialism is characterized by two processes. The first was the process of emptying the colonized world of meaning. The second process focused on colonizing the different ‘other’ into sameness by replacing the pre-colonial uncivilized culture of developing nations with civilized post-colonial subjects (Nandy, 2004). However, Bhabha (1994) argued that such sameness only exists on the surface, and that the assimilation that colonization appears to achieve is instead ‘mimicry’.

**Mimicry**

The Oxford dictionary (Soanes et al., 2001) describes that in biology, mimicry refers to the close external resemblance of an animal or plant to another. As a mimic, the animal or plant takes on the appearance of another to deter predators or for camouflage. As a mimic, Bhabha (1994) explained, the colonial subject reproduces a copy of the colonizer’s behavior to become almost, but not quite, the same. As such, mimicry is “at the same time consensual and conflictual” (Bhabha, 1994, p. 86), supporting the emergence of the two voices of the subaltern described by Spivak (1990). By introducing the concept of mimicry Bhabha developed another theoretical perspective on the appropriation of dominant discourse by subverted individuals or groups.

Hall (2004) referred to mimicry as a conceptual shift whereby those who are marginalized by occupying a place outside the dominant center, become exteriorized within the circle. In this position, the mimic can look colonized, but by being ‘not quite white’ (Fanon, 1952/1967), the colonized mimic exists as a ‘dangerous other’. 
Drawing on Fanon’s work in *Black Skins, White Masks* (Fanon, 1952/1967) Bhabha (1994) described that these ‘dangerous others’ adopted such camouflaging mimicry as a subversive strategy to counteract colonization. By appearing the same, Bhabha’s colonized subjects aimed to convince the colonizer that they had assimilated and similar to their animal counterparts could deter predation. Unlike their animal counterparts, however, colonial mimics did not want to entirely escape the attention of the predator. Instead, beneath the simultaneous resemblance and menace of the colonial mimic (Ashcroft et al., 2000) there is a need to be noticed. Bhabha (1994) proposed that these oppositional desires of the colonial mimic create an ambivalence over identity.

**Ambivalence and Mockery**

As a psychoanalytical term, ambivalence refers to a continual fluctuation between wanting one thing and wanting the opposite. Adapted to postcolonial theory, ambivalence represents the simultaneous attraction and repulsion that the colonized subject exhibits towards the colonizer and the process of colonization (Ashcroft et al., 2000). In order to reconcile such conflicting desires, Bhabha (1994) explained that the colonized ‘mimic’ is not only able to resist subjugation, but is also able to adopt the behavior of the colonizer in such a way that it mocks colonial authority.

According to the Oxford Dictionary (Soanes et al., 2001): to mock is to “mimic contemptuously” (p. 830), and is a form of imitation designed to “ridicule” (p. 820) the original. Therefore, by mocking the colonizer, the colonized mimic is not subverted, but instead his/her ambivalence decanters colonial authority from absolute to partial (Bhabha, 1994). Within the partial submission of mockery there is a space for partial resistance.

According to Bhabha (1994), when ambivalence is manifest as mockery the clear cut relationship between colonial domination and colonized subservience is disrupted. The mimic slides “ambivalently between the polarities of similarity and difference” (McLeod, 2000, p. 53). For the colonial subject who is condemned to such a derivative existence, the mockery of deliberately being ‘not quite white’ is a way to express simultaneous longing and rejection. Mockery is a solution to the problem of
wanting the colonial rule without the colonial, or in the words of Mahatma Gandhi “wanting the tiger’s nature, but not the tiger” (Gandhi, 1958, p. 30). In the context of postcolonial resistance, ambivalence means that while the colonized subject submits to the power of colonial authority by mimicking colonial sameness, mockery sets this desire alongside the counter-narrative of the colonized subject. According to the postcolonial scholar Leila Gandhi (1999), mockery does so politely, but firmly declines the seduction of colonialism.

Of importance to this thesis is that together, the ambivalent nature of mimicry and mockery challenge the stereotypical representations that the Orientalists used to fix and define the colonized ‘other’. Instead of accepting the Orientalist ‘constructed’ image of the subjugated, colonial ‘other’, Bhabha (1983, 1990, 1994, 1997) suggested that colonization only appears to be successful in dominating the colonial subject. In terms of data analysis, this means that alongside Spivak’s work, Bhabha has provided another way to deconstruct Indonesian nurses’ responses to the activities of the CJSSP. The concept of deceptive appearances is particularly relevant to deconstructing CJSSP initiatives to reform the DIII program in the context of apparent similarities between Indonesian and western entry-to-practice nursing education. By examining these similarities for evidence of mimicry and mockery, rather than assuming that they represent compliance with international standards, a subaltern perspective on the applicability and acceptability of international standards for nursing may be made visible.

Also of importance to this thesis is that Bhabha not only identified an ambivalent response to colonization on the part of the colonial subject, but put forward the view that colonizers themselves also have an ambivalent attitude towards the colonized subject. According to Bhabha (1997), colonizers also exhibit simultaneous attraction and repulsion for the colonized subject to become an exact replica of themselves. This means that while on the surface colonizers may represent the ambivalence of the colonized subject as an undesirable response to colonization, underneath this representation of partial reproduction of colonial assumptions, habits and values is also welcomed. For example, Dutch colonials bemoaned the lack of uniform adoption of the Dutch language across the different cultural groups within Indonesia. However, they were at the same time grateful that only the members of elite Javanese society
were able to speak the language of their European colonizers. If Indonesian people had uniformly adopted Dutch language in preference to their own indigenous dialects, then, the Dutch would have had to deal with both a population who resembled themselves much more than was comfortable and a united opposition that threatened Dutch sovereignty (Malik, 1980).

Therefore, colonizers are not blinded by a desire to produce compliant subjects to the extent that they are willing to accept mockery and risk the creation of sites of resistance. Colonizers overwhelmingly seek to maintain an unequal balance of power. Therefore, consistent with the colonial and neocolonial discourse of development, colonization is limited by the value it has to the colonizer. That is, colonizers are not prepared to risk empowering colonial peoples to achieve a level of development whereby the colonized can resist subjection. In the words of Ashcroft et al. (2000), if colonization is too successful, it “would be too threatening” (p. 13). Colonizers therefore are more comfortable with partial reproductions of themselves.

According to Bhabha (1997), resistance to the colonized subject becoming a mirror image of the colonizer by both the colonized subject and the colonizer places the relationship between the imposter and the genuine article in a constant state of ambivalence. On the surface, both parties want the mimic to be the same as the original, but underneath both players know that the power of the lead actor and the resistance of the understudy can only be preserved by a subtle difference (Bhabha, 1994). Importantly, in the context of this thesis, Bhabha’s concepts of mimicry, mockery and ambivalence provide an opportunity to further explore the voice of the powerful Indonesian subaltern. For example, appropriation of the voice of the dominant center can be seen in the wording of the Terms of Reference for the CJSSP (IBRD, 2001). However, during my interactions with Indonesian nurses prior to commencing this thesis, their desire to comply with the competencies that define the contemporary, internationally mobile nurse appeared to be offset by resistance to wholesale adoption of international standards for nursing within the DIII program.

Similarly, when reflecting on my exposure to the context of Indonesian nursing prior to commencing this thesis, I was not convinced that Indonesian nursing needed to unreservedly adopt the dominant image of the nurse. Bhabha’s concept of
ambivalence therefore, provides a way to unpick both the Indonesian nurses’ and my perceptions of the acceptability of responses to specific initiatives of the CJSSP. The concept of ambivalence can be used to deconstruct how these perceptions influenced how success and failure of CJSSP initiatives to internationalize the DIII program was constructed by the Indonesian nurses and myself. It also enables the development of alternative knowledge about the factors that influenced transferability of western expertise within the specific non-western, once colonized setting of Indonesian entry-to-practice nursing education.

Hybridity

In trying to do two things at once – creating a colonized subject that is similar to, yet different from the colonial imposed culture, the colonial subject and the colonizer together open up a third hybrid space of cultural identity. Bhabha called hybridity the “third space of enunciation” (1994, p. 37). As a third space, Bhabha’s ‘space of enunciation’ was representative of a blending of the first and second spaces of ambivalence: the ambivalence of the colonial subject and the ambivalence of the colonizing force respectively. Within this space ambivalence creates a hybrid culture that resists and has the potential to reverse the imperialist structures of domination in the colonial situation (Young, 1995). In this sense, hybridity does not embrace the notion of equal cultural exchange. Indigenous culture is not entirely retained - the power imbalance between the colonizer and the colonized is too great for this to be possible.

According to Bhabha (1994), the space within which hybridity takes place therefore is on the border of the shared ambivalence experienced by both the colonizer and the colonized. By virtue of the tensions created by ambivalence on this border between the colonizer and the colonized subject, hybridity becomes an inevitable form of disruption to the homogeneity that colonialism seeks to achieve. As such, hybridity undermines the authenticity of the imposed colonized culture. What is more, the hybrid culture that arises at such points of resistance is characterized by a cultural impurity that has the potential to counter the exoticism of the ‘other’ that is embedded in modern liberal notions of cultural diversity (Reimer-Kirkham & Anderson, 2002).
The concept of hybridity, therefore, offers an alternative (postcolonial) theoretical perspective to move beyond the colonial constructions that divide peoples and knowledge belonging to the dominant center, and peoples and knowledge belonging to the inferior margins. It challenges the agenda for global homogeneity and cultural consistency by opening up a space within which cultural difference and heterogeneity can operate (Culley, 2006). By introducing the concept of hybridity, Bhabha (1994) therefore also provided a model for resolving the tension between mimicry and ambivalence and the power play between the marginalized and the dominant group. By proposing a blending of the two players into a new, hybrid personality, Bhabha’s (1994) third space provides a place from which a new discourse and alternative knowledge that transcends the polarities of colonial encounters can emerge (Bhabha, 1994; Gandhi, 1999).

In Chapter 2, I proposed that existing research, while identifying the reduced capacity of non-western nurses to comply with international standards and the limited success of western interventions to improve this capacity, largely fails to offer any solutions to this situation. Hybridity creates possibilities for an alternative conceptualization of the engagements occurring within the CJSSP. Rather than assume that instances of incompatibility between western and non-western nursing represent failure, the notion of hybridity can be used to examine the data for instances where such incompatibility instead creates opportunities to improve Indonesian entry-to-practice nursing education. By examining examples of such success in Indonesian nursing education for their hybrid components, postcolonial theory can generate new understandings about the appropriateness of international standards for improving nursing education in the specific local context of Central Java, Indonesia. At the same time, examining these examples of hybridity provides a space for rejecting dominant hegemonies and reconceptualizing these engagements as legitimate challenges to the authority of western expertise.

**Conclusion**

In this chapter I have identified postcolonialism as a theoretical perspective that is compatible with the intention of this thesis to explore the questions of desirability, applicability and acceptability of western expertise and international standards for
nursing outside my pre-existing view from the western center. By situating Indonesia and Indonesian peoples as a once colonized nation and the CJSSP as a neocolonial ‘development’ endeavor, I have highlighted the particular synergy between postcolonialism and the generation of such alternative knowledge. That is, I have identified that postcolonialism provides a way for me to challenge dominant discourses surrounding preparation of the contemporary, internationally mobile nurse that take into account the specific context of DIII nursing education. In particular, postcolonial theory provides a framework for exploring the interactions between Indonesian (non-western) nurses and myself (as a western nursing expert) who by virtue of our participation in the CJSSP occupy a shared historical space of development. Drawing on the work of Said, Spivak and Bhabha, I have identified that this shared historical space has been marked by the violence and ambivalence of colonialism and unequal power relations between western and non-western peoples. In turn, I have identified the different perspectives these postcolonial scholars potentially contribute to deconstructing interactions that occurred within the CJSSP. The next chapter presents the conceptual and practical elements of the ethnographic methodology employed for this thesis and defends the choice of ethnography as a methodological approach for the thesis and its compatibility with postcolonial theory.
Chapter 4

Mapping the Territory

Introduction
This chapter emphasizes the importance of examining place, space and landscape, and involving once-colonized people when planning and conducting research in a previously colonized nation (Radcliffe, 1994). The chapter begins by describing the essential components of an ethnographic method. Tensions between ethnography guided by traditional positivist science, and the postmodern influences on postcolonial ethnography, are explored. The preparation undertaken prior to commencing this thesis; the participants involved in the research; and the data collection techniques of participant observation, interviewing, and document review, are presented. The cyclic nature of data collection and data analysis is described and the specific use of postcolonial theory as an analytical framework is explained. Ethical considerations and the influence of postcolonial theory on each aspect of the research process are highlighted.

Ethnography as Methodology
Ethnography is traditionally defined as a methodology of scientific inquiry to describe and understand the unique nature of peoples and cultures (Leininger, 1985). The word ethnography is derived from two Greek words *ethnos* (people) and *graphein* (writing). In combination, these two words refer to a way of collecting, analyzing and representing information about human lives (Vidich & Lyman, 2000). Using traditional modes of ethnography, data are collected through observing behavior in the natural environment (context) of the studied population. These observations are recorded as field notes to identify meanings. Interpretations are tested and confirmed by successive observations. Participants are also interviewed and documents reviewed to further validate findings. Similarly, the validity of interview data is verified through repeated observation (Bruni, 1995). According to Hammersley and Atkinson (1983), such ethnographic methods mimic common sense ways of understanding the experience of living that humans have engaged in since the beginning of time.
Ethnographers do not ‘test’ theories under experimental circumstances. However, by converting common sense into a scientific method ethnographers do employ specific procedures to produce reliable empirical data about the behaviors of groups of people within specific settings (Hammersley & Atkinson, 1983). Ethnographers participate in the culture that they are trying to understand. By entering into first hand interactions with people in their everyday lives, ethnographers have access to an understanding of the beliefs, motivations and meanings that underpin behavior, which cannot be gained from second hand accounts (Tedlock, 2000). Such empirical data are particularly valuable in situations where the purpose is to develop an understanding of how groups interact with, adapt to, and participate in larger political and economic systems (Chambers, 2000).

Ethnography appears to be particularly compatible with this thesis. The literature review demonstrated that little empirical data exists on the specific influence of the context in which non-western nursing takes place. In collecting data for the thesis, I had the opportunity to directly observe Indonesian nursing activities from within the natural context. The research questions of this thesis arose from a desire to make sense of the everyday behavior and interactions between myself as a western expert and the Indonesian participants who represented a specific group of nurses. I was not testing a hypothesis. I was not able to ‘make sense’ of the Indonesian nurses’ simultaneous desire and rejection of western expertise and compliance with international standards for nursing from the ‘second hand’ data provided in the initial reports from the CJSSP and reports from previous projects (for example DONMT-WHO, 2002; Hennessy, 2001; Rahim-Hillan, 2002). Moreover, these interactions represented local responses to global economic and political forces that could not be understood from a position on the outside, looking in as a remote, ‘outsider’ researcher (Mohammed, 2006).

**Tensions between Ethnography as Methodology for the Thesis and Postcolonialism**

Despite such apparent compatibility with this thesis, there are also significant tensions between an ethnographic methodology and a postcolonial approach to developing new understandings about nursing in the non-western, once-colonized setting of Central Java, Indonesia. In particular, the historical underpinnings of ethnography have
positioned ethnographers as complicit in maintaining dominant western hegemonies. The social anthropologist Malinowski (1961) is credited for claiming ethnography as a scientific strategy. However, like the Orientalists before him (Said, 1993), Malinowski and his 20th Century contemporary ethnographers produced objective, colonizing accounts of field experiences that reflected the positivist, scientific paradigm of studying the strange, foreign, alien ‘other’ (Rosaldo, 1989). Importantly, being simultaneously imbedded in, but separate from the culture in which their research took place, Malinowski and others claimed to capture the essence of participants’ experiences and report on understandings of people’s behavior more accurately than the insider participants could report themselves (Bruni, 1995).

It would appear then, that there are tensions between ethnography as a research methodology and this thesis as a postcolonial project. Traditional forms of ethnography may serve to reinforce colonial notions of culture as static. It could sustain marginalizing definitions of Indonesian nurses according to their difference from western nurses and support western nurses’ claims to both know and speak on behalf of the ‘other’. In the context of this thesis, an ethnographic approach founded on such traditions would not disrupt dominant knowledge, but instead would potentially perpetuate the colonizing endeavor of western science in nursing. It may also reinforce the liberalist notions of the exclusive position of the researcher as a rational, scientific, independent witness who can objectively interpret data and subsequently describe the meanings, intentions, motives, attitudes and beliefs that underpin the behaviors of the studied population (Meleis & Im, 1999).

Despite such tensions, postcolonial scholars are increasingly embracing ethnographic approaches (for example, Anderson, 2000a, Anderson, 2000b; Anderson, Reimer-Kirkham, Browne, & Lynam, 2007; Mohammed, 2006; Racine, 2003). Rejection of the positivist and imperialist foundations of ethnography has been made possible by the influence of postmodern and poststructural theories on ethnographic research methods. Under these influences, ethnography has evolved over time so that located in the current historical context ethnography has been reconstructed in a way that distances itself from its colonial foundations. Accordingly, whilst postcolonialism is a theory in its own right, postcolonial ethnographic research draws heavily on the postmodernist foundations of postcolonial theory. For example, the reflexive
components of postmodern approaches to research are used by postcolonial ethnographers to acknowledge the voice of the other. They are used to decenter knowledge production as an objective endeavor, which in traditional positivist ethnography denies the researcher’s own historical, political and socially located influence. Postcolonial ethnography also draws upon postmodernist research traditions to acknowledge alternative, multiple, and partial constructions of reality as opposed to seeking to reinforce dominant hegemonies by uncovering universal truths (Anderson & McCann, 2002).

The next section of this chapter describes the influence of postmodern perspectives on ethnography and in turn, the opportunities that this creates for postcolonial ethnographers. Consideration is given to how postcolonial theory influenced each component of the research process used in this thesis.

*Postcolonial Ethnography as a Postmodern Construct*

According to Denzin and Lincoln (2000) ethnography has undergone six stages of transformation since the days of Malinowski. They referred to these stages of transformation as “historical moments” (Denzin & Lincoln, 2000, p.12). Importantly, transformation has come about by progressive rejection of the positivist foundations of ethnography. The most significant disruption occurred in the 1970s when ethnographers embraced postmodern perspectives (Hammersley & Atkinson, 1983). Postmodernism rejects the meta-narratives of scientific certainty, rationalism, universality, order, and objectivity (Grbich, 2004), which underpinned both traditional ethnography and colonization. Instead, postmodernism sees the world as fragmentary, discontinuous and chaotic (Culley, 2006). The postmodern world is occupied by human beings who make sense of such chaos by being concretely situated and “historically engaged with others under particular social, political and cultural conditions” (Lumby & Jackson, 2003, p. 152). This view of the world has particular implications for the postmodern ethnographer, the first of which is to challenge the positivist notion that there is a single truth that can be uncovered through scientific research.
Disputing notions of discovering truth

The ethnographers of Denzin and Lincoln’s (2000) first and second moments disregarded the positivist notion that universal truths can only be derived from experiments where quantitatively measured variables are manipulated in order to identify relationships (Hammersley & Atkinson, 1983). However, the ethnographers of these first and second moments did not completely escape the influence of positivism. Instead, they claimed that the formal rules they put into place to govern ethnographic research ensured that data were ‘real’ and produced unbiased facts that represented reductive, causal explanations of cultural phenomena (Bruni, 1995). The findings of ethnographic research therefore, could be considered to be equally valid scientifically derived truths as those facts derived from quantitative research methods. Starting from Denzin and Lincoln’s third historical moment however, ethnographers began to dispute the existence of a single truth. Instead, influenced by philosophers such as Nietzsche, Derrida and Foucault, they conceptualized truth as multiple realities that are constructed by the individual occupying a particular contextual and discursive space (Lumby & Jackson, 2003). Such constructed truth is inextricably linked to dominant discourses of power within society (Foucault, 1980).

For the postcolonial ethnographer, such a perspective on truth legitimizes a departure from ethnographies influenced by the imperialist binaries of inferior/superior, civilized/uncivilized and notions of the static, bounded cultures (Culley, 2006). It rejects the idea of a singular truth about cultural identity (May, 1999), emphasizing instead an identity that is constructed by both the researcher and the researched, whose everyday experiences derive meaning from discourses within the context in which they are embedded (Racine, 2003). The multiple realities of everyday life experiences render culture as “constantly made and remade, ever changing, fluid and shifting” (Culley, 2006, p.148).

For this thesis, such a re-conceptualization means that there can be no single truth about the relationship between western and non-western cultures. Nor can such a single truth account for the relationships between western and non-western nursing and in turn Indonesian nurses and western nursing experts engaged in a project to internationalize Indonesian nursing. Adopting an ethnographic methodology informed
by such a theoretical perspective instead recognizes that multiple truths can exist side by side. My research endeavor could move away from the traditional approach of stereotyping responses and searching for immutable, cultural differences between Indonesian nurses and their western counterparts. Instead, as a postcolonial ethnographer I held a healthy respect for the partiality and contextuality of truth. I could explore the everyday experiences that construct Indonesian nurses and myself as embedded responses to the complex interplay between the local and global social, political, and economic world as they were occurring in the specific historical moment as we engaged in a project to internationalize Diploma III (DIII) nursing education (Racine, 2003).

Importantly, this focus also meant that I was not exploring the culture of Indonesian nursing that was fixed to a pre-colonial time, waiting to be discovered as a naturally occurring phenomenon when I commenced this thesis (Mohammed, 2006). Instead, Indonesian nursing was constantly being constructed. The responses to the CJSSP therefore reflected the local and global discourses and power relationships that influenced the specific encounter between western and non-western nurses and me as both a participant in the CJSSP and the researcher. Therefore, adopting the position that truth is both partial and contextual meant that not only could I break free of the notion of culture locked in a fixed historical moment (Mohammed, 2006), but that I could also break free of the traditional position of the ethnographer as a disembodied subject who objectively and impartially uncovered such truths (Hammersley & Atkinson, 1983).

*Rejecting the notion of researcher objectivity*

Central to the scientific process of discovering truth in traditional ethnography was a necessary dualism that separated mind/thinking (object) and body/actions (subject). By putting into place measures to control subjectivities such as feelings, emotions and reactions, the researcher, as a single unitary identity could at the same time participate bodily/subjectively in the foreign natural setting while remaining an objective outsider (Descartes, 1912; Hume, 1777/1975). The separation of subject and object guaranteed value-free observation and a ‘God’s eye’ view from which the world can be converted into indisputable facts (Haraway, 1991). However, the ethnographers of Denzin and
Lincoln’s (2000) fourth historical moment rejected such a position and instead developed an increasing awareness of how the researcher affects the research process, research outcomes and research report. If ethnographers could portray people as constructing the social world through their interpretations of it and their actions based on such interpretations, Geertz (1973, 1983) proposed that there was also a considerable likelihood that the research descriptions were not objective reports on phenomena removed from the researcher’s influence. Instead, unable to adopt a single unitary entity of either insider (subject) or outsider (object), the researcher as both insider and outsider influences and is influenced by the researched (Merriam, Johnson-Bailey, Lee, Kee, Ntseane et al., 2001). Such a perspective also means that the studied culture can never be written about in a neutral way, but instead, the research report is based on the location from which cultural phenomenon is viewed (Mohammed, 2006).

Therefore, under the influence of postmodern theory, the postcolonial researcher no longer lays claim to developing knowledge or producing a text that is based on insights into naturally occurring phenomenon that are independent of his/her influence or interpretation. For the postcolonial ethnographer, this means a move from objectifying the culture of the studied population as independent of the researcher and resisting engaging in ethnography as a colonizing activity (Prior, 2007). Instead, the postcolonial ethnographer should be both aware and raise awareness of the influence of the binary constructions of east and west, inferior and superior, civilized and uncivilized (Said, 1993). Applied to this thesis, it was important to recognize that such binaries positioned me and the research participants in relation to each other.

It was also important for me to consider that the western, dominant hegemonies and dominant discourses embedded in the contemporary image of nursing were likely to be positioned as the taken-for-granted, centered norm (Reimer-Kirkham & Anderson, 2002). Therefore, the way in which the Indonesian participants in the CJSSP and I measured ourselves and each other against the benchmark of the contemporary, internationally mobile nurse was likely to flow over into our interactions as researcher and research participants. Accordingly, the interactions between me and the research participants were included, not removed from the research data. How dominant hegemonies influenced my interpretation of the data were also brought to the
foreground, as part of the analysis rather than eliminated as researcher bias. This foregrounding did not occur naturally, however, so to do this I adopted reflexive strategies and made deliberate attempts to challenge dominant hegemonies by elevating marginalized knowledge to a central position within this thesis.

*Reflexivity*

Rather than distorting the ability to experience the reality of the research participant (Hammersley & Atkinson, 1983), acknowledging the researcher’s multiple subjectivities helps the researcher to avoid imposing the researcher’s reality on interpretations of the experiences of the researched (Merriam et al., 2001). For example, my subjectivity was created by discursively constructed knowledge about myself that was both subject to control and dependence on others and my own interpretation of self (Foucault, 1982). Some of the positions available to me within this research included: a senior academic with responsibility for curriculum development and academic administration within my own institution; a nurse educator colleague to the Indonesian Dosen participants; a former teacher to some Dosen who also participated in the HPV fellowship; a doctoral candidate; and an Australian expatriate living both my professional and personal life day-by-day in an unfamiliar non-western environment. Most importantly, I was also positioned as a western nursing expert and potential colonizer.

For the postcolonial ethnographer locating the process of ethnographic research as inevitably reflecting the prejudices and pre-understandings of the ethnographer as a cultural interpreter acknowledges these multiple subjectivities and provides a way of resisting engaging in ethnography as a colonizing activity (Mohammed, 2006). Applied to this thesis, such a reflexive position meant acknowledging my positioning as an ‘outsider’ researcher, and ‘outsider’ westerner influenced by colonial discourses and binary constructions that position east and west, as inferior and superior, uncivilized and civilized respectively (Merriam et al., 2001; Said, 1993). It also meant acknowledging that I was also researching my own interactions with CJSSP participants wherein I occupied the position of a western expert that supported the dominant western hegemonies surrounding the image of the contemporary, internationally mobile nurse. In such a position, western hegemonies and dominant
discourses embedded in the contemporary image of nursing were likely to be replicated as the taken-for-granted, centered norm by myself and accepted without question by the research participants (Reimer-Kirkham & Anderson, 2002). For example, as the western nursing expert, I embodied the image of the contemporary, internationally mobile nurse as constructed by the dominant thinkers and producers of ideas in nursing. Without intentionally doing so, my interactions with Indonesian nurses reinforced how the western nurses that constructed the dominant image of the contemporary, internationally mobile nurse expected all nurses to see themselves (Davis, 1999). Accordingly, the influence of these discourses on the interactions between the research participants and me were included, not removed from the research data. How the dominant discourses of liberalism and humanism, which underpin both the Orientalist construction of the other and the western hegemonic construction of the contemporary, internationally mobile nurse, influenced my interpretation of the data was also brought to the foreground as part of the analysis. These influences were neither denied nor eliminated as researcher bias as would occur if this thesis was formulated within a positivist paradigm and conducted according to traditional ethnographic conventions.

In adopting a reflexive position I also needed to acknowledge my location as an ‘insider’. I could identify with the participants as fellow participant in the CJSSP, an ‘insider’ nurse and ‘insider’ nurse teacher. I was also an ‘insider’ by virtue of being subject to the contextual influences of being embedded in the everyday life of the DIII program and therefore the unique social, political and environmental conditions that constructed everyday life in Central Java, Indonesia. Rather than being in danger of ‘going native’ as ethnographers of Malinowski’s time feared (Hammersley & Atkinson, 1983), I adopted instead the postcolonial stance of connecting my understandings of the contextual factors that underpinned being embedded in the local situation to the contextual factors that underpinned constructions of Indonesian nursing.

From a postcolonial perspective, this meant that I could use my insider position to develop knowledge that challenged the dominant hegemonies of differences between western and non-western nurses as attributed to static, culturally bound behaviors. This approach is consistent with Denzin and Lincoln’s (2000) fifth historical moment.
of ethnography where the postmodern perspective replaces the search for grand
narratives with “local, small scale-theories fitted to specific problems and particular
situations” (p. 17). That is, I was not searching for understandings about Indonesian
nursing that could be universally applied to non-western nurses participating in
nursing as a global, professional scientific discipline. Instead, I was searching for an
understanding about how the specific circumstances of entry-to-practice education in
Central Java Indonesia influenced some seemingly incongruent responses to the drive
for global consistency in nursing demonstrated by the participants in the CJSSP. The
commitment to include the voice of participants in this thesis is also consistent with
Denzin and Lincoln’s fifth historical moment.

**Giving voice to the research subject**

By attempting to develop an understanding of Indonesian nursing from an insider
position I did not assume the traditional position of claiming to represent the voices of
the Indonesian participants. Importantly, reflexivity also removes the absolute
authority of the ethnography over claiming complete understanding of the researched
and producing authoritative accounts whereby the researcher can speak on behalf of
the researched (Tedlock, 2000). Accordingly, I paid attention to the voices of the
participants themselves as important contributors to knowledge development, rather
than as marginalized subjects of the research process (Meleis & Im, 1999). These
previously marginalized voices were also deliberately included in the text. Such
strategies represent a significant move away from the traditional, colonial
ethnographies where the voices of the ‘natives’ were considered to contaminate the
data and were excluded from ethnographies to preserve authority of the author
(Geertz, 1973).

Importantly, the practice of including marginalized voices in research conducted by
postcolonial scholars also acknowledges the multiple subjectivities of the research
participants (Spivak, 1990). In particular, a postcolonial approach demands that
researchers avoid the colonial practice of assuming that all research participants exist
within one homogenous ‘other’ group. Instead postcolonial researchers are
encouraged to deconstruct participants’ responses to colonization in a way that
acknowledges the heterogeneity of people positioned within subservient groups
(Spivak, 1988a, 1988b, 1990). Such deconstruction was particularly useful in this thesis. It enabled me to uncover how the persistence of power relationships beyond their colonial foundations influenced everyday practices and responses to CJSSP initiatives. It provided a theoretical basis for a departure from traditional ethnographic techniques that exclude the subaltern knowledge that was so important from a postcolonial perspective to gain insights that cannot be gained from ‘centered’ or dominant positions (Racine, 2003). How a commitment to such a perspective and other departures from ethnography as a colonial endeavor influenced the practical conduct of this thesis is described in the following sections of this chapter.

The Fieldwork of this Thesis
This section of the thesis provides details of how a commitment to postcolonial scholarship shaped my preparation for the ethnographic research, selection of the research sites, gaining access to the research sites, gaining ethical approval, and recruitment procedures. It also describes the characteristics of participants and the richness of data that arose from such a commitment.

Research Preparation: Learning About Indonesia and Learning Bahasa Indonesian
In preparing for this thesis, I wanted to enter the field with as much understanding of the Indonesian context of nursing as possible. From a postcolonial perspective, this meant possessing a thorough understanding of Indonesia’s colonial history so that I could develop insights into how this potentially affected present day interactions between participants as they were situated in the Indonesian context and me. I was also particularly aware that much of what is written about Indonesia embodies the colonist practices of emphasizing Indonesia’s difference from the western world, and closer to home, difference from Australia (Philpott, 2001). In recognition of such biases, I attempted to read western authored information about Indonesia using the strategies of postcolonial literary critique that acknowledge the position from which the author writes (Young, 2003). Having Philpott’s (2000) alternative reading of Indonesian history, his 2001 paper and Burke’s (2000) paper, to read alongside the dominant texts (such as Cribb, 2000; Grant, 1964; Kingsbury, 1998; Ricklefs, 1993)
were useful in this endeavor. Whilst the dominant texts highlight the discourses of Indonesian strangeness that dominate Australian constructions of Australian-Indonesian relations, the work by Philpott and Burke drew my attention to the influence of Orientalist discourses upon such constructions of Indonesian people and Indonesian history.

I also read as much Indonesian authored literature as possible. However, this presented significant difficulty as very little of this material is written in English. Although I was committed to learning the national Indonesian language (Bahasa Indonesia), it was impossible to do so to the necessary level to translate much of this literature prior to entering the field. Importantly, my motivation for learning Bahasa Indonesia was not based on Malinowski’s (1961) recommendation that ethnographers should learn the ‘vernacular’ in order to think like the object of study. Nor was my primary motivation for learning to speak the Indonesian national language related exclusively to the advantages of limiting the use of interpreters (Birbili, 2000). Instead, in line with positioning this thesis as a postcolonial project, my commitment to learning Bahasa Indonesia was one of the strategies I adopted to decenter my position as a representative of nursing’s western centre.

English is the dominant language of nursing globally (Davis & Tschudin, 2007) and is purported to unify the profession (Krozy & McCarthy, 1999). Therefore, limited English language fluency often constructs nurses from non-English speaking backgrounds as inferior to western nurses (Hagey, Choudhry, Guruge, Turruttin, Collins et al., 2001). Research into the experiences of American scholars employed in Japan however, illustrated that the connection between language competency and marginalization also occurs in reverse (Furuta, Petrini & Davis, 2003). These English speaking nursing scholars experienced significant marginalization when employed in a non-western country where English was not the dominant language. Therefore, in this thesis, I denounced the colonizing processes of English language by using my beginning proficiency in Bahasa Indonesia to place myself in a marginal position in relation to the Indonesian nurses who were fluent in this language.
Research Sites

The work plan of the CJSSP (IBRD, 2001) involved the Australian technical consultants conducting workshops for the Indonesian participants. The workshops were followed by site visits by the consultants to support application activities designed to consolidate and apply the participants’ new knowledge and skills. ‘On-the-job training was also included in the work plan. This training involved the consultants supporting specific individuals to implement changes to the curriculum, new teaching and learning methods, and to develop clinical competencies. The research sites included the classrooms and nursing laboratories of six government AKPER (nursing academies), wards and departments within five government Rumah Sakit Umum (general hospitals), and one government Puskesmas (community health centre). These were the sites where both the theoretical and practical elements of DIII nursing education took place and where the CJSSP was conducted. The Office of DinKes (Provincial Health Office) where the Indonesian members of the CJSSP Management Committee were located and management meetings took place was another research site. Interviews and participant observations were also conducted at the CJSSP Office, which was the base for the consultants and the venue for some of the workshops. The final research sites were three purpose specific conference venues where six workshops were conducted.

These research sites were widely dispersed, located on the eastern, central and western north coast; the eastern and central highlands; and in the south east of the province. Accordingly, they represented the breadth of environmental and socioeconomic conditions in Central Java. Of relevance to data collection was that travel between sites took between two and seven hours. As I was always accompanied on these journeys by one or more of the Bilingual Secretaries, with or without Ministry Officers, the CJSSP car also became a site where data were collected.

The size of the AKPERs ranged from the smallest with 240 students to the largest with 515 students. Staffing levels were not directly proportional to student numbers with the lowest number of teaching staff at a single AKPER being 48 (a ratio of 9.4 students to 1 staff member) and the highest 68 teaching staff members (representing a ratio of 3.5: 1). Indonesian hospitals are classified according to their ownership, size
and services provided. All of the clinical sites were government owned, but represented three different types. One Type A hospital was included as a research site. Type A Rumah Sakit have between 750-1000 beds and are located in the capital city of a province. They represent the highest level of referral and provide broad specialist health services (Azwar, 1996). Two Type B hospitals were included in the clinical research sites. Type B Rumah Sakit have between 400-700 beds and are located in regional cities. The two Type B hospitals included in the study provided a maximum of 11 specialty services, including surgery, emergency medicine and adult and neonatal intensive care units. However, patients with specific illnesses, or requiring specific diagnostic services were referred on to Type A Rumah Sakit (DepKes RI, 1986).

The remaining three sites were Type C hospitals. A Rumah Sakit Type C is a hospital established in a regional town that provides inpatient and outpatient general medical, surgical, pediatric, and maternity health services (Azwar, 1996; Shields & Hartarti, 2003). The three Type C hospitals included in the study ranged between 100-400 beds, had limited emergency services, and no facilities for critically ill patients (Badan Pusat Statistik (BPS) Propinsi Jawa Tengah, 2000).

One Puskesmas was also included as a research site. Puskesmas were community health centers where a multi-disciplinary team provided inpatient and outpatient services including ante and postnatal care, uncomplicated medical care (particularly management of gastroenteritis in children) and minor surgical care such as hernia repairs and minor gynecological procedures (Shields & Hartarti, 2003). Due to the low allocation of gross national product for health spending (Marzolf, 2002), all of these sites operated on a user pays system. This meant that ‘users’ paid for their bed, nursing and medical services, food, linen, pharmaceuticals, and any other equipment or supplies required to implement nursing and medical care (Aitken & Seibold, 2003; Shields & Hartarti, 2003).

The potential research sites were dictated by the Terms of Reference of the CISSP (IBRD, 2001). I decided to include all sites where the CISSP took place in the research and not limit the research to one or two sites. My intent was to sample as broadly as possible to allow for the widest range of perspectives and provide
opportunities for the multiple voices of the participant groups to emerge (Spivak, 1993). Accordingly I felt that the sites would enable me to collect data on a range of experiences and interactions. I believed the diversity of responses to internationalization of the DIII program arising from these sites would minimize the risk of me producing a colonizing, stereotypical account of Indonesian nursing.

_Gaining Access to the Research Sites_

Whilst I had access to the field by virtue of my insider role as one of the Australian nursing consultants providing western expertise to the CJSSP, I required approval of the Head of DinKes (the Provincial Ministry of Health) to gain access for the purposes of research (Appendix 3). Gaining access to individual sites was subsequently facilitated by formal letters of introduction from DinKes that described my role as both a researcher and CJSSP participant. Students who had completed or were nearing completion of their Master’s degrees at each site were particularly keen to facilitate my data gathering.

Gaining approval and subsequent access was made easier by the fact that I was known to the Head and staff of DinKes and many Dosen at the research sites. For four years prior to commencement of this thesis we were jointly engaged in the HPV fellowship program whereby Dosen from Central Java AKPER studied for Master’s degrees at the Australian University where I was employed. During this engagement, I held a leadership and teaching role and supervised students’ research while they were engaged in the HPV fellowship program. My involvement with the Head and staff of DinKes had included collaborative selection and development of coursework subjects and the research component of the Master’s program. Two visits by DinKes staff were also made to Australia. During this time our shared interest in researching initiatives to improve Indonesian health practitioner education had been discussed and we had established collegial relationships. I had also established my credibility as a researcher and gained respect for following DinKes procedures by collaboratively designing and then supervising research projects for Master’s students that took place within clinical and academic sites under DinKes control. Findings had also been regularly reported back to DinKes staff.
My involvement in the Master’s level research was perceived by both DinKes and the alumni as beneficial to health service delivery within the province. From a postcolonial perspective, this thesis therefore built upon an initial relationship with the research field that illustrated my desire to avoid replicating the abuses of colonial researchers. Instead I had established a commitment to investing time in, collaborating with, and giving back to the community within which the research took place (Mohammed, 2006).

**Recruitment Procedures**

Due to delays in ethics clearance, participant recruitment began three months after the CJSSP had commenced. By this time I was well known to all potential participants. Recruitment occurred by first verbally informing the participants about the research, then providing this same information as a plain language statement document (Appendix 4 or 5). Potential participants indicated their desire to volunteer to participate in the research by signing a consent form (Appendix 5 or 6). All verbal and written information used to recruit participants in this way was provided in both English and Bahasa Indonesia. In line with a postcolonial approach, the translations of written materials that I produced were attended to by Dosen who were potential participants and who were encouraged to use this opportunity to influence the methodological procedures of the research.

I also selected Dosen to translate the materials based on their high level of English language competency and familiarity with research procedures. These capabilities were known to me through their participation in the HPV fellowship program. Each translation was conducted by two people and then verified by two additional people with bilingual skills (Appendix 8). Information about the research or the CJSSP that was produced in Indonesian by DinKes was translated by the Bilingual Secretary into English for me to verify.

There were seven cohorts of participants in this study: Dosen, AKPER Directors, Clinical Instructors, Kepala Bangksa (ward nurse managers), Ministry of Health Officers, Bilingual Secretaries (interpreters) and students. Except for the student group, all participants were employees of the provincial or national Ministry of
Health. There were some shared recruitment procedures and some procedures were individualized to the specific cohorts. The specific methods of recruitment are described in the next sections of this chapter.

**Recruiting Dosen, AKPER Directors, and Kepala Bangksa participants**

Dosen, AKPER Directors and Kepala Bangksa participants in this research represented a convenience sample. If they were employed within the AKPER and Rumah Sakit Umum (RSU) nominated by DinKes to participate in the activities of the CJSSP, then they were eligible to participate in all data collection activities of the research. These eligible Dosen, AKPER Directors and Kepala Bangksa were invited to participate in the research during their attendance at information sessions held at each research site. These information sessions were held immediately after information sessions convened to describe the goals and activities of the CJSSP. DinKes convened the CJSSP information sessions and gave me permission to use these meetings to also recruit participants into the research. DinKes provided formal letters of invitation for potential participants to attend as is normal practice for such meetings within the research sites. I would not have had access to recruit participants without these letters of invitation.

During the information sessions, the purpose of the research, the content of the plain language statement, the expectations of participants and the requirements of written consent were explained. As I describe under the heading ‘Ethical Approval’ later in this chapter I had concerns over the requirements of the University of Melbourne, Human Research Ethics Committee to include specific statements in the consent forms, plain language statements and other participant recruitment documents. In contrast to the members of the ethics committee, I felt these statements did not accurately describe the association between my research, the CJSSP, DinKes and World Bank funding. Therefore, I took particular care to clearly distinguish this thesis from the CJSSP during the information sessions. I especially differentiated my dual positions of technical consultant within the CJSSP and as a researcher gaining access to the research sites by virtue of my participation in CJSSP activities. In line with my recognition of the position of power that I occupied as the CJSSP technical consultant, I also attempted to minimize the potential for unintended coercion by leaving the
short versions of the plain language statement and consent form with the potential participants for a minimum of two weeks before I returned to each site to collect them. Importantly, I also highlighted that participation or non-participation in the research was not linked to selection for participation in CJSSP activities where there were specific inclusion criteria. The possibility of requesting the long version of the plain language statement and consent form was also raised at this point.

Additional forms were left with the administrative staff at each site for potential participants who had been unable to attend the information session. When I collected the forms from Dosen, AKPER Directors, and Kepala Bangksa who agreed to participate, we went through the content on a one to one basis regardless of whether the participant had attended the information session or not. Only two participants requested the longer version of the consent form and plain language statement.

Following receipt of the signed consent forms, I verbally informed each participant about their participation in the research activities. Participation would either coincide with their participation in CJSSP or they would be contacted at work to participate in specific observations or interviews that were separate from the CJSSP. This contact occurred through a letter endorsed by DinKes. They received these letters via their AKPER or RSU Director. This process was not intended as a coercive measure, but none of the participants withdrew from the research following volunteering to participate. Therefore, it must be acknowledged that such a process was likely to have significantly influenced their continued participation. There was no alternative to this process as it was necessary in order to officially exempt participants from their workplace. Although this did not sit well with my research training in western, liberal academia, it was compatible with a postcolonial perspective that called for me to respect local practices and maintain a collaborative, rather than superior outsider relationship with DinKes.

**Recruiting Clinical Instructor participants**

Clinical Instructor participants in this research were purposively selected. As a purposive sample, the Clinical Instructors were selected specifically because they were likely to have a view on the topic under study (Burnard & Naiyapatana, 2004).
While the inclusion of Kepala Bangksa in the research sample was for the purpose of gaining a broad understanding of baseline clinical nursing practices, the inclusion of Clinical Instructors was for the purpose of exploring specific responses to internationalizing the DIII curriculum. Therefore, to be eligible to participate in the research, Clinical Instructors were not only required to be employed by the RSU nominated by DinKes as included in the CJSSP scope of works (IBRD, 2001), but were also required to participate in specific workshops that contributed to the implementation activity of ‘Developing the Practical Field’ (IBRD, 2001).

The recruitment process involved me providing the entire group of potential Clinical Instructor participants with information about the research in the same way and at the same time as the Kepala Bangksa. However, of the 28 Clinical Instructors who attended these information meetings, only the eight Clinical Instructors nominated by DinKes to participate in the ‘Developing the Practical Field’ workshops were later asked to participate in the research. This request to participate was issued at the beginning of the first CJSSP workshop in which they were involved. The request to participate occurred at this time, rather than prior to the workshop, so that there was no fear of being withdrawn from participating in CJSSP activities as a consequence of not volunteering to be involved in the research.

Recruiting Ministry Officer participants

Recruitment of Ministry Officer participants also represented purposive sampling. I particularly wanted to understand the simultaneous desire for and rejection of western expertise from the perspective of the Indonesians who had formulated the brief for internationalizing the DIII curriculum and who were responsible for overseeing the contractual activities of the Australian consultants. Accordingly, the criteria for inviting Ministry Officers to participate in this research were that they had been involved in developing the CJSSP brief. They were also required to be members of the management committee that had overseen the contractual negotiations and continued to oversee the activities included in the implementation work plan. I presented the same information about the research to this group of seven Ministry Officers as I had to all other potential participants. I invited them to participate in the research at an informal meeting soon after the CJSSP commenced.
During this information session, the group itself decided that five members were the most appropriate participants: four from the Provincial Office (DinKes) and one from the National Office (DepKes). I was unsure of how they arrived at this decision, but it appeared to be based on the chosen member’s anticipated level of involvement with the CJSSP. That is, it was anticipated that the members of the management group who were selected to participate in the research would have a more active role in the day-to-day activities of internationalizing the DIII curriculum compared to the members who were not chosen to participate in the research. These chosen members immediately signed the consent forms signaling their agreement to participate. Once again, this recruitment process did not sit well with my western research training but was compatible with a postcolonial perspective that called for me to respect local practices and maintain collaborative relationships with the Indonesian Ministry of Health.

**Recruiting student participants**

A convenience sample of students was sought from six groups of students aged between 18-55 years who were enrolled in the fifth semester of the DIII program and studying at one of the six DinKes AKPER included in the CJSSP. This was the only group of students that were available to participate in both the information session and focus group interviews prior to commencing clinical placements. These placements commenced on a set date for all students at all six AKPERs participating in the CJSSP. The legislation that mandated the introduction of the DIII curriculum also mandated it as the minimum qualification required for practice as a nurse or midwife in Indonesia. Therefore, by 2003 when this thesis commenced, students included both high school graduates and SPK nurses upgrading their qualifications. The criteria for potential inclusion in the research were broad enough to recruit students both undertaking the DIII program directly following completion of secondary school and students who were nurses upgrading their SPK qualifications. This mix of participants was essential to gain the perspectives of both cohorts of students that were anticipated to be different by virtue of their prior experiences of clinical placement. That is, it was anticipated that school leaver students would be drawing on previous experiences, whilst SPK students would be anticipating the relationship between the theoretical and practical components of the DIII curriculum.
Potential student participants were invited to participate in the study during information sessions presented at the beginning of a scheduled classroom lesson. The invitation was conducted in the same way as the other information sessions held to recruit other cohorts into the study. One week later an announcement was also placed on the student notice-board (Appendix 9). This announcement reminded students of the potential to participate. It also advertised the time and venue of the primary data collection activity they were to be involved in: a focus group interview. I was well known to these students by the time of the invitation to participate. I had been engaged in participant observation activities relating to the academic and clinical laboratory components of the DIII program for two months prior to conducting the information session.

**Participant Characteristics**

A total of 112 persons agreed to participate in the research: 49 Dosen, 6 AKPER Directors, 5 Kepala Bangksa, 8 Clinical Instructors, 5 Ministry Officers, 4 Bilingual Secretaries, and 35 students. The demographic details of these participants were collected using a short questionnaire that accompanied the consent form for each cohort (Appendices 10 - 13). Whilst the demographic questionnaire was specifically developed for this study, it asked questions that related to gender, age, qualifications and work experiences that are common to many survey instruments (Jackson & Furnham, 2000).

To ensure validity and reliability of the questionnaire in the Indonesian context, the translated terms used in these demographic questionnaires replicated those used in previous studies conducted in Central Java Indonesia by Masters level research students that I had supervised (for example Wahyudi, 2003). Each questionnaire was also piloted by ten HPV fellowship students who were asked to examine the questionnaires for ease of understanding and appropriateness for the purpose of gathering information about the research participants (Appendix 14). All participants commented that the instructions and the questionnaire format were clear and easy to understand. They also stated that all the questions were relevant to the aims of the study. However, they suggested that Indonesian terms, rather than the original English
terms, should be used for qualifications and that an additional column be included for participants to indicate whether they gained their qualifications in Indonesia or overseas. These recommendations were incorporated into the revised demographic questionnaires.

The final version of each of the demographic questionnaires was written in English with Indonesian translations appearing alongside or below the English language information/questions. This technique was used so that I could easily recognize the relationship between questions and answers during data entry. The demographic data arising from these questionnaires are presented in Tables 1 and 2.

Importantly, the characteristics of each group were consistent with the overall characteristics of the group that they represented, including the student group that included both school leaver entrants and SPK nurses upgrading to DIII qualifications (Central Java Provincial Ministry of Health, 2001; Departmen Kesehaten Jawa Tengah (DinKes), 2003). The demographic data also revealed some important characteristics of each group in comparison to other groups within the sample. For example, Dosen and Ministry Officer cohorts had significantly higher level qualifications than the AKPER directors and the members of the Kepala Bangksa and Clinical Instructor cohorts. Similarly, while a large proportion of the Dosen cohort (76%) and all of the Ministry Officers had gained these qualifications overseas, none of the clinical participants or AKPER Directors had worked or studied overseas.

In contrast, both Kepala Bangksa and Clinical Instructor cohorts had extensive clinical experience, but Dosen and AKPER Directors, despite lengthy employment in nursing education had very little clinical experience. This group composition was particularly beneficial for exploring the question of simultaneous desire and rejection of western expertise and western standards for nursing because of their different levels in exposure to both western discourses within nursing and the reality of local interpretations of best practice. The participants’ qualifications were also significant in terms of their direct relationship with English language fluency. This situation meant that there were high levels of English language fluency amongst Dosen, and Ministry Officers and low to no English language fluency amongst AKPER Directors, clinical participants and students. The difficulties that such variation in English
language capabilities presented underpinned the utilization of bilingual interpreters for data collecting. The Bilingual Secretaries who acted as interpreters for me during research activities were not invited as participants in the research itself, but instead spontaneously volunteered to do so. I accepted their voluntary participation as it promised to enhance the research significantly. Their unique characteristics and the importance of their contribution to the data as participants are described in the next section of this chapter.

**Bi-lingual Secretary participants**

The title ‘Bilingual Secretary’ is used for four participants and refers to a role within the CJSSP that included providing administrative (secretarial) support and interpreter services to the Australian technical consultants. All were fluent in written and spoken English, Bahasa Indonesia, Javanese and dialects unique to Central Java. Three Bilingual Secretaries volunteered to participate in the research by presenting me with a signed consent form following their participation in the information sessions as an interpreter. The fourth Bilingual Secretary had already agreed to participate in her role as a Dosen and when she changed roles she was keen to continue to participate in the research. Her demographic details are included in the Bilingual Secretary participant group.

Whilst I had not originally intended for the Bilingual Secretaries to be participants in the research, their participation was in line with this thesis as a postcolonial project. Postcolonial theory acknowledges the contribution of each person’s position to his/her interpretation of what is seen and what is said (Spivak, 1992). It also acknowledges the important role that language plays in the construction of meaning and how language is used as a mechanism for marginalizing and excluding the other (Meleis & Im, 1999). There is also a concern about how the power relationships between researcher and the researched impact on research data and research findings (Bruni, 1995; Radcliffe, 1994). Accordingly, it is argued that when using interpreters, researchers should include the interpreters in the generation of knowledge, consider their impact on the research findings, and debate conceptual issues with them (Temple, 1997; Temple & Edwards, 2002). Therefore, by including the Bilingual
Table 1 Participant age, gender and employment characteristics (N = 112)

<table>
<thead>
<tr>
<th>Type</th>
<th>no.</th>
<th>Average age (years)</th>
<th>Male no.</th>
<th>Male %</th>
<th>Female no.</th>
<th>Female %</th>
<th>Average employment in the clinical field (years)</th>
<th>Average employment in the AKPER (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dosen</td>
<td>49</td>
<td>28.4</td>
<td>24</td>
<td>52</td>
<td>25</td>
<td>26</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>AKPER Director</td>
<td>6</td>
<td>48</td>
<td>3</td>
<td>66</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
<td>23</td>
</tr>
<tr>
<td>Kepala Bangksa</td>
<td>5</td>
<td>41</td>
<td>2</td>
<td>40</td>
<td>3</td>
<td>3</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Clinical Instructor</td>
<td>8</td>
<td>41</td>
<td>3</td>
<td>37.5</td>
<td>5</td>
<td>5</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Ministry Officer</td>
<td>5</td>
<td>50</td>
<td>2</td>
<td>40</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilingual secretary</td>
<td>4</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>1.5</td>
<td>6</td>
</tr>
<tr>
<td>Student</td>
<td>35</td>
<td>21</td>
<td>15</td>
<td>43</td>
<td>20</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant type</td>
<td>No qualification</td>
<td>SPK</td>
<td>DIII</td>
<td>DIV</td>
<td>S1</td>
<td>S2</td>
<td>Overseas masters degree in nursing</td>
<td>Overseas Masters degree in midwifery</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------</td>
<td>-----</td>
<td>------</td>
<td>-----</td>
<td>----</td>
<td>----</td>
<td>-----------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td></td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
</tr>
<tr>
<td>Dosen</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>AKPER Director</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>33</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Kepala Bangksa</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>20</td>
<td>3</td>
<td>60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinical Instructor</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>13</td>
<td>3</td>
<td>38</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Ministry Officer</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Bilingual secretary</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>Student</td>
<td>30</td>
<td>86</td>
<td>5</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Secretaries as participants in this research I not only explored how specific terms were defined from their particular position, but also acknowledged how the interpretation process involved more than the sum of the words (Spivak, 1992). I also explored their perspective on what participants were saying and doing, rather than just treating their interpretations as literal translations (Bassnet, 1994).

These perspectives came from their professional positions, the relations of power between the Bilingual Secretaries and the other research participants and their locations within the same historical, social and economic environment as the participants. For example, I have already mentioned that one of the Bilingual Secretaries was also a Dosen. She occupied a very senior position within the Polytechnic and by virtue of this was at the same time a key informant. As a key informant she was able to facilitate my easy access to research sites, and potentially threatening to the students and junior Dosen participants.

Two of the other Bilingual Secretaries were also Dosen, but were employed at the local University rather than the AKPER, had held their positions for only six months and were not known to the other research participants. Their perspective on some of my observations, and the explanations they gained from the other research participants was quite different to that of the senior Dosen acting as a Bilingual Secretary. Similarly, the fourth Bilingual Secretary offered another perspective again. Prior to her appointment in the role of the Bilingual Secretary she had worked as a DinKes Officer facilitating the secondment of Dosen to the HPV fellowship project. She was not a nurse, but held a Masters of Public Health from an overseas university, was familiar with nursing education within the AKPER, and was known to a large number of the participants as an ally within DinKes. As a result, the contributions that the Bilingual Secretaries made to my understanding of the tensions between desiring and rejecting western expertise and international standards for nursing as participants in the research was just as important as their contribution as interpreters.

Data Collection
Data from the primary data sources of participant observations, focus groups, and individual interviews were collected over a 15-month period from April 2003 to June,
2004. These activities were conducted sequentially, and repeatedly. For example, Dosen and Clinical Instructors who consented to participate in the research were invited to participate in one or more of the data collection activities. They were first observed during a CJSSP workshop. Next, they participated in a focus group where I explored the implications of the content of the workshop on their everyday practices within the DIII program. One or more Dosen or Clinical Instructors would then be invited to participate in an individual interview. During this interview I further explored issues relating to the applicability and acceptability of western expertise and international standards for nursing that arose during the focus group. Similarly, observations of students, Dosen and Clinical Instructors engaged in their everyday practices were followed by individual interviews designed to gain each individual’s perspective on the interactions and meanings relating to the observed activity.

Data were also analyzed between each data collection activity for specific themes relating to the desirability and rejection of western expertise and international standards for nursing. As one type of data provided information, I sought either confirmation of my interpretations or alternative interpretations during the next data collection activity. I also explored secondary data sources such as curriculum documents, institutional policies and CJSSP reports to contextualize the primary data. Finally, as well as recording my findings in field notes, I also kept a reflective journal that constituted my perspective on each of the data collection and CJSSP activities.

This cyclic method of data collection and analysis was consistent with the positivist influenced strategy of simultaneous triangulation (Marcus & Liehr, 1998). However, in line with my commitment to a postcolonial approach, I did not use this multi-method strategy to capture objective reality. Instead, in line with Denzin and Lincoln’s (2000) alternative purpose of triangulation, I collected these multiple data as an attempt to secure an in-depth understanding of the phenomenon under investigation. In this case I used a number of methodological practices as a strategy to add rigor, breadth, complexity, richness and depth to my understanding of the phenomenon of simultaneous desire and rejection of western expertise and international standards for nursing. The incorporation of what I have called the Rashomon technique, as described under the section entitled ‘Individual interviews’, is also consistent with Richardson’s (2000) rejection of the traditional concept of
triangulation in favor of the concept of crystallization. The contribution that each method made to identify the simultaneously occurring multiple, refracted realities, of the participants is described in the following sections of this chapter.

**Participant Observation**

Twenty-nine participant observations, totaling 180 hours were conducted over the 15-month period of data gathering (Appendix 15). During each observation, the research participants were overtly observed while engaged in activities relating to the CJSSP or educational or clinical practices relating to their involvement with the DIII program. The educational and clinical practices that were observed were chosen specifically for their anticipated contribution to understanding the degree to which Indonesian nursing complied with the competencies requirements articulated in the literature for the contemporary internationally mobile nurse.

Ten observations took place in the clinical research sites. Seven observations took place in the AKPER, observing both lecturing and laboratory teaching. One observation took place at a teacher training day for AKPER staff convened by *Persatuan Parawat Nasional Indonesia (PPNI)* (the National Indonesian Nursing Association). Five observations took place at the CJSSP workshops. Six observations of administration activities were conducted. Three of these observations were of the CJSSP management meetings where achievement of CJSSP goals and objectives, progress with the work plan, and monitoring for compliance with contractual obligations were discussed. The remaining three observations took place at meetings relating to educational policy. The duration of the observation period was between one hour (for some meetings) and eight hours during the CJSSP workshops. Clinical observations were generally of three hours duration. Although it was planned to conduct the participant observations either randomly or at a pre-arranged time, logistical and security considerations meant that random observations were not possible. Accordingly, observations had to be scheduled to coincide with CJSSP activities.

I participated in all observations in my role as a technical consultant of the CJSSP, and deliberately engaged with the participants in order to understand what they were
doing and saying. As a result, I was an active participant during collection of these observational data (Hammersley & Atkinson, 1983). For example, in my role as the Australian technical consultant I had specific learning facilitation activities that involved engaging with the workshop participants at the same time as observing and questioning them about their interactions with each other and me during the CJSSP workshops. Similarly, I was both a committee member and a researcher during each of the CJSSP management committee meetings that I observed. I had specific reporting duties at each of these meetings and my interactions with the other participants were defined by my responsibilities as a committee member and by my role as a researcher. I was not an invisible observer, but instead both recognized my influence on other participants during the observational situation and actively engaged with participants to probe issues that were raised and appeared important to answering the questions of this thesis.

My role during the clinical practice and teaching observations was to assess current Indonesian nursing practice and benchmark against international standards. This meant observing unsolicited behaviors, asking to see specific practices, and asking and answering questions about practices in relation to Australian practices. In order to ensure that the research participants were aware that I was engaged in these activities as both a fellow (insider) participant in my role as a CJSSP consultant and an (outsider) observer in my role as a researcher, I was careful to gain verbal consent from each participant at the beginning of an observational activity. I reminded the participants of their option to withdraw from the research at the time of the observation and that I would not record any observations of their practice in my field notes if they did not wish me to do so. I did encounter this situation once, when all participants felt that it would be too stressful for the student for me to observe a clinical examination. Accordingly, I did not proceed.

On numerous other occasions, the research participants were keen for me to include our joint participation in the CJSSP in my research. From a postcolonial perspective I was keen to involve them in the knowledge generation process and so took their advice on some occasions. However, on other occasions I declined as informed consent had not been gained from other participants in the activities that they were
asking me to include in the research and ethical considerations influenced me not to comply with their requests.

My participation in all of these activities also had the potential to influence behavior of the participants so that I was observing the behavior and practices as these were carried out for my benefit rather than as they naturally occurred. However, the breadth of observational data that I collected, the duration of my presence and the strategy of exploring observational data with group and individual interviews minimized this potential adverse influence on the reliability of the data I was collecting.

As Hammersley and Atkinson (1983) recommend, observational data collection commenced with adopting a wide focus. I used a broad checklist to guide my observations as recommended by Spradley (1980). This checklist was pasted into the front cover of each of my field note journals and included prompts as listed in Table 2. As I began to identify themes across all data collection methods, my data collection became much more focused. I particularly looked for specific contextual issues that influenced practice. I also looked for practices that challenged the authority of western nursing and looked for examples of hybridity (Bhabha, 1994).

Participant observations were documented as field notes and in my reflexive journal. The techniques I used for documenting observational data, the conventions I followed and issues relating to collecting and documenting data in two languages are described under the heading: ‘Documenting and Recording Data’ (pp. 126 - 130).

**Focus groups**

Eight focus groups were conducted during the first eight months of data gathering (Appendix 16). The conduct of focus group interviewing was chosen as a data collection method for a number of reasons. It allowed me to gain multiple perspectives in a time efficient manner (Hughes & DuMont, 1993). Focus groups also complemented the participant observation approach by allowing me to structure an engagement with participants that both explored developing concepts emerging from the data and created interactions between participants (McLafferty, 2004).
Table 2 Checklist used to guide participant observations

- Describe the participants, including relationships between participants;
- Describe the practice;
- Ask myself and the participants the underpinning theory guiding this practice; Explore the participants and my own comparisons of this practice to local and international best practice standards;
- Does the practice demonstrate acceptance or rejection of western expertise and international standards?
- Describe the context – particularly in comparison to western contexts of practice;
- Ask for participants’ impressions of the influence of context on their practice;
- If the practice or setting has been previously observed, is there any difference between observations?
- Does the observed practice support or undermine reported practices, and interview data?
- Is there a pattern emerging?
- Does it add anything new to the existing knowledge?

For example, the open ended questions that I used to structure these engagements created the situation where participants both responded to my questions and to other group members’ answers. They sought clarification of each other’s contributions, asked for and spontaneously provided examples relating to my questions, agreed or disagreed with each other, and deferred to or argued with each other and me.

A positivist perspective conceptualizes the benefits of interaction between participants as giving the method a high level of face validity (Krueger & Casey, 2000). On the other hand, the fact that participants’ contributions can be confirmed, reinforced, contradicted or rejected within the group is consistent with the postcolonial endeavor of eliciting multiple perspectives on the same topic. Such purposeful creation of interactions is considered appropriate for collecting in-depth information about topics on which there may not be consensus amongst the group (Twinn, 1998). Therefore, this distinguishing feature of the focus group method was particularly appropriate for exploring simultaneous desirability and rejection of western expertise and
international standards for nursing. It is also considered to be a useful method for identifying situated meanings that otherwise may have gone unnoticed due to my position as a western ‘outsider’ (Hughes & DuMont, 1993). This method had also previously been successfully used for research in non-western cultures and in situations where the researcher and participants had varying degrees of competency in both English and another language (for example, Hughes & DuMont, 1993; Twinn, 1998).

**Conducting the focus groups**

Each focus group was held at the participant’s place of work or study and moderated by myself. I did however, have the assistance of the Bilingual Secretary, as I followed the advice of Esposito (2001), Temple (1997) and Twinn (1998) who recommended that focus groups should be undertaken in the participant’s first language. Accordingly, although I began interaction in English, the Bilingual Secretary would translate my questions into Bahasa Indonesia. Participants then either responded in Indonesian or English, depending upon which language they were most comfortable with. The Bilingual Secretary then translated Bahasa Indonesian responses back into English. I then either probed the responses further, or proceeded to the next question on the focus group guide.

As my fluency in Indonesian improved, my reliance on the Bilingual Secretary for translating my questions and the participants’ responses progressively decreased. This was particularly important as from a postcolonial perspective language is not simply a sum of words, but instead both constructs and is constructed by socially and historically embedded experiences (Spivak, 1992). Similar to the situation noted by others (such as Esposito, 2001; Temple, 1997; Twinn, 1998), translations were prone to distortion according to the experiences of the Bilingual Secretary and myself, which influenced our understandings of language. For example, when I asked one of the Bilingual secretaries to ask a participant “How did you decide to do that?” she instead asked “Why did you do that?” Similarly, I understood one of the participant’s responses as “We need new equipment”, whilst the Bilingual Secretary translated, “She says their equipment is not as good as your Australian equipment”. There was a risk that I might not choose the appropriate Indonesian words to ask questions, or
interpret the responses from my own perspective. However, like Temple and Edwards (2002), I decided that if I discussed the data with the translator after the event, I could avoid total reliance on her during the event and produce more reliable data.

A written record of all focus groups was contained within my field notes and reflexive journals (see pages 126-129). In addition, the two student focus groups were audiotaped. Audiotaping is recommended by some researchers for recording data during focus groups (Twinn, 1998). However, to do so requires good quality recording equipment that will capture multiple voices across varying distances (Hughes & DuMont, 1993). As I only had access to this type of equipment for the focus groups with students, I was unable to audio tape the other group interviews.

*The focus group guide and moderating the discussion*

The focus group guide provided structure to the group interviews. As the moderator of each focus group, I used a guide to start discussion and then to direct my questioning as the discussion proceeded. I would first ask a question according to the focus group guide. I would then formulate and ask other questions related to participants’ responses and interactions that arose during the discussion. Then, when it appeared that all perspectives had been explored, I would move on and ask the next question on the focus group guide. There were four focus group guides: two for Dosen participants, one for clinician participants, and one for student participants. Each guide contained questions about Indonesian nursing that were designed to compare Indonesian nursing to the dominant image appearing in the literature, to compare documented practices with actual practices and to explore questions arising from the participant observations. The questions in the focus group guides were not meant to be prescriptive. Instead, they were designed to direct group discussion and stimulate conversations that would afford access to the discourses that constructed the participant’s experiences relating to the research topic (Hughes & DuMont, 1993). The guides for each focus group discussion are included as Appendices 17-20.

The questions in the focus group guides had not been previously validated, but consistent with a postcolonial approach, I requested the assistance of the research participants to check the questions for ease of understanding and appropriateness for
the purposes of gathering information about the research topic. The same group of ten Dosen/HPV fellowship students who had assessed the demographic questionnaire, and who by this time were research participants, were involved in this activity. They were asked to provide written feedback on the form that appears as Appendix 21. All reviewers commented that the questions were relevant to the aims of the study. Three of the reviewers highlighted the need to inform participants that the questions were only a guide and that each person’s opinion was important. This information, as well as how I anticipated the focus group to proceed was outlined at the commencement of each focus group. The importance of a briefing that includes rules about respect for individual contributions and the role of the moderator have been highlighted as particularly important in research with non-western participants (Twinn, 1998).

The role of the moderator is reported to be critical to the quality of the data produced (McLafferty, 2004). As the moderator I followed Hughes and DuMont’s (1993) recommendations for culturally anchored research, which positioned the moderator’s role as one of channeling discussion to meet the objectives of the research. They also recommended that the moderator directs discussion to give all participants a voice and to implement strategies to avoid domination of the discussion by any one person. From a postcolonial perspective, this meant that I was particularly observant of the power relations within the group and actively sought contributions from participants who appeared to be marginalized by others.

**Composition of the groups**

Of the eight focus groups conducted, four comprised Dosen and AKPER Directors from the six AKPER. These focus groups explored topics relating to the current and desired implementation of the DIII curriculum and teaching and learning strategies employed within the program. The two focus groups that explored issues relating to the clinical component of the DIII curriculum comprised Dosen and Clinical Instructors respectively. Two focus groups that included different groups of DIII students explored students’ motivations for entering the program and the relationship between the clinical and theoretical components of DIII nursing education.
Although the composition of each group was predominantly determined by the topic under discussion, I also took into account dependant relationships between participants. For example, I avoided interviewing students and Dosen or Dosen and Clinical Instructors in the same focus group when inviting potential participants. When individuals with dependent relationships were within the same group, I did not explore topics related to this dependant relationship. For example, I did include both Dosen and AKPER Directors in the same focus groups exploring the nature of the curriculum, teaching and learning within the DIII program, but avoided raising issues relating to human resource management and administration of the AKPER.

**Size and number of focus groups**

The size of the focus groups varied from a minimum of five participants to a maximum of 18 participants. There are no clear guidelines in the literature about the number of participants in the group. The concensus appears to be that the group size should be large enough to generate interactions that produce multiple perspectives, but not be so large that it is difficult to facilitate contributions from all members (McLafferty, 2004). With this information in mind, the respect for turn-taking in conversations that I had observed during participant observations meant that the large groups were manageable. There is also no evidence on the ideal number of focus groups required to extract the participants’ perspectives on the research phenomena. The consensus appears to be that sampling should cease when no new concepts emerge (McLafferty, 2004). In this respect the number of focus groups conducted for this thesis on each topic proved to be adequate.

**Individual (Key Informant) Interviews**

Twenty face-to-face key informant interviews of between one hour and three hours duration were conducted over the fifteen month period of data gathering (Appendix 22). The interview participants were considered to be key informants as they were persons with specific knowledge, represented each of the specific groups involved in the research, and these were people who were willing to communicate with me about the particular phenomenon I was researching (Marcus & Liehr, 1998). As described
by Hammersley and Atkinson (1983), some interviews were solicited and others were unsolicited.

**Unsolicited interviews**

Unsolicited interviews took place when the research participants and I traveled together in the CJSSP car. The long periods spent traveling between research sites often meant that the research participants who accompanied me took this opportunity to discuss their interpretations of the participant observations and focus group interviews. They provided me with their insights into what happened, why they thought specific phenomenon occurred, and the interactions between participants. The participants were particularly concerned with ensuring that I had understood the observed phenomenon ‘correctly’ (Hammersley & Atkinson, 1983).

My role in these interviews was to direct the conversation to probe the relationships between their insights and my research question and to ask questions about how they thought these phenomena contributed to my research. We also discussed how their particular subjectivities influenced their interpretations of the data I had collected and compared and contrasted them to my own. Such an approach was consistent with my commitment to the postcolonial endeavor of recognizing the importance of the historical and contextual influences on each individual’s subjectivity, and including previously marginalized voices in the process of knowledge development. The unsolicited nature of these interviews and the informal setting of the CJSSP car also gave me an opportunity to provide the space for these participants to use their own distinctive ways of talking (Mohammed, 2006). Rather than more formal responses that occurred during solicited interviews, the interaction during these unsolicited interactions took place in English, Bahasa Indonesia and Central Javanese dialects. Accordingly, these interactions were particularly valuable for me with regards to learning about contextual embeddings of language, as opposed to the literal translations of words (Bhabha, 1994; Spivak, 1992; Temple & Edwards, 2002).

Some of the unsolicited interviews were individual interviews and some involved two or three key informants. By virtue of the serendipitous nature of the interviews that included more than one key informant, and the way they were conducted, I have not
referred these interviews as focus groups. In particular, interaction between participants was not a key feature of these interviews, nor was it deliberately encouraged as it was in the focus group interviews. Similarly, I did not use an interview guide for these unsolicited data. Instead, the interviews consisted of the participants offering me their individual perspectives on a particular topic, my responses to and interpretations of their insights, and their subsequent responses to me.

**Solicited interviews**

The solicited interviews included in this research were all individual interviews. They were designed to follow-up concepts revealed during focus groups, and explore the relationships between specific aspects of DIII education, CJSSP initiatives, and international standards for nursing. Most importantly they were designed to understand observed phenomena from multiple perspectives. In recognition of the postcolonial commitment to acknowledging the heterogeneity of subaltern peoples (Spivak, 1988b), I was interested in using individual interviews to explore the multiple perspectives of participants who occupied different positions within Indonesian nursing education. I wanted to understand the different ways that individual participants understood and constructed Indonesian nursing’s compliance with the specific international competencies of evidence based practice, student centered teaching and learning, critical thinking, and individual accountability and their reactions to CJSSP activities relating to the same.

With this goal in mind, I planned to interview each participant who had been one of a number of participants involved in one of the activities of either the CJSSP or the everyday implementation of the DIII that I had observed and considered to be of particular relevance to understanding the relationship between global consistency and local uniqueness in nursing education. In addition, in recognition of the great potential for researchers to influences participants responses and the danger of constructing the reality of others, I also wanted to employ an interview technique that would assist me to avoid such traps, but still reject the positivist notion that I could escape my own subjectivity in the process (Merriam et al., 2001). An interview method referred to as
the Rashomon technique, which had previously been used for research in Indonesia (Hull, Rusman & Utomo, 1996) appeared compatible with the task I had set myself.

**The Rashomon interviewing technique**

The Rashomon technique is based on a Japanese film produced in 1950 (Kurosawa, Richie, & Akutagawa, 1987), which explores the event of a rape and murder of a woman through the widely differing accounts of four witnesses. The story as told by each witness is highly believable, but contradictory to the accounts of the other witnesses. The possibility for contradiction suggests to the viewer that there may not be any single truth about the incident, just different perceptions and interpretations of reality. Because the accounts all relate to a single, concrete event it does however mean that there is a possibility of understanding events in more than one way, each as critical as the other to understanding the event, or phenomenon being researched, in its entirety (Heider, 1988).

When applied to ethnographic research, the Rashomon technique particularly also highlights the subjectivity of the researcher’s own recollections. It draws upon notions of reflexivity to encourage the ethnographer to simultaneously suspend both belief and disbelief when interviewing the participants of the observed event or phenomenon of interest in which the researched and the researcher had previously participated (Hull et al., 1996). Hull et al. had previously used this technique to gain an understanding of, and inform policy relating to, maternal or infant mortality in the rural areas of West Java and Lombok, Indonesia. These researchers recorded the reported memories of between four to seven participants who had different roles in the same dramatic event. They encouraged each participant to provide detailed accounts of what they experienced and observed, and what they interpreted as the causes and responsibilities involved in producing the particular outcome - a woman's or infant's death or survival.

**Using the Rashomon technique in this thesis**

Using the Rashomon technique in this thesis meant that I first identified the observed event relating to the participant’s compliance with, or reactions to CJSSP activities
relating to one of the identified competencies of the contemporary, internationally mobile nurse. I then interviewed each of the participants who were involved in this observed event. For example, the student practical examination that I had observed provided me with particular insights into Indonesian nurses’ interpretations of the relationship between theory and practice, critical thinking and decision making, teaching and learning strategies, compliance with local and international standards, and accountability for practice. I had already recorded my version of this event in both my field notes and my reflexive journal. Using the Rashomon approach, I interviewed the student participant, the Dosen participant, the Kepala Bangksa participant and the Bilingual Secretary who had accompanied me and translated the conversations that occurred during the event.

During these interviews, I asked that each participant recollect the event and tell me how they understood this event in relation to standards for education or the activities of the CJSSP. In line with the Rashomon technique, I asked each participant to respond to my request by talking about the event as if they were telling me a story. Story telling appeared appropriate for the particular purpose of these interviews because of its reported ability to elucidate the subjective interpretations of relationships between individual actions and the wider social and cultural contexts of the event (Cohen & Mallon, 2001). I tried to minimize my influence on their stories by interrupting only to clarify my understanding of what they were saying, or to stimulate further recollections by asking about an element of the event that they had not yet covered.

The interviews were conducted in the participant’s place of work or study and only one interview was audio tape recorded. The reasons for this are described in the section of this chapter entitled ‘Audiotaped records’. The remaining interviews were recorded in my field notes, and included both the participant’s stories and my interpretation of how these stories each contributed different and shared understandings to my overall knowledge of each event. The contribution that these interviews made to my changing subjective positioning was recorded in my reflexive journal.
Secondary Data Sources

Secondary data sources were used to supplement the primary data collection methods described above. These sources included documents associated with DIII nursing education such as the written version of the curriculum, syllabus, teaching plans and AKPER education policies and procedures. I received verbal permission to access all of these documents and in many cases a participant would provide me with a particular document because they thought it would contribute to my understanding of a particular element of Indonesian nursing. For example, in the clinical field I was taken to the Kepala Bangksa’s office to specifically look at the Standard Operating Procedure (SOP) manuals. Emails from myself to academic colleagues (including, but not limited to the other SSP technical consultants) provided valuable data on my perspective on specific CJSSP initiatives and participants’ responses about these initiatives, as did the formal CJSSP reports. The CJSSP reports of the first activities of the CJSSP, which occurred prior to commencement of this thesis, were particularly valuable data sources. A list of the CJSSP reports appears as Appendix 23.

Documenting and Recording Data

All data collection activities were documented as both field notes and reflexive journal entries. I separated these different types of records by using two sets of color-coded notebooks. I did this to acknowledge the partiality of my understanding of data, and the influence of my own position on both the data collection and interpretation process. I also attempted to audio tape some interviews, but this was largely unsuccessful as is described under the heading ‘Audiotaped records’.

Field Notes

Consistent with my commitment to a postcolonial perspective, I understood my field notes to constitute a textual representation of the phenomenon that I observed during observational and interview data collection activities (Grbich, 2004). In my field notes I documented responses to the prompt questions described in the previous section of this chapter under the heading: ‘Participant Observation’. I also documented participants’ responses during focus groups and individual interviews. Paying attention to Webb and Kevern’s (2001) recommendations, I also wrote information
about the interactions that occurred during focus group discussions, and not just the
responses of the participants.

I documented participant responses during all data collection activities as a mixture of
summaries and verbatim quotes, being careful as Hammersley and Atkinson (1983)
advise to clearly distinguish the two. In this way, I clearly distinguished what was said
by the participants themselves by using quotation marks. Hammersley and Atkinson
also advise that it is important not lose “situated vocabularies” (p.153). Paying
attention to situated vocabularies meant that as the research progressed and I became
more fluent in Indonesian, more and more of my notes were written in Bahasa
Indonesia rather than English. This focus on Bahasa Indonesia rather than English did
present some problems with data analysis later. Some grammatical and syntactical
structures did not cross the borders of the two languages (Birbili, 2000) and the
meanings became more obscure as my fluency in Bahasa Indonesia diminished over
time and I no longer had access to situated informants. These field note entries were
not intended to represent accounts of reality. Rather, in tandem with my reflexive
journal entries, they constituted a way in which I could recall and then analyze the
ways in which both the research participants and I had constructed reality within this
thesis (Borbasi, Jackson & Wilkes, 2005).

**Reflexive Journaling**

My reflexive journaling was guided by the work of feminist geographers Gillian Rose
(1997), Donna Haraway (1991) and Sandra Harding (1991, 1992), and postcolonial
feminist scholars such as Lynne Staeheli and Victoria Lawson (1994) and Sarah
Radcliffe (1994) who critiqued western researchers’ activities in Third World settings.
Although these authors were not all postcolonial scholars, Rose aligned their work
with the postcolonial concern of acknowledging the colonizing power of the
researcher. Accordingly, entries in my reflexive journal were guided by a list of
prompts as illustrated in Table 4.

These prompts were designed to include my own contribution to the thesis within the
data, to explicitly acknowledge my position, and to situate my knowledge
development.
Table 4 Prompts for reflexive journaling

Reflective questions:
- What is the participant’s response to my presence?
- Is my interpretation an example of a false claim to universal applicability of knowledge, which acts to subjugate the knowledge of the other?
- Am I constructing the participants and myself as transparent, knowable selves?
- How do the data change my constructions of the participants and myself and Indonesian and western nursing?
- What is my point of reference for making sense of the data?
- Are my perceptions and situated responses changing in response to making sense of the data?

Remember:
- Look ‘inward’ to my own identity and ‘outward’ to understand the relation between my interpretations and the wider world;
- Make the circumstances surrounding data collection explicit;
- Include power relations as part of the landscape of the thesis by commenting on relations between myself and the participants.

By revealing contradictions as well as uncertainties in interpretation of events the entries into my reflexive journal brought the authority of my academic knowledge into question and traced my shifting subjectivities. As Rose (1997) so aptly put it, such an understanding of the relationship between myself and the research journey: “… insists that we are made through our research as much as we make our own knowledge” (p. 316).

However, despite departing from the positivist underpinnings of traditional ethnographic techniques, I did adhere to Malinowki’s (1961) recommendations regarding the importance of recording these texts as close to the observational activity as possible. I adopted two strategies to achieve this aim. Firstly, I wrote brief notes in my field note journal during the actual observation. This was not difficult in the early stages of data collection as there was time to do this when the Bilingual Secretary interpreted what I had said for the participants. In the later stages, as I became more
fluent in Indonesian myself, I often had to stop conversations while I took notes. This stopping of conversations did not appear to interrupt the natural occurrence of the phenomena I was exploring as once again, the research participants were keen for me to capture my understandings of the situation.

The second strategy that I employed was to expand on these brief notes immediately after the observation activity. Serendipitously, the distances between research sites were particularly helpful in this endeavor. I spent many hours in the car traveling between sites or returning home after observational activities. This process not only provided an opportunity to make detailed notes, but also to engage the Bilingual Secretaries in knowledge production. I would write in both my field note journal and my reflexive journal, tell the Bilingual Secretary about my interpretations and then update both journals to record the two perspectives and my reflections on these together. We were frequently also accompanied by one of the Ministry Officers, so I often incorporated a third perspective into my entries. In this way, my reliance on memory and the potential for changes in my subjectivity that could later distort my original interpretations of phenomena was minimized (Hammersley & Atkinson, 1983). Moreover, the construction of data as a crystal like formation was maximized (Richardson, 2000).

**Audiotaped Records**

In recognition of the difficulties reported by others (for example, Temple, 1997) when attempting to simultaneously interview and take notes in two languages, I planned to audiotape the individual interviews. According to the details of the plain language statement, participants had the option to agree or decline the use of a tape recorder during their interviews. The first interview participant declined. The second participant agreed, and I used a handheld Sony M-470 ‘Pressman’ micro-cassette voice recorder for this interview. However, she asked for recording to be discontinued when her English language skills were inadequate and she reverted to Bahasa Indonesia. This made the interview very disjointed. To avoid the potential of valuable data being missed, we agreed to discontinue recording. The same phenomenon occurred in the next two interviews. The participants subsequently confirmed my
observation that they attempted to use English rather than speak in their first language because they were being recorded.

The phenomenon of participants sanitizing their views has been reported as one of the potential drawbacks to using audio recording (Polgar & Thomas, 1995). In this thesis recording these interviews did not facilitate, but rather detracted from the research process. In addition, when I checked my field notes against the first four recordings I had made, they were an accurate reflection of the interview content, so I chose to abandon audio taping during subsequent key informant interviews.

When good quality equipment is available, audio recording focus group discussions conducted in two languages has also been advocated (Hughes & DuMont, 1993; Twinn, 1998). Although I attempted to record the first focus group with Dosen participants, the handheld micro-cassette voice recorder I had previously used for individual interviews did not produce a clear recording. In contrast, the classroom where the two student focus groups were held had an amplifier system and two microphones that connected to a cassette recorder. I had one microphone and the other microphone was passed from participant to participant. The resultant audiotape was suitable for verbatim transcription. This was attended by me and one of the Bilingual Secretaries and our translation was verified two years later by a bilingual Indonesian Master’s student who was not involved in the CJSSP.

Perhaps it was the novelty of using a microphone with students who had previously demonstrated a passion for Karioke, but in contrast to the responses of key informants, this group of participants was not inhibited by audiotaping their responses. They appeared to speak freely in both English and Bahasa Indonesia. The benefit of being able to concentrate on the discussion without having to take notes (Spradley, 1980) was invaluable.

**Ethics Approval**

Ethics approval was gained from the Human Research Ethics Committee at The University of Melbourne (Appendix 24). Ethical principles of informed consent confidentiality of data, anonymity of participants and research sites, and secure
storage of data as described in the National Health and Medical Research Council (NHMRC) National statement on Ethical Conduct in Human Research (2007) were included in the research design and adhered to throughout the research.

It is also important to highlight that my commitment to a postcolonial perspective warranted a significant deviation from the University specified procedures for plain language statements and gaining written informed consent. I challenged the lengthy format and language of the University templates for these two documents (Appendix 25). This challenge was in line with the postcolonial concern of acknowledging how individuals are shaped by different historical and political positioning (Reimer-Kirkham & Anderson, 2002) and the need for researchers to be aware of the power relations embedded in research interactions (Anderson & McCann, 2002). Whilst the University requirements reflected the influence of liberal ideals of freely choosing individuals and protecting the rights of individuals situated in a democratic, English language speaking society, the research participants did not share the same positioning. Instead, I indicated to the members of the Human Research Ethics Committee that my experience with Indonesian nurse teachers over the previous four years had revealed that Indonesians viewed official letters as unnecessary unless they were orders to be obeyed. Accordingly, the alternative plain language statement that I submitted for approval by the University of Melbourne Human Research Ethics Committee included the following paragraph intended to ensure that the document itself was not coercive: “I know from an Indonesian perspective it may seem that this letter and the wording of the forms is rather formal, but this is because the same wording is used for all research” (Appendices 4 and 5).

Moreover, it was also my experience that the normal way of communicating information in Central Java is through verbal communication and that there is a range of literacy and a low level of compliance with reading detailed written information. This is particularly true of lengthy written materials. In recognition of this situation, I developed a long and a short version of the plain language statement and the consent form (Appendices 4-7). It was my belief that the short version of each document covered the essential ethical considerations and that it was more likely that potential participants would read this information if it was presented in such a format. The short version was sent to all potential participants and a longer version that complied
with the usual University format for the plain language statement and consent form was also available for all participants. That is, the short version of these documents included a sentence acknowledging that a longer version was available from the researcher upon request. It was my belief that if this strategy was not adopted, then there was the potential for participants to volunteer without reading any of the information provided and therefore being inadequately informed about the project.

These departures from usual University format were approved without question and I was satisfied that I had both observed the intent of ethical requirements and at the same time avoided marginalizing the research participants through potentially colonizing practices of the academy (Staeheli & Lawson, 1994). However, the University of Melbourne, Human Research Ethics Committee insisted on the inclusion of statements within the documentation deemed essential to comply with ethical requirements that clearly associated my research with the CJSSP, the Central Java Ministry of Health and World Bank funding. I believed that this request undermined my attempts to avoid colonizing practices.

The request to include specific statements arose from concerns expressed by members of the ethics committee regarding my dual role as a researcher and as a technical consultant whose activities in the research setting were funded by the World Bank. To this end, the members of the Human Research Ethics Committee insisted on inclusion of statements such as: ‘Sister School Project: A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank’ within the plain language statements, consent forms, and other printed materials recruiting participants to the research. This request to clearly associate the research with the CJSSP was contrary to my attempts to differentiate the research from my potentially colonizing role as a consultant of the CJSSP, and the funding bodies who set the Terms of Reference of the CJSSP (IBRD, 2001). I indicated to the ethics committee members that such statements did not accurately reflect the relationship between the research and these institutions. Although I was researching activities that took place within the CJSSP, the research was not a component of the CJSSP itself.
Similarly, although my research was supported by the Central Java Ministry of Health, it was not supported by the Ministry as a component of the CJSSP. It was supported as an independent academic endeavor. Finally, although World Bank funds enabled me to remain in Indonesia for several months, my research itself was not funded by the World Bank. I did not receive any monies from any institutions for the conduct of this research. Nor was I required to report the outcomes of my research to the Central Java Ministry of Health, the World Bank or any other organization. However, my argument that such a statement was not an accurate reflection of the relationship between the research and the CJSSP was not acceptable to the committee. As a PhD student I felt I was in a position of powerlessness to resist the authority of this committee and so ironically was subject to the colonizing practices of the academy myself.

**Ethical Compliance**

Ethics approval was gained for 30 participant observations, 8 focus groups and 20 key-informant interviews involving 50-100 participants over an eight-month period. Whilst I adhered to the number of participant observations and interviews, the number of participants (N=112) and the duration of the research (15 months) both constituted variations to the original terms of approval. These variations occurred, and were approved, when an unexpectedly large number of students volunteered to participate in the focus groups, and when there were unforeseen delays in the implementation of the CJSSP (particularly relating to contractual, security and financial issues) respectively. Approval of the extension and variation to numbers is included as Appendix 26.

**Data Analysis**

Data analysis was undertaken in two phases: firstly during ethnographic data collection and secondly when I returned to Australia after data collection had finished.
Cyclic Data Collection and Data Analysis

Typical of an ethnographic methodology, data collection, data recording and data analysis occurred in a cyclic manner (Spradley, 1980). Once I had recorded data in my field note journal and my reflexive journal, I would re-read these entries and compare and contrast them to previous entries and my previous analysis. One of the criticisms of using postcolonial theory as an analytical tool is that doing so can create categories that reinforce positivist binaries and colonize the data (Young, 2003). Therefore, in this first phase of data analysis I did not categorize data according to postcolonial themes. Instead, I examined the data to identify patterns and develop theoretical concepts relating to the influence of dynamic historical, economic, geographical, social and other contextual factors on Indonesian nurses’ and my own responses to western expertise and international standards for nursing.

I used the technique of making analytical notes within my field notes and reflexive journal to record the relationships I was noting between different data, and as prompts for areas to explore during subsequent data collection (Hammersley & Atkinson, 1983). I also used these analytical notes to guide my discussions with the research participants themselves about my developing understandings.

Documenting analysis during data collection

As Hammersley & Atkinson (1983) recommended, I distinguished the analytical notes from my field note and reflexive entries by enclosing my analytical notes in square brackets “[ … ]”. These analytical notes included comments about whether I perceived particular participant responses to competencies for the contemporary, internationally mobile nurse as: similar to or different from Australian or western practices; looking the same as Australian or western practices, but were in reality different; made no pretence of being the same as Australian or western practices; and why no pretence was deemed to be necessary. I tried to identify situations within the data as examples of reflecting either desire for, or rejection of western expertise and international standards for nursing and identify specific contextual influences directly relating to either desire or rejection in that particular instance. I looked for instances that opened up spaces for hybrid responses. When making analytical notes in my reflexive journal I particularly identified data that reflected how my coming to know
Indonesian nursing practices challenged my preconceptions about Indonesian nursing, how this challenged my understandings of Australian or western practices and how this challenged the western discourses that played such a role in shaping my understanding of nursing.

Data analysis following completion of data collection

After data collection was complete I returned to the postcolonial literature that had informed my selection of postcolonial theory as an analytical model for data analysis. From this literature I compiled a list of defining postcolonial features that represented themes and sub-themes of the work of Edward Said (1972, 1975, 1978, 1988, 1993), Gayatra Spivak’s (1988a, 1988b, 1990, 1993) and Homi Bhabha (1983, 1994, 1997, 1990) (see Appendix 27). Guided by this list, I searched the data for instances or examples that were consistent with: images of Indonesian nursing as influenced by Orientalist representations of otherness and my complicity with western colonization of Indonesian nursing (Said); of passive and powerful resistance to western colonization of Indonesian nursing (Spivak); and hybrid responses to western colonization of Indonesian nursing (Bhabha).

I identified themes and sub-themes within the data by highlighting text in different colors. I also pasted notes on the edges of pages so that I could easily identify where specific data were located. In addition I kept a running list of data examples on the ‘defining features’ list in a column adjacent to the defining feature. Some data related to more than one defining feature, there were no data that corresponded to some of the defining features, and other data did not relate to any defining feature at all. How I chose to report the relationship between the data and the defining features of a postcolonial perspective is described in the following section of this chapter.

Reporting the data

Once I had grouped the data under the themes and sub-themes occurring within my list of defining features, I identified examples that I perceived to be most relevant to answering the research questions. I then organized the examples to be presented in one or more of the findings chapters. These chapters are entitled ‘Representations of
Otherness’ (Chapter 6), ‘Deconstructing ‘other’ voices (Chapter 5), and ‘Looking in the Mirror’ (Chapter 8), in recognition of the three main themes that emerged during analysis. Whilst allocation of text to each of these chapters does represent categorization of data I attempted to avoid positivist essentialist and marginalizing portrayals of participants’ responses. I attempted to do this by including large portions of participants’ narratives within the text to demonstrate how they constructed their knowledge and how I have constructed my findings. Consistent with my dedication to a postcolonial perspective, I have also used the same data in more than one findings chapter to demonstrate the multiple interpretations and juxtapositions of data gained from single and multiple observations, interviews and focus groups.

Given the use of large portions of participants’ narratives within the findings chapters, protecting the anonymity of participants was particularly important. Anonymity was protected by coding the data according to: a) the research site; b) the data source (e.g. Participant observation, focus group or key informant interview); c) the data record it was taken from (e.g. Field note, reflective journal, email); and d) the informant. For example, the code PkCO1, FN, D1 denoted data that were taken from the research site aliased as Pk. It also denoted that it was the first participant observation of clinical practice (CO1), that it was reported in my field note journal (FN), and that the informant involved was one of the Dosen aliased as D1. All of the data codes that I used appear in Appendix 28.

In recognition of the ‘crisis of representation’ within the field of qualitative research (Denzin & Lincoln, 2000), I was committed to presenting the findings of this thesis in a way that acknowledged the partiality of knowledge, the process of knowledge construction, the voices of the participants, the interpretive and constructed nature of text, and my own embedded position within the text (Tierney, 2002). Accordingly, I chose to write in the first person when clearly providing a perspective within this thesis that reflected my own experiences, subjectivities and interpretation of events and phenomena. I also chose to use Indonesian titles for participants where they used these titles themselves. For example, I refer to nurse teachers within this thesis as Dosen and nurse managers as Kepala Bangksa. Similarly, I do not refer to Indonesian nursing students as Mahasiswa Keperawatan, because the English term was used more frequently by participants regardless of whether they were speaking Indonesian
or English. In addition, to acknowledge my shifting subjectivity across the duration of the research, if I had written my field notes or reflexive journal entries in Bahasa Indonesia, I preserved this use of language in the text of this thesis, and bracketed the English translations for the benefit of the reader.

Nor did I attempt to sanitize the text of this thesis so that it was free of describing identities in fixed, binary ways that reflect colonialist language (Mohammed, 2006). To do this would be to deny the influence of colonialism on both myself, the Indonesian nurses participating in this research, and the hegemonic nature of western nursing. Instead, I deliberately highlighted the colonial influences within the text in an attempt to uncover how as nurses we both individually and collectively participated in reproducing hegemonic discourses. I have explored these discourses from a postcolonial standpoint that acknowledges the formation of nursing’s identity as more complicated, contested and fluid than previous author’s writing about cultural influences on nursing have proposed.

Credibility

Credibility, or ‘trustworthiness’, of research findings derived from qualitative methods is an issue of considerable debate (Silverman, 2001). Under positivist conventions, ethnographers defended the credibility of their research by drawing on two central concepts: validity and reliability. Validity refers to whether the methods used to collect information produce data that truly reflects an exploration of the concept or phenomenon under investigation. Reliability refers to the accuracy of the data generated by the researcher (LoBiondo-Wood & Haber, 2001). Within a positivist paradigm, such validity and reliability is largely derived from establishing distance between the object of study and the researcher, controlling variables to facilitate replication of results, and a belief in the possibility of obtaining and universally applying single truths (Lather, 1991). Such derivation of validity and reliability present significant problems for research, such as this thesis, that involves close interaction with people, deliberate explication of the historical, social and economic conditions that shape interactions between people, and a dedication to uncovering multiple understandings of phenomena.
Whilst some researchers have rejected the need to establish credibility of research that is conducted outside the positivist paradigm (see for example, Agar, 1986), I do not subscribe to this position. Instead, I have adopted the position of Hammersley and Atkinson (1983) who pointed out that it would be paradoxical for ethnographic research to claim legitimacy without some conventions to check findings. As a result, I draw upon Silverman’s (2001) view that my research should represent a systematic attempt at describing and explaining the phenomenon under investigation and hold up to scrutiny against some critical questions. The questions that I have used to judge the credibility of this thesis are presented in Table 5. These questions have been derived from my exploration of the historical traditions of validity as it relates to ethnographic work and Silverman’s “Criteria for evaluation of research “ (p. 222), blended with the epistemological position and theoretical concerns of this thesis that reflect my commitment to a postcolonial perspective. I have organized these questions under the three areas of “pragmatic”, “process” and “political-ethical validity” as proposed by Riley (2005, p. 126).

Many of the questions posed in Table 5 are interrelated. Therefore, evidence of how I have addressed each measure of credibility has appeared in one or more section of this chapter. For example, when I described the cyclic nature of data collection and data analysis, I noted how I used analytical notes to guide my discussions with research participants. Involving research participants in knowledge development is a key quality of research guided by a postcolonial perspective (Mohammed, 2006). However, it is also a key method of ensuring the validity of research findings. Therefore, it is important to note that in this thesis, consistent with what others (such as Manias & Street, 2001) have found, the participants in this research did not want to read verbatim transcripts. In fact, they did not want to read data at all, but instead wanted me to read back to them. As a result, to maintain a commitment to ensuring credibility of the findings of this thesis I would verbally share the content of my analytical notes with one or more of the key informants. By using this technique I was able to elicit the research participants’ perspectives. They were able to add new direction to my analysis, or as we neared the end of data collection, confirm or contradict whether the concepts that I was developing were consistent with previous analyses.
Table 5 Criteria for Judging the Validity of Postcolonial Ethnography

<table>
<thead>
<tr>
<th>Pragmatic validity</th>
<th>Do the methods of research:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Achieve what they set out to do?</td>
</tr>
<tr>
<td></td>
<td>- Consistently demonstrate the application of postcolonial theory?</td>
</tr>
<tr>
<td></td>
<td>- Invoke an immediate feeling of authenticity?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process validity</th>
<th>Were data collection and analysis:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Clearly articulated?</td>
</tr>
<tr>
<td></td>
<td>- Reflective of a systematic decision making process that could be mapped across the research process?</td>
</tr>
<tr>
<td></td>
<td>- Consistent with the espoused dedication to the multi-method strategy of crystallization?</td>
</tr>
<tr>
<td></td>
<td>- Sensitive to the complexities of gathering, recording and presenting data in different languages</td>
</tr>
<tr>
<td></td>
<td>- Organized in such a way that there was a clear distinction between data and it's interpretation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Political-ethical validity</th>
<th>Does the thesis:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Incorporate an openness and transparency relating to the position of the researcher in the generation of knowledge?</td>
</tr>
<tr>
<td></td>
<td>- Foster an understanding of the historical, social and economic situations that intersect to organize interactions between western and on-western once, colonized people?</td>
</tr>
<tr>
<td></td>
<td>- Disrupt dominant discourses and convey the complexity and fluidity of cultural understandings?</td>
</tr>
<tr>
<td></td>
<td>- Openly acknowledge and clearly incorporate the voice of the research participants?</td>
</tr>
<tr>
<td></td>
<td>- Demonstrate a commitment to reflexivity?</td>
</tr>
<tr>
<td></td>
<td>- Openly and transparently acknowledge the partiality of ethnographic understandings?</td>
</tr>
</tbody>
</table>

Finally, the overall pragmatic validity of my work can only be measured against whether I have answered the substantive questions that concerned me. Therefore, credibility in this area only becomes evident through reading the thesis in its entirety. Similarly, in this chapter I have explained how the theoretical underpinnings of a
postcolonial ethnographic approach have guided each stage of the research process. However, judgments about process and politico-ethical validity are particularly dependant on the information and analysis presented in the remaining chapters of this thesis.

**Conclusion**

In this chapter I have explored the methodological underpinnings of a postcolonial ethnographic technique. I have contrasted these underpinnings with the traditional positivist approach to ethnographic research and have described the challenges of implementing a postcolonial approach in the specific context of Indonesia. I have also described the challenges created by the context in which the research took place. I have described how the data were analyzed and presented in a way that disrupts the dominant discourses surrounding internationalization of nursing education and practice. The next three chapters report the findings of this thesis.
Chapter 5

Representations of ‘otherness’

Introduction

This is the first of the three chapters presenting findings. Based on the work of Edward Said (1972, 1975, 1978, 1993), I present an analysis of the ‘image’ of Indonesian nursing as an ‘Orientalist’ construction that stems from the colonial mandates of the ‘civilizing’ mission of European imperialism. The title for this chapter, “Representations of ‘otherness’ refers to uncovering discourses that position nurses, nursing practice and nursing education in Indonesia as ‘different’ from dominant western constructions. The ‘representations of otherness’ illustrate how colonial discourses shape the ‘image’ of Indonesian nursing viewed from both the center (a western interpretation) and the margins (the local interpretations).

Images of Eastern Inferiority and Western Scientific Superiority

Two-and-a-half centuries after colonization of ‘the Orient’ I can relate my perceptions of Indonesian nursing practice and nursing education to the Orientalist depictions that influence westerners to see a particular ‘image’ of the east. This influence involves an image that is defined by the binary of civilized and uncivilized behavior and is translated over time into present day assumptions of western scientific superiority over an inferior eastern illogical ‘other’.

A particularly poignant illustration of perceptions of western superiority and Indonesian inferiority occurred very early in data collection. It took place during one of my first visits to a hospital where students engaged in the clinical placement component of the DIII program. The setting of the observation was a 12-bed nursery in one of the Type C Rumah Sakit Umum (hospital) included in this study. The 12 beds included two cribs, four isolettes and six bassinets. There were two babies in each crib, one baby in each isolette, two babies each in two of the bassinets, one baby each in the other three bassinets and one cat in the sixth bassinet. A portable suction unit with one-liter capacity glass bottle reservoir was in the center of the room. It was
half full of green fluid and while I was there it was used for three babies. I also noticed there were two pink, well toned, normal birth weight full-term babies receiving oxygen therapy. These babies had been born via caesarean section four hours previously. When asked why these particular babies were receiving oxygen therapy, the reason given was that the protocol requires oxygen therapy for two hours for all babies delivered via caesarean section.

In my field notes I recorded:

I am not sure what I was most shocked by: the ‘top and tailed’ babies; the multi-use suction (by the volume of fluid in the jar it had obviously been used many times before); or the cat in the bassinet. There were no ID labels on any babies – how unsafe is that? What potential there would be for a mix-up? Was there a policy for this? Ugh- the suction, along with the fact that the bottle obviously hadn’t been emptied, the risk of transmitting infection from one baby to another must be phenomenal – where is the knowledge about infection control? And the cat – I am at a complete loss – can there be any logical explanation? (PkCO1, FN)

My Indonesian informants: two Dosen, the Direktor of Hospital Nursing Education and the Kepala Bangksa (Head Nurse) were most apologetic about the Nursery.

D4: Ibu [a term of respect for a woman] Robyn, you are shocked, we [Kepala Bangksa and Dosen] are so embarrassed. Our equipment is so old – maybe part of the project SSP you could ask for more isolettes for us? And we have only one ventilator, maybe you can ask for one of those for us too. (PkCO1, D4)

This response, compared to my notes, demonstrated contrasting perceptions from the center and the margins. The perception from the margins (the Indonesians’ perceptions of themselves) is a sense of inferiority about equipment. According to postcolonial theory such feelings of inferiority are derived from a long history of colonial domination (Ashcroft et al., 2000). In contrast, my concern as the western expert, was not with the equipment, but was with the knowledge underpinning the
practices that I observed. As my concern about the thinking behind practice demonstrates many aspects of the western center, I will return to this issue after deconstructing the participants’ reference to deficiencies in equipment.

**Inferior Equipment as a Defining Feature of Poor Practice**

In the instance relating to my experience in the nursery, I ignored the informants’ reference to inferior equipment and so may well have reinforced these perceptions of inferiority through my silence (Spivak, 1990). However, I was not to remain silent on this issue for long. Instead, I repeatedly probed the relationship between equipment and practice as the construction of inferiority relating to technology was repeated throughout data collection. During all site visits, participants referred to inferior technology as a key factor (if not the only factor) influencing the nature of nursing practice. Requests for equipment outnumbered requests for advice about how to improve practice. For example, the following exchange occurred between the Kepala Bangksa of a pediatric ward and me. She was explaining to me why a student nurse whom we had both observed during her practical examination did not wash her hands prior to or after administering the injections.

**KB3:** *It is difficult to get my staff to use them* [the policies, which are referred to in the Indonesian Health System as ‘Standards’ or ‘SOPs’, both abbreviations for Standard Operating Procedures].

**RA:** *So did the student follow the ‘Standards’?*

**KB3:** *No, she just followed ‘the routine’. It is our problem here. Look at the two basins we have I have tried to get running water but it is not happening.*

**RA:** *Have you tried a barrel with a tap?* [I had seen this strategy at another site].

**KB3:** *Oh yes, but it didn’t work, the patient’s families used it to wash dishes [crockery that they brought in to hospital with the food they were required to supply for the patient] and it kept running out, so the nurses didn’t get to use it all. Now we are back to the basins that nursing staff don’t use. If we had running water, then nursing staff would all wash their hands. That would be ‘the routine’. (SgCO6, Iv3, KB3)*
This exchange typified the reported relationship between a lack of hand washing equipment, national prescribed standard operating procedures (SOPs) for hand washing and failure to follow the ‘Standards’ which was referred to as ‘the routine’. The ‘Standard’ in this instance was the two-basin hand washing technique, which was the national prescribed approach to hand washing when running water was not available (Hennessy, 2003). One basin contained a diluted antiseptic solution and the other contained water for rinsing after washing with the antiseptic. ‘The routine’ for health professionals in hospitals was that they had no consistent approach between rinsing before or after washing in the antiseptic solution and sometimes there were three basins so that rinsing could be performed both before and after the antiseptic solution. A linen hand towel was always used at the end for hand drying as prescribed. ‘The routine’ meant that the same hand towel often remained in use for a number of days and both the water and the antiseptic solution were changed on an ad-hoc basis. ‘The routine’ was also affected by the concentration of antiseptic solution used in hand washing, which was governed by the amount of solution available. As stores of the solution decreased, so too did the ratio of antiseptic to water.

The student’s perspective was similar to that of the Kepala Bangksa when I asked her about how she perceived her hand washing performance during the examination.

S1: *I don’t know whether I have done it* [hand washing] *right. The running water is a problem. They teach us to wash our hands before and after touching the patient, but ‘the routine’ is not the same.* [Most nurses do not wash their hands before and after touching the patient]. *The two basins are very unhygienic. That is what our lecturers say. So ‘the routine’ is probably better than washing your hands. Much safer for the patient.* (SgCO6, Iv4, S1)

Both the student nurse and the Kepala Bangksa asked me what the practice is like in Australia. I described that there are usually many hand washing basins with running water on each ward. These hand washing basins in Australia are generally in the room or just outside the room so that nurses can still watch their patients while they wash their hands.
KB3: So there is no problem with nurses following the ‘Standard’ in Australia. But you can see we are not so lucky here in Indonesia. (SgCO6, Iv3, KB3)

Similar to the view held by Dosen and clinical nurses, a theme that occurred in each of the two student nurse focus groups was their perception that the most significant difference between nursing in Australia and nursing in Indonesia was the equipment in the hospitals. The following comment was made by a student after a discussion relating to the aim of the CJSSP to improve DIII graduates’ nursing skills and knowledge.

S15: I think the reason why Indonesian students [of the DIII program] cannot immediately go to Australia and get jobs when we graduate is because we do not know the equipment. The equipment in Australia is so much better than in Indonesia, we wouldn’t know what to do. We don’t know about ventilators and you must know about ventilators to be a nurse in Australia. They would know that we don’t have many ventilators in Indonesia, so we could not pretend. That is why we need the SSP, so Indonesian nurses can go to Australia. (SFG2, S15)

This response was not only representative of other student comments made during the focus group, but also helped me to further deconstruct the exchanges between myself, the Kepala Bangksa and the student relating to the observations of hand washing practices. Together, these data demonstrate the presence of a discourse within Indonesian nursing relating to the importance of technology as a defining feature of optimal standards for nursing practice. Such a definition of optimal nursing practice demonstrates that latent Orientalism in this instance had influenced the ‘image’ of Indonesian nursing viewed from the margins to construct their own practice as inferior.

Superior Intellectual Processes Define Western Practice

The data presented in the previous section were typical of the way the Indonesian participants equated quality of practice with access to technology. In contrast, my
response to this explanation of the difference between Indonesian and Australian nursing from the student did not identify the lack of technology as a determinant of suboptimal practice. Instead, it demonstrated an attempt to change the focus from the equipment, to a focus on scientific knowledge and intellectual processes underpinning use of technology. My response was recorded in my field notes as follows:

Yes, the equipment in Australia is different to Indonesia, but this is only part of the reason that Indonesian nursing qualifications are not recognized as equivalent to Australian nursing qualifications. Students cannot possibly learn about all equipment. Equipment changes so much that students must instead learn the principles relating to the use of equipment and then learn how to problem solve so that principles can be applied to many different situations. Undergraduate nursing students in Australia don’t all learn about ventilators either, but you are correct, you wouldn’t be able to pretend you knew. I don’t think Australian nurses would know that you don’t have many ventilators in Indonesia, but this isn’t something you would want to pretend anyway. It would not be safe to pretend. One of the things that the SSP is hoping to achieve is for the DIII program to have a focus on students learning important principles (for example, about breathing), learning to apply these to different situations (for example if a patient can’t breath), learning to identify what you don’t know (for example how a ventilator does the breathing for a patient), and learning how to logically think through a new situation you encounter so that you can prepare to practice in different environments. This is just one part of improving Indonesian nursing practice, but the SSP alone will not mean Indonesian nursing students can immediately go to work in Australia. (SFG2, FN, RA)

In changing the focus from equipment to learning however, I did not deny the perception of Indonesian inferiority. Instead, I expanded the concept of inferiority beyond equipment to also relate to the capacity for rational thinking. I also touched upon the area of assumed inferior ethical conduct. The Orientalist underpinnings of assumptions relating to irrational thinking and inferior ethical processes are explored in further detail later in this chapter. In the meantime, the following data excerpts illustrate an exploration of the importance of the discourse of technology to
Indonesian nurses’ definitions of good and bad nursing practice. The data also illustrate how Indonesian nurses perceived the relationship between ‘Standards’ (protocols), inferior equipment, perceptions about western expectations of practice and the activities of the CJSSP.

The Bilingual Secretary who was present at the student nurse focus groups and the student nurse examination knew of my concern about what I had observed in both of these instances relating to tensions between ‘Standards’ and ‘the routine’. The following excerpt demonstrates her interpretation of my ‘expert’ assessment of nursing practice.

B1: *Ibu Robyn, you are shocked again, but the equipment here [another Category C hospital] is better than most sites. I understand that you are worried about hand washing techniques, but here you don’t need to worry they have running water. So the ‘Standard’ and ‘the routine’ will be the same. This is a good site for the SSP. It is easier for students to learn the skills the same as in Australian [nursing] programs.* (TeCO10, FN, B1)

This data excerpt illustrates that there was a general assumption that the western expert would attribute deficits in practice to the lack of equipment. It was assumed that deficits in skills and knowledge of DIII students could be explained by the differences in equipment used in Indonesian and Australian hospitals. Similarly, the Indonesian participants assumed that the lack of technology that I observed influenced my expert assessment of deficits in the nursing care being implemented. In this instance, the lack of technology was considered to be the limited access to plumbing, which as the Bilingual Secretary noted, was a major issue that impacted on nurses’ ability to follow ‘Standards’. Of the many different types of health services that I visited across Central Java, most were without running water and those with running water did not have plumbing in all wards/departments. Similarly, one Dosen participant who had studied nursing in Australia confirmed that this is not just a situation confined to hospitals, but is a factor that also governs everyday hand washing practices.
D20: Ibu Robyn, hand washing is a problem of thinking. Only the homes of the most wealthy and the hotels for westerners have running water. Most people do not have running water at home, so it is not a tradition to wash hands like it is in Australia. The Indonesian culture has a negative influence on the hand washing behavior of nurses. Hand washing is not a part of every day hygiene practices at home. Therefore, it is not ‘second nature’ for nurses to wash their hands following such activities as eating, going to the toilet, and handling soiled equipment or materials. Children do not learn to wash their hands, mothers do not wash their hands, men do not wash their hands when they come home from work, hand washing is not taught in schools. So why would nurses think of hand washing as automatic? (Iv6, D20)

This explanation illustrates the pervasiveness of the colonial concept of culture as defined by difference from the west. In this instance, the participant identified a local customary way of thinking, learning and behaving as determining deviation from the prescribed standard of nursing practice. This Dosen perceived that western ‘culture’, rather than nursing culture mandated by protocols, influenced the professional behavior of western nurses. Her underlying assumption was that western nurses wash their hands at work because they wash their hands at home. Orientalist assumptions that the east cannot escape its own backwardness are also evident in this excerpt. It would appear from this participant’s explanation that introducing running water in the hospital would have little effect on nurses’ hand washing practices if there was not a simultaneous change in the wider community to facilitate a change in the broader, local ‘culture’ of hand washing.

So, while I had come to understand that running water was a significant factor limiting hand washing, both in the hospital and wider community setting, what I was interested in exploring was not hand washing in the absence of running water, but rather, hand washing as it differed from the Indonesian ‘Standards’. That is, my focus was on understanding how and why the actual practices were different from the prescribed practices, because the prescribed practices were formulated in the context of assumed absence of running water.
Technology Defines Difference

In light of the perceived interconnectedness of local ‘culture’ and nursing practice, it was also interesting that the Indonesian participants’ definitions of correct and incorrect practice (both their own and the Australian measures they used) were based on assumptions that technology dominates western nursing practice. One Dosen provided an explanation for such assumptions:

D19: Ibu Robyn, we know that there is a problem in students being able to follow the correct technique. They just follow’ the routine’ of the ward. It does not matter that we have the English textbooks or that we show them videos of the correct practice. Students just do the same [routine] as the ward staff. We even show them ER [an American television series set in an emergency department] so they can see what is the best practice. But it doesn’t even help. We are lucky because we have the good equipment in the AKPER [academy], but they do not have this equipment in the hospital. But that is the problem of Indonesia, how can it be improved when we cannot afford the equipment? (FN, D19)

Such perceptions of Oriental inferiority and western superiority reinforce that the colonial discourse, which is underpinned by the concept of coming to know oneself by knowing what oneself is not (Said, 1993), is applied on both sides of the cultural divide. The data demonstrate that both I as the ‘expert’ observer and the participants defined Indonesian nursing practice using the measure of difference from western practice. The Indonesian participants particularly attributed this difference to inferior technology, whilst I was more concerned about rationality.

Images of Eastern Irrationality versus Western Logic

For me, rationality meant firstly using what I perceived to be the logical intellectual process of identifying principles that underpinned an evidence based practice guideline. The second logical step was to use this principle to translate evidence based guidelines from one situation to another according to the technology available. Based on such rationality, I interpreted the participants’ persistent explanations that practice was directly related to resources and that it would not improve until resources
improved as illogical. Accordingly, my concern was that this type of illogical explanation demonstrated a lack of underpinning evidence based knowledge that should instead mandate maintenance of basic standards of practice despite the lack of available resources. For example, the following field note entry was written after I had observed a nursing student use the same equipment to attend to a number of consecutive patient’s wounds.

*I was very concerned with this practice. It did not follow evidence based guidelines to prevent contamination of one wound from another. However, they both [the Kepala Bangksa and Dosen who accompanied me on this visit] were happy with the student’s performance. So, I asked was this the normal practice. This is what the Kepala Bangksa said:*

*Ibu Robyn it is what we do here. The ‘Standard’ is for it [the equipment] to be put in the [steam] sterilizer after each procedure. The sterilizer takes too long and we do not have enough equipment so ‘the routine’ is to do what you have seen. It is the best we can do until we have more equipment.*

*I didn’t believe that this was ‘the best they could do’. The ‘all or nothing’ approach did not make sense. There should be a way of maintaining optimal practice in spite of the lack of resources... I needed to check the evidence relating to prevention of cross-contamination using chemical sterilization to see if this adaptation of the ‘Standard’ would still comply with principles of infection control. I didn’t understand why Dosen who accompanied me had not already done this. When we discussed the situation on our way back to the AKPER he explained that he had some of the literature that I needed in his office.*

*But Ibu Robyn, all of my attempts to improve practice, which “I know is terrible” have been [based on] trying to get them more equipment so that they could use the sterilizer according to the ‘Standard’. (PuCO3, FN, RA, KB2 & D4)*
This excerpt demonstrates how I was influenced by the dominant western discourse of logical intellectual processes so that I interpreted the Indonesian nursing practice that I had observed and the explanations provided by the research participants as demonstrating an absence of rationality. I believed that the Indonesian participants were unable to purposefully identify evidence based principles from a specific evidence based guideline. Nor were they subsequently able to use deductive knowledge to adapt these principles to a technologically inferior situation. Moreover, the interaction relating to the sterilization processes typified what I perceived to be a lack of logic in decision making relating to the everyday process of implementing nursing practice.

**Logic is Missing from Decision Making**

Once again, I was interested in probing underneath the Oriental discourse of eastern inferiority that positioned Indonesian nursing practice as different as a consequence of inferior technology, equipment and resources that support implementation of nursing practice. I wanted to understand why Indonesian nursing practice appeared to be so different, and therefore on the margins, from Australian nursing. In the literature review (Chapter 2) the nursing process (Doenges et al., 2006), was positioned as originating from hegemonic discourses arising from nursing’s western center. Australian nursing, consistent with international standards for nursing, is underpinned by the nursing process (Brown & Edwards, 2005). Similarly, the nursing process was particularly prominent in the philosophy of the DIII curriculum. It was also referred to frequently during classroom teaching that I had observed, and was included as a component of student assessment tasks scheduled throughout the DIII program. Therefore, I was interested in why adoption of the nursing process did not appear to lead to logical decision making in the clinical setting. The following data excerpt illustrates how the judgements I made about deficiencies in Indonesian nursing practice using the nursing process as a measure of decision making capability can be deconstructed as reflective of the Orientalist dichotomy of logical/illogical.

Returning to my first visit to a nursery, my field notes record that I asked the Kepala Bangksa and Clinical Instructor who accompanied me why the babies who did not look like they needed oxygen were receiving this treatment.
KB1: *Ibu Robyn, this is the protocol, every baby receives oxygen for 2 hours if they have been delivered via Caesarean section.* (PkCO1, FN, KB1)

RA: *Why are they still receiving oxygen even though the two hours has passed?*

CI2: *Ibu Robyn, it is the nurses’ decision to continue this, based on the respiratory condition of the baby and respiratory rate. We don’t have an oximeter, like you do in Australian hospitals, so we must just rely on what we see.* (PkCO1, FN, CI2)

This response did not make sense to me at all and in my field notes I recorded:

*If the nurses were relying on what they saw, then they should have made the assessment that the babies no longer needed oxygen therapy. The question is— if nurses can’t demonstrate adequate assessment skills to discontinue oxygen, is the reason that the protocol is there in the first place to cover the lowest possible common denominator? i.e. should guarantee that all babies would receive oxygen therapy so that the baby most in need will be adequately treated and it doesn’t matter if the baby who doesn’t need oxygen gets something extra? But this was not logical either as there were babies in this nursery who were not born via caesarian section but were in severe, respiratory distress and did not have oxygen therapy. What protocol covered this situation?* (PkCO1, FN, RA)

This field note entry exemplified my dependence on the nursing process as a logical western scientific framework for nursing practice and my assumption that such logic appeared to be missing from Indonesian decision making in implementing nursing care. The nursing process is recognized as a systematic approach to fulfilling the goals of nursing care. It is also considered to be a rational way of organizing decision making (Brown & Edwards, 2005). Based on the nursing process I assumed that patient assessment underpinned the planning, implementation and evaluation of nursing care in the situation I had just observed. Similarly, the western concept of evidence based practice heavily underpins the use of clinical practice guidelines translated into institutional protocols (Eaton, Henderson & Winch, 2007). In this case,
such protocols existed as the ‘Standards’ (SOPs) that were formulated to guide Indonesian nursing. However, implementing such protocols is also dependent upon interpreting assessment data and following decision making cues based on these interpretations. So, when there appeared to be a disconnection between assessment and the care that I observed, and then a disconnection between assessment data and the use of protocols that guided care, I questioned the ‘oriental’s’ ability to follow the logic of western scientific processes. At the same time, I was influenced by an Orientalist assumption that if not based on logic, practice must instead be based upon ‘mystic wisdom of the East’ (Said, 1993). Such a construction of eastern knowledge prompted a deeper search for rationalism, objectivity and logic. I specifically searched for data that would help me understand the interaction between the use of the nursing process and the use of clinical protocols (Standards/SOPs) to guide Indonesian nursing practice. My field notes document that I attempted to determine the relationship between assessment data, protocols and observed nursing practices at each site I visited.

After visiting the first nursery I was particularly interested in the administration of oxygen to the babies in other nurseries and relationship between physical assessment data, the decision making processes and protocols for interventions. In all five other nurseries that I visited there were similar discrepancies between the babies who were receiving oxygen, the ones who I would have assessed as requiring oxygen and the ones that the protocol determined needed oxygen. (SoCOS, FN, RA)

Similarly, when I asked the nurses about why one baby was receiving oxygen and another was not, the answer was always “Standard Rumah Sakit” (Hospital Policy). Other examples of wholesale application of clinical practice guidelines related to medication administration. One example appeared in data collected during a nursing student practical examination. I had witnessed the student administer intravenous Dexamethasone (a medication normally administered as an immunosuppressant or to decrease intracranial pressure in head injured children) to a baby admitted to the children’s ward with a fever. Trying to tease out the relationship between theory and practice, I asked the student why she thought this medication was ordered by the medical staff. I recorded her response as:
**S1:** Dexamethasone is given to all babies with fever. It is the SOP. (SgCO6, Iv4, S1)

During subsequent interviews with the Clinical Instructor and Kepala Bangksa supervising this student’s examination, I confirmed that in children’s hospital settings, Dexamethasone was reported to be given to all babies with fever. Not only was this practice contrary to any of my knowledge relating to the pathophysiology of fever and the pharmacological properties of Dexamethasone, but there was also no discrimination based on the cause of the fever. Another example was the administration of Intravenous (IV) therapy. During my visits to the seven Puskesmas I had observed that most pediatric patients were receiving intravenous therapy when they did not show symptoms of dehydration. The following excerpt from my field notes describes one nurses’ explanation of the reason for this situation and my reaction to this information.

I asked, “Is he receiving any IV medications? I was thinking that this might be the reason for the IV. “No, it is not the protocol” was the reply. “The protocol is just IV fluids”. Suspecting that the baby was receiving the fluids based on the protocol but not on individual assessment I asked, “How long will the baby continue on the IV?”. The nurse appeared unsure and discussed this with her colleagues. “According to the protocol”, was the reply. “How do you decide when to stop the IV”, I asked. “According to the protocol”, was the reply again. Thus, I concluded that the baby was likely to receive IV therapy regardless of hydration status. The question is whether it [IV therapy] is also ceased regardless of individual status. In which case, the whole point of having a protocol is rendered null and void. (PgCO5, FN, D23, RA)

Influenced by the unequal Orientalist binaries of rational/irrational and logical/illogical I perceived that the Indonesian response to the problem of both identifying and implementing best nursing practice was deficient. I concluded that the decision making processes used by the Indonesian nurses in this study to decide upon nursing actions were not only different to western decision making processes, but were seriously flawed from my perspective. Of particular significance was that given the central place that the nursing process occupied within the DIII curriculum I had
assumed that the nursing process represented a cognitive process that was common to both Indonesian and western nursing practice. I had assumed that adopting the nursing process meant that there was a shared rationality between the Indonesian nurses participating in this study and myself as the western expert.

Absence of Shared Rationality

The apparent absence of shared rationality was a great concern to me. While a postcolonial deconstruction of my field notes revealed that I was significantly influenced by the Orientalist binary of western rationality and eastern irrationality. However, my field notes also revealed that I had difficulty accepting that such a dichotomy was immutable. I was not entirely convinced that Indonesian and Australian nurses could be so different. The following excerpts from my field notes demonstrate the contrasting positions of me as the western expert relying on the scientific underpinnings of nursing practice to make sense of what I observed, and me as the western expert struggling to find a shared logic that I could work with to improve practices that I had classified as inferior.

I was not particularly concerned about the age or lack of equipment. According to the logic of my evidence based practice technology enhances outcomes but does not replace basic principles of rationality that underpin safe practice For example, the use of identification (ID) labels is based on logical principles of providing an obvious means of differentiating one baby from another, acknowledging parentage and matching the right baby to the right treatment. (PkCO1, FN, RA)

Searching for Rationality

From my position as the western expert, heavily reliant on an evidence based framework, to not have such a process in place rendered Indonesian nursing practice in this instance, irrational, illogical and unsafe. However, the following excerpt from my field notes demonstrates that I struggled to search beyond first impressions for local rationality that would instead position Indonesian nurses away from the margins of Orientalist constructed inferiority and towards the western ‘logical’ center.
I wondered whether I was jumping to conclusions over the ‘apparent’ lack of safe practice relating to ID bands. Perhaps the different Batik [traditional Indonesian dyed material] wraps identified each baby to a particular family or cultural group. (PkCO1, FN, RA)

And later, when I observed the same omission for adult patients:

I thought that perhaps ID bands weren’t necessary because (unlike in Australia) a member of the family was always with the patient. But this didn’t hold for all instances because if the family was particularly poor, no-one could afford to stay with the patient because they needed to work to pay for each medical intervention. (MgCO4, FN, RA)

Again, this data excerpt demonstrates that when faced with practice that was ‘different’ from the western evidence based practice that I was familiar with I attempted to search for rationality. Similarly, I searched for an alternative rationality when my own rationality did not fit the situation. For example,

Similar to most ICUs and Nurseries that we have visited, the SOP is to remove shoes and put on gowns before entering the unit. Unlike in operating suites in Australia, the staff do not put on “inside shoes” [shoes designated to be worn only inside the operating suite], but instead walk around barefoot. This does not make sense. The whole purpose of wearing the gown is for occupational health and safety reasons, but not wearing shoes exposes the nurse to greater risks of potential injury [such as needle stabs or stepping on sharp objects]. I wonder do they understand this problem? (PuCO2, FN, RA)

And the answer:

When I asked about this practice, the Kepala Bangksa [Head nurse] replied, ‘We are doing this for infection control [not occupational health and safety] because we don’t need to worry about catching anything from the babies.’ Not only does this expose the nurses to occupational health and safety risks, but it is pointless. My knowledge is that the research evidence shows that the single-
The most important infection control measure in ICUs/nurseries is hand washing and those shoes, sticky mats, red-lines on the floor and gowns do not have any impact on nosocomial infection rates. So there are a couple of issues with this practice…Once again this is an illustration of running with an idea or adopting a practice from a text book/expert that is applied without full understanding of the underpinning evidence. I worry that practices I speak about or recommend will be implemented without this [understanding] and so lose the underpinning logic to become irrational. (PuCO2, FN, RA & KB5)

When I could not find rationality, I reverted to viewing the situation from the center by reconstructing the practice I had observed as attributable to lack of scientific knowledge. My field notes reveal that this viewing the situation from the center is something I consistently did during data collection. Perhaps I found the need for scientific knowledge more reconcilable with my construction of Indonesian practice as in need of developing through western expertise, than a lack of rationality that was innately Oriental and could not be overcome. This construction also placed the responsibility for improving practice squarely on the shoulders of the superior western expert. This is consistent with the Orientalist notions of undeveloped Orientals requiring western development (Parpart, 1995) and the accompanying neocolonial discourse of development (Ashcroft et al., 2000). For example, in a progress report to the other expert members of the CJSSP Australian technical team I concluded that deficiencies in the application of the nursing process and evidence based protocols meant that:

The foreign consultants will need to work closely with academic and clinical partners to develop processes to address the issue of bridging the theory/practice gap. (Em, RA)

In this excerpt, my reference to the theory/practice gap referred to the apparent lack of connection between possessing theoretical knowledge of the nursing process and actually using the nursing process as a basis for decision making in the clinical practice situation. Accordingly, this excerpt constitutes an example of how the Orientalist stance of western superiority over eastern inferiority influenced both my
interpretation of the clinical practice situation and my perceptions of necessity of
development through the application of western expertise.

Undeveloped and Requiring Development

When faced with practices where I considered there was an oversight of critical
importance to safe nursing practice, the data reveal that I consistently decided that
what appeared to be a lack of rationality was instead lack of underpinning knowledge
upon which to base logical intellectual processes. As the rational expert I believed
that it was my responsibility to change this situation. Based on the Orientalist
dichotomy of developed western knowledge and undeveloped eastern mysticism, this
meant replacing the existing illogical use of current knowledge with a new logical
way to apply this knowledge to the practical situation. Returning again to the missing
processes of identifying patients:

_I came to the conclusion that one of the key elements missing from clinical
practice and therefore should be addressed in the DIII program was not just
information about procedures to identify patients. Gaining knowledge that
underpins such policies and skills in the translation of research into practice
was essential if such changes are to be introduced in the face of a long history
of tradition. (PgCO5, FN, RA)_

Similarly, my expertise informed me that the fact that equipment was ‘old’ should not
have made any difference to implementation of what I considered to be ‘basic’
principles of infection control. While glass suction bottles have been replaced with
plastic self-contained, single use, disposable containers in many settings, these
devices also need to be changed between patients. I interpreted the apologetic
responses and the accompanying perceptions of the reasons for my being shocked, as
knowledge consistent with a low level of development, in need of improvement
through education. According to my field note entry:

_There is obviously a serious deficit in knowledge of infection control among
the nurses that work in this area and I’m not sure whether the Indonesian
nurses are apologizing for the poor equipment to hide the knowledge deficits,_
or whether they seriously think I would be shocked by the equipment itself. Given the classification of Indonesia as a developing country, and the lack of public funding for health, I was expecting equipment of this type. I was more shocked by the brand spanking new ventilator that was sitting in the corner of the nursery – surely funds could have been used better on continuing education in infection control rather than on expensive equipment that no-one has the knowledge to use? (SoCO8, FN, RA)

This excerpt demonstrated how my perceptions of the need for knowledge can be attributed not just to the influence of Orientalist perceptions of inferiority of non-scientific thought but also by the west coming to know itself by what it is not (Said, 1993). By examining Indonesian nursing practice I was prompted to reflect upon Australian nursing practice and its underpinning knowledge base, which I had previously taken for granted. Influenced by Orientalist discourses, the way that I reflected on Australian nursing practice was from the position of contrasting the Indonesian practice that I determined to be on the margins of dominant nursing knowledge to Australian practice that aligned with the knowledge from the center. The unspoken text behind this excerpt was that by classifying what I observed of Indonesian nursing as developing I was constantly defining the western based practice of Australian nursing as contrastingly developed.

The ‘image’ of Indonesian nursing as needing development was not only defined through my view from the center. It was also defined by the Indonesian nurses’ coming to know their own practice by what it ‘was not’. In an attempt to resolve the question in my field notes about whether the apologies for equipment were a strategy to hide knowledge deficits or whether they were a true reflection of misguided perceptions relating to my expectations about equipment, I asked one Dosen who accompanied me on a clinical site visit the following question:

Why do the Indonesian nurses always apologize for the equipment when I am trying to understand what they know about their practice? (MgCO4, FN, RA)

The response from this Dosen was:
D11: I do not understand your question Ibu Robyn. Of course the equipment is the problem; equipment is how they do their [nursing] practice. If the equipment is old, or they do not have the equipment, they cannot do their practice like in Australia. This is what they know about their practice. They are answering your questions. (MgCO4, FN, D11)

Pre-Conceptions of the Need for Development

Orientalist perceptions of the East had led to a pre-conception among Indonesian nurses that equipment would be inferior to western equipment. In the data described so far, the Kepala Bangksa, Dosen, clinical nurses, students and the Bilingual Secretary had assumed that I expected a lower standard of equipment in Indonesia because of Indonesia’s developing status. This assumption was indeed correct, and given the strong influence of Orientalist discourse, my perceptions could only be defined through comparison to the ‘developed’ west (Mignolo, 2000). The major difference however, was that I did not accept that this need for equipment excused poor practice. Instead I believed that such a misguided assumption was one of the major reasons that confirmed the need for development by an expert possessing western scientific knowledge and rationality.

The interaction between my low expectations of Indonesia’s development status and my understanding of Indonesian practice based on comparison to the developed practices of western nursing was particularly evident when I analyzed attempts to identify specific areas for practical field development. The following entry in my field notes describes an observation of a student examination conducted in a pediatric ward of the largest of the six clinical data collection sites. The nursing student was being examined on her nursing interventions relating to care of a three-month-old baby diagnosed with sepsis. I was particularly interested in the examination procedure as one of the concerns relating to the DIII program was that it produced graduates who were not clinically competent (Rahim-Hillan, 2002). According to my field note entry:
A number of issues concerned me:

1. There was no apparent checking of a written order prior to preparing the medication;
2. There was no hand washing prior to preparing the equipment or donning gloves;
3. There was no double checking of the medication during preparation. Only the student examined the vial;
4. The lecturer was unsure of the baby’s diagnosis;
5. Dexamethasone being administered for sepsis is not to my knowledge evidence based and hypothetico-deductive (therefore illogical);
6. The lecturer’s reason for administering Dexamethasone was, “We give all babies with fever Dexamethasone” (this was not a theory/evidence based answer);
7. There was no identification system for the baby;
8. The student did not attempt to identify the baby. Given the lack of identifying data, she could have asked the parents, but there was no communication with either the baby or parents by the student of the examiners;
9. Despite the presence of kidney dish the student carried an uncapped needle to the bedside and then re-capped the needle after use (the lecturer said this was OK because they are not worried about possible blood-borne viruses from a needle stick injury from a baby);
10. There was no patient assessment before or after administering the drug to the baby;
11. No documentation of drug administration;
12. No hand washing following procedures.

Thus, for the student there were significant breaches of safe practice for administration of medication, infection control and occupational safety.

(SgCO6, FN, RA)

The breaches that I identified were those relating to western concepts of safe practice for medication administration, western standards of infection control and occupational health and safety, and apparently no logical connection between the evidence for practice, planning, implementation and evaluation of nursing care. At this point I had
come to the conclusion that these western concepts were not incorporated into Indonesian practice because they encompassed areas of knowledge deficit that were in need of western development.

In addition, the valorization of technology as a defining feature of best nursing practice to the detriment of observing basic principles of patient and staff safety, hygiene and infection control reinforced my assumption that knowledge of underpinning scientific evidence was missing. Accordingly, I determined that Indonesian nurses may not be hopelessly irrational, but instead Indonesian nursing knowledge was under developed. Viewed from such an alternative position I was hopeful that improved practice may be achieved with the aid of western expertise. The following section of this chapter explores data associated with the CJSSP activities conducted under the goal of ‘Developing the Practical Field’, looking for evidence of neocolonial constructions of Indonesian nursing as undeveloped and in need of expert western assistance to develop.

**Developing the practical field**

The purpose of the activities to address the CJSSP goal of ‘Developing the Practical Field’ was to develop and implement processes to improve the practical component of the DIII curriculum. Specifically, there was a need to more closely align scientific knowledge and practical skills so that DIII students could achieve improved competency in the clinical setting (Aitken, et al., 2004). One particular area of focus was responding to the statement within the CJSSP terms of reference: “Contributing factors for poor practice are believed to be that … nurses who supervise students in the clinical area (clinical instructors) lack scientific knowledge” (IBRD, 2001, p. 1). The following data excerpt demonstrates that I believed that data collected to inform the development of CJSSP activities confirmed such perceptions. It also illustrates that I believed my expert assistance needed to take the form of developing the clinician’s scientific knowledge of both evidence for practice and how to use the nursing process for some interventions relating to three specific areas of nursing practice. These three areas were: medication administration, infection control and the implementation of oxygen therapy.
This data excerpt is from a progress report that I wrote to other members of the Disciplinary Development Team three weeks prior to the first of three ‘Developing the Practical Field’ workshops. This workshop was to involve 20 Dosen and 10 Clinical Instructors and was included in the CJSSP work plan to specifically address the perceived deficit in Clinical Instructor’s knowledge of evidence based practice. The excerpt was written seven months into the eighteen-month data collection period of this thesis.

In preparation for the first ‘Developing the Practical Field’ workshop I have read back over my [field] notes and the reports [SSPR2-3] of the clinical focus group [FG1], the Academy focus groups [FG2-FG6], the ‘Disciplinary Development’ workshops [WO1, WO2], the ‘Disciplinary Support’ workshop [AO1] and the many discussions and site visits [I have participated in], I have consistently noted deficiencies in Indonesian nursing practice relating to medication administration, infection control and the implementation of oxygen therapy. There are problems in each of these areas with knowledge about evidence relating to best practice, following SOPs and using a logical nursing process approach to implementing these nursing activities. So these three areas should be priorities for my expert assistance while [I am] in-country [in Indonesia] and concentrating on these topics will make the best use of your [the other Australian technical consultant’s] expertise while you are in-country. (WO3, Em, RA)

Two weeks prior to the planned workshop I had collected participant observation data and conducted interviews with a Kepala Bangksa, a student nurse and two Dosen relating to what I perceived to be a typical example of unsafe medication administration practices by Indonesian nurses. Accordingly, with this data fresh in my mind I sent the following update to my previous email:

In combination with the data from previous clinical observations, and focus group and individual interviews with AKPER Directors, Dosen, Kepala Bangksa, and Ministry Officers my most recent information about the practical examination I am suggesting that we should make medication
Developing improved medication management

The other Australian 'expert' nursing consultants agreed that medication management should be the key focus of practical examples for topics included in the first workshop program. These topics included strategies to bridge the theory practice gap, methods of clinical teaching and policy and procedure development for the clinical placement component of the DIII curriculum. The CJSSP participants had identified these topics as issues impacting on the quality of student clinical learning and the perceived poor relationship between Dosen and the Clinical Instructors. The following field note excerpt describes the approach I used in the workshop.

In order to address these issues and draw attention to as many of the deficits I had observed in Indonesian nursing practice relating to medication management I decided to use a case scenario based on some of the medication management practices that I had observed and determined to be unsafe. The case scenario was designed to highlight the mismatch between 'the routine' that I observed and the SOP that should be followed. By the end of the session Dosen were required to develop their own laboratory teaching exercise for students to demonstrate that they could practice according to the SOP prior to embarking on clinical practice in the hospital. As the session was towards the end of the workshop, the participants had already been prepared with content relating to evidence based practice and the nursing process. Therefore, in an attempt to close the gap between the theoretical use of these concepts and their practical implementation, I deliberately structured the activities to correspond with the assessment, planning, intervention and evaluation elements of the nursing process. (FN, WO3)

Deconstructing the development activity

Deconstructed from a postcolonial perspective, this excerpt reveals that I had designed this educational session as a way to role model the logical development of
knowledge as I understood this process from my own western education. I specifically divided the information into a simple step-by-step approach of linking knowledge in a rational manner. Whilst these are methods that I use consistently in my teaching practices in the Australian setting, deconstructing the development activity also revealed that in this instance I implemented such methods in a way that demonstrated how I was particularly influenced by Orientalist discourses. I assumed a superior position to the Indonesian participants to oversimplify this process because I believed that their thought processes were prone to being ‘illogical’ compared with my own. I would normally not have made such assumptions or used such a directive method for Australian nurses in similar academic or clinical positions.

Moreover, the same Orientalist discourses of superiority and inferiority may also have influenced the Indonesian participants’ receptiveness to the simplistic way I structured the process. As these tasks were undertaken within a workshop that was conducted a significant way into data collection period, prior knowledge of my perceptions and my experience of Indonesian nursing practice may have made the participants receptive to the step-by-step approach that I took during the development activities. They were by this time aware that I constantly questioned the legitimacy of practices that they had previously thought were of an adequate standard and had come to accept this as part of my ‘expertise’. They also knew that I was worried that they followed ‘the routine’ and not the standard (SOPs) but that when I was speaking about Indonesian clinical practice I was speaking from knowledge of Indonesian nursing and not assumptions about practice that I had not witnessed. For example the following interaction occurred during the scenario activities:

RA: Let’s go back a step. What about the fact that the student re-capped the needle, you didn’t include that on your list [of unsafe practices]. Is this the ‘Standard’ or ‘the routine’?

D9: It is not the ‘Standard’ or ‘the routine’ Ibu Robyn, so this scenario would not happen. We do not teach re-capping needles because it is unsafe, a student would not do this.

RA: (raising eyebrows) Do you think I would have included this practice in the scenario if I did not know that students did this [deleted name]?
D9: (looking embarrassed) Maaf [apology], Ibu Robyn, you are correct and it [the scenario] is a good way for us to learn. I know that you must have seen this [re capping needle] yourself, but it would not have been one of my students. (WO3, FN, D9, RA)

Analyzed from a postcolonial perspective, such acknowledgment of my prior knowledge may therefore have also influenced the Indonesian participants’ acceptance of my simplistic method of teaching as consistent with my position at the center of western knowledge and their position on the margins. At the conclusion of the final activity, I was pleased with the outcome. Not only had the workshop content addressed the brief for ‘Developing the practical field’, but the range of educational strategies that were implemented to develop the participants’ knowledge in each of the topic areas. The workshop content also fulfilled another of the developmentally focused briefs of the CJSSP, which was to “… improve the Diploma III program through: transferring knowledge and skills by applying internationally standard teaching –learning methodologies and technologies” (IBRD, 2001, p. 2). In the workshop report that was submitted to the CJSSP monitoring committee as part of contractual requirements I wrote:

**Workshop outcomes:**

**New knowledge:**

- Further development of skills in critical thinking and reflection relating to clinical teaching and learning;
- Best practice in facilitating clinical teaching and learning;
- Relationships between national standards, standard operating procedures and competencies. (WO3, SSPR6)

**Sustaining Development**

The workshop report included reference to consolidation (follow-up) exercises. Consolidation exercises consisted of activities that gave workshop participants the opportunity to practice skills learnt during the workshop and implement strategies developed in the workshops during their normal teaching duties. In the consolidation exercises following this workshop participants were required to: identify other SOPs;
become familiar with the evidence for best practice that underpinned the SOPs; and include this information in practical laboratory experiences. The specific knowledge development task that I set the group that I had been working closely with was to develop a practical laboratory experience relating to performing a simple wound dressing.

Two weeks later I visited the academy to meet with the two Dosen and one Clinical Instructor who had attended the workshop. In my field notes I recorded the following outcomes of the knowledge development intervention:

*Today I was booked to observe two laboratory teaching sessions. The first was the new session that two Dosen and one CI [Clinical Instructor] had formulated to teach students how to do a simple dressing. The second session was supposed to be the session based on the lesson plan developed in the workshop. When I arrived, the two Dosen and CI apologized profusely that there would only be one lesson for me to observe. They had not developed the [second] new one.*

*The medication management lesson that they showed me however, did not resemble what they had done before [in the workshop]. The students did not have a copy of the SOP and did not commence the procedure by assessing the patient’s identity and his/her vital signs. The students did not plan to administer the medication by reading the drug order and the teacher did not ask the student to describe the rationale for giving the specific medicine. Nor did the students give the Intravenous injection using a non-touch technique and they [students] re-capped the needle instead of placing it straight into the sharps container. Finally, the students did not assess the patient’s vital signs after giving the drug. Instead, when each student had demonstrated to the teacher that they could gather together the equipment, inject the substance into the IV tube and return all of the equipment to the procedure trolley ready for the next student, the teacher signed their skills list. (TO2, FN, D4, D5, CI2, S8, RA)*

I concluded this entry in my field notes with the following assessment and question:
This was a disaster! What had happened to the new knowledge that they had developed in the workshop? (TO2, FN, D4, D5, CI2, S8, RA)

The following dialogue from my field notes describes the answer to this question and my response:

D5: *Ibu Robyn, you see, we cannot do the same teaching when you are not here?*
RA: *What do you mean, when I am not here? I am here now today.*
D5: *I mean, we have shown you what we normally do, not what you want to see. You want to see us do what we learnt in the workshop, but teman teman saya [my friends] will not do that. They need to see some reward.*
RA: *It is good that you have shown me what you are doing otherwise I would not know that you have not used the new knowledge from the workshop. But I don’t understand about your friends, it is you I have just been watching.*
D5: *Yes, you have been watching me, but we all must agree to do the same.*
RA: *But [deleted name] you are the most senior person in this area; they will do what you say.*
D5: *No, they need the reward, they need to have the education from you, the same as we [Dosen and CI] have had (TO2, FN, D5, RA)*

In my field notes I also made a comment about this explanation:

*Although the explanation was convoluted, it was typical of the type of answers I often receive. It is like taking off layers of an onion, but never getting to the core. Each time I think that I understand and peel something off, there is something else underneath that is equally as illogical. The only thing that I understand here is that the development exercise was not a success and it seems to be linked to the physical presence of the consultant. (TO2, FN, RA)*

The previous excerpt demonstrates the frustration that I felt when trying to understand the participant’s responses to the development activity, from my western frame of reference. The answer to why I had not seen the expected new teaching practices
acknowledged that the participants were aware of my expectation but described a contributing factor that I had been unaware of up until this point. I thought that a lack of scientific knowledge was the reason for teaching techniques that did not link evidence based theory to practice. From my knowledgeable position at the center I had concluded that a simple step-by-step teaching process that linked theory to practice was the solution to overcoming knowledge deficits at the margins where the Indonesian participants were located, and so a way forward for improving Indonesian teaching and clinical practices.

One of the additional ‘layers’ that I referred to in this excerpt, and had been unaware of, was the complex interaction between the individual CJSSP participants and their wider peer group. Australian continuing education for nurses in hospital settings is heavily reliant on a ‘train the trainer’ model whereby one nursing staff member participates in an educational development activity and then returns to the workplace to implement and then teach others his/her new knowledge (Gabb & Keating, 2005). With such a model as my frame of reference I had not understood that this was incompatible with the Indonesian approach as the following field note excerpt reveals:

*It appears that before any single member of the group could change their practice (regardless of his/her seniority) there needed to be consensus among all group members to make the same change. Moreover, to come to this consensual position, all Dosen needed to have attended the same workshop.*

*(TO2, FN, RA)*

This issue of group consensus, along with questioning if experts are shown what they want to see or what really occurs, is explored in greater depth in the ‘Subaltern resistance’ and ‘Mimicry’ sections of Chapters 5 and 6. The relationship between reward and attendance at the workshop, which is another ‘layer’ associated with this data excerpt, is described later in this chapter in the section entitled ‘Reversion to uncivilized immoral behavior’. In the meantime, my influence on participants adopting new behaviors highlights an important aspect of colonization: the physical presence of the colonizer.
Colonial Occupation of Foreign Territories

Implicit in the definition of colonization is the physical presence of the colonizer in the occupied territories. Time and time again I wrote in my field notes:

*Nothing has been done since the last time we [the Australian consultants] visited this site.* (TO1, TO2, TO6 FN, RA)

And from the participant’s perspective:

*No, we have not done anything. We [Dosen] were waiting for you to come again and do it for us like last time.* (TO1, TO2, TO6, FN, D1, D4, D5, D6, D16, D17)

As described in the Chapter 3 Indonesian history includes many examples of colonial occupation of Indonesian territories (particularly military). Colonial officers would be sent to enforce a new law, but once the occupying force departed the population would revert to their previous behavior. My field notes demonstrate that I consistently attributed the need for my presence to the Indonesian participants’ colonial past.

Deconstructing these field note entries revealed that, similar to the absence of shared rationality, there was also a lack of shared expectations of the responsibilities of each participant of the development activities. The CJSSP contract implied a partnership between the consultants and the participants: “The Sister School Program (SSP) is a collaborative program between the Central Java Provincial Ministry of Health, the newly formed Health Polytechnics; Surakarta and Semarang, and the partner overseas health professional education institutions” (IBRD, 2001, p. 2).

The concept of an equal partnership however, was clearly incompatible with the Orientalist influences on the CJSSP that I have described so far. The following excerpt from my field notes describes my awareness of this incompatibility:

*How could the expectations be shared when the inequality of the partnership was a key defining feature of the project? How could a partnership be equal when it was described in the brief as ‘collaboration’ between the sub-

170
professional Indonesian nurses and experts from ‘a prestigious overseas educational institution’? (AO2, FN, RA)

Unequal Distribution of Responsibility

How such unequal distribution of responsibility related to the development process is illustrated in another excerpt from my field notes:

*It seems that responsibility for development solely rests on the shoulders of the consultants. We [expert consultants] are the only ones expecting a collaborative approach. They [the Indonesian participants] expect us to do all the work and then [for the expert consultants] to be entirely responsible for the outcomes, especially the failures! (WO6, FN, RA)*

There were clearly incompatibilities between how I expected educational and practice development to be achieved and how the Indonesian participants expected this development to be achieved. Deconstructed from a postcolonial perspective, these incompatibilities reflected the ‘image’ of Indonesian nursing constructed from the margins. That is, the responses from the Indonesian nurses who participated in this research appear to indicate that they constructed themselves as in need of development. They also regarded that responsibility for such development belonged to me who they constructed as representing nursing’s western center.

Reversion to Mystic Wisdom of the East

At the time, I did not identify the influence of the Orientalist construction of the ‘other’ and how this possibly influenced the way Indonesian nurses constructed their image of themselves. Moreover, I did not consider this as a potential factor influencing the failure of development activities. Instead, I attributed many failures to the Indonesian participants reverting to a ‘mystic wisdom’ of the east without the sustained presence of western expertise. Said (1978) referred to ‘mystic wisdom’ as one of the Orientalist constructed dichotomies that distinguishes eastern illogical thinking from western rationality. In the absence of a logical explanation for behavior, ‘mystic wisdom’ was used by the Orientalists as an umbrella term that included
explanations for behavior that were mysterious and unexplainable using western logic. Such explanations were instead based on spiritual customs, indigenous (local) knowledge systems, ritual, tradition, ‘magic’ or any other explanation that appeared to have no western scientific basis. The following field note entry was made midway through the data gathering process. It describes what I perceived to be an illogical explanation for permitting cats (that logically posed a significant infection control risk to babies) in the nursery where sick babies resided.

Yet again there were cats sleeping in the cots in the nursery. I had come to expect low levels of hygiene and general cleanliness, but this [the cats] was something that I didn’t think could be explained by a lack of knowledge about infection control procedures. Nor did I think it could be influenced by the choice of following ‘the routine’ rather than the SOP. When I asked about the cats, the answer that I was given was typical of the logic I am coming to expect: “Ibu Robyn, of course we have cats in the nursery. I know other consultants have been to our hospitals and told us that it is not good [practice], so we have sent the cats away. But this does not last long, because if we do not have cats, then we have rats in the nursery and that is much worse”. How could I respond to this answer? Why don’t they just get rid of the rats, and then there would be no problems with the cats – but I’m not going to ask [about getting rid of the rats] because I don’t think I want to know the answer! (SoCO8, FN, CI8, RA)

Not only does this excerpt demonstrate my expectations of inferior standards in the Indonesian practice setting, and frustration with what I thought to be illogical thinking, it also reinforced a growing assumption that any rationalism imparted by a western expert was not strong enough to overcome the centuries old Indonesian ‘mystic’ wisdom. I had assumed that local knowledge systems, customs or spiritual beliefs that were stronger than western logic had led to the acceptance of cats in preference to rats. Rather than adopting the western scientific wisdom that placed both in an equal category of undesirability, the cats would remain while the threat of rats persisted. My reference to not wanting to know why the rats remained implies that I suspected an answer that from my western frame of reference would be derived from wisdom that was equally ‘mysterious’. Similarly, I began to suspect that even if
the participants appeared to adopt western logic while I was on site, the reliance on mystical wisdom would return when I was not there. In an attempt to improve the likelihood of sustainable teaching and practice improvement (development) initiatives, I thought that an alternative strategy might be to work with, rather than against mystic wisdom. However, the gap between western logic and Indonesian mystic wisdom appeared to be too great for such a strategy to be successful. In the final report of the CJSSP (Aitken et al., 2004) I wrote the following:

Accordingly, the consultants viewed the SSP as an opportunity to further develop this valuable human resource [nursing] by assisting the SSP participants to implement educational reform rather than dictating the nature of the reform and orchestrating activities as ‘outside’ consultants. The approach taken by consultants is not unfamiliar to Javanese culture, evidenced by the saying: ‘better to be given the fishing rod than be given the fish’. While it is recognized that this methodology takes significant time the principles learnt by participants and the skills developed will provide a sound basis for sustainability… the participants expressed the view that it would be much easier for the consultants to ‘provide the fish’. (p. 22)

This excerpt provides another example of my continued struggle to find compatibility between the collaborative approach that originated from my position at the western center and what I had interpreted to be unique Indonesian mystic wisdom. However, it did not convey the frustration that I had about failure to sustain practice improvement initiatives in the absence of western expertise. The original data that this report was based upon illustrate my frustration with assumed reversion to Indonesian mysticism much more strongly than the paragraph in the CJSSP report just cited. It was gathered during an individual interview when I probed the participant for clarification about another failed knowledge development initiative.

D17: Ibu Robyn, you know we have the Javanese saying about the fisherman and the fish?
RA: Yes [identity deleted], I have heard it many times. This is the same as what we are trying to achieve. Perhaps I should use it more often so that they [CJSSP participants] know we share the same philosophy.
D17: Ah, but that is where you are wrong Ibu Robyn. In Central Java we do not believe this saying. We are smarter, we just want the fish. So you see, giving us a fishing rod will never work!

RA: This is so frustrating [identity deleted], it does not make sense.

D17: But it does make sense to us Ibu Robyn!

RA: I think this is something I will never understand.

D17: Maybe when you start thinking in Javanese. (Iv16, D17)

I interpreted the references to wanting the fish rather than the fishing rod as confirmation that the Indonesian participants expected to ‘be developed’. Moreover, of particular importance was the original conversation that illustrates how an Orientalist perspective led me to interpret this situation as eastern mystical wisdom competing with western rationality/logic. Together the CJSSP report entry and the excerpt from the interview illustrate how I came to perceive that mystical wisdom significantly contributed to the presence of the western expert (who was the one using the fishing rod) as a critical factor in determining the success or failure of development activities.

An alternative interpretation of the reference to not wanting to fish and instead wanting the fish provided is that the person concerned prefers the work to be undertaken by someone else. This explanation fits with another Orientalist discourse: eastern indolence/laziness compared to western activity/hard work.

**Laziness as an Obstacle to Developing Improved Infection Control Teaching in the Laboratory**

Laziness is constructed by the Orientalist as a typical oriental response to development efforts by the colonizer and reinforces the necessity of an occupying presence to achieve development goals. Applied to the situation of the SSP, this understanding about laziness meant that for me there was an alternative, or additional, understanding of the decision to reject the fishing rod in preference for receiving the fish. According to Orientalist discourses such a response to development may have been that instead of (or possibly as well as) being of inferior intellect, the Indonesian participants were simply lazy. They just wanted to be handed solutions for improving
practice and did not want to contribute an equal amount of work to the development initiative.

The application of the assumption of laziness as an explanation for failed development initiatives is illustrated in my field notes relating to the specific activity of improving the incorporation of infection control principles into teaching students wound dressing in the academy laboratory. One of the homework exercises for the participants of the ‘Developing the practical field’ workshop was to apply their knowledge of preparing a laboratory based learning activity relating to medication management to another technical nursing activity. The participants described in the following field note excerpt chose to demonstrate that they taught students to practice according to the SOP for wound dressing techniques.

RA: *I do not understand. This is not the model we used in the Laboran [workshop].*

D4: *Ibu Robyn, you are correct. We do not have time to get the SOP and there is no time for all of the students to demonstrate back to the lecturer. So, we ask the students to get the SOP and to read it and practice it in the afternoon.*

RA: *So, there is another session in the afternoon so that you can apply what you learnt in the Laboran after all.*

D4: *Belum [not yet] Ibu Robyn. We do not work in the afternoon, it is up to the students to do the learning themselves. That is just the way it is.*

RA: *And do the students do that when no-one is there to supervise them?*

D4: *(laughs)… Ibu Robyn, what do you think, they are lazy and if no-one is there (shrugs shoulders) who knows?*

RA: *I don’t know [identity deleted], but you know what, I have traveled three hours to see no improvement and this is not the first time this has happened. My time is too valuable to waste like this. I will be working this afternoon. Maybe I will supervise the students.*

D4: *(laughs) Ibu Robyn, that is a good idea, they will do it properly if you are here.*

_I don't think this Dosen realized that I was not making a joke. I was actually very angry and although it would be a good strategy [for me] to demonstrate_
how to involve and assess each student, I was not going to go to all of this trouble if he couldn’t be bothered to be there. He has reinforced my understanding of the laboratory practice that we are trying to improve.

However, how can it improve when it is not only the students who are lazy? I have seen Dosen schedules here and because there is so many staff they have ample time for preparation. And [name deleted] has been granted time release specifically to work on the SSP initiatives. Also, Dosen only teach in the mornings, so what do they do all afternoon? Why couldn’t this Dosen be in the laboratory to supervise? I suspect he is working elsewhere. Maybe that’s what he means by ‘that is just how it is’. We will never replace the nonsense of demonstration and re-demonstration if this whole situation can’t be changed.

(TO2, FN, D4, RA)

This excerpt illustrates a number of Orientalist influences. It reinforces earlier data that led to my classifying much of the existing teaching as substandard and illogical, and also demonstrates how I believed my own teaching to be superior to the local techniques. My growing assumptions relating to the importance of my physical presence as a factor contributing to success of development initiatives is also illustrated as is my perception that laziness on the part of the participants contributed to the development initiatives failing to improve practice. Contrasting images of Dosen work practices from the center (my assumptions) and the margins (the informant’s perspective) appear in this excerpt. Clearly, Dosen did not perceive the academic staff to be lazy, instead indicating that students could learn by themselves. Based on the Orientalist dichotomy of western hard work and eastern laziness I constructed the absence of teacher-directed learning as laziness on the part of Dosen in this excerpt. An alternative image of work practices (that I frequently apply in my own teaching) would be that Dosen were not lazy, but instead were incorporating a student-centered learning activity (self-directed learning) into their teaching strategy.

Moreover, with the reference to ‘a suspicion of working elsewhere’, this excerpt touches upon the influence of another Orientalist discourse on my construction of Indonesian nursing, that of eastern immorality. According to the Orientalists, reliance on mystical wisdom also rendered the oriental prone to uncivilized behavior, particularly immorality. Mystic wisdom is seen as an excuse for not complying with
western standards of morality. The following section of this thesis describes how I was influenced by such Orientalist discourses to construct the behavior of Indonesian nurses according to the binaries of western morality versus eastern immorality and western honesty versus eastern dishonesty to construct juggling more than one job as associated with uncivilized behavior.

Reversion to Uncivilized Immoral Behavior

Focus groups (FG1-FG6) attended by Dosen and AKPER directors of the six participating academies revealed that many Dosen who worked in the government academy in the morning and also worked in a private academy in the afternoon. Alternatively, the more junior Dosen may arise early to cook at a street side warung [food stall] or sell stationery or general groceries from the front room of their rumah kecil [small home]. Having more than one job is actually more the norm than the exception in Indonesia. In fact, with the low salaries that most Indonesian Ministry of Health employees earned it was a necessity for providing their families with the basics of food, shelter and clothing (Rahim-Hillan, 2002). Given this context, such practices were compatible with the western side of the Orientalist dichotomy (hard work) and I therefore came to a degree of acceptance of this practice.

However, when such practices constituted what I saw through my western construction of morality as a conflict of interest, I considered these work practices to instead represent immoral behavior. For example, in the previous excerpt relating to the workshop participants’ failure to demonstrate a new teaching technique I had interpreted the statement ‘that is just how it is’ to be the use of mystical wisdom to hide the fact that this Dosen was juggling more than one job. According to the Orientalist binary of western honesty and eastern dishonesty (Said, 1978), I constructed this statement as a deception. I assumed deception because I considered that in this instance juggling two jobs was preventing this Dosen from fulfilling both his routine teaching obligations at the academy and the specific teaching obligations that he was required to fulfill as a participant in the CJSSP.

A review of the teaching schedules revealed that despite having some mornings free from teaching in the government academy, Dosen who were concurrently employed
by two institutions did not use this time to teach in the private academies. Instead, they chose to teach in the private academy during the afternoon when they were not free from teaching duties in the government academy. As a result, these Dosen did not comply with the government academy schedule that allocated them to teach in the laboratory during the afternoon. Therefore, in the context of receiving a salary from the academy and paid time release from normal teaching activities to facilitate his participation in the CJSSP, this Dosen who had participated in the CJSSP workshop failed to fulfill both his employment requirements and CJSSP participant tasks despite opportunities within the teaching schedule to do so. Influenced by the Orientalist dichotomy of western honesty/eastern dishonesty I constructed this behavior as dishonest.

In addition, I believed that the participant who had failed to implement improved teaching techniques and all of his colleagues who did the same were managing their two employment commitments to the detriment of best teaching practice. Data collected during the focus group with Dosen (FG1) supported the perception described in the previous field note excerpt that students would not practice skills during unsupervised laboratory practical sessions.

D21: One of the problems with students learning practical skills before they go on field practice is that they do not have enough practice in the academy.
RA: But I have seen the teaching schedules and I thought that each afternoon students have time in the laboratory to practice.
D21: Yes they do, Ibu Robyn, but they are not supervised and without supervision they do not come and if they do come how can they learn without a teacher? (FG1, FN, RA, D21)

During the second student focus group (SFG2), students also confirmed that they expected learning to be teacher-facilitated and when I discussed this with one of the Bilingual Secretaries she provided the following background:

B2: Ibu Robyn, our [schooling] system in Indonesia is different to how I think students learn in Australia. The teacher reads from a book or writes on the board and the students take notes. They then repeat the information and write
it down so that they can do the exam later. I think it is what you call rote learning. So, when students come to the AKPER, this is the type of learning that they know. This is also the example that Dosen have had, so this is the same type of teaching they do. Students do not know how to learn without the teacher. (SFG2, FN, B2)

Based on this insight into teaching practices and student learning strategies the CJSSP technical team had decided that under the brief of ‘Developing the practical field’, a key initiative for improving clinical practice competency amongst DIII graduates was to improve the teaching within the laboratory sessions and to increase teacher attendance in the laboratories in the afternoons. Therefore, when juggling two jobs was implemented in such a way that Dosen failed to attend the afternoon laboratory sessions I considered that such uncivilized deceptive/immoral behavior was another contributing factor to the failure of CJSSP practical field development initiatives.

I had identified that scheduling was not a major impediment to juggling two jobs. Therefore, from my perspective, the practices that I had constructed to be dishonest could be avoided, I probed this issue further. On further investigation, I found that another compounding factor was that the SKS (standard credit system) allocated the same points (and therefore salary) to one hour of lecturing as three hours of laboratory teaching. As laboratory teaching was always scheduled in the afternoons at the government academy and always in the mornings at the private academy, participants who had concurrent employment in both institutions always maximized their income by avoiding laboratory teaching whenever possible. That is, irrespective of their allocated government teaching schedule they chose to work in the government academies in the morning and the private academies in the afternoon, so that their work patterns coincided with the times when they would receive a higher salary for lecturing rather than the lower salary for laboratory teaching. This system of remuneration therefore also proved to be a serious impediment to CJSSP initiatives that were designed to develop the practical field by improving student preparation for practice in the laboratory setting. As one senior academic confirmed:

D4: Teman teman saya [my friends/fellow Dosen], need incentives for participating in the SSP. They need to see some reward Ibu Robyn. When we
supervise an examination we get an incentive payment, when we go to the Laboran we get per Diem [payment for attending] and travel [payment for travel to the venue]. There is no incentive to improve the laboratory teaching. There is no incentive for the students to attend. Students are already passed in the morning session. If Dosen did what you are suggesting, then we would need to pass them in the afternoon. But there would be no Dosen in the afternoon. Maybe the SSP could pay incentives for the laboratory? Then Dosen might be able to change the practice. (TO2, FN, RA, D4)

While this appeared to be a possible strategy, viewed from my western moral perspective, such a payment would in my opinion border on a form of corruption. From such a perspective what the Indonesians termed Korupsi, was a significant obstacle to implementing initiatives to improve practices throughout the CJSSP. Moreover, individual interviews with provincial Ministry (DinKes) Officers (Iv2, Iv17, Iv19) revealed that incorporation of incentive payments as part of normal work practices was condoned at the highest levels. The following excerpt from my field notes provides an example of how I perceived that corruption at senior levels of administration affected the outcomes of the CJSSP implementation activities. It related to the process for choosing nurse academics and clinicians for participation in the workshops.

The task of selecting participants who complied with our [Australian consultants] criteria [for participating in the workshop] was the responsibility of DinKes Officers. While some of the participants indeed met these criteria, others did not. For example, some participants did not meet the criteria of being involved in day-to-day academic or clinical teaching, and when they attended the workshops, they did not engage in the workshop activities. It appeared that, typical of DinKes processes, these participants were selected based on positional authority as they were all senior Dosen. (FN, WO3)

From my western perspective, I did not understand why the western logic of choosing participants with qualifications and experience most likely to assist in implementing changes was not followed. I did not understand why such important personnel would waste what I assumed to be valuable time attending a workshop that being very
practical in nature was largely irrelevant to their roles. The following excerpt from my field notes contains an explanation that is consistent with Indonesian national data on motivating factors for participation in continuing education (Hennessy, 2001). It also provides insight into the relationship between seniority, work allocation and income.

Senior Dosen are chosen to come to the workshop so that they can receive the per diem [payment for attending] and travel [payment for travel to the venue]. The Direktor (of the AKPER) chooses these Dosen because they are senior, not because they meet the criteria. Dosen will give the Direktor some of their reward in return for being chosen. It is just like the Kelas Khusus [Excellent Class: a cohort of students within the DIII program who receive 60% of their tuition in English]. The ‘Fellowship’ graduates [World Bank funded project that sponsored Dosen to obtain Masters Degrees in Australia] who speak the best English do not get to teach the Kelas Khusus because they are mostly junior Dosen. The senior Dosen are given this privilege, because there is extra payment for this teaching. It does not matter that they don’t speak any English; it is the payment that matters. So, the Kelas Khusus is not really excellent after all. The Direktor still writes on the report that it is taught 60 percent in English because there is a special payment for the Kelas Khusus and she will be able to use it for her office or to buy a new Direktor’s car. Her friends [the senior Dosen] will not say any different because they are the ones getting the benefit [of the additional teaching payment]. (Iv7, D10)

Viewed from the Orientalist perspective it appeared that the decisions related to who participated in development activities reflected the embedded nature of corruption within the DIII nursing program. Moreover, as there would be little contribution to the desired outcomes of the development activities from these workshop participants, my perception was also that this was an immoral wasting of public funds that had been invested in a loan from the World Bank and would contribute to Indonesia’s national debt over the next decade. A small number of other Indonesian nurses participating in the research expressed a similar view to the participant who provided the data relating to the use of selection criteria in the previous excerpt. However, as illustrated in the following field note excerpt they did not appear to share my concern relating to the
morality/immorality of such practices. Instead they accepted that such practices simply reflected the situation in Indonesian society more generally:

D20: *Ibu Robyn, in Indonesia we call it KKN- Korupsi, Kolusi and Nepotisme* [corruption, collusion and nepotism]. *KKN is an everyday part of Indonesian life, receiving payment for an opportunity that you would not get otherwise, or just paying someone something extra to make life easier. We cannot really complain... One day I will be the senior Dosen and it will be my turn to get the reward.* (Iv6, D20)

The participant who contributed these data was clearly attempting to reassure me that, viewed within the wider context of Indonesian society, the corruption within the DIII program was not as bad as my western interpretation led me to believe. Her explanation however, did not reassure me, but instead under the influence of the Orientalist discourses reinforced my perceptions of eastern immorality in the form of deception (the maid and the documentation) as a widespread phenomenon and not just something restricted to a few participants in a small practice development initiative. It also highlighted the importance of payments for services and the following section of this chapter reveals how I incorporated this knowledge into my data collection activities to achieve a better understanding of the decision making process relating to implementing or withholding patient treatments.

*Developing Improved Oxygen Administration Practices*

In the section entitled ‘Logic is missing from decision making’ I previously described the apparent lack of logical application of the nursing process to decision making relating to commencement and cessation of oxygen therapy. The answer I received when I asked why one baby was receiving oxygen and another was not was consistently “*Standard Rumah Sakit*” [Hospital Policy]. However, the nurses’ actions did not reflect the SOP, so I just kept probing by asking the nurses different questions. The following excerpt from my field notes describes how one nurse finally elaborated on the SOPs relating to clinical care in the nursery.
RA: According to the SOP this baby should be receiving oxygen, but he is not, is there another ‘Standard’ that I don’t know about?
CI8: Yes, Ibu Robyn, there is a SOP for each paket [payment level] and this baby has no-one to pay the fee. He will die of course. (SoCO8, FN, RA, CI8)

Importantly, my comment at the end of this field note entry reveals how I eventually came to understand why the nursing process was irrelevant to the practice of oxygen administration in the neonatal nursery and in any other publicly funded clinical practice setting.

*The CIs answer confirmed my suspicion and finally solved the mystery about ‘Standard Rumah Sakit’. (SoCO8, FN, RA, CI8)*

The allocation of resources based on the ability to pay had been previously demonstrated at other clinical sites included in this research. So by the time that I recorded the above observation and interaction in my field notes it was not a shock to me that the decision making process relating to administration of oxygen therapy was not based on assessment of physiological parameters. I was not shocked that decisions instead were underpinned by a protocol that dictated implementation of treatment according to a sliding scale payment structure. Accordingly, I attributed this situation as a reflection of a different ‘eastern’ morality. However, I was shocked by what I perceived to be a lack of moral concern on the part of the nurse who simply acknowledged that the baby, whose parents could not afford the treatment, would die.

*Uncivilized Attitudes Towards Life and Death*

One of the most persistent (latent) influences of Orientalism was the creation of the ‘image’ of the east as uncivilized (Said, 1993). Such latent Orientalism particularly influenced me to attribute a lack of civilizing influences upon clinical decision making as one of the factors contributing to failed development initiatives. As I was interested in determining the logic behind Indonesian nurses’ decision making processes, my field notes included many descriptions of clinical situations where I would have expected the nurse to make a decision about implementing nursing care based on physiological assessment data. During the data analysis process it became
clear that my concern relating to an apparent disregard for the sanctity of life was a common theme amongst many clinical situations that I had chosen to document. I also acknowledged this theme towards the end of the data collection period. The following field note entry was made after observing a critically ill patient cared for in a ward situation because his family could not afford the expense of a higher level of care.

*I think what has continually worried me has been the situations that I observe where nurses don’t appear to be worried that their lack of recognition of signs and symptoms, lack of scientific knowledge to relate symptoms to underlying processes, lack of ability to apply knowledge to practice and the lack of understanding about the functioning of equipment may contribute to the death of their patients. The sickest babies I have ever seen are those in the nurseries here in Central Java. Patients with the worst head injuries are not in the Intensive Care Unit and I have never seen patients with 78% burns nursed on a ward before…. But now I understand that the allocation of resources is not based on the nurses’ judgment, it is based on the ability to pay. This is somehow much worse… It is pointless teaching nurses assessment skills if this is how the [health] system works. But, I guess this is how Indonesians view life, so why did I expect the health system to be any different? (SoCO8, FN, RA)*

Deconstructing this data excerpt from a postcolonial perspective my reference to ‘how Indonesian’s view life’ demonstrates how I was influenced by the Orientalist dichotomy of civilized west and uncivilized east to making a negative assumption about the value placed on human life. The following excerpt from my field notes provides an illustration of some of the data that had lead me to such an assumption. It also illustrates that the ‘image’ of Indonesia as less civilized in attitudes towards life and death was not just an ‘image’ from the center, but also influenced the ‘image’ held by those occupying the margins.

*MO3: *Ibu Robyn, you are almost as upset about that lady going to die as you always are when we see the sick babies. You must remember that it is different here in Indonesia. Remember the other day when there was a crowd blocking that street in the village? You did not see the charcoal man hanging on the*
[electricity] wire. We did not tell you then because you would be upset, like you were when we would not stop so you could help the men in the motor bike accident. But death is something that happens everyday in Indonesia. We have too many people to be worried. There is over 200 million [population] now, imagine if we saved everyone who was going to die. How would the health system cope with more people? So you see, you might think it is not OK, but it is necessary. (PkCO9, FN, RA, MO3)

Therefore, not only did I classify Indonesian nurses’ decision making processes as sub standard, but I also came to consider that such decision making was compatible with a health system that reflected the low morality of the wider community. These excerpts and many of the other extracts from the data contained in this chapter also highlight that nursing is embedded in the local context in which it is enacted. In this instance, nurses upheld the local view that dying was a common phenomenon and was also perceived to be a useful means of controlling the rapid population growth.

**Orientalist Discourse Denies the Space for an Alternative Image of Indonesian Nursing**

The Orientalist discourses that construct the local Indonesian context as uncivilized and in need of development accordingly positioned Indonesian nursing as ‘different’ from the dominant western constructions of nursing. Positioning Indonesian nursing according to such Orientalist constructions did not allow a space for either me, or the Indonesian participants to consider an alternative image of Indonesian nursing that shifted it away from the margins and towards the western center. For example, the data extracts describing constructions of laziness and corruption, decisions relating to allocation of resources and attitudes toward life and death in the previous section of the thesis reveal my pre-occupation with understanding a ‘different’ morality within Indonesian nursing. However, when the research participant described the relationship between the Indonesian context and the health care system, my reflexive journal entry indicates that I realized that we had both been blind to the similarities between the western and Indonesian health systems within which we as nurses were both required to practice.
What an oversight! I had been so focused on what I had assumed to be a lack of knowledge, illogical decision making processes, and a lack of rationality that all of this time [9 months into the research] I had failed to explore the possibility that the SOP that the nurses referred to following was not the protocol relating to delivery of oxygen therapy. Instead, it was the SOP relating to delivery of services within a poorly funded health system. This is not entirely dissimilar to the situation in Australia where we have a two tiered health system: public and private. Regardless of the fact that not even the publicly funded health care is free in Indonesia, there is still the choice of level of service according to ability to pay…. This revelation about the SOP also caused me to revise my perceptions about the ‘morality’ relating to the value of human life. In Australia there has recently been an ethical debate about the allocation of scarce health dollars to premature babies less than 26 weeks old. With an aging population, many of the people opposed to allocation of funds to the very sick pre-term neonate argue that health care dollars would be better placed in funding care at the end of life. So, is this any different from Indonesia? (SoCO8, RJ, RA)

The data extract revealed the ethical dimensions associated with Indonesian health care. It also revealed how I began to consider not only the differences, but also the potential similarities between Australian and Indonesian nurses and to revise some of my interpretations of Indonesian nursing practice. From this point on there was a noticeable change in my field note entries. The entries now included interpretations of Indonesian nursing that challenged the dichotomies inherent in Orientalist discourses. I was now interested in how the allocation of resources acted as an obstacle to the success of development initiatives as demonstrated by the following excerpt.

Once I knew that the allocation of oxygen therapy was based on whether the family could afford to pay, I had to think seriously about teaching physical assessment. Since the very first site observation, all subsequent observations, focus group interviews and individual interviews had highlighted that assessment skills are something that are not translated from theory into practice. I had made this a priority in the work of developing the practical field, but what use are good assessment skills if they have no relevance to the
remainder of the decision making process? No wonder teaching assessment skills appears to be so unsuccessful. It does not matter if the nurse knows and correctly assesses all of the respiratory parameters that indicate severe respiratory distress. If there is no money for oxygen, how can best practice be implemented? (MgCO8, FN, RA)

Similar questioning of my previous interpretations of clinical practice prompted me to ask more questions to explore again the other failed development initiative of removing cats from the nursery that is described earlier in this chapter under the heading of ‘Reversion to mystic wisdom of the East’.

RA: Why don’t you get rid of the rats?” [I asked, thinking this would be the logical solution].
CI9: Yes, the other [Australian] consultants said the same thing, but to get rid of the rats, we would have to get rid of the chickens, and we need the chickens to lay eggs to feed the sick children. (SoCO8, FN, RA, CI9)

This data excerpt illustrates that the influence of Orientalist discourses in this instance had previously led me to believe that mystical wisdom was far stronger than western logic, and had distracted me from probing further the contextual factors that influenced nursing practice. While the presence of cats, rats and chickens was far from the best practice guidelines for infection control in western hospitals, there was a logical reason for this situation as opposed to the purely ‘mystic’ reason that I had previously concluded was the sole rationale underpinning practice. Moreover, without understanding and addressing each component of the chain, development initiatives were bound to fail. The Orientalist discourse of ‘difference’ had led me to see a marginal ‘image’ of Indonesian nursing, excluding the possibility of an alternative image of Indonesian nursing that was better positioned to deliver health care to the Indonesian population than the western nurse positioned at the center.

An ‘other’ Image of Indonesian Nursing
In summary, the data findings presented in this chapter have provided specific examples of how Orientalist discourses have influenced the construction of an image
of Indonesian nursing as ‘different’ from dominant western constructions of nursing (Mohammed, 2006). The data findings have demonstrated that such difference is defined by a lack of scientific knowledge, illogical decision making processes, lack of rationality, reliance upon mystic wisdom, laziness, and uncivilized behavior (Said, 1978). Discourses relating to these defining features of difference contributed to a shared construction of Indonesian nursing from both my position at the center and from the Indonesian participants’ position at the margins (Hagey & MacKay, 2000).

A discourse of technological inferiority was found to exclusively influence Indonesian nurses’ own perceptions of the inferior standard of Indonesian nursing practice. Failed development initiatives within the CJSSP have been described and deconstructed to reveal that success was influenced by the ability of western expertise to supplant persistent local practices. The physical presence of western experts was important for sustaining development initiatives (Xu et al., 2001). During development activities there was a constant tension created by a lack of shared rationality and responsibility for success (Bruni, 1995; Lynam, Browne, Reimer-Kirkham & Anderson, 2007). Such incompatibility between the development provider and development recipients has been deconstructed to reveal the pervasive influence of the Indonesian nation and its people being constructed as ‘developing’ (Parpart, 1995).

On the other hand, low levels of technological and economic development contributed to constructions of Indonesia as a developing nation and profoundly influence the nature of Indonesian nursing practice. Informed by an awareness of these contextual influences, previous images of difference were re-visited to explore the possibility of moving away from an image of Indonesian nursing constructed at the margins and towards reconstructing an image of Indonesian nursing as sharing similarities with nursing’s western center (Reimer- Kirkham & Anderson, 2002). In the next findings chapters I move beyond the Orientalist discourses of technological inferiority, irrationality, and dependence on western development that have been uncovered in this chapter to further explore blurring of the boundaries between ‘difference’ and similarity.
Chapter 6
Deconstructing ‘other’ Voices

Introduction
This chapter draws on the work of Spivak (1988a, 1988b, 1990, 1993) to deconstruct the voices of the Indonesian ‘other’ to uncover the existence of a powerful subaltern. It reveals how some of the Indonesian participants in the CJSSP reversed the colonial master/colonized slave relationship by adopting the position of powerful subaltern. It illustrates how these participants deliberately appropriated dominant discourses to resist western subjugation and to participate as members of the global nursing profession on their own terms.

Appropriation of Dominant Discourses
Bhabha (1994) described the success of colonization as only superficial. In Can the Subaltern Speak? (Spivak, 1988a) Spivak proposed that such deceptive appearances are not created by assimilation, but instead by subalterns appropriating dominant discourses for their own purpose. In this thesis the Indonesian members of the CJSSP management committee appropriated the dominant discourse of ‘development’ to set the Terms of Reference (IBRD, 2001). Using this discourse, they positioned the CJSSP within the human resource development requirements of the World Bank loan and implied that the activities of the CJSSP would take place within a ‘development’ model. As a background to the World Bank loan application, the Central Javanese Sister School Management Committee wrote:

In Central Java, 80% of nurses and midwives are “sub-professional”, having graduated from SPK institutions (at the same level as senior high school). Moreover, the quality the Diploma level (DIII) program is believed to be poor. Contributing factors are believed to be that nursing and midwifery teachers generally lack clinical skills while nurses who supervise students in clinical area (clinical instructors) lack scientific knowledge. Further, Nursing and
Midwifery Academies in Central Java no longer met the standards set by the Ministry of Education …

It was therefore identified that the DIII curriculum needed reform; teaching and learning methodologies needed substantial improvement; skills exchange and collaboration between teachers and clinical instructors needed to be established; and management systems and facilities development needed to be focused around modern, internationally accepted educational practice. (IBRD, 2001, p. 1)

This excerpt demonstrates how the Indonesian members of the CJSSP management committee adopted the broad discourse of development to position Indonesian nursing and nursing education as under-developed. This excerpt also shows that this position of under-development could not be constructed without also appropriating the dominant discourses that link the professionalization of nursing to international standards for nursing practice and education. That is, to define themselves as under-developed, the Indonesian participants in the CJSSP needed to have a ‘developed’ benchmark against which their own level of development could be measured (Parpart, 1995). The references to reforming teaching and learning methodologies, improving skills exchange and initiating modern, internationally accepted educational practices were examples of appropriating the dominant voice in nursing that links standards for educational preparation to international consistency of graduate outcomes. The Indonesian members of the CJSSP management committee further appropriated the dominant voice in nursing by judging specific components of nursing education as in need of reform at the same time as classifying Indonesian nursing as sub-professional. By making such a link between education and practice, the Indonesians adopted the dominant voice in nursing that measures professional status against the competencies that define the contemporary, internationally mobile nurse.

The interaction of the discourse of development and the hegemonic discourse that defines contemporary nursing are particularly evident in the references to improving the scientific knowledge of clinicians. In this excerpt, clinicians were considered to be sub-professional because they lacked the scientific development necessary to meet competency requirements of the contemporary, internationally mobile nurse.
The presence of the discourse of development within interactions between the Indonesian participants in the CJSSP and me was also identified in Chapter 5. A portion of the same excerpt presented above was deconstructed in Chapter 5 to illustrate how the Orientalist discourses of inferiority influenced the Indonesian participants in the CJSSP to construct themselves as under-developed. However, such deconstruction assumed that the image of under-development is passively accepted by a powerless subaltern. Listening instead, for the voice of the powerful subaltern and taking into account the once-colonized and now globalized context in which the loan application and terms of reference were formulated, opens up the possibility of an alternative interpretation of this excerpt. The following excerpt from an interview with a key informant who occupied the role of Bilingual Secretary occurred relatively late in the data collection process. It demonstrates how the dominant discourse of development was appropriated, not to serve the purpose of improving Indonesian nursing in Indonesia, but to serve the purpose of creating opportunities for Indonesian nurses to work overseas.

RA: *If the aim of the SSP is to improve the health of the population, then isn’t it more important for us* [the Australian consultants] *to work with Dosen to ensure that the DIII program produces a more competent graduate? But the Dosen don’t seem to want to include the SSP initiatives in the core business of the DIII program. They seem to see the new teaching and learning strategies and practical field development activities as just for the purpose of the SSP. For example, the new practice of Dosen supervising critical thinking activities in the practical lab was only done as a demonstration during my follow-up visit after the workshop. No-one is doing this now, they are still teaching in the Private [AKPER] in the afternoons and leaving the students on their own in the [Ministry AKPER] laboratory. Also, facilitating ‘hands on’ practice opportunities for students is still not a priority for every student, if it happens at all, these Dosen say it will only happen in the SSP demonstration wards.*

B1: *Yes, Ibu Robyn you are confused and correct at the same time. The idea [of the CJSSP] is not for [producing] nurses for Indonesia. There are already too many DIII graduates with no jobs. So, the idea of improving the DIII program… is for [preparing] Indonesian nurses to work overseas. This is a*
good solution for the [nursing] surplus but we cannot do this without an internationally recognized curriculum. That is why we are having the SSP. Why would Dosen do SSP activities for the regular DIII program? We will only need to do the SSP activities for the programs for nurses to work overseas, like the new AKPER in [location deleted] that my friends [names deleted] will be in charge of. That is why they are chosen to do the SSP activities. (Iv13, B1)

This interview with the Bilingual Secretary was a significant revelation to me as the excerpt from my field notes indicates.

The interview [with the bilingual secretary] was the first time that the agenda for exporting nurses has been overtly linked to the activities of the SSP. Since the outset [of the SSP], there has been an undercurrent of the World Bank loan being acquired deliberately to finance the hidden agenda of setting up nursing schools specifically to prepare Indonesian nurses for the global market. But until now, it has only been like a whisper that is quickly covered up by statements like ‘we need our nurses to meet international standards so that nursing in Indonesia will be better’. (Iv13, FN)

As the excerpts show, the Indonesian participants appropriated the dominant discourse of developing nursing very successfully. Listening for the voice of the powerful subaltern rather than interpreting the data through the dominant Orientalist lens, revealed that the Indonesian participants in the CJSSP did not adopt the discourse of development to implement global standards for local practice. Instead, they adopted the discourse of development to resist such subjugation and participate as members of the global nursing profession on their own terms. That is, my Orientalist influenced interpretation of the link between developing local practice and internationalizing Indonesian nursing was based on the assumption that improving local Indonesian nursing education would lead to recognition for Indonesian nurses by the international nursing community. According to this interpretation, if Indonesian nurses wanted to be recognized, they would need to change local practices to comply with international standards. In contrast, in the position of powerful subaltern the Indonesian participants in the CJSSP had decided to bypass improving local nursing.
For them, the focus of the CJSSP activities to internationalize the DIII curriculum was on educating nurses for direct entry into the global nursing workforce.

In this instance, Indonesian resistance to colonization from nursing’s western centre occurred from within, rather than from outside the dominant discourse. The Indonesian participants in the CJSSP who adopted the position of powerful subaltern did not draw on indigenous knowledge to deny the need to develop Indonesian nursing that was to take place in the local situation. They did not defend the priority of exporting nurses in preference to improving local practices by providing explanations that were characteristic of ‘the mystic wisdom of the east’, ‘eastern irrationality’, ‘eastern laziness’ or ‘eastern immorality’. Such responses would have been consistent with the Orientalist binaries that separate eastern (non-western) nursing from western nursing and so would have relegated them to the margins of the discipline. Instead, they rationalized the focus on preparing nurses for working overseas using arguments based on the hegemonic discourses relating to scientific knowledge, rational decision making, lifelong learning and professional autonomy that define nursing’s western centre. Therefore, in these excerpts, the voice of the subaltern did not originate from the margins, but firmly located itself alongside the voice of the centre (Spivak, 1990).

The ease with which the Bilingual Secretary engaged with the dominant discourses to resist confinement to the assigned position of under-development is illustrated by another excerpt from the same interview.

RA: Don’t you think that using the activities of the SSP to export nurses is inconsistent with the purpose of the World Bank loan? The people of Central Java will be paying back the money for years to come, but not seeing any benefit; their health will not be improved by exporting nurses, but the health of people in the countries they [Indonesian nurses] go to will be improved because they [the Indonesian nurses] will help solve the nursing shortage in that country.

B1: Of course we have thought of that Ibu Robyn [spoken in a very offended, perhaps even angry voice]! When the nurses return to Indonesia they will
come back with knowledge from developed countries and will improve hospitals here in Indonesia. That is a good outcome for our people’s health.

RA: But why would they come back [name deleted]? They will have a job overseas, much better salary, much better living conditions. That is why they will want to do the study in the first place, that is why they will want internationally recognized qualifications. You have just said that internationally recognized qualifications are of no benefit in Indonesia.

B1: Ibu Robyn, of course we have thought of that too. Before they are allowed to do the course [to prepare for working overseas] they will have to sign a commitment to return to work in Central Java. Just like the Fellowship recipients [the World Bank funded project preceding the SSP that provided scholarships for nurse teachers to gain Master’s degrees overseas], they will have to work in the Ministry institution for two years for every one year spent overseas. But they will be assigned to important positions and receive much higher salaries than they would ever have achieved if they had just stayed in Indonesia. This is a good incentive. They can have overseas experiences but they are rewarded to return to their families. Their home is Indonesia and they would prefer to live here more than anywhere else in the world. It is a win-win situation. (Iv13, RA, B1)

This exchange illustrates how the Bilingual Secretary and I both spoke with voices derived from dominant discourses to defend our attitudes towards Indonesian nurses participating in the global workforce. The voices of those who represent dominant nursing (for example, the International Council of Nurses) propose ethical recruitment policies that discourage migration of nurses from developing countries to developed countries (ICN 2001 reaffirmed in 2007). My response echoes the concern that the phenomenon of ‘brain drain’, whereby experienced nurses from the non-western world move to western countries with a low burden of disease (UN, 2006) and leave behind inexperienced personnel (Daly & Lumley, 2005; Kingma, 2001; Ortin, 1990) to deal with the highest global burden of disease is unethical (Bloice & Hallinan, 2007; Daly & Lumley, 2005; Kingma, 2001).
In contrast, the Bilingual Secretary counteracted my criticism by appropriating the voice of the dominant centre that supports migration from developing to developed countries. She may as well have directly quoted the voice of the World Health Organization (World Health Assembly, 2001; WHO, 2004c) and the United Nations (United Nations, 2006) who cited the capacity-building contributions of returning nurses to their own health systems as a significant benefit of migration. In this instance, her engagement with the dominant discourses of individual and professional autonomy functioned to resist confinement of Indonesian nurses to their colonized place in the developing world.

At the same time, her engagement with these dominant discourses was compatible with the local context. She did not deny that Indonesia’s position as a developing nation constituted a ‘push’ factor for migration, but instead described a pragmatic solution to retaining Indonesian nurses lured by the opportunities in the west. Again, her use of the term ‘win-win situation’, a term frequently used to describe the benefits of a free market economy, illustrated a powerful appropriation of a western discourse.

Appropriating the dominant voice also functioned to place us on equal footing. My reaction to the plan for preparing Indonesian nurses for migration reflected Orientalist assumptions of western superiority. My adoption of a position on the high moral ground drew on the Orientalist stereotype of the uncivilized Oriental. I was influenced by the Orientalist binary of western morality and eastern immorality (Said, 1993) to interpret the desire to prepare nurses for the global market rather than improve the quality of local nurses as unethical. Rather than passively accepting the discourse that positioned migrating non-western nurses as on the margins of ethical conduct or putting forward a stereotypical, irrational point of view, the Bilingual Secretary counteracted my criticism with an argument derived from the centre. By doing so she rejected my monopoly on expertise and particularly resisted the master/slave dichotomy that defines the colonizer and the colonized subject (Spivak, 1998b).

*The Master/Slave Narrative*

The parallels between the master/slave dichotomy and the expert/novice binary are particularly relevant to the interactions between the Indonesian participants and me in
the CJSSP. As described in Chapters 3 and 5, my assumptions of expertise were based on the nursing literature that situates western nursing as more developed than non-western nursing (Davis, 1999; Holt et al., 2000; Lash et al., 2000) and Orientalist constructions of western scientific superiority compared to Indonesian eastern irrationality. During 19th and 20th Century colonization, such superiority legitimized patterns of domination to facilitate transplantation of the imperial civilization into the peripheral territories. Now, in the 21st Century, I can identify how this pattern of colonial domination persists to legitimize my authority in the dominant position of western expert and domination over the Indonesian participants to facilitate transplantation of standards for nursing from their western centre into Indonesian nursing on the margins.

The following email was sent from me to the group of Australian nursing consultants scheduled to join me in Central Java to conduct a re-evaluation of teaching practices. Their brief was to verify that the learner-centered methods they had introduced during a previous visit had been adopted by participating Dosen and applied in their everyday teaching practice. A calendar of technical consultant visits had been authorized by the CJSSP management committee six months previously. The Australian participants in the CJSSP had made arrangements for their normal academic duties to be covered while they participated in these scheduled overseas trips. However, a week prior to this scheduled visit an ad-hoc week-long meeting, unrelated to the CJSSP, but involving all of the intended Indonesian participants was convened. Dosen would no longer be able to participate in the scheduled CJSSP activities.

My email illustrates the contrasting reactions to this deviation from planned activities by the Indonesian partners and me. It provides an example of the parallel between the constructions of expert/novice and the master/slave pattern of domination and how this was played out in interactions relating to transplanting western nursing standards for educational practice to the specific setting of Central Java.

*I told the Ministry Officer that it was not an acceptable alternative for the Australian consultants to do something else [during the scheduled visit]. We needed to see evidence of change in practice by the participants and we have*
specified time and time again that the SSP activities must take priority over local activities.

The Ministry Officer was adamant that the meeting [unrelated to the CJSSP] would not be cancelled. So, I said that I would instead cancel the visit, reminding her how important you are [the visiting Australian Consultants] and that as a Professor you weren’t about to waste your time coming here if the particular participants couldn’t demonstrate acquisition of improved teaching skills.

The Ministry Officer responded that we would be in breach of the [World Bank] contract if the visit was cancelled.

There was no point wasting time with [the Ministry Officer]. I have bypassed her and gone straight to [Indonesian chair of CJSSP management committee] and reminded him that our initial assessment of teaching concluded that Dosen do not meet the standard required. I have spent considerable time and effort in training Dosen according to the latest research, and this visit is necessary to verify achievements. I explained that you [the visiting Australian Consultants] are the experts in the field and you are only available at the scheduled time. Without your assessment of Dosen performance, there could be no sign off that the objective has been achieved. So, I told him that if you are not able to assess Dosen teaching practices [because Dosen are involved in other activities], then I will cancel your visit and they [Indonesian management committee members] will be in breach of the contract. (Em, TO4 & TO5, RA, MO2, MO3)

In this email my references to the limited availability of the experts and CJSSP activities taking priority over local activities related to the DIII program demonstrates how I used constructions of western superiority to dictate when activities would take place and who would be involved. Reference to the considerable time and effort spent to change inferior practices to compliance with international standards, and the need for experts to verify levels of performance demonstrates how I justified Indonesian inferiority and subordination to the Australian experts. My references to research
based interventions and the need to see evidence illustrates how scientific knowledge contributed to the construction of western superiority in this instance.

Importantly, this email also illustrates a number of ways in which the Indonesian participants resisted domination by the Australian consultants and rejected the master/slave narrative.

**Resistance to the Master/Slave Narrative**

In this same email, I indicated that prior to the impromptu scheduling of the week-long AKPER meeting I had believed that the CJSSP workshops would proceed as planned because:

> The ‘Terms of Reference’ document has been approved and the Ministry stamped invitations have been sent out to each participant. (Em, TO4 & TO5, RA, MO2, MO3)

That is, I believed I had complied with the Indonesian procedures that were necessary to implement CJSSP activities that required attendance by more than five Indonesian participants. Compliance with such procedures meant that while I may have had the authority of the western expert with regard to the types of activities designed to transfer western knowledge and skills to Indonesian participants, I had no authority to make these activities happen. I had to comply with the local systems of approval (and rejection) and so did the Indonesian participants who were not permitted to attend unless they received the official (stamped) invitation.

Moreover, official invitations were not issued unless the Terms of Reference complied with Indonesian regulations for educational activities. A committee of Indonesian experts met to review each of the Terms of Reference that I submitted and more often than not I had to make changes before they were approved. The changes generally involved specifying exactly what the Australian consultants would be teaching in place of statements such as ‘student directed activities’, ‘student directed role plays’, ‘problem solving activities’, ‘reflective exercises’. I used these broad statements to signify that the specific nature of the activities would be dependant on
the interactions between the participants and the workshop facilitators. As ‘learners’, the participants would identify activities that best assisted them to achieve their individual learning goals. However, the Indonesian members of the CJSSP management committee did not support this lack of control on the part of the facilitator. Instead they stipulated that the Terms of Reference would not be approved until I itemized each of the activities that the facilitator would direct the participants to do. In this way, the Indonesian experts used their local authority to challenge my learner-centered teaching strategies and reverse the master/slave relationship. The positions of centre and margins were reversed, with the Indonesian experts locating teacher-centered strategies at the centre and my western student-centered strategies on the peripheries. When I questioned why the Terms of Reference had not been approved, one of the committee members who evaluated the Terms of Reference explained:

*Ibu Robyn, there is nothing wrong with your Terms of Reference. You are teaching the SSP participants that it is important to adhere to standards [for conducting workshops] and that is exactly what we are doing. Your Terms of Reference just did not comply to the ‘Standard’, so we are making sure that it does.* (Iv19, MO3)

This excerpt provides an example of Spivak’s powerful subaltern (Spivak, 1990). The Ministry Officer appropriated the dominant discourse of ‘standards’ to resist subjugation using language originating from within, rather than outside the dominant western centre. They deliberately drew attention to the parallels between my assumed authority over teaching Indonesian nurses to comply with international standards for nursing education and practice and their authority over local standards for nursing education. By couching their decision making in the language of ‘standards’, rather than directly challenging learner-centered teaching, they avoided exerting their authority as a form of resistance from the margins.

The email that I wrote to the Australian Consultants also demonstrated that my attempts to dictate when CJSSP activities would occur and who would participate in them were not always successful. Activities could be delayed while waiting for the Terms of Reference to be approved and/or official invitations to be issued.
Alternatively, as in the situation this email describes, other activities unrelated to the CJSSP could take priority. Once again, this situation was often justified by the Indonesian participants appropriating the dominant voice as the following field note excerpt illustrates:

*I was able to get an appointment with [Indonesian chair of the CJSSP management committee] and he justified the disruption to the planned SSP timetable by quoting me back to myself: “Ibu Robyn, tidak apa apa [do not worry] the visit [referred to in the email] will take place, but we need to be sensible about this. It is you that keeps reminding us that it would be um, um (he searched for the word for a while then asked a colleague for the English translation) unethical for us to just use the SSP initiatives for [training] nurses for overseas. The purpose of the meeting in [location deleted] is to disseminate the information about the SSP activities so that the Directors of the AKPER will support including SSP strategies in teaching by all staff and not just the SSP participants. It [the meeting] is a change management strategy; we are trying to do this the western way”. He then proceeded to draw a concept map about how he thought the changes were going and then found a paper from Harvard Educational Review for me to read so I could understand the theory he was using. He then reminisced about his time studying for his Master’s degree in the United States. (FN, MO2)*

The speaker in this field note did not succumb to a position of subservience, but rather, adopted the dominant position by using my voice and the dominant discourses relating to ethical recruitment and change management. He also appropriated the dominant discourse of assimilation and placed himself in an equal, if not superior position to me by referring to a scholarly article, situating his concept map in change management theory, and reminding me of his Master’s level qualifications. Such reversal of the Master/slave narrative is a hallmark of Spivak’s powerful subaltern (Spivak, 1990).
Reversing the Master/Slave Narrative

A particular strategy used by the Indonesian participants for ‘turning the tables’ on the master/slave relationship was by assuming the dominant voice in relation to contractual obligations. Whilst I constructed the involvement of the Australian consultants in the CJSSP as taking place under the auspices of a development brief, the members of the Indonesian management committee constructed the roles and responsibilities of both overseas and local partners in a different way. They resisted confinement to the assigned position of ‘developing’ by treating the CJSSP brief as a contract through which they were the master who controlled the activities of Australian consultants. For example, in the email described earlier (pp. 196-197), both the Indonesians and I referred to contractual obligations relating to the scheduled visit to Indonesia by members of the Australian consultant team. Despite the different ways of constructing the role of the CJSSP consultants, in this instance both the Indonesian Ministry Officer and I used the threat of breach of contract to try and establish a position of domination over each other. Such interactions occurred frequently throughout the research period, particularly in relation to the in-country (in Central Java) presence of the Australian experts and the scheduling of contract payments. The following excerpt is taken from another report that I wrote to my fellow Australian consultants.

*The ‘bottom line’ from the CJ [Central Java members of the] management committee is that it is their money that is paying for the SSP... and that unless we spend a total of 110 weeks ‘in-country’, they [the Indonesians] will not sign the ‘start up’ clause nor transfer the first scheduled payment.* (Aitken, 2002, p.1)

The interactions relating to contractual obligations demonstrated that the relationship between the Australian and Indonesian participants in the CJSSP was not an equal partnership. However, this inequality defied the prevailing Orientalist influenced western assumptions that positioned the Indonesian partners as the inferior party. Instead, deconstructed from a postcolonial perspective, the relationship between the partners in the CJSSP was influenced by a powerful subaltern response to past and more recent histories of colonial incursions. While many western incursions into
Indonesia are framed under the guise of development activities, a postcolonial view of both past and present day western involvement in Indonesia instead positions these activities as western capitalist endeavors (Philpott, 2000). In this instance, the Indonesian management committee members have appropriated capitalist discourses to reverse the western master/Indonesian slave narrative and assume the dominant position. Of importance in this respect is that although an Orientalist influenced reading of the CJSSP Terms of Reference positions the partnership as ‘development’ focused, the CJSSP was not funded by unsolicited western development monies. Instead, the CJSSP was funded by a World Bank loan that was initiated, and had to be re-paid by the Indonesians. Therefore, as powerful subalterns, the Indonesians have positioned the CJSSP as an Indonesian initiated trading arrangement rather than an Australian initiated development project.

From this perspective, the terms of the contract defined the arrangement whereby the services of the Australian consultants were engaged for the specific purpose of facilitating entry into the global nursing marketplace for Central Javanese nurses. Under these terms, the Australian consultants were the ‘hired’ help as illustrated in the following extract of an email from me to the other members of the ‘expert’ team.

[The Australian Project Manager] thinks that the only way that we are going to get this contract off the ground is to realize that they [the Indonesians] are, as it says in the project brief: ‘the client’. [The Australian Project Manager] says that it is a case of the customer always being right. We are in essence, being hired by a client who, regardless of the finer detail, has total control over our contractual obligations because they [the Indonesians] are the paying customer. I have adjusted our activity schedule so that 111 weeks of our time is spent in-country in Central Java. It will mean that rather than run the project from Australia and have brief specifically targeted visits, I will have to run the project from Indonesia. It will not mean any additional activities, just my sustained in-country presence. But that seems to be what they [the Indonesians] want, they want to see us so that they can make sure that they are not paying us to do SSP activities while we do something else in Australia. (Em, RA)
Not only does this data excerpt illustrate how the Indonesian members of the CJSSP management committee positioned themselves as powerful subalterns, but it also provides another analytical perspective on the colonial occupation of foreign territories and indigenous responses to this. By demanding a specific amount of time spent in-country by the Australian consultants, the Indonesians embraced the notion of occupation and challenged my perceptions of the homogeneity of the subaltern group.

**Heterogeneity within the Subaltern Group**

Implicit in the definition of colonization is the physical presence of the colonizer in the occupied territories. In Chapter 5 I explored how I interpreted the historically embedded responses to my physical presence at the various teaching or clinical sites as both passive resistance and passive acceptance of physical colonization. According to Spivak (1988a) such responses to colonization are typical of the powerless subaltern.

However, the data excerpt describing how the Indonesian management committee members mandated the presence of the Australian experts reveals a different response to the issue of my physical presence (and that of the other consultants). In this case, rather than being subject to their colonial history of occupation, the discourse of occupation was appropriated by the Indonesians to represent powerful resistance to western subjugation.

Similarly, the Indonesian management committee members absolved the Indonesian participants’ responsibility for success or failure of CJSSP activities from a powerful position, rather than the subservient position adopted by Dosen and clinical nurse participants. The Indonesians did not adopt the position of the ‘other’ who by virtue of their inferior position are inherently unable to live up to international expectations. Instead, they placed responsibility for success or failure of CJSSP activities exclusively on the shoulders of the ‘hired’ experts. By appropriating dominant discourses to reverse the master slave relationship, the Australian consultants, as the ‘hired’ experts were responsible for both their own activities and the activities of the Indonesian participants. As the following excerpt also illustrates, the discourse of
contractual obligation meant that if the Central Javanese Dosen and clinicians failed to reach the international standards for nursing, then this was not the fault of the Indonesian participants. Instead it represented a failure to comply with contractual obligations on the part of the Australian consultants.

The extract comes from my field notes involving a conversation with five Dosen during the final CJSSP workshop. Many Dosen participants had attended a meeting the week prior to the workshop where other senior teaching staff had reported on their evaluation visits to Central Kalimantan and South Sulaweisi. As part of the evaluation strategies for the three SSPs, AKPER staff members from each Province traveled to the other two Provinces to assess the outcomes of their respective SSP contracts.

D2: *What are we going to do when our friends come to Jawa Tengah [Central Java] to look for visible outcomes of the SSP? We have done the work that was required, but we were already experienced before the SSP started.*

D17: *The SSP participants were not so advanced in Kalimantan Tengah [Central Kalimantan] or Sulawesi Selatan [South Sulaweisi], so it is easy for them to demonstrate outcomes.*

D13: *Ya, some of my friends say that there is nothing from the SSP that can be applied to the institution in Jawa Tengah because we were already doing it. Also, my friends say that in Kalimantan Tengah or Sulawesi Selatan the SSP consultants have been teaching in the classroom and been supervising students in the field practice.*

D2: *Their [Central Kalimantan and South Sulawesi] consultants have re-written the curriculum. In Jawa Tengah you have not done that. You have expected us to do the international standard teaching in the class and in the laboratory and the CIs [Clinical Instructors] to do new methods in the field practice.*

D5: *We have had to develop the local and national subjects [in the DIII curriculum], in the other provinces, the SSP consultants did that for them.*

D11: *Based on the situation of my institution, some of my friends are pessimists with the program.*
D13: You say that the [Australian University] will not let us write on our graduate’s transcripts that you recognize it [the Central Java DIII program] as international standard.

D5: Well, that was the consultant’s responsibility, not the burden for us.

D13: In my opinion if we are to be internationally recognized we need the international curriculum from Australia, not our curriculum, and you need to teach it. (WO6, FN, D2, D5, D11, D13, D17)

This excerpt demonstrated how the discourse of contractual obligation was used by some of the more senior Dosen to allocate responsibility for perceived inconsistencies between the CJSSP Terms of Reference (IBRD, 2001) and the visible outcomes of the project. My response to the criticism was one that I had used many times during implementation of the CJSSP activities. It was generally used to encourage participation and in contrast to the discourse of contractual obligations, drew on a discourse of equal partnerships whereby our responsibility was to teach the knowledge and skills, and the Indonesian participant’s responsibility was to do the work. Some of the responses that I had previously received to such an explanation are described in Chapter 5 and were spoken in the voice of the passive subaltern. They drew on Orientalist discourses of Indonesian inferior knowledge, inferior equipment and practices and reinforced my Orientalist constructions of Indonesian nursing conforming to dominant stereotypes of eastern laziness and immoral behavior.

However, by examining data relating to the contractual elements of the CJSSP I have now revealed that the subaltern response to colonization is not homogenously passive, and not all Indonesian participants in the CJSSP conformed to the image of the powerless subaltern. Instead, the data reveal the existence of a powerful subaltern response and a group within the subaltern cohort who exerted power from the margins to usurp my authority that I had assumed was derived from my position within the centre.

**Conclusion**

The chapter illustrates how the discourses relating to international standards for nursing and the attributes of the contemporary, internationally mobile, were
appropriated by some of the Indonesian participants in the CJSSP and how such appropriation influenced my work as the western expert. Using Spivak’s (1993) model for deconstruction the voice of the subaltern, data analysis revealed that such appropriation of dominant discourses meant that I mistakenly believed that the Indonesian participants and I shared similar motivations for improving the DIII nursing program.

Deconstructing the voice of the subaltern also revealed how the western discourse of contractual obligation was appropriated by the powerful members of the group to decenter, rather than submit to, my assumed authority over all CJSSP participants. Such appropriation of the dominant voice meant that the Indonesian participants could reverse the Orientalist constructed master-slave relationship to instead participate in the CJSSP activities on their own terms. By recognizing the heterogeneity of the subaltern group and deconstructing the data to listen for the voice of the powerful subaltern, I have therefore uncovered an explanation for why western expertise was, on the one hand highly desirable, but on the other hand, appeared to be resisted by the Indonesian participants. The next chapter explores how the resistance manifest by the powerful Indonesian subaltern participants created an ambivalent similarity between western (colonizing) nursing and Indonesian (colonized) nursing.
Chapter 7

Looking in the Mirror

Introduction
This chapter draws on the work of Bhabha (1983, 1990, 1994, 1997, 1998) to explore the processes of mimicry and mockery that created perceptions of similarity between western and Indonesian nursing as experienced in the CJSSP. It explores how such perceptions of similarity influenced my expectations of transferability of western expertise, and the applicability and acceptability of international standards for nursing to the specific context of Central Java, Indonesia. In *Location of Culture*, Bhabha (1994) argued that construction of the ‘other’ relies upon false assumptions that culture is a static entity and denies the influence of contextual elements. This chapter therefore, particularly explores the influence of contextual factors upon appearances of similarity between Indonesian and western nursing.

The chapter also examines how such constructed similarity functioned to both resist western expertise based on notions of global consistency, and to open up a new space where local and universal practices could be reconciled to produce a copy rather than an exact replica of western nursing. As a result, outcomes of the CJSSP that were deemed to be most successful by both the Australian and Indonesian participants are deconstructed and positioned as illustrations of hybridity, occupying the space that is left on the borders between difference and similarity (Walker, 1997).

Ambivalence
In Chapter 6 it was revealed that an intense desire to achieve international mobility constituted a significant motivation for the Indonesian participants in the CJSSP to engage in activities aimed at reforming the DIII curriculum. On the other hand, the data in this chapter reveal that despite the attraction of exporting surplus DIII graduates, Indonesian nurses wanted to maintain a distinctly local implementation of the DIII program. Bhabha (1994) refers to the tension between wanting the colonial without submitting to colonization as ambivalence. Like Spivak’s (1988a) passive and
powerful subaltern, Bhabha’s ambivalent colonial subject reconciles these conflicting desires in two different ways. As a ‘mimic’, the ambivalent colonial subject pretends to comply with western authority by camouflaging resistance to colonization. Alternatively, by ‘mocking’ western authority, the ambivalent colonial asserts indigenous authority to decenter colonial assumptions of universality of western knowledge. In the following sections of this chapter, the apparent similarity between the clinical component of the DIII program and international standards for nursing education is deconstructed. The presence of ambivalent responses of mimicry and mockery are exposed as a mechanism used by Indonesian nurses to maintain local practices while at the same time appearing to work towards achieving internationalization of DIII education.

**Mimicry**

In this research, it initially appeared that Indonesian Dosen had adopted a western model for preparing students for clinical practice and supervising them while they completed placements in the *Rumah Sakit Umum* (hospitals) and *Puskesmas* (Community Centers). Dosen were also required to follow guidelines that appeared to incorporate a western approach to the examination processes used to ensure students achieved clinical competence requirements. However, when the activities of Dosen were deconstructed according to the concept of mimicry, the appearance of assimilation was found to reflect a close external resemblance to, but not compliance with western standards for preparation for entry into nursing practice. Instead, the close external resemblance between Indonesian and western nursing education was found to represent a camouflaging device. Typical of the ‘mimic’, such camouflage appeared to be adopted to protect the clinical elements of Indonesian entry-to-practice nursing education from interference from the Australian experts. The next section of this chapter explores how mimicry was used in this way during the CJSSP.

**Reproducing a copy of the colonizer to guard against interference**

The following data excerpt relates to a key informant interview with two Dosen. The interview was designed to follow up on a focus group (FG1) where Dosen had identified specific areas of deficiency in entry-to-practice nursing education that they
perceived needed to be addressed in order to internationalize the DIII program. I initiated the key informant interview with these Dosen by requesting their assistance to ensure that I had correctly interpreted data collected from the focus group and my review of the curriculum documentation. According to the key informant interview:

RA: *The total SKS* [the units of measurement for each component of the DIII curriculum] is divided into *‘Teori’* [theory] and *‘Professi’* [practical], but by my calculations, this means that 85.5% of the DIII is theory and only 14.5% is practical. International standards for nursing curricula say that the balance between the amount of time spent on theory and the amount of time spent in clinical practice should recognize the equal importance of both elements [of the curriculum].

D10: *Ibu Robyn, you make the wrong calculation. ‘Teori’ means taught in the AKPER and ‘Professi’ means taught in the clinical [setting]. But, you should calculate Laboratory hours plus clinical [hospital placements] plus field practice [community placements] to get the correct percentage.*

D20: *(Quickly adds up the SKS). It is 55.5% Teori and 44.5% Professi. This is cukup [satisfactory] ya? It is international standard?*

RA: *Yes, in Australia, when overseas nurses apply for registration [a licence to practice as a generalist nurse] it is generally expected that a minimum of 40% of the entire program is clinical practice. The Nurses Board of Victoria [an Australian state licensing authority] requires that there is a 50/50% division between contact hours for theory and practice to accredit university curricula [sic]. This is in line with other international standards (e.g. the American Essentials of Baccalaureate education [AACN, 1998].*

D10: *That is good; we do not need to change this. And our laboratory schedule is also good?*

RA: *Yes, from what I understand, the students have an opportunity to have ‘hands on’ practice doing technical skills [in the Laboratory] in the afternoon after they have learnt the relevant theory in the morning. Is this correct?*

D20: *Ya, Ibu Robyn, we have used the Canada model.*

RA: *We will need to do some work on the scheduling of clinical practice though. Am I correct that hospital/community placements are not scheduled*
until the final three semesters? This creates a large gap between the theory and ‘hands on’ learning in the practice setting.

D20: You are correct Ibu Robyn, I don’t know that we can change this [subject scheduling], it is the National Curriculum requirement. But the organization [of student clinical practice experiences] is international standard?

RA: Yes, it appears to be organized in a similar way to western nursing programs. Am I right, when students do ‘hands on’ practice in the clinical placement they are supervised by a clinical nurse who has a minimum of two years experience and Diploma III level qualifications?

D10: Ya, SPK nurses [high school trained nurses] are not permitted to supervise the students. They [students] should not be supervised by nurses who don’t have the qualification to explain how theory and practice are put together.

RA: One Dosen also visits the students each day when they are on placement. Is that correct?

D10: Ya, the purpose [of this visit is] also [to] assist the student to link theory and practek [clinical practice]. It is our [Dosen] responsibility to assess the case study. It is also how we [Dosen] keep contact with ‘the reality’ [of the clinical situation].

RA: This sounds similar to the lecturer/practitioner roles in the United Kingdom.

D10: Ya, it is true, [this is] why there are two supervisors. At our AKPER we already get the [clinical] skills that the SSP [Terms of Reference] says we need and we have been trying to improve the knowledge of the clinical supervisors. But it would be good to have assistance from the SSP consultants to help our clinical friends get more knowledge.

(FGI, Iv6, RA, D10, D20)

The key informant interview excerpt illustrates my initial perceptions of the apparent similarity between the practical component of the DIII curriculum and western standards for nursing education. It also illustrates how my perceptions were reinforced by these Dosen. They simultaneously aimed to convince me that their participation in the implementation of the clinical component of the DIII curriculum was already
consistent with western standards and did not need further development by the Australian technical consultants.

As data collection continued, however, I came to understand that the appearance of similarity was often just that, an appearance. Moreover, this appearance camouflaged the fact that the Indonesian nurses had adopted elements of the international standards for nursing on their own terms and not as subordinate to them.

**Indonesian nurses’ resist subordination by adopting the behavior of the colonizer on their own terms**

In the key informant interview excerpt describing the various elements of the clinical component of the DIII curriculum, there were two critical assumptions on my part about laboratory practice and hospital/community learning experiences. In turn, these assumptions underpinned my perceptions of similarity between Indonesian nursing education and international standards for nursing. The assumptions were that laboratory practice and clinical learning experiences included ‘hands on’ (experiential) learning by students and that these activities were supervised by nurses who were clinically competent.

These assumptions were not fulfilled in terms of laboratory practice. Students were supposed to engage in ‘hands on’ practice and they were supposed to be supervised by Dosen. However, observational data revealed that these activities did not actually occur. Students rarely attended the laboratory practice experiences because Dosen were not there to supervise them. Dosen were not there to supervise because they were teaching in the private academy. The deliberate scheduling of the laboratory practice component of the DIII curriculum occurred not to facilitate closeness between theory and practice, but to facilitate additional income opportunities for Dosen. Dosen had adopted the behavior of western nursing, but on their own terms; terms that were consistent with the socio-economic context in which they were embedded.

Such ‘mimicry’ was described by Bhabha (1994) as being both consensual and conflicting. The Indonesian nurses had adopted a consensual position by including
laboratory practice in the DIII curriculum. However, the implementation of laboratory practice conflicted with the dominant model for ‘hands on’, supervised learning experiences as mandated by the colonizing forces of western nursing.

An image that is at the same time consensual and conflicting

This section describes that a similar consensual and conflicting situation existed in relation to the hospital/community learning experiences component of the DIII curriculum. The following key informant interview excerpt was with the same two Dosen who participated in the key informant interview (Iv9) described in the previous section. It was conducted two months later, after I had spent some time observing Dosen supervising DIII students’ participating in hospital and community learning experiences.

RA: From the focus group discussion [FG1], the [syllabus] documents I have seen and the last time we spoke [Iv6], I had the impression that when the students went on clinical placement [to hospitals and the community] they had a list of skills to achieve.

D10: Ya, you are correct Ibu Robyn, they must have the forms [clinical skills lists] signed or they don’t finish the placement. Why do you ask?

RA: I have now visited students in six RSU [hospitals] and one Puskesmas [Community Health Center] and everywhere it is the same. They are not doing ‘hands on’ clinical tasks, they are sitting at the nurses’ station or in the handover room, or they are in one large group watching one of the clinical nurses do a procedure.

D10: Ibu Robyn, you speak the truth, this is what always happens in the clinical [placement]. There are too many students for them to do the ‘hands on’ practek [practical nursing skills].

RA: You must have many students who have to repeat the clinical placement then? Or do some students just never graduate?

D20: Oh no Ibu Robyn, it is OK, no one fails. The forms are signed once they have seen the clinical procedure.

RA: So, they don’t actually have to perform the skill for the item on the list to be “signed off”?
D20: Now you understand, Ibu Robyn, it is not so hard after all. (Iv7, RA, D10, D20).

Once again, there was an appearance of similarity between the Indonesian DIII program and western standards for nursing: a proportion of the DIII program was dedicated to mandatory clinical placements and students had to achieve specific clinical skills. However, while students attending clinical placements represented Indonesian nurses’ adoption of a consensual position in relation to international standards for nursing, at the same time it conflicted with the dominant model that requires such skills are achieved through ‘hands on’ practice and demonstration of competence.

The following data excerpt is from an interview with one of the Bilingual secretaries who was also a member of PPNI (Indonesian Nurses Association). She therefore had an extensive understanding of the implementation of the DIII program both within Central Java and nationally. Earlier in the interview she had confirmed that excessive student numbers existed across the country. She cited her own example of a ratio of 50 students to 4 or 5 Clinical Instructors as the norm for paediatric placements in the Level A hospital in the capital city of Central Java. Her response during the interview demonstrates how the context of the DIII program influenced the reproduction of a copy of the western clinical component of the curriculum that was at the same time consensual and conflicting.

RA: Why are there so many students [B2]?

B2: It is very complicated as you know Ibu Robyn. The first reason is that there are so many academies. Not just the government AKPER [academies], but the private academies as well. This means there are so many students who must do clinical [placements] and not enough hospitals.

RA: Why are there so many academies when there are not enough clinical placement sites?

B2: Because the government has accredited them all.

RA: But how I understand the Indonesia accreditation system is that they [the AKPER] must achieve a certain standard to be given a license [to conduct the
DIII] and if their graduates cannot achieve the competencies, then they would not be accredited.

B2: But Ibu Robyn (she laughs), they do achieve the competencies. It is the same for all students. The real quality is poor, but they [the students] all have the chance to observe the procedures, so they all are ‘signed off’.

RA: Oh yes, I forgot. But tell me why there are so many academies when I know there is zero growth in government employment [of nurses] and your colleagues tell me that as few as 10% of graduates are employed when they finish.

B2: (she laughs again and shrugs her shoulders) It is KKN [Korupsi, Kolusi and Nepotisme - corruption, collusion and nepotism]. This is exactly why there are so many AKPER. They [the owners of the academies] are making very big money and because there are no jobs, no one ever knows that their graduates are not good. (Iv8, RA, B2)

Once again, this excerpt illustrated how Dosen, AKPER owners and AKPER Directors in this instance adopted the behavior of western nursing on terms that were consistent with the socio-economic context in which the nursing behaviors were embedded. The following section illustrates how the mimicked resemblance that was almost the same, but not quite (Bhabha, 1994) explains why the CJSSP initiatives to facilitate achievement of clinical competency were destined to fail.

A resemblance that is almost the same, but not quite

The appearance of similarity between Indonesian and western nursing programs was created by the fact that it was necessary for AKPER to send students on clinical placement to comply with rules of the DIII program and maintain national accreditation. However, the Indonesian context in which these rules were implemented negatively influenced the transferability of my western expertise; the applicability and acceptability of international standards for clinical practice that mandated competency achievement; and the desirability of a western model for the clinical component of the DIII program.
For example, the solutions that I had proposed to improve student competency outcomes were based on data gathered during participant observations in the clinical field. These data suggested that competency achievement in the clinical placement component of the DIII program was impaired due to an imbalance between the number of students and number of clinical placements available. This is also a problem in Australia and other western countries (Harrison, 2004; Jackson & Daly, 2008). Accordingly, I anticipated that solutions such as restricting intakes of students according to the available clinical places, implementing priority arrangements with clinical placement providers, and allocating cohorts of students to clinical placements at different times would be transferable to the DIII program. The following excerpt from my field notes demonstrates how the interview with the Bilingual Secretary changed my view.

My expertise relating to achieving competency in clinical practice was based on three linked assumptions. The first is that ‘hands on’ practice is essential to achieve competency. The second is that competency is only achieved when it can be demonstrated. The third is that according to the rules of supply and demand nursing programs that do not achieve competency will not survive. Hospitals will not provide clinical placements to students from nursing schools that do not prepare students adequately for clinical practice (hence the necessity of a good laboratory skills program) and will not employ students from programs who produce graduates without the necessary competencies. Word travels fast. The general public soon knows which graduates get jobs and the number of applicants to inferior programs falls. Clinical errors by graduates of a particular school also draw the attention of the regulation authority. In Australia, it is in the nursing School’s best interests to produce competent graduates. I now understand that in Central Java (and probably Indonesia more broadly) there is no such link, so my expertise is irrelevant. (FN reflection on Iv8)

This field note entry illustrated that without the close link between supply, demand and regulation, my expertise based on the assumption of necessity for competency was of no use in this situation; it was not transferable. Similarly, the solutions that I had proposed to increase the likelihood of DIII graduates achieving competency were
not applicable to the Indonesian situation. These solutions all aimed at facilitating ‘hands on’ practice for students, which my new knowledge about competency revealed, were not necessary. Therefore, they were neither relevant nor appropriate to the Indonesian situation. Moreover, the following excerpt illustrates that the contextual circumstances meant that even if achieving ‘hands on’ practice was applicable to the Indonesian situation; my Australian-based solutions would not be deemed acceptable.

**B2:** *Ibu Robyn, you say there must be lower numbers of students for them to have ‘hands on’ practice, but we are not able to reduce the numbers of students. You can make this recommendation but it is Pusdiknakes who decides. The SSP [brief] is not [wide] enough for you [the Australian consultants] to make recommendations about numbers of students. Even if you could make this recommendation, it would not happen. AKPER are, how do you say in English: dia punya banyak rupiah?*

**RA:** Lucrative?

**B2:** *Ya, and many government officials own the AKPERs so will not agree to losing their own incomes.*

**RA:** *But maybe the [Government] RSU [hospital] would agree to lower numbers of students. They could make a priority arrangement like between RSU [a Catholic private hospital] and AKPER [the private academy it owned]. They have an exclusive agreement [the private hospital only provides clinical placements for students from this one academy]. So, we could include this in the MOUs [Memorandum of understanding between the SSP academies and government hospitals] that we have been working on.*

**B2:** *The [Catholic private] RSU is different Ibu Robyn. The AKPER [owned by the private hospital] only has a small number of students because RSU [the Catholic private hospital] does employ them [the students] when they graduate, so they must be competent. Also, they do not receive an income from the students.*

**RA:** *Are they competent when they graduate?*

**B2:** *Ya, they are, I would go to [the Catholic private hospital] for treatment.*

**RA:** *What do you mean [by] an income from the students?*
This data excerpt demonstrates that the Indonesians involved in the system that governed the academies and hospitals participating in the CJSSP would not tolerate or submit to a reduction in student numbers or priority arrangements. However, it also showed that there were some exceptions to this situation. The reference to the Catholic private hospital revealed that in the context of a closer relationship between graduate attributes and employment opportunities, the solutions based on my western expertise could be transferable, applicable and acceptable in the Indonesian setting. This is a particularly significant revelation. The data describing the Catholic private hospital’s implementation of the DIII program support Bhabha’s (1994) assertion that culture is fluid and constructed through dynamic contextual elements, rather than static and demonstrated by stereotypical behavior. If the contemporary nursing attribute of clinical competency could be achieved by some Indonesian nurses, then failure of the CJSSP initiatives to achieve competency could not be solely attributed to an inherent ‘difference’ between Indonesian and Australian nurses and an incompatibility between Indonesian and Australian nursing cultures. Instead, the failure of CJSSP initiatives that aimed to improve students’ clinical competency could be reconstructed as an incompatibility between competency requirements embedded in a specific local context and competency requirements put forward as universally relevant.

Despite the desirability of western expertise for the purpose of achieving international accreditation for the DIII program, the local context of the CJSSP meant that the Indonesian participants were neither receptive to, nor would agree to undertake the solutions that I proposed. Instead, the solutions that I presented as necessary to achieve international standards for nursing and subsequent entry into the global nursing workforce were rejected. Such a response is consistent with the postcolonial concept of ambivalence whereby the colonized subject exhibits simultaneous attraction and repulsion towards the colonizer and the process of colonization (Ashcroft et al., 2000; Bhabha, 1994).
According to Bhabha (1994), when mimicry is used to camouflage ambivalence, it represents a passive response to the ambivalence of wanting the colonial but not wanting to submit to colonization. An alternative response to such ambivalence over colonization occurred when the appearance of similarity between Indonesian nursing and western nursing decentered western authority relating to standards for nursing education. Bhabha referred to this ambivalent response as mockery.

**Mockery**

Mockery converts mimicry from a process of resisting western authority because it is incompatible with the local context, to resisting such authority because it is ridiculous in any context. In the context of this thesis, the data suggest that in some instances the Indonesian participants in the CJSSP flouted western authority. They actually proposed that elements of western expertise and western derived international standards for nursing were not only inappropriate in the Indonesian setting, but were also inappropriate in any setting. The following data excerpt provides an example of how the Indonesian participants in this research mocked the assumption that academic processes can guarantee achievement of clinical competency as an outcome of the clinical placement component of nursing education. It also confirmed previous data that indicated the Indonesian participants mocked the assumption that graduation from entry-to-practice education guarantees achievement of stated competency outcomes.

The excerpt relates to my observation of a student’s final examination. I was not clear whether she had passed or failed, and therefore was eligible or not eligible to graduate. According to my western perspective, she would have failed and not graduated, but both Dosen participants who I interviewed said that she had failed, but would graduate. In order to make more sense of this situation, I interviewed the Kepala Bangksa (Head Nurse) who had also participated in the examination. She made the following contribution to clarifying my understanding:

**KB3:** You are correct, Ibu Robyn. I do not think she should have passed, but I am there just to facilitate the examination and to make sure that there are no mistakes done to the babies. Dosen make the final decision. They have the authority to do this.
RA: But I thought that the clinical member of the exam team was there for [his/her] clinical expertise and did influence the decision.

KB3: Maybe, but the clinical member was not there.

RA: What do you mean; the clinical member was not there?

KB3: Ibu [one of the paediatric nursing staff] was the one who received the payment for the exam, but she decided not to help. It is just an income to her and she is not really necessary because in the end, Dosen make the decision. Dosen do not worry if clinical staff is not there, as long as the exam meets the written criteria it is OK.

RA: But neither Dosen seemed to be familiar with the patient care.

KB3: That is true, Ibu Robyn. Many Dosen have never practiced after graduation from the S1 [degree course] or DIII, but they still decide if the student passes. This is because the exam is not important. Even if they did agree with me and see that the student was not competent, if she passed the case study, then she would pass the clinical and graduate. (SgCO7, Iv3, KB3, RA)

It appeared from this interview that the clinical examination was a farce. Contrary to my interpretation of the first focus group with Dosen (FG1) and the written guidelines for DIII clinical examinations, the implementation of the DIII program did not comply with international standards (WHO & STT, 2006) that require the clinical component of entry to practice education to be examined by nurses with clinical expertise. Nor did the examination process conform to Australian and international models for competency assessment that require the student to demonstrate both technical competence and application of the underpinning theoretical knowledge when carrying out a clinical skill (ANCI, 2002; Bryant, 2005; Foyster, 1990; Gonczi, 1994; Gurvis & Grey, 1995; Sullivan, 1995). Five months after this student examination, I observed some more student examinations that confirmed this conclusion. Moreover, the following interview with one Dosen examiner explained how the clinical assessment process separated, rather than united, technical skills and theoretical knowledge. Again, I thought that one of the students had failed the examination.

RA: I don't understand the outcome. Did the student pass or fail?
D1: The student failed the exam, but he passed the case study, so he has passed the clinical.
RA: Are the case study and the exam different, I thought they were the same?
D1: No, Ibu Robyn. They are different. The exam is just for skills, and if they do this wrong, it is not their fault. It is the fault of the CI [clinical instructor]. The case study is the written report. It is how we judge the [student’s] knowledge.
RA: Who marks the case study?
D1: Dosen responsible for the subject marks the paper and two Dosen do [assess] the verbal report.
RA: When I was in [location deleted] I watched another examination and then interviewed the Kepala Bangksa. At that time she said that Dosen make the final decision [about the result]. Is this what she meant? If the CI does not pass [the student for] the clinical exam, but the Dosen pass the [student’s] paper and the written report, the student passes the clinical subject?
D1: You are correct. The exam is worth 10%, the verbal case study report is 10% and the written case study is 80%.
RA: Is this the same for all of the clinical subjects, not just the final exam?
D1: Yes, because most students will not get a clinical position when they first graduate, it is not important that they do not have the technical skills. They will soon forget these and it is the [clinical] staff’s responsibility to teach them if they do not do it [technical skills] correctly. Is there something wrong with our process Ibu Robyn? Do you recommend doing something different?
RA: I am not sure. I will have to think about this very carefully. (TeCO9, Iv15, D1, RA)

Together, my field note excerpt and the excerpts from my interviews about the examination process illustrate that my assumption that the DIII academic processes should guarantee achievement of clinical competency were false. It was flawed for two reasons. Firstly, I had interpreted the information about the DIII program from my own frame of reference. I had not taken into account the contextual influences on Indonesian nursing that meant most Dosen began teaching upon graduation from the DIII or nursing degree programs without ever having practiced as a clinical nurse. Nor did I understand that competency assessment was separated into its two parts: skills
acquisition and application of theory to practice, with the latter weighted so heavily that the former had no relevance. Secondly, and more importantly, I had assumed that the processes used to guarantee achievement of clinical competency in the clinical placement component of the DIII program would be successful because they were similar to the Australian processes with which I was familiar. Prior to observing the Indonesian assessment process, I had not considered that Australian processes may be just as unlikely to achieve their stated aim as were the processes used in the DIII program. That is, I had assumed that while academics defined the competencies necessary for students to achieve, both Australian and Indonesian entry-to-practice education delegated the responsibility for clinical assessments to clinicians because they were the experts in assessing competency.

Therefore, by mocking the process of competency assessment, the Indonesian participants in the CJSSP prompted me to question the wisdom of benchmarking Indonesian educational practices against an Australian model. What if, as the Indonesian situation implied, Australian clinicians only assessed skills and not the integration of theoretical knowledge, skills and professional attitudes that define the competency attributes of the contemporary, internationally mobile nurse? As described in the next section, in causing me to ask such a question, the Indonesian participants decentered my authority over the examination process and compliance with international standards.

**Mockery decenters western authority**

The following field note excerpt was made immediately after the interview (Iv15 above) with Dosen who took part in the clinical examination. It provides an example of how the Indonesian nurses’ resistance to colonization in the form of mockery opened my eyes to the possibility that the Australian processes, which I assumed to comply with international standards, may also fail to guarantee achievement of clinical competency.

*I managed to avoid responding to her [D1’s] questions: “Is there something wrong with our process Ibu Robyn? Do you recommend doing something different?” Her explanations had shaken the foundations of my expertise*
about ensuring students graduated with guaranteed competencies. While Australian academics generally have 5-10 years of clinical experience before teaching nursing, and competency is tested immediately upon employment following graduation, some of the things this observation and follow-up interviews have revealed could also be applied to the Australian situation. The DIII processes pretty much indicate that clinical assessment is meaningless in terms of competency assessment. That it does not examine competency, but examines competence. That is, clinical assessment examines technical proficiency. In Australia, while academics have designed competency assessment tools, our collaborative partnerships (that are designed to close the theory practice gap), place the clinician in the position to assess practice outcomes [of students]. It is the clinician and not the academic who teach the student how to 'practice' and assess competency. Because students do get jobs [when they graduate], the clinicians have a vested interest in ensuring that they are able to perform clinically. So, time and time again, they say the competency forms are useless, they [clinical instructor equivalent] ask for skills lists and it appears that if the student can do the task, their competency form will be signed off. For this reason, we also use reflective practice journals, clinical portfolios and case studies as assessment tasks (remember reference: Harris, Dolan & Fairbairn, 2001). In some instances we do the same thing [as the DIII] and allocate higher percentages to these [assessment] tasks. Many universities I have worked at also don’t grade clinical – instead allocating a Pass or Fail only. Perhaps the Indonesian nurses are just being more honest. Perhaps, clinical assessment is meaningless in terms of competency development and we should just admit that it is really about skills acquisition and employment readiness. So, I still have no recommendation about whether the DIII exam process needs to change! (TeCO9, FN)

The data presented in this section therefore identify that as the colonized ‘mimic’, Indonesian nurses were not only able to resist subjugation by western nursing, but were also able to adopt the behavior of the colonizer in such a way that they decentered the authority of western derived universal standards for nursing. Based on earlier data describing the limited employment opportunities for students following graduation
from the DIII program (e.g. Iv8), it would be easy to presume that a small weighting was applied to the clinical exam simply because ‘hands on’ competence would never be tested.

However, analyzing the data from a postcolonial perspective revealed that the Indonesian imitation of the western process for clinical competency assessment, ridiculed the assumption that observation of clinical practice can establish achievement of all elements of competency. It mocked the authority of my colonizing expertise in such a way that caused me to question the appropriateness of both my expertise and the competency elements of international standards for nursing to either the Indonesian (non-western) or Australian (western) settings. Accordingly, the ambivalence of the Indonesian participants wanting the colonial without submitting to western colonization opened up a space where the clear cut Orientalist constructed binary of western (colonial) superiority and Indonesian (colonized) inferiority was disrupted. Bhabha (1994) referred to this space as the “Third Space of enunciation” (p. 54) wherein colonization is translated and negotiated to create a new hybrid culture.

**Hybridity**

A hybrid culture arising from ambivalence to colonization is therefore the antithesis of the essentialist concept of culture as a static set of behaviors differentiating dominant from subservient groups (Bhabha, 1994). Precipitated by ambivalence, hybridity represents cultural change that is “neither the one nor the other” (Bhabha, 1994, p. 37). Through a process of negotiating circumstances that are often contradictory and antagonistic, the hybrid outcome is something new that represents contributions from both pre-colonial and colonial cultures (Culley, 2006). In the context of this thesis, the model of clinical competency assessment within the DIII program represented a hybrid model.

Importantly, by disrupting my perceived authority over internationalizing the clinical component of the DIII program, this hybrid model of clinical competency assessment constituted a key turning point for me. On the one hand, the circumstances underpinning implementation of this model of clinical competency assessment caused
me to become sceptical of the authority of the western knowledge upon which my expertise was based. On the other hand these circumstances also enabled me to consider the presence of a new space to understand and apply uniquely local interpretations of international standards and still achieve the CJSSP goal of internationalizing Indonesian nursing. The following data excerpt demonstrates how Indonesian ambivalence opened up this new ‘in-between space’ (Bhabha, 1994, p. 54). In this new space the Indonesian practices that I had previously marginalized contributed instead to developing new knowledge and a new model for clinical teaching and learning.

Now that I have shifted my thinking to consider clinicians as the key determinants of employment readiness and the skills acquisition component of competency, I think I have come up with a solution for improving the laboratory component of the DIII. If clinicians, rather than academics were to be recruited to teach the ‘hands on’ skills in the laboratory, it would solve a number of problems. It would ensure that the person teaching actually has clinical skills [remembering that many Dosen have never practiced following graduation]. And it would solve the biggest problem of all: there would be no need to disrupt the current teaching schedule that allows Dosen to work in both the government and private academies. So, students would actually get supervised ‘hands on’ practice and the incentive payment to clinicians would over-ride the fact that the clinician may never have to rely on the competence of the graduate, which is currently a disincentive for clinicians to engage with students in the clinical area. Whilst, lab practice does not expose the students to real life situations, at least they are doing more than observing, which is all they do at the moment. (Em, RA)

When I suggested this solution to the CJSSP participants, they responded as follows:

D4: *Ibu Robyn, that does seem like a good idea. It [the proposal] would also solve the same problem that you say you have in Australia. You know, where students learn skills in the laboratory that are not the same as what is really done in hospital.*
CI2: The lab practice could also be done in the hospital to make it easier for the CI [Clinical Instructor].

AD2: It is good that there would be no need to change the [teaching] schedule, but I am not sure how I will find the finance to pay the CI. The Dosen are being paid to be in the laboratory even though they are not there, so the budget is already spent.

KB2: There is DiKlat [health education division within the provincial Ministry of Health] money for training for CIs. At this time we send the CI to laboran [seminars/workshops] in [location deleted]. If the AKPER could teach the CI what they want them to do in the laboratory, for the first education [session] then we could pay the paket [incentive payment for attending training] to the CI to continue the lab supervision. (Iv17, AD2, CI2, KB2, D4, D5, RA)

Until this time, I had only seen resistance to colonization and had believed that such resistance rendered successful implementation of changes, particularly to the clinical component of the DIII program, impossible. The data reveal that I had developed an awareness of the contextual determinants of resistance to universal standards. In possession of such knowledge I no longer attributed failure to comply with a western model of laboratory practice as based on an insurmountable problem of cultural incompatibility between Indonesian and western nursing. In data presented in Chapter 5 I had drawn upon the static image of Indonesian laziness (to explain why Dosen did not engage in laboratory supervision) and immorality (to explain why they instead engaged in private teaching). Influenced by this Orientalist construction of culture I had denied the contribution of the contextual elements of low remuneration and individual economic survival that dictated such work patterns. By moving away from the Orientalist construction of Indonesian nursing and moving towards seeing an image of Indonesian nursing constructed through the dynamic experiences at the margins, improving laboratory practice no longer was an insurmountable problem. I could also incorporate the previously marginalized knowledge contributed by the Indonesian nurses into my existing knowledge about the determinants of skills development. Using this combined knowledge, I was able to propose a hybrid model for laboratory practice.
The new model was not the same as the western model of academics supervising ‘hands on’ practice, nor was it the same as the Indonesian model of not supervising laboratory practice at all. I had now used my expertise to ensure that the proposed model also complied with the international standard for nursing that dictated skills development is supervised by skilled practitioners. However, one of the interview participants pointed out that it did not entirely meet international standards for competency development.

RA: [D5] you have not said anything yet, what are your thoughts?
D5: Ibu Robyn, it is a good idea, but I worry that the CI [Clinical Instructor] only cover skills and do not worry about the theory. You have told us that competency is both knowledge and skills. Dosen have the knowledge, but they are no longer teaching the skills.
RA: Yes, you are correct [D5]: I still have not resolved this issue. We have an Australian saying “Do not throw out the baby with the bath water”, and perhaps with my new understanding about assessing being competent versus competence, I have done this. Do you have any suggestions?
D5: Maybe only the CIs who have done the SSP activity to improve their scientific knowledge should do [teach in] the lab?
RA: That is a good suggestion but you have given me another idea. At [name deleted] University and maybe at [another] University [name deleted] also, junior Dosen must do some clinical practice. Would it be possible for junior Dosen to team teach with the CI? Or do they [junior Dosen] also need to teach in the private AKPER in the afternoon?
AD2: Ya, it would be possible. Junior Dosen do not work at the private academy yet and they are supposed to help the senior Dosen in the lab. They do not do this [teach in the lab] because they follow the example of senior Dosen and are maybe too scared to show the students that they [junior Dosen] do not know the clinical skill themselves. If I decree that they help the CI, they will not need to do the skill, but can explain the theory. (PkCO1, PkC08, Iv11, AD2, D4 & D5)

This data excerpt illustrated that I had again acknowledged the contextual influences on the implementation of laboratory practice. These same contextual influences had
underpinned resistance to the western model I had previously used as a measure for compliance with universal standards for nursing. Now I had created a space for valuing marginal knowledge that underpinned the alternative Indonesian implementation of laboratory practice. Not only did I incorporate this knowledge in my proposal for improving laboratory outcomes, but I also provided further opportunities for knowledge from the Indonesian participants to shape the initiative.

Whilst I still adopted the position of the expert driving the change, it appears from the data that this approach also encouraged contributions from the Indonesian participants. In the past, I had been particularly concerned about the counterproductive effect of the powerful subaltern resistance demonstrated by the Indonesian participants that placed the responsibility for initiatives entirely on my shoulders as the ‘hired help’. Analyzed from a postcolonial perspective, this change in my approach suggests that I had developed a hybrid model for applying western expertise to a non-western setting.

**A Hybrid Model of Western Expertise that is Acceptable to the Colonized**

According to Young (1995), hybrid models emerge from Bhabha’s in-between space (Bhabha, 1994) through a process of reconciliation precipitated by the colonizer both acknowledging and attempting to address the elements of resistance to colonization by the colonized subject. The following excerpt illustrates how I came to satisfy the competing needs of using my expertise to achieve the contractual obligations of internationalizing the DIII program, working with the Indonesian participants’ resistance to absolute acceptance of western nursing authority. This process acknowledged my growing awareness that western knowledge was only partially transferable to the once-colonized, non-western setting of Indonesian nursing. It illustrates how I reconciled the knowledge derived from nursing’s dominant western center, which gave me my expert status, with the resistance to such knowledge from the margins. It also illustrates how such reconciliation was an essential approach to dealing with participant’s responses to interventions that threatened to jeopardize achieving the contractual requirements of the CJSSP.
One thing that appears compatible with Indonesian culture is the use of Terms of Reference (TOR) to describe activities. One of the problems with the clinical placement experiences for DIII students is a lack of guidelines for the person providing clinical supervision. So, we [the Australian technical consultants] thought that a PD (Position Description, which resembles a Terms of Reference document) for the CI [Clinical Instructor] would be useful for improving the clinical component of the DIII program. The model that we put in place for the workshops was for us to mentor the CIs and Dosen to work collaboratively to improve the processes for clinical placement experiences [for DIII students]. So, we provided an Australian model and then set a follow-up task for the participants from each academy and its clinical partner organization to work together to develop an Indonesian version of our template PD [position description]. The CI and Dosen were very reluctant to do this because normally the TOR are developed by Ministry Officers with higher authority. Consequently, no work was completed on these documents outside the workshop. Instead, the work moved ahead during the workshop when I could direct the activity. The CI and Dosen did not split into the groups we assigned, but instead asked me to scribe and insert the consensual statements they developed as text into the template we had provided. Uniformity was a priority. Everyone wanted one single PD to apply to all DIII students and didn’t want to make a contribution without the agreement of all participants present. This made the process very lengthy, but in the end, a document was formulated that no one person was responsible for. And while the CI and Dosen all agreed, they handed ownership of the document over to me. “We have done our best Ibu Robyn”, said one participant, “but it was your idea”. (WO3, FN)

The excerpt demonstrates that while my expertise was valued for providing the template to work with, my position as subservient to the Indonesian participants was reinforced by my role as the scribe. I was responsible for doing the work, which complied with the reversed masterslave relationship and the expectations that accompanied my occupation of their territory. The modified version of group work was acceptable because it did not leave any one person responsible for the change, or identify any one person’s contribution to the document. Similarly, my expert authority
was used to absolve individuals from assuming responsibility for any failure. If the position description did not work to clarify the role of the CI and to improve student experiences, it would be my fault. The outcome proved successful, but in this case my role as an expert did not exactly replicate either the western model of collaboration that I had previously used or the Indonesians version of subaltern resistance that gave me sole responsibility for doing the work. Nor was my expertise rendered completely subservient to their demands. As such, it was “neither the one nor the other” (Bhabha, 1994, p. 37); it was a hybrid model for expertise.

**A Hybrid Model of Western Expertise that is Acceptable to the Colonizer**

According to Young (1995), one of the key features of successful hybridity is that the hybrid replica is acceptable to both the colonized and the colonizer. The hybrid model therefore not only needs to satisfy the elements of resistance to colonization on the part of the colonized subject but also needs to satisfy the colonizer’s ambivalence towards creating an exact replica of colonial culture (Bhabha, 1994). In the context of this research my ambivalence was related to wanting to use my western expertise to introduce improvements in Indonesian nursing, but not to create an Indonesian replica of the western nurse. The following excerpt from my field notes demonstrates how the Indonesian nurses were not the only participants in the CJSSP who were resistant to creating an exact copy of western nursing.

*Although I now recognize that it was naïve for me to assume that the underpinning motivation for the SSP brief [included in the Terms of Reference for the SSP] for internationalizing the DIII curriculum was to improve the health of the Indonesian population (as described in the primary objective statement), I could not change my contributions to SSP to exclusively serve the purpose of preparing Indonesian nurses for export. I wanted to make improvements to the DIII program that improved Indonesian nursing practice at home. How unethical is it to send the best prepared nurses to western countries where there are so many more resources for health and leave the inferior nurses to manage the greater burden of disease [in Indonesia]? It is bad enough that the Indonesian nurses have to practice in such a resource poor health system, but how unethical is it for a loan that the people will*
repay over the next few decades, to be used to support the western health care system [by supplying nurses to meet health workforce deficits] and not the health system in Indonesia? So, my best way forward I believe is to focus on the international standards that will raise the quality of Indonesian nursing IN Indonesia. I should no longer be concerned that this is not the same as ensuring that DIII graduates meet the standard necessary to meet migration requirements. The Indonesian nurse IN Indonesia does not need to practice the same as an Indonesian nurse or a western nurse prepared for practice IN a western country. (RJ Oct, 2003)

My resistance towards creating an exact replica of western nursing therefore also created a space for introducing a new model of western expertise in this particular non-western research setting. In this hybrid model the transferability of my western expertise became dependant on my ability to create interventions that simultaneously responded to the Indonesian participants’ desire for internationalization of the DIII curriculum, the critiques that lay beneath Indonesian resistance to western standards for practice, and my own motivation to internationalize the DIII curriculum. That is, my expertise became a reflection of how well I could utilize the in-between space of resistance to support the underlying Indonesian agenda for exporting DIII graduates to western countries. At the same time it also had to be compatible with my commitment to ensuring that interventions improved domestic nursing practice aligned with the aim of improving the health of the Indonesian population.

The next section of this chapter presents some examples of such hybrid models. The examples have been chosen for their specific correlation with the international standards for nursing education and practice that were named in the Terms of Reference for the CJSSP (IBRD, 2001) and appear in the dominant literature as essential competencies for international mobility.

**Hybrid Models for Indonesian Nursing**

The dominant literature proposed that international mobility is facilitated by compliance with international standards for nursing that are in turn derived from key competencies for contemporary nursing practice (ICN, 2003). These key
competencies mandate that graduates from entry to practice programs have technical competency to provide ‘hands on’ preventative and curative care for individuals in a wide range of health care settings and using a wide range of technology (Kessenich, Guyatt & DiCenso, 1997). Graduates prepared for international mobility should also have a sound scientific knowledge base and critical thinking skills in order to deliver care that is evidence based (Alderman, 2001). Programs that aim to prepare nurses for international practice should demonstrate a close relationship between the theoretical and practical components of the curriculum (Bourbonnais, Langford & Giannantonio, 2008; Landers, 2000). A hybrid model for developing ‘hands on’ competency has already been described on page 224. The following sections of this chapter deconstruct CJSSP interventions relating to evidence based practice, the acquisition of critical thinking skills and closing the gap between theory and practice. In each instance, these interventions were perceived to successfully achieve the goals of the CJSSP for both the Indonesian nurses and me. Each example provides insight into the relationship between hybridity and resolving issues surrounding acceptability and applicability of western standards for nursing practice in the non-western setting of Indonesian nursing. The examples also highlight the contextual influences on Indonesian nursing practice that challenge Orientalist assumptions of static cultural inferiority of the east and superiority of the west.

A Hybrid Model for Evidence Based Practice

As a member of a professional, scientific discipline, the dominant discourses emphasize that the contemporary nurse engages in clinical practice that is based on the best scientific evidence and not tradition, ritual and intuition (Alderman, 2001; Benner, 1999; Duffy et al., 1995; Gerish & Clayton, 1998; Hicks & Hennessy, 1997; Kessenich et al., 1997; Parse, 1992; Watkins, 2000). The following interview excerpt describes the disparity between these universal evidence based standards for nursing practice and the hand washing practices of students graduating from the DIII program prior to the CJSSP intervention.

RA: So what is the situation now, what is wrong with Indonesian DIII graduates?
D2: Well, when I see my students [on clinical placement] I am disappointed…. They do not follow standards they just follow the ‘routine’.

RA: So, why don’t they implement evidence-based practice in the ward?

D2: They are too afraid, they follow the senior nurse who tells them how it’s done in the clinical setting and not what we teach.

RA: Why do you think that the senior nurse does not follow the standards?

D2: Well, because she doesn’t have them, or because she just follows the ‘routine’, because the ‘routine’ is the reality.

RA: What is the reality?

D2: There is not enough equipment to follow standards. For example, there is running water in the AKPER laboratory [where students learn], but there is no running water in the ward, so how can they follow the standard?

RA: What about gloves? Could the student wear gloves to do a complicated dressing?

D2: There are gloves in the laboratory, but the patients have to pay for the gloves in the clinical [setting]. Most students are not allowed in the Kelas VIP [areas of the hospital reserved for wealthy patients], so students can wear gloves if they want to pay.

RA: Does this ever happen?

D2: No. So how can DIII graduates reach international standards?

RA: The strategy [of using alcohol hand washing solution] that we [CJSSP Australian nursing experts] put in place at [another clinical site] seemed to be successful. Maybe it will also work at [the hospital that was the focus of this interview]. (Iv20, D2, RA)

In this excerpt the local context of practice negatively influenced the potential for DIII graduates to comply with standards for infection control in a number of ways. Students’ responses to the hierarchical structure within the clinical setting render them responsible to clinicians (and not Dosen) while on clinical placement. Unfortunately, as highlighted in other observational data, being responsible to clinicians appeared to perpetuate practices based on ‘routine’, rather than scientifically based standards for practice. When practices were based on ‘routine’ this meant they were most likely implemented according to the equipment and supplies that were available, rather than scientific evidence. In the instances described in this excerpt, the equipment and
supplies that were available were insufficient for practice to comply with international standards for infection control. Therefore, the comment: ‘how can DIII graduates reach international standards?’ demonstrated a concrete example of the conflicting desire for complying with international standards within the practical component of the DIII program and the reality of achieving this goal.

The following data excerpt describes how the strategy of introducing alcohol hand washing solution was compatible with Indonesian nurses’ desire for international recognition and promised to reconcile local uniqueness with global conformity. The use of alcohol ‘hand rub’ as an alternative to hand washing with running water was instituted in one of the hospital nurseries participating in the CJSSP. It was considered successful by both Indonesian and Australian members of the CJSSP management committee as nurses embraced its use during my in-country presence and continued this hand washing technique beyond the conclusion of the CJSSP (Aitken, 2004b).

[One of the Australian expert nursing consultants] described that [the Australian hospital where she works] has waterless hand washing solution at each isotope. She explained that the research evidence shows that the single most important infection control measure in ICUs/Nurseries is hand washing and those shoes, sticky mats, red-lines on the floor and gowns do not have any impact on nosocomial infection rates. The [Indonesian] ICU nurse thought that this might be possible as the [Medical] Director was interested in recommendations for hand washing. It appears that the Director would be concerned about the cost, but would be receptive to the idea that the cost for hand washing solutions could be offset by savings in laundering gowns. The nurse also thought that the Director would be more receptive to the idea of waterless solution because she liked nurses to become more ‘technological’, like in Australian hospitals. This confirmed my earlier observations that Indonesian nurses perceived western nursing practice to be scientifically superior by virtue of the equipment they used. She also mentioned that it [alcohol solution for hand washing] would be a ‘technical’ intervention and viewed with respect from the patients’ families. Accordingly this [alcohol solution for hand washing] was perceived as a far superior intervention compared to the barrels with taps system that was reported to fail because
families used the water to wash patients’ dishes, leaving none for nurses to wash their hands. (SoCO8, FN)

In this excerpt the Indonesian nurses’ comments reveal how introducing alcohol hand washing solution was compatible with the way that Indonesian nurses have constructed the image of the contemporary, internationally mobile nurse according to the western discourse of nursing as a scientific profession. It also reveals that this nurse believed that her construction of contemporary nursing was shared by the Medical Director and members of the general population. This revelation was evident in the section of the excerpt that contrasts the use of alcohol hand rub solution with another intervention to improve hand washing practice initiated by a World Health Organization (WHO) funded program (WHO, 2003).

The WHO initiative was not considered to be successful because it did not elevate nurses’ hand washing activities above everyday hand washing activities. As a ‘technological’ intervention, alcohol hand rub promised to have this effect. Therefore, according to this excerpt, a shared local construction of hand washing within nursing as a ‘technological activity’ promised to enhance the acceptability and applicability of introducing alcohol hand rub as an infection control measure. The excerpt also reveals that the attraction of costs being offset by savings also rendered this intervention for improving infection control standards as compatible with the resource restrictions within the local context of Indonesian nursing practice. This was important, as resource restrictions were frequently highlighted by the CJSSP participants as reasons why Indonesian nurses did not (and could not) comply with international standards for nursing.

Whilst the previous two excerpts explain the significance of using alcohol hand washing solution with regard to addressing Indonesian ambivalence over accepting western standards for practice, the following data excerpt explains my ambivalence towards perceived Indonesian resistance to internationalization.

Until the visit to [observation site SoCO8], I had focused on trying to find a way to introduce running water to health care facilities as the evidence based intervention for improving hand washing practice. The Indonesian CJSSP
participants had consistently raised this as a priority, but appeared resistant to investing the financial resources required. Instead, they requested that CJSSP funds were used to upgrade the plumbing in the demonstration wards [clinical sites chosen to display CJSSP interventions]. I was not about to do this, the CJSSP money was not for infrastructure. (SoCO8, FN)

Therefore, the intervention of introducing alcohol hand rub to improve hand washing practice became a hybrid solution. It arose from a site of resistance from both the colonized and the colonizer, neither of whom were prepared to invest in running water. As an alternative to running water, alcohol hand rub was both compatible with international standards for infection control, and compatible with Indonesian nurses’ expectations of the CJSSP experts supplying ‘technical solutions’. It was also a hybrid solution because it was a replica of a western practice that was not an exact copy. In the western situation, alcohol hand rub supplements running water and is generally available in copious amounts in clinical settings (Bischoff, Reynolds, Sessler, Edmond, & Wenzel, 2000). In the Indonesian situation, it totally replaced running water and a single dispenser serviced the entire 15-bed nursery. However, as the colonizer, this imperfect replica was acceptable to me because it was compatible with my goal of improving nursing practice in Indonesia but would not jeopardize standards for evidence based nursing in western countries should Indonesian nurses migrate to practice overseas.

**A Hybrid Model of Encouraging Critical Thinking Skills**

As indicated in Chapter 2, critical thinking skills and problem solving techniques are essential attributes of the contemporary, internationally mobile nurse. According to Shin et al. (2006), critical thinking is goal-orientated, meaningful thinking that allows nurses to make decisions in response to problems and choices encountered in personal or professional situations. It is a way of problem solving that is based on collecting information from observation, experience, reflection, inference and then analyzing this information according to evidence based on scientific principles and methods rather than common assumptions. Data presented in Chapter 5 revealed that I had grave doubts about both the capacity of Indonesians nurses to engage in such critical thinking, and my ability to facilitate a change in methods of teaching used by Dosen
to encourage students to acquire these skills. In these data I attributed this perceived lack of capacity to the Orientalist characteristic of irrationality, contrasted with the rational scientific basis for western nursing. However, the following data excerpt reveals that my perceptions on the ability of Indonesian nurses to comply with these elements of international standards for preparation of contemporary, internationally mobile nurse changed as I became more aware of the contextual influences on Indonesian nursing.

*Indonesian DIII nursing students have graduated from an elementary education...* [where] the main teaching and learning approaches encourage students to passively absorb information rather than actively engage in learning. The teacher is seen as the primary source of knowledge and while this has not promoted student learning independence it is important to acknowledge that this is often an appropriate (and indeed necessary) educational model in the context of resource limited settings.

*Students therefore, enter DIII programs ill-equipped to cope with greater individual responsibility for their own learning. While many teaching staff have had overseas experiences and education, they too have largely been educated in a system where student-centered learning does not predominate. A sudden change to PBL [Problem Based Learning] would challenge both students and teachers alike and most likely result in poorer, rather than improved learning outcomes. (SSPR3, Appendix 8, p.4).*

This excerpt identified that the potential for engaging students in learning that promoted critical thinking skills was limited by contextual factors relating to the resource poor nature of the learning environment and the predominant style of learning that was common to both students and Dosen. As implementing problem based learning strategies was a specified activity within the CJSSP Terms of Reference (IBRD, 2001), I was keen to identify a way forward that acknowledged these contextual factors. The following excerpt from my field notes describes the initiative that I implemented and its success in terms of changing the teaching practices of Dosen and student’s learning processes.
D18 and D19 did well. The lesson was about cardiac failure. Their previous lesson plan consisted of presenting content from the prescribed text book as overhead projections, students completing a multiple choice test, then a teacher driven discussion relating to the test outcomes. They abandoned this to instead show the students a DVD [a short digitalized video that I supplied] about the cardiac cycle around which a number of group activities were then structured. They were of course receptive to the technology of using the video, which offset their reluctance to relinquish their didactic contribution… Although a bit reluctant to get started, by the end of the session, students were fully engaged in the group activities and actively asked questions. [The participating] Dosen appeared a little intimidated by this and deferred many questions to me, but it was a great improvement on the previous session. At the end, students completed the multiple question test and the [participating] Dosen were astounded by the almost 100% pass rate. They have now developed a similar lesson plan for the topic of Acute Renal Failure. (TO7, FN, RA, D18 & D19)

Analyzing these data from a postcolonial perspective, the success of this initiative can be attributed to the hybrid nature of the intervention. It was a copy of western teaching and learning practices, but was not an exact replica. Whilst Dosen still maintained some control over the learning activity they also provided students with opportunities to move away from a passive approach to learning in a supported way. This was made possible by the use of audiovisual materials donated by the CJSSP. Both Dosen and students alike had previously demonstrated that they were influenced by a local discourse of technology that placed western nursing as more advanced than Indonesian nursing. Using the DVD capitalized on this discourse of technology so that the success of the initiative was enhanced by contextual factors that supported change.

The hybrid model of problem based learning could also be analyzed to satisfy my goal of improving Indonesian nursing without being dominated by the reversed master/slave relationship. I had come to understand that the Indonesian participant’s interpretation was for me (as the western expert) to transplant an exact copy of western nursing education and practice into a stand-alone DIII program specifically
for preparing nurses for export. In this instance, the success of this initiative was incorporated into the everyday business of teaching and learning within the existing DIII program. The preparation of a second lesson plan promised a commitment to this practice. It therefore satisfied my commitment to improving nursing in Indonesia.

The excerpt also illustrates the importance of the reversal of the master/slave relationship for facilitating success of CJSSP initiatives. In this excerpt, the participating Dosen managed the threat to their own position of authority over knowledge posed by students’ new found independence by deferring responsibility for success or failure of student learning to me. In previous sessions where they attempted to introduce new problem based learning strategies without my active participation, they had to assume this responsibility themselves. Therefore, once again, the occupying presence of the colonizer was particularly important for removing some of the critical barriers to internationalizing the DIII curriculum. As the following field note excerpt illustrates, the importance of my presence for ensuring the success of this initiative prompted me to reconsider my previous assessment of the capacity for introducing scenario based teaching in the laboratory setting.

*My attempt to [introduce scenario based teaching in the laboratory] may not have failed because Dosen couldn’t link the stages of the nursing process, the SOPs, theoretical concepts, evidence based theory and clinical decision making. Instead, it now appears that it failed because the SSP participants had no individual authority. The whole group needed to approve the change before it could be implemented. Dosen who didn’t participate [in the CJSSP] were not convinced by their colleagues (no matter how senior) [they were] but instead needed to be convinced by me as the western expert. No one would agree to the change until they all had received the same information from me as the SSP participants. They also needed to receive this instruction under the same circumstances as the SSP participants, receiving the incentive payments that accompanied attendance at a workshop that involved travel. The SSP participants were not worried that they hadn’t fulfilled the purpose of the exercise. The SSP participants implied that not implementing new teaching methods was a reflection on my lack of insight into what was needed and not their failure to adopt new strategies. This explained why they didn’t pretend*
that they would implement new practices. They would only implement scenario based teaching if I used my authority over their colleagues and was present to supervise the change. (PkTO2, FN, RA, D5, D6, D7)

In this excerpt the contextual factors of group consensus and need for incentives to participate in CJSSP activities influenced the success of the CJSSP intervention. My failure to acknowledge the reversal of the master/slave relationship was also a factor that contributed to Dosen not incorporating the new teaching strategies I proposed into their existing lesson plans. I did not realise that the reversed master/slave relationship that constructed my role as the western expert made me directly responsible for success or failure of a given intervention and demanded my physical presence. According to the opinions of Dosen recorded in this excerpt, they were not at fault for failing to adopt the behaviors of the colonizer. Instead, I was at fault for not complying with my position within the locally embedded hierarchy of decision making. If I had have possessed such insight, I should not have expected these Dosen to change their practices until I had provided the same continuing education opportunities to all Dosen at the AKPER. However, the Indonesian nurses’ ambivalence over accepting my de-contextualized approach to creating an exact replica of a western nurse teacher, together with my ambivalence to doing this on their terms, created a space for a hybrid model to emerge.

In this instance, the hybrid model that arose from such ambivalence was a departure from my previous focus on Dosen both teaching critical thinking skills and complying with the international standards for closing the gap between the theoretical and clinical components of the DIII program (Gillespie & McFetridge, 2006). Instead, I proposed that Clinical Instructors should participate in teaching the laboratory component of the DIII curriculum. The following data excerpt describes how this idea constituted a way forward for encouraging students to acquire critical thinking skills, and at the same time provided a solution for developing improved ‘hands on’ competency.

*It appeared that the only way that I was going to improve teaching in the laboratory was to come up with another alternative. Running an additional workshop for all Dosen from AKPER [Academy Pk] was outside the [CJSSP]*
budget. Even if the AKPER could provide the funds, I now knew that Dosen were unlikely to jeopardize losing their income from teaching in the Private AKPER [to participate in laboratory teaching in the government academy] and so it would seem a waste of resources to try and do this. However, we still had budget for improving scientific knowledge of the CIs [Clinical Instructors]. So, I could run the same session for the CIs that I did for Dosen. The CIs would be paid travel [allowance] because the workshop could be held at the AKPER, and they could endorse the new practice as a group. The only person amongst academic staff who would have to approve the change would be the AKPER Direktor. He would be keen to do this, because his AKPER would be a [CJSSP] showcase and I would spend much time there, so if it doesn’t work, it would be my fault and not his. (PkTO2, RA)

This idea constituted a hybrid model for facilitating teaching methods that encouraged students to use critical thinking skills. According to the western model that appears in the literature, and that I was familiar with, the laboratory practice component of entry-to-practice nursing education is normally the domain of academic staff (Murray, Grant, Howarth & Leigh, 2008). Our apparently shared desire to create an exact replica of western entry-to-practice nursing education had led both the Indonesian participants in the CJSSP and me to focus on addressing deficits in the laboratory practice component of the DIII through developing the teaching skills of Dosen. Influenced by this dominant western approach to entry-to-practice nursing education, neither the Indonesian participants nor I had previously considered addressing deficits in the laboratory component of the DIII curriculum by developing teaching skills of Clinical Instructors.

As the excerpt illustrates, developing the teaching skills of Clinical Instructors instead, arose from a site of resistance from both the colonized and the colonizer. The Indonesian Dosen resisted adopting the new teaching strategy because of the complex interaction between the individual CJSSP participants and their wider peer group. Also, in the context of low base salaries, the wider peer group were resistant to engaging in continuing education without financial incentives. I was resistant to providing such financial incentives. I believed they would not reap any benefit because the obstacle of Dosen losing their income from a second job would still need
to be overcome. The alternative of providing training for the Clinical Instructors to learn how to promote critical thinking reconciled western and Indonesian approaches to encouraging the acquisition of new teaching strategies to enhance student’s critical thinking skills. It also capitalized on, but did not entirely embrace, the need for group consensus and incentive payments. The following excerpt is from a focus group with the eight Clinical Instructors who participated in this hybrid initiative.

CI2: *Ibu Robyn, we are so enthusiastic to be getting new teaching skills. We do not have many chances for this* [to participate in continuing education]. *It is also good to be able to teach the students how to do the practices according to the standard and not the routine. We do not have these chances normally.*

RA: *What do you mean you don’t have the chances?*

CI2: *We do not have the new equipment like in the AKPER.*

CI6: *There are too many students at once when they are at our hospital.*

CI4: *Dosen are normally in charge of learning in the DIII.*

CI7: *It is good that we can all learn at the same time, then we will all be able to do the same [teaching] practice.*

CI8: *I have not learnt about critical thinking before. I have not had chances for [continuing] education. It is a privilege, and there is the Paket [accommodation and travel allowance] so I am trying very hard to learn the new way of teaching and will be proud to put it into practice.* (The group as a whole nodded, or said ‘Ya’ to indicate their agreement with this particular statement).

RA: *It is good; you have all learnt very well and have demonstrated that you can use the new teaching strategies.* (FG6, CI1-CI8, RA)

For me, the responses from the Clinical Instructors during this focus group reinforced the likely success of this alternative approach to improving the laboratory component of the DIII curriculum. The espoused effort the Clinical Instructors made to adopt the new strategies was in contrast to their Dosen colleagues who made no apology for non-compliance. Their reactions confirmed that it was acceptable for the CJSSP to intervene in the local situation by enhancing opportunities for Clinical Instructors to participate in financially supported continuing education. The reference to limited continuing education opportunities also highlighted the difficulties and expense
associated with implementing education once nurses had entered practice. This confirmed that improving entry-to-practice education was critical to improving Indonesian nursing.

The Clinical Instructors’ reference to the disparity between equipment in the AKPER and the clinical setting, the large numbers of students on placement at any one time also confirmed previous data relating to the barriers to internationalizing DIII education. So too did the reference to hierarchal factors which gave Dosen the authority over both academic and clinical outcomes of the DIII program.

As the colonizer, this imperfect replica of western approaches to training was acceptable to me because, while it capitalized on some features of Indonesian behavior, it also was not an exact replica of Indonesian practices. The Clinical Instructors were paid to attend, but their attendance was productive as opposed to paying all Dosen to attend when they would never contribute their new skills to the laboratory sessions. The following excerpt is from an interview with the AKPER Director. It illustrates that this hybrid solution was not only acceptable to the Clinical Instructors, but that this way of implementing international standards for nursing was also acceptable to Dosen as compatible with the unique context of Indonesian entry-to-practice nursing education.

AD2: *Ibu Robyn, I think that [my suggestion about involving CIs in the laboratory teaching] is good. We will be the only academy that is doing this, so it will bring us great prestige that our students meet the international standard. The CIs should agree because they will have more income and they will have the honor of working at the AKPER. We should just choose the CIs from the hospitals with the best equipment so that they are more likely to know the international standard.* (*Iv11, AD2*)

The Director’s reference to ‘best equipment’ reinforces the recurring theme of discourses of technology that assume a close relationship between superior equipment and meeting international standards for nursing practice. The Director’s reference to ‘honor’ also highlighted the influence of prestige on the compatibility between involving Clinical Instructors in teaching ‘hands on’ skills in the laboratory. It also
prompted me to explore the perceived lack of prestige relating to Dosen engaging in clinical practice in both the laboratory and hospital settings. The relationship between the status afforded to the theoretical and practical components of the DIII curriculum and the influence this had on implementing CJSSP initiatives to close the gap between theory and practice is described in the next section.

**A Hybrid Model for Closing the Gap between Theory and Practice**

As indicated in Chapter 2 western derived international standards for entry-to-practice nursing education highlight an academic presence in the clinical setting as a mandatory requirement to narrow the gap between theory taught in the classroom and practice in the clinical setting (Andrews & Roberts, 2003; Brennan & Hutt, 2001; Corlett, 2000; Fisher, 2005; Landers, 2000; Neary, 2000). Such clinical credibility in turn, is identified as one of the essential attributes of academic staff who teach in nursing programs that will prepare nursing students to graduate as a contemporary, internationally mobile nurse (WHO & STTI, 2007).

With this literature in mind, the model for improving the clinical skills of Dosen consisted of releasing them from academic duties and engaging them in clinical practice with the Clinical Instructors. This side-by-side practice was to take place in the clinical facilities affiliated with one AKPER participating in the CJSSP. The following data excerpt describes some of the factors that led me to choose this AKPER, to believe that this intervention would be a success, and the apparent failure of the Dosen to live up to my expectations.

*This AKPER was chosen...was because there is an MOU between [RSUPk] and [academy Pk] that allows for some mutual educational activities. Because it is located over the back fence of the AKPER, Dosen seem to go there more frequently than Dosen of other AKPER visit their partner clinical sites. The frequent visits appear to have built up a significant rapport between Dosen and clinical staff. Moreover, there is a surplus of Dosen at this AKPER [text explaining the reason for the surplus has been deleted] ... and the AKPER Direktor can therefore release academic staff from classroom teaching activities to attend the RSU [hospital] with no financial ramifications. There*
was therefore, an agreement that two Dosen would spend time with the CI [Clinical Instructor] who would supervise their participation in ‘hands on’ patient care and acquisition of new clinical skills. (TO8, FN)

Given the local socio-economic influences on teaching practices, which were highlighted in Chapter 5, the reference to ‘no financial ramifications’ in this excerpt was important. ‘No financial ramifications’ meant that while Dosen were engaging in this CJSSP activity, they would still be paid their lecturing rates, which were significantly higher than the rates for engaging in clinical activities. At the same time the Director was able to release these Dosen from their teaching duties and not have to pay additional funds for the staff who assumed these responsibilities in their absence. Hence, there was no financial penalty for Dosen participating in activities to develop their clinical skills. Nor was the AKPER Director placed under any financial pressure by supporting this initiative. I assumed that this guaranteed the success of this initiative. However, the following excerpt reveals this did not occur.

Except for when [one of the other Australian Consultants] or I accompany them, Dosen have not spent the one day per week in the RSU as planned. (TO8, FN)

I therefore spent significant time during interviews with these Dosen trying to identify the reasons for their failure to engage in ‘hands on’ clinical practice. The following excerpt from the final contract report for the CJSSP draws on data from these interviews (Iv 9, 10, 11 & 14) to provide an explanation for the lack of success in achieving the goal of improved clinical competency of Dosen.

It is important to note that despite overcoming the many logistical and financial barriers to lecturers [Dosen] practicing in the clinical field the [Australian nursing technical] consultants believe that the degree of success for this initiative was limited by cultural factors that establish a clear distinction between the academic and professional components of the curriculum and the respective roles of the lecturer and clinician. There is a culture that students ‘learn’, institutional clinical instructors ‘do’ and lecturers ‘teach’. For the lecturer to learn from the institutional Clinical Instructor [CI], a change in the balance of knowledge and authority between the two
professionals would need to occur. Teachers would be perceived to assume the role of a “learner” and “doer” and the institutional clinical instructor would be perceived to assume the role of a teacher. Moreover, if the lecturer is to gain the skill to ‘do’ then there will be little role distinction between the institutional clinical instructor and the lecturer (Aitken et al., 2004, p. 106).

Power relationships established within the local context that defined distinct identities for both clinical and academic staff therefore, prohibited implementation of the western model of faculty practice/lecturer practitioner for academic staff to achieve clinical credibility through demonstrating clinical competency. From a postcolonial perspective, ambivalence with regard to Dosen engaging in clinical practice could be attributed to maintaining allegiance to a local system in preference to a globalized alternative. The Indonesian nurses appeared to place much higher value on retaining local authority relationships that structured the heterogeneity of the subaltern group, than complying with alternative relationships imposed by internationalization of the DIII curriculum (Spivak, 1988b). According to the excerpt from the final CJSSP contract report, the heterogeneous structure of the Indonesian nursing group could largely be constructed by Dosen having authority over teaching within the DIII curriculum. Their authority over teaching and assessment of both theoretical and clinical learning defined their identity as superior to both students and clinicians. Dosen were not expected to engage in learning activities or clinical practice as part of their identity. These activities were the exclusive domain of students and Clinical Instructors respectively.

Although hybrid solutions had been found to improve teaching and learning in other ways, hybridity in these instances had not undermined Dosen authority over theoretical knowledge. For example, there was little opposition to Clinical Instructors facilitating laboratory learning because neither group conceptualized this change as contravening the deliberate separation of the clinical and academic components of the DIII curriculum. Similarly, the introduction of scenarios that represented a modified problem based learning strategy gave students greater participation in the classroom. However, the hybrid model that facilitated this initiative ensured that neither Dosen nor students perceived that the new method represented a change to who was in control of the learning process.
In contrast, narrowing the gap between theory and practice by “up-skilling academy staff in practical skills” (IBRD, 2001, p. 5) constituted an unacceptable change to the local balance of power. The following excerpt is from an email I wrote to my fellow Australian CJSSP technical consultants. It identifies how a hybrid model for reducing the gap between theory and practice arose in recognition of the futility of trying to overcome both Dosen and Clinical Instructor resistance to Dosen becoming an exact replica of their western academic counterparts.

Given the factors that we [Australian technical consultants] now understand to define the roles of Clinical Instructor [CI] and Dosen, it would seem better to capitalize on this knowledge, rather than attempt to change the same. My proposal is that the [Pk Dosen] instead engage in weekly visits to the RSU to observe specific clinical practices related to their current teaching. The purpose of their observation will be to understand the ‘reality’ of clinical practice, but also to evaluate current clinical practice in the light of SOPs and the research literature. When Dosen identify areas where clinical practice is not consistent with the SOPs and/or evidence based practice, they could then provide tutorials for the CIs and contribute to a change in policy/protocol or practice. This will preserve the CI’s domain of clinical practice, and Dosen domain of knowledge. While it will not address the goal of improving ‘hands on’ skills of Dosen, it will address the underlying agenda of reducing the gap between theory and practice within the DIII curriculum. It will also increase an academic presence in the clinical setting, enhancing achievement of the goal to improve cross institutional collaborations. It will help address the goal of improving clinical practice [within the objective of ‘Developing the Practical Field] and finally, it will significantly assist in addressing the goal of improving the scientific knowledge of the CIs. (Em, RA to Australian Consultants)

Once again, this intervention can be deconstructed as an example of hybridity. In its new form, the intervention reconciled the tension between the Indonesian participant’s desire to adopt a western model, and their simultaneous desire to resist colonization. This hybrid solution engaged Dosen in the clinical setting in a role consistent with their authority over knowledge and also maintained Clinical
Instructors authority over practice. Therefore, the hybrid solution incorporated a response to resistance to colonization that was designed to take into account the contextual influences within the world of the colonized. At the same time, from the perspective of the colonizer, the greater contact with the ‘reality’ of nursing experienced by Dosen meant that this hybrid model remained consistent with the principles of narrowing the theory-practice gap that underpinned the original intervention. The following excerpt from the CJSSP final report illustrates how successful this hybrid initiative was in terms of narrowing the gap between the theoretical and practical components of the DIII curriculum.

At [Pk] a close relationship between two lecturers [Dosen] and three CIs [Clinical Instructors] has been established. All participants identified knowledge, skills and best practice deficits in the area of wound management and this has provided the basis for collaborative activities. Lecturers [Dosen] have observed wound dressing practices demonstrated by the CIs. The lecturers have become familiar with the Standard Operating Procedures (SOP) for wound management and have provided translated literature relating to evidence based practice to the CIs. Recommendations for improved practice have been developed collaboratively between the SSP [Australian] consultants, the CIs and the lecturers [Dosen] and will be put forward to hospital management. (Aitken et al. 2004, p. 19)

Therefore, this hybrid model of generating closeness between Dosen, Clinical Instructors and the theoretical and clinical components of the DIII curriculum represented an acceptable and applicable way of internationalizing the DIII program because the intervention was aligned with contextual factors that influenced local practice.

**Conclusion**

This chapter has built upon the previous findings chapter that identified Indonesian resistance to, and rejection of, both western expertise and compliance with universal standards for nursing. Drawing upon the work of Homi Bhabha (1983, 1990, 1994, 1997, 1998), this chapter revealed that such resistance, in the form of mimicry and mockery, created a space for hybrid models to emerge. Without such resistance, it is
doubtful that I would have recognized the lack of transferability of my western expertise to the unique setting of Ministry of Health Nursing Academies in Central Java Indonesia. Nor may I have questioned the appropriateness of international standards for nursing in both Indonesian and western nursing settings. Such awareness particularly created a space where interventions that were satisfactory to both me (as the colonizer) and the Indonesians (as the colonized) could be developed. As a result, these hybrid interventions were able to reconcile the tension between the questionable applicability of international standards for nursing practice to the Indonesian context, the desirability of internationalizing the DIII curriculum, and the contractual obligations of the CJSSP Terms of Reference that specified how the same was to be achieved.
Chapter 8

A View from a New Place

Introduction

The aim of this thesis was to understand Indonesian nurses’ apparently paradoxical responses to internationalization of the Diploma III (DIII) program. This thesis explored why Indonesian nurses considered western expertise and compliance with international standards for nursing to be highly desirable for the purpose of internationalizing entry-to-practice nursing education; yet, during the implementation activities of the CJSSP they often resisted and rejected efforts to incorporate these standards within the DIII program.

Two subsidiary questions also guided the endeavor of understanding the paradox of simultaneous desire and rejection of western expertise and international standards for nursing. These questions aimed to explore the tensions between promoting global consistency and respecting local uniqueness in nursing education and practice. The first subsidiary question asked: How does the local context within which nursing education and practice are situated, influence the acceptance and applicability of international standards for nursing in the specific setting of Central Java, Indonesia? The second subsidiary question asked: How transferable is western expertise based on notions of global consistency and international standards for nursing to the unique setting of Ministry of Health Nursing academies in Central Java, Indonesia? Using a postcolonial approach to answer these questions, this thesis examined the historical, social and economic context in which the CJSSP took place. It also examined the contextual responses of the Indonesian participants in the CJSSP to the activities and interventions of the Australian technical consultants. Particular attention was also paid to understanding the historically located interactions between the Indonesian and Australian participants in the CJSSP and the effect that these interactions had on internationalizing the DIII program.

The postcolonial understandings generated by this thesis are in contrast to the dominant understandings about internationalizing nursing education and practice. The
existing nursing literature has almost exclusively ignored the potential influence of contextual factors on the transferability of western expertise to non-western settings and the ability of non-western nurses to comply with international standards for nursing. The existing literature has described an incompatibility between western and non-western nursing that was attributable to an immutable, static, difference between the learned behaviors, beliefs and values of western and non-western nurses (for example, Hsu, 2006, 2007; Upvall et al., 1999; Xu et al., 2002). Therefore, the title of this chapter: ‘A new place’, highlights the conceptual reorientation that this thesis creates with regard to the desirability and rejection of international standards for nursing, the applicability and acceptability of a universal image of the nurse, and the transferability of western expertise to nursing education and practice in non-western settings.

The chapter begins with addressing the desirability of western expertise and international standards for nursing. It then examines the contrasting resistance to, and rejection of, western expertise and international standards for nursing. Comparisons with previous research are made, where the findings underpinning this thesis are positioned in relation to underlying assumptions of past work. Recommendations for reconstructing perspectives on the transferability of western knowledge and international standards for nursing and using new approaches to improving non-western entry-to-practice nursing education are explored. The chapter concludes with the strengths and limitations of the thesis in relation to its contribution to the nursing discipline.

**Desirability of Compliance with International Standards for Nursing in Indonesian Entry-To-Practice Nursing Education**

This thesis has identified that compliance with international standards for nursing practice and education was considered desirable by Indonesian nurses. The data reveal that the desirability of such compliance related to an aspiration by Indonesian nurses to participate in the global nursing workforce. When analyzed from a postcolonial perspective, Indonesian DIII students, Dosen, clinical nurses and Ministry of Health Officers believed that in order to participate in the global nursing workforce, Indonesian nurses needed to become more like western nurses.
The benchmark against which Indonesian participants in the CJSSP measured ‘becoming more western’ was the competency standards that underpin the image of the contemporary, internationally mobile nurse. In practical terms, Indonesian participants in the CJSSP espoused a desire for both theoretical and clinical teaching to become more learner-centered. They wanted nursing practice taught within the DIII program to be evidence based. There was a focus on the importance of technology for learning theory and clinical practice within the DIII program and technological competency as outcomes for graduates. Indonesian participants wanted internationalization of DIII entry-to-practice nursing education to improve the status of Indonesian nursing from “sub-professional” to “professional” (IBRD, 2001, p. 1). That is, from the perspective of the Indonesian participants in the CJSSP to become more western, meant incorporating the competency standards for the contemporary, internationally mobile nurse within the DIII program. Therefore, this thesis supports the view put forward by Davis (1999), Burnard and Naiyapatana (2004), and Xu et al. (2001) that the image of the contemporary, internationally mobile nurse is a western, hegemonic construction. Indonesian nurses were not alone amongst non-western nurses in deferring to this western defined image of the contemporary, internationally mobile nurse. Instead, conforming to international standards that underpinned entry-to-practice nursing education was desirable to Indonesian nurses because these standards were generally considered universally applicable and not questioned by many nurses worldwide (Bieski, 2007; United Nations, 2006).

Indonesian Nurses Desire for Compliance with International Standards Reflects the Hegemonic Influence of Western Nursing

Indonesian nurses, and other nurses globally are subject to similar hegemonic forces of western nursing that dictate a single definition of nursing (Davis, 1999; Sochan & Singh, 2007; Spitzer & Perrenoud, 2006). Characteristic of hegemonic processes (Leighton, 2005), the notion of a single definition of nursing is ubiquitous. For example, this thesis demonstrated the pervasive influence on Indonesian nursing exerted by the definition of the contemporary nurse implicit in the International Council of Nurses ‘Framework of Competencies for the Generalist Nurse’ (ICN, 2003). The data revealed that these specific competencies both underpinned the CJSSP Terms of Reference (IBRD, 2001) and consistently guided interventions
designed to achieve internationalization of the curriculum. The ICN competencies represent a particularly subtle form of social control through their role in benchmarking standards for entry into the ICN as the peak professional body of nursing as a global discipline. In 2003 when this thesis commenced, these competencies were also used as the basis for determining equivalency between entry-to-practice nursing qualifications gained in different countries worldwide (European Union, 1989). As equivalency of entry-to-practice education forms part of the eligibility criteria for practice in countries with membership of the ICN, these competency standards also determined global mobility (Bieski, 2007). Subsequent to completing data collection for this thesis, the link between the ICN competencies and the specific purpose of addressing concerns over the international variability of nursing education and eligibility for the title of ‘nurse’ (Morin & Yan, 2007) has been strengthened. This strengthening has occurred with the recent release of draft global standards for global initial (entry-to-practice) nursing and midwifery education by the World Health Organization and Sigma Theta Tau International (WHO & STTI, 2006, 2007). These new global standards reinforce the pervasive acceptance of western derived competencies based on a single definition of nursing as the benchmark against which all nursing is measured.

Moreover, as a hegemonic construction, a universally applicable definition of nursing is promulgated to be in the best interests of all nurses (Holt et al., 2000). Therefore, most nurses willingly submit to the western derived notion that a single definition of nursing is necessary for a profession that claims to be global (Davis, 1999). The literature presented in Chapter 3 confirmed this phenomenon. For example, Pang, Wong, Dorcas, Lai, Lee et al. (2002), Saksomboon et al. (2002), and Stockhausen and Kawashima (2003) described non-western nurses’ attempts to relinquish attributes that defined nurses in their local contexts of practice in preference for adopting attributes that characterize nursing implemented in western societies. These authors and others (for example, Kao et al., 2006; Pang et al., 2004; Upvall et al., 1999) identified that non-western nurses willingly attempted to adopt the attributes of the contemporary, internationally mobile nurse. These same authors also found that non-western nurses did so despite the fact that the ideologies underpinning western nursing were significantly different to the ideologies that underpin non-western societies. However, except for a small number of authors (such as Burnard &
Naiyapatana, 2004; Davis, 1999; Xu & Zhang, 2005; Xu et al., 2001), the existing literature provided little insight into why non-western nurses would believe being more like western nurses would be beneficial. Particularly, when doing so created significant conflict with non-western, culturally embedded beliefs, values and behaviors.

The data presented in this thesis revealed that characteristic of the operations of power within hegemonic discourses (Leighton, 2005), non-western nurses may be convinced to willingly comply with western constructions of nursing and with international standards for nursing. They may perceive the potential benefits of assimilating with western nursing outweigh the potential negative consequences of embracing western ideologies. In the case of the Indonesian nurses in this study, they willingly invited western influences into the Indonesian nursing context because of a desire to join the global community of nurses. Indonesian nurses were motivated by a desire to ‘fit in’ to achieve professional recognition in their own country and to participate in the professional global nursing workforce. Of significance to this thesis, was that such a desire to professionalize, both in their own country and as a part of the global nursing workforce was also evident in nursing in the Philippines (Lorenzo et al., 2007). Of particular importance to the Indonesian participants was that the international migration figures confirmed that the desire to ‘fit in’ and to internationalize entry-to-practice nursing education in the Philippines was compatible with the goal of joining the global community of nurses. That is, Indonesian nurses saw western intervention into Philippino entry-to-practice nursing education as a success story. The Philippino example was particularly referred to by the CJSSP management committee and DIII students as a benchmark against which the success of CJSSP interventions would be judged.

*The Influence of Colonial Discourses on the Desire to Comply with International Standards Underpinning Entry-To-Practice Nursing Education*

Importantly, when deconstructed according to a postcolonial perspective, the discourses that underpinned Indonesian nurses’ desire to ‘fit in’ were not only consistent with the contemporary image of nursing as a western hegemonic
construction. These discourses were also consistent with the notion of a global consistency in nursing being constructed by the colonial discourse of assimilation.

**The colonial discourse of assimilation and membership of nursing as a global profession**

The colonial discourse of assimilation is based on an ethnocentric derived suspicion of non-western peoples (Kavanagh, Absalom, Beil, & Schliesmann, 1999). This thesis proposes that an ethnocentric derived suspicion of non-western nursing was evident in the policies of western countries that place limits on the migration of non-western nurses within the global nursing community (Bieski, 2007; Hawthorne, 2001; Kline, 2003). In order to overcome fear of diluting western nursing as a professional, scientific discipline, this thesis proposes that international mobility is therefore limited to those nurses who ‘fit in’ with the western derived contemporary image of the nurse. From a postcolonial perspective, such a basis for assimilation is founded on the need to neutralize the potentially negative influence of inferior Oriental (non-western) standards for nursing on nurses practicing within Occidental (western) settings (Mignolo, 2000; Said, 1993).

In this thesis, findings confirmed that under the influence of the Orientalist discourse of difference (Said, 1993), western nurses constructed non-western nurses as inferior to themselves. In terms of meeting criteria for international mobility, western nurses construct non-western nurses as inferior by their failure to embrace international standards within entry-to-practice programs and as graduates of these programs. For example, this thesis revealed that as the western expert, I initially considered that if DIII students, like nursing students in China (Kao et al., 2006; Xu et al., 2001) and Japan (Hisama, 2001; Pang et al., 2003; Yamashita, 1998) graduated without reaching the international benchmark of independent decision making, then they would be inferior to their western counterparts.

Similarly, in the early phases of the CJSSP I considered that teaching practices of Dosen and Clinical Instructors, like academic faculty and clinical teachers in Pakistan (Upvall et al., 1999; Upvall et al., 2002) and Thailand (Pimpanyon et al., 2000; Saksomboon et al., 2002), were inferior to western teaching practices. Without a focus
on learner-centered techniques and critical thinking strategies, I considered it unlikely that the DIII program would produce graduates who ‘fit in’ with nursing in western countries. Like Kao et al. (2006), Takahashi (2004), and Upvall et al. (1999), I thought that focusing on the most practical way to implement practice (what Indonesian nurses referred to as ‘the routine’) rather than evidence based practice, denied Indonesian graduates of the DIII program the status of ‘Professional nurse’.

In turn, the data of this thesis also supported the proposition that a fear of such inferior attributes diluting the western nursing profession underpinned the criteria against which eligibility for migration was judged. Although my perceptions of Indonesian nurses and nursing education changed as I became more aware of the contextual influences on practice, the data revealed that the western hegemonic construction of nursing was so powerful that I could not completely escape its influence. For example, some of the hybrid solutions that were implemented as part of the CJSSP were acceptable to me because they addressed local contextual issues and improved nursing in Indonesia, but did not threaten to negatively influence practice that occurred outside Indonesia. In contrast, I did not support the implementation of hybrid strategies that addressed local contextual issues but had the potential to undermine western nursing standards should Indonesian nurses achieve the goal of migrating.

The data revealed that even if it was an appropriate response to the local situation, I consistently held and espoused the view that unless the DIII program addressed the gap between evidence based knowledge and clinical practice, incorporated learner-centered teaching approaches, and focused on developing students’ critical thinking and problem solving skills, Indonesian nurses would not achieve international recognition. Moreover, both the Indonesian participants and I consistently located the responsibility for overcoming this barrier to migration as my contractual duty. That is, in my capacity as the western expert, I was responsible for addressing the negative influence of local standards on the potential for DIII graduates to participate in the western nursing workforce. Therefore, in this thesis the discourse of assimilation was accompanied by the neocolonial discourse of development.
The neocolonial discourse of development and the potentially colonizing endeavor of western intervention into non-western nursing education

The discourse of development draws on the latent Orientalist discourses of non-western inferiority and western superiority to divide the world into undeveloped (or under-developed) non-western (Third World) nations and developed western (First World) nations (Pletsch, 1981). This thesis proposes that the discourse of development accompanies globalization of the nursing profession and so renders western intervention into non-western nursing education as a potentially colonizing endeavor.

The findings of this thesis identified that a fear of non-western nurses not ‘fitting in’ defined both my reluctance as the western expert to unreservedly admit Indonesian nurses to the western nursing profession, and the Indonesian participants’ perceptions of the need for development in order to realize their desire for international mobility. When Indonesian nurses’ perceptions of their own practice were explored, it was revealed that they, like me, feared that they did not ‘fit in’ with the image of the contemporary, internationally mobile nurse as a member of a scientific discipline. They particularly feared that a lack of technological advancement and resources negatively influenced their ability to apply evidence based theory to nursing practice. For these Indonesian nurses, technological inferiority overwhelmingly defined their failure to assimilate into the global nursing profession. However, the data revealed that as the western expert charged with the contractual obligation to “develop” (IBRD, 2001, p. 1) Indonesian nursing, I did not have the same interpretation of the negative influence of local standards on the potential for DIII graduates to participate in the western nursing workforce. Whilst I recognized the contextual barriers to Indonesian nurses ‘fitting in’ with the international community of nurses, I interpreted their focus on resources as compounding their inferiority, rather than defining their difference from western nursing. Accordingly, when I measured Indonesian nurses against the benchmark of nursing as a scientific discipline, I believed that they required my help in both incorporating rational decision making within entry-to-practice nursing education and making a rational assessment of their own ability to ‘fit in’.
Such an assessment of Indonesian nursing and the need for western intervention into the DIII program was consistent with the discourse of development that positions western and non-western people in specific relationships to each other within the globalized world of the 21st Century (Easterly, 2006). By contrasting western rationality and non-western irrationality, my assessment was consistent with the discourse of development that positions the First and Third Worlds within the global economy according to their stages of liberalization (Mignolo, 2000). As a consequence, I also subscribed to the liberalizing component of colonialism that has been described as a more insidious form of psychological control than physical colonization (Browne et al., 2005). I conceptualized my responsibility as one of ‘developing’ Indonesian entry-to-practice nursing from its uncivilized and irrational pre-CJSSP status to a liberalized post-CJSSP state. I envisioned that in this liberalized state graduates of the DIII program would leave behind their traditional mentality that prohibited the possibility of utilitarian and scientific thinking (Mignolo, 2000). Instead, once internationalized, I believed Indonesian graduates of DIII entry-to-practice education would embody the attributes necessary to join the liberal, scientific, humanistic global nursing profession.

Importantly, such potential for western interventions to represent psychological colonization of non-western nursing was not an aberration restricted to the activities of the CJSSP. Such an approach to internationalizing non-western entry-to-practice nursing education has previously been reported by nursing scholars such as Chan and Wong (1999), Conway et al. (2002), DeSantis (1987, 1988, 1995), Jayasekara and Schultz (2006) and Xu et al. (2001). These nursing scholars all referred to the activities of western nurses in reforming nursing curricula in non-western countries as modernizing non-western nursing through introducing liberal and humanistic philosophies. They also used the term development to define these activities. Similarly, the preface to the World Health Organization and Sigma Theta Tau International standards (WHO & STTI, 2007) implies that when non-western entry-to-practice nursing education fails to prepare graduates to comply with international standards for nursing, it cannot move from the peripheries and towards nursing’s center without development.
As a result, the perceived deficiencies described above do not simply position Indonesian nurses as ‘not fitting in’. Instead, the liberal discourses that underpin both the image of the contemporary, internationally mobile nurse and western interventions into non-western entry-to-practice nursing education, position Indonesian nurses on the margins of the profession of nursing and locate western nursing at the center.

**International Standards Define the Margins and Center of Nursing**

Exclusion from membership of the International Council of Nurses (ICN), the self-proclaimed voice of global nursing, (Hancock, 2004) constituted evidence of marginalization of Indonesian nursing. Low participation in the global nursing workforce also attested to Indonesian nurses’ marginal status (Aitken, 2006). During the activities of the CJSSP relegation to the margins was particularly demonstrated through the contrasting stereotypical Orientalist images of Indonesian and western nurses. For example, in the previous section of this chapter I identified contrasting assumptions about Indonesian nurses’ technological inferiority and irrationality in comparison to western nurses.

Other examples of constructed oppositional identities were also exposed in this research. They included my initial Orientalist influenced impressions of Indonesian nurses as ‘lazy’ and ‘corrupt’ (Said, 1993). By contrasting these constructions with the oppositional Occidental image of hard-working, ethical western nurses (Said, 1993), I excluded Indonesian nurses from nursing’s civilized western center. While such oppositional identities existed both the Indonesians and I determined that Indonesian nurses could not be considered full members of the liberal, scientific, humanistic global profession. Therefore, the oppositional identities ascribed to Indonesian and western nurses also meant that gaining full membership to nursing’s western center was not an easy process. Like Meleis and Im (1999), this thesis uncovered a western exclusivity within nursing that existed as a pervasive hegemonic discourse and defined the terms upon which membership of nursing’s center could be achieved.

Acknowledgment of such unequal power relationships that underpin the drive for consistency in nursing practice and education is largely absent from the dominant
nursing literature. Authors such as Jayasekara and Schultz (2006), Upvall et al. (2002), and Xu et al. (2002), largely attributed non-western nurses inability to comply with the conditions of membership of nursing’s western center due to incompatibilities between western and non-western cultures. In contrast, by uncovering the constructed nature of the oppositional characteristics that define membership and exclusion from nursing as a global profession this thesis exposes unequal power relationships between western and non-western nurses. Importantly, from a postcolonial perspective the existence of such a pervasive discourse of exclusivity also provides an explanation for the Indonesian participants in the CJSSP desire for western expertise.

**Discourses of Western Exclusivity within Nursing Defines the Desirability of Western Expertise**

This thesis has revealed that the specific competencies formulated by the ICN (2003) guided interventions to achieve the goal of internationalizing Indonesian entry-to-practice nursing education. Tang and Anderson (1999) have previously highlighted that the authority of western experts, such as those who developed these competencies is based on western exclusivity. That is, western nurses who claim to speak on behalf of all nurses (International Center on Nurse Migration, 2005), have assumed the responsibility for defining what nursing is, what nursing should be and the exclusive conditions of entry into nursing as a globalized profession (Holt et al., 2000).

In this thesis, Indonesian nurses were marginalized because entry-to-practice nursing education did not produce graduates that complied with the image of the contemporary, internationally mobile nurse. Therefore, the authority of western nurses over all nurses marginalized Indonesian nurses from entry into the global profession. However, this same authority also defined Indonesian nurses’ desire for my western expertise as it applied to internationalizing Indonesian entry-to-practice nursing education. As an Australian nurse who met the Australian Nursing and Midwifery Council’s competency standards (ANMC, 2005) I complied with the exclusive conditions of entry into the ICN and nursing as a globalized profession. I was therefore a representative of nursing’s center. In addition, the expert knowledge and skills that I brought to the CJSSP was based on my leadership status within a nursing
education system that prepared nurses to comply with the ICN standards. Australian undergraduate nursing education is rated as equivalent to entry-to-practice nursing qualifications in other ICN member countries worldwide (Parker & McMillan, 2007). As a result, the data revealed that I was also positioned as having the desirable qualifications for assuming responsibility for the implementation activities of the CJSSP. The western expertise that underpinned my participation in the CJSSP (and the Australian consultant’s participation) was implicitly desirable because it represented undisputed knowledge from nursing’s western center (Conway et al., 2002; Davis, 1999). Indonesian nurses on the margins wanted affiliation with the center, and so initially appeared to willingly submit to an intervention that promised to do this (Holt et al., 2000).

This thesis, however, challenges such apparent ‘willingness’ on the part of the Indonesian participants in the CJSSP. Instead, data suggested that this engagement represented colonization of non-western nurses by the dominant west. From a postcolonial perspective, western expertise was an implicit element of the colonizing process (Spivak, 1993). A colonizer and colonized relationship existed between me as the representative of the dominant authority within nursing and the Indonesian participants of the CJSSP as marginalized, inferior, subaltern others (Said, 1993; Spivak, 1988a). Moreover, a postcolonial analysis revealed that I initially anticipated that the Indonesian participants would willingly submit to the authority of the west because I held false assumptions about the homogeneity of the subaltern group (Spivak, 1988a). As the CJSSP unfolded the heterogeneity of the Indonesian group became apparent. In contrast to my initial assumptions that all participants in the CJSSP were equally subject to the authority of my western expertise, such ‘willingness’ to submit to the exclusive authority of western nursing experts was not universal after all. Despite a powerful desire for affiliation with the western center of nursing, some of the Indonesian participants only partially submitted to the CJSSP as a potentially colonizing activity.
Contextualizing Indonesian Resistance to Western Expertise and Compliance with International Standards for Nursing

While Indonesian nurses desired membership of the global nursing community, and therefore internationalization of Indonesian entry-to-practice nursing education, not all participants in the CJSSP wanted the DIII program to be ‘colonized’ by western experts. Instead, a postcolonial analysis of the relationship between the Indonesian members of the CJSSP management committee and me (as the western expert) revealed a group within the subaltern cohort who deliberately decentered my authority. Characteristic of Spivak’s (1988a) powerful subaltern group, members of the CJSSP management committee appropriated the voice of western nursing as a strategy to limit the influence of the Australian technical consultants within the DIII program. While the management committee was in favour of the western nursing experts implementing initiatives that would promote global mobility, they were resistant to westernization of the core activities of entry-to-practice nursing education. That is, they anticipated that western initiatives would only apply to a small group of AKPER (Nursing academy) staff who would prepare nursing students specifically for the global workforce. They did not anticipate, and attempted to limit the application of western initiatives to the preparation of graduates for the local nursing workforce that was the core activity of AKPER staff.

In addition, where western influences appeared to extend into the core activities of DIII nursing education a postcolonial analysis revealed that this apparent assimilation was in fact a manifestation of powerful resistance to potential western colonization of Indonesian nursing (Bhabha, 1994). Appearances of similarity between preparation of nurses for the local Indonesian workforce and preparation of nurses in western settings were consistent with Bhabha’s theory of mimicry. By mimicking elements of western entry-to-practice nursing education, the Indonesian nurses who led the implementation of the DIII curriculum resisted the complete adoption of international standards for nursing in the preparation of nurses for the local Indonesian workforce.

The findings showed that such mimicry occurred when there were significant incompatibilities between the local context of nursing practice and education and western nursing practice and education. For example, the nursing process (Doenges &
Moorhouse, 2006) appeared to be the underpinning framework for teaching both nursing theory and practice within the DIII program. However, as Cooke (2003) observed, the DIII curriculum was not arranged according to a decision making model that promoted knowledge development specific to the discipline of nursing. Instead the curriculum was arranged according to a physiological systems model that is traditionally used in medical education in Indonesia (Direktorat Jenderal Pelayanan Medik, 1993). This curriculum model aligned with the local context of nursing practice that placed nurses in a subservient relationship with doctors (Shields & Hartarti, 2003). In addition, the teaching methods within the medical curriculum model did not attempt to promote the type of critical thinking or decision making necessary for nurses to make autonomous clinical decisions within the scientific, rational framework of the nursing process.

These characteristics of the medical model underpinning the DIII curriculum also aligned with the clinical context in which DIII graduates practiced. Indonesian nurses did not make autonomous, evidence-based decisions in the workplace and graduates of the DIII program did not use the nursing process to guide implementation of patient care. Therefore, despite initial appearances of the nursing process underpinning the acquisition of clinical competency, the reality of the local situation was that the nursing process did not guide student learning within the clinical component of the DIII program. It did not guide ‘hands on’ student activities while in the laboratory. The nursing process did not guide student practice on placement, nor did it guide assessment of competency.

These findings are different to previous research on global consistency of nursing practice and education and non-western nurses’ compliance with international standards for nursing within entry-to-practice nursing education. The existing literature described that many non-western nurses willingly accepted the imposition of standards from nursing’s western center to entirely replace existing, locally situated curricula frameworks for entry-to-practice nursing education. Further, non-western nurses did this despite some incompatibilities between non-western and western nursing practice and education, as described in the Indonesian situation. For example, Anne Davis (1999) and Yu Xu et al. (2002) observed that medical dominance in China particularly limited nurses’ capacities for autonomous decision making.
However, in contrast to the situation described in this thesis, Zhaomin Xu et al. (2001) and Sun, Xu, Xu, and Zhang (2001) stated that western interventions resulted in Chinese nurses embracing the nursing process in the face of significant barriers and applying the nursing process to the local context. In fact, the inclusion of the nursing process as a framework for entry-to-practice nursing education was put forward by Xu et al. (2001) and Sun et al. as evidence of the success of western interventions into Chinese nursing during the post-Mao era. Therefore, in contrast to the findings of this thesis, Chinese nurses consistently attempted to use the nursing process despite the local context of medical dominance over nursing education and practice.

Xu et al. (2001) and Sun et al. (2001) attributed Chinese nurses’ willingness to implement the nursing process and to persist with its implementation over so many years to the overwhelming desire to professionalize Chinese nursing. The Chinese nurses who were the driving force behind curriculum reform willingly accepted the assistance of western nursing experts to incorporate the nursing process into entry-to-practice nursing education because they believed it would fulfil their goal of distinguishing nursing from the medical profession. Like the Indonesian nurses in this thesis, Chinese nurses’ locally derived motivation to professionalize was also accompanied by a desire for Chinese entry-to-practice nursing education to be rated equivalent to western nursing curricula in the international workplace (Sun et al., 2001). Chinese nurses also wanted to assimilate with nursing’s western center. Therefore, in line with the findings of this thesis, local and global forces coincided so that Chinese nurses willingly responded to the hegemonic influence of western nursing and the colonizing activities of western experts. Chinese nurses believed that the use of the nursing process within western nursing entry-to-practice education had already positioned western nursing as an autonomous profession and wanted their own curricula to comply with this international standard. Chinese nursing leaders wanted nursing curricula to “… reflect state-of-the-art global nursing education” (Xu et al., 2001, p. 181).

Importantly, Sun et al. (2001), Zhaomin Xu et al. (2001) and Yu Xu et al. (2002) did not suggest, as this thesis does, that Chinese nurses’ willingness to submit to western authority over nursing entry-to-practice positions western nursing as hegemonic and western expertise as potentially colonizing. Instead, Xu et al. (2002) summarized the
position of their colleagues by proposing that the long history of western interventions into Chinese nursing education set the scene for resolution of current incompatibilities between Chinese and western entry-to-practice nursing education. They proposed that Chinese nursing would continue to become more westernized and less distinctly Chinese. This explanation is consistent with the colonial discourse of assimilation and colonial assumptions that occupation enhances the likelihood of successful colonization (Said, 1993). The findings of this thesis however, are not consistent with the view that physical occupation by western experts increases the likelihood of international standards for nursing colonizing Indonesian entry-to-practice nursing.

**New Understandings of the Impact of Physical Occupation on the Internationalization of Non-western Nursing**

In this thesis, the colonial discourse of occupation was appropriated by the most powerful members of the subaltern group who used it as a mechanism for resistance to internationalization of the DIII program. The Indonesian members of the CJSSP management committee insisted that the Australian (expert) technical consultants should spend a specified amount of time in Indonesia. The management committee used this requirement as a way to reverse the Orientalist defined master/slave relationship between the western experts and the Indonesian management committee.

Rather than giving western experts unlimited opportunities to erode existing practices within the DIII program, the data revealed that being in-country meant the Australian consultants were subject to local standards when implementing the activities of the CJSSP. This situation meant that western experts were limited to those activities that were most desired by the Indonesian members of the CJSSP management committee. For example, activities that involved CJSSP technical consultants teaching Dosen how to incorporate multi-media with their teaching methods were encouraged. These activities were highly desirable because they were consistent with the discourse of technology, and preserved the superior position of Dosen within the local educational hierarchy. In contrast, activities that were designed to engage Dosen in ‘hands on’ clinical practice were limited by the management team insisting that the CJSSP consultants comply with stringent local administrative processes. These local processes limited opportunities for releasing Dosen from their normal teaching duties
and engaging in clinical activities. Engaging in such activities was also continued to be undesirable when these barriers were removed because the power relations between Dosen, clinicians and students within the local hierarchy would be disrupted.

Therefore, despite a desire for western expertise and international standards for nursing, some Indonesian participants in the CJSSP also resisted the potentially colonizing activity of internationalizing the DIII program by dictating the terms of western influence. This thesis proposes that such resistance represents ambivalence to the wholesale acceptance of western expertise and international standards for nursing within the DIII program. Prior to this research, such ambivalence was predominantly attributed to cultural incompatibilities between western and non-western nurses (for example, Jayasekara & Schultz, 2006; Shin et al., 2006; Upvall et al., 1999). However, the static definition of culture used by previous researchers denied the complexities of the historical and contextual space where nursing in both western and non-western settings takes place (Gustafson, 2007).

**Static Definitions of Culture Deny Complexities of Historical and Contextual Spaces Where Nursing Takes Place**

By taking a postcolonial approach this thesis has uncovered the influence of Indonesia’s history of colonization upon the cultural milieu in which Indonesian nursing takes place. This thesis has also demonstrated the incompatibilities between western and non-western nursing from the contextual location of the Indonesian participants in the CJSSP, rather than from a western position that situated their apparent failure to develop as a consequence of their inferiority. Accordingly, I propose that Indonesian nurses’ apparently incongruent simultaneous desire for, and resistance to western expertise and internationalization of nursing education and practice reflected a locally embedded response to the global colonizing activities of western nursing. The locally embedded response to global consistency reflects the historical location of Indonesian nurses as citizens of a once-colonized nation.

An examination of Indonesian history revealed that Indonesian people had never willingly worn the chains of colonization, particularly when disadvantaged by the hegemonic ideologies that characterized colonial incursions (Philpott, 2000). Instead,
they adopted elements of colonization that benefited their local situation (such as trading partnerships), and resisted colonial attempts to displace the Javanese as the indigenous leaders of Indonesian economic and political society. Ambivalence arose, for example, when trading partnerships threatened the core values of Indonesian indigenous governance. The ambivalence to western colonization of Indonesian nursing is not dissimilar.

This thesis has revealed that ambivalence to CJSSP activities arose when being internationally recognized meant accepting the dominant western hegemony of nursing and rejecting locally situated meanings or the reality of Indonesian nursing. Dosen participating in the CJSSP were ambivalent to the CJSSP initiatives to increase their participation in the practical component of the DIII curriculum. Whilst they desired internationalization of the DIII curriculum, Dosen did not want western interventions that narrowed the gap between theoretical and practical components of Indonesian entry-to-practice nursing education. Instead, appearances of compliance with international standards for clinically credible academic faculty were often consistent with the ambivalent response of mimicry (Bhabha, 1994).

During interviews, Dosen explained their participation in the laboratory practice and clinical placement components of the DIII curriculum. A postcolonial analysis revealed that these explanations were designed to convince me as the western expert that Dosen participated according to international standards. By doing so, Dosen aimed to protect entry-to-practice nursing education from CJSSP activities that would interfere with the locally embedded separation of the practical and theoretical components of the DIII curriculum. It was not until I observed the failure of Dosen to engage in ‘hands on’ practice in laboratory sessions and clinical placement that I probed the description of these elements of the DIII curriculum more deeply. This subsequent probing revealed that accepting CJSSP interventions that incorporated ‘hands on’ practice by Dosen would mean rejecting local practices that optimized their own incomes. Engaging in ‘hands on’ practice would also mean rejecting locally constructed images of Dosen that were derived from their position of dominance over clinicians and students. According to the local hierarchy, Dosen taught, students learnt, and clinicians acted.
Other researchers have reported hierarchically situated images within nursing in non-western countries such as China (Lu, 1993) and Pakistan (Upvall et al., 2002). These authors also reported a similar reluctance for academic faculty to engage in clinical skills because of a higher status within both the disciplinary hierarchy and the wider social structure. However, the knowledge that this thesis contributes to understanding non-western nurses’ compliance with international standards for nursing is different to the contribution of these authors. In particular, both Lu and Upvall et al. demonstrated a perspective that was influenced by the dominant, static construction of culture within non-western settings and Orientalist constructions of cultural differences between non-western and western nurses. These authors both put forward the view that the distance between the theoretical and practical components of entry-to-practice programs could not be narrowed unless there were significant changes to the hierarchical structures influencing the implementation of nursing education in the unique cultural milieu of China and Pakistan. These authors also suggested that hierarchical differences defined the separation between non-western nurses who did not comply with international standards for nursing and western nurses who did.

In contrast, the mockery that this thesis uncovered as an ambivalent response to internationalization of the DIII curriculum suggested that Indonesian nurses did not completely define themselves as different from western nurses. Instead, by mocking western approaches to competency assessment within western entry-to-practice nursing education, Indonesian participants raised the possibility that western nurses also did not, and should not comply with their own international standards. That is, the mockery that Dosen made of competency assessment suggested that the international standards guiding these assessment processes were inappropriate to ensuring congruence between the theoretical and practical components of curricula in any setting.

Therefore, by carefully ‘unpicking’ the contextual influences on Indonesian entry-to-practice nursing education, this thesis revealed that appearances of similarity between the DIII program and western entry-to-practice nursing education did not exclusively represent compliance with international standards for nursing. Instead, similarities also constituted local, historically situated ambivalent responses that reflected Indonesian nurses simultaneous desire for and rejection of western expertise and
international standards for nursing. Such ambivalent responses opened up a space for new knowledge about the appropriateness and acceptability of international standards for both the DIII program and entry-to-practice nursing education more generally. As a result, the rejection of international standards for nursing may be an appropriate local response to internationalization of Indonesian entry-to-practice nursing education. It may also be an essential element of improving entry-to-practice nursing education on a global level. This proposition is unique to this thesis.

The acceptance of international standards for nursing by non-western nurses and the potential for achieving global consistency in nursing practice and education has been researched by many others (Jayasekara & Schultz, 2006). However, other researchers (for example Lu, 1993; Pang et al., 2003; Shin et al., 2006) have predominantly proposed that non-western nurses need to set aside locally situated practices that reflect inherent differences between western and non-western contexts in which nursing takes place. There is almost a total absence of literature proposing that the drive for consistency in entry-to-practice nursing education may be detrimental to improving nursing practice and education in either non-western, or western nursing settings (Davis, 1999). The next section explores how ambivalence to internationalization of the DIII program was resolved in a way that opened up a potential space for improving entry-to-practice nursing education in Central Java, Indonesia. It particularly focuses on how engaging with, rather than marginalizing, the differences between Indonesian and western nursing education created such possibilities.

**Ambivalence Opens Up a Potential Space for Improving Indonesian Entry-to-Practice Nursing Education**

Indonesian nurses in this thesis seldom accepted western interventions within entry-to-practice nursing education unreservedly. Instead, there was a persistent tension between the applicability of western initiatives and locally defined standards for practice. The decision to accept or reject the CJSSP initiatives (and therefore the western expertise and hegemony of western nursing) was dependant on whether compliance with international standards for nursing or consistency with standards within entry-to-practice nursing education in the local context was more highly
valued. Occasionally there was an alignment between locally situated standards within the context of the DIII program and western standards for entry-to-practice nursing education. This alignment was accompanied by high levels of engagement with CJSSP initiatives to improve Indonesian nursing. For example, Dosen embraced the practice of including multi-media in preference to didactic teaching strategies. This represented an alignment between the local standard that valued technology as one of the most important defining features of the contemporary, internationally mobile nurse and the western standard of encouraging student-directed learning. However, the motivation for Dosen adopting these teaching strategies was not to enhance student participation, but was to strengthen their superior position in relation to students. Therefore, while this alignment led to engagement with CJSSP initiatives and apparent compatibility between international and local standards for nursing education, it did not represent assimilation.

More frequently however, there was little compatibility between international standards for nursing and local practices. Whilst other authors (such as Pang et al., 2004 and Upvall et al., 1999) attributed such incompatibility to culturally embedded perceptions of the role of the nurse, this thesis showed that Indonesian standards for entry-to-practice nursing education were defined by the context within which nursing in Central Java took place. There was low compatibility between the nursing care that DIII graduates were able to implement in the local setting and the international standards that required graduates to practice according to evidence based guidelines. In the Indonesian context, widespread poverty and a fee-for-service health system meant that evidence based practice and the nursing process were theoretical models for nursing rather guiding principles for actual bedside practice. The low resource situation in which Indonesian nurses practised meant that the supplies and equipment necessary for evidence based care were seldom available. If patients or their carers could not finance particular interventions, such as oxygen therapy for babies, then these plans of care were abandoned.

Moreover, the high numbers of students competing for clinical experiences led to students having few opportunities to put evidence into practice. Despite a strong emphasis on evidence based practice and scientifically based decision making within the theoretical component of the DIII curriculum, this low resource situation
contributed to a distinct gap between what was taught in the classroom and the clinical role of both nursing students and graduates of Indonesian entry-to-practice nursing education.

Importantly, the contextual factor of low opportunities for students engaging in ‘hands on’ practice showed that in contrast to previous studies undertaken in ‘Oriental’ cultural milieu (for example, Hsu, 2006; Pang et al., 2004; Stockhausen & Kawashima, 2003), there was a lack of emphasis on skill acquisition within Indonesian entry-to-practice nursing education. While Indonesian nurses frequently followed ‘the routine’, rather than evidence based policies and protocols, this departure from international standards did not represent a preference within the discipline of nursing for ritual and tradition over scientifically informed practice.

The dominance of the discourse of technology within Indonesian nursing highlighted that nurses in Indonesia defined nursing as a scientific discipline. Dosen, clinical nurses, students and Ministry Officers consistently refuted my Orientalist assumptions that ‘the routine’ was based on mystical Indonesian religious traditions. Instead, they used ‘the routine’ to make rational decisions. The fact that nurses did not adhere to scientifically derived practice was not because they preferred ‘the routine’ to evidence based practice. Implementing ‘the routine’ was a rational response to implementing scientifically informed practice when the technology to do so was not available.

Together, the low emphasis on skill acquisition within the DIII program and high emphasis on scientifically derived practice described in this thesis refutes the dominant simplistic categorization of nursing as either a scientific-western or task based non-western discipline.

Importantly, it was this strong emphasis on Indonesian nursing as a scientific discipline that provided an opportunity for resolving the incompatibility between international and local standards for entry-to-practice nursing education and creating opportunities for improving local Indonesian nursing practices within the inadequately resourced setting of Central Java. It was evident in the Terms of Reference for the CISSP (IBRD, 2001) that the most influential Indonesian nurses in the Province were committed to improving the DIII program for the purpose of
advancing nursing from a “sub-professional, to professional discipline” (IBRD, 2001, p. 1).

This commitment to elevating the standing of the nursing discipline within the local context, along with the desire to facilitate overseas migration laid the foundations for improving graduate outcomes from the DIII program. These two driving forces opened up the opportunity for improvements to the standard of entry-to-practice nursing education by becoming a higher priority than complying with local practices that did not measure up to international standards (Aitken, 2006). That is, no matter how undesirable the western practice that guaranteed international recognition for Indonesian nurses might be, if perpetuating local standards would not guarantee this desired outcome, then a mandate for change to local practices was generated.

The desire to comply with international standards created opportunities to reconcile the differences between globally and locally defined standards that influenced Indonesian entry-to-practice nursing education. However, these opportunities were not immediately recognizable. Instead, these opportunities often arose as occasions of passive or powerful subaltern resistance to CJSSP initiatives. Importantly, if such tension between the desire for international standards and the questionable local applicability of the globally defined competencies did not exist, then CJSSP activities that challenged locally defined competencies may have been rejected outright. Without such ambivalence, globally defined competencies may have been wholeheartedly, but inappropriately accepted and therefore doomed to failure.

For example, it appeared that independent, critical thinking and problem solving skills were not essential attributes for a DIII graduate who would practice in the local situation. Instead, locally defined competencies meant that DIII graduates would adopt the collective decision making patterns of other nurses and follow ‘the routine’, which represented the most practical way to implement practice in the resource-poor, fee-for-service health care system. There was great potential for Dosen to outrightly reject CJSSP interventions aimed at promoting independent, critical thinking and problem solving skills within entry-to-practice nursing education. However, Indonesian Dosen, unlike the Japanese nurses described by Davis (1999), Yamashita (1998) and Hisama (2000, 2001), did not entirely reject these interventions in favor of
complying with local collective decision making traditions. Instead, Indonesian Dosen partially resisted and partially accepted the inclusion of problem based learning strategies within the DIII program. For example, Dosen resisted the application of problem based learning strategies within the DIII program when they perceived that these modifications to local practices undermined the authoritative role of the teacher. However, Dosen accepted the application of problem based learning strategies within the DIII when they perceived that it did not give students too much control over their own learning. This opportunity for embracing change arose because Dosen believed that if they did not foster critical thinking and problem solving abilities of students, then they would not be able to achieve the goal of producing graduates who complied with the requirements of a professional, contemporary, internationally mobile nurse.

Similarly, Indonesian Dosen did not wholeheartedly embrace problem based learning strategies within the DIII like the Thai nurses described by Pimparyon et al. (2000) and Saksomboon et al. (2002). Despite the desire for graduates to participate in the international marketplace, participants in the CJSSP also experienced what Saksomboon et al.’s referred to as “competing ideologies” (p. 647). However, unlike Thai nurses, Indonesian Dosen, clinicians and students held on to the traditional hierarchical relationships that defined who questioned other people’s beliefs. By doing so, they resisted totally abandoning the local standards for teaching and learning in favor of a purely student-centered technique. As Shin et al. (2006) found, if the Indonesian participants in the CJSSP had completely abandoned their local standards, initiatives to improve student learning would most likely had failed. Student-centered techniques were incompatible with the local Indonesian education system that largely relied on teacher-centered techniques such as rote learning. Therefore, if the change from traditional education to a more student-centered technique was too great, student learning would have been compromised, not enhanced (Khoo, 2003). Once again, this resistance opened an opportunity for change.

As the Indonesian management committee’s desire for internationalization dictated the CJSSP terms of reference, the Australian technical consultants were under contractual obligations to find a way of improving teaching and learning within the DIII program. Accordingly, it was essential for a solution to be found that would not place Dosen, Clinical Instructors and students in irreconcilable positions in relation to
each other, or constitute radical departure from familiar ways of teaching and learning.

The ambivalence of wanting and not wanting internationalization of the DIII program also reinforced the desire for western expertise. The role of the western expert proved to be of most value not for instituting changes to Indonesian entry-to-practice nursing education by colonizing locally defined resistance, but for identifying hybrid solutions for improving local practices. The next section of this chapter describes how, by exploring hybrid solutions to improving locally embedded standards within the Indonesian DIII program, this thesis uncovered a new perspective on improving both local and global nursing entry-to-practice nursing education.

A New Perspective on Improving Entry-to-Practice Nursing Education in the Context of Globalization

The knowledge arising from this thesis constitutes a powerful warning against ignoring the hegemonic nature of western nursing when engaged in the work of improving entry-to-practice nursing education in both western and non-western contexts. By rejecting their own knowledge and attempting to replace it with western derived definitions of nursing and models for entry-to-practice nursing education, non-western nurses forfeit opportunities for utilizing the desire for international acceptance to improve nursing in their local context (Aitken, 2006). The consequence of nurses from the western center ignoring the hegemonic nature of western nursing is that prospects for incorporating alternative knowledge from the margins to improve western nursing education and practice are overlooked (Davis, 1999).

Opportunities for Hybridity to Improve Entry-to-Practice Nursing Education in Non-western Settings

This thesis suggests that there should be concurrent acknowledgment of the western specificity of competencies relating to the contemporary, internationally mobile nurse and acceptance that attention needs to be paid to evaluating the merits of individual standards as they apply to the local context. In the Indonesian context, following ‘the routine’ was preferred to autonomous, scientific clinical decision making processes
and evidence based practice. Critical thinking and problem solving skills were not encouraged by Dosen. Technological competency was highly valued but not evident in practice. Demonstrating competency by engaging in ‘hands on’ practice within the DIII program was not a priority for either Dosen or nursing students. These local standards contrasted significantly with the western standards for entry-to-practice nursing education that underpinned the CJSSP Terms of Reference (IBRD, 2001).

However, when successful CJSSP initiatives were analyzed from a postcolonial perspective, it was revealed that incompatibilities between local and international derived standards did not preclude improving Indonesian entry-to-practice nursing education. Instead, as Samoan nurses had found (Barclay, Fenwick, Nielen, Poston-Anderson, Stowers et al., 1998), these incompatibilities could be overcome by recognizing the specific contextual factors that influenced the application of unique local standards to the DIII program. Led by Pelentante Stowers, Samoan nurses examined the merits of western models of nursing in terms of improving the health of Samoan people (ICN, 2005). They identified compatibilities and incompatibilities between western standards and local standards and then developed new knowledge to create a Samoan model of nursing that represented a hybrid way of professionalizing Samoan nursing.

Similar to Stowers’ approach to professionalizing Samoan nursing (Barclay et al., 1998), the way forward in this thesis was to analyze the merits of both western standards and Indonesian standards against uniquely local historical, social, and economic factors. The new knowledge that emerged created a space for moving forward. Locally defined standards were blended with western standards and applied within the DIII program to implement a uniquely Indonesian translation of international standards for nursing practice and education. For example, the potential for evidence based practice to improve ‘the routine’ was opened up by the CJSSP establishing collaborative relationships between Dosen and Clinical Instructors. Dosen identified the most recent international standards for a given practice. They worked with Clinical Instructors to identify how the principles underpinning these standards could be used to improve local practices within the restrictions of the resources available in the local context. A new practical way to implement practice (i.e. a new ‘routine’) was then initiated as a copy, but not exact replica, of
international best practice. Although the CJSSP initiatives did not represent a major shift as occurred in Samoan nursing, both hybrid examples took the most pertinent elements of western nursing and used them in concert with local practices.

In this thesis, hybrid interventions avoided both complete failure of western derived initiatives and the perpetuation of Indonesian practices that negatively impacted on the competency outcomes of DIII graduates. Previous to these hybrid interventions, DIII graduates neither met the competency requirements for practice in their own local setting, nor the competency requirements for international mobility (Hennessy, 2001; Rahim-Hillan, 2002). While hybrid solutions did not entirely achieve the Indonesian participants’ desire for international recognition, they did lead to significant improvements in local practice.

One hybrid solution was to replace senior Dosen, with Clinical Instructors and junior Dosen for teaching the laboratory component of the DIII program. Although clinical nurses did have clinical skills that senior Dosen did not possess, and junior Dosen did not have conflicting commitments in private academies, this initiative could not completely resolve the gap between theory and practice. Without resolution of this gap, the DIII program would not meet the standards for entry-to-practice nursing education that guarantee international mobility (WHO & STTI, 2007). However, this hybrid initiative did improve the way that evidence based practice was incorporated into students’ learning. Similarly, whilst it did not improve the clinical skills of the current generation of Dosen, it did put in place strategies for future generations. It also ensured that students gained ‘hands on’ practice supervised by clinically credible nurses. In this way, the findings concur with the evaluation of a collaborative initiative between WHO and Pusdiknakes (Human Resource Development section of the National Ministry of Health) (Aitken, 2004a). Similar to the hybrid initiatives explored in this thesis, the WHO and Pusdiknakes project demonstrated that capitalizing on the desire for international acceptance constituted a significant opportunity for improving Indonesian nursing as it was implemented in the local context.
Opportunities for Hybridity to Improve Entry-To-Practice Nursing Education in western Settings

The insights gained about western nursing by virtue of the Indonesian nurses’ resistance to colonization adds to the body of knowledge regarding the capacity of hybrid solutions to influence western nursing. The case for non-western nurses influencing western nursing has only been made by a few nursing scholars (for example: Anderson & McCann, 2002; Racine, 2003; Reimer-Kirkham et al., 2007) and examples are rare. Davis (1999) and Holt and colleagues (2000) called for a reverse flow of knowledge between western and non-western nurses in relation to autonomy and evidence based practice respectively. However, they did not provide any evidence of this occurring. Yu Xu et al. (2002) suggested that western nurses could learn from Chinese nurses to include traditional Chinese approaches to healing an alternative treatment paradigm within western Baccalaureate programs. In this respect, Zhaomin Xu et al. (2001) described the efforts of Professor Juying Lin to integrate Chinese nursing knowledge into global nursing science.

In this thesis, by exposing Indonesian nurses’ capacity for mimicry I uncovered similarities between Indonesian and Australian nursing that were not anticipated. This led me to develop a new respect for the contextual influences on nurses’ capacities for autonomous practice and the ability to implement the nursing process. Previous to conducting the research, I had assumed that western nurses made rational, scientifically derived decisions relating to each aspect of the nursing process. However, when unpicking Indonesian nurses’ failure to implement care based on assessment data, I was prompted to consider that Australian nurses also operated within a health-care system that limited interventions based on the availability of specific resources. Although the relationship between rationing resources and such decisions are largely hidden in western contexts, this does not negate the disconnection between what is taught in entry-to-practice nursing education and what occurs in the reality of the clinical practice setting.

Similarly, Indonesian nurses’ capacity for mockery revealed a disconnection between the stated competency outcomes of the DIII program and the processes that should ensure graduates acquire such attitudes, skills and knowledge. This disconnection
prompted me to consider the importance of the forces of labor supply and demand in maintaining standards for entry-to-practice nursing in any setting. Such forces equally apply to non-western and western settings, and therefore challenged me to evaluate the appropriateness of current internationally benchmarked academic processes for assessing competency outcomes of entry-to-practice nursing education in my own country.

These insights reveal that there is a potential for non-western nursing to contribute to western entry-to-practice nursing education and so, to also reconstruct and develop the characteristics of graduates participating in the global profession. If equal importance can be afforded to “universal commonalities, collective characteristics, and individual distinctiveness” (Duffy, 2001, p. 493), then the potential for reconstructing the current, exclusive definition of nursing may be realized. The challenge is for this voice from the margins to be heard by the dominant center. A starting point for advancing such a challenge is to reconstruct the role of the western expert.

**Re-Conceptualizing the Contribution that Western Nursing Experts Can Make to Non-western Nursing**

One of the sub-questions of this research was “how transferable is western expertise based on notions of global consistency and international standards for nursing to the unique setting of Ministry of Health Nursing Academies in Central Java Indonesia?” This question recognized how embedded western expertise is in the western nursing practice setting and the hegemony of western nursing. Like the applicability of international standards, this thesis showed that western expertise was only transferrable when there was a direct alignment of international and local best practice. The real value of my expertise was only realized when a two way flow of knowledge existed (Xu et al., 2001). It was not my ability to colonize Indonesian nursing that proved successful for achieving the goal of improving DIII education in Central Java. Instead, the transferability of my knowledge to the Indonesian situation was defined by my ability to facilitate content knowledge that could be accepted, rejected, or incorporated into hybrid solutions. Adopting this position of a facilitator
of hybrid solutions is in contrast to the role of an expert as described in the CJSSP Terms of Reference (IBRD, 2001) and the literature (De Santis, 1987, 1995; Parpart, 1995). By assuming the position of facilitator I was able to encourage Indonesian participants to consider rejecting local standards for nursing that influenced both content and teaching and learning strategies within the DIII program. I was also able to depart from the dominant discourse of development that situated the mismatch between my exclusive authority as the voice of nursing’s western center and the Indonesian CJSSP participants’ negative responses to my expertise as a problem located within non-western nursing (Pearson, 1986). That is, I positioned myself as a facilitator for identifying opportunities for hybrid responses to internationalizing Indonesian entry-to-practice, rather than as responsible for converting the DIII program into an exact replica of western entry-to-practice nursing education. By doing so, I no longer attributed failure of CJSSP interventions to an irreconcilable culture of difference between Indonesian (non-western) and western nursing.

This approach differs significantly from the activities of other western experts that perpetuate the colonial discourses of development (for example, DeSantis, 1987, 1988, 1995). As a facilitator of hybrid solutions, the position that I adopted also contrasts with the dominant understanding that attributes failure of western interventions to non-western nurses, rather than the joint responsibility of both parties within international collaborations based on a counterpart models (see for example, Jayasekara & Schultz, 2006). Moreover, my recognition that failure of western interventions was partly my responsibility meant that I was also able to move on from such ‘failures’. This new understanding helped me to critically appraise the application of international standards for nursing in my western practice setting.

Importantly, my ability to assume this newly defined role of facilitator related to being embedded in the local Indonesian context. Subject to the Indonesian participants adopting the position of the powerful subaltern, I became the ‘other’ and was forced to abandon colonial constructions of western superiority and Indonesian inferiority (Young, 2003). Also, as other researchers have found (Button, Green, Tengnah, Johansson & Baker, 2005), the value of immersion in the local setting counteracts the limited understanding of non-western settings demonstrated by many
western consultants working on internationalizing entry-to-practice nursing education programs (Xu et al., 2001).

Therefore, not only did my immersion in the local context of the DIII program undermine the potential for western occupation to become a colonizing endeavor, but it also opened up a space for rejecting latent Orientalist models that commonly guide western interventions into non-western entry-to-practice nursing education. As described in Chapter 4, a commitment to the ideals of Transcultural Nursing underpins the approach used for many western interventions into non-western nursing education (DeSantis, 1988; Jayasekara & Schultz, 2006; Xu et al., 2001). Transcultural nursing, however, is not compatible with the re-conceptualized image of the western facilitator that I am proposing. Transcultural theory perpetuates the colonial focus on difference, ignores the historical and contextual influences on culture (Bruni, 1988; Hall, 2004) and so prevents the development of hybrid solutions. Therefore, one of the recommendations arising out of this research is that re-conceptualizing western expertise must include re-conceptualizing how western experts approach and derive understandings of the local setting in which non-western nursing takes place. This thesis also raises the question of whether the ability to use such expertise to facilitate hybrid solutions is an imbedded characteristic of an expert, or a characteristic of the individual expert. Further research is needed in this area.

The next section of this chapter describes the strengths of the thesis. It highlights the value of a postcolonial, ethnographic approach for disrupting dominant understandings (Racine, 2003) of the applicability of western expertise and international standards to non-western entry-to-practice nursing education. It also describes how adopting a postcolonial ethnographic approach to critique the status quo (Walker, 1995) contributed research based knowledge to improve practice in situations where western experts are engaged in internationalization of non-western entry-to-practice nursing education. In Chapter 4, I proposed that the credibility of the thesis related to achieving these outcomes and presented criteria against which such credibility could be judged. The strengths of the thesis are consistent with meeting the credibility criteria of Pragmatic, Process and Political-ethical validity.
**Strengths of the Thesis**

A review of the existing literature (Chapter 2) revealed gaps in understanding the tension between promoting global consistency and respecting local uniqueness in entry-to-practice nursing education. One gap was that existing research predominantly explored the applicability and rejection of international standards for nursing using techniques that focused on gathering data that reported behaviors as static moments in time. In contrast, one of the strengths of this thesis is that it explored the historical influences on the acceptability and applicability of western derived competencies in the day-to-day activities of the CJSSP. By doing so, the thesis uncovered explanations for resistance to internationalizing the DIII program that related to contemporary and historically embedded power relations between western and non-western nurses. Past researchers have assumed that tension between local and global consistency should be resolved by non-western nurses abandoning local practices (Burnard & Naiyapatana, 2004). By paying attention to the voice of powerful subaltern resistance, the thesis has shown that preserving local uniqueness in non-western nursing is essential for improving both non-western and western nursing education and practice.

Such a conclusion could not have been reached without adopting a postcolonial perspective, incorporating multiple methods of data collection and using the Rashomon technique for interviewing. When used together, a postcolonial perspective and these methodological techniques gave this thesis particular strength. These theoretical and methodological approaches provided a way to simultaneously acknowledge the hegemonic nature of western nursing (Davis, 1999), to incorporate an understanding of the heterogeneity of subaltern responses to internationalization (Spivak, 1988a), and to uncover understandings located outside nursing’s dominant western center (Racine, 2003). The findings of this thesis involved a departure from assumptions of the homogeneity of non-western responses to internationalization. This departure exposed understandings from the powerful group of participants within the CJSSP, the group whose knowledge was at the greatest risk of being marginalized, because it was in greatest conflict with dominant understandings of internationalization (Spivak, 1988a). The powerful subaltern group of participants in the CJSSP not only challenged the authority of western expertise, but also suggested that from the perspective of once-colonized people, preserving local uniqueness was
central to any reformulated image of the contemporary, internationally mobile nurse. It was from analyzing the voices of this group that the thesis proposed the hybrid model for western intervention into non-western entry-to-practice nursing education. Through a postcolonial ethnography, it was possible to acknowledge the silenced voices from the margins and to propose possible solutions for improving the outcomes of future engagements between western ‘experts’ and non-western nurses.

Another important strength of this ethnographic study was that it explored the influence of western scholarship upon non-western nursing as it was occurring. Previous research predicted the influence of western scholarship on non-western entry-to-practice nursing education by exploring non-western nurses’ perceptions about the potential for incorporating competency attributes of the contemporary, internationally mobile nurse within local curricula (for example, Xu et al., 2002). In this thesis, assumptions about the hegemonic influence of western scholarship on non-western nursing are supported by evidence of Indonesian nurses reactions to actual attempts to incorporate each competency attribute of the contemporary, internationally mobile nurse within the DIII curriculum. This evidence was derived from data collected as internationalizing activities took place within the everyday activities of Indonesian entry-to-practice nursing education. Similarly, whilst other researchers have reported or observed competency outcomes after an internationalizing intervention had taken place (Conway, et al., 2002; Saksomboon et al., 2002), this thesis reports on competency outcomes over the duration of western interventions into non-western nursing.

This was an important strength of the thesis because reactions to western interventions into the DIII program changed over time. The acceptability and applicability of initiatives to improve the competencies of the CJSSP participants changed as relationships formed. Relationships between the western and non-western participants were influenced by the heterogeneity of the group participating in the CJSSP, and acceptability and applicability of interventions were influenced by different contextual factors occurring across the duration of the project. Such complexities were captured by using an ethnographic approach. It is doubtful that these complex determinants of competency would have been elucidated by evaluative research.
conducted at the end of the CJSSP that elicited responses at a specific moment in time.

Another important strength of this thesis was that postcolonial theory not only contextualized Indonesian nurses’ responses to internationalization of entry-to-practice nursing education, but it also provided a way to contextualize international standards for nursing with the globalized world of the twenty-first century. Indonesian nurses’ resistance to and rejection of western colonization not only denied the universality of international standards but also highlighted their specificity. That is, international standards were not perceived to be global benchmarks for nursing education and practice, but were specific standards that reflected expectations for nurses entering western nursing practice. Unfortunately, this link between standards for nursing and control of entry into western nursing practice settings is not consistent with the dominant understanding of their purpose or their actual use. The dominant understanding is that international standards signify the professionalization of nursing as a discipline and so define the ways in which all nurses, regardless of the context in which it takes place, should practice and be prepared for entry-to-practice (WHO & STTI, 2007). As a result, the dominant understanding of the application of international standards to non-western entry-to-practice nursing education is that international standards can be used to improve non-western nursing through professionalizing non-western nurses. However, this thesis revealed that the discourses of development and assimilation underpin the use of international standards. Therefore the need to ‘fit in’ has supplanted the need for entry-to-practice nursing education worldwide to improve in a way that meets the needs of the unique contexts in which nursing is practised.

Whilst international standards may claim to be universally applicable, the findings of this thesis suggest that they are instead benchmarks for maintaining the exclusivity of western nursing and limiting the global mobility of non-western nurses who threaten the homogeneity of nursing’s western center. At the same time, the difficulties I had in escaping my own western positioning also constitute one of the limitations of the thesis as described in the next section of this chapter.
**Limitations of the Thesis**

Recognizing the influence of occupying a dominant western position is an important foundation for developing new understandings about the desirability, acceptability and transferability of international standards and western expertise in non-western contexts. However, whilst I paid attention to acknowledging my position, it is inescapable that the thesis findings reflect a western interpretation of the phenomenon under investigation. My interpretations of observational data and attempts to reconcile conflicting interview data pose a risk of reconstructing the research participants from my position and not their own (Racine, 2003). Therefore, while this thesis highlights the benefits of a reflexive, postcolonial approach, it also highlights the need for research by non-western nurses who can raise their own voice from the margins in defense of the legitimacy of locally derived images of nursing and standards for nursing practice and education.

The recommendation that non-western nurses contribute to knowledge about the constructed nature of nursing is also important to overcome another limitation of the thesis. Although I became fluent in the national Indonesian language, the potential for misunderstandings and misinterpretations was ever present (Birbili, 2000). As language is a process that involves more than the sum of words, there was a risk for the intent of my questions to participants being lost when I translated them from my thinking in English to my speaking Bahasa Indonesia. Similarly, that when I translated the Indonesian participants’ responses from Bahasa Indonesia back into English, there was also a risk that I lost the intended meanings (Temple, 1997). When my fluency in Bahasa Indonesia improved I wrote field notes in this language, and then translated them back into English during the write-up phase of the thesis. It is possible that the contextual meaning was lost with both the passage of time and because I was no longer embedded in the local situation and speaking Bahasa Indonesia in everyday interactions (Temple & Edwards, 2002).

According to Birbili (2000, p. 2), gaining “conceptual equivalence or comparability of meaning” is one of the major difficulties in research when the language of the population under study is different from that of the written representation of the research. Applied to this thesis, Birbili’s statement means that although I have made
attempts to first define, then consistently use common Indonesian terms in this written record of the thesis, there are some grammatical and syntactical structures in Indonesian that do not exist in English (Ercikan, 1998). Therefore, the written record may not convey the same importance as when either spoken in the local Indonesian context or written in Indonesian. For example, in Central Java the terms Dosen, Kepala Bangksa and Ministry Officers are always used respectfully when speaking in Indonesian. They are also capitalized in written documents to convey the respect for the person occupying each position. I have followed this convention throughout this thesis. However, even though I have explained this convention, the meaning may not be so significant to a western reader of the thesis.

Another decision that I made was to use a combination of ‘literal’ and ‘free’ translations (Agustina, 2002; Honig, 1997) in the written record of this thesis. A literal translation that consists of a word-by-word equivalence between Bahasa Indonesia and English is not always readable and can impair the reader’s understanding of the event or interaction. As a result, I have sometimes risked misrepresenting the meaning of an original quotation by creating quotations that “read well” (Rubin & Rubin, 1995, p. 273). Similarly, I have attempted to use equivalent idiomatic expressions in direct quotations, but some expressions that existed in Central Java did not have an equivalent meaning in English and the significance may have been lost (Birbili, 2000).

The risk of this thesis representing a narrow perspective on internationalization of Indonesian entry-to-practice nursing was minimized by examining the activities of the CJSSP from the perspectives of Ministry Officers, Dosen (including AKPER Directors), bilingual secretaries, clinicians (including Kepala Bangksa and clinical instructors), and students. However, medical doctors and scientists also teach in the DIII program and their perspectives have not been included. Similarly, whilst fieldwork encompassed observation of medical staff, how they interacted with the participants in this research and how they practiced within the low resource context, they were not interviewed. Whilst pressures do not exist with regard to exporting Indonesian medical personnel, there are significant pressures for the medical curriculum to comply with international standards for entry-to-practice education in order to improve health outcomes (WHO 2004a; World Bank, 1998). Therefore, a
logical extension of the thesis would involve observations and interviews with medical staff. In the medically dominated Indonesian health care system (Shields & Hartarti, 2003), this process would assist in understanding the implications of attempting to apply global standards for decision making and evidence based practice within resource-poor, non-western practice settings.

The original Terms of Reference for the CJSSP (IBRD, 2001) included reform of the nursing and midwifery DIII programs. Once the implementation phase commenced, and the nursing and midwifery schools were incorporated into Polytechnics, the brief was widened to include other disciplines taught at diploma level within these new institutions. Therefore, another logical extension of the thesis would involve exploring the perspectives of midwives, dentists, physiotherapists, occupational therapists, radiographers and environmental health workers. These participants’ perspectives would contribute to a broader understanding of the applicability and acceptability of western expertise and the transferability of international standards for entry-to-practice nursing education across disciplinary boundaries.

Another group that is not represented in this thesis is the Australian technical consultants. Observing and interviewing other western nursing scholars during activities designed to internationalize non-western entry-to-practice nursing education would also add to the body of knowledge about the influence of dominant constructions of nursing on both the ‘expert’ and the non-western participants.

In summary, the limitations of the thesis are consistent with meeting the credibility criteria of Pragmatic, Process and Political-ethical validity proposed in Chapter 5. Recognizing the limitations of the thesis particularly addresses the criteria of demonstrating a commitment to a reflexive approach, paying attention to the complexities of gathering, recording and presenting data in different languages, and acknowledging the partiality of ethnographic understandings.

**Conclusion**

The thesis adds important new knowledge to nursing in a globalized era. It specifically cautions against the universal application of western derived international
standards for nursing, but does not advocate that they be disregarded entirely. There is no doubt that there were low levels of competency in key areas of Indonesian nursing when benchmarked against the competencies that define the contemporary, internationally mobile nurse. However, the Indonesian nurses’ simultaneous desire for and resistance to internationalizing Indonesian nursing education demonstrated that contextually appropriate improvements could be achieved. For graduates of the DIII program who would become Indonesian nurses working in Indonesia, this is probably a significant step towards achieving the goal of professionalization.

In this thesis, western derived benchmarks for nursing and the desire to participate in the global nursing workforce constituted a powerful, additional motivating force for initiating hybrid solutions that promised to improve local Indonesian nursing education and practice. This force should not be underestimated and should be capitalized on to influence policy at higher levels than could be achieved within the CJSSP. For Indonesian nurses to reach a stage whereby they could readily join an international labor market, the thesis showed that the magnitude of change required was beyond that manageable by the nursing profession alone.

Nevertheless, the successful implementation of hybrid solutions did challenge the dominant understanding that culture defines nursing and is a ‘problem’ for nursing as a profession (Holt et al., 2000). While culture was shown to be a defining feature of context, it was not the only defining feature and was not static (Gustafson, 2007). This interpretation of culture opens up a space where reciprocal exchanges can take place between western and non-western nurses to the benefit of the entire profession (Davis, 1999; Xu & Zhang, 2005; Xu et al., 2001). Hybridity also challenges the position of structural advantage experienced by nurses who set the agenda for global consistency in nursing, positioning western nursing as the unspoken and centered norm (Blackford 2003; Mohammed, 2006; Reimer-Kirkham & Anderson, 2002). The thesis therefore challenges the dominant understandings of western nurses as experts in non-western settings; western nurses as capable of speaking for and defining all nursing; and all nurses, regardless of context, aspiring to a western derived definition of nursing.
References


Easterly, W. R. (2006). The white man's burden: Why the West's efforts to aid the rest have done so much ill and so little good. New York: Penguin Press.


Pusat Pendidikan Educati dan Kebudaya, & Directorate Jenderal Tinggi Educati.


London: Routledge.

Appendix 1

Central Java Sister School Program (CJSSP) Terms of Reference

SISTER SCHOOLS PROGRAM: NURSING AND MIDWIFERY
CENTRAL JAVA PROVINCIAL HEALTH SERVICE

THE FIFTH HEALTH PROJECT – IBRD NO.4374 IND

TERNMS OF REFERENCE

International Bank for Reconstruction and Development, 2001
Jakarta Stock Exchange Building, Tower 2, 11th & 12th Floor
Jln Jendral Sudirman Kav 52-53
Jakarta 12190, Indonesia
BACKGROUND

The Fifth Health Project focuses on human resource development for the Indonesian health sector, with the ultimate aim of improving services for the poor and disadvantaged. The project aims to:

- Achieve improved efficiencies in the utilization of health professionals.
- Achieve more equitable distribution of these personnel.
- Improve the quality of health professional practices, and
- Increase the skills of health professionals.

The project operates in three provinces, including Central Java. In addition, a number of central agencies within the Ministry of Health have a responsibility to support developments at province and district levels.

The Central Java Provincial Health Office is already investing in upgrading the qualifications of a number of its staff who are lecturers in the ministry owned and operated Health Polytechnic as a step toward meeting the needs of the local population for improved health services. The current knowledge and skill levels of staff involved in teaching nursing and midwifery present major problems and it is believed that upgrading the qualifications and experience of staff training future health professionals will make an important contribution toward improving services for the community. However, other steps are also required. The curriculum needs reform; teaching and learning methodologies need substantial improvement; more flexible delivery modes need to be introduced and facilities development needs to be focused around modern, internationally accepted educational practice.

In Central Java, 80% of nurses and midwives are “sub-professional”, having graduated from SPK institutions (at the same level as senior high school). Nursing and Midwifery Academies in Central Java no longer meet the standards set by the Ministry of Education, which has now specified that they should offer award programs at one level above currently offered DIII (three year Diploma) programs. A major collaborative effort is required to improve nursing and midwifery practices and management in the community.

In accordance with the changing of policy decentralization and with the growing demand for higher quality health services, the Central Java Provincial Health Office intends to reform their Nursing and Midwifery educational systems in order to produce better qualified health professionals. The province has decided to facilitate this through educational collaboration with a well-qualified, prestigious overseas teaching institution.

At the present time, teachers of nursing and midwifery generally lack clinical skills while nurses in the clinical area who are clinical instructors lack scientific knowledge.

The Sister School Program (SSP) will be a collaborative program between institutions in Central Java and an overseas health professional education institutions. The vision of this program is to improve the capacity of training institutions in Central Java to produce qualified health professionals who are confident, dynamic, accountable, and effective in both front line service delivery and at referral level.

The national Centre for Health Workforce Education (CHWE) is responsible for providing guidance and technical assistance as well as supervision to the quality of programs and activities. Central Java Provincial Health Office will monitor, coordinate and provide technical assistance to the training institutions and the overseas partners. The training institutions will manage and apply the new learning processes and administration arrangements. The province and the institutions will co-ordinate activities in the implementation arrangements. The overseas health professional education institution's will provide technical advice and assistance to achieve specified goals to achieve this vision of the SSP.
A. OBJECTIVE AND GOAL

The general objective:
To improve the quality of professional health manpower educational institution especially in nursing and midwifery that meet international standards.

The specific objective
To improve learning process through cooperation program with local and foreign health professional education institution/s in the matter of:
1. Development of Curriculum
2. Teaching and learning methodologies;
3. Development of practical field;
4. Development of educational management;
5. Development of Human resources (teaching staff, clinical tutor, supporting staff and students);
6. Development of equipment: Information technology, facilities, infrastructure

Goal:
The Program goal was to improve Diploma III Programs through:
a. Improving nursing and midwifery training education management.
b. Transferring knowledge and skills by applying internationally standard teaching-learning methodologies and technologies.
c. Establishing a continuing education system to improve the capability of nursing and midwifery personnel who are working in health care services settings.

B. PROGRAM TIME AND DURATION

The Program duration will be 15 (fifteen) months from signing of contract.

C. ACCOUNTABILITY

The Sister School will be working together with the team from 6 institutions under the supervision and co-ordination of Central Java Provincial Health Office. Curriculum initiatives will be undertaken in consultation with the (CHWE).

D. SCOPE OF WORKS AND ACTIVITIES

The Consultants will be working together with the 5 (five) Nursing School (Diploma III Level) and 3 (three) Midwifery School (Diploma III level) within the context of Health Polytechnic. The following are the schools:

Schools managed by Health Polytechnic Semarang:
1. D-III Nursing Semarang
2. D-III Nursing Purwokerto
3. D-III Nursing Pekalongan
4. D-III Nursing Blora
5. D-III Midwifery Magelang
6. D-III Midwifery Semarang

School managed by Health Polytechnic Surakarta
7. D-III Nursing Surakarta
The Consultant will perform services within the following scope of works:

1. Curriculum development and implementation;
2. Teaching and learning methodologies;
3. Development of the practical field;
4. Educational management development;
5. Human resource development;
6. Information technology, facilities, infrastructure and system support management;
7. Development of a sustainable relationship;
8. Program monitoring;
9. Management services.

E. CRITERIA OF INSTITUTION FOR SISTER SCHOOL PROGRAM

Local health manpower educational institution:
- Number and quality have meet standard and requirement from Ministry of National Education and Ministry of Health;
- The related program must be fully accredited and its graduates will get certificate or diploma according to recognizable degree from Ministry of National Education and Ministry of Health;
- Available curriculum must meet national curriculum;
- Number of total credit for each level of education

Foreign health manpower educational institution:

Nursing
- Sister school program is developed with institutions within the country that has diplomatic relation with Indonesia
- The institution must be accredited in its country, in Indonesia and Internationally;
- The institution uses English in learning process
- The institution must have programs in nursing diploma and Master;
- The institution produces registered Nurse;
- The institution has clinical orientation;
- The teaching staffs have working experience in ASIA, minimal 5 years working experience and master degree;
- The institution that has experience in sister school program;
- The institution can provide support and guidance in delivering learning process, and opportunity for local institution to create fully-recognized graduates from both institutions;
- The institution can provide aid for local student to be able to learn in foreign institution and pursue degree from both institutions

Midwifery
- Sister school program is developed with institutions within the country that has diplomatic relation with Indonesia
- The institution must be accredited in its country, in Indonesia and Internationally,
- The institution uses English in learning process
- The institution must have programs in midwifery diploma and Master;
- The institution has direct entry midwifery educational program
- The institution produces registered midwife;
- The institution has clinical orientation;
- The teaching staffs have working experience in ASIA, minimal 5 years working experience and master degree;
- The institution that has experience in sister school program;
- The institution can provide support and guidance in delivering learning process, and opportunity for local institution to create fully-recognized graduates from both institutions;
- The institution can provide aid for local student to be able to learn in foreign institution and pursue degree from both institutions

F. STRATEGY & MECHANISM

<table>
<thead>
<tr>
<th>Goal</th>
<th>Strategy</th>
<th>Mechanism</th>
<th>Indicator of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1 Develop and improve the quality of curriculum and learning methodologies</td>
<td>Competency based curriculum development</td>
<td>Review and assessment of competency, topic, syllabus compared to its sister school On-the-job-training</td>
<td>Evaluation report Key competencies Professional value and attitude Develop topic and syllabus that are international standard for credit transfer between institutions Establish a pathway for recognition of prior learning (RPL) for application to experienced nursing and midwifery personnel</td>
</tr>
<tr>
<td>Development of learning methodology and evaluation system</td>
<td>Evaluation of application of learning methodology in connection with achievement of competency standard Improvement of evaluation system Introduce more flexible delivery modes Develop students' and teacher's pack in problem based learning methodology and self directed learning methodologies</td>
<td>Evaluation report Upskill academy and Clinical staff in teaching and learning methodologies that encourage student participation, problem solving, critical thinking and decision making Teaching and learning plans produced by academy staff Develop learning materials for self directed learning, competency based learning and</td>
<td></td>
</tr>
</tbody>
</table>

D:\dip02\My Documents\yuswanti\SSP documents\contract-SSP-CP6.ssp c J A2.Scope of Work.doc
<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Develop the practical field</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-the-job-training</td>
<td>Evaluation of practical standard</td>
</tr>
<tr>
<td>problem solving</td>
<td>Development of practical standard</td>
</tr>
<tr>
<td>Use new technologies in teaching</td>
<td>Evaluation of academic staff</td>
</tr>
<tr>
<td></td>
<td>Evaluation of CI</td>
</tr>
<tr>
<td></td>
<td>Evaluation of equipment in laboratory and practical field</td>
</tr>
<tr>
<td></td>
<td>Development of clinical and community practical field</td>
</tr>
<tr>
<td></td>
<td>Develop collaboration between academy and practical field</td>
</tr>
<tr>
<td></td>
<td>Sense of high quality professional judgement</td>
</tr>
<tr>
<td>Goal 3</td>
<td>Develop educational administration</td>
</tr>
<tr>
<td>On-the-job-training</td>
<td>Evaluation of administrative standard</td>
</tr>
<tr>
<td></td>
<td>Development of administrative standard and tools to improve management &amp; administrative procedure</td>
</tr>
<tr>
<td></td>
<td>Evaluation of administrative staff</td>
</tr>
<tr>
<td></td>
<td>Evaluation of administrative equipment</td>
</tr>
<tr>
<td></td>
<td>Exchange system</td>
</tr>
<tr>
<td></td>
<td>Exchange staff</td>
</tr>
<tr>
<td></td>
<td>Evaluation report</td>
</tr>
<tr>
<td></td>
<td>Upskill administrative staff</td>
</tr>
<tr>
<td></td>
<td>Implement new practices, policies, procedure and systems</td>
</tr>
<tr>
<td></td>
<td>Skills exchange between Sister Schools</td>
</tr>
<tr>
<td><strong>Goal 4</strong></td>
<td><strong>Develop Human Resources</strong></td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal 5</strong></td>
<td><strong>Develop facilities,</strong></td>
</tr>
<tr>
<td><strong>Development, materials and infrastructure</strong></td>
<td><strong>nursing and midwifery laboratory</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Computer laboratory</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Language laboratory</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Library</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Multi purpose room</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Dormitory</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| <strong>Goal 6</strong> | <strong>Improve the quality of learning processes</strong> | <strong>Develop and implement processes of educational management and quality assurance</strong> | <strong>Evaluation of educational management and quality assurance processes</strong> | <strong>Evaluation report</strong> |
|            |                                             | Establish an exchange program for teachers and students | <strong>Develop standard</strong> | <strong>Upskill academy staff in administration and quality assurance skill</strong> |
|            |                                             | Develop mechanism for credit transfer | <strong>Exchange system</strong> | <strong>Establish quality indicators for curriculum teaching and learning and practical field</strong> |
|            |                                             |                           | <strong>Exchange staff</strong> | <strong>Improve learning environment</strong> |
|            |                                             |                           | <strong>On-the-job-training</strong> | <strong>Credit transfer arrangements between institutions</strong> |
|            |                                             |                           |                     | <strong>Exchange programs for students and teachers</strong> |</p>
<table>
<thead>
<tr>
<th>Goal 7</th>
<th>Provision of internationally recognized qualifications</th>
<th>Review and assessment compared to sister school</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provision of internationally recognized qualifications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop plan for crediting local graduates to Sister School's programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continuity of Sister School Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop standard and design criteria for credit recognition/exchange</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Design assessment/examination procedures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Design performance standards for lecturers &amp; graduates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop MOU between Sister Schools</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluation report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop topic and syllabus that are international standard for credit transfer between institutions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of local graduates undertaking internationally accredited studies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MOU between Sister Schools</td>
<td></td>
</tr>
</tbody>
</table>

G. PROGRAM MONITORING
- Establish comprehensive monitoring system (involving both institutions)
- Implement comprehensive monitoring system

H. PROVIDE MANAGEMENT SERVICES
- Conduct financial management
- Provide administration support
- Provide project reports
The strategy of “Competency based curriculum development” (IBRD, 2001, p. 5), although listed under the goal of “Develop and improve the quality of curriculum and learning methodologies” (IBRD, 2001, p. 5), in reality, provided a framework for the Central Java Sister School Program (CJSSP). This aligned with literature that links standards for nursing practice and education to the competencies that define the contemporary, internationally mobile nurse. The concordance between this literature, these competencies and key elements of the CJSSP Terms of Reference (IBRD, 2001) is mapped in the table below. The elements of the CJSSP Terms of Reference are abbreviated as follows: CJSSP Goal (G); Strategy (S); Mechanism (M); Indicator of Achievement (IoA).

**The contemporary, internationally mobile nurse is an autonomous professional**

<table>
<thead>
<tr>
<th>Characteristic/Performance indicator</th>
<th>CJSSP Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Individual autonomy, self-determination;</td>
<td>(S) Competency based curriculum development (IBRD, 2001, p. 4)</td>
</tr>
<tr>
<td>• Professional accountability;</td>
<td>(IoA) Professional value and attitude (p. 4)</td>
</tr>
<tr>
<td>• Engages in legal and ethical practice;</td>
<td></td>
</tr>
<tr>
<td>• Responsibility for individual and professional judgment and actions;</td>
<td></td>
</tr>
<tr>
<td>• Recognizes limits of one’s own competence;</td>
<td></td>
</tr>
<tr>
<td>• Is not subservient to medicine</td>
<td></td>
</tr>
</tbody>
</table>

Supporting literature:
Benefield, Clifford, Cox, Hagenow, Hastings et al., 2000; Davis, 1999; Mawn & Reece, 2000

ICN Framework of Competencies for the Generalist Nurse (ICN, 2003) performance indicators:
“Professional, ethical and legal practice” (pp. 25-26).
The contemporary, internationally mobile nurse is a member of a scientific discipline

<table>
<thead>
<tr>
<th>Characteristics/Performance indicators</th>
<th>CJSSP Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing is:</td>
<td></td>
</tr>
<tr>
<td>• A rational scientific discipline;</td>
<td>(S) Develop and implement</td>
</tr>
<tr>
<td>• Independent from, but of equal</td>
<td>processes to achieve match</td>
</tr>
<tr>
<td>scientific validity as medicine;</td>
<td>between scientific</td>
</tr>
<tr>
<td>• Informed by politically neutral,</td>
<td>knowledge and practical</td>
</tr>
<tr>
<td>impartial knowledge development;</td>
<td>skill to achieve critical</td>
</tr>
<tr>
<td>• Nursing Care is implemented using:</td>
<td>competencies…in the field”</td>
</tr>
<tr>
<td>• Objective reasoning and research</td>
<td>(IBRD, 2001, p. 5).</td>
</tr>
<tr>
<td>techniques;</td>
<td></td>
</tr>
<tr>
<td>• Evidence and not tradition, ritual</td>
<td>(M) Evaluation of practical</td>
</tr>
<tr>
<td>and intuition;</td>
<td>standard (p. 5).</td>
</tr>
<tr>
<td>• Rational decision making using the</td>
<td>(M) Development of practical</td>
</tr>
<tr>
<td>nursing process.</td>
<td>standard</td>
</tr>
<tr>
<td></td>
<td>(IoA) Professional value</td>
</tr>
<tr>
<td>Supporting literature:</td>
<td>and attitude (p. 4).</td>
</tr>
<tr>
<td>Doenges &amp; Moorhouse, 2003; Doenges,</td>
<td>(IoA) Upskill CI [Clinical</td>
</tr>
<tr>
<td>Moorhouse &amp; Muir, 2006; Duffy, Foster,</td>
<td>Instructor] in scientific</td>
</tr>
<tr>
<td>Kuiper, Long &amp; Robinson, 1995; Gerish &amp;</td>
<td>knowledge (p. 5)</td>
</tr>
<tr>
<td>Clayton, 1998; Gustafson, 2005;</td>
<td>(IoA) Improve practical</td>
</tr>
<tr>
<td>Leighton, 2005; Parse, 1992, 1999;</td>
<td>standard of nursing (p. 5)</td>
</tr>
<tr>
<td>Puzan, 2003.</td>
<td>(IoA) Sense of high</td>
</tr>
<tr>
<td>ICN Framework of Competencies for the</td>
<td>quality professional</td>
</tr>
<tr>
<td>Generalist Nurse (ICN, 2003)</td>
<td>judgement (p. 5).</td>
</tr>
<tr>
<td>performance indicators:</td>
<td></td>
</tr>
<tr>
<td>“Care Provision and Management”</td>
<td></td>
</tr>
<tr>
<td>(pp. 27-29);</td>
<td></td>
</tr>
<tr>
<td>Evidence based decision making is</td>
<td></td>
</tr>
<tr>
<td>included as a key principle of care</td>
<td></td>
</tr>
<tr>
<td>provision (p. 28). The nursing process</td>
<td></td>
</tr>
<tr>
<td>is described under five headings that</td>
<td></td>
</tr>
<tr>
<td>match the five phases of the nursing</td>
<td></td>
</tr>
<tr>
<td>process (pp. 27-29)</td>
<td></td>
</tr>
</tbody>
</table>

Background:
The nursing process appears as an integrating theme for the DIII curriculum (Pusat Pendidikan Edukasi dan Kebudaya, Directorate General Tinggi Edukasi, 1999a).

The contemporary, internationally mobile nurse is proficient in rational decision making AND is prepared for local and international practice by an educational system that encourages development of critical thinking, problem solving for rational clinical decision making

<table>
<thead>
<tr>
<th>Characteristics/Performance indicators</th>
<th>CJSSP Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nurse:</td>
<td></td>
</tr>
<tr>
<td>• Has critical thinking and problem</td>
<td>(G) Develop the practical</td>
</tr>
<tr>
<td>solving skills to support technical</td>
<td>field (IBRD, 2001, p. 5).</td>
</tr>
<tr>
<td>proficiency;</td>
<td></td>
</tr>
<tr>
<td>• Makes systematic evidence based</td>
<td></td>
</tr>
<tr>
<td>clinical decisions;</td>
<td></td>
</tr>
</tbody>
</table>

324
<table>
<thead>
<tr>
<th>Characteristics/Performance indicators</th>
<th>CJSSP Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gathers information using comprehensive assessment processes;</td>
<td>(IoA) Sense of high quality professional judgement (p. 5).</td>
</tr>
<tr>
<td>• Sorts and clusters information into actual and potential problems;</td>
<td>(G) Develop and improve the quality of curriculum and learning methodologies (p. 4)</td>
</tr>
<tr>
<td>• Draws on previous experiences to make clinical judgments about information;</td>
<td>(M) Evaluation of application of learning methodology in connection with achievement of competency standard (p. 4)</td>
</tr>
<tr>
<td>• Identifies causal aetiologies;</td>
<td>(IoA) Upskill academy and Clinical staff in teaching and learning methodologies that encourage student participation, problem solving, critical thinking and decision making (p. 4)</td>
</tr>
<tr>
<td>• Classifies problems as diagnoses using scientific taxonomy;</td>
<td>(IoA) Teaching and learning plans produced by academy staff (p. 4)</td>
</tr>
<tr>
<td>• Relates diagnoses to each other;</td>
<td>(M) Introduce more flexible delivery modes (p. 4)</td>
</tr>
<tr>
<td>• Identifies individual strategies, interventions and outcomes;</td>
<td>(M) Develop students’ and teacher’s pack in problem based learning methodology and self directed learning methodologies (p. 4)</td>
</tr>
<tr>
<td>• Identifies and rectifies situations where outcomes are not met;</td>
<td>(IoA) Achievement of critical competencies by students (p. 5)</td>
</tr>
</tbody>
</table>

Supporting literature: Brown & Edwards, 2005; Clark & Lang, 1992; Doenges & Moorhouse, 2003; Doenges, Moorhouse & Muir, 2006;

ICN Framework of Competencies for the Generalist Nurse (ICN, 2003): Critical thinking, problem-solving skills, interpretation of data, and the application of sound clinical judgment appear in the key principle statements for the nursing process based professional activities of care provision and management (pp. 27-29)

(IoA) Sense of high quality professional judgement (p. 5).

(G) Develop and improve the quality of curriculum and learning methodologies (p. 4).

(M) Evaluation of application of learning methodology in connection with achievement of competency standard (p. 4).

(IoA) Upskill academy and Clinical staff in teaching and learning methodologies that encourage student participation, problem solving, critical thinking and decision making (p. 4).

(IoA) Teaching and learning plans produced by academy staff (p. 4).

(M) Introduce more flexible delivery modes (p. 4).

(M) Develop students’ and teacher’s pack in problem based learning methodology and self directed learning methodologies (p. 4).

(IoA) Achievement of critical competencies by students (p. 5).

(IoA) Develop learning materials for self-directed learning, competency based learning and problem solving (p. 4).

(IoA) Use new technologies in teaching (p. 5).

(IoA) Higher quality teaching and learning environments in academies (p. 6).

(G) Develop facilities, materials and infrastructure [in academies] (p. 6).
The contemporary, internationally mobile nurse is technically competent AND is prepared for local and international practice by an educational system that includes practical learning experiences for students.

<table>
<thead>
<tr>
<th>Characteristics/Performance indicators</th>
<th>CJSSP Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nurse provides</td>
<td>(G) Develop the practical field (IBRD, 2001, p. 5).</td>
</tr>
<tr>
<td>• ‘Hands on’ care;</td>
<td>(M) Evaluation of practical standard (p. 5).</td>
</tr>
<tr>
<td>• Preventative and curative care;</td>
<td>(M) Development of practical standard (p. 5).</td>
</tr>
<tr>
<td>• Care using a wide range of technology</td>
<td>(M) On-the-job-training (p. 5).</td>
</tr>
<tr>
<td>ICN Framework of Competencies for the Generalist Nurse (ICN, 2003) performance indicators: “Care Provision and Management” (pp. 27-29); Technical proficiency is described under the “care implementation” heading (pp. 27-29).</td>
<td></td>
</tr>
<tr>
<td>World Health Organization and Sigma Theta Tau International Global Standards for Initial Nursing and Midwifery Education (WHO &amp; STTI, 2007) performance indicators:</td>
<td></td>
</tr>
<tr>
<td>Standard 2 Programme Curriculum 2.1: Curriculum design (p. 7); 2.2: Core curriculum (p. 7); 2.3: Curriculum partnerships (p. 8);</td>
<td></td>
</tr>
<tr>
<td>Standard 3 Academic Faculty/Staff 3.1: Academic Faculty/Staff (p. 9); 3.2: Clinical supervisors (p. 9); 3.3: Professional development (p. 9).</td>
<td></td>
</tr>
<tr>
<td>Standard 5 Programme Graduates 5.1: Assessment (p. 13); 5.2: Outcomes (p. 13); 5.3: Characteristics (p. 13)</td>
<td></td>
</tr>
<tr>
<td>(IoA) Improve practical standard of nursing … in health provider unit (p. 5)</td>
<td></td>
</tr>
<tr>
<td>(IoA) Use new technologies in teaching (p. 5)</td>
<td></td>
</tr>
<tr>
<td>(IoA) Develop topic and syllabus that are international standard for credit transfer between institutions (p. 4)</td>
<td></td>
</tr>
<tr>
<td>(G) Develop facilities, materials and infrastructure [in academies] (p. 6)</td>
<td></td>
</tr>
<tr>
<td>(IoA) Standard of equipments according to its sister school (p. 6)</td>
<td></td>
</tr>
<tr>
<td>(IoA) Achieve working mechanism between educational institution and health provider unit where students do their practice (p. 5)</td>
<td></td>
</tr>
</tbody>
</table>
The contemporary nurse is prepared for local and international practice by an educational system that demonstrates concordance between the scientific basis for nursing and the clinical practice of nursing

<table>
<thead>
<tr>
<th>Characteristics/Performance indicators</th>
<th>CJSSP Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching staff demonstrate clinical credibility by their:</td>
<td>(S) Develop and implement processes to achieve match between scientific knowledge and practical skill to achieve critical competencies in nursing … practice in the field (IBRD, 2001, p.5)</td>
</tr>
<tr>
<td>• Clinical competence;</td>
<td></td>
</tr>
<tr>
<td>• Scholarship in the practice setting;</td>
<td>(M) Evaluation of academy staff (p. 5)</td>
</tr>
<tr>
<td>• Knowledge about clinical practice;</td>
<td>(IoA) Upskill academy staff in practical skill to achieve critical competencies (p. 5)</td>
</tr>
<tr>
<td>• Familiarity with clinical protocols and procedures;</td>
<td>(M) Develop collaboration between academy and practical field (p. 5)</td>
</tr>
<tr>
<td>• Continued clinical engagement in the practice setting;</td>
<td>(IoA) Skills exchange between academy staff and CIs [clinical instructors] (p. 5)</td>
</tr>
<tr>
<td>• Collaboration with clinical staff/services</td>
<td>(IoA) Achieve working mechanism between educational institution and health provider unit where students do their practice (p. 5)</td>
</tr>
</tbody>
</table>

Teaching staff demonstrate effective clinical teaching

Supporting Literature:

ICN Framework of Competencies for the Generalist Nurse (ICN, 2003, p. 18): the competencies are described as guiding curricula to produce graduates with competencies for local and international practice

World Health Organization and Sigma Theta Tau International Global Standards for Initial Nursing and Midwifery Education (WHO & STTI, 2007)

Performance Indicators:
Standard 2 Programme Curriculum
2.1: Curriculum design (p. 7);
2.2: Core curriculum (p. 7);
2.3: Curriculum partnerships (p. 8);
Standard 3 Academic Faculty/Staff
3.1: Academic Faculty/Staff (p. 9);
3.2: Clinical supervisors (p. 9);
3.3: Professional development (p. 9).

(G) Develop and improve the quality of curriculum and learning methodologies (p. 4)

(M) Evaluation of application of learning methodology in connection with achievement of competency standard (p. 4)
Characteristics/Performance indicators | CJSSP Terms of Reference
--- | ---
Standard 5 Programme Graduates  
5.1: Assessment (p. 13);  
5.2: Outcomes (p. 13);  
5.3: Characteristics (p. 13) | (IoA) Upskill academy and Clinical staff in teaching and learning methodologies that encourage student participation, problem solving, critical thinking and decision making (p. 4)

(IoA) Achievement of critical competencies by students (p. 5)

(IoA) Develop learning materials for self-directed learning, competency based learning and problem solving (p. 4)

The contemporary, internationally mobile nurse is able to provide care in a wide range of health care settings

Characteristics/Performance indicators | CJSSP Terms of Reference
--- | ---
The nurse is internationally mobile  
Supporting literature:  
ANCI, 2002; Bieski, 2007; Canadian Nurses Association (CNA), 2005; Hancock, 2004; Hawthorne, 2001; Thompson, 2002 | (G) (S) Provision of internationally recognized qualifications (IBRD, 2001, p. 7)

(M) Develop standard and design criteria for credit recognition/exchange (p. 7)

(M) Design performance standards for lecturers & graduates (p. 7)

(IoA) Develop topic and syllabus that are international standard for credit transfer between institutions (p. 7)

ICN Framework of Competencies for the Generalist Nurse (ICN, 2003, p. 31-32): Competencies are described as sufficiently broad to apply internationally so that they can be used for defining standards for nursing practice and education at both a local level and as benchmark standards that facilitate global migration and licensure

References
the teacher/lecturer in practice: findings from a case study in adult nursing.
_Nurse Education Today, 20_(3), 178-188.
competency standards for registered and enrolled nurses_. Retrieved June 15,
2004, from
_http://www.anmc.org.au/docs/Principles%20for%20the%20Assessment.pdf_
faculty of full- and part-time generic BSN, LPN-BSN and RN-BSN Nursing
al. (2000). Nursing leaders predict top trends for 2000. _Nursing Management,
31_(1), 21-24.
their work? A descriptive survey among Swedish-approved clinical
supervisors. _Journal of Nursing Education Management, 15_(8), 853-861.
Bieski, T. (2007). Foreign-Educated nurses: an overview of migration and
credentialing issues. _Nursing Economics$, 25_(1), 20-34.
clinical evaluation tool for baccalaureate nursing students. _Nurse Education in
Practice, 8_(1), 62-71.
learning in practice: The experiences of two clinical nurse educators. _Nurse
Education in Practice, 1_(4), 181-188.
Assessment and management of clinical problems_. Sydney, Australia: Mosby.
Canadian Nurses Association (CNA). (2005). _Position statement: Regulation and
integration of international nurse applicants into the Canadian health system._
Retrieved December 5, 2007, from _http://www.cna-
nurses.ca/CNA/documents/pdf/publications/PS79_Regulation_e.pdf_
Cooke, M. (1996). Nursing students' perceptions of difficult or challenging clinical


Appendix 3

Permission for Access to Research Sites and Research Participants

FROM: HP - I PROF. JATENG

PEMERINTAH PROPINSI JAWA TENGAH
DINAS KESEHATAN
Jl. Piere Tendedan No 24 Telp. (024) 3511337, 3511351, 3511352, 3511349, 3517459, 3581961
Fax 3517463 Kode Pos 50131 Kotak Pos 026 Semarang

26th February 2003

The Fifth Health Project
Central Java Province
Jl. Piere Tendedan 24 Semarang
Central Java Province – Indonesia

To:
Professor Judith Parker
Head of School
School of Nursing
Level 2, 723 Swanson Street
Carlton, VIC 3053, Australia

This letter certifies that the Sister School technical consultants have permission to access employees of Dinas Kesehatan for activities as specified in the work plan.

Head of Provincial Health Office
Central Java Province

[Signature]

Dr. Krishnapuya, MS
NIP 140125272
Appendix 4

Plain Language Statement – Short Version

THE UNIVERSITY OF MELBOURNE
SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES
SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) supported by the Central Java Ministry of Health and
funded by the World Bank

Plain Language Statement

< date>
Dear potential participant

The Sister School Project is part of the Fifth Health Project (HPV) supported by the Central Java
Provincial Ministry of Health and funded by the World Bank to improve nursing and midwifery
educational institutions in Central Java, Indonesia. Professor Judith Parker and Ms. Robyn Atiken from
the University of Melbourne are members of the team of technical consultants who are particularly
interested in issues relating to the context of nursing practice in Central Java and current practices relating
to Diploma III nursing education.

This research is supported by the Central Java Ministry of Health and is part of the Fifth Health project
funded by the World Bank. The research will help policy-makers and nursing colleagues to develop and
implement new educational practices and so will contribute to implementing curriculum reform of the
DIII program. It is anticipated that such changes will also improve the quality of care delivered by health-
care personnel. Other benefits of the project include the opportunity to share information with colleagues
who you might not otherwise have the chance to meet. There will also be the opportunity for exchange of
knowledge and skills with the researcher(s) who will be located in-country for a considerable length of
time during the project.

We invite you to participate in this project. Participation is voluntary and while the Central Java Ministry
of Health has supplied your name and contact details, your participation or non-participation in the project
will not affect your position as an employee. The researchers will not have access to personal and/or
confidential data without your specific consent. Following consent to participate in the project the
researcher(s) may contact you directly by phone, fax, email or letter, to participate in any or all of the
components of the study. Either yourself or the Ministry of Health will supply your contact details. The
study is comprised of four components conducted over an 8-month timeframe:
a) a short questionnaire
b) face-to-face focus group interviews (1 – 4 per participant)
c) face-to-face individual interviews (1-3 per participant)
d) observation of everyday learning and/or teaching practices (1-3 per participant)

If you agree to participate you will be invited to complete and return a short questionnaire containing
questions about your personal details, such as education, age and work experience that will be used to

School of Nursing
Faculty of Medicine, Dentistry & Health Sciences
The University of Melbourne Victoria 3010 Australia
Telephone: +61 3 8344 0800 Fax +61 3 9347 4172
provide an overview of the characteristics of persons involved in the D3 program. The questions will be written in both Bahasa Indonesia and English and will take approximately 10 minutes to answer. If you complete this form we will assume that you are giving your consent to providing this information.

You may also be asked to participate in between one or all of the other three components of the project. You will be invited to indicate your willingness to participate in all components by signing a consent form at the beginning of the study, and your verbal consent to participate will be requested prior to each interview and observation. A bilingual secretary will be present at all times. Both verbal and written information will be available in both Bahasa Indonesia and English. All interviews and observations will take between 1-3 hours, and take place at the academy, clinical site or Sister School Office at a pre-arranged time in work or study during the 8-month period of the project.

The researcher(s)’ observations will be kept in confidence, data will be kept secure and you will not be able to be identified from any of the research data or published results of the project.

After your contribution, you are welcome to attend a research presentation and/or request a copy of the summary of the findings.

Finally, we would like to explain to you that in accordance with University Policy, the researchers were required to apply for permission to undertake this research from the Human Research Ethics Committee of The University of Melbourne. Conditions of permission are (1) provisions of this letter explaining the research and what you could be asked to do; and (2) a consent form which you must sign if you agree to take part. This is meant to be reassuring for you that you can choose or not choose to take part without any consequences and that you will not be harmed by taking part. I know from an Indonesian perspective it may seem that this letter and the wording of the forms is rather formal, but this is because the same wording is used for all research. In addition, if you would like more information about the study, a more detailed version of this both this letter and the consent form is available.

So, if you would like to participate, please indicate that you have read and understood this information by signing the accompanying consent form and returning it in the envelope provided along with the questionnaire relating to your personal details. The researcher(s) will then contact you to arrange for your participation in further components of the study as they are scheduled.

Robyn is the contact person of the study if you require further information or have problems concerning the study. When in Indonesia her contact details are C/ Polyteknik Kesehatan – Semarang, Jln. Tirto Agung Pedalangan Banyumanik Semarang, Central Java 5026; Telephone: 024 747 1251. When in Australia she may be contacted at the School of Nursing, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Level 1, 723 Swanston Street, Carlton 3053, Australia telephone +61 3 83440773. Her email is the same both in Indonesia and Australia: robyn@unimelb.edu.au.

If you have any complaints about any aspect of the study or the way in which it is being conducted, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph. 8344 7507, or fax: 9347 6739.

Thank you for your time.

Professor Judith Parker & Robyn Aitken
Principal Investigators
Appendix 5

Plain Language Statement – Long Version

THE UNIVERSITY OF MELBOURNE
SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES
SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and
funded by the World Bank

Plain Language Statement

<date>

Dear potential participant

The Sister School Project is part of the Fifth Health Project (HPV) supported by the Central Java Provincial Ministry of Health and funded by the World Bank to improve nursing and midwifery
educational institutions in Central Java, Indonesia. Professor Judith Parker and Ms. Robyn Aitken from
the University of Melbourne are members of the team of technical consultants who are particularly
interested in issues relating to the context of nursing practice in Central Java and current practices relating
to Diploma III nursing education.

This research is supported by the Central Java Ministry of Health and is part of the Fifth Health project
funded by the World Bank. The research will help policy-makers and nursing colleagues to develop and
implement new educational practices and so will contribute to implementing curriculum reform of the
DIII program. It is anticipated that such changes will also improve the quality of care delivered by health-
care personnel. Other benefits of the project include the opportunity to share information with colleagues
who you might not otherwise have the chance to meet. There will also be the opportunity for exchange of
knowledge and skills with the researcher(s) who will be located in-country for a considerable length of
time during the project.

The study will be conducted over an 8-month period of time and includes the researchers administering a
short questionnaire, conducting face-to-face focus group interviews, face-to-face individual interviews
and observation of everyday learning and/or teaching practices.

We invite you to participate in this study. If you agree you will be invited to complete and return a short
questionnaire containing questions about your personal details, such as education, age and work
experience that will be used to provide an overview of the characteristics of persons involved in the DIII
program. The questions will be written in both Bahasa Indonesia and English and will take approximately
10 minutes to answer. If you complete this form we will assume that you are giving your consent to
providing this information.

You may also be asked to participate in between one or all of the other three components of the project.
You will be invited to indicate your willingness to participate in all components by signing a consent
form at the beginning of the study, and your verbal consent to participate will be requested prior to each

1 of 3
interview and observation. A bilingual secretary will be present at all times. Both verbal and written information will be available in both Bahasa Indonesia and English. All interviews and observations will take place at the academy, clinical site or Sister School Office. Interviews and observations will take place at a pre-arranged time in work or study hours during the 8-month period of the project.

If you agree to participate you may be invited to attend between one and four focus group interviews that involve meeting face-to-face with the researcher(s) and a group of other persons such as teachers, clinical nurses and persons from the Office of the Provincial Ministry of Health who are involved in the D3 nursing program. During the interview you will be asked to respond to particular questions about the D3 program and your responses will be recorded using field notes and an audio tape-recorder. The focus group will take between 1 and 3 hours of your time.

You may also be invited to participate in between one and three individual interviews that involve meeting face-to-face with the researcher(s). During the interview you will be asked to respond to particular questions about the D3 program and your responses will be recorded using field notes and an audio tape-recorder. The individual interview will generally take approximately 1 hour, but may take up to 3 hours of your time.

You may also be invited to participate in the observation component of the study that will involve the researcher(s) observing your everyday work in the classroom or clinical facility. The researcher(s) will be a participant observer by virtue of engaging in the teaching activity with you. The observations will take place between one and three times over the 8-month period of the project. Each observation will take between 1 and 3 hours of your time.

It is not anticipated that you will experience any discomfort relating to the research. However, should you feel any discomfort during the interview sessions you may withdraw at any time during the study. Furthermore, data collection relating to observing your everyday practices will be discontinued at your request or if the researcher(s) assesses the level of discomfort as unnecessarily harmful. Follow-up debriefing and counselling will be offered to participants to be taken at their discretion. Should you choose to withdraw from the study you may also request to withdraw any unprocessed data previously supplied.

The researcher(s)’ observations will be kept in confidence and you will be allocated a code number to protect your identity. Computerized data will be password protected. Information provided by you will be used only for the purposes of this project. The field notes and audio-tapes recording the interviews and observations and the questionnaire data will be stored in a locked filing cabinet in the researchers’ workplace in either Indonesia or Australia for the duration of the study. The only people who will have access to the data will be the researchers unless otherwise disclosed by Australia law and Indonesian law. On completion of the study all data will be returned to Melbourne by the researcher(s) where it will be stored in locked facilities at the School of Nursing until it is destroyed five years following completion of the project report.

Results of the study will be published as aggregate data in interim and final project reports to the Ministry of Health and World Bank and may be published in conference papers. You will not be specifically identified from any publications or in any recommendations arising from this study.

After your contribution, you are welcome to attend a research presentation and/or request a copy of the summary of the findings.

School of Nursing
Faculty of Medicine, Dentistry & Health Sciences
The University of Melbourne Victoria 3010 Australia
Telephone: +61 3 8344 0800 Fax +61 3 9347 4172
So, if you would like to participate, please indicate that you have read and understood this information by signing the accompanying consent form and returning it in the envelope provided along with the questionnaire relating to your personal details. The researcher(s) will then contact you to arrange for your participation in further components of the study as they are scheduled.

Robyn is the contact person of the study if you require further information or have problems concerning the study. When in Indonesia her contact details are C/- Politeknik Kesehatan – Semarang, Jln. Tirto Agung Pedalangan Banyumanik Semarang, Central Java 5026; Telephone: 024 747 1251. When in Australia she may be contacted at the School of Nursing, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Level 1, 723 Swanston Street, Carlton 3053, Australia telephone +61 3 8344 0773. Her email is the same both in Indonesia and Australia: robyna@unimelb.edu.au.

If you have any complaints about any aspect of the study or the way in which it is being conducted, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph. 8344 7507, or fax: 9347 6739.

Thank you for your time.

Professor Judith Parker & Robyn Aitken
Principal Investigators
Appendix 6

Consent Form – Short Version

THE UNIVERSITY OF MELBOURNE
SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

Consent form for persons participating in research projects

SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health
and funded by the World Bank

Name of participant:

Name of investigator(s): Prof. Judith Parker, Ms. Robyn Aitken

1. I voluntarily and freely consent to participate in the World Bank funded project named above, the particulars of which have been explained to me and will include
   - a short questionnaire containing questions about my personal details, such as education, age and work experience;
   - between 1 and 4 face-to-face focus group interviews of between 1 and 3 hours during which time the researcher will record my responses using an audio tape recorder;
   - between 1 and 3 face-to-face individual interviews of between 1 and 3 hours during which time the researcher will record my responses using field notes and an audio tape recorder;
   - an observation of my everyday learning and/or teaching practice of between 1 and 3 hours during which time the researcher will document my activities using field notes;

2. A written copy of the information has been given to me to keep.

3. I acknowledge that:
   (a) The project is for the purpose of research and that the possible effects of the research have been explained to me to my satisfaction;
   (b) My participation in the research is voluntary and that my participation or non-participation the research will not affect in any way my position as a student or employee with the Ministry. I have also been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data previously supplied;
   (c) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements and that I will not be able to be identified in any data, results or publications arising from the research.

Signature ___________________________ Date ___________________________

(Participant)

Signature ___________________________ Date ___________________________

(Witness to consent)
Appendix 7

Consent Form – Long Version

THE UNIVERSITY OF MELBOURNE
SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

Consent form for persons participating in research projects

SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

Name of participant: 

Name of investigator(s): Prof. Judith Parker, Ms. Robyn Aitken,

1. I voluntarily and freely consent to participate in the project named above, the particulars of which have been explained to me
   - and will include a short questionnaire containing questions about my personal details, such as education, age and work experience;
   - and may include any or all of the following
     - between 1 and 4 face-to-face focus group interviews of between 1 and 3 hours during which time the researcher will record my responses using an audio tape recorder;
     - between 1 and 3 face-to-face individual interviews of between 1 and 3 hours during which time the researcher will record my responses using field notes and an audio tape recorder;
     - an observation of my everyday learning and/or teaching practice of between 1 and 3 hours during which time the researcher will document my activities using field notes;

   A written copy of the information has been given to me to keep.

2. I authorise the researcher or his or her assistant to use with me focus group interviews, individual interviews and observation sessions referred to under (1) above.

3. I acknowledge that:
   (a) the possible effects of the focus group interviews, individual interviews and observation sessions have been explained to me to my satisfaction;
   (b) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data previously supplied;
   (c) The project is for the purpose of research;
Appendix 7
Consent form: long version

(d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;

4. I consent to interviews being audiotaped;

5. I understand that:

a) The Sister School Project is part of the Fifth Health Project (HPV) supported by the Central Java Provincial Ministry of Health and funded by the World Bank to improve nursing and midwifery educational institutions in Central Java, Indonesia;
b) The Ministry of Health, Central Java has provided my contact details but that participation or non-participation in the research will not affect in any way my position as a student or employee with the Ministry;
c) The researchers will not have access to personal and/or confidential data without your specific consent;
d) A bilingual interpreter will be present throughout the interview and observation components of the study and all information (verbal and written) will be available in both Bahasa Indonesia and English;
e) The research data collected will be collated and aggregate data will be published in reports to the Central Java Ministry of Health and the World Bank, and may be published in conference papers and/or dissertations. Any data that may identify me, will be not be used;
f) Individual results will not be released to any person except at my request and on my authorization;
g) The School of Nursing, The University of Melbourne, will provide a report of the outcomes upon request;

6. The security of the data obtained, including field notes is assured following completion of the study.

Signature ___________________________ Date ___________________________

(Participant)

Signature ___________________________ Date ___________________________

(Witness to consent)
Appendix 8

Verification of Translation Form

THE UNIVERSITY OF MELBOURNE
SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES
SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

VERIFICATION OF ACCURACY OF TRANSLATION

I have reviewed the following documents and concur that they are accurate translations of English language to Bahasa Indonesia

Plain language statement – short version
Plain language statement – long version
Consent form – short version
Consent form – long version
Short questionnaire – lecturer participants
Short questionnaire and advertisement – student participants
Short questionnaire – clinical participants
Short questionnaire – PMO participants

NAME (PRINT):

SIGNATURE:

DATE: LOCATION:
AN INVITATION FOR STUDENTS TO PARTICIPATE IN RESEARCH

You are invited to participate in a focus group interview. This interview is being conducted by Ms. Robyn Aitken as a component of the Sister School Project (SSP) Research. The SSP research is part of the Fifth Health Project (HPV) supported by the Central Java Provincial Ministry of Health and funded by the World Bank to improve nursing and midwifery educational institutions in Central Java, Indonesia.

The focus group interview is for the purpose of understanding aspects of the practical component of the D3 program from the student perspective.

If you are interested in participating, the focus group interview will be held on 01 September 2003 at the Pekalongan Nursing Academy in Classroom F12 at 10am.

You may have received information about the research when researchers spoke in your class, or if you weren’t present information has been left in the library in a box at the counter marked “Sister School Project”. Alternatively, you may like to contact me directly on (024) 747 1251 at Politeknik Kesehatan - Semarang or email at robyna@unimeLF.edu.au or handphone: 0817 054 6507 and I will provide you with verbal information.

I look forward to meeting you at the focus group interview

Robyn Aitken School of Postgraduate Nursing, The University of Melbourne, Australia
Appendix 10

Questionnaire for Dosen Participants

ID CODE

Questionnaire_Lecturer participants

THE UNIVERSITY OF MELBOURNE

SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

Short Questionnaire

Dear Participant

Thank you for agreeing to participate in the Sister School Project that is part of the Fifth Health Project (HPV) supported by the Central Java Provincial Ministry of Health and funded by the World Bank to improve nursing and midwifery educational institutions in Central Java, Indonesia.

This questionnaire has been designed to obtain information regarding participants in the project. It is anticipated that it will take only 10 minutes of your time to complete. These questions seek information about you of relevance to the project. They can be answered by indicating your preferred response. Completion and return of this questionnaire will indicate your consent to provide this information for the purposes of the study. You will be allocated a code number to protect your identity and you will not be able to be identified from any publications arising from this study.

Please return the completed questionnaire along with your signed consent form to Ms. Robyn Altken, Sister School Office: C/- Polyteknik Kesehatan – Semarang, Jln. Tiro Agung Pedalangan Banyumanik Semarang, Central Java 5026 using the postage paid envelope provided.

Thankyou for your assistance

Professor Judith Parker & Robyn Altken
Chief Investigators
THE UNIVERSITY OF MELBOURNE

SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

Short Questionnaire

1. What is your sex? (please ✓ the correct choice)
   Male
   Female

2. What is your age in years?

3. What year did you graduate from your first course in Nursing?

4. Have you ever worked as a clinical nurse? (please ✓ the correct choice)
   Yes
   No
   Please go to question 5
   Please go to question 6

5. How long did you work as a clinical nurse? (Years/months)

6. What are your professional qualifications? (please ✓ each qualification that you possess)

   Please ✓ to indicate Local or overseas (O/S) qualification

   SPK
   D3
   D4
   S1
   S2
   PhD

7. How long have you worked as a teacher in the academy? (Years/months)

Thank you for completing this questionnaire. Please return it in the postage paid envelope along with your signed consent form to Ms. Robyn Aitken, Sister School Office: C/- Politeknik Kesahatan – Semarang, Jln. Tirto Agung Pedalangan Banyumanik Semarang, Central Java 5026

School of Nursing
Faculty of Medicine, Dentistry & Health Sciences
The University of Melbourne, Victoria 3010 Australia
Telephone: +61 3 9344 0000 Fax +61 3 9347 4172
http://www.nursing.unimelb.edu.au
Appendix 11

Questionnaire – Clinical Participants

ID CODE

THE UNIVERSITY OF MELBOURNE
SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

Short Questionnaire

Dear Participant

Thank you for agreeing to participate in the Sister School Project that is part of the Fifth Health Project (HPV) supported by the Central Java Provincial Ministry of Health and funded by the World Bank to improve nursing and midwifery educational institutions in Central Java, Indonesia.

This questionnaire has been designed to obtain information regarding participants in the project. It is anticipated that it will take only 10 minutes of your time to complete. These questions seek information about you of relevance to the project. They can be answered by indicating your preferred response. Completion and return of this questionnaire will indicate your consent to provide this information for the purposes of the study. You will be allocated a code number to protect your identity and you will not be able to be identified from any publications arising from this study.

Please return the completed questionnaire along with your signed consent form to Ms. Robyn Altken, Sister School Office: C/- Polyteknik Kesehatan – Semarang, Jln. Tirto Agung Pedalangan Banyumanik Semarang, Central Java 5026 using the postage paid envelope provided.

Thank you for your assistance

Professor Judith Parker & Robyn Altken
Chief Investigators

School of Nursing
Faculty of Medicine, Dental & Health Sciences
The University of Melbourne, Victoria 3010 Australia
Telephone: +61 3 9344 0000 Fax: +61 3 9347 4372
http://www.nursing.unimelb.edu.au
1. What is your sex? (please ✓ the correct choice)
   Male
   Female

2. What is your age in years?

3. What year did you graduate from your first course in Nursing?

4. How long have you worked as a clinical nurse? (Years/months)

5. What are your professional qualifications? (please ✓ each qualification that you possess)

<table>
<thead>
<tr>
<th>SPK</th>
<th>D3</th>
<th>D4</th>
<th>S1</th>
<th>S2</th>
<th>PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   Please ✓ to indicate Local or overseas (O/S) qualification
   local O/S

6. Have you ever worked as a teacher in the academy? (please ✓ the correct choice)
   Yes
   Please go to question 7
   No You have completed the questionnaire

7. How long did you worked as a teacher in the academy?
   (Years/months)

Thank you for completing this questionnaire. Please return it in the postage paid envelope along with your signed consent form to Ms. Robyn Aitken, Sister School Office: C/- Politeknik Kesehatan – Semarang, Jln. Tirto Agung Pedalangan Banyumanik Semarang, Central Java 5026
Appendix 12

Questionnaire – Ministry Officer Participants

ID CODE

Questionnaire_Ministry Officers

THE UNIVERSITY OF MELBOURNE

SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

Short Questionnaire

Dear Participant

Thank you for agreeing to participate in the Sister School Project that is part of the Fifth Health Project (HPV) supported by the Central Java Provincial Ministry of Health and funded by the World Bank to improve nursing and midwifery educational institutions in Central Java, Indonesia.

This questionnaire has been designed to obtain information regarding participants in the project. It is anticipated that it will take only 10 minutes of your time to complete. These questions seek information about you of relevance to the project. They can be answered by indicating your preferred response. Completion and return of this questionnaire will indicate your consent to provide this information for the purposes of the study. You will be allocated a code number to protect your identity and you will not be able to be identified from any publications arising from this study.

Please return the completed questionnaire along with your signed consent form to Ms. Robyn Altken, Sister School Office: C/- Politeknik Kesehatan – Semarang, Jln. Tirta Agung Pedalangan Banyumanik Semarang, Central Java 5026 using the postage paid envelope provided.

Thank you for your assistance

Professor Judith Parker & Robyn Altken
Chief Investigators
ID CODE

THE UNIVERSITY OF MELBOURNE

SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES
SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank
Short Questionnaire

1. What is your sex?  (please ✓ the correct choice)
   Male  
   Female

2. What is your age in years?

3. How many years have you worked in the Provincial Health Office?

4. What are your professional qualifications? (please ✓ each qualification that you possess)
   Dentist  Go to question 7
   Nurse  Go to question 5
   Medical Doctor  Go to question 7
   Midwife  Go to question 7
   Public Health  Go to question 7
   Other (Please specify)  Go to question 7

5. Have you ever worked as a clinical nurse? (please ✓ the correct choice)
   Yes  No
   Please go to question 5  Please go to question 8

6. How long did you work as a clinical nurse? (Years/months)

7. What are your professional qualifications? (please ✓ each qualification that you possess)
   Please ✓ to indicate Local or overseas (O/S) qualification
   SPK  
   D3  
   D4  
   S1  
   S2  
   PhD  

Thankyou for completing this questionnaire. Please return it in the postage paid envelope along with your signed consent form to Ms. Robyn Aitken, Sister School Office: C/- Politeknik Kesehatan – Semarang, Jln. Tirto Agung Pedalangan Banyumanik Semarang, Central Java 5026

School of Nursing
Faculty of Medicine, Dentistry & Health Sciences
The University of Melbourne, Victoria 3010 Australia
Telephone: +61 3 9344 0000 Fax: +61 3 9347 4172
http://www.nursing.unimelb.edu.au
Appendix 13

Questionnaire – Student Participants

ID CODE

Questionnaire_student

THE UNIVERSITY OF MELBOURNE

SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

SISTER SCHOOL PROJECT
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

Short Questionnaire

<date>
Dear Participant

Thank you for agreeing to participate in the Sister School Project that is part of the Fifth Health Project (HPV) supported by the Central Java Provincial Ministry of Health and funded by the World Bank to improve nursing and midwifery educational institutions in Central Java, Indonesia.

This questionnaire has been designed to obtain information regarding participants in the project. It is anticipated that it will take only 10 minutes of your time to complete. These questions seek information about you of relevance to the project. They can be answered by indicating your preferred response. Completion and return of this questionnaire will indicate your consent to provide this information for the purposes of the study. You will be allocated a code number to protect your identity and you will not be able to be identified from any publications arising from this study.

Please return the completed questionnaire along with your signed consent form to Ms. Robyn Altken, Sister School Office: C/- Polyteknik Kesehatan – Semarang, Jln. Tfto Agung Pedalangan Banyumanik Semarang, Central Java 5026 using the postage paid envelope provided.

Thankyou for your assistance

Professor Judith Parker & Robyn Altken
Chief Investigators

School of Nursing
Faculty of Medicine, Dentistry & Health Sciences
The University of Melbourne, Vicb., 3010 Australia
Telephone: +61 3 9344 6000 Fax +61 3 9347 4172
http://www.nursing.unimelb.edu.au
1. What is your sex? (please ✓ the correct choice)
   Male
   Female

2. What is your age in years?

3. Which semester of the DIII Nursing program are you currently studying? (please ✓ the correct choice)
   Semester 1
   Semester 2
   Semester 3
   Semester 4
   Semester 5
   Semester 6

4. Have you participated in clinical practice or field work as part of the DIII course? (please ✓ the correct choice)
   Yes
   No
   Please go to question 5
   Please go to question 6

5. Which semester of the DIII Nursing did you participate in clinical practice or field work? (please ✓ as many semesters as apply)
   Semester 1
   Semester 2
   Semester 3
   Semester 4
   Semester 5
   Semester 6

Thank you for completing this questionnaire. Please return it in the postage paid envelope along with your signed consent form to Ms. Robyn Alkken, Sister School Office: C/- Polyteknik Kesehatan – Semarang, Jln. Tirto Agung Pedalangan Banyumanik Semarang, Central Java 5026
Appendix 14

Questionnaire Pilot Feedback Form

A study to explore issues relating to the context of nursing practice in Central Java and current practices relating to Diploma III nursing education.

DEMOGRAPHIC QUESTIONNAIRE PILOT FEEDBACK FORM

1. Please comment on the layout/format of the questionnaire.
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

2. Please comment on the clarity of the questions.
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

3. Given the main aims of the questionnaire, how relevant have you found the questions?
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

4. What questions might you feel need to be deleted?
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................
5. Given the main aims of the study what other areas do you feel need to be explored?

6. What other question might you suggest need to be added?

7. Please comment on the appropriateness of the accompanying letter to participant.

8. Please comment on the conciseness of instructions.

9. Approximately, how long did you need to complete the questions?

10. Please state any further comments.
### Appendix 15

**Schedule of Participant Observations**

<table>
<thead>
<tr>
<th>Topic of Observations</th>
<th>Research Site</th>
<th>Data Code</th>
<th>Participants</th>
<th>Duration (hrs)</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Practice</td>
<td>Nursery</td>
<td>PkCO1</td>
<td>KB1, B1</td>
<td>3</td>
<td>April, 2003</td>
</tr>
<tr>
<td>Medical (ICU/HDU)</td>
<td>PuCO 2</td>
<td>D10, B1</td>
<td>3</td>
<td>May, 2003</td>
<td></td>
</tr>
<tr>
<td>Surgical</td>
<td>PuCO3</td>
<td>D10, B1</td>
<td>3</td>
<td>May, 2003</td>
<td></td>
</tr>
<tr>
<td>Surgical (Burns)</td>
<td>MgCO 4</td>
<td>KB5, B1</td>
<td>3</td>
<td>May, 2003</td>
<td></td>
</tr>
<tr>
<td>Puskesmas</td>
<td>PgCO 5</td>
<td>D23</td>
<td>3</td>
<td>June, 2003</td>
<td></td>
</tr>
<tr>
<td>(Also teaching observation)</td>
<td>Paediatrics and student examination</td>
<td>SgCO6</td>
<td>D1, B2, KB3, S1</td>
<td>3</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Surgical</td>
<td>PkCO7</td>
<td>D4, D5, KB2, CI2, CI3, B3</td>
<td>3</td>
<td>August, 2003</td>
<td></td>
</tr>
<tr>
<td>Nursery</td>
<td>SoCO8</td>
<td>D16, D17, CI8, KB4, B4</td>
<td>3</td>
<td>September, 2003</td>
<td></td>
</tr>
<tr>
<td>Surgical (Neuro)</td>
<td>PkCO9</td>
<td>D4, D5, KB2, CI2, CI3, B4</td>
<td>3</td>
<td>October, 2003</td>
<td></td>
</tr>
<tr>
<td>(Also teaching observation)</td>
<td>Student examination (Te)</td>
<td>TeCO10</td>
<td>D1, D4, D5, S13, S29, B3, B4</td>
<td>3</td>
<td>November, 2003</td>
</tr>
<tr>
<td>Topic of Observations</td>
<td>Research Site</td>
<td>Data Code</td>
<td>Participants</td>
<td>Duration (hrs)</td>
<td>Month</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------</td>
<td>-----------</td>
<td>--------------</td>
<td>---------------</td>
<td>------------</td>
</tr>
<tr>
<td>Teaching Practice</td>
<td>Classroom and Laboratory (Sg)</td>
<td>TO1</td>
<td>D1 – D3, B2, AD1</td>
<td>3</td>
<td>July, 2003</td>
</tr>
<tr>
<td>Classroom and Laboratory (Pk)</td>
<td>TO2</td>
<td>D5 - D7, B2, AD2</td>
<td>3</td>
<td>July, 2003</td>
<td></td>
</tr>
<tr>
<td>Senate Meeting</td>
<td>TO3</td>
<td>D1 – D20, AD5, D28, D21, D22, D25, D23, D46-D48, B1</td>
<td>6</td>
<td>September, 2003</td>
<td></td>
</tr>
<tr>
<td>Classroom and Laboratory (Pu)</td>
<td>TO4</td>
<td>D8-D10, AD3, B2</td>
<td>3</td>
<td>October, 2003</td>
<td></td>
</tr>
<tr>
<td>Classroom and Laboratory (Mg)</td>
<td>TO5</td>
<td>D11-D13, AD4, B2</td>
<td>3</td>
<td>October, 2003</td>
<td></td>
</tr>
<tr>
<td>Classroom and Laboratory (So)</td>
<td>TO6</td>
<td>D15-D17, AD5, B2</td>
<td>3</td>
<td>November, 2003</td>
<td></td>
</tr>
<tr>
<td>Classroom and Laboratory (Bl)</td>
<td>TO7</td>
<td>D18 – D20, D52, AD6</td>
<td>3</td>
<td>November, 2003</td>
<td></td>
</tr>
<tr>
<td>Student examination (Pk)</td>
<td>TO8</td>
<td>D4, D5, AD2, B4</td>
<td>2</td>
<td>November, 2003</td>
<td></td>
</tr>
<tr>
<td>Topic of Observations</td>
<td>Research Site</td>
<td>Data Code</td>
<td>Participants</td>
<td>Duration (hrs)</td>
<td>Month</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>-----------</td>
<td>--------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Curriculum Development/Teaching &amp; Learning</td>
<td>Workshop 1</td>
<td>WO1</td>
<td>Not attended</td>
<td>40</td>
<td>January, 2003</td>
</tr>
<tr>
<td>Developing the Practical Field II (competencies, student assessment, SOP)</td>
<td>Workshop 4</td>
<td>WO4</td>
<td>D1 – D20, CI 1 – CI 8, B1, B2</td>
<td>40</td>
<td>September, 2003</td>
</tr>
<tr>
<td>Developing the Practical Field III (Evidence Based Practice, Showcase wards, best practice CI, MOUs, critical thinking)</td>
<td>Workshop 5</td>
<td>WO5</td>
<td>D1 – D20, CI 1 – CI 8, B1, B2</td>
<td>40</td>
<td>October, 2003</td>
</tr>
<tr>
<td>Topic of Observations</td>
<td>Research Site</td>
<td>Data Code</td>
<td>Participants</td>
<td>Duration (hrs)</td>
<td>Month</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------</td>
<td>-----------</td>
<td>--------------</td>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Administration Practices</td>
<td>Disciplinary Development Workshop</td>
<td>AO1</td>
<td>AD 1 – AD 6, MO1 – 3, MO5, B1</td>
<td>6</td>
<td>June, 2003</td>
</tr>
<tr>
<td>CJSSP progression and outcomes</td>
<td>Monitoring meeting (DinKes office)</td>
<td>AO2</td>
<td>MO1 – 3, MO5, B1</td>
<td>2</td>
<td>July, 2003</td>
</tr>
<tr>
<td>National curriculum accreditation</td>
<td>National Accreditation evaluation (AKPER Sg)</td>
<td>AO3</td>
<td>AD1, D1, D23, D25, B2</td>
<td>3</td>
<td>October, 2003</td>
</tr>
<tr>
<td>Curriculum changes</td>
<td>DinKes Office</td>
<td>AO4</td>
<td>AD5, D1, B1, D17, MO4</td>
<td>2</td>
<td>November, 2003</td>
</tr>
<tr>
<td>CJSSP progression and outcomes</td>
<td>Monitoring meeting (DinKes office)</td>
<td>AO5</td>
<td>MO1 – 3, MO5, B2</td>
<td>2</td>
<td>December, 2003</td>
</tr>
<tr>
<td>CJSSP progression and outcomes</td>
<td>Final evaluation meeting (DinKes office)</td>
<td>AO6</td>
<td>D1-D20, AD1 – AD8, MO1 – 3, MO5, B1, B2</td>
<td>2</td>
<td>June, 2004</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>180</td>
<td></td>
</tr>
</tbody>
</table>

* Ethics approval was not gained in time for observing this workshop. Data relating to this workshop was instead retrieved from the CJSSP Inception Report

**Participant codes:** AD = AKPER Directors; B = Bilingual Secretaries; CI = Clinical Instructors; D = Dosen; KB = Kepala Bangksa; MO = Ministry Officers; S = Students
## Appendix 16

### Schedule of Focus Groups

<table>
<thead>
<tr>
<th>Topic of Focus Group</th>
<th>Research Site</th>
<th>Participants</th>
<th>Data Code</th>
<th>Duration (hrs)</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>Workshop 2</td>
<td>5 Dosen: D15, D16, D17, D21, D22, B1</td>
<td>FG1</td>
<td>3</td>
<td>May, 2003</td>
</tr>
<tr>
<td>Curriculum, Teaching and Learning</td>
<td>AKPER Sg/So</td>
<td>18 Dosen: D1-3, D15-17, D21-25, D26-32, AD 1, AD5, B1</td>
<td>FG2</td>
<td>3</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Curriculum, Teaching and Learning</td>
<td>AKPER Pk</td>
<td>10 Dosen: D4-7, D33 - D38, AD2, B1</td>
<td>FG3</td>
<td>3</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Curriculum, Teaching and Learning</td>
<td>AKPER Pu/Mg</td>
<td>17 Dosen: D8-9, D11-13, D39-50, AD3, AD4, B1</td>
<td>FG4</td>
<td>3</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Clinical</td>
<td>Workshop 3</td>
<td>8 Clinical Instructors: CI 1 – 8, B1</td>
<td>FG6</td>
<td>2</td>
<td>July, 2003</td>
</tr>
<tr>
<td>Topic of Focus Group</td>
<td>Research Site</td>
<td>Participants</td>
<td>Data Code</td>
<td>Duration (hrs)</td>
<td>Month</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------</td>
<td>--------------</td>
<td>-----------</td>
<td>---------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Enrolment in D3 and learning experiences</td>
<td>AKPER Pk</td>
<td>17 D3 Students S2 – S18, B3</td>
<td>SFG1</td>
<td>2</td>
<td>September, 2003</td>
</tr>
<tr>
<td>Enrolment in D3 and learning experiences</td>
<td>AKPER Pk</td>
<td>17 D3 Students S19 – S34, B3</td>
<td>SFG2</td>
<td>2</td>
<td>November, 2003</td>
</tr>
</tbody>
</table>

**Participant codes:** B = Bilingual Secretaries; CI = Clinical Instructors; D = Dosen; S = Students
Appendix 17

Focus Group Guide – Dosen Participants

THE UNIVERSITY OF MELBOURNE

SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

SISTER SCHOOL PROJECT (SSP)
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

FOCUS GROUP DISCUSSION INTERVIEW GUIDE
Topic: Teaching & learning & curriculum
Participants: Dosen

Briefing:
As a participant in this research you have been invited to contribute to one or more focus group interviews. These interviews are designed to explore specific aspects of Diploma 3 (DIII) nursing education such as:
- How it compares to international nursing standards;
- How you anticipate the SSP will impact on Indonesian nursing;
- The reality of DIII nursing education compared to the documents I have reviewed; and
- To assist me with interpreting what I have observed about the DIII program and Indonesian nursing.

I am most interested in your different opinions and whether you can confirm, reinforce, contradict or reject what someone else has to say.

Everyone’s perspective is equally important and I ask everyone to respect each other’s contribution so that no-one feels that they cannot speak.

My role is to direct the discussion to make sure that it assists me explore my research topic and we do not get distracted.

I have some questions that I will use to guide the discussion, but anticipate that your contribution will lead to further questions.

The Bilingual Secretary will translate my Bahasa English into Bahasa Indonesia, although I will try to speak as much Indonesian as possible. She will also translate your Indonesian responses back into English to make sure I have understood them.

Please feel free to speak in either English or Bahasa Indonesia according to which is most comfortable for you.

I anticipate that the discussion will last between 2 to 3 hours.
Although you have already signed a consent form to agree to participate, you are free to withdraw at any time during the discussion and request that your contribution is removed from my data.

I will be writing notes during the discussion to keep a record of your contribution.

This particular discussion will focus on exploring the *Professi* component of the DIII program.

**Interview questions**

1. Can you tell me who in your academy is responsible for arranging practical experience?

2. Can you tell me who in the clinical area is responsible for arranging practical experience?

3. At what level does practical experience commence?

4. Can you tell me what experiences come first and in what areas and agencies?

5. Can you tell me is there a cost associated with practical experience?

6. Do you have a model that guides practical experience?

7. Can you tell me who is the person who oversees the whole process?

(Prompt: who keeps track of students’ progress, achievement of competencies, who keeps the record? What type of record?)

8. What qualifications do clinical instructors have and are they the same in all settings?

9. Can you tell me what other preparation do they [the clinicians] have?

10. Is there a program of ongoing staff development for clinical instructors?

11. Can you tell me how the academic staff are involved in practice, particularly related to competencies?

12. Can you tell me what problems are faced by students in the clinical area?

13. Can you tell me what problems are faced by academics in the clinical area

14. Can you tell me what problems are faced by clinical instructors in the clinical area?
Appendix 18

Focus Group Guide – Dosen Participants

THE UNIVERSITY OF MELBOURNE

SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

SISTER SCHOOL PROJECT (SSP)
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

FOCUS GROUP DISCUSSION INTERVIEW GUIDE
Topic: Teaching & learning & curriculum
Participants: Dosen

Briefing:
As a participant in this research you have been invited to contribute to one or more focus group interviews. These interviews are designed to explore specific aspects of Diploma 3 (DIII) nursing education such as:
- How it compares to international nursing standards;
- How you anticipate the SSP will impact on Indonesian nursing;
- The reality of DIII nursing education compared to the documents I have reviewed; and
- To assist me with interpreting what I have observed about the DIII program and Indonesian nursing.

I am most interested in your different opinions and whether you can confirm, reinforce, contradict or reject what someone else has to say.

Everyone’s perspective is equally important and I ask everyone to respect each other’s contribution so that no-one feels that they cannot speak.

My role is to direct the discussion to make sure that it assists me explore my research topic and we do not get distracted.

I have some questions that I will use to guide the discussion, but anticipate that your contribution will lead to further questions.

The Bilingual Secretary will translate my Bahasa English into Bahasa Indonesia, although I will try to speak as much Indonesian as possible. She will also translate your Indonesian responses back into English to make sure I have understood them.

Please feel free to speak in either English or Bahasa Indonesia according to which is most comfortable for you.
I anticipate that the discussion will last between 2 to 3 hours.

Although you have already signed a consent form to agree to participate, you are free to withdraw at any time during the discussion and request that your contribution is removed from my data.

I will be writing notes during the discussion to keep a record of your contribution.

This particular discussion will focus on exploring the Curriculum and teaching and learning methodologies used in the DIII program.

**Interview questions**

1. What in your opinion is the goal of the curriculum and do you believe this goal is achievable? (Prompts: If yes, why and how? If not, why not and what would you recommend?)

2. In your opinion, does the curriculum fulfil the needs of the profession and of the community? (Prompts: If yes, what and how? If not, what would you change, or add to the curriculum; and how and why you would change it?)

3. In your opinion, do the teaching methods and processes proposed in the curriculum appropriate for the level of the course? (Prompts: If yes, why and if not, why not? Give examples.)

4. In your opinion, are the teaching references and assessment requirements as stipulated in the curriculum appropriate for the course? (Prompts: If yes, why are they appropriate? and if not, why not, give examples)

5. In your opinion, what is possible to change about the curriculum? Give examples of areas that can change and areas that cannot change.

6. What teaching methods do you mostly use in everyday teaching?

7. Why do you use these methods?
8. In your opinion, do you think that the students learn much through the teaching methods that you use?
(Prompts: If yes, how do you know that the students learned? Give examples.)

9. In your opinion, do you think the assessment methods employed per subject truly reflect the abilities of the students?
(Prompts: If yes, give examples. If not, give examples why not. And suggest different ways of assessment that you think will better assess what the students know or understand.)

10. Do students evaluate your teaching performance?
(Prompts: If yes, how do they do this? Is it formal or informal? If not, why don’t they evaluate your performance? Would you include a student evaluation of both the subject and your teaching of the subject at the end of each semester? If not, why not?)

Appendix 19

Focus Group Guide – Clinician Participants

THE UNIVERSITY OF MELBOURNE

SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

SISTER SCHOOL PROJECT (SSP)
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

FOCUS GROUP DISCUSSION INTERVIEW GUIDE
Topic: Teaching & learning & curriculum
Participants: Clinical Instructors

Briefing:
As a participant in this research you have been invited to contribute to one or more focus group interviews. These interviews are designed to explore specific aspects of Diploma 3 (DIII) nursing education such as:
- How it compares to international nursing standards;
- How you anticipate the SSP will impact on Indonesian nursing;
- The reality of DIII nursing education compared to the documents I have reviewed; and
- To assist me with interpreting what I have observed about the DIII program and Indonesian nursing.

I am most interested in your different opinions and whether you can confirm, reinforce, contradict or reject what someone else has to say.

Everyone’s perspective is equally important and I ask everyone to respect each other’s contribution so that no-one feels that they cannot speak.

My role is to direct the discussion to make sure that it assists me explore my research topic and we do not get distracted.

I have some questions that I will use to guide the discussion, but anticipate that your contribution will lead to further questions.

The Bilingual Secretary will translate my Bahasa English Into Bahasa Indonesia, although I will try to speak as much Indonesian as possible. She will also translate your Indonesian responses back into English to make sure I have understood them.

Please feel free to speak in either English or Bahasa Indonesia according to which is most comfortable for you.
6. In your opinion does the student’s classroom learning, practical laboratory teaching and study references prepare the students adequately for clinical practice? 
   (Prompt: If yes, why? and if not, why not? Give examples).

7. How are the students evaluated in clinical practice? 
   (Prompt: Give examples. Would you use a different method of evaluation? If yes, give examples.

8. How do you evaluate your performance relating to supervising students? 
   (Prompt: Do you set goals and objectives? Do you receive feedback from students?)

9. How do students evaluate your clinical teaching performance? 
   (Prompt: Do students provide you with feedback? Give examples)

10. Does student’s clinical practice change existing practices and/or the agencies’ delivery of health care? 
   (Prompt: If yes, how and give examples. If not, why not?).

11. In your opinion what is the most important change to the clinical component of the D3 program that you would like to see?
Appendix 20

Focus Group Guide – Student Participants

THE UNIVERSITY OF MELBOURNE

SCHOOL OF NURSING, FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES

SISTER SCHOOL PROJECT (SSP)
A component of the Fifth Health Project (HPV) Supported by The Central Java Ministry of Health and funded by the World Bank

FOCUS GROUP DISCUSSION INTERVIEW GUIDE

Topic: Being a student within the D3 curriculum – particularly clinical aspects
Participants: Students

Briefing:
As a participant in this research you have been invited to contribute to one or more focus group interviews. These interviews are designed to explore specific aspects of Diploma 3 (DIII) nursing education such as:
- How it compares to international nursing standards;
- How you anticipate the SSP will impact on Indonesian nursing;
- The reality of DIII nursing education compared to the documents I have reviewed; and
- To assist me with interpreting what I have observed about the DIII program and Indonesian nursing.

I am most interested in your different opinions and whether you can confirm, reinforce, contradict or reject what someone else has to say.

Everyone’s perspective is equally important and I ask everyone to respect each other’s contribution so that no-one feels that they cannot speak.

My role is to direct the discussion to make sure that it assists me explore my research topic and we do not get distracted.

I have some questions that I will use to guide the discussion, but anticipate that your contribution will lead to further questions.

The Bilingual Secretary will translate my Bahasa English into Bahasa Indonesia, although I will try to speak as much Indonesian as possible. She will also translate your Indonesian responses back into English to make sure I have understood them.

Please feel free to speak in either English or Bahasa Indonesia according to which is most comfortable for you.
I anticipate that the discussion will last between 2 to 3 hours.

Although you have already signed a consent form to agree to participate, you are free to withdraw at any time during the discussion and request that your contribution is removed from my data.

I will be taping you when you speak into the microphone to keep a record of your contribution. Please raise your hand to signal that you would like your contribution recorded.

This particular discussion will focus on exploring the D3 program from your perspective as students and will particularly focus on the Profesi component of your education.

**Clinical Interview questions for students (Pertanyaan Klinis untuk Mahasiswa):**

1. Was the choice to become a nurse yours?
   *Apakah menjadi perawat menjadi pilihan saudara?*

2. If yes, what was your motivation for commencing nurse training?
   *Bila ya, apa motivasi saudara memulai belajar menjadi perawat?*

3. If you did not choose to become a nurse, who decided that you study DIII Nursing?
   *Bila anda tidak memilih untuk menjadi perawat, siapa yang memutuskan saudara untuk belajar di DIII Keperawatan?*

4. What in your opinion is the purpose of field practice experiences for you as a student?
   *Menurut pendapat saudara apa tujuan pengalaman praktek lapangan untuk saudara sebagai mahasiswa?*

5. What have you learnt in laboratory practice that you feel will assist you with your field practice experience?
   *Apa yang saudara pelajari di laboratorium yang saudara anggap akan anda membantu saudara di praktek klinik?*

6. What affect do you believe that field practice experience will have on your ability to care for the patient?
   *Dampak apa yang saudara yakin bahwa pengalaman praktek klinik akan mendukung kemampuan saudara merawat pasien?*

7. How do you expect to develop knowledge and skills during field practice experience?
   *Bagaimana saudara berharap untuk mengembangkan pengetahuan dan keterampilan selama praktek klinik (siapa yang saudara harapkan untuk membantu pembelajaran klinik?*
Appendix 21

Focus Group Guide Pilot Feedback Sheet

THE UNIVERSITY OF MELBOURNE

A study to explore issues relating to the context of nursing practice in Central Java and current practices relating to Diploma III nursing education.

FOCUS GROUP INTERVIEW GUIDE PILOT FEEDBACK FORM

1. Please comment on the clarity of the questions.
   ..........................................................................................................................
   ..........................................................................................................................
   ..........................................................................................................................
   ..........................................................................................................................

2. Given the main aims of the focus group interviews, how relevant have you found the questions?
   ..........................................................................................................................
   ..........................................................................................................................
   ..........................................................................................................................
   ..........................................................................................................................

3. What questions might you feel need to be deleted?
   ..........................................................................................................................
   ..........................................................................................................................
   ..........................................................................................................................
   ..........................................................................................................................

4. Given the main aims of the study what other areas do you feel need to be explored?
   ..........................................................................................................................
   ..........................................................................................................................
   ..........................................................................................................................
   ..........................................................................................................................
5. What other question might you suggest need to be added?

6. Approximately, how long do you think it will take to explore these questions in a group discussion forum?

7. Please state any further comments.
## Appendix 22

### Schedule of Individual (Key Informant) Interviews

<table>
<thead>
<tr>
<th>Primary topic of interview</th>
<th>Research Site</th>
<th>Participants</th>
<th>Data Code</th>
<th>Duration (hrs)</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of project</td>
<td>CJISSP Office</td>
<td>B1</td>
<td>Iv1</td>
<td>1</td>
<td>May, 2003</td>
</tr>
<tr>
<td>Clinical Observation (SgCO6)</td>
<td>AKPER Sg</td>
<td>D1</td>
<td>Iv2</td>
<td>1</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Clinical Observation (SgCO6)</td>
<td>AKPER Sg</td>
<td>KB3</td>
<td>Iv3</td>
<td>1</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Clinical Observation (SgCO6)</td>
<td>AKPER Sg</td>
<td>S1</td>
<td>Iv4</td>
<td>1</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Clinical Observation (SgCO6)</td>
<td>AKPER Sg</td>
<td>B2</td>
<td>Iv5</td>
<td>1</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Clinical Observations (PkCO1, PuCO2, PuCO3); Workshop observation (WO3); Teaching Observation (TO4, TO7)</td>
<td>CJISSP Office</td>
<td>D10 &amp; D20</td>
<td>Iv6</td>
<td>2</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Primary topic of interview</td>
<td>Research Site</td>
<td>Participants</td>
<td>Data Code</td>
<td>Duration (hrs)</td>
<td>Month</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------</td>
<td>--------------</td>
<td>-----------</td>
<td>----------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Clinical Observations (PkCO1, PuCO2, PuCO3); Workshop observation (WO3); Teaching Observation (TO4, TO7)</td>
<td>CJSSP Office</td>
<td>D10 &amp; D20</td>
<td>Iv7</td>
<td>2</td>
<td>August, 2003</td>
</tr>
<tr>
<td>Clinical Observations (PkCO1, PuCO2, PuCO3, MgCO4, PgCO5, SgCO6, PkCO7) Teaching observations (TO1, TO2); Workshop observations (WO1, WO2, WO3)</td>
<td>AKPER Pk B2</td>
<td></td>
<td>Iv8</td>
<td>1</td>
<td>August, 2003</td>
</tr>
<tr>
<td>Clinical Observations (PkCO1, PkC08)</td>
<td>AKPER Pk D4 &amp; D5</td>
<td></td>
<td>Iv9</td>
<td>1</td>
<td>September, 2003</td>
</tr>
<tr>
<td>Clinical Observation (PkCO8)</td>
<td>RSU Pk KB2, CI2 &amp; CI3</td>
<td></td>
<td>Iv10</td>
<td>1</td>
<td>September, 2003</td>
</tr>
<tr>
<td>Primary topic of interview</td>
<td>Research Site</td>
<td>Participants</td>
<td>Data Code</td>
<td>Duration (hrs)</td>
<td>Month</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------</td>
<td>--------------</td>
<td>-----------</td>
<td>---------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Clinical Observations</td>
<td>AKPER Pk</td>
<td>AD2, D4 &amp; D5</td>
<td>Iv11</td>
<td>2</td>
<td>September, 2003</td>
</tr>
<tr>
<td>(PkCO1, PkC08);</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching Observation (TO2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Car</td>
<td>B3 &amp; B4</td>
<td>Iv12</td>
<td>3</td>
<td>September, 2003</td>
</tr>
<tr>
<td>Data interpretation</td>
<td>Car</td>
<td>B1</td>
<td>Iv13</td>
<td>3</td>
<td>October, 2003</td>
</tr>
<tr>
<td>so far</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative practices,</td>
<td>DinKes Office</td>
<td>MO2</td>
<td>IV14</td>
<td>1</td>
<td>October, 2003</td>
</tr>
<tr>
<td>CJSSP purpose and outcomes,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative</td>
<td>AKPER Sg</td>
<td>D1</td>
<td>Iv15</td>
<td>1</td>
<td>November, 2003</td>
</tr>
<tr>
<td>observations (AO1 – AO6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Observation</td>
<td>AKPER So</td>
<td>D17</td>
<td>Iv16</td>
<td>1</td>
<td>November, 2003</td>
</tr>
<tr>
<td>(TeCO10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CJSSP purpose and outcomes,</td>
<td>AKPER So</td>
<td>D17</td>
<td>Iv16</td>
<td>1</td>
<td>November, 2003</td>
</tr>
<tr>
<td>Teaching Observations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(TO1-TO7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary topic of interview</td>
<td>Research Site</td>
<td>Participants</td>
<td>Data Code</td>
<td>Duration (hrs)</td>
<td>Month</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------</td>
<td>--------------</td>
<td>-----------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Clinical Observation (Pk CO9, TeCO10), Teaching Observation (TO8)</td>
<td>AKPER Pk</td>
<td>D4 &amp; D5</td>
<td>Iv17</td>
<td>2</td>
<td>November, 2003</td>
</tr>
<tr>
<td>Clinical Observation: (PgCO5)</td>
<td>Car</td>
<td>D23</td>
<td>Iv18</td>
<td>2</td>
<td>November, 2003</td>
</tr>
<tr>
<td>CJSSP purpose and outcomes, Administrative observations (AO1 – AO6)</td>
<td>Car</td>
<td>MO3 &amp; MO5</td>
<td>Iv19</td>
<td>3</td>
<td>December, 2003</td>
</tr>
<tr>
<td>CJSSP purpose and outcomes</td>
<td>DinKes Office</td>
<td>B2</td>
<td>Iv20</td>
<td>1</td>
<td>December, 2003</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>31</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Participant codes:** AD = AKPER Directors; B = Bilingual Secretaries; CI = Clinical Instructors; D = Dosen; KB = Kepala Bangksa; MO = Ministry Officers; S = Students
## Appendix 23

### Central Java Sister School Program Reports

<table>
<thead>
<tr>
<th>Name of Report</th>
<th>Content of report</th>
<th>Code</th>
<th>DATE Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inception Report</td>
<td>Including Appendices:</td>
<td>SSPR1</td>
<td>January 2003</td>
</tr>
<tr>
<td></td>
<td>1. Report: Baseline status of the D3 Nursing and Midwifery program in Central Java;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. In-country activity record – program months 1 &amp; 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. QA survey results: Human Resources baseline status;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Report: Educational administration baseline status;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Report: IT, systems, facilities and infrastructure baseline status;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim Progress Report 1</td>
<td>Including Appendices:</td>
<td>SSPR2</td>
<td>April 2003</td>
</tr>
<tr>
<td></td>
<td>1. In-country activity record: program months 3 &amp; 4;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Report: Disciplinary Development workshop follow-up activities-January 03;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Report: In-country activity schedule-February 03;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Report: Disciplinary Development and Disciplinary Support workshop follow-up activities-February 03;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Report: Workshop 1: IT, systems, facilities and infrastructure;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Report: IT, systems, facilities and infrastructure site visits;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Report: Workshop 1: HR management and educational administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Report</td>
<td>Content of report</td>
<td>Code</td>
<td>DATE Submitted</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>------</td>
<td>----------------</td>
</tr>
</tbody>
</table>
| Interim Progress Report 2 | Including Appendices:  
2. Report: Workshop 2: IT, systems, facilities and infrastructure;  
3. Report: Workshop 2: HR management and educational administration  
4. Report: Collaboration activities with WHO CPDMS program for nurses and midwives in hospitals and community health  
5. Report: Jakarta visit 5-8 June 03;  
6. Analysis of the field practice component of the D3 nursing and midwifery curriculum in Central Java;  
7. Report: Workshop 1: Developing the Practical Field  
8. Analysis of Problem Based Learning and the SSP | SSPR3 | September 2003 |
<p>| Special Report        | January &amp; February Workshops: (Nursing &amp; Midwifery; IT, systems, facilities and infrastructure; HR and educational administration) | SSPR4 | February 2003  |
| Special Report        | May &amp; June Workshops: (Nursing &amp; Midwifery; IT, systems, facilities and infrastructure; HR and educational administration) | SSPR5 | June 2003  |
| Special Report        | July Workshop (Nursing &amp; Midwifery)                                               | SSPR6 | September 2003 as part of Int. Report 2 |
| Special Report        | September Workshop (Nursing &amp; Midwifery) and September visits (IT, systems, facilities and infrastructure; HR and educational administration) | SSPR7 | September 2003 |
| Special Report        | Workshop 4 (Nursing &amp; Midwifery)                                                  | SSPR8 | October 2003 |</p>
<table>
<thead>
<tr>
<th>Name of Report</th>
<th>Content of report</th>
<th>Code</th>
<th>DATE Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Report</td>
<td>Workshop 5 (Nursing &amp; Midwifery)</td>
<td>SSPR9</td>
<td>December 2003</td>
</tr>
<tr>
<td>Special Report</td>
<td>WHO/Pusdiknakes meeting 12.11.03</td>
<td>SSPR10</td>
<td>December 2003</td>
</tr>
</tbody>
</table>
Appendix 24

Ethical Approval

15 April 2003

Professor J Parker & Ms R Aitken
School of Nursing

Dear Professor J Parker & Ms R Aitken

I am pleased to advise that the Health Sciences Human Ethics Subcommittee approved the following project at its 363 meeting:

HPV 5 Central Java Sister School Project
Professor J Parker & Ms R Aitken
HREC No. 030159

The Project has been approved for the period: 15/4/03 to 31/2/03 It is your responsibility to ensure that all people associated with this particular project are made aware of what has actually been approved.

Research projects are normally approved to 31 December of the year of approval. Projects may be renewed yearly for up to a total of five years upon receipt of a satisfactory annual report. If the project is to continue beyond five years a new application will normally need to be submitted.

Please note that the following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and/or disciplinary action.

(b) Limit of Approval: Approval is limited strictly to the research proposal as submitted in your application.

(c) Variation to Project: Any subsequent variations or modifications you might wish to make to your project must be notified formally to the Human Ethics Sub-Committee for further consideration and approval. If the Sub-Committee considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised project.

(d) Incidents or adverse effects: Researchers must report immediately to the Sub-Committee anything which might affect the ethical acceptability of the protocol including adverse effects on subjects or unforeseen events that might affect continued ethical acceptability of the project. Failure to do so may result in suspension or cancellation of approval.

(e) Monitoring: Projects are subject to monitoring at any time by the ethics committee.

(f) Annual Report: You must submit an annual report on this project at the end of the year, or, at the conclusion of the project if it continues for less than a year. Requests for annual reports are sent out by the Human Research Ethics Office in November/December of each year. Failure to submit a progress report at the end of the year will mean approval for your project will lapse.

(l) Auditing: All projects may be subject to audit by members of the Sub-Committee.

If you have any further queries on these matters, or require additional information, please do not hesitate to contact me on telephone no. 8344 7507 or e-mail: k.murphy@unimelb.edu.au.

Please quote the HREC registration number and the name of the project in any future correspondence.

On behalf of the Sub-Committee I wish you well in your research.

Yours sincerely,

Kate Murphy
Executive Officer, Human Research Ethics

Melbourne Research and Innovation Office
The University of Melbourne Victoria 3010 Australia
Telephone: +61 3 8344 7114 Fax: +61 3 9347 6739
URL: http://www.unimelb.edu.au/research

c c. Chair, DHEAG, School of Nursing
Appendix 25

Explanatory Statement Accompanying Ethics Submission

This explanatory attachment was submitted in order to justify changes to the normal format of the plain language statement and consent forms regarding a project to improve nursing and midwifery educational institutions in Central Java.

1. Plain language statement:

Experience with nurses teaching in these academies over the last four years has revealed that Indonesians view official letters as unnecessary unless they are orders to be obeyed. Accordingly, the plain language statement includes a paragraph explaining the purpose of the document in order to ensure that participation is voluntary and the plain language itself is not in any way coercive.

2. Plain language statement and consent form:

Furthermore, it is the researchers’ experience that the normal way of communicating information in Central Java is through verbal communication and that there is a range of literacy and a low level of compliance with reading detailed written information. This is particularly true of lengthy written materials. Accordingly, the researchers have developed a long and short version of both the plain language statement and the consent form. It is the researchers’ belief that the short version of each document covers the essential ethical considerations and that it is more likely that potential participants will receive this information if it is presented in such a format. This version will be sent to all potential participants and a longer version that complies with the usual format of the plain language statement and consent form will also be available for all participants. It is the researchers’ belief that if this strategy was not adopted, then there is the potential for participants to volunteer without reading any of the information provided and therefore being inadequately informed about the project.
Appendix 26

Variation to Ethical Approval

Thank you for submitting the annual report for the above project for 2003. The information provided in the annual report satisfies the criteria for confirmation of continuing human research ethics approval for the project for 2004. The project is now approved until 31st December 2004.

If it is planned to make any amendments to the research in the coming year, please note that they must be submitted for approval by the Human Research Ethics Committee, and written notification of approval must be received before they can be implemented.

If you have any queries regarding this approval, please contact the Human Research Ethics Secretariat within Melbourne Research and Innovation Office on 9344 2071.
Appendix 27

A Postcolonial Compass for Interrogating the Data

Below is the list of defining features of the three key themes of postcolonial theory that were used to interrogate the data. The left hand column is for a running list of data examples.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- The Indonesian participants are:</td>
<td></td>
</tr>
<tr>
<td>- Without advantages of European progress in Science (technology);</td>
<td></td>
</tr>
<tr>
<td>- Backward;</td>
<td></td>
</tr>
<tr>
<td>- Behavior is irrational, subjective, lacking logic because behavior is based on mystic wisdom;</td>
<td></td>
</tr>
<tr>
<td>- Decisions are based on intuition, subjectivism, romanticism;</td>
<td></td>
</tr>
<tr>
<td>- Feminization;</td>
<td></td>
</tr>
<tr>
<td>- Undeveloped and requiring ‘development’;</td>
<td></td>
</tr>
<tr>
<td>- Immoral, sinful behavior;</td>
<td></td>
</tr>
<tr>
<td>- Laziness;</td>
<td></td>
</tr>
<tr>
<td>- Cowardliness;</td>
<td></td>
</tr>
<tr>
<td>- Untrustworthiness;</td>
<td></td>
</tr>
<tr>
<td>- Defined by difference from the west;</td>
<td></td>
</tr>
<tr>
<td>- Violence;</td>
<td></td>
</tr>
<tr>
<td>- Required ‘occupation’ for ‘civilization’;</td>
<td></td>
</tr>
<tr>
<td>- Culturally inferior;</td>
<td></td>
</tr>
<tr>
<td>- Biologically inferior;</td>
<td></td>
</tr>
<tr>
<td>- A problem to be solved;</td>
<td></td>
</tr>
<tr>
<td>- Linked to powerlessness in western society who WELCOME subjection;</td>
<td></td>
</tr>
<tr>
<td>- The Orient is all the west is NOT</td>
<td></td>
</tr>
<tr>
<td>Subaltern Studies</td>
<td>Data examples</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>The powerless subaltern</strong></td>
<td></td>
</tr>
<tr>
<td>- Binary division of the centre and the margins – central and marginal knowledge;</td>
<td></td>
</tr>
<tr>
<td>- What is said and what is not said (spoken knowledge and silences of rejected</td>
<td></td>
</tr>
<tr>
<td>knowledge that equally contribute to definitions);</td>
<td></td>
</tr>
<tr>
<td>- Central knowledge is valued;</td>
<td></td>
</tr>
<tr>
<td>- Behavior that conforms is good practice;</td>
<td></td>
</tr>
<tr>
<td>- Marginal knowledge is inferior;</td>
<td></td>
</tr>
<tr>
<td>- Behavior that does not conform is bad practice</td>
<td></td>
</tr>
<tr>
<td><strong>The powerful subaltern</strong></td>
<td></td>
</tr>
<tr>
<td>- Subaltern appropriates dominant narratives to become powerful and resist</td>
<td></td>
</tr>
<tr>
<td>subjugation;</td>
<td></td>
</tr>
<tr>
<td>- Resistance to the colonial narrative from within the rather than from outside</td>
<td></td>
</tr>
<tr>
<td>the dominant narrative;</td>
<td></td>
</tr>
<tr>
<td>- Engagement with compared to insularity from the dominant narrative to resist</td>
<td></td>
</tr>
<tr>
<td>confinement to the assigned position of ‘developing’ and assigned place in the</td>
<td></td>
</tr>
<tr>
<td>‘developing world’;</td>
<td></td>
</tr>
<tr>
<td>- Resistance to the master/slave narrative;</td>
<td></td>
</tr>
<tr>
<td>- Turning tables on the master/slave relationship/roles</td>
<td></td>
</tr>
<tr>
<td><strong>Heterogeneity versus assumed homogeneity of the subaltern group</strong></td>
<td></td>
</tr>
<tr>
<td>- Identification of elite and oppressed divisions within subaltern group;</td>
<td></td>
</tr>
<tr>
<td>- The divisions of powerless and powerful within the subaltern group;</td>
<td></td>
</tr>
<tr>
<td>- Responses to colonization and resistance versus acceptance of colonization</td>
<td></td>
</tr>
<tr>
<td>within the subaltern group</td>
<td></td>
</tr>
<tr>
<td>Hybridity/ The Mimic/ Ambivalence</td>
<td>Data examples</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Mimicry</strong></td>
<td><strong>- Adopting the culture of the colonizer on his/her own terms and not subordinate;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Reproducing a copy of colonizers manner, behavior and culture;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Resemblance that is almost the same but not quite;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- An image that is at the same time consensual and conflictual</strong></td>
</tr>
<tr>
<td><strong>Ambivalence</strong></td>
<td><strong>- Wanting one thing and wanting the opposite at the same time;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Mockery decentring authority from absolute to partial acceptance;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Deliberately being ’not quite white’ - partial resistance;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Simultaneously longing and rejecting;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Wanting the colonial rule without the colonial (the expertise without the expert);</strong></td>
</tr>
<tr>
<td><strong>Hybridity</strong></td>
<td><strong>- Unequal cultural exchange;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Indigenous culture is surrendered for a copy of colonial that is not an exact replica;</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Replica’s that are acceptable to both colonized and colonizer (because Colonizer’s don’t want exact replica either);</strong></td>
</tr>
<tr>
<td></td>
<td><strong>- Space in which cultural difference can operate</strong></td>
</tr>
</tbody>
</table>
Appendix 28

Data Codes

Data code for primary and secondary data recordings

The following codes were used to denote the source of the recorded data. The Sister School Program Reports were also numbered.

<table>
<thead>
<tr>
<th>Source of Recorded Data</th>
<th>Data Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Note Journal</td>
<td>FN</td>
</tr>
<tr>
<td>Reflexive Journal</td>
<td>RJ</td>
</tr>
<tr>
<td>Email communication</td>
<td>Em</td>
</tr>
<tr>
<td>Sister School Program Report</td>
<td>SSPR 1 - 10</td>
</tr>
</tbody>
</table>

Data codes for participants

There were seven groups of participants. Anonymity of each participant was ensured by allocating a two part code. The first part of the code denoted his/her membership of a participant group. The second part of the code consisted of a number that identified the individual within the participant group.

<table>
<thead>
<tr>
<th>Participants Group</th>
<th>Group Code</th>
<th>Number of Participants</th>
<th>Combined Group and Individual codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dosen</td>
<td>D</td>
<td>49¹</td>
<td>D1 – D49</td>
</tr>
<tr>
<td>AKPER Directors</td>
<td>AD</td>
<td>6</td>
<td>AD1 - AD6</td>
</tr>
<tr>
<td>Clinical Instructors</td>
<td>CI</td>
<td>8</td>
<td>CI1-CI8</td>
</tr>
</tbody>
</table>

¹ Note, one of the Bilingual secretaries was also a Dosen and her demographic details are included in both groups
<table>
<thead>
<tr>
<th>Participants Group</th>
<th>Group Code</th>
<th>Number of Participants</th>
<th>Combined Group and Individual codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kepala Bangksa</td>
<td>KB</td>
<td>5</td>
<td>KB1–KB5</td>
</tr>
<tr>
<td>Ministry Officers</td>
<td>MO</td>
<td>5</td>
<td>MO1 – MO5</td>
</tr>
<tr>
<td>Bilingual Secretaries</td>
<td>B</td>
<td>4</td>
<td>B1 – B4</td>
</tr>
<tr>
<td>Students</td>
<td>S</td>
<td>35</td>
<td>S1 – S35</td>
</tr>
<tr>
<td>Researcher</td>
<td>RA</td>
<td>1</td>
<td>RA</td>
</tr>
</tbody>
</table>

**Data codes for participant observations**

The AKPER and clinical (Rumah Sakit Umum and Puskesmas) sites were coded according to their geographical location using a two letter alias:

<table>
<thead>
<tr>
<th>Site Code</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bl</td>
<td></td>
</tr>
<tr>
<td>Mg</td>
<td></td>
</tr>
<tr>
<td>Pk</td>
<td></td>
</tr>
<tr>
<td>Pu</td>
<td></td>
</tr>
<tr>
<td>Sg</td>
<td></td>
</tr>
<tr>
<td>So</td>
<td></td>
</tr>
<tr>
<td>Pg</td>
<td></td>
</tr>
</tbody>
</table>

Site codes were paired with activity codes to denote the activity that was the focus of the observation (e.g. MgTO)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Code</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Practice Observation</td>
<td>CO</td>
<td>Took place in RSU or Puskesmas</td>
</tr>
<tr>
<td>Teaching Practice Observation</td>
<td>TO</td>
<td>Took place in AKPER unless otherwise specified</td>
</tr>
</tbody>
</table>
Activity codes were paired with numbers to identify the specific observation and the timing of the observation within the 15months of data collection (eg. MgTO5)

<table>
<thead>
<tr>
<th>Data Code</th>
<th>Month</th>
<th>Data Code</th>
<th>Month</th>
<th>Data Code</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO1</td>
<td>April, 2003</td>
<td>TO1</td>
<td>July, 2003</td>
<td>WO1</td>
<td>January, 2003</td>
</tr>
<tr>
<td>CO4</td>
<td>May, 2003</td>
<td>TO4</td>
<td>October, 2003</td>
<td>WO4</td>
<td>September, 2003</td>
</tr>
<tr>
<td>CO5</td>
<td>June, 2003</td>
<td>TO5</td>
<td>October, 2003</td>
<td>WO5</td>
<td>October, 2003</td>
</tr>
<tr>
<td>CO7</td>
<td>August, 2003</td>
<td>TO7</td>
<td>November, 2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CO8</td>
<td>September, 2003</td>
<td>TO8</td>
<td>November, 2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CO9</td>
<td>October, 2003</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CO10</td>
<td>November, 2003</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Data codes for focus groups**

Focus groups were coded to identify the topic and the timing of the observation within the 15 months of data collection.

<table>
<thead>
<tr>
<th>Topic of Focus Group</th>
<th>Participants</th>
<th>Data Code</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>Dosen</td>
<td>FG1</td>
<td>May, 2003</td>
</tr>
<tr>
<td>Curriculum, Teaching and Learning</td>
<td>Dosen</td>
<td>FG2</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Curriculum, Teaching and Learning</td>
<td>Dosen</td>
<td>FG3</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Curriculum, Teaching and Learning</td>
<td>Dosen</td>
<td>FG4</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Curriculum, Teaching and Learning</td>
<td>Dosen</td>
<td>FG5</td>
<td>June, 2003</td>
</tr>
<tr>
<td>Clinical</td>
<td>Clinical Instructors</td>
<td>FG6</td>
<td>July, 2003</td>
</tr>
<tr>
<td>Enrolment in D3 and learning experiences</td>
<td>Students</td>
<td>SFG1</td>
<td>September, 2003</td>
</tr>
<tr>
<td>Enrolment in D3 and learning experiences</td>
<td>Students</td>
<td>SFG2</td>
<td>November, 2003</td>
</tr>
</tbody>
</table>

**Data codes for individual (key informant) interviews**

Each of the 20 individual interviews was identified by the code: Iv and a number from 1 – 20 to identify the particular interview.
Appendix 29

Research Outputs

Conference Presentations


Aitken (2005). *Conducting a needs assessment to identify areas of priority for knowledge and skill development for Nurses and Midwives throughout the South Asian region*. Paper presented as member of the WHO South East Asian Regional Office (SEARO) team facilitating a workshop to assist health worker training responses post Tsunami at the 2nd annual Faculty of Nursing Universitas Indonesia International Nursing Conference, Bali Indonesia


Ministerial presentations

Presentation to the Undersecretary and staff of the Center for Health Manpower Education, Ministry of Health, Republic of Indonesia and the Chief nurse and staff of the Directorate of Nursing and Medical Technics, Ministry of Health, Republic of Indonesia November 2003 convened by the Principal Nurse Advisor WHO South East Asia Regional Office
Reports


Peer Reviewed Publications

The following publication draws on the findings of this thesis and reports on further research confirming that the tension between local and international standards for nursing occurs at both the provincial and national levels of Indonesian government and the nursing profession.


Book Chapters

Author/s:
Aitken, R. L.

Title:
Internationalizing nursing education in Central Java, Indonesia: a postcolonial ethnography

Date:
2008

Citation:

Publication Status:
Unpublished

Persistent Link:
http://hdl.handle.net/11343/35093

File Description:
Internationalizing nursing education in Central Java, Indonesia: a postcolonial ethnography

Terms and Conditions:
Terms and Conditions: Copyright in works deposited in Minerva Access is retained by the copyright owner. The work may not be altered without permission from the copyright owner. Readers may only download, print and save electronic copies of whole works for their own personal non-commercial use. Any use that exceeds these limits requires permission from the copyright owner. Attribution is essential when quoting or paraphrasing from these works.