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**The Fijian Diploma of Nursing Curriculum:  
An indigenous case study of a curriculum change**

**A thesis presented in fulfilment of the requirements for the degree of**

**Doctor of Philosophy**

**in**

**Nursing**

**at Massey University, Palmerston North, New Zealand**

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MASSEY UNIVERSITY  
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## Abstract

This thesis explores an educational change process in Fiji and used a case study methodology to examine the introduction of the 2004 Diploma of Nursing programme in the Fiji School of Nursing. The three-year competency based curriculum was developed and funded by the Australian government through the Fiji Health Sector Improvement Project (FHSIP) with limited participation of the local teachers at the Fiji School of Nursing. Many problems beset the programme, beginning with its rushed implementation at the end of an academic year and the incompleteness of the curriculum document. Teachers questioned the quality and nature of the competency based curriculum, and the absence of many supportive networks and resources to facilitate curriculum change. The majority of the staff did not understand the competency-based nature of the curriculum and its requirements.

Using the *vanua* indigenous research framework and Fullan's educational change theory to guide and inform the case study, qualitative methods of data collection and analysis were employed, including documentary analysis, participant observations and interviews. Talanoa, a culturally appropriate method of data collection for Pasifika people was used in both individual and group interviews. The research found indigenous nurses continue to be colonised and made to reproduce western ideologies and nursing values, perpetuated by the use of external educational aid and expertise. The execution of the curriculum project and the decision-making flowed from the Ministry of Health down to the Fiji School of Nursing, without consultation with the school's staff, reflecting the former colonial administration where such a top-down approach was acceptable. Neo-colonialism is therefore regarded as the dominant paradigm where indigenous nursing leaders emulated the dominant behaviour of their former colonisers on their fellow indigenous subordinates. Moreover, it is argued here that foreign-influenced curricula continued to produce nurses who are not adequately prepared to care for the indigenous Fijians, and contributed to the attrition of Fijian nurses to countries whose values underpin the curriculum.

## **Dedication**

*To my dear mother, Adi Ela Walesi Volavola who patiently supported me throughout my years away from my family and was called to rest shortly before my Oral Examination, this thesis is dedicated to her memory.*

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*“And we know that God causes everything to work together for the good of those who love Him and are called according to His purpose for them” (Romans 8:28)*

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## Glossary of Fijian words

### B

Bula: Greeting, literally means 'life' or 'health'

Bure: House mainly for the men

### I

I dola ni cakacaka: Ceremony to mark the commencement of work, project

I Sevusevu: Yaqona ceremony to present visitors or guests or relatives to ask permission to enter village or to work in a Fijian community or household.

### K

Kabekabe: food gifting in the Nadroga dialect

Kalou: God/Supernatural deity

Kalou Vu: Ancestral spirit

Kaukauwa: Strong or powerful

### M

Mamaqi: Stinginess

Mataqali: Clan

### T

Ta'ita'i: food gifting (in the dialect of Udu )

Tekiteki: Decorative flower behind the ear or the on hair

Tiko I bure: Initiation of young boys through circumcision after which they can live in the 'bure' like adults.

Tokatoka: sub-clan

Turaga: Chief

## **V**

Vale:	Dwelling house
Vakaturaga:	Chiefly demeanour or chief like manners
Vanua:	Land, Government or people
Veidokai:	Respectful
Veinanumi:	Considerate of others
Veirokorokovi:	Humility /mutually respectful towards others
Veivakaturagataki :	To accord respectful gestures towards others
Viti:	Fijian for Fiji

## **Y**

Yaqona:	Kava or traditional drink made from the root or stem of the Piper Methysticum
Yavu:	Raised foundation of earth mound of a house
Yavusa:	Tribe, largest patrilineal grouping of families related by blood; may also be referred to as the vanua or government.

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## **Chapter 1: Introduction**

The phenomenon under investigation in this study is Fiji's Diploma of Nursing programme, which was implemented at the Fiji School of Nursing (FSN) in September 2004. My interest in this topic arose out of my experiences in teaching undergraduate nurses in Fiji. During the time of implementation, some concerns were raised about the quality of the programme and the skills of nurses graduating from the competency-based nursing curriculum; in particular, whether these nurses were adequately prepared to work with minimal supervision in Fiji's geographically challenged health services. In addition, the relevance and appropriateness of an externally funded and produced Fiji nursing curriculum has been questioned by the teachers – in particular, the curriculum's ability to adequately prepare nurses to meet the health needs of a predominantly indigenous Fijian population. This chapter provides a contextual background to the study and an overview of the thesis. The discussion centres on the rationale and the aims of the study with brief theoretical orientations to the topic of research.

### **1.1 The geographical context of nursing**

The successful implementation of any educational programme for nurses and health professionals must consider a number of contextual factors. For Fiji, such factors include the complex influence of the geography of the country, the multiethnic and multiracial nature of the population and the politico-economic history and potential influence of the dominant educational ideologies inherited from its colonial history. Like many Pacific island countries with underdeveloped communication systems, Fiji's geographical layout has challenged the country's health care system in the provision of an appropriate and accessible health care service to all its population. Geographically, the provision of health services is chiefly determined by the accessibility of the rough and underdeveloped interiors of the major islands. The planning and the subsequent implementation strategies of health policies and services should therefore influence

the components of Fiji's Diploma of Nursing curriculum. Curricula for nurses and health professionals need to prepare responsive and dynamic health care professionals who are effective in such contexts of practice.



Figure 1. Map of the Fiji Islands  
(Source: Mapsouthpacific.com)

Fiji has a land area of approximately 18,376 square kilometres spread over 332 islands in the central Pacific Ocean. Approximately 110 of these islands are inhabited (Figure 1). The two largest and most important islands are Viti Levu and Vanua Levu. Viti Levu hosts the capital Suva together with many important industrial centres. The islands of Fiji are mainly mountainous with tropical rainforests. The mountain peaks reach up to 1,300 metres for the highest in the centre of Viti Levu and there are other high mountains in the other larger islands of Kadavu in the South, and Taveuni in the North. The chain of islands to the west is called the Mamanuca and the Yasawa groups that were made famous by *Treasure Island* and other movies such as *Blue Lagoon*. The island groups are popular tourist destinations as they host a plethora of five star resorts and exclusive holiday spots. While tourism is an important commodity for Fiji's economy, it has also challenged the Ministry of Health (MOH) to provide relevant and

accessible health care in areas isolated by communication systems and the absence of specialist and expert medical emergency care. Tourism has also impacted the rural Fijians' lifestyle and economic viability, which impinge on the peoples' health choices and outcomes.

The South and Eastern parts of Fiji are covered by collection of islands called the Lau group to the east, the Lomaiviti in the centre most part of the country and Kadavu to the South. The Fiji islands occupy 7,300 square kilometers of archipelagic waters and share 200 nautical miles of exclusive economic zone with Tonga to the east on Minerva reef (Walsh, 2006). Rotuma Island, which lies some 500 kilometres north, has a special administrative status in Fiji and is home to a more Polynesian strain of people distinctly different from the Fijians. Viti Levu hosts a number of major towns and cities and many smaller urban centres. Vanua Levu has three main towns of Labasa, Nabouwalu and Savusavu. Taveuni hosts Matei and other smaller centres including an airport. Urban centres on the other islands serve as administrative centres for the Fiji government as well as its main service distribution centre for health, education and other essential community services.

Transportation within and between the islands can be cumbersome, expensive and is easily affected by changes in environmental conditions such as the weather and natural disasters. Most islands have airstrips, which are serviced regularly by local airlines. Shipping services continue to provide the much needed transportation system for the island groups and facilitate business transactions among the main urban island centres and the smaller isolated islands. Fiji's position on the hurricane belt makes it vulnerable to major natural disasters and hurricanes, tropical cyclones and recently the El Nino effect has become a new threat to the country. The distribution of islands in terms of sizes and their location from the main administrative centres together with threats of natural disasters challenges the nursing curriculum to be more creative and dynamic in the way it addresses natural disasters and other environmental threats such as the El Nino weather pattern, global warming and rising sea levels in the Pacific.

## **1.2 Population**

The enumerated population in 2007 was 827,000 (Fiji Government Statistician, 2007), an increase of 52,823 from the last census in 1996. The country's population was, however, estimated to reach 944,720 in 2009 (United Nations Development Programme, 2008). Indigenous Fijians number 473,983; Fiji Indians account for 311,591 and other ethnic groups account for the remaining 42,326. There was a significant change in the indigenous Fijian population, which increased by 82,164 in comparison with the ethnic Indian population which decreased by 27,227 from the 1996 figure (Fiji Trades Investment Bureau, 2009). While the indigenous Fijians and Indian rural populations decreased by 8,768 and 36,708 respectively, the indigenous population in the urban areas increased by 49,427. Fiji had an annual population growth rate of 1.6% from 1970 to 1990 and 1% to 0.6% from 2000 to 2008. This is probably due to the high protection rate associated with family planning and an on-going emigration of skilled and professional workers overseas, which accelerated after the 2000 military coup.

Even though the population of Fiji is highly concentrated within the two main large islands of Viti Levu and Vanua Levu, approximately two fifths of the total population permanently resides in rural villages and communities including those on isolated or outer islands. The loss of skilled and professional workers continues to affect the quality of services, such as the provision of health care services to a population that is widely distributed amongst groups of remote and isolated islands with limited communication systems and infrastructure. The nature of the geographical distribution of the island groups, together with the population that ranges from 200 in a smaller island to around 2,000 in larger islands, makes the provision and maintenance of services a constant challenge for the Fiji government. This is made worse by the fact that most of the indigenous populations reside in the interior of the larger main islands and are isolated by rough terrains and mountain ranges. Fiji, like the rest of the Pacific island countries has continuously been challenged by the geographical and communication difficulties in providing any kind of service to its sparse population

distribution. This is also made worse by the high cost of educating its workforce and the challenge of retaining them within the country.

The consistent concentration of the indigenous Fijian population in rural areas and villages over a concerted time period is evidence of cultural conformity amongst the Fijian people, as well as the pervasiveness of certain elements of the indigenous Fijian culture. Such elements need to be explored and addressed so that their impacts and importance in indigenous Fijian health are addressed within the health services and the education curriculum. Moreover, ethnic Indians who form the second major population group also need to be addressed in the curriculum in terms of their culture, health perspectives and practices. Any curriculum – regardless of the model or approach used – needs to integrate the cultural differences that exist within a population of any country. However, the 2004 Fiji Diploma of Nursing curriculum largely reflects European culture and western medical perspectives and practices, and is expected to prepare nurses to practice with a population comprising indigenous Fijians, ethnic Indians, Chinese, other Pacific Islanders, and only 0.9% Europeans.

### ***The Fijian people***

The origins of the indigenous people of Fiji continue to be a topic of investigation amongst social scientists and anthropologists. However, many authorities have settled on the evidence of artifacts such as ‘Lapita’ pottery, and the similarity of languages of Fijians and South Americans, Polynesians and Melanesians to suggest the possible origins of the Fijians. Regardless of the lack of scientific evidence, Fijians know where they came from as all the tribes in Fiji can trace their origins and lineage to their ancestors, their *Kalou Vu* (ancestral spirit or God). Many tribes in Fiji trace their descent to the landing of a powerful chief and his household who were said to have journeyed from the East of Africa in a large canoe. Descendants of this chief are believed to have populated many areas in Fiji. It is however also known that Fiji was not only populated by the descendants of this chief, but by other means of social integration with the Polynesians, Micronesians and Melanesians in Oceania whose descendants continue to live in Fiji. Europeans, Chinese and Indians reached Fiji during

the periods of colonialism in the Pacific and have also remained in the country and identify Fiji as their home (Walsh, 2006).

Fijians themselves did not have a name for their country. The name *Viti* (Fijian for Fiji) was what the Tongans called the island group. This name was adopted by the Methodist missionaries who first evangelized the Fijians and translated the English bible to the *Bau* dialect (largely spoken by the Eastern parts of Fiji), which became the standard Fijian language. Fijians continue to live within their families, tribes and clans and maintain their identity and close affinity with the land of their ancestors. Fijian culture continues to dictate the lives of ordinary Fijians despite it being affected by social changes of the 20<sup>th</sup> century. Many Fijians who work in urban towns and cities choose to retire in their home villages and not in the urban areas (Ravuvu, 1983; Walsh, 2006). Even though some may own homes and live in the urban areas, it is not unusual for them to build a house or second home in their villages. Homes or properties within their tribal land and villages are a social expectation of their continued attachment and identities with the land of their ancestors. This movement of population is fairly constant and keeps the concentration of Fijian population in rural areas for long periods of time.

### ***The Indo-Fijians***

The majority of the Indo-Fijians are descendants of indentured labourers brought from India by the British colonial government to work in the sugar cane plantations in 87 ships between 1879 and 1916, when the system was terminated (Walsh, 2006). There were also free migrants from India who came to Fiji as entrepreneurs, jewellers, traders and merchants and colonial clerks. Punjabi policemen and former army officers also retired to Fiji as cultivators and herdsman, mechanics and other trades, making Fiji their home. At the end of the indentured system there were 60,000 Indians living in Fiji without any clearly defined plan of the British government as to whether they were to stay or return to India. With natural growth and further migration from India and other parts of the world, the Indian population had outstripped the Fijians and other ethnic groups by more than 50% in the 1970s (Mangubhai, 1984b).

The presence of Indians in Fiji has had lasting influences and impacts on Fiji's political and economical development and helped shape the educational policies of such a multicultural society as Fiji. When the Indians were brought to Fiji, they came with their various languages and religions such as Hinduism, Sikhism, Buddhism, Christianity and Islam. They also came from different parts of India making them very culturally diverse from each other. These various groups and sub-groups of Indians formed a political group to petition the colonial government on their welfare needs as well as the education needs of their children.

In 1929, with the cessation of the indentured labour system, the progressive Indian population demanded equal opportunities for education and development similar to that of Europeans. Such demands prompted Fiji's colonial government to address educational issues for Indians as well as for the Fijians, who had until then, appeared to be content with whatever was done to them. The Indian thirst for education accelerated the development for indigenous Fijians and set the trend for the development of privately administered schools based on the different religions and cultural groups as well as other ethnic groups in Fiji (Mangubhai, 1984a).

There has been little intermarriage within the Indian castes or religions, as well as with other ethnic groups in Fiji. Indo-Fijians have also adopted many aspects of the Fijian culture, and many speak and understand the Fijian language and the different tribal dialects in their localities. They have adopted Fijian food, traditional medicine and have readily accepted the drinking of Kava as Fiji's national drink to the point of abuse. While they have maintained their mainstream religions and folk festivals, the degree of integration with the other cultures in Fiji is often underestimated. In his observations of Indo-Fijians' depth of assimilation of Fijian lifestyle, Geraghty stated, "for all their differences, the Fiji Indians have become far more like Fijians than most people, including themselves, usually realise" (cited by Walsh, 2006, p.113).

Indo-Fijians mostly live in rural farming areas of the two main islands and the main urban centres of the country. However, there are also a number of families living in some of the small island groups for generations as traders or shopkeepers for the islanders. According to Walsh (2006) the Indo-Fijian population has steadily decreased since the 1987 and 2000 political coups, and a marked internal migration of Indo-Fijian families from rural farming areas to urban centres was noted at the end of their farm lease agreements with indigenous Fijian landowners. However as Walsh (2006) further noted, the urbanisation of Fiji has been a continuous trend since 1966 when only 33% of Fiji's population lived in urban areas, with an increase of 13% recorded in 1996. Significant movements in population from rural to urban centres create structural changes to the environment, housing, employment, education, health and social services. Such changes need to be included in the review and development of primary health care strategies and family health nursing models and practices used by the health and nursing divisions. Moreover, such changes should be reflected in the curriculum content of a nursing programme, along with the health impacts of population dislocation, urbanisation, social and cultural breakdowns.

### **1.3 The socio-political and economic context**

Fiji gained political independence in 1970 after 96 years of British colonial rule. The colonial experience laid the foundation for Fiji's social, political, economic and educational structure and processes. Fiji is today a republic after having gone through three coups by the Fiji Military Forces. The first two in 1987 and 2000 were carried out in the name of indigenous supremacy and nationalism. In 2006 the third coup was carried out to remove a government that, according to the Fiji military, was considered to be rife with corrupt and racist leaders and policies.

Fiji in the pre-coup era was ruled by a parliamentary democracy based on a written constitution modelled on a Westminster style of government. Parliament had equal representation of both major ethnic groups. In 1990, a constitution giving more power to indigenous Fijians was promulgated by decree. Affirmative action policies mostly in

areas of Indian dominance such as education, businesses and government employment were the main preoccupation for the Fijian dominated government (Puamau, 2001). In 1997, however another constitution was adopted which ensured better representation of the two major groups; the Fijians and the Indians in Parliament in a 71 member House of Representatives. Under this constitution, the Head of State is a President who is appointed by the Great Council of Chiefs; a 51 member body of hereditary chiefs in Fiji. The President then appoints the Prime Minister and the members of Cabinet from the members of Parliament. The members of parliament are elected by a General Election and the Senate members are appointed. At the time of writing this thesis, the 1997 constitution had been abrogated and Fiji was being ruled by the Military government under an emergency decree that replaced the constitution.

Fiji's economy is largely based on and supported by primary products and agriculture. Although sugar remains an important commodity its continued position in the economy is highly dependent on the volatile ethnic and political tensions between the farmers and the government, and the indigenous Fijians and the Indians. Tourism contributes the highest revenue to the government and is closely followed by the remittances of Fijian nurses and soldiers working abroad. Fiji is blessed by an abundance of rich natural resources such as gold and other minerals, mineral water, fish, and forests. Diversification of such resources and other domestically produced goods continue to support an economy, which has become very sensitive and dependent on internal political stability as well as on international trade and economic trends. Fiji's ability to maintain a reasonable degree of diversification enabled the economy to withstand the shocks of the year 2000 coup even after the tourism industry collapsed (FTIB, 2009). Taxation concessions and reforms to assist the manufacturing sectors in exports are also helping in the foreign earning capacity of the Fiji government.

The Fiji economy is significantly deregulated since the 2006 coup, which has restrained government's expenditure and emphasised an efficient use of domestic resources to

produce exports. This can boost foreign reserves and domestic earnings. Like many other Pacific countries, foreign aid is an essential feature of Fiji's economy in terms of making capacity building or ventures projects possible. Gounder (2005) claims about 95% of bilateral aid for Fiji comes from Australia, Japan and New Zealand, and multilateral aid is given by the Asian Development Bank, the European Union and the United Nations. Aid of any kind has the potential to increase economic growth and sustainability but can also induce a state of dependence by the recipient, which potentially leads the country to debts, poverty and a permanent state of underdevelopment (Hancock, 1991; Hughes, 2003; B. Knapman, 1986; Luteru & Teasdale, 1993).

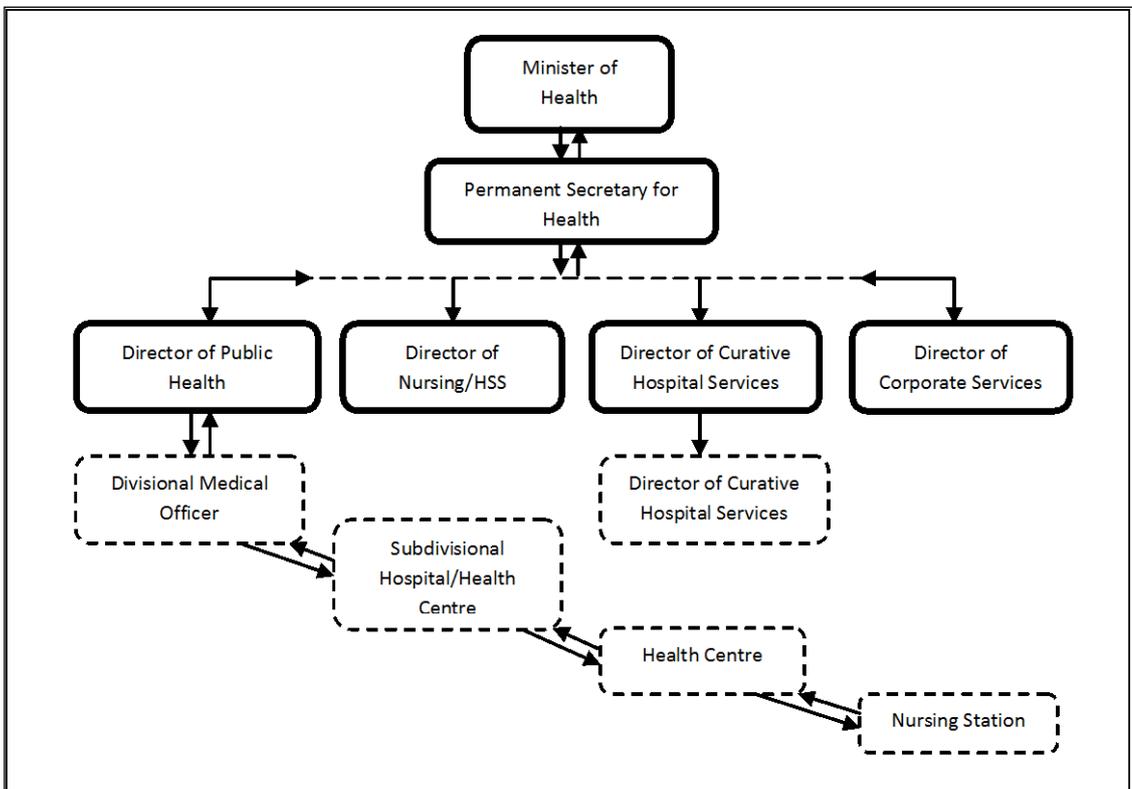
#### **1.4 The health situation**

Fiji is relatively healthy compared to some tropical countries as it is blessed with the absence of some tropical diseases such as malaria and cholera. The life expectancy at birth has remained fairly constant for both male and females at 66 years and 72 years respectively for the past ten years. Fiji's infant mortality rate of 12.3 deaths per 1,000 reflects the high coverage of the immunisation programmes which have been constant at 99-100 % for many years, except for 2005 when there was an outbreak of measles and the coverage was at its lowest of 95% (Fiji Ministry of Health, 2005b). The country has been declared Leprosy free since the 1990s with an incidence rate of 1 per 10,000 of the population. It also has a well controlled low incidence of tuberculosis for the past decade. However, the country's health status indicators highlight the triple burden of rising non-communicable diseases; the re-emergence of previously controlled communicable diseases such as tuberculosis, and the threat of infectious diseases affecting the younger members of societies such as sexually transmitted infections and human immune-deficiency virus (HIV) and acquired immune-deficiency syndrome (AIDS). The principal causes of mortality and morbidity for the major ethnic groups are respiratory diseases, cancer and non-communicable diseases (Fiji Ministry of Health, 2005a, 2008). In addition, the high incidence of skin and intestinal infections indicate the need to strengthen sanitation and primary health care (PHC) strategies for

a population regularly stricken by natural disasters, limited resources and an unstable economy.

**The health services**

Health care delivery is organised and managed within three major divisions. The four administrative divisions normally used by the Fiji government are the Eastern, the Western, the Northern and the Central divisions. The MOH, however, has combined the Eastern division (which covers the sparsely scattered island groups of Lau, Kadavu and Lomaiviti) and the Central division (which covers the densely populated Suva city and Nausori Town areas including villages and settlements) into one administrative division for ease of operation. The divisions are organised in a similar structure that integrates curative, preventative and rehabilitative functions at all levels in all divisions. All administrative divisions have a base referral hospital and a number of sub-divisional hospitals. A director and an executive multidisciplinary team manage each division including the referral hospitals (See Figure 2).



*Figure 2. Ministry of Health administrative structure*

Note. \*All four administrative divisions follow similar structure.

Fiji's health service is predominantly publicly funded with a comparatively small private sector. There is a proliferation of privately run hospitals within the main urban centres with a promise of growth against the increasingly complex public health system. The government fully funds all public services, and therefore is the main employer of health workers and professionals.

Fiji's expenditure on health amounts to approximately 20% of the national budget and is often boosted by external aid and donations from other countries. In 2005, the country's total expenditure on health was around 3% of the GDP since 1988 and in 2006 was 4.0% compared to Japan's 7.4% and New Zealand's 9.4% in the same period (World Health Organization, 2010). Fiji's health budget is heavily focused on the operational costs of hospitalisations, drug purchases and usage, the salaries of its workers and the rising cost of overseas specialist treatment of its citizens. Health services in Fiji are free, although a very few special procedures such as special x-rays and dental treatment are charged at a minimal rate for the public patients. While services such as outpatients and all clinics including antenatal and postnatal clinics are free, hospital admissions including deliveries and maternity care are charged at 50 cents per day. Deliveries, surgeries and medications are dispensed free of charge from the public hospitals and rural clinics. Almost all of Fiji's preventative health programmes such as immunizations, vaccinations, and family planning programmes are externally funded by the World Health Organisation (WHO), the United Nations International Children's Fund (UNICEF) and other international agencies.

Fiji's health services followed the British model of administration until the 1980s when a major re-structuring of the community health care services was done to accommodate the primary health care strategies that were adopted from the WHO. The government's Eighth Development Plan for the period 1981 to 1985 was formulated on the basis of the primary health care "Health For All by the year 2000"

(HFA2000) slogan . The MOH also used the nine components of primary health care as set out by the WHO as the basis of all its health activities from 1981. These were nutrition, safe drinking water, environmental sanitation, control of communicable and chronic diseases, immunisation, appropriate health care, family planning, health education and essential drugs. The restructuring of the community health division also strengthened the nursing division by the creation of a nurse advisor position for community health nursing. A new position of a director for primary and preventative health care was also created within the MOH to direct and supervise the implementation of all Primary Health Care (PHC) programmes in Fiji. In the community, the creation of village health workers to assist in the delivery of health services to the grassroots people and also to create a direct communication link from the people to the hospitals and to the MOH.

Primary Health Care (PHC) has been the key driver of health reforms in Fiji since ratifying the HFA 2000 global strategy in 1978. Successive governments have never deviated from this strategy and have continuously produced health plans structured around or based on the broad principles of primary health care. The Fiji government's strategic plan for the period of 2005 to 2008 was built on primary health care goals and strategies established by previous governments (Ministry of Health Women and Social Welfare, 2007).

In ratifying the global strategy of HFA 2000 in 1978, Fiji implemented PHC strategy in three ways. First, the whole health care service structure was reviewed and the communication structure within the service was re-structured to reduce obstacles to information dissemination in all directions and to reduce the bureaucratic formalities within the primary health care service. Second, a number of education programmes were instituted to facilitate the HFA principles and strategies for primary health care. These included the creation of mid-level practitioners to serve in rural remote areas of the country, the introduction of the WHO three-year PHC based Diploma of Nursing programme at the Fiji School of Nursing and the change in the Fiji School of Medicine's Bachelor of Medicine and Bachelor of Surgery programme to a problem-based Primary

Care Practitioners' (PCP) programme in 1992. The latter programme was abolished a few years later, after continuous opposition by the Fiji Medical Association. Third, the introduction of multi-sectoral and inter-sectoral collaboration, as strategies for information dissemination and empowerment, was a powerful tool in the implementation of PHC strategies in Fiji. Community consultation and participation, including government, non-health and non-government workers, the lay community and representatives of all different ethnic communities in the country were involved in all community health projects and plans. The WHO (World Health Organisation, 1986) reported that each component of the health sector plan in the Fiji government's Eighth Development Plan required the participation of at least 24 government agencies in order to make a plan successful.

The regional policy paper by the WHO, called the New Horizons for Health, emphasised people have the potential to make long-term differences in their health as well as in the health of others using the concepts of health promotion and health protection (Han, 1997). New Horizons for Health formed the foundation of the 'Healthy Islands' theme for the 17 Pacific Island countries that signed the 1995 *Yanuca* Island Declaration on Health in the Pacific in the 21<sup>st</sup> century. The concept of Healthy Islands as a strategy and a tool aimed to affect the New Horizons for Health paradigm (Finau & Dever, 1994). The strategy focused on people at the local level and offered a way for health to become a national issue for the whole country, and not just for the health workers. The declaration stated:

- New challenges in health in the 21<sup>st</sup> century call for clarity of purpose and broad based participation to achieve Healthy Islands;
- Healthy Islands should be places where children are nurtured in body and mind; environments invite learning and leisure, people work and age with dignity and ecological balance is a source of pride (Finau & Dever, 1994, pp. 71-72).

The strategic plan of the MOH for the period of 2005 to 2008 outlined the following goals:

1. Provision of health services which are affordable, well planned, quality health services (such as preventive, diagnostic, clinical, pharmaceutical and rehabilitative) to everyone in Fiji;
2. Protection of health: review, develop and implement policy, legislation, regulation and standards for the safety and protection of the health and well being of the people of Fiji;
3. Promotion of health: development and maintenance of effective partnerships that empower all stakeholders to promote health and reduce risk factors related to communicable and non-communicable diseases;
4. People in health: the development and retention of a valued, committed and skilled workforce to enhance the delivery of quality health services; and,
5. Productivity in health: develop and strengthen the use of integrated management systems to empower managers to maximize resources and promote continuous improvement at all levels of health service delivery (Ministry of Health Women and Social Welfare, 2007, pp. 16-17).

The PHC strategy broke down a lot of barriers in the delivery of health services as it allowed for consultations with health service consumers to determine the best methods of implementing changes. It also acknowledged the already existing traditional lines of communication and authorities in Fiji's different ethnic communities and maximised its use in PHC.

The strategy also acknowledged the already available health resources, such as traditional knowledge of health and practices, and the use of existing traditional healers and birth attendants to influence and assist in the delivery of health services. Retired nurses living in their own traditional communities were invited to provide mentorship and training for lay village health workers in basic hygiene skills, dressings and managing a village health clinic. Traditional birth attendants were given education in the prevention of sepsis or complications in deliveries to supplement their traditional knowledge. This strategy, for the first time since Fiji's colonisation by Great Britain, acknowledged the Fijian and other ethnic groups' diversity and traditional

perspectives on health and illness. Dialogue and collaboration followed the traditional lines of communication and authority, which allowed for positive information sharing and guaranteed the full support of the population. Additionally, the strategy made everyone responsible for their own health and the health choices they make. Fijian villages and Indian settlements, various women’s organisations for all ethnic groups, non-health organisations and religious denominations and groups all became active participants in the PHC strategies for their communities.

A well defined administrative system for each health division ensures the provision of a comprehensive health service, usually led by a medical officer with support from a health sister or nurse manager, health inspector, a dental officer, clerical and administrative staff. For administrative purposes the divisions are further broken down into sub-divisions, medical areas and nursing areas. Hospitals within a sub-divisional area are called sub-divisional hospitals, and clinics within medical areas are called health centres, which denote a resident medical officer is stationed in the centre. A nursing area consists of a clinic managed independently by a district nurse. District nurses are usually placed within geographically isolated areas and are expected to carry out a full range of clinical routines such as out-patient clinics and other special medical and obstetric clinics within a given population boundary. District nurses are also expected to carry out the normal community health work of other health professionals such as health inspectors, dental and school health clinics, domiciliary care, home visits, village inspections, and provide monthly and quarterly statistical updates to the MOH. Sub-divisional hospitals and health centres offer a limited range of primary and secondary level of care, whereas the base referral hospitals may offer a full range of all levels of health care within their divisions. Table 1.1 describes the coverage of health facilities in Fiji.

*Table 1. Coverage by Health Facilities*

Type of Facility	Central	Western	Northern*	Eastern*	Total
Divisional Hospital	1	1	1	1	4

Sub-Divisional Hospital	1	3	3	3	10
Area Hospital/Health Centre	1	1	*	2	4
Maternity Hospital	1	1	*	*	2
Health Centre	15	12	12	6	45
Nursing Stations	18	30	20	26	94

Note: \*In the Northern and Eastern divisions, maternity units and area hospital facilities are provided within the sub-divisional general hospitals. Source WHO (1986) with updated figures cited in Walsh, (2006).

In 2001, an AusAid sponsored health review team restructured and reformed the MOH. In the same process the nursing division, which consisted of the Director of Nursing, and two assistant directors based at the MOH headquarters, was abolished while other Directors were kept intact. The administration structure of nurses within the MOH was also re-aligned so that medical officers and other non-nursing/medical personnel now supervised nurses who were directly supervised by a nursing officer. The Fiji Nursing Association (FNA) threatened industrial action and challenged the government to reinstate the Director of Nursing position. The government reluctantly conceded to the FNA request and reinstated the position together with the health system standards responsibilities but without a job description for the Director of Nursing post.

### ***Health Personnel***

Fiji's health service has been hampered by a chronic shortage of health professionals, largely due to migration. Although the Fiji School of Nursing (FSN) and Fiji School of Medicine (FSM) are capable of meeting the country's health services needs, the continuous loss of graduates means the Schools have to train more graduates than required for Fiji's health service needs. However, evidence reveals that only 35% of Fiji's health service doctors are local graduates and 65% of doctors are expatriates from Asian countries, the United Kingdom, Australia, New Zealand and Africa (Walsh, 2006). It is notable that whilst the Fiji School of Nursing strives to keep its western influenced curriculum recognised abroad, it is recognised such a curriculum makes its graduates highly marketable worldwide, and graduates are attracted by better salaries and conditions of service that Fiji cannot match. Additionally, Fiji lost many of its specialist trained doctors and nurses to developed countries due to lack of practice opportunities in Fiji. The loss of skilled workers in the health profession is a contributing factor to the failure to establish specialist medical services in Fiji for almost three decades. The vacuum, created by the lack of specialist medical services, is filled by nurses, as the Fiji government tries to prepare nurses as both generalists and multi-skilled practitioners. Fiji therefore has to prepare nurses who can function in any clinical setting, anytime they are called upon. Such demand on the health services has impacted on the way undergraduate nurses are educated and prepared for service in Fiji.

Fiji's health personnel are largely educated locally by the Fiji School of Medicine and the Fiji School of Nursing. Previously separate regional institutions, the two Schools were merged in January 2010 to form the School of Health and Medical Sciences of the newly established Fiji National University. The former Fiji School of Medicine offers a degree in Medicine and Surgery as well as in Dietetics, Physiotherapy, Health Inspection, Radiology and Laboratory Technology. In 2009, before the merger of the two schools, the Fiji School of Medicine implemented a degree in Public Health Nursing for the South Pacific regional registered nurses. The medical school also offers

postgraduate specialist training for doctors in Surgery, Medicine, Obstetrics and Gynaecology as well as Paediatrics.

The School of Nursing continues to prepare nurses for registration at diploma level and has a handful of post registration courses in midwifery, public health, management and Nurse Practitioner. The bridging programme for a Bachelor of Nursing degree from James Cook University continues into its eighth year in addition to other Australian universities that have been providing similar courses in Fiji. The Fiji government provides scholarships for individual students that are enrolled at the Fiji School of Nursing. Students are bonded for government service for the same number of years of their training. Many nurses accumulate valuable work experience during their bond service years and leave Fiji for better opportunities abroad once their bond is completed.

### **1.5 The legal structures for nursing and nursing education in Fiji**

The Nurses, Midwives and Nurse Practitioners' Act (1999) (MOH, 1999) regulates all nursing practice and nursing education. This regulation has been in place as an Ordinance since 1956 after the transfer of the New Zealand nursing curriculum to Fiji in 1955. The previous legislation known as the Nurse' Ordinance, provided for the education of the local class of nursing students called the 'colony class', while the New Zealand class was under the supervision of the Nursing Division in New Zealand. The current legislation is called the Nurses, Midwives and Nurse Practitioners' Act after Fiji's independence from Great Britain.

The administration of the school is the responsibility of the MOH through the Nurses, Midwives and Nurse Practitioners' Board of Fiji (NMNP). The NMNP Board is the regulatory body with the responsibility of registering nurses for practice in the country. The Permanent Secretary for Health chairs the Board and the Director of Nursing Services acts as the Registrar and Secretary to the Board. The Minister for Health appoints the members and they include the four divisional nursing heads, the Principal

of the Fiji School of Nursing, a representative of the Nurse Practitioners and a member that represents the general public.

In 1988, the NMNP Board formed a committee known as the Nurses Academic Committee (NAC) to oversee the development, implementation, and review of relevant policies required by the School of Nursing. The NAC has an independent chairperson and committee membership is made up of the Principal of the school, four senior lecturers who are coordinators of various programmes, the Student Nurses' Association representative, representatives from the Ministry of Education and the Fiji School of Medicine.

In 2005, a second School of Nursing was established and privately administered by the Then India Sanmarga Ikya (TISI) Sangam to offer an undergraduate course in nursing but was only allowed by the Nurses, Midwives and Nurse Practitioner Board of Fiji (NMNP) to teach the 2004 Diploma of Nursing programme. Both Schools of Nursing are subject to the regulatory authority of the NMNP Board. However, the Sangam School of Nursing has its own academic committee, which assists in the administration and implementation of all relevant educational policies for its school of nursing, as well as its other educational institutions in Fiji.

Teachers and other staff of the Fiji School of Nursing are appointed by the government through the MOH, and the positions of teachers are equivalent to senior nursing positions within the clinical areas. For example, the position of the Senior Tutor is equivalent to the Matron in the hospital and the Deputy Principal is equivalent to the Senior Matron of a large Base hospital. Tutors are equivalent to those nursing managers at supervisory or ward managers' level. In such a context, the MOH manages its nursing establishment for Fiji by appointing and transferring nurses across any practice setting at any time from clinical to academic and vice versa without considering the educational preparation of nursing officers.

Over the past thirty years, nursing education internationally has moved from hospital-based nursing education to institutions of higher learning. The Pacific countries, Australia and New Zealand began reforming their nursing education systems in the 1970s. Western Samoa started teaching an undergraduate degree programme from the National University of Samoa in 1991, while the Solomon Islands relocated its undergraduate nursing programme from the MOH to the College of Higher Education (SICHE) within the Ministry of Education. In contrast, Fiji, formerly a regional centre for nursing and medical education in the South Pacific, has continued to teach a Diploma of Nursing programme within a hospital-based School of Nursing under the direct administration of the MOH.

Despite the global movement of nursing education to tertiary institutions, the Fiji government resisted a number of recommendations to merge the Fiji School of Nursing with the Fiji School of Medicine in order to create a School of Health Sciences within the University of the South Pacific (Bacchus, et al., 2000; Bank, 1993). Government resistance to change was based on the fact that the exodus of nurses from Fiji had become a national crisis and the government needed to have complete authority over the School in order to meet its strategic plans for health services. The Government however, agreed to strengthen the capacity of the Fiji School of Nursing by reviewing the 1983 Diploma of Nursing curriculum and to upgrade it to a degree programme as well as up-skilling the faculty's qualifications to graduate and postgraduate levels. However, the revised 2004 curriculum was implemented at the Fiji School of Nursing as Diploma of Nursing programme, and not a degree programme as initially commissioned by the Fiji government.

## **1.6 The 1983 Diploma of Nursing curriculum**

The 1983 Diploma of Nursing curriculum was developed and funded by the WHO and the UNFPA and taught from 1983 to 2006 at the Fiji School of Nursing. The curriculum was primary health care based and focused and was used as the vehicle to mobilise the primary health care strategy advocated by the WHO in the late 1970s. The curriculum

was comprehensive in its coverage of all aspects of general and specialist nursing in the hospital and in community health. The curriculum prepared the student with a broad foundational knowledge of social sciences such as sociology, psychology, education, research, and management and provided the platform for further development to a degree level. The Diploma of Nursing curriculum was offered in a nine-trimester schedule covering three years of full time study and used the mastery assessment method for clinical proficiency. The clinical assessment method prepared the graduate for expert independent practice at graduation, which worked well for Fiji's geographically sparse population. While the 1983 curriculum had served Fiji well in its earlier years of implementation, most of the PHC programmes such as Community Health Nursing, Family Health Nursing and their clinical components suffered after the WHO and UNICEF transferred the funding of the curriculum to the Ministry of Health. Supportive subjects such as communication and creative writing were taken out completely while sociology, psychology, nursing theories and educational methods had their hours reduced.

### **1.7 The 2004 Diploma of Nursing curriculum**

The Fiji School of Nursing took 21 years to change its curriculum from a primary health care based and focused curriculum to a competency-based Diploma of Nursing curriculum in September 2004. The new curriculum was a product of an AusAid sponsored project and led by a team from the James Cook University in Australia. At the time of its development, AusAid was sponsoring many other health improvement projects in the Pacific, including Fiji's Ministry of Health. The main aim of AusAid was to help improve the delivery of health services to the Pacific people through reforms in health administration and training (AusAID, 2002). The review and the development of the new curriculum was seen as a strategy for the improvement of health services to the Fijian people through increasing the quality of educational preparation of nurses, to be more relevant and contemporary (Usher, 2004b).

The three-year competency-based Diploma of Nursing curriculum uses an educational framework based on adult learning theories, problem solving, critical thinking and reflective thinking philosophies. Self-directed learning and discovery learning theories and methods were advocated as teaching and learning strategies in the curriculum. While the 1983 Diploma of Nursing curriculum provided a teacher-proof approach to teaching and learning with model lectures, tutorials and scenarios prepared for all subjects, the 2004 curriculum expected the teachers to write up their own subject contents, tutorials and assessment tools as the course progressed. The 1983 curriculum used an objectives model of curriculum development that directed all aspects of teaching and learning, in contrast to the self-directed and discovery learning philosophy used by the 2004 curriculum. It could be argued that the teacher-proof approach used by the 1983 curriculum was more relevant to Fiji, as the majority of teachers at the Fiji School of Nursing lacked teaching qualifications and were posted directly from clinical practice areas to the school.

The prominent feature of the 2004 curriculum was its competency-based framework, using a set of competencies developed by the South Western Pacific Nurse Registration Authority (SWPNRA) leaders at a meeting held in Hong Kong in 2002 (Lum, 2002). The main rationale for the SWPRNA meetings was to draw up a standardised set of nursing competencies to screen nurses from the Pacific seeking registration in New Zealand and Australia (Australian Nursing Council Inc., 2006). The strategy of the SWPRNA in drawing up a set of common competencies for overseas nurses especially from developing countries is a replication of the colonial practice of imposing western medical ideologies and values for the less powerful indigenous people. The adoption of common competencies by foreign countries in their undergraduate curricula served to ensure that nurses from developing countries will continue to be dependent on developed countries for validation of standards for nursing practice.

The 2004 Diploma of Nursing is structured within six semesters over a three-year period, differing from the previous curriculum's three terms per year structure for three years. A clinical block in each semester varies in length according to the year,

getting longer as students progressed to the third year. Correspondingly, the theoretical weeks shorten as the curriculum progresses through to the end of training. The profile of the Fiji School of Nursing registered nurse graduate includes the following:

- Be able to use the skills of critical analysis, reflection and inquiry in relation to their provision of health care and undertake all nursing practice in a professional manner;
- Appropriately respond to the needs of patients and families with respect and empathy;
- Provide quality nursing practice based on their understanding of the health care system in Fiji and the tradition and values of the Fiji nursing profession;
- Provide a holistic nursing care based on Fiji's multicultural values of respect for difference, cultural diversity and spiritual affiliation;
- Have a sound theoretical understanding of the contemporary knowledge base of the local and international profession of nursing;
- Have the expertise to deliver safe care based on a primary health care model that includes the ability to assess community needs, teach, and evaluate outcomes;
- Be capable of birthing women and have an awareness of the associated nursing care and health issues;
- Assess, plan, implement and document appropriate nursing care for people of all ages experiencing illness, injury or emotional needs, for the acute and chronically ill, the disabled, and others in need of care;
- Understand and able to apply the principles of evidence based practice, anatomy/physiology, and pharmacology to nursing;
- Demonstrate skills necessary to implement the principles of safe, scientific and ethical nursing care for a beginning level of registered nurse practice;
- Work together in a co-operative relationship with other health care providers;
- Recognise the importance of self-development and on-going education;
- Be aware of own limitations and the legal requirements related to the profession including the scope of practice;
- Recognise the principles of administration and leadership and implement, as required, their roles as leaders and managers in nursing and of health care teams (Usher, 2005, p. 8).

The curriculum philosophy (Appendix 2B) was broadly stated in goals and objectives and not as a statement of beliefs, values and attitudes about nursing, the person and the nursing education processes. Within a nursing curriculum, the philosophy reflects the society's aspirations and beliefs about the central concepts of nursing and education ( Keating, 2006). The philosophy within a curriculum justifies a philosophic approach to teaching, learning and assessment and dictates the nature of evaluation of the programme and of the graduates. In curriculum evaluation and analysis, the philosophy guides the development of evaluation frameworks and assists the evaluator in making concluding judgements about a programme of study (Stake, 1996).

### ***The administration of the curriculum***

The four subject strands: foundational nursing knowledge, nursing practice, primary health care and personal and professional development are simultaneously taught through the three years (Usher, 2003). Each team within the school curriculum has a team leader or the strand coordinator. The responsibility of the strand coordinator is to lead and guide the team on the implementation of each subject within the strand. Each team member is responsible for each subject within the strand, who is known as the subject coordinator. The subject coordinator plans the teaching and assessment blueprint for his or her subject, and delegates tutorial responsibilities to other team members.

### ***The clinical component of the curriculum***

The objectives of clinical learning are planned around the preparation of students for competent practice, as set by the NMNP Board of Fiji. Clinical learning aims to enhance the development of the psychomotor and interpersonal skills and attitudes required to meet the competency standards. Clinical education covers 65 weeks; equivalent to 2,600 hours of clinical practice. As mentioned earlier in this chapter, the depth of clinical learning also increases from the first year through to the 3<sup>rd</sup> year, as students are able to understand and correctly apply theory to complex nursing situations. Despite the curriculum requirement of placing first year students in low care and low dependency facilities in Fiji, these students are placed in all areas of nursing such as

the acute wards, Accidents and Emergencies, Obstetrics and Gynaecology wards, General Medical and Surgical wards, General Outpatients and Special Clinics. The five weeks of clinical rotation to a low dependency facility, outlined in Table 1.2 below, was not facilitated by the Fiji School of Nursing due to the non-availability of such centres in Fiji. There are very few Old Peoples' homes or low care residents in Fiji and all hospitals have high care facilities. The 2<sup>nd</sup> year students' clinical learning is focused on medical and surgical nursing, maternity and mental health practice. Students then progress to complex and specialised nursing situations, and community health placements in their 3<sup>rd</sup> year.

*Table 2. Overview of Clinical Placements*

Year	Semester	Weeks	Area
1	Semester 1	5 week	Low dependency nursing
	Semester 2	8 weeks	Medical-surgical plus paediatric nursing
2	Semester 1	7 weeks	Maternity nursing plus medical-surgical nursing
	Semester 2	13 weeks	Maternity or mental health nursing plus medical-surgical nursing
3	Semester 1	14 weeks	Maternity/obstetric nursing, high dependency nursing, perioperative nursing, accident and emergency nursing;
	Semester 2	18 weeks	Intensive care nursing, community nursing, rural nursing, medical-surgical nursing
Total Clinical Placements:		65 weeks	

Note. Source Usher (2003)

### ***Implementation of clinical learning***

The planning and implementation of the clinical component of the curriculum is the responsibility of the class coordinator. A 'Master Plan', which is a blue print of the three-year academic programme for all levels of training, tabulates classroom and clinical placement plans for the curriculum.

Teachers have the primary responsibility for providing clinical supervision as part of their teaching responsibilities. The Fiji government contracts retired tutors to work as clinical supervisors on a seasonal or part-time basis in specific areas of clinical placements in the hospital. However, specialised nursing areas such as the coronary care unit or intensive care unit, the operating theatre and the specialised hospitals such as the psychiatric hospital are left to the teachers.

### ***Preceptorship in the new curriculum***

The use of preceptors is fairly new at the Fiji School of Nursing. Preceptorship is a method of teaching where an experienced nurse provides one on one direct guidance and role modelling to a student or a less experienced nurse, in addition to a normal clinical caseload or work responsibility (Barnett, 1992). Consistent with Australia's rationale for using preceptors in its nurse education programmes (Beattie, 1998; Grealish & Carroll, 1998; Shamian & Inhaber, 1985; Spears, 1986), Fiji's decision to use preceptors was related to the Fiji School of Nursing's inability to provide adequate supervision of the clinical component of the curriculum. Therefore, clinical supervision of students was left to the clinical staff when the School adopted the competency-based curriculum. However, instead of one preceptor to a preceptee, Fiji has one preceptor to groups of students ranging in number from three to six in any one shift. Clinical preceptors selected by the Ministry of Health work full time in their clinical role with the hospitals and in community health and therefore at most times are not able to devote quality time to students. While the previous curriculum had teachers supervising the students in clinical settings, the 2004 curriculum has teachers teaching and facilitating tutorials throughout the day in different classes.

### ***Assessment of clinical learning***

Competent clinical practice reflects the ability of the student to integrate knowledge, skills and appropriate behaviour and attitudes from all four-subject strands. The assessment of the students' clinical effectiveness aims to ascertain their levels of competence, which aids in determining the progress of students from one level of practice to another. Clinical assessment tools are structured around, and are measured against the Fiji Nursing Competencies (adapted from the Hong Kong model, 2002). The four basic core competencies for registered nurses in Fiji include functional competency, personal competency, people and team competency and organisation effectiveness. The components of each of the four competency criteria are appended as Appendix 2.A.

The Fiji School of Nursing graduated its first cohort of the new curriculum in 2007. Candidates needed to complete all clinical competencies and pass all theoretical examinations set at the end of the three years (NMNP Board: Qualifying examination policy, 2007). In addition, candidates must pass an OSCE (Objective Structured Clinical Examination) to demonstrate competency before they can qualify for registration with the NMNP Board of Fiji. Two cohorts of the new curriculum have graduated and are now practicing practising in Fiji.

### **1.8 The Rationale for the study**

Nursing education in Fiji has never been a subject of a scientific investigation except in curriculum reviews sanctioned by the Fiji government. Many complaints relating to the skill levels of the Fiji School of Nursing graduates have surfaced in the past few years calling the School to review its curriculum and clinical teaching components. The new programme was implemented on the 18th September 2004; towards the end of a normal academic year for tertiary institutions in Fiji. The Faculty staff pleaded to defer the programme to the beginning of the following academic year citing unreadiness of staff to implement a brand new curriculum. The lack of readiness by the faculty was related to the following:

1. Lack of awareness of the use of competencies by the majority of the teaching staff;
2. The absence of an operational policy to guide staff on the newly developed competency-based curriculum;
3. The absence of competency assessment criteria and guidelines from the Nurses, Midwives and Nurse Practitioners' Board (NMNMP) to guide the faculty;
4. The lack of relevant resources required to support the implementation of a new curriculum;
5. The faculty had neither the time to create awareness of the changes in the curriculum nor to develop the required assessment forms and formats for the competency-based curriculum; and
6. There were two other cohorts of students from the older curriculum who numbered 164 and 144 in class and were in the second and third years of the

programme respectively. Both cohorts were taught by the same number of staff who were also expected to teach the new curriculum.

Apart from the difficulties stated by faculty, the first intake student roll was 198. Since 1983 the process of selecting students for the Fiji School of Nursing was the prerogative of the Fiji School of Nursing. However in the past eight years staff from the MOH headquarters, who are not nurses but general office administrators, are included in the selection committee. This committee conducts interviews and selects students for the Fiji School of Nursing, with minimum contribution from or consultation with the school. The absence of faculty's decision-making powers in relation to student intakes is compounded by the lack of resources and aggravated the problems in teaching and learning processes, which ultimately affected the performance of students. The problems faced by the faculty in implementing a new curriculum were further compounded by the use of clinical competency assessment methods for assessing clinical skills of students.

The faculty staff after the implementation phase became aware of the limitations of the competency-based curriculum against a population that expects our nurses to be expert practitioners on graduation. Such limitations included the lack of clinical experience plans for year one students and the requirement that they be rotated only to low care clinical areas. Fiji does not have low care institutions except for the few old people's homes that are managed by the social welfare department of the government. Moreover, the lack of clinical tools and objectives for clinical learning created a lot of anxiety amongst staff at the Fiji School of Nursing. Other limitations of the competency-based curriculum realised by the staff after its implementation included the nature of the competency assessment forms, which were not clearly understood by both teachers and clinicians. The high number of students in the class compared to the clinical hours and the areas that needed to be covered made an impossible demand for competencies to be attained by students. The first graduates of the new curriculum delivered by the Fiji School of Nursing and the TISI Sangam School of Nursing began work in Fiji in September 2007 and February 2008, respectively.

As a faculty member of the Fiji School of Nursing, I know from experience our graduates are expected to work with minimal supervision after graduation. There are no supportive programmes to support graduates after graduation; the shortage of experienced registered nurses does not allow them the luxury of being under supervision in an internship programme, and the general lack of resources to support any such programmes are some of the issues that are of concern to the Fiji School of Nursing.

The impact of the competency-based curriculum and its method of clinical assessment can have far-reaching impacts on the lives and general wellbeing of Fiji's population. Competency-based curricula have been implemented successfully in more developed countries such as New Zealand and Australia for reasons, which are related to the context of nursing practice in those countries. However, the success of a curriculum approach used in one country does not guarantee the same success in the next country. Thus, research into the contextual relevance of the competency-based curriculum for under-graduate nurse education in Fiji may yield insights into the indiscriminate use of international curricula and other educational reforms and could thus help make nursing education more relevant and appropriate for nurses who practice in Fiji. Fiji's physical geography, the remoteness of some of its inhabited islands and the interior of the two main islands pose a challenge to maintaining the best and most comprehensive medical services.

The adoption of a qualitative research design and the triangulation of research methods such as case studies and the *Vanua* (Indigenous) Research Framework for this study is the first one of its kind in Fiji. For the first time the relevance of a curriculum programme in nursing in Fiji is being investigated. The research is useful and relevant to my work as a nurse educator in Fiji and it will also be relevant for other similar societies in the Pacific who may be exposed to similar curricula problems or difficulties.

## **1.9 The Aims of the study**

The aims of the study are as follows:

1. To explore the 2004 competency-based Diploma of Nursing curriculum document in its origins and nature, its implementation process, identifying its strengths and shortcomings, its relevance to Fiji; and to make appropriate recommendations for its improvement;
2. To examine the ways in which the people involved (teachers, students, clinicians and the consumers of health services) responded to the curriculum change and their experiences in the implementation of a new curriculum;
3. To discover the relevance of nursing and health knowledge taught within the nursing curriculum to meeting the health and nursing needs of the Fijian people;
4. To provide policy makers with relevant information and insights that may contribute towards more effective formulation and implementation of future curriculum change and innovation; and contribute to the research literature on curriculum change in nurse education in developing countries.

### ***The research approach***

A qualitative research approach was considered an appropriate framework for this study. Morse and Field (1996) suggested the use of qualitative research methods when there is little known about a phenomenon or when the investigator suspects the available knowledge about a phenomenon or theory may be biased. Although descriptions of qualitative research methods given by different authors vary considerably, Burgess (1985) points out that most writings devoted to qualitative research emphasise participant observation and in-depth interviews that allow the researcher to learn firsthand about the phenomenon under study. Qualitative methods are useful when a phenomenon is described from an 'emic' perspective which is the perspective of the native, the indigenous, the patient or the caregivers or relatives (Vidich & Lyman, 1994). Stake's (1995b) case study method guided the research and this is discussed in depth in chapter four of the thesis.

The focus of this study is to explore the relevance and the appropriateness of an educational change in a nursing programme in its ability to meet the health needs of the indigenous people of Fiji. An appropriate indigenous framework known as 'Vanua' research developed by Nabobo-Baba (2006) was used to inform the methodology of research. *Vanua* research is an attempt to decolonise research methodologies, which have been claimed to be perpetuating colonialism, and breeding neo-colonialism in previously colonised societies (Smith, 1999). Similar to *Kaupapa Maori*, *Vanua* research is based on Fijian epistemology and the holistic integration of the people, the land and their spiritual dimensions. The research framework identifies its characteristics, its nature, its research ethics, methods of data collection and analysis. A detailed discussion of the framework is presented in chapter four of the thesis.

The following research questions guided this study:

- a. What were the main objectives of the 2004 Diploma of Nursing curriculum?
- b. Why did the Fiji School of Nursing change its curriculum for the under-graduate nursing programme?
- c. Who were the participants in the development and the implementation of the curriculum?
- d. How relevant was the curriculum in terms of its content, teaching methods used and the assessment of students learning?
- e. How was the curriculum administered?
- f. What were the major factors affecting its implementation?
- g. How relevant were the methods of clinical assessment to the context of nursing practice in Fiji?
- h. What was the general expectation of the stakeholders (i.e. the MOH, the clinicians, faculty staff, the consumers) of the graduates' skills levels at graduation?
- i. What broader organisational changes and processes could be implemented in Fiji in order to better support a curriculum change such as the current Diploma of Nursing curriculum taught at the two schools of nursing in Fiji?

## **1.10 The organisation of the thesis**

The thesis is organised into nine chapters.

*Chapter one* provides the context and an overview of the study and sets out to describe the aims and the rationale of the study. It also describes the research questions and the research approach taken for the study.

*Chapter Two* introduces and discusses the colonial context of nursing education in Fiji. The colonial experience influenced and impacted the development of educational ideas and philosophies that guided the nursing curricula in Fiji.

*Chapter Three* provides a critical review of literature for this study. The chapter focuses on the curriculum under study drawing on the literature on competency-based curricula for nurses, the educational philosophies and their relevance to a variety of educational contexts.

*Chapter Four* discusses the methodology and a detailed description of the fieldwork that was undertaken to collect the data.

*Chapters Five and Six* discuss the analysis and the results of the study. The findings are presented under major headings or themes as they emerged from the analysis.

*Chapter Seven* is a presentation of the analysis of the curriculum content using the Vanua research framework to identify its relevance and safety for the indigenous people of Fiji. The chapter also describes the analysis of the teaching methods and their appropriateness for indigenous students.

*Chapter Eight* presents discussions on pertinent issues and themes that emerged from the study and the implications for nursing in Fiji.

*Chapter Nine* is the final chapter, which discusses the implications of the study. It includes practical considerations and recommendations in curriculum development in the Pacific, the theoretical implications of the study, its limitations and the implications for further research in the area of competency-based curriculum.

The impact of using an indigenous framework in this study and its implications for future researchers in health in Fiji is also discussed.

## **1.11 Summary**

This chapter has provided an introduction and an overview of the research and presented briefly the nature of the curriculum and the background to its implementation. The next chapter describes the context in which the curriculum was developed and implemented and explores how the context can create a major influence on the success or failure of the curriculum change.

## **Chapter 2: The colonial experience of nursing**

### **2.1 Introduction**

Colonisation is a practice by which a powerful country directly controls a less powerful country and uses their resources to increase its own power and wealth (Wendt, 1972). In such a system of government, there is usually a degree of oppression and subordination of people, culture and ideas by the coloniser, which can alienate the colonised in their own country. There is also a prevalent spirit of superiority of the powerful over the powerless, which could lead to lasting psychological oppression, or to an inferior mentality of the oppressed population. The colonisation of a country involves the control and total domination of all levels of existence of indigenous people including their cultures, their institutions and identities. In Fiji, Nightingale's regimental and secular based ethos dominated Fijian indigenous values of caring which thrived in a prevailing British colonial system of government. The use of Freire's model (1993) to study the prevalence of oppressed group behaviour in nurses is evidence of this concern within the profession (Matheson & Bobay, 2007). In this chapter, Fiji's colonial history as the context of the development of nursing is described and further explored in its influence on nursing education and practice.

### **2.2 Fiji's colonial history**

Over two hundred years after its first sighting by Abel Tasman in 1643, Fiji was voluntarily ceded to Her Majesty Queen Victoria of Great Britain in 1874, by its chiefs, who sought protection from unscrupulous European settlers, dealers and traders that were already active in the Pacific. Derrick (1946) recorded that some settlers, marooned sailors and deserters "were the lowest and worst scouring of the ports of the old world" (p.37). They contributed to the internal tribal unrest as well as the dubious appropriation of lands from the indigenous Fijians. However, these were not

the only Europeans or foreigners to impact Fiji prior to British colonisation. Christian missionaries also arrived in 1835 to evangelise indigenous Fijians.

The cession of the Fijian islands specifically entrusted Her Majesty Queen Victoria and her heirs to rule Fiji and her people “justly and affectionately”(Wright, 1986, p. 179). This had implications for the colonial experience Fiji went through for its 96 years under British rule. The document called the Deed of Cession contained the aspirations of the Fijian chiefs and their request for direct governance by Great Britain. Britain ruled that the indigenous Fijians were to be governed separately and indirectly by their own hereditary chiefs within their own customary laws and traditional culture, and that they would continue to own and occupy their traditional tribal lands (Macnaught, 1982). The Deed of Cession prohibited the sale of native lands and facilitated the repossession of some native land wrongfully taken from the Fijians by Europeans. The Deed of Cession also prohibited the forced labour or employment of the Fijians by European farmers and preserved Fijian customs and traditions by upholding them as governing laws within their traditional villages or communities. The colonial government became its guardian, with the first Governor of the colony confiscating all lands already possessed by the European settlers and returning them to their indigenous owners (Macnaught, 1982). An indirect taxation system of chiefs by the colonial government ensured that ordinary Fijians paid their taxes in kind to their chiefs who were in turn taxed by the government in the form of produce, which was sold or exported by government for revenue. Indigenous Fijians therefore lived separately and culturally isolated, discouraged by colonial rules to integrate with the other ethnic groups. Remarkably after 96 years of British rule, Fiji emerged at independence with most of its traditional institutions, land ownership, cultures and customary processes intact, but with an extensively colonised state of mind and worldview.

## **2.3 Colonial influences on health and the development of health institutions**

The cession of Fiji to Great Britain set forth a number of events that influenced the development of the health care institutions in the country. Such events included the Cession ceremony itself where indigenous chiefs from remote parts of the country, who had limited previous exposure to Europeans, converged to witness the event on the former capital of Fiji, which is located on the island of Ovalau. The convergence of Fijian high chiefs also demanded the observance of lengthy ceremonies and an extended period of time was spent on the island due to the nature of transportation at the time which was mainly through canoes or ships (Haggett & Cliff, 1985; Macnaught, 1982; Scarr, 1984). The immediate impact of the Deed of Cession and the subsequent gatherings of high chiefs on Ovalau to observe traditional Fijian protocols was the outbreak of several diseases. Such protocols are documented by Haggett and Cliff (1985) in their geo-spatial study of the spread of measles in the Pacific. Contrary to popular beliefs, the measles epidemic was introduced into Fiji by its own chiefs, who were on an official visit to Sydney, Australia, after the Deed of Cession in 1874. The movement of the measles from Sydney to the Pacific, which infiltrated the isolated indigenous Fijian tribal societies, occurred when these chiefs returned following an elaborate welcoming ceremony. The impact of the measles on the indigenous population was intense and devastating, compounded by the effects of the other new diseases affecting the indigenous Fijians. The 1875 measles epidemic reduced Fiji's indigenous population by two thirds and threatened the colonial government's native 'preservation' policies. It was labeled the period of the 'great decrease of the race', marked by high infant mortality rate and the continuing decline of the indigenous population (Haggett & Cliff, 1985).

An ongoing labour problem for the new colony resulting in the importation of labour from outside Fiji was a major event that greatly influenced the health outcome of the country. The inability of European planters and settlers to employ Fijians pushed the colonial government to the importation of indentured labourers from India and other

Melanesian countries in the Pacific such as the Solomon Islands and Vanuatu (formerly British Solomon Islands Protectorate and New Hebrides respectively). With the migration of Europeans into the Pacific, socio-cultural contact and assimilation were inevitable and so were the resultant foreign diseases that afflicted the indigenous populations. The influx of migrants to Fiji also brought in diseases such as Tuberculosis, Typhoid, Dysentery, Chicken Pox and sexually transmitted diseases. The fatal impact of introduced organisms and diseases to which indigenous groups had not been previously exposed to was similar in most colonised countries of the world including Fiji (Gracey, 2009).

The work of Christian missionaries in the islands, which began in the early 1830s, is well documented (C. Knapman, 1986; Lukere, 2002; Mangubhai, 1984a; Otsuka, 2006). Missionaries not only changed the indigenous Fijians spiritual beliefs but also taught them to read and write, as well as to use western medicine and a western concept of caring. According to Knapman (1986) missionaries who came from England had their wives trained as nurses in Australia before travelling to Fiji. Missionaries, especially the Methodists and the Roman Catholics, built small cottage hospitals and training schools in major parts of Fiji including Labasa, Kadavu and Ba. In the 1980s, only the Ba Mission hospital and nurse training school was left and that was eventually taken over by the Fiji government in 2004. The Roman Catholic church owned the Naiserelagi maternity hospital in the province of Ra. Christian missionaries worked mostly with the Fijian and Indian communities while the colonial government and private companies provided the medical and nursing care for the European population. Such work continued well into 1930s when New Zealand took over the administration of the country's nursing service in order to standardise nursing care for all populations (Lambie, 1956).

## **2.4 Regionalism in the Pacific**

Nursing developments in Fiji were also influenced by the early regional approaches to improving health services within the Pacific British colonies such as Fiji and Samoa. The development of regional organisations and the renewed interest in the Pacific by the

colonising powers are important as they influenced the development of nursing education in Fiji and the Pacific. One of the earliest regional approaches to Pacific problems was the formation of the South Pacific Health Board (SPHB) in 1944 to oversee the health services and the training of health personnel for the Pacific island British colonies or dependencies. The SPHBs work influenced the regional approaches to the preparation of medical and nursing personnel of Pacific islanders as well as the standardisation of health services for all island countries. New Zealand, as the administrative arm of Great Britain in the Pacific, administered the health services of Samoa from 1920 to 1965 and Fiji from 1936 to 1970. New Zealand dominated the SPHB in terms of membership and in its interest in overseeing the work and welfare of its New Zealand nurses and doctors working out in the islands (Lambie, 1956). The SPHB became redundant when British colonies like Samoa and Tonga gained independence in the early 1960s; and Fiji and Kiribati followed in the 1970s. The health functions of the SPHB were taken over by the South Pacific Commission (SPC), which was established in 1947 with the USA, Great Britain, France, Australia, New Zealand and Holland all taking the lead to strengthen international cooperation over socioeconomic welfare of the people of the Pacific (Oliver, 1989). The SPC was established and located in Noumea. It functioned as an advisory body to the South Pacific administrations on issues related to economic development, social welfare, education and health, while maintaining a non-political and non-military stance.

After the Second World War (WWII), many regional health activities and campaigns were commissioned from Wellington for the Pacific island colonies. The USA-based Rockefeller Foundation led a campaign against yaws and other tropical diseases in the Pacific (Lambie, 1956). New Zealand was actively involved in the implementation of the many health and rehabilitation projects and plans for the rest of the Pacific colonies such as Fiji, Samoa, British Solomon Islands and others. The Rockefeller Foundation's significant influence in the Pacific was funding the centralisation in Fiji of training for both medicine and nursing for the Pacific islands (Guthrie, 1979).

## **2.5 British colonial influence on the Development of Nursing**

Historically, the development of nursing and nursing education in Fiji is similar to New Zealand and Samoa in that they were all British colonies and their educational ideologies were heavily influenced by Great Britain. Fiji, like its other Pacific counterparts was also heavily influenced by the developments of nursing in England, especially the Nightingale system of training. From the late 1860s to the 1880s, Pacific colonies such as Australia, New Zealand and Fiji were already receiving their first batch of fully trained and qualified nurses from London's St Thomas' Hospital (Kinross, 1984; Lambie, 1956; Russel, 1990). These Nightingale ladies set up training programmes wherever they practised without wasting any time. Their efficiency and professionalism were noticed everywhere and this further enhanced Nightingale's image and reputation for being the greatest nursing reformist in her time. Australia received her first lot of nurses from England in 1860, New Zealand in 1883 and Fiji in 1892 (Kinross, 1984; Russel, 1990; Volavola, 1988).

From 1897 onwards, European women in Fiji were trained by British nurses, recruited from St Thomas' hospital in England. Similar to Nightingale's school in England, the Lady Probationer programme was set up in Suva's Colonial hospital and enrolled European nurses. The graduates from this programme were able to get registered in New South Wales, Australia. While European nurses worked within the hospital, and nursed the European patients, the indigenous Fijian nurses were sent out to the rural communities to care for their people who in turn paid for their services in kind. However, the indigenous Fijian nurses who were trained under the six-month Obstetrics programme and supervised by European nurses were also expected to emulate the Nightingale ethos and its philosophy. Supplemented with strong regimental discipline, the Nightingale system of training revolutionised the quality of nursing everywhere and set the pace for nursing service and education in Fiji, which has continued to this day. As a result, the Nightingale system of training and its nursing ideologies, such as hospital based education for its nurses, continued to influence Fiji

for more than 100 years; change was unacceptable and often strongly resisted not only by nurses themselves but by the general public as well.

Apart from nurses' registration through the recognition of nursing programmes for European nurses in Fiji, Australia's influence is reflected in the numerous small scale nursing schools and cottage hospitals. These were built across Fiji for the various Christian churches that were based in Australia but were evangelising in Fiji. Australia was also influential in the provision of nursing and health services for Australian companies such the Emperor Gold Mining and the Colonial Sugar Refining company workers and their families. Australia's link was effectively terminated when New Zealand took over the administration of nursing services in the country at the invitation of Fiji's colonial government. The changes were completed when the Australian nurses returned to Australia and were replaced by New Zealand registered nurses in the health service as well as in the nursing school (Lambie, 1956).

## **2.6 The basis of Separatism and Elitism Fiji**

The separatist policy of Fiji's colonial government, which marked its colonial administration worldwide, was well established and accepted by indigenous Fijians. An already hierarchical society, indigenous Fijians accepted the elitist approach to their separate governance led by their own hereditary chiefs at communal and provincial levels (Wright, 1986). From the initial period of colonisation in the 1870s to the 1960s, segregation and ethnic isolation into provincial boundaries was reinforced by the use of Fijian customary laws to legitimise western laws of trespassing into towns and designated European territories. While the separatist policy of colonial government worked well with the use of the elite Fijian chiefs as the colonial mouthpiece to their own people, the Fijians were contented that such a system of government preserved their culture and their identity as indigenous Fijians (Macnaught, 1982). However, Battiste (2000) contends that isolation and segregation of the colonised people is an important colonising tool with devastating results:

A fundamental weapon used by colonisers against the colonised is to isolate the colonised from outside sources of information and knowledge and then

bombard them with propaganda carefully aimed at convincing them that they are backward, ignorant, weak, insignificant and very, very fortunate to have been colonised (p. 7).

The separatist policies of the colonial government influenced the whole country and its administration. The indigenous Fijians were administered within a local government system known as the Native Affairs governed by hereditary chiefs. Similarly the organisation of churches and schools from primary to secondary levels followed racial lines. Within the education system Europeans had their own primary and secondary schools while the elite Fijians (children of chiefs) were sent to special schools separate from commoner Fijians. Such an arrangement of schooling for Fijian chiefs prepared them for employment in the government administration system and was seen as a strategy for the total colonisation of the Fijian people (Macnaught, 1982; Wendt, 1972).

#### ***Separatism in nursing education and services***

The policy of separatism marked the beginning of nursing education in Fiji in the separate training of European women and indigenous Fijian women (Lukere, 2002; Volavola, 1988). Lambie (1956) noted in 1926 that two separate classes were conducted for nurses in Fiji. In 1907, indigenous Fijian women were separately trained by British nurses in a six-month obstetric nursing course that had no written syllabus or programme. These women, according to Lambie (1956), were ill prepared for work within a community which was rife with infectious diseases. However, Lukere (2002) contends that the obstetric training prepared the indigenous nurses for their main mission which was to help counter and eradicate the practice of traditional Fijian midwives in indigenous communities.

The spirit of separatism continued after the initial relocation of European training from Fiji to New Zealand in 1926 in the form of the New Zealand General Nursing curriculum being taught from Fiji in 1955. The New Zealand curriculum's relocation to Fiji served two purposes: one was to discourage and redirect Pacific island women from training in New Zealand to a central school in Fiji and also to provide opportunities for indigenous nurses with academic abilities to aspire to becoming

sisters and being in-charge over their own people. The separation of the training and administration of European and indigenous nurses in Fiji epitomised the culture of separatism and elitism in colonial Fiji and the degree to which it was silently accepted by indigenous Fijians indicated the depth of colonisation of Fiji and its people.

The provision of health services also separated the services of indigenous Fijians and Europeans into separate hospital wards, where European nurses cared for their own and Fijian nurses looked after their own people. In addition to separate health services, two separate systems of remuneration existed for Europeans and indigenous nurses and doctors. While the colonial government paid for the services of European nurses who were also civil servants, the department of Native affairs paid for the non-civil servant indigenous Fijian nurses (Volavola, 1988).

By 1938, New Zealand had initiated changes by taking over Fiji's nursing service as well as reviewing and reorganising the training programme for both the Europeans and indigenous Fijians. New Zealand registered nurses (NZRN) were placed in charge of the hospitals, community health and child welfare units. A one-year training programme for Indigenous Fijian nurses was created and the programme for Europeans was stopped by transferring the remaining students to New Zealand to complete their training. New Zealand reviewed the Fijian indigenous nurses' curriculum twice; once in 1938 and again in 1945 resulting in a two-year and a three-year curriculum for general and obstetrics nursing respectively (Lambie, 1956). With funding from the Rockefeller Foundation, New Zealand was able to implement the NZ General Nursing curriculum with the establishment of the Central Nursing School in Fiji in 1955. The localization of the NZ curriculum in Fiji centralised nursing education for the countries of the South Pacific. This arrangement was later perceived by the indigenous nurses as a 'reproduction' of the European class and created deep seated divisions amongst the indigenous Fijian students of both New Zealand and the Fiji classes (Volavola, 1988). New Zealand continued its administration of the nursing services in Fiji until Fiji's Independence in 1970, however supervision of the NZ curriculum by the Nursing

Council of New Zealand continued until the programme was phased out from Fiji in 1977.

Colonial leaders in Fiji's legislative council from 1936 to 1946 debated Lambie's proposal for changes in the training of nurses in Fiji. The issue of training different ethnic groups of nurses in one programme under one roof was unacceptable to Europeans and the type of nursing service that each group could be employed in was just as ethnically sensitive thus the debates reflected the deep seated problems about ethnic segregation prevalent at the time:

The greatest demand we have at present is in child welfare system which works in the field, and in most of these places part-European girls could not be employed. We would not staff the Colonial War Memorial hospital fully with part Europeans because we must use that as our training hospital for Fijians...(council papers 28. Para 9 cited in (Volavola, 1988, p. 36).

I think in all country hospitals, it would be very desirable to have probably a European sister in charge, and a part European assistant under her- a girl who has been trained, and the Fijian girl, and then the Indian, and possibly native nurses below them (Hon H.B.Gibson) cited in (Volavola, 1988, p. 37).

Such debates on ethnic stratification also reflected the social attitude prevalent at the time. European doctors and nurses only practised on European patients, and the same for other ethnic groups. Just as it was seen as degrading for a European to practice on indigenous Fijians or Indians, it was equally unthinkable for the different ethnic groups, the Europeans or part-Europeans and the indigenous Fijians to train within the same hospital (Colony of Fiji, 1946). New Zealand's reorganisation of nursing in Fiji in 1936 after Samoa in the early 1920s reinforced the already existing separatist ideologies that were prevalent in Fiji.

### ***Nursing services and administration***

At the time of New Zealand's involvement with nursing in Fiji, indigenous nurses, although supervised by New Zealand, worked within the Native Affairs department, which was a separate establishment from the colonial government. The nurses were therefore not employed by the colonial government but by the various provincial establishments they were assigned to. The New Zealand nurses worked mainly in the

hospitals as Matrons and sisters in charge as well as in the newly established Child Welfare Clinics. The School of Nursing was administered by the New Zealand Nursing Council and staffed by New Zealand sisters as tutors. Even though the indigenous Fijian nurses worked under the supervision of New Zealand nurses, they were not directly administered by the colonial government. The Fijian nursing service and those of Samoa and other Pacific Island colonies were directly administered by the New Zealand Department of Health's Island nursing division (Lambie, 1956). While the Fijian colonial government paid the salaries of the New Zealand nurses including their superannuation contributions to New Zealand, the indigenous nurses were paid by the Native Affairs department.

### ***Separatism perpetuated by the New Zealand curriculum in the Pacific***

By the end of 1953 the New Zealand Nursing Council advised the South Pacific Health Board, an authority administering the Pacific health services based in Wellington, that the New Zealand curriculum would be taught from Fiji from 1954 (Barclay, et al., 1998; Volavola, 1988). The New Zealand curriculum was offered separately from the local Fijian three-year certificate of nursing and obstetrics programme also administered by the New Zealand Nursing Council. The New Zealand curriculum was offered in Fiji for the first time in 1955, when the New Zealand government with funds from the Rockefeller foundation established the Central Nursing School in Suva, catering for the regional students of the Pacific islands. The School was modelled on the Fiji based Central Medical School; which had become the Pacific region's medical training centre.

While the New Zealand curriculum enrolled students with higher academic abilities, the local Fijian curriculum enrolled those with a slightly lower academic ability. This created a two-tier system where those in the New Zealand curriculum graduated as New Zealand registered 'sisters', and those graduating from the Fijian curriculum were Fijian registered Staff Nurses, working under the supervision of the New Zealand registered nurses. The graduates were categorised into the 'boss' (Sister) and the 'worker' (Staff Nurse), where the Sisters were treated favourably by the government through the provision of houses, allowances, higher salaries, in-service training and

opportunities for overseas in-service training. Similar effects were recorded in Samoa where New Zealand registered indigenous nurses were more privileged than their local counterparts, which according to Barclay et al. (1998) perpetuated a colonial and neo-colonial relationship between Europeans and indigenous nurses and later on amongst the indigenous nurses themselves. In Fiji this system of training contributed to hostile relationships between the two separate graduate of indigenous nurses, and influenced the establishment of two separate nurses' organisations, which existed in Fiji for almost 20 years (Volavola, 1988). The system of training re-introduced the separatist system which had earlier existed in Fiji, whereby the New Zealand registered indigenous sisters supervised indigenous staff nurses, and helped perpetuate a neo-colonial relationship between the indigenous graduates of both curricula.

## **2.7 Educational ideas in Fiji and the Pacific**

Crocombe (1989) made an interesting comparison of educational and administrative ideologies prevalent in the Pacific during the colonial period by the colonising powers of Great Britain and France. He identified two main political systems that existed in the Pacific pre-European contact: aristocracy in Micronesia and Polynesia (which includes Tonga, Fiji, Hawaii, Cook islands, Samoa) and democracy in Melanesia (which includes Solomon Islands, Papua New Guinea and Vanuatu) (Crocombe, 1989). He found that the British government upheld and reinforced chiefly systems, and to a large extent traditional cultures were preserved. On the other hand, Crocombe (1989) observed France systematically destroyed traditional chiefly systems and introduced government policies that aimed at imbuing indigenous peoples with French culture and nationalism.

### ***Separatism and elitism in education policies***

According to an early Pacific educator Albert Wendt (1972), Christianity and colonisation had one common objective; to change the indigenous people from their primitive culture to the superior culture of the settlers. Educational policies prepared chiefs and their children in separate institutions from commoners by building separate

schools. Commoners were educated in district public and mission schools. European children were educated separately from the chiefs and other ethnic groups in schools, such as Suva Grammar School or the Levuka Public School, while Christian missions also had their own schools for most of their congregations. Wendt (1972) described the irrelevant education curricula in the Pacific designed by the colonial powers as similar to a 'lobotomy operation or a lifelong dosage of tranquilizers'(p. 2). According to Wendt, the education systems of the South Pacific were not programmed to educate people for development, but to "fashion minor and inexpensive cogs for the colonial machine such as clerks, glorified office boys, typists, officials of all shapes and sizes and a few professionals all made to be subordinate and dependent on European expertise- European culture"(p. 2). Formal education in the South Pacific was usually based on the assumption that the cultures of the colonisers were superior to indigenous cultures, and thus reinforced their ideologies and the hegemonic relationships that ensued. Education functioned as an agent of socialization for the European culture and had a dominant influence in the Pacific impacting all Pacific cultures and people.

## **2.8 Colonisation of indigenous knowledge and spaces**

The colonisation of indigenous spaces for Fijians includes the replacement of traditional practitioners of health with non-traditional practitioners and the usurpation of the respect and authority normally accorded to the traditional healers by the newly trained indigenous western practitioners. Lukere (2002) documented that the Fiji colonial administration's decision to train Native Obstetric Nurses in 1908 was directly related to the decrease in population and the "intense disapproval" of traditional midwives and their 'barbaric practice' (p. 103). Many indigenous peoples, especially the most vulnerable (infants and children), did not survive many of the diseases and infections introduced by incoming migrants. While Fijian men from chiefly households were trained to help with vaccinations and thereafter for medical practice (Montague, 1930), Fijian women of chiefly ranks were also trained as Native Obstetric Nurses to help change the indigenous practices of health (M. C. Anderson, 1945; Cereby,

Undated) and as a strategy to administer and make the Public Health Act more acceptable to the Fijian people (Volavola, 1988). It is argued here that the introduction of nursing education, first for obstetric nurses and later for general nursing, was a deliberate policy of the colonial government to change the customs, the traditions and health practices of the indigenous Fijians. This was achieved by shifting the blame for the high mortality rates of infants from foreign diseases and poor immunity, to the indigenous mothers and Traditional Midwives and their health practices.

The policy to replace traditional midwives with Native Obstetric Nurses was supported by the Christian mission schools' curriculum which sought to construct indigenous mothers and traditional practices of health as backward, dirty and uncivilized (Lukere, 2002). As the main candidates in mission schools were indigenous Fijian students, the mission schools were also active in the colonisation of indigenous knowledge and spaces by supplying candidates for nursing. Lukere (2002) records the nature of the examination papers for mission schools in which students are asked to provide reasons for the high infant mortality rates of indigenous Fijians. Some answers given by students included:

Because their mothers do not take care of them... There is altogether too much dirt and filthy...If a child is ill, let it be taken at once to the doctor...Let the chiefs stir themselves to buy cow's milk so that little children may be able to get good milk when necessary (p. 109).

Indigenous Fijian children were first educated to criticise and reject their own cultures and to challenge Fijian traditional authorities. The Christian ideology of 'cleanliness is next to godliness' influenced the general primary school curriculum, and therefore basic hygiene and basic housekeeping skills were deemed appropriate knowledge for young Fijian girls (Mangubhai, 1984a).

The strategy of training indigenous Fijian men and women of high birth to work as medical practitioners and nurses served to remove and replace the traditional holders of health knowledge and practices from indigenous societies. The colonial government took advantage of the respect that indigenous Fijians have for their chiefs which are unquestioned authority (Lukere, 2002; Quain, 1948). The replacement of traditional

healers and practitioners by chiefs and others trained within the western medical model was deemed inappropriate as the traditional leaders of the people could not be the holders of such knowledge. The traditional healers and practitioners maintain a balance of rank and order in Fijian society, and their identity legitimates their spaces and their land-owning rights within their own tribes. The colonial government exploited the Fijians' culture of respect and deference for their chiefs by using such spaces to instil western knowledge and remove traditional knowledge by the very people that are supposed to be custodians of Fijian culture.

Cultural spaces in a Fijian context also refer to abstract notions such as respect normally accorded to people of rank, spiritual reverence, authority and expertise. Such spaces as that normally accorded to traditional healers were removed and re-distributed to Fijians whose traditional roles in society are different. Respect for healers was replaced by doubt, rejection and challenge by the same indigenous people they are supposed to serve. The impacts of the colonisation of indigenous knowledge and spaces have been linked to socio-somatic disorders characteristic of social dislocation, dispossession and impoverishment of indigenous people (Kunitz, 1994).

## **2.9 De-colonisation and Self-determination**

In the early 1960s, the movement towards independence of former British colonies all over the world became eminent in the Pacific as Western Samoa took precedence in declaring independence in 1968, followed by Fiji in 1970. Decolonisation brought in independence and self-determination; and for some, freedom. However, political independence and self-government also means greater responsibility and accountability for decision making and governance. In the words of Fiji's first Prime Minister Ratu Mara, "Among the more formidable tasks we had to assume on independence was responsibility for the conduct of our own foreign affairs department and policy"(Mara, 1997, p. 113). Similarly, Fiji had to establish its own health service department and policies as well as many other new service departments.

The declaration of Fiji's independence severed formal colonial ties with New Zealand and impacted government administrations including the health services and nursing education. Fiji's health services replicated health policies of the previous colonial government and took over the administration of the two education institutions; the Central Medical School and the Central Nursing School. Greater responsibility and accountability for practice was also placed on the newly formed Fiji Nurses and Midwives Board (now the Nurses, Midwives and Nurse Practitioners' Board of Fiji).

New Zealand continued to offer its General Nursing curriculum in Fiji until it was withdrawn in New Zealand in the early 1970s. The withdrawal of the New Zealand curriculum meant that Fiji needed to develop its own curriculum and for the first time since the 1930s had to supervise its own nursing education programme. Fiji's newly acquired self-governing status provided direct access to services from the World Health Organisation and major funding agencies to support health education programmes and services. As a developing country, Fiji was regarded as an aid receiving country and was therefore offered aid in a variety of forms by developed countries and international organisations (Mara, 1997). Similar opportunities for funding and external aid contributed to the consecutive developments and implementation of nursing curricula after the withdrawal of the New Zealand curriculum in the late 1970s. Fiji phased out both the New Zealand and the previous Fijian curricula in 1977, and in 1978 implemented a WHO funded comprehensive general and obstetrics curriculum using the 'Body Systems' approach. For the first time there was going to be only one curriculum for all nurses in Fiji. The Fiji School of Nursing changed its name from its regional status of Central Nursing School. This curriculum was taught until a Diploma of Nursing curriculum was developed with WHO assistance and implemented in 1983. It can be argued that externally funded educational projects and curriculum change for nursing have contributed to the persistent imposition of foreign nursing values and medical ideologies in Fiji's nursing practice.

## **2.10 Summary**

Nursing education in Fiji continues to be influenced and dominated by its colonial heritage. Such influences include the early separatist policies of the colonial government which dictated the separate educational systems for European and indigenous nurses and the separation of health services for indigenous Fijians and Europeans. The chapter also exposed the powerful hegemonic position of the dominant western medicine and its culture over the education of nurses and the administration of health. Such domination of western medicine over indigenous health perspectives reflects the depth of colonisation of the indigenous Fijians and their knowledge systems. The chapter also discussed one of the earliest regional educational ventures in the Pacific which was the regional training schools for nursing and medicine; both of which were externally initiated, funded and facilitated the colonisation of indigenous ideologies of health as well as western educational philosophies. The next chapter presents a critical review of international literature on such educational ideas that continue to be externally initiated in Fiji and their fit in the context of indigenous health and practice in Fiji.

## Chapter 3: Fiji Nursing and Educational Change

### 3.1 Introduction

Historically, nursing education has undergone unprecedented changes in the past century in terms of its structure, focus of curricula and its location in educational institutions. The early development of nursing and nursing education was influenced by its dominance in hospital reforms and the culture of preparing nurses for hospital leadership and authority. The absence of research literature on nursing education and curricula in the Pacific signifies the depth of colonisation, the degree of assimilation of the indigenous nurses by western medical and nursing knowledge and the invisibility of indigenous nurses in positions which would enable them to contribute positively to the literature and evidence on indigenous nursing.

The previous chapter described the colonial context of the study, including the impact of colonialism on the development of nursing education and services in Fiji. This chapter presents Fullan's educational change theory and the Fijian indigenous *Vanua* research framework, as theoretical frameworks for this study. These frameworks enable the research to locate the components of the curriculum change process such as the participants, curriculum and the change process itself within the educational context of Fiji. This chapter also reviews literature on the major issues that impact on nursing education and practice in Fiji, such as the changing approaches and designs of nursing curricula, colonisation and educational hegemony, educational change and external aid in education, and the issue of indigeneity in western health systems.

In the past two decades, a strong theoretical understanding of the stages of educational change processes has been covered in literature. Significant in educational change and school reforms is Fullan's work (1991; 2007; 2008) which also

comprehensively draws on his contemporaries in educational change research such as Berman and McLaughlin (1978) and Huberman and Miles (1984). Fullan's work is especially relevant and useful as a framework in understanding the processes of changing the Diploma of Nursing programme at the Fiji School of Nursing.

Fullan (2007) identified three interrelated phases in the educational change process. These are the initiation phase, the implementation phase and the institutionalisation phase. Generally, Fullan's change theory has applicability to national initiatives or whole systems reforms as well as school based changes, developments such as curriculum initiatives and reforms. Fullan's change theory describes the dynamics of interactions and interrelationships amongst the variables and components of the change process such as individuals, and structures within an organisation. Such interaction internally within the organisation and externally within the organisational context is becoming increasingly important in understanding the success or failure of educational changes and innovations. More importantly, factors within an organisational context that may facilitate or impede the change process (political, economic, socio-cultural and geophysical) need to be understood in the examination of an educational change process. Literature on educational change covers important variables such as those that can impede or facilitate an educational change. Variables such as political histories and influences in educational systems, authority, colonial legacy of differentiation and neo-colonialism, cultural perceptions within academia, and differences in educational visions and perspectives of stakeholders and consumer groups. The *Vanua* indigenous research framework (Nabobo-Baba, 2006) was therefore useful in complementing Fullan's analysis of an educational change. The *Vanua* indigenous framework informed the case study approach in this study and assisted in locating the variables and the participants of the change process within the context of the indigenous Fijians.

The *vanua* indigenous framework is grounded in Fijian epistemology, which is based on the holistic integration of the people, the land and their spiritual dimensions. The Fijian worldview is based on three interrelated dimensions of human existence; *Lagi*

(heaven) *vuravura* (physical world) and *Bulu* (the afterlife world of the spirit or the underworld). Fijians make all references to their customs, their traditional practices and events in this world to the three interrelated concepts. The Fijian view of a person is a composite of three dimensions of God/ancestral spirit, the land and the physical being, and all references to a person (or a family) is made to these three dimensions. Fijians believe that any disturbances or changes in any of the three dimensions or composites will affect and destabilise the others. This view is important in this study as the focus of the research is the relevance of the knowledge component of the Diploma of Nursing programme in preparing nurses to care for the Fijian people.

### **3.2 Educational change: Approaches and processes**

Educational reform and educational changes have long histories characterised by discourses and contests over the rationale for change, the complexity for the participants in the change, for whose benefit is the change and for what results (Macdonald, 2003). MacDonald identified three models of curriculum change and reform spanning the decades of 1960s to the 1970s; 1970s to the 1980s and the 1980s to the 1990s. The top-down approach to change was common in the first decade and sought to minimise the influence of the teachers on the curriculum change, popularising the 'teacher-proof' curriculum package. The top-down approach used subject experts who produced curricula within centrally located units away from schools and the teachers who would eventually implement the changes. Teachers had a subsidiary and strictly implementation role in the process. Teacher-proof curricula were characterised by tight relationships between objectives, curriculum content and assessment tools, and had direct references to prescribed texts from which subject contents were developed. Countries adopting a top-down approach to curriculum also established national curriculum development units, curriculum reviews and supervised implementation at a national level.

Early educational reforms in South Pacific countries from 1970 to 1975, used a top-down approach to changes in the junior secondary school curriculum by producing and

disseminating curricula materials from Fiji, before establishing national curriculum development units within the Pacific island countries (Vudiniabola, 1998). Fiji's 1983 Diploma of Nursing programme used a top-down approach and the tight relationships between the objectives, the contents and the assessments did not allow much space for teachers to be creative, have any major influence over what they taught, to evaluate or make changes. Potential disadvantages of such approaches include teachers becoming disinterested in what they teach and a general lack of creativity and versatility in updating curricula content. Another disadvantage is that teachers become tempted to teach to examinations, and in nursing only examinable skills and procedures are taught.

The bottom-up approach was popularised in the decade of 1970s to the 1980s after revelations of the weaknesses of the top-down approach to curriculum changes. The absence of active teacher participation from the initiation stage to the implementation stage led to the bottom-up approach, also known as School-Based Curriculum Development (SBCD) (Macdonald, 2003). Kemmis and McTaggart (2001) referred to SBCD as the democratisation of curriculum change where the real experts of curriculum development, the teachers, were given the reigns to lead the process. However, literature identified this approach also led to problems such as poorly resourced and assessed curricula, as the content was only as good as the teachers who developed it (Vickers, 1992).

Partnership as an approach to curriculum change evolved from critiques of both the top-down and bottom-up approaches, and according to Fullan (1999), and Kirk (1988) suffered from slippage between conception of ideas for innovation and their practical application in the change process. Fullan (1999) argued curriculum change is collaborative, multidirectional and requires across-boundary collaboration and partnerships amongst administrators, curriculum developers, professional associations, researchers, teacher educators, teachers and parents. In support of Fullan, Adams (2000), and Mc Ginn (1999) pointed out that curriculum change is most effective when both top-down and bottom-up partnerships are used as this nurtures a

sense of ownership of the change, with consequent commitment and accountability by all stakeholders to ensure successful change. Kirk and MacDonald (2001) identified the partnership approach was the model of choice in most health and physical education curriculum changes at national and international levels. However, MacDonald (2003) pointed out when partnership approaches fail, critics tend to blame teacher resistance, incorrect implementation strategies and design rather than flaws in their own assumptions about schooling, teaching and learning.

Theory building in the management of educational change according to Mortimore and Mortimore (1995), can be traced back to Taylor's (1911) work on management. Gross, Chiacquinta and Bernstein (1971) contributed significantly to the understanding of educational change especially at the implementation phase where they identified five important factors critical to the success of the change. These factors include the clarity with which staff understand the innovation, the capability of the staff to carry it out, the availability of the resources required, the compatibility of the existing organisational arrangements and the commitment of time and effort given by the staff to the innovation. The general feature of the change process is that it involves individuals, structures and practices within an organisation and at various levels in the education system. Therefore, thorough understanding of the change process, actors, ideologies and structures involved and effective interaction among them is increasingly necessary for successful implementation of an innovation.

Fullan (2007) identified three broad phases in the change process: initiation, implementation and institutionalisation. Each stage involves change in structure, practice and belief in various combinations. According to Fullan (2007), the initiation phase extends from the first conception of an idea for a change to the decision to implement it. The initiating idea can take many forms ranging from a decision by a single authority to a broad-based mandate to institute reforms and changes. The implementation phase begins with the attempt to put the innovation and practices into wider use (Michael Fullan & Pomfret, 1977). The transition from the initiation phase to the implementation phase needs careful handling so the stakeholders

involved support the ideas and the practices being implemented. The scale of change however, depends considerably on the values, beliefs and expectations held by the participants at various levels in the systems. Institutionalisation only eventuates if the change is accepted and becomes an integral part of practice (A. Sharma, 2000). However, institutionalisation cannot be realised if the change is rejected, modified, postponed or totally abandoned by the stakeholders. Institutionalisation by description may or may not eventuate at all if the change cannot be implemented in its totality. Furthermore, Fullan (2007) maintains institutionalisation is an extension of the implementation phase whereby judgments and decisions for continuation, rejection, modification or abandonment are usually taken. Successful institutionalisation occurs when the change becomes an ongoing part of the system. This depends a lot on the effectiveness of the initiation and implementation phases. According to Miles (1987), institutionalisation is also made possible; (a) when commitment for the innovation to continue is made at policy level; (b) when the external support is adapted to specific institutional needs; (c) where efforts are taken by the institution's leaders to maintain the new practices; and (d) where a sense of ownership among the users exists.

### **3.3 Factors associated with the change process**

There are many factors associated with a planned or action-oriented change. Fullan (2007) designated specific, yet interrelated, factors that contribute to or are associated with successful innovation at different phases of the change process. Factors and variables relevant to this study include; relevance of the innovation to the social and cultural contexts, access to information, advocacy, cultural safety, advocacy from central administration, principal and teacher advocacy, external change, management, community support, government policy, funding, readiness of the users to adopt the innovation, and the availability of the resources to carry it out. While these factors are interactive, the need for change can be embedded in any or several of these factors. It bears mentioning here that political factors (authority, colonial legacy, neo-colonialism), cultural perceptions (both academic and traditional) and different visions of education and development (that is by various ethnic groups and social classes) act

to facilitate or impede the change process. The scale of change, however, depends considerably on the values, beliefs and expectations held by the participants at various levels in the systems.

Goddard and Leask (1992) and Fullan (2007) added other variables relevant to successful initiation of changes such as the quality and clarity of goals and means of changes. These variables may determine the acceptability and adoption of changes or its rejection by stakeholders. Access to ideas for innovation for teachers depends largely on information and communication infrastructures available to them at their point of work. Teachers' work locations, which may include geographically challenged environments and work overload, may influence access to information and can affect the success of an innovation. Nevertheless, education administrators located within urban centres with ready access to communication networks and professional interactions with colleagues may be better positioned to implement change. Fullan (2007) and Huberman and Miles (1984) pointed out how central government or central administration tend to be powerful brokers for innovations, and could be advocates for successful initiation. Likewise, the availability of external change agents such as international donors plays an active role in the initiation of changes in most developing countries. However, Johns (1992) and Sharma (2000) warned that administrators can also promote changes and actively seek funds and resources as a form of legitimising their power, influence and authority within their administration jurisdiction. Furthermore, Sharma (2000) claims developing countries have become dependent on external aid to fund educational innovations, so very few changes are ever planned without first securing funds from external sources.

### **3.4 External Aid in Education**

In the literature, aid is discussed in its designation as official development assistance (ODA) extended to developing or underdeveloped countries by a developed country. This type of aid differs from emergency humanitarian aid, extended by the same developed country for another country regardless of its economic status in times of

natural or man-made disasters. Lim (1985) identifies three reasons why developed countries give aid to other countries. First, is the humanitarian reason that richer countries feel obligated to share their wealth with lesser developed countries (LDC) and with those who are economically poor. Second, external aid is given for the political interest of the donor, especially if the poor countries are strategically positioned to the former. Regional and geographical security for the donor country can be enhanced if the recipient country and population appreciate the spirit in which aid is given, which in the long term may secure lasting friendship and cooperation. Third, aid is given for the economic gain of the donor country itself with no real concerns for the first two reasons.

The provision of external assistance or external aid by the more affluent countries and former colonialists to their former colonies or dependencies became prevalent during the post World War II (WWII) period. At first, the extension of economic assistance was based primarily on humanitarian reasons as the former colonialists could not continue the same degree of assistance for their former colonies. Assistance in the form of technical expertise for agriculture, education, health, human resources personnel maybe provided through external aid. Aid is not only used in recipient countries but a major portion of it could also be used in the donor country by providing educational scholarships or technical training and work experience.

The social and psychological basis and impacts of aid and its contribution to the success or failure of an external aid programme is also an important perspective in the review of literature. Moghaddam (1990) stated that psychological processes such as motivation, attitudes, attributions and perceptions are central to the experience of participants in a developmental project. Allen (1992) declared that no model, hypothesis, or theory of social change is worth much if it simply omits most aspects of human behaviour and makes no reference to how people feel and think about aid and development. Similarly, Carr, McAuliffe, & MacLachlan (1998) stated aid cannot be completely understood without an acknowledgement of the human factors involved in any aid project. The impact of aid on the human capacity, resources and recipients is

multifaceted and requires discussion. Such impacts include feelings of inadequacy and hopelessness when local experts are overlooked for expatriates who may lack necessary basic knowledge, cultures of local countries and needs (Puamau, 2005; Thaman, 1993). In projects where local counterparts are appointed, the exorbitant fees and pay packages paid to expatriate consultants tend to create negative and hostile feelings from the local counterparts (Nabobo, 2003). Such psychological influences have the potential to determine the success or failure of an aid project (Carr, et al., 1998).

The moral foundation of external aid underpins the obligation developed countries have in the transfer of aid to those in the economically poor or underdeveloped countries. Opeskin (1996) identified four principal approaches to transferring resources across countries. First, the giving of aid is morally wrong as it tends to foster a culture of dependency on the part of the recipient. Moreover, giving of aid tends to discourage self-reliance and self-determination on the part of the recipient country. Many economies of the Pacific island countries are heavily dependent on aid (Luteru & Teasdale, 1993), and some countries chose to remain protectorates and colonies of developed countries because their dependence on the developed countries for resources (Bray, 1993). The effects of external aid in the Pacific were identified long ago by Luteru (1985), when he declared that aid was like a drug of addiction; the more one partakes of it, the more dependent one becomes. Twenty years later, the Pacific island countries have become so dependent on external aid that most of their economies cannot survive without it. Second, Opeskin (1996) states that:

The transfer of resources to developing states is not a matter of moral obligation at all but a matter of charity or benevolence. We do good to give but are not entirely blameworthy if we fail to do so (p. 23).

On the contrary, while many of the aid projects appeared to be acts of charity or benevolence towards the education system in Fiji, the primary beneficiaries were the foreign consultants and the universities they came from. A number of educational projects externally funded in Fiji were noted by Baba (1985) and Puamau (2005) to have been executed with the primary objective of benefitting the donor's home

institutions. Third, humanity as the basis of an obligation to give in order to relieve misery, suffering or distress requires the donor to give to the needy without great sacrifice. The fourth basis of the transfer is related to some concepts of social justice such as the maleficence of aid whereby aid is transferred from developed countries to developing countries in a masked objective of assisting the poor and underprivileged populations. In actual fact according to Hancock (1991) aid in any form promotes dependence, stifles progress, abilities and skills of locals and promotes corruption and a wasteful behaviour of the recipients. Hancock continues that aid tends to impose foreign solutions to local problems without consideration of the local context. In this context, aid is considered as morally wrong and is expected to cause more harm than good. Such a view finds support in accusations that aid to poor countries does little to improve the economic status of the country and the welfare of the people since the major portion of aid is siphoned off to corrupt officials, privileged consultants and aid agencies' staffs (Opeskin, 1996, p. 23). Aristotle's distributive and corrective justice is closely related to notions of exploitation and colonisation, such as the 1974 United Nations' Declaration on the Establishment of a New International Economic Order which called for the rights of peoples of states and countries under foreign occupation, apartheid or colonial domination to full compensation and restitution of their environment, their natural resources and their socio-cultural systems.

### **3.5 External aid in Education**

The Pacific as a region is littered with aid and remnants of aid projects. External aid in education has thrived in the Pacific region for the past 50 years. The state of the Pacific governments, their economies, their educational programmes and institutions including their graduates are the products of external aid. Luteru and Teasdale (1993) declared that due to Pacific island countries' limited resources, geographical and economical isolation from world markets, and their vulnerability to external trade forces, almost all are dependent on some form of aid. The execution of educational aid projects in the Pacific varies amongst the donors and more so amongst the government and non-government sources. Baba's (1985) critique of the Australian

government's educational aid identified the difference between the AusAid sponsored assistance and the International Development Programme (IDP) of Australian universities and colleges assistance, was the latter was more collaborative. The IDP sponsored by the Higher education institutions of Australia, independent from the Australian government and had established a good working relationship with the University of the South Pacific.

Educational aid is big business. Developed countries spend huge portions of their annual budgets on external aid. According to Knapman (1986) proponents of foreign aid believe the extension of aid will expand third world development opportunities, and resources and expertise at concessional rates rather than market prices. Australia and New Zealand are the two major providers of aid to most Pacific island countries, even though they are small in comparison to countries such as the United States of America and Great Britain. Australia provided more aid to the Pacific island countries, including Papua New Guinea, than to any other country or a region (such as the Asian continent) (Hughes, 2003).

A number of internal critiques of Australian external aid have been undertaken, beginning with the reports of Commission on international development also known as the Pearson Commission (1969), the Brandt Commission (1980) (Harris, 1982), the Jackson Report (1984) (Lim, 1985) and the Simons Report (1997) (Warr, 1998). While the Brandt Commission identified some shortcomings with external aid, such as wastage and corruption, it was argued that aid was usefully spent to eradicate poverty, and support rural development, health and education. According to the Simons Report, the multiple political, humanitarian, and security objectives of the Australian Aid programme, contributed to the failure of aid making a direct impact on the low income populations in recipient countries (Mullen, 1999). On the other hand, the Jackson Report represented "a watershed in the delivery of Australian overseas aid development assistance (ODA)" (Luteru & Teasdale, 1993, p. 294). The Jackson Report indicated a shift from a humanitarian platform for aid to one aimed at gaining more political and economic interest for Australia and its institutions. This report set in

motion a fresh perspective of external aid, especially for educational assistance to the Pacific islands (Albinski, 1995; Baba, 1985; Bray, 1993; Luteru & Teasdale, 1993).

Baba (1985) analysed Australia's business of educational aid in the Pacific and highlighted the practice of giving aid but using Australian academics, experts and institutions. This practice according to Baba was not only paternalistic but also undermined Pacific academics, local institutions and expertise, and he concluded it was a deliberate policy on the part of the Australian government. Educational aid such as that given by Australia ensures funds are returned to Australian institutions (Sanga, Chu, Hall, & Crowl, 2005). Remenyi (1991) concluded in his assessment of Australia's trade behaviour that "the countries to which Australia gives aid also tend to be those that import from Australia. ODA [Overseas Development Assistance] is a trade promoting boomerang" (p. 3). Whatever perspective is taken about external aid, Knapman (1986) explained important issues that remain:

Aid allegedly encourages the belief that the prime determinants of development can be had for nothing, and thereby undermines self reliance. Concessional loans and grants replace (rather than supplement) domestic savings; imported technology depresses domestic research and development efforts; food aid diminishes agricultural self-reliance; and a pauper mentality displaces national pride (p. 145).

The Fiji Health Sector Improvement Project (FHSIP) funded the revision and the implementation of the Diploma of Nursing curriculum at the Fiji School of Nursing. The FHSIP was a part of the AusAid's AusHealth International, which was carrying out extensive health reforms in the Pacific island countries including Fiji. The review of the previous Diploma of Nursing curriculum fitted in well with definitions and descriptions of educational aid provided by cosmopolitan countries for the small island states in the Pacific in its initiation and implementation. The role of AusAid in the re-structuring and review of Fiji's health services began in 1999. AusHealth International's Milestone document (AusAID, 2002), stated the Fiji project was Australia's response to a series of reports in which there was a need to meet Fiji's health needs efficiently, quickly and effectively. The work of AusAid in the Pacific Island countries health service reforms is similar to its previous involvement in the Pacific in the 1920s. Cameron-Smith (2010) described Australia's long standing obsession with medical and health domination in

the Pacific by mapping strategies such as centralising Pacific health training research and leadership within Australian institutions. According to Cameron-Smith, Australia produced the Austral-Pacific regional zone map, which it considered to be within its sphere of political influence. Australia's ambition was, "Not only to safeguard the Commonwealth but to fulfil dreams of Australian hegemony in the Pacific islands through the establishment of dominance over imperial medicine and native administration" (p. 60).

In 1993 AusHealth International, on behalf of AusAid, began health service reforms in Fiji as part of the health reforms AusAid was funding for Pacific Island countries such as Tonga, Solomon Islands and others. In the process of reviewing and restructuring Fiji's health services, the Fiji School of Nursing as a health resource institution, was also included for a review and upgrade of its curriculum in preparation for amalgamation with the Fiji School of Medicine (Biscoe, 2000; Usher, Rabuka, Nadakuitavuki, Tollefson, & Luck, 2004).

AusAid was also involved in the up skilling of teachers' qualifications at the Fiji School of Nursing from an undergraduate to a Master of Nursing degree in preparation for the implementation of the new curriculum and the merger of the School of Nursing with the Fiji School of Medicine. Both degrees and other courses, such as the Intensive Care Unit/Coronary Care Unit (ICU/CCU) nursing, were all provided by the James Cook University (JCU) by distance education, with the JCU staff travelling regularly to conduct on-campus block courses in Fiji. This type of arrangement did not recognise or utilise local institutions, such as The University of the South Pacific or other local university campuses for the University of Southern Queensland and the Central Queensland University who had been providing similar courses in Fiji for a long period of time. The Simons Report strongly advised against such practices by Australia as such arrangement resulted in a wastage of funds that could be better utilised within the recipient country, or diverted to other useful ventures (Mullen, 1999).

The international transfer of educational programmes and practices that aimed to keep professionals and practitioners on par with each other and up-to-date with technologies and approaches also had its fair share of problems and shortcomings. Sir Michael Sadler (1979) warned international educational consultants and planners that events outside the schools mattered more than those inside, as they govern and interpret those inside:

We cannot wander at pleasure among the educational systems around the world, like a child strolling through a garden and pick off a flower from one bush and some leaves from another, and then expect that if we stick what we have gathered into the soil at home, we shall have a living plant, but if we have endeavoured, in a system of education, we shall in turn find ourselves better able to enter into the spirit and tradition of our own national education, more sensitive to its unwritten ideals, quicker to catch the signs, which threaten it and the subtle workings of hurtful change (p. 229).

Crossley (1993) echoed Sadler's warning, which was especially pertinent in the global context of rapid international travel, technologies, communications together with an increased growth in international consultancy services by developed countries. The nature of aid projects and international consultancy patterns pose a very real danger where advisors have little or no comparative experience or knowledge in the cultural background of the countries they are engaged in. The competency-based Diploma of Nursing curriculum is an example of such educational aid. The curriculum was externally developed, funded and supervised by external experts with minimal involvement of the local teachers. A curriculum consultant was appointed to oversee the implementation of the curriculum at the Fiji School of Nursing when it became evident that the nursing faculty was reluctant to implement the new curriculum late in 2004. Failure to implement the curriculum in August 2004 would have been seen as a failure on the part of the AusAID project in Fiji.

### **3.6 Colonisation and hegemony in education**

Spivak's (2004) description of colonialism as a "permanent operation of altered normality" (p. 524) is relevant in most colonised institutions of the Pacific, such as Fiji where the altered state of normality was actualised through processes of hegemonic imposition of colonial or western language, knowledge and culture. The altered state

of normality was therefore conducive to the colonialists' survival, and the demise of the colonised and its indigenous institutions. Philips (1992) suggested school systems of the colonised societies served the urban elite and disregarded the diverse traditional indigenous structures pertinent to the people's survival. The education system was the most effective tool of colonisation whereby western ideas and cultures were imposed on indigenous people, and reproduced through the formal curriculum.

Thaman's (1994) statement that the colonisation of the Pacific education systems consisted of the "introduction of manifest as well as the hidden curriculum of the dominant ideologies and cultures of the metropolitan countries of Europe, and lately, Australia, New Zealand" (p. 5) is similar to the history of nursing education. The imposition of dominant western medical and nursing ideologies and cultures of Europe, Australia and New Zealand has been a consistent feature of nursing curricula in Fiji for the past hundred years. Such dominant ideas have continued to influence the practice of indigenous nurses and impacted the Fijian indigenous people's traditional cultures, health and knowledge. It can be argued that nursing education in Fiji has been a vehicle for the imposition of foreign values and ideologies of health and caring, to the point of alienating the indigenous Fijians and others from their own values and practices. Nursing education privileged the colonialists' health perspectives and their health needs were addressed to ensure their survival.

Thaman (1994) stated that schooling in the Pacific, including Fiji, did not aim at "the transmission of important elements of their cultures, but at the cultural transformation of most of the young and in some cases, alienating them from the traditional cultures of their parents and grandparents" (p. 7). Similar strategies of colonisation occurred in the history of medical education of indigenous Fijian practitioners where graduates were expected to be agents of civilization, and would help their own people to accept western medicine (Stuart, 2006). According to Thaman, Pacific curricula socialise indigenous students into a new culture. Instead of renewing them, the curriculum provides them with a passage out of their culture:

In many Pacific island countries when a person completes primary school s/he leaves the village for the nearest town, when s/he finishes high school s/he leaves the island for the capital city; and when she obtains a degree, s/he leaves for Australia, New Zealand or the USA (Thaman, 1994, p. 7).

While it can be argued that foreign education (and nursing) consultants and advisers are sensitive to the indigenous cultures in the Pacific countries, some may not be. Many Pacific island educators themselves were educated purely in western knowledge paradigms and may have detached themselves from their own traditional cultures for a long time (Bray, 1993; Hereniko, 2000). Fijian nurse graduates have become highly marketable especially in western countries whose educational and health ideologies have been reproduced in the Fijian nursing curriculum. Fiji is forced to keep training its nurses to meet its health manpower needs; knowing that it will lose them to countries that will offer salaries that Fiji can hardly compete with. Armstrong (2005) reported Fiji graduates 120 to 150 nurses annually but loses 50% every year to external migration.

### **3.7 Nursing education: Changes and reforms**

The development of nursing education was characterised by the spread and dissemination of Nightingale's philosophy of nursing by her graduates to all British colonies, including New Zealand and Australia. This had a colonising effect on the indigenous people similar to the colonising effect of western medicine on traditional health systems, which existed in newly colonised countries. Lambie's (1956) testimony stated that her mission to reform nursing in the British colonies of Fiji and Samoa was more meaningful as she was serving the interest of the Empire. As discussed in Chapter 2, the history of nursing education in Fiji reflected the colonising influences of Great Britain prevalent in the early 20<sup>th</sup> century. The development of nursing in New Zealand and Australia reflected contemporary practice in Great Britain and influenced the development of formal nursing and education of nurses in the South Pacific colonies.

While nursing education managed to evolve from the hospital apprenticeship system to a university or college based curriculum, it has been difficult to shrug off its subservient status to medicine (Burnard & Chapman, 1990). Formal nurse education and practice in Fiji continues to reflect the Nightingale system and the British nursing

tradition introduced by New Zealand and Australia over one hundred years ago. In fact the apprentice style of nurse education introduced into Fiji in the late 1800s lasted until 1983 with the introduction of a North American influenced curriculum. Similar trends were reported in Australia by Daly and Jackson (1999) where the apprentice type of nurse education lasted until 1988 when it was completely phased out in New South Wales. Daly and Jackson indicated this North American nursing influence led to the explosion in nursing scholarship and research. New Zealand did not completely phase out its hospital-based programmes until late 1980s despite a World Health Organisation (WHO) consultant's recommendation in the 1970s to relocate nursing education to the university setting (Carpenter, 1971).

Even though Fiji has a Diploma of Nursing that could be delivered from a tertiary institution, the Ministry of Health chose to continue teaching it within the hospital system (Waqatakirewa, 2004). Developments in nursing in the United States of America (USA) were more progressive and liberating in practice than their British counterpart. Fiji's 1983 Diploma of Nursing curriculum, developed by a WHO consultant from the USA, presented a more liberal integrative curriculum approach. Supportive subjects like sociology, psychology, nursing studies and theories, and nursing research aimed to stimulate critical thinking and introduced alternative epistemologies into undergraduate nursing (Castilo, 1983). However, Rodgers (1987) maintained that the depth of assimilation of nursing leaders in Fiji to the British traditions and Nightingale ethos (such as obedience, duty and respect) prevented the liberal intent of the curriculum from being realised. Even though nursing education in Fiji was modelled and revised to include nursing research, critical thinking and evidence-based nursing practice, the teachers' academic preparation to facilitate such a change in the paradigm of nursing education and practice needed to be questioned.

### ***Curriculum development in nursing***

Nursing curricula have long been influenced by the major curriculum theories of Tyler's objectives model, Taba's interactive model and Wheeler's cyclical model (Burnard & Chapman, 1990). These three models all advocate a systematic approach to curricula

using distinctive stages or processes which are dynamic, interactive and are well suited to professional and vocational programmes like nursing (Greaves, 1987). Kerr (1968) proposed a useful model for nursing, which not only complemented the objective approaches of Tyler and Taba, but also offered four critical questions to guide nursing education and curriculum development today. These questions are:

- What is the purpose of the curriculum?
- Which knowledge, attitudes, beliefs and skills are to be valued and used?
- What learning experiences and methods are to be applied? and
- How are the results to be assessed and evaluated?

(Greaves, 1987, p. 4)

Tyler (1996) reviewed his own seminal curriculum theory developed over four decades previously and concluded that very little had changed and these four guiding questions continued to have contemporary relevance for curriculum development and evaluation.

Iwasiw and Goldenberg (2005) argued the purpose of nursing programmes was to prepare nurses who would impact the community they served by contributing to the quality of life and health of individuals. The 1986 National League for Nursing and the Society for Research in Nursing Education recommended nursing faculties employ cost-effective community-based health promotion and disease prevention perspectives in response to market-driven health care services and culturally diverse consumers (Keating, 2006). Bevis (1989) also argued nursing curricula needed to reflect changing trends, demographics, national circumstances, economics, clients' values and beliefs, teaching and learning philosophies, and nursing practice and education. Furthermore, Allen (1977) asserted a nursing education programme should ideally be developed in response to the health situation and needs of a particular community or country.

The curriculum development, revision or change process is influenced and determined by multiple factors, some demanded by consumers. Keating (2006b), echoing Rains (1998), argued a dynamic curriculum should be pertinent to the needs of society, and therefore, faculty must become aware of international and national trends in health care, as well as the skills and competencies required for a successful practice. It is

argued here that such factors are interrelated, complex and in a constant state of change.

Factors prompting a curriculum change include a changing context of practice and revision of nursing practice standards demanding new teaching and learning approaches, such as evidenced-based practice and competency-based education. Demands affecting the nature, focus and content of the nursing curriculum include demands arising from legislative and registration authorities. Klineberg (1994) expanded on these factors to include changes and trends in demography (such as population structures, trends and projections), the economic environment affecting health service delivery, social networks and family structures, and the nature of a country's health service delivery. Increasingly multicultural and multi-ethnic populations demand the health needs of their clients are included in curricula and the preparation of nurses. Consideration of the environment in the nursing curriculum places the faculty in a position to be innovative and futuristic. For instance, the environmental issues of pollution, the threat of global warming on greenhouse effects and rising sea levels, man-made and natural disaster, and bio-terrorism are also significant concerns for nursing globally. Importantly, nursing curricula in the Pacific should consider environmental and marine conservation issues impacting on island inhabitants' survival and spiritual and physical wellbeing, which may also result in dislocation and re-location to other countries.

### ***Competency-based education***

Globally nursing education has been consistently challenged to produce graduates who are knowledge workers. Knowledge workers, according to McAllister (2001) are people who apply theoretical knowledge relevant to the discipline (p. 305). Nursing curricula are also required to produce graduates who are not only knowledge workers but are also clinically competent. Therefore, in its bid to ensure professional accountability and responsibility to the public, nursing education has moved from structure and process based education to competency-based education and measurement of outcomes. Lafferty (1997) stated that over the years, the function of nursing education has been

focused on “protecting the general public from incompetence and maintaining professional standards” by producing competent practitioners (p. 281).

Competency-based programmes define the desired outcomes of education; the outcome driving the educational process. The use of competency-based curricula in the undergraduate programme and in-service programmes has increasingly gained momentum in New Zealand and Australia in the past two decades. The Nursing Council of New Zealand commissioned a number of exploratory studies to determine the required competencies for all levels of nursing since the late 1970s (Street, 1978, 1979, 1980). By the 1990s, the Nursing Council of New Zealand had published guidelines for competence-based practising certificates for registered nurses and midwives (Nursing Council of New Zealand, 1996a, 1996b).

Many institutions have, for the past decade, re-structured their courses around competencies set by registration authorities in their countries. Whittington and Boore (as cited in Ashworth, 1991) described the competency-based curriculum for nursing as a sensible and logical strategy for a skills-based profession. They went further, indicating where there was a continuous assessment of skills and knowledge beyond graduation, competencies could be useful in determining the levels of practice for registered nurses. The necessity to have a valid basis for determining the eligibility for registration as has been a major contributing factor to develop competencies (Cameron, 1989).

Percival (as cited in McMillan, Bujack, & Little, 1995) described competencies as personal attributes of nurses, their specialised knowledge, cognitive, technical and interpersonal skills and traits, and desired patterns of behaviour that are simultaneously conveyed within a nurse-client environment. Wilson (as cited in (McMillan, Bujack, & Little, 1995) raised a caution about competency-based education that while it had considerable merit to recognise skills and qualifications, there was a potential for significant cultural bias in competency testing. Other problems related to competency-based nursing programmes include the individualistic nature of

competencies, and that they are not suited to nurses learning in groups or from each other (Ashworth & Morrison, 1991). A further identified problem of a competency-based curriculum is the ability of the assessor to decide and objectively state the students' level of performance. Ashworth & Morrison (1991) stated that there is "enormous, unavoidable scope for subjectivity especially when the competencies being assessed are relatively tangible ones" (p. 260).

Developed countries that successfully implemented competency-based curricula, such as New Zealand and Australia, have graduate programmes providing needed professional and clinical support for new graduates after registration. However, these programmes are expensive, especially for countries like Fiji that do not have the funds to support such programmes. An Australian study on nursing education in the higher education sector found employers wanted graduates who can enter employment with minimal need for further training, supervision or orientation (Reid, 1994). Further, they needed graduates who are aware of workplace needs and requirements, and preferably have 'more' than beginning competence.

### **3.8 Impact on indigeneity**

The term 'indigenous' is defined here to refer to the aboriginal population of a country or area who are usually the first recorded inhabitants. Other alternative terms used as according to the indigenous peoples' preference are the Aboriginal and Torres Strait Islanders of Australia, the First Nations of Canada and the United States of America, the Native Hawaiians of Hawaii and Tangata Whenua for the Maori of New Zealand. However, definitions of indigeneity must also consider countries where internal colonisation and genocide took place and the native population was almost completely eradicated. According to Stephens et al. (2006):

Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them (p. 2020).

Apart from the definitions of indigeneity, the issue of what it means to be an indigenous person also has its implications on their ability as a group to fully exhaust rights and privileges as well as pool resources for support and self-restoration. Indigenous people universally locate themselves within the land of their ancestors, distinct languages and dialects, cultures, educational and knowledge systems which are significantly different from the mainstream western cultures.

The health of indigenous peoples and their vulnerability to many diseases and illnesses has been a source of great concern for many societies globally (Armstrong, 2004; Ring & Brown, 2002). In the past two decades, health research overwhelmingly indicates colonisation impacts on the health status of the indigenous people in Canada, the United States of America, Australia and New Zealand (Cunningham & Stanley, 2003; Durie, 2004). Furthermore, colonialism has impacted on almost every facet of the indigenous person's life such as health, education, economic productivity and her or his total existence. The model (Figure 3) provided by Cunningham and Stanley (2003) clearly describes the impacts of colonialism in most indigenous societies. Literature on indigenous health suggests a direct relationship between the worsening indigenous health status to histories of domination, oppression and subjugation of the indigenous people by the colonising powers (Durie, 2004; M. King, Smith, & Gracey, 2009; Ring & Brown, 2002). Undoubtedly, colonisation brought with it dominant western ideologies of education, medicine and health practices, which were foreign and hostile to the indigenous people. The health of indigenous Fijians is similar to the indigenous people of New Zealand and Australia, except Fijians represent the majority population in the country. Indigenous Fijians have the highest rate of morbidities in all age groups, including non-communicable diseases and communicable diseases, accidents such as motor vehicle accidents, and psychiatric conditions.

In New Zealand, Durie (2001) proposed four main classification factors according to causes of diseases amongst indigenous people of New Zealand. Genetic predisposition is related to diseases such as diabetes, alcohol disorders and some types of cancers. Socio-economic disadvantages are related to disease and ill-health which are caused

by social deprivation such as unemployment leading to stress, malnutrition, lack of access to health facilities and medicine and treatment, poor housing hygiene and illiteracy. Resource alienation refers to the health impacts of environmental resource degradation, pollution of fishing grounds, logging and dredging of waterways, building of dams, which are sources of ill-health and spiritual oppression and disengagement for many indigenous peoples.

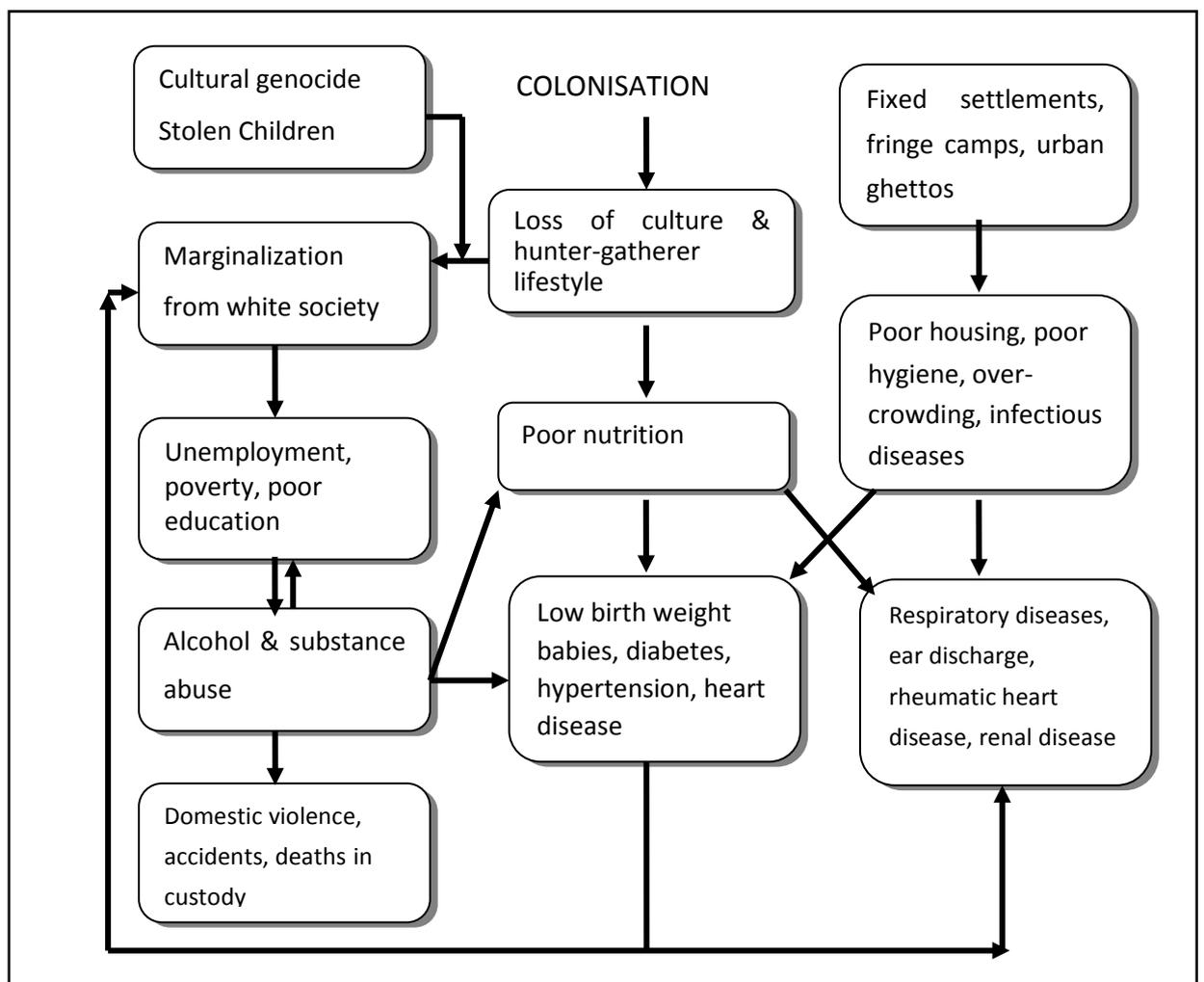


Figure 3. Model of the impacts of colonisation on indigenous people

(Adapted from Cunningham & Stanley, 2003)

Cultural alienation can cause deterioration of ill-health amongst indigenous people in situations where the clinician and the client are from two different cultural backgrounds. Apart from the differences in the languages and ethnicity, some

countries such as Fiji have difficulties with situations where indigenous health providers are educated within the western medical paradigms and advocate western ideologies of health when working with fellow indigenous countrymen, without consideration of the indigenous Fijian perspective of health. Further, political oppression is one of the most common and long running causes of socio-somatic and psychosomatic illnesses amongst indigenous populations. Political oppression is related to dispossession of traditional lands, fishing grounds, waterways and rivers, forests and the forceful destruction of customary laws (Bird, 2002). Moreover, political oppression also creates spiritual oppression and the social dislocation of indigenous youths, loss of identity of young adults, loss of language and a sense of being.

Several countries have developed strategies to measure and assess indigenous health and to manage the incidence of diseases affecting the indigenous populations. Smylie et al. (2006) identified a number of strategies for measuring the performance of national health systems in addressing indigenous health. While comparing Canada, Australia and New Zealand, Smylie et al. documented New Zealand's progress in the development of models, policies and strategies aimed at improving and arresting ill-health for Maori in almost all areas of health services and health categories. *Te Pae Mahutonga* which is a Maori specific model of health promotion complements Durie's (2004) *Te Whare Tapa Wha* model, which can be used to measure the health status of an indigenous Maori person using the four tenets of Maori perspective of health; that is, *Taha Wairua* for the spiritual part of health, *Taha Tinana* the physical body, *Taha Hinengaro* for the intellect and emotions, and *Taha Whanau* for family and human relationships.

In Canada, indigenous groups representing their various tribes contributed information to strengthen the indigenous health information system and thereby develop their own model for measuring their health. According to Smylie et al. (2006) Australia is yet to develop a model to measure and assess indigenous health status. Earlier in 2004, New Zealand hosted a series of meetings with indigenous Maori health providers to develop a health monitoring framework which later became the *He Korowai Oranga*

(the Māori health strategy) (A. King & Turia, 2002). *He Korowai Oranga* identifies both universal indicators of health such as mortality and disability as well as Maori specific indicators, such as Maori cultural identity and health and social determinants.

Chino and De Bruyn (2006) suggested for capacity building or any other strategy to work for indigenous communities, the wounds caused by colonial subjugation, abuse, oppression and racism need to be acknowledged and allowed to heal. This view finds support in another suggestion that Australian nurses themselves need to acknowledge their part in the alienation and oppression of indigenous Australians and develop strategies towards reconciliation (Jackson, Brady, & Stein, 1999). Such strategy requires nurses to confront the legacy of colonisation and invasion and reflect upon the role that nurses may have played in the systematic domination of the indigenous people. Goold (2001) also supported this view when she made the following statement:

I do not believe that many Australian nurses are capable of delivering culturally appropriate safe care to the Australian indigenous person until there is an attitudinal change on the part of those teaching nursing and on the students themselves. Also needed is for those providing care to be sensitive to the needs of those entrusted to their care. To have the capacity to listen to and see the indigenous person as a human being with human needs. To be able to treat people as they themselves would wish to be treated (p. 99).

A second strategy was the implementation of primary health care services through community-controlled services such as health centres serviced by indigenous doctors and nurses. Armstrong (2004) notes that “indigenous people tend only to go to a service owned and operated by their own people” (p. 17). Fiji’s health service uses a primary health care approach dominated by indigenous health providers, but this has not guaranteed an improved health status for indigenous Fijians. The important part of the service is that the health ideologies, perspectives and practices advocated by the indigenous practitioners are safe and support the indigenous perspective of health.

In an effort to address the health of indigenous Australians, the Deans of the Australian medical schools produced an indigenous health curriculum framework in

2004 for implementation across the country's medical schools. The purpose of the curriculum according to the document was to provide medical schools with a set of guidelines for "success in developing and delivering indigenous health content in core medical education" (Phillips, 2004, p. 5). If Australia can initiate national strategies to address indigenous health by using the very tool for implementing and extending western ideologies in health and medicine, one can then justifiably expect similar strategies to be utilised by Australian academics and curriculum consultants working in countries with similar challenges to indigenous health.

### **3.9 Summary**

The literature explored in this chapter exposed a major knowledge gap in relation to the impact of colonisation on the health of indigenous Fijians as well as the continuing legacy of neo-colonialism and imperialism through external aid in health and nursing. Educational change in any discipline, be it medicine or nursing, is a normally a welcomed opportunity for professional, academic or technical development. However, the change process has also been the vehicle by which former colonial powers continue their legacy of colonialism and domination of indigenous knowledge structures and systems by advocating foreign ideologies, health perspectives and practices through education programmes. While the literature explored on indigeneity emphasised the need to be culturally competent in nursing, especially in Australia and New Zealand, Fiji's nursing education programmes continue to ignore the need to do so. The second framework used in this study which is the *Vanua* indigenous framework locates the curriculum and the participants in the Fijian indigenous context and this is described in detail in the next chapter.

## **Chapter 4: Methodology**

### **4.1 Introduction**

The previous chapter discussed the literature review for this study. This chapter describes the research strategy; the research framework that informed the methodology; and provides a detailed description of the fieldwork that was carried out to collect the data for this study.

### **4.2 Conceptual framework for the study**

The research framework integrates the *Vanua* research framework (Nabobo-Baba, 2006) and Fullan's educational change theory (Fullan, 2007) within Stake's case study method (Stake, 1995a). The framework design represents a 'coconut' tree (Figure 4), which is, in a Fijian context, a holistic representation of all that is useful and life giving. The coconut tree is chosen here because of its usefulness in the daily survival of a person, a family and a community. The nuts (fruits) are eaten raw or cooked, the shells serve as drinking cups for highly ritualised ceremonies and for soups, ornaments and jewellery, utensils, buttons; and the husk is platted into tough ropes, used as sutures for muscles and tendons and as ties for umbilical cords in newborns. The flesh of the young coconut is used to feed the premature baby and the juice is given to treat gastroenteritis and diarrhoea in infants and children. Apart from a refreshing drink on a hot day, the coconut itself contains the much needed mineral replacements for the body lost through sweating. The leaves are used for mats, brooms, hats, food baskets, roofing covers and decorative vases for flowers. The trunk of a coconut tree is used for furniture and walls, fences, and firewood. The roots have many uses from hair dyes to medicines for many ailments. The young flowers of a coconut are used to treat a postpartum psychotic disorder and the juice of the coconut is used to increase the production of breast milk in a lactating mother, and as a rehydrating fluid for severe

diarrhoea in children. Fijians continue to use the coconut tree in a custom where a newborn's umbilical cord is buried under a newly planted coconut tree in the belief that the child will grow up and be rooted in the land of his/her birth, and like a coconut tree; will be a useful member of society and live a productive life (Seruvakula, 2000). I also chose the coconut tree to model the *Vanua* research framework because the tree has become a symbol of the Pacific and has been synonymous with countries of the Pacific and its indigenous people.

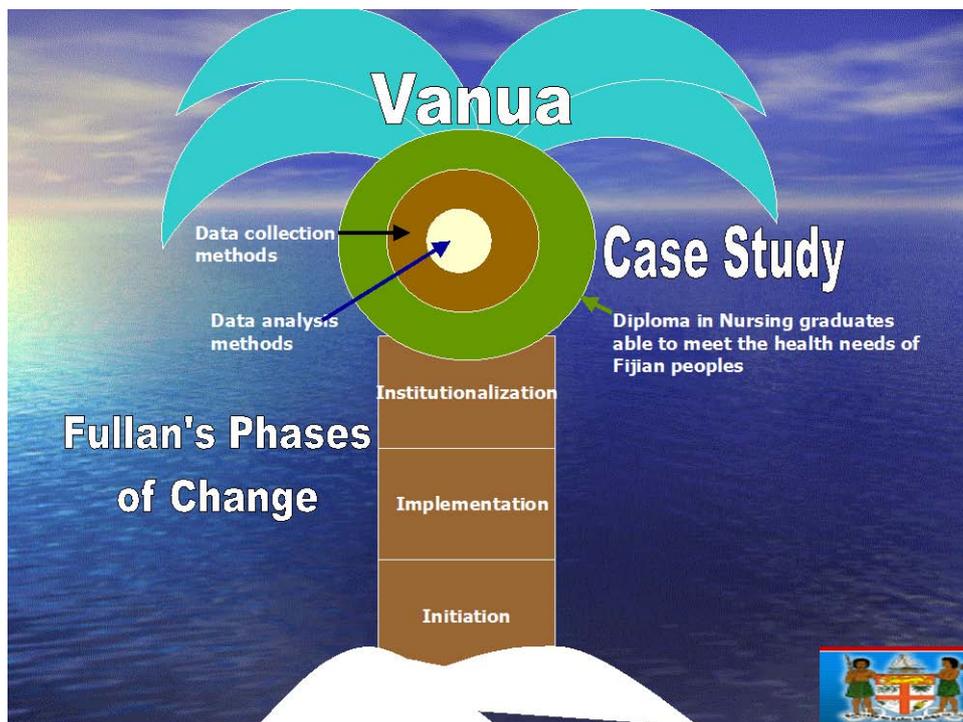


Figure 4. The components of the research model

### 4.3 The Vanua indigenous research framework

The *Vanua* research framework developed by Nabobo-Baba (2006) is used in this study to inform the case study method. The approach is grounded in indigenous Fijian epistemology that according to Nabobo-Baba (2006) is based on the holistic integration of the people, the land and their spiritual dimensions. As previously stated, the Fijian indigenous worldview is based on three interrelated dimensions of human existence: *Lagi* (heaven), *Vuravura* (physical world) and *Bulu* (the afterlife world of the spirit or underworld). Fijians tend to make all references to their customs, their traditional practices and events in this world to the three interrelated concepts. *Lagi* is the place where the Christian God lives and *Vuravura* is referred to as this physical world we live in. *Bulu* is the world of the spirits including the ancestral spirits. Many Fijians accepted Christianity through the belief that their ancestral Gods (in *Bulu*) and their Chiefs (Kings) were specially ordained or called by God (in *Lagi*/heaven) to rule over them. Christianity in many ways reinforced the interrelatedness and interconnectedness of the three dimensions of the Fijian worldview. Fijian chiefs continued to be revered as they are seen as an extension of the Gods and can possess '*Mana*' or power similar to the Gods or spirits. Ceremonies and traditional protocols observed are normally done to appease the spiritual ancestors or Gods (Ravuvu, 1983).

The Fijians' view of a person is a composite of three dimensions of God/ancestral spirit, land and the physical being. All references to a person (or a family) are made to the three mentioned composites (Figure 5). Any change or disturbance in any of the components of a person will affect the other two dimensions. This view is important in my study, as the focus of the research is the relevance of the knowledge component of the 2004 Diploma of Nursing programme in preparing nurses to care for the Fijian people. The Fijian indigenous worldview and their indigenous epistemology (Figure 6) guided the data collection process, the identification of relevant and appropriate protocols to be observed in a Fijian traditional context, and the analysis and interpretation of data.

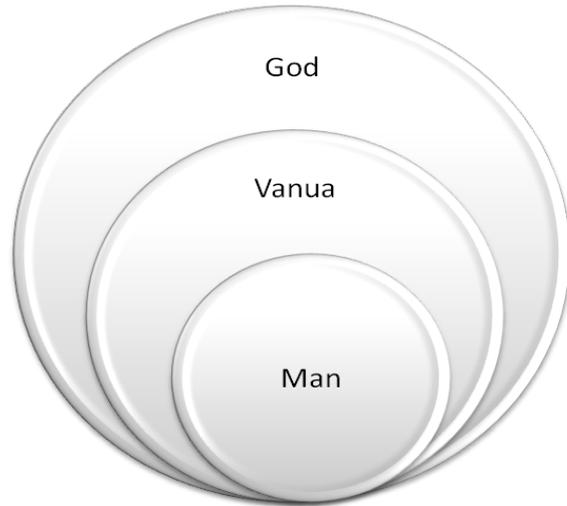


Figure 5. The Fijian indigenous worldview of a person

Similar to Kaupapa Maori (Smith, 1999) and the Tongan framework *Kakala* (Thaman, 2003c), the *Vanua* framework purports to ensure the research process is culturally sensitive and appropriate to the research participants and to the context of study, and the knowledge that emerges from this research is relevant and useful to the nursing profession in Fiji.

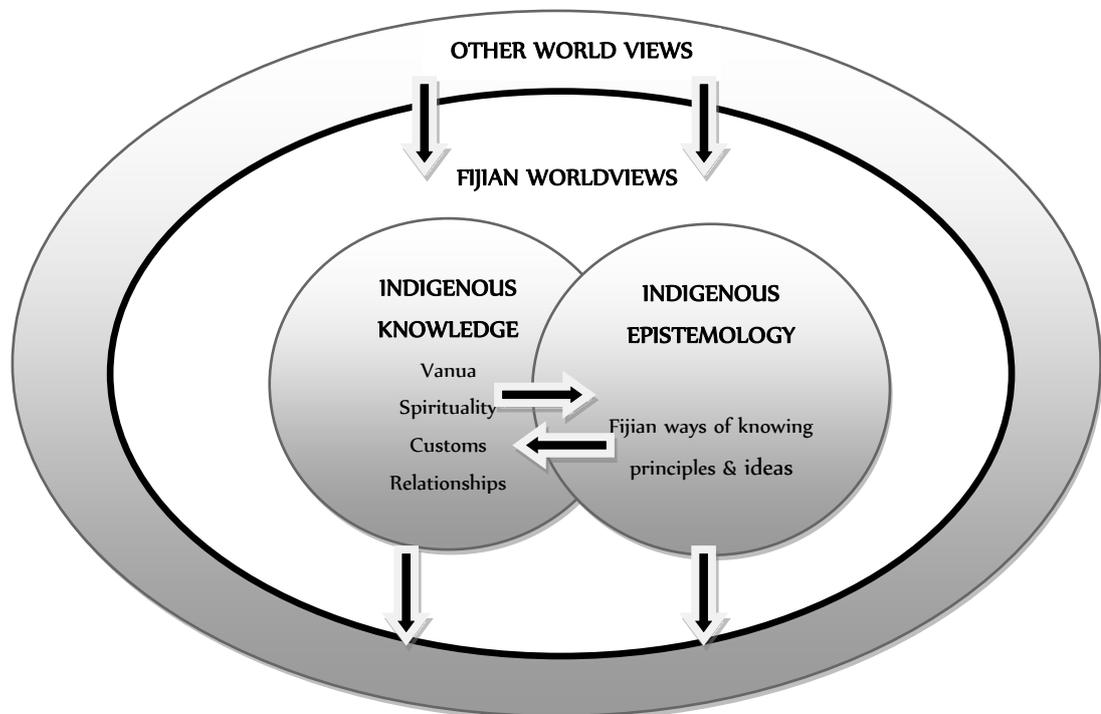


Figure 6. The Fijian worldview and epistemology Note. Adapted from (Nabobo-Baba, 2006)

The *Vanua* framework informed the case study and enabled the voice of indigenous Fijian nurses and teachers at the Fiji School of Nursing (FSN) to be heard. The framework privileges indigenous knowledge, indigenous epistemology and gives precedence to traditional Fijian customs and protocols to be used by the teachers at the FSN.

The choice to use the *Vanua* framework was also based on my belief the people involved in the study were Fijian; that is, the majority of the students at the FSN were Fijians and the dominant Fijian culture outside the school and hospitals. Also it was my conviction that indigenous Fijians have been passive recipients of western epistemologies for over a hundred years since European colonisation.

Contemporary studies and research in the Pacific describe the use of western methodologies by indigenous researchers and academics as a form of neocolonialism (Smith, 1999; Thaman, 2003c). The use of indigenous research frameworks in the Pacific is a form of de-colonisation for the indigenous peoples, who were subjected to western colonisation in the last century. Professor Konai Thaman, a respected Pacific academic and an outspoken advocate for de-colonisation of western educational philosophies in the Pacific, believes de-colonisation is about valuing alternative ways of thinking about our world, and developing philosophies of education that are culturally inclusive and are rooted in the indigenous cultures of the Pacific (Thaman, 2003c).

As already discussed in Chapter 2, Fiji's history of colonialism has directly influenced the way Fijian nurses are educated and trained to reproduce western educational ideologies, including western medical and health knowledge, and to regard all other knowledge systems as superstitious or irrelevant. The systematic dominance of Fijian nurses by western medicine and nursing philosophies and systems of government has contributed to a culture of silence among indigenous nurses. The prevailing culture of silence is therefore reinforced by the Christian and Fijian traditional values of respect,

duty and obedience to authority. The use of an indigenous research framework in this study aimed to contribute to the de-colonisation of health and nursing philosophies in Fiji and hopefully in the Pacific.

#### **4.4 The research design: Case study**

Case study methods involve a collection and recording of data about a case or cases and the preparation of a report or a presentation of the case (Stenhouse, 1985). The case study in its simplest form involves the researcher making a detailed examination of a single subject, group or phenomenon (Bogdan & Bilken, 2007). A case is selected which is typical or is representative of other cases. However, a sample of one case cannot be said to be representative of other cases. Case study research is not a sampling research where a case is studied in order to understand others (Stake, 1994).

Case studies are conducted in order to understand a 'unique' or an interesting case or phenomenon. Yin (1994) contends case studies are empirical inquiries that investigate a contemporary phenomenon within its real life context. Stake (1995a) however, views case study as a research strategy that can either be qualitative or quantitative in nature, or a synthesis of both approaches, and states it is "a process of learning about the case and the product of our learning" (p. 237). Appleton's (2002) description of case study research as an "intensive analysis in which the inquirer attempts to examine and understand key variables to determine the "dynamics of a situation" (p. 82) is also applicable to this study.

I chose to use Stake's (1995a) intrinsic single case study design (Figure 7), which I felt was most appropriate and relevant to my research topic. Intrinsic case studies attempt to understand a case or a unit of analysis without trying to project the findings to other similar cases. In intrinsic case studies, the researcher may have an intrinsic interest in a particular 'case' because nothing or very little is known about the case and there is a need to better understand it. According to Stake, case studies are useful strategies for research when the boundaries between the phenomenon and the context are not

clearly evident, and the interrelationship of people and the context tend to be significant in the search for a helpful explanation of the phenomenon under investigation. He therefore advocates the use of a disciplined and qualitative method of inquiry.

There are four key elements that characterise case studies – they are contexts, boundaries, time and intensity (Mariano, 1993). Lincoln and Guba (1985) agree with studying a phenomenon in its context, which is important for a number of reasons. These are first, the research activity and interaction with the phenomenon under study should take place in its entity in order to fully understand it. Second, the context is an important element in determining the study findings and its interpretation. Values are inherent and intrinsic components of the contexts and can influence the findings of the research study, and last the “belief in complex mutual shaping rather than linear causation which suggest that the phenomenon must be studied in its full scale influence field” (Lincoln & Guba, 1985, p. 39). This view of case study research is applicable to this study as the case under investigation is located within the wider context of nursing and within Fiji as a country in the Pacific. This wide context makes the case under investigation complex, and would influence the analysis of information collected in this study.

Mariano (1993) and Stake (1995a) both contend the boundaries of the case study investigation are clearly demarcated so that the researcher clearly identifies what ‘is’ and ‘is not’ the case. This was important in this study as the boundaries of authority between the FSNs management and Fiji’s Ministry of Health are not clear, and decision making processes often overlap. This is evident in how the FSN is precariously located within the direct administration of the Ministry of Health through the Director of Nursing Services. Therefore the FSN lacks academic and professional autonomy in the sense that the Nurses, Midwives and Nurse Practitioners’ Board of Fiji closely monitors the activities of the School starting from its programme implementation to the final examination of its candidates through its academic arm called the Nurses Academic Committee. The Ministry of Health itself is involved heavily within the School’s major

activities, having representatives on the selection committee, students' disciplinary committee, and the supervision of all external examinations of the School (Downes, 2001a). The prominence of the role of the Director of Nursing services within the Fiji School of Nursing's business plan is indicative of the type of external influence the School receives from the Ministry of Health. All teaching and auxiliary staff appointments are made by the Ministry of Health and not the Fiji School of Nursing (Usher, 2005).

The development and the review of the curriculum under study is the result of a decision by the Ministry of Health and not the Fiji School of Nursing. For an outsider, the boundaries between the context of nursing education and the unit of analysis, which is the curriculum under study, are unclear. For insiders like me, such unclear boundary lines and external decision-making have been a cause of frustration as they contribute to no clear line of authority.

Ragin (1992) also described the importance of boundaries defining cases in terms of "places and periods". This study clearly identifies the period of study as from the year 2004 in which the case, the Diploma of Nursing curriculum, was first implemented in Fiji and 2008 when this study was conducted. Therefore the boundary of the case is identified by time or period. The fourth element of a case study described by Mariano (1993) is the importance of the researcher having sufficient time within the case under study to become familiar with it. The researcher requires adequate time allowance during the research process to be fully immersed within the setting, and to focus in-depth on the case itself in order to 'unearth the intricacies and the subtleties' of the case (Stake, 1994), and so the investigation and data collection methods are fully exhausted (Appleton, 2002). This requirement was met fully, as I have spent the preceding two years (2004 to 2006) coordinating and teaching within the programme. In addition to this, I spent over three months of data collection on site in Fiji.

The case in this study is the Diploma of Nursing curriculum currently taught within its real life context in Fiji. It is an example of an educational change initiated externally to

the Fiji School of Nursing. That is, the curriculum was written and developed by Australian consultants from the James Cook University in Australia with very little input from the local faculty at the Fiji School of Nursing. After the curriculum was endorsed by the Nurses, Midwives and Nurse Practitioners' Board of Fiji, the curriculum consultants responsible for the newly developed curriculum pushed for its implementation in August 2004 and continued to supervise its implementation for the first three years.

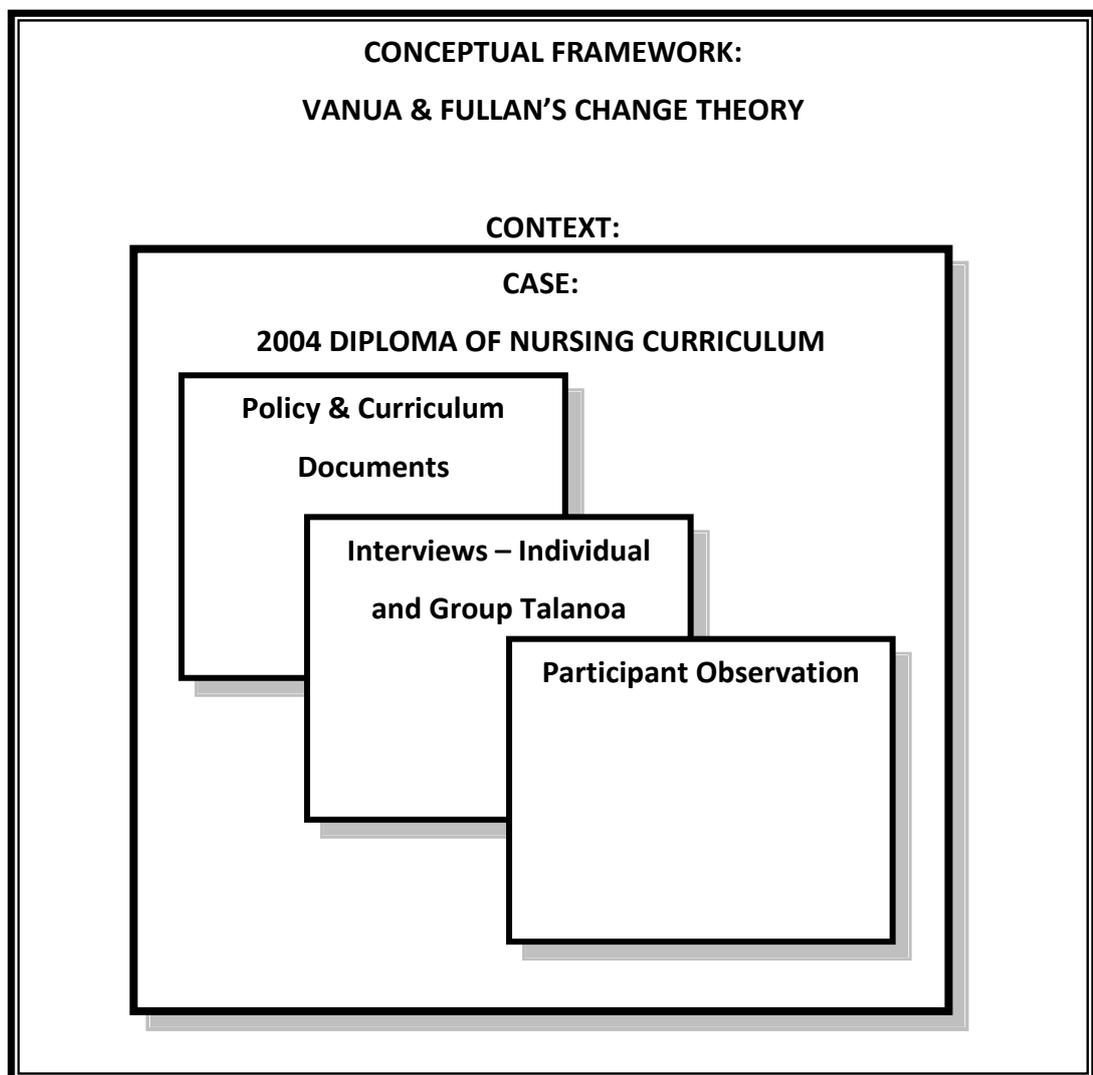


Figure 7. The intrinsic type 2 embedded single case study design

This curriculum was chosen as the 'case' for this study because there were many concerns raised by faculty and stakeholders before and during the implementation of the programme. Teachers expressed concerns that they did not understand the new competency-based curriculum model, and that the competencies to be used in clinical assessments were not identified. The teachers were alarmed they lacked knowledge of the curriculum approach to implement it with confidence. The teaching methods advocated in the new curriculum were new and most teachers were not educationally prepared to use them. Previous nursing curricula in Fiji had used Primary Health Care and body systems approaches. Teachers were familiar with a mastery method of assessment used in the previous curriculum.

#### **4.5 Fullan's Educational Change Theory**

In order to place the study in its appropriate educational perspective, Fullan's educational change theory (2007) was used to supplement the indigenous research framework. The case in this study is the 2004 Diploma of Nursing curriculum in Fiji. As mentioned above, it was an external educational aid funded project with very little local input. Fullan's theory is most appropriate as it places the case in its relevant context, whereby educational and curriculum issues such as the contextual relevance of the curriculum content, the teaching and learning philosophies used, the issue of leadership in an institution undergoing an educational change, the educational preparedness of the teachers and the students to accept and implement a new educational innovation, and the issue of ownership of a new curriculum by the institution and the stakeholders are adequately addressed.

Fullan's theory of educational change identifies three phases in the change process: initiation, implementation and institutionalisation (Fullan, 2007). Each of the stages involves a change in structure, practice and belief in various combinations. The general feature of the process involves individuals, structures and practices within the organisations and at various levels in the education system. Therefore, a thorough understanding of the change process, actors, ideologies and structures involved and

effective interaction among them is increasingly necessary for successful implementation of an innovation.

### ***Initiation***

The initiation phase consists of the total process that leads up to, and includes, a decision to adopt or proceed with a change (Fullan, 2007). This may take many different forms ranging from a decision by a single authority to a broad-based mandate. This stage begins with the genesis of an idea that may take many years before such an idea can develop into a school or an education system. There are many factors associated with a planned or action-oriented change. Those relevant to this study include: the relevance of Fiji's Diploma of Nursing curriculum to the social and cultural context of nursing practice, access to information, advocacy, cultural safety, advocacy from central administration, the role of the Principal of the school, and teacher advocacy. In addition, external change, management, community support, government policy, funding, readiness of the users to adopt the innovation and the availability of the resources to carry it out are also significant factors to be considered (Fullan, 1991). These factors are interactive and the need for change can be embedded in any or several of these factors. Often change such as a new curriculum is redefined and modified in many ways before it becomes part of the work of those individuals and the school systems that initially originated it. Mobilisation of staff around the idea is an important activity in this phase (Fullan, 1991). The rationale for change in the educational preparation for the nurses in Fiji according to the curriculum consultants was three pronged. First, the dynamic growth of health care systems and technology, changes in demography, epidemiology, technology and medicine in Fiji and on the international front required a change in the nurses' curriculum. Second, the Australian consultants stated (mistakenly) the previous curriculum "was foreign as it was written by New Zealanders" (Usher, 2004a, p. 1), and should be localised and developed by the local staff. In fact, the World Health Organisation's curriculum consultant Nellida Castillo, the Fiji School of Nursing staff, and the senior nurse managers in the Ministry of Health had developed the previous curriculum in the early 1980s. And third, the

new curriculum should enable the Fiji School of Nursing to progress toward recognition by the university sector in the future.

Within the initiation stage of curriculum change, the strength of advocacy for such a change can easily decide the success or the failure of any innovation. Teacher advocacy or administrator advocacy can take many forms as they are dependent on the type of administration that runs the school. For the Fiji School of Nursing, administrator advocacy for the new curriculum was quite significant as the Ministry of Health teamed up with the AusAid consultants to advocate for and push for the implementation of the curriculum at the Fiji School of Nursing.

### ***Implementation***

The second phase in the process of educational change is implementation, which according to Fullan (2007), is “putting the initial ideas and practices or a set of activities and structures new to the people attempting or expected to change into wider use” (p. 84). The nature of the change according to Fullan (2007) can be externally imposed, or developed and adapted to suit local conditions and staff preference. Implemented changes may be modified or planned according to the needs and preference of those affected. The scale of change, however, depends considerably on the values, beliefs and expectations held by the participants at various levels in the system. Responsibilities have to be shared and spread in order to empower those who are taking on the innovation.

The transition from initiation to implementation should be handled with extreme care so a widening of groups and individuals involved in the change process support the ideas and practices advocated in the new change. The implementation stage has to be managed and someone has to assume the administrative and leadership role. The process of implementation indicates the actual grounding of an idea mooted in the initiation process.

Implementation process is only possible if the key variables or factors, which can determine success or failure of the educational change, are closely examined and addressed accordingly. Such factors may be internal (within the institution or the education system) or external (from outside the education system, government or country) and according to Fullan (2007) are interdependent and not isolated from each other. These factors are sets of variables, categorised into three main groups according to the nature of their influence on the educational change: i) characteristics of change, ii) the local characteristics and iii) the external factors.

Characteristics of change require the need for a change in the curriculum at the Fiji School of Nursing to be identified by the teachers involved in its implementation. It is not enough for the teachers to accept the change without understanding the rationale for a new curriculum and its practical application. The concept of clarity influences implementation and tends to be a significant and a common problem in change processes (M Fullan, 2007). In the case of the Diploma of Nursing in Fiji, attempts were made to identify clear goals, underlying philosophy of the curriculum, and how they were clearly interpreted and implemented by teachers, reflected in their teaching methods and the content of the curriculum. A lack of clarity in a new curriculum could lead to teachers' teaching previous curriculum content, and using teaching methods that they are comfortable with.

The quality and practicality of an innovation is a critical factor in the implementation process. The quality of a change such as a new curriculum refers to the nature of the implementation including the methods of teaching and the content of what is taught. For the new Diploma of Nursing curriculum in Fiji, quality could be compromised when such a change in the programme is politically driven, such as the external pressure exerted for immediate commencement without ample consideration for the readiness of the faculty, and when the availability of teaching resources and the timeline between the initiation decision and the start-up period is too short.

Local factors comprise social conditions and organisations that influence the change and the curriculum implementation process. These factors include the qualities of leadership exhibited by the principal, the governing board such as the Nursing Council and the teacher characteristics such as their enthusiasm, creativity, personality and their willingness to learn and share knowledge. In this study, factors such as the relationship between the Nurses, Midwives and Nurse Practitioners Board of Fiji and the Fiji School of Nursing will be examined by analysing the academic policies and the 'decisions' made by the board on the new curriculum. This is relevant as such policies and decision-making processes directly influence the outcome of the implementation of a new curriculum.

Fullan (2007) described external factors as influences on implementation within the context of a broader society. They include the availability of support for the School, the clarity in which people express their need for the new curriculum, the availability of funds and resources for the change and the implementation-monitoring policies that are being used to assess the success or failure of an innovation. Moreover, a change has to be supported by external assistance, technical help and physical resources at the right time and place. For Fiji, the latter external factor is relevant since the Fiji government and the Australian Aid consultants were heavily involved in the implementation phase of the project.

The key factors identified by Fullan (1991) related to the characteristics of change are need, clarity, complexity, quality and practicality. Factors associated with local characteristics include local environment, school community and school staff. External factors relate to government and other agencies that are important sources of resources. The key themes related to effective implementation are vision building, evolutionary-planning, initiative taking and empowerment, staff development and resource assistance and monitoring/problem coping (Fullan, 2007). All these six themes in concert are required for substantial change to occur and their gainful employment depends largely on the leadership of the organisation concerned.

### ***Institutionalisation***

Successful institutionalisation occurs when the change becomes an ongoing part of the system. This depends on the effectiveness of the two former phases. Institutionalisation is also made possible when (a) at the policy level commitment is made for the innovation to continue; (b) the external support is adapted to specific institutional needs; (c) there are efforts taken by the institution's leaders to maintain the new practices; and (d) where there is a sense of ownership among the users. It bears mentioning here that political factors (such as authority, colonial legacy, neo-colonialism), cultural perceptions (both academic and traditional) and different visions of education and development (that is, by various ethnic groups and social classes) act to facilitate or impede the change process (Miles, 1987). These perspectives are not sufficiently emphasised in the literature. Therefore this study will explore the experiences of teachers, students, and clinical nurse-educators in clinical settings, parents and members of the communities who represent the consumers of health services in Fiji. In addition the research will examine the ways in which the teachers develop their expertise, and how their attitudes and behaviour are influenced by a range of institutional, social, cultural, economical and political factors. Furthermore, an effort is made to identify the forces which shape the ways in which these participants responded to the demands made upon them, to examine the ways in which the complexities of change are reduced or increased for programme participants and by its participants. I also intended to examine the ways in which the people involved in the curriculum responded to the curriculum change and their experiences in implementing a new programme. The results from the study will provide policy makers with relevant information and insights that may contribute towards more innovations in nursing education in Fiji.

#### **4.6 The Research setting**

This research was carried out in Fiji at the Fiji School of Nursing, which primarily teaches the 2004 Diploma of Nursing curriculum. Supplementary data was also collected at the TISI Sangam School of Nursing; a privately run institution which

teaches the same curriculum. The decision to collect supplementary data from the TISI Sangam School of Nursing was made for the purpose of comparing observational notes and experiences of the teachers implementing the same curriculum in two different settings.

The Fiji School of Nursing was chosen ahead of the TISI Sangam School of Nursing because it is wholly administered by the Fiji government and the school roll accounts for more than 75% indigenous Fijians and 25% of other ethnic groups such as Indians, Chinese, Pacific Islanders and others. The TISI Sangam School of Nursing has a roll of about 90% Indian students and about 10% of Fijians and others. The choice of the FSN as the main research setting was attractive as it is familiar grounds for me having worked there for over 18 years. The school is a normal work place for me and my presence would have minimal disruption to academic activities within the school and classrooms. Similarly, the TISI Sangam School of Nursing staffs previously worked at the FSN and are known to me. The Fiji School of Nursing and the TISI Sangam School of Nursing are both western academic institutions with operational policies supported by western systems of government. The use of an indigenous framework served the purpose of acknowledging and documenting what would normally be relegated to 'behind the scenes' if only an academic 'western' research framework was used.

#### **4.7 Research participants: Recruitment process and the insider researcher**

In 2007, I made a presentation to the Ministry of Health in Fiji requesting ethical approval for my research and access to data sources within the Ministry of Health. The Ministry of Health gave me unlimited access to all documents in all the main administrative divisions in Fiji including the records section of the Ministry. These letters of approval are appended. The inclusion and exclusion criteria I had set for the participants included the following. All participants chosen had been involved in the curriculum at any one or more of Fullan's (2007) change phases, such as at the initiation stage implementation, and institutionalisation phases. Some participants

were asked to participate in the study because of their experience in teaching the curriculum although they were not involved in the coordination of the subject or the strand. Other participants, at least four, were strand coordinators within the new curriculum and they also taught various subjects in their strand. Administrators or leaders, such as the Director of Nursing and the Deputy Directors were also interviewed about their roles in the initiation of the change and the decision to implement the programme.

There were three subgroups of participants identified for this study; the common denominator was their degree of involvement with the curriculum change at the Fiji School of Nursing:

1. First level: Nurse administrators from the Ministry of Health, members of the Nurses, Midwives and Nurse Practitioners Board of Fiji and the Nurses Academic Committee.
2. Those actively involved in the implementation of the programme, including the Principal or her deputy, the coordinators of the programmes and those teachers who worked in the classrooms and in the clinical areas.
3. Those directly affected by the change of curriculum – the students and graduates. Included were registered nurses who were the first graduates of the new curriculum and had just joined the service in the previous seven months.

I also made presentations to two groups of students in their final year of training after approaching the Acting Principal and Year 3 coordinator for their consent. Students volunteered to listen to my second presentation where I described the research objectives in detail and answered questions related to their participation in the study. They were also asked to attend any of the three focus groups (see the Ethics section later in the chapter). Earlier in the research period, I had made my preference known to the class for the participation of indigenous Fijian students, because they were the majority population in the school and fitted in well with my indigenous research framework. However, Indian students wanting to participate were able to. I had

planned for three groups of six to seven members, but this number grew to nine for two groups.

A similar process was used for the graduates of the programme who were already practising as registered nurses in hospitals. For this group, I made the initial contact with the nurse managers of the hospitals which were selected on the basis of accessibility by car as well as for the availability of graduates. The nurse managers explained and distributed information sheets to those who indicated their willingness to participate. They only signed the consent form after I had further explained the study and their role on the day of the meeting. The final selection and inclusion of participants was not an easy task for me. I had to remind those who volunteered that I could not interview all of them due to methodological requirements. However, I did not encounter a situation where a participant refused to be involved or withdrew his/her participation after an initial involvement.

As an insider, the selection of participants for my research was influenced by my knowledge of the curriculum and the subject structure. I knew the coordinators of each strand and as they were also the most senior people in the school it was easy for me to approach them individually for their participation.

In giving permission to access Year students, the coordinator responded saying in Fijian “*Naita, oqori nodaru gone vuli. Ni cakava ga na ka o ni via cakava*”. Literally, she said Naita (a relationship between her people and my people) these are our students. You do what you want to do with them. In the Fijian context, what she meant was, they are our children. We will do what is best for them and we will do them no harm. Using students (children) even though they are adults means they are still vulnerable. They needed guidance and they were still learning. This places an enormous responsibility on an indigenous researcher on the way participants should be treated.

## **4.8 Data collection design**

Data was collected using a number of qualitative methods, including the:

- 1) collection and analysis of primary documents relevant to the case under investigation;
- 2) conduction of in-depth interviews using the culturally appropriate method of *Talanoa*, and
- 3) use of participant observation.

### ***Documentary analysis***

The collection of relevant documents was carried out during the first stage of data collection. The Ministry of Health made all records and reports in the Ministry's archives and records division available to me. A full list of documents accessed is appended. Documents collected were critically examined for authenticity and accuracy of dates and events. Documents such as reports were also used to identify people who later became participants in the study. Verifications of events, of people's roles and levels of involvement in the curriculum change were also cross-checked. The documents were also used to corroborate and augment evidence from other sources. Direct interpretation of data from these documents assisted in the analysis of information gathered from interviews and observations. A major problem encountered with this use of documents was the absence of some official records and reports at the Fiji School of Nursing. Weaknesses of documentary analysis are the biases of the writer and the incompleteness of the record over which the researcher seldom has any control. However, it was also noted the predominant oral tradition of indigenous Fijians could contribute to the laxity in record keeping of Fijian dominated western institutions.

### ***Participant observation***

In-depth interviews were conducted concurrently with participant observation. The participant observation was undertaken in two phases; the first phase involved mainly observing what was happening in classrooms and hospital settings during the

assessment periods. Observations were centred on two main activities; (a) the teaching methods that the teachers used in classrooms and tutorial sessions, and (b) the clinical supervision of students by clinical tutors or clinicians who were also nurse managers of the various wards in the hospitals. These practices were assessed against the teaching methods advocated in the curriculum. The leadership styles of the principals of the two schools of nursing were also assessed and compared in order to understand the impact of their leadership on the implementation and institutionalisation of the curriculum in their different schools. As this study became progressively focused, insights gained from this personal experience and from total immersion helped to improve the research questions and techniques. The unstructured observations confirmed or contradicted issues raised in the literature.

The second phase which formed the formal data gathering exercise involved activities such as participating in pedagogy, attending meetings, talking to research participants, taping speeches and discussions, interviewing and making field notes, completing diaries, writing minutes and memos, and collecting relevant documents and information. There were many informal discussions with the participants during tea breaks in the staff room, taking part in two farewell functions for retiring staff as well as after hours' functions for staff and students. This helped to create healthy and trusting relationships with respondents so that they could participate freely in the work of the school and that the activities that occurred in 'my presence' did not significantly differ from those that occurred in 'my absence'.

The strategy of participant observation also had a number of shortcomings. Gall, Borg and Gall (2007) pointed out that some of the more serious problems with the approach include the ethical problem of deception and reactions if the deception is discovered:

- the observer's participation may significantly modify the phenomenon one is studying, thus providing false information;
- the researcher may become emotionally involved and lose objectivity which may ultimately render the data collected unreliable; and

- the observer may have difficulty taking notes of observations, and therefore rely on memory and recording equipment.

### ***Talanoa***

*Talanoa* has increasingly gained popularity in its use by indigenous researchers in the Pacific as a culturally appropriate method of collecting data from the indigenous people of the Pacific (Nabobo-Baba, 2006; Otsuka, 2006; Prosser, 2006; Vaiioleti, 2006). *Talanoa* is a process whereby two or more people dialogue or where there is an interchange of information. The nature of *Talanoa*, the content of what is shared and the protocols observed vary according to context, to the age and relationships of the participants and the time of interaction. The *Talanoa* approach replaces in-depth interviews as a preferred and culturally appropriate method of data collection in this research. As a data collection strategy, *Talanoa* can be, first, an illuminating supplement as well as it cross-validates data gathered through other methods. Like in-depth interview, *Talanoa* is a two way process whereby the researcher can gauge whether the participants understand the issues raised and can determine the reason why an individual responds in a particular manner. Second, the method allows for the collection of data or information, which has direct bearing on the research objectives. Third, like interviews, the process makes it possible to record spontaneous answers, which may be more informative and in-depth. Finally, because of its open-ended nature and flexibility, it is possible to illicit more answers to issues and problems involved.

There are many variations of *Talanoa* depending on the nature of the information that is gathered and shared. In a Fijian context, the nature of *Talanoa* also depends on the social status of the people involved, the context in which it occurs and the time of using the *Talanoa* approach. There are formal sessions where people who are largely passive listeners and are not expected to contribute or voice an opinion, and there are some who have the authority to speak on behalf of the rest of the listeners. Such people speak and everyone else listens. However, in informal *Talanoa* sessions, social status is disregarded and the nature of the stories or information shared usually

encourages the participation of all invitees, and all sources of inhibitions are identified and addressed. The researcher's role may be a cause of inhibition and it is therefore important that a lighthearted atmosphere is created through sharing of niceties, drinks or a kava bowl without the formalities of a kava ceremony.

In other types of *Talanoa*, the participants could be friends, or close relatives with the same age group or may have common interest. Such *Talanoa* is very informal and the context is informal and less structured. There is lighthearted exchange of stories, jokes and drinking of Kava or tea. Passers-by can be invited to join in the dialogue and participants can leave and re-enter as they please. However, when using *Talanoa* in a data collection exercise the researcher needs to ensure that the context and the participants do not become obstacles to the sharing of information. The process needs to be well structured and supervised so that *Talanoa* brings out the required information, and the participants are not intimidated by technological equipment such as tape recorders, cameras, note books and pens. It has also been recorded by western researchers who had used *Talanoa* for data collection in Fiji that Fijians tended to 'lie' or give false information for some unknown reason, and when confronted, the informants tend to behave as if lying was not a serious offense (Otsuka, 2005, 2006).

### ***Protocols for Talanoa in group discussions***

Following a group discussion strategy, *Talanoa* was used to guide culturally appropriate discussion protocols and procedures. The processes of *Talanoa* were tape recorded for convenience, as writing during the sessions is considered insensitive and inappropriate in the Fijian context. In this group discussion, a formal presentation is made by the researcher to open the discussion and welcome the participants. In a Fijian village context an appropriate *yaqona* ceremony known as *I Sevusevu* would be made by me (researcher inviting the participants) to acknowledge their presence and formally invite them to the discussion. The *I Sevusevu* is normally accompanied by a presentation of a bundle of *Yaqona* roots paired with a formal speech which acknowledges the spirit of support and the sacrifice of personal time and resources to participate in the discussions. The *I Sevusevu* is always presented by a visitor when first

entering a Fijian village or a local person coming home after a lengthy absence, and is based on the concept of respect for the '*Vanua*' (land) and the people that own the land.

This Fijian ceremony is well documented (Ravuvu, 1983) and it is acknowledged as the gate keeper to Fijian hospitality. The participants, in response to my presentation are expected to reply and 'normally' commit their time and information to be given to me with some measure of caution as to its use and disposal. Participants generally do not refuse to participate after the presentation of *yaqona* ceremony and if they do, they would rather be physically absent than be silent or voice their refusal personally in a kava ceremony. The method of *Talanoa* is appropriate when formalities can become obstacles to the sharing of information and experiences. It was recommended to be used in my study because these graduates were my students and the student-teacher relationship in a Fijian context can be an obstacle in my data collection. In a *Talanoa* session, the participants are free to discuss issues, which may be important to them or to the study and are allowed to deviate a little from the topic if there are signs the topic does not sit comfortably with them. After a moment of deviation the discussions should be steered back to the topic by the researcher. However, in a focused *Talanoa*, discussions are usually managed and directed by the researcher so that time is not wasted on irrelevant issues. *Talanoa* in a Fijian context, if uncontrolled may digress to mere gossip, and this can render the data useless.

One of the greatest challenges with the data collection method used above was the lack of continuity in data collection and time management. Whilst it is acknowledged that time in a Fijian traditional society is not valued as it is in western academic settings (Liamputtong, 2010), it is also important that indigenous researchers are mindful of the time allocated for data collection and the amount of resources that are wasted if left uncontrolled. Fijians are 'communal' oriented people and like to gather in groups to *Talanoa* or contribute to informal or formal discussions. It is not uncommon to encounter uninvited contributors to a *Talanoa* session when

researching in a Fijian community and it is equally culturally inappropriate to ask them to leave or not to contribute (Prosser, 2006).

#### **4.9 Ethical considerations**

In 2007, approval for this study was gained from the Massey University Human Ethics Committee: Northern (MUHECN 07/057). In the same year, approval was also gained from Fiji's Ministry of Health Ethics Committee to conduct this study in Fiji. Both approvals are appended. There are marked differences in the way western academic institutions and traditional indigenous epistemologies define research protocols such as ethics, consent and authority (Nabobo-Baba, 2006), and these differences are described as they occurred in the research process later in this chapter. Using the indigenous Fijian research framework created a 'space' for Fijian protocols and practices relevant to ethical issues for documentation and acknowledgement. In this research both perspectives and protocols were observed and documented as they occurred at various stages of the fieldwork.

Formal western academic protocols required the approval of the Massey University Human Ethics committee and the Fiji government's Ministry of Health's Research and Ethics committee before I could proceed with data collection. The Ministry of Health had earlier approved my literature search within the Ministry of Health and had also written to officially inform the Fiji School of Nursing of my research needs and requirements. Even though I was a staff of the Fiji School of Nursing, and could have just 'walked' in and collected my data and 'walked' out, it was appropriate to pay my respects in a traditional manner to my colleagues and the school management as a token of appreciation and respect for their work in the school. Another ethical consideration when a researcher is researching his/her own institution is related to 'self-crusading' or self- advancement opportunities for some participants. This occurs when a participant uses the researcher as a vehicle to advance his/her own opinion to the view of senior officials in the Ministry or the government (Hayes, 2006). The

researcher was also mindful of the need for objectivity and confidentiality of information sources and this was observed throughout the data collection process.

#### **4.10 Accessing the participants: Gaining entry and re-entry into the research site**

Using the *Vanua* research framework created a 'space' for Fijian protocols and practices, relevant to the research process, to be adhered to and documented as they occurred at various stages of the fieldwork. *Vanua* research also privileged the indigenous Fijian nurses as well as the Fijian indigenous processes of teaching and learning and researching within a education institution informed by western traditions. Appropriate protocols to secure the support and cooperation of the students and staff were followed. Fijian protocols are embodied in its ethos such as *vakaturaga* and *veivakaturagataki* (to make someone feel important or showing respects normally reserved for chiefs), *veirokorokovi* and *veidokai* (mutual respectful relationships between two parties or two people) and *veinanumi* (to be considerate towards one another) (Ravuvu, 1987). The ethics of using the framework dictates that the researcher acknowledges and affirms existing protocols (western and indigenous) and that the participants (students and staff) are treated with respect at all times (Nabobo-Baba, 2006).

##### ***The I Sevusevu***

As a token of appreciation and acknowledgement of my colleagues, the *I Sevusevu* marked my formal re-entry into the school – my previous place of work. The *I 'Sevusevu'* is a way of presenting a 'face' to the people either in unfamiliar territories or familiar grounds. It is a traditional custom whereby a visitor pays respects on arrival at home, a village (a meeting) to the 'owners of the land' and requests are tabled and are usually given by the host. In such ceremonies, *yaqona* (or food items as tea) is formally presented to the leaders and staff and then shared in the same room. Acceptance of the 'presentation' is demonstrated by partaking in the ceremony and the *yaqona* or the food that is provided by the visitors. The *I Sevusevu* is also

performed when a person of higher rank or status visits a village or a function and the host will present *kava* to the person in acknowledgement and recognition of his status (Ravuvu, 1983). In my case, the school is familiar grounds. The staffs are my colleagues and are more like a family to me. The school set up is similar to a Fijian village where members have prescribed roles and statuses. As a member, I am traditionally obligated to adhere to protocols as a show of respect for my colleagues and my leaders. Instead of presenting *yaqona* (since it is prohibited in government offices and schools) tea, cakes and chocolates as substitute were shared with light-hearted accounts of my experiences in New Zealand, and then I was informed of news and developments of the school in my absence. I went prepared with many small souvenirs for the staff, my friends and relatives in the school. The gifts varied according to the nature of friendships, collegiality and social connectedness. For example, there were souvenir key rings, mugs and diaries decorated with Paua shells for the staff and principal, a few metres each of Maori printed dress materials for some relatives and an embroidered cardigan for a retiring colleague. While I wanted to portray a student image to my colleagues, I also knew that to come empty-handed was traditionally perceived as 'selfish' and '*mamaqi*' (stinginess). However, the *I Sevusevu* and the gifting of friends, colleagues and relatives ensured that subsequent individual meetings and data collection processes would proceed uninterrupted for the rest of my stay at the school.

#### **4.11 Confidentiality**

The issue of confidentiality of data and of participants' identities formed a very important aspect of the Massey University ethics application. Maintaining confidentiality of information and of participants is one issue that legally and morally binds the student researcher to the ethics committee's initial approval. The issue of remaining anonymous in a research study and being given a pseudonym for participants did not sit very well with my older participants. Some of them appeared very disappointed that their contributions would remain anonymous and their identity would not be revealed. For these participants, to participate or to contribute to something that would improve the educational preparation of nurses was something

to be proud of. To hide behind a pseudonym was considered to be sneaky and one told me after the interview that she felt as if her information was 'suspicious' and needed verification by another person. Nabobo-Baba (2007) related similar experiences in a Fijian village setting in her research. However, the younger participants such as the student groups and graduates needed to be assured of their anonymity for fear of victimisation by the Fiji School of Nursing and the Ministry of Health. This is understandable since these are younger members of society and they knew that voicing their opinions was inappropriate in the Fijian context. I did not seek the names or the identities of the graduates until I met them as they were previously my students and I did not want to pre-empt any conclusions regarding their participation.

#### **4.12 Consent process**

The presentation of the *I Sevusevu* to indigenous Fijians and their subsequent acceptance of it indicated their consent to participate in the study. The presentation of the *I Sevusevu* is also referred to by previous indigenous researchers as a *I Dola ni cakacaka* (an official commencement of the meeting or research process) (Prosser, 2006) and as an essential element of methodology (Waqavonovono, 1980). Ravuvu (1983) describes the *I Sevusevu* as the 'gatekeeper' to traditional Fijian protocols and the acceptance of the researcher to carry out a study within the *Vanua* depends on the presentation of the *I Sevusevu*. While the students and the new graduates happily signed the consent forms, the older participants were reluctant to sign. Even though these participants were educated and knew the value of consent forms, there were verbal expressions of reluctance and a concern on my part for their participation in this study. Therefore I needed to explain to the older participants the need to sign the consent forms, as this was Massey University requirement, which provided evidence that they willingly participated in my study.

#### **4.13 The insider-outsider location of the researcher**

The opportunity to research my own place of work and to use the indigenous framework presented a multiplicity of roles and responsibilities for me, as a staff

member and an indigenous Fijian. I have taught at the Fiji School of Nursing for 18 years and have taught two different Diploma of Nursing programmes at undergraduate levels. I was also mindful that I already had an exceptional amount of information regarding the school, the new curriculum and the operations of the institution. Maintaining objectivity with my data was one of the important issues that I needed to be aware of. Within the indigenous framework, it is important that the researcher does not appear to be already well informed and to outdo the participants. To downplay one's awareness of the issues of research is seen as appropriate and respectful towards the participants. In a Fijian context, to be asking questions about issues that one should know is tantamount to playing ignorance or pretending to be a visitor/guest. When I explained the questions that I was going to ask, one of the participants remarked like this: "*O kemuni ni kila vinaka sara tiko ga na kece kece...*" meaning that I knew everything about the school and its affairs (the answers to my questions). In an indigenous research study, Nabobo- Baba described a similar reaction of her people at *Vugalei* when she started asking questions (Nabobo-Baba, 2006). Her people questioned her motives in asking those questions. To ask such questions was seen to be playing ignorant or being stupid as it implied that they (her people) have not brought her up correctly. The challenge was to maintain objectivity in my data and it was not easy for an insider researcher or for an insider and temporary outsider to pretend 'not to know' and ask questions to which he/she already knew the answers.

Even though I was on study leave and a full time researcher, the fact remained I was staff and I had a lot of knowledge that my colleagues could access while I was there with them. During the study period, there were numerous occasions that I would be drawn into meetings and team discussions on assessments or examinations and other aspects of the curriculum. While I preferred to be an observer at most of the staff meetings, I would frequently be asked to contribute to discussions on the curriculum and students' assessments. While I was mindful of the ethical aspects of researching into my own institution, I also felt as an indigenous Fijian I needed to offer assistance and direction when it was requested. In my first week at the school, during morning tea, I learned the nursing practice team had not completed the health assessment

modules and they had only two weeks left before the students went out to the clinical areas. I observed the team discussing the odds and whether it was possible to complete their teaching in the following semester. Knowing that this was impossible for the team, I offered to complete the teaching for them. As I stood up, I was half expecting one of the teachers to counter my offer to teach, as I was only there to do my research but this did not happen. I quietly left the staff room and went into class using the power point lectures I had used at Massey University. Previous Fijian village-based studies by non-indigenous researchers stated that the success of any research within Fijian villages requires that the researchers are honest, have patience, are able to listen to them, are caring and are useful contributors to village or community functions (Defrain, Defrain, & Lepard, 1994).

As an indigenous Fijian, I had to be seen first as having concern for the institution and the welfare of the school. This meant that I also contributed to all the functions and obligations of the school such as contributing to the school farewell for its retiring principal and helping out with the Student Nurses' Christian Fellowship Crusade by providing refreshments and sandwiches for the evangelist team. On the very first day at the school, I received two student nurses from my province who heard that I had 'returned' and came to inquire about their students' tertiary allowance normally given by the province. I wanted to tell them that I was on leave and I did not know anything about their allowance or why it was not given earlier in the year. But in the indigenous Fijian worldview, being on study leave did not remove one's traditional obligations. I contacted the provincial office and I was promised that the allowance would be distributed immediately. As I was the only person from my province at the school, I had to ensure that there is a system in place for these students so they did not miss out on getting their annual allowance. To just focus on the collection of data and information would have been seen as 'un-Fijian' and selfish. I also realised from this exchange with the students that western academic institutions in Fiji do not have formal indigenous processes or channels of communications that could be accessed by Fijian provincial councils and their members when the need arises.

#### **4.14 Data analysis**

The analysis of the data collected for this study was guided by the curriculum evaluation model proposed by Stake (1996). The overarching frameworks of Fullan's educational change theory and the Fijian indigenous framework provided the interpretive paradigms required for the interpretation of data. Data collected from three qualitative methods and the documents collected for the case were triangulated within Stake's model to address the research questions in this study.

Stake (1995b) recommends strategic methods of analysing data be employed in any research, and he proposed the direct interpretation and the categorical aggregation of data until something can be said about them as a class (Stake, 1995a). The analysis of data takes into account the requirements of the indigenous Fijian framework, Stake's programme evaluation model and Fullan's theory of educational change. The indigenous worldview and indigenous epistemologies were used to critically analyse the Diploma of Nursing programme and its teaching and learning assessments and strategies. Direct interpretation of documents, interview and group discussion data, and observational information were carried out, aggregated and thematically analysed and grouped using three levels of nursing practice standards which are the professional level, the indigenous or traditional level and the government or ministerial level (Nursing Council of New Zealand, 1996a).

Consistent with qualitative research methods, data analysis had already begun in the field while collecting data. In order to reduce the threat of researcher bias in the interpretation of data and findings, Costa's (1992) recommendation that the analysis should be done collaboratively by the researcher and the participants was adopted. The rationale for collaborative analysis is that the participants are given a 'right of reply' and to confirm any interpretation, to support or to clarify the data at analysis level. During the transcribing of interviews and discussions, any issues, which I identified as requiring immediate redress by the school, were attended to prior to leaving the fieldwork site. This was consistent with the Vanua indigenous framework

whereby presenting the data back to the people for validation and for acknowledgement for their support is recommended. The Vanua indigenous framework also requires that I fully carry out the analysis of data as an indigenous researcher in this study (Nabobo-Baba, 2006).

#### **4.15 The Analysis Model**

Stake (1996) proposed a matrix of three components for the organisation of data collected. These are antecedents, transactions and outcomes (Figure 8). The three matrices form the intentions of the curriculum or a programme and the evaluator's job is to find out if these intentions were met. Antecedents are related to factors that exist prior to the implementation of a programme under investigation, and are what Fullan (2007) refers to as initiation. Information such as the initiation of ideas for a change may form the motivating factor for the implementation of a programme. Fullan (2007) in his theory of educational change contends ideas that eventually lead to and guide the development of a new programme, and the continuous persistence of that idea to see the implementation period through are important components of the first matrix. Such an idea may form the main intention for a change, which is the new programme or a new curriculum.

The available resources already accessible to the institution to support the new programme such as the library, the laboratories and internet facilities, the faculty staff who are qualified to implement the programme and the students' entry levels are included in the first matrix. Antecedents also include the relevant legislation that should support the implementation of the programme, which is considered mandatory. The level of preparedness of the stakeholders and consumers to accept the change also contributes to the success or the failure of the programme. Antecedents further include prerequisites (subjects) required to ensure that successful learning takes place. In nursing programmes, there are a number of subjects considered important antecedents, such as the biological and physical sciences, psychology and English language. Some institutions, such as the Fiji School of Nursing,

may make computer literacy a compulsory prerequisite for students. Antecedents are normally intentional to ensure successful implementation, in which case they can be strengthened, revised and improved intentionally to accommodate the change.

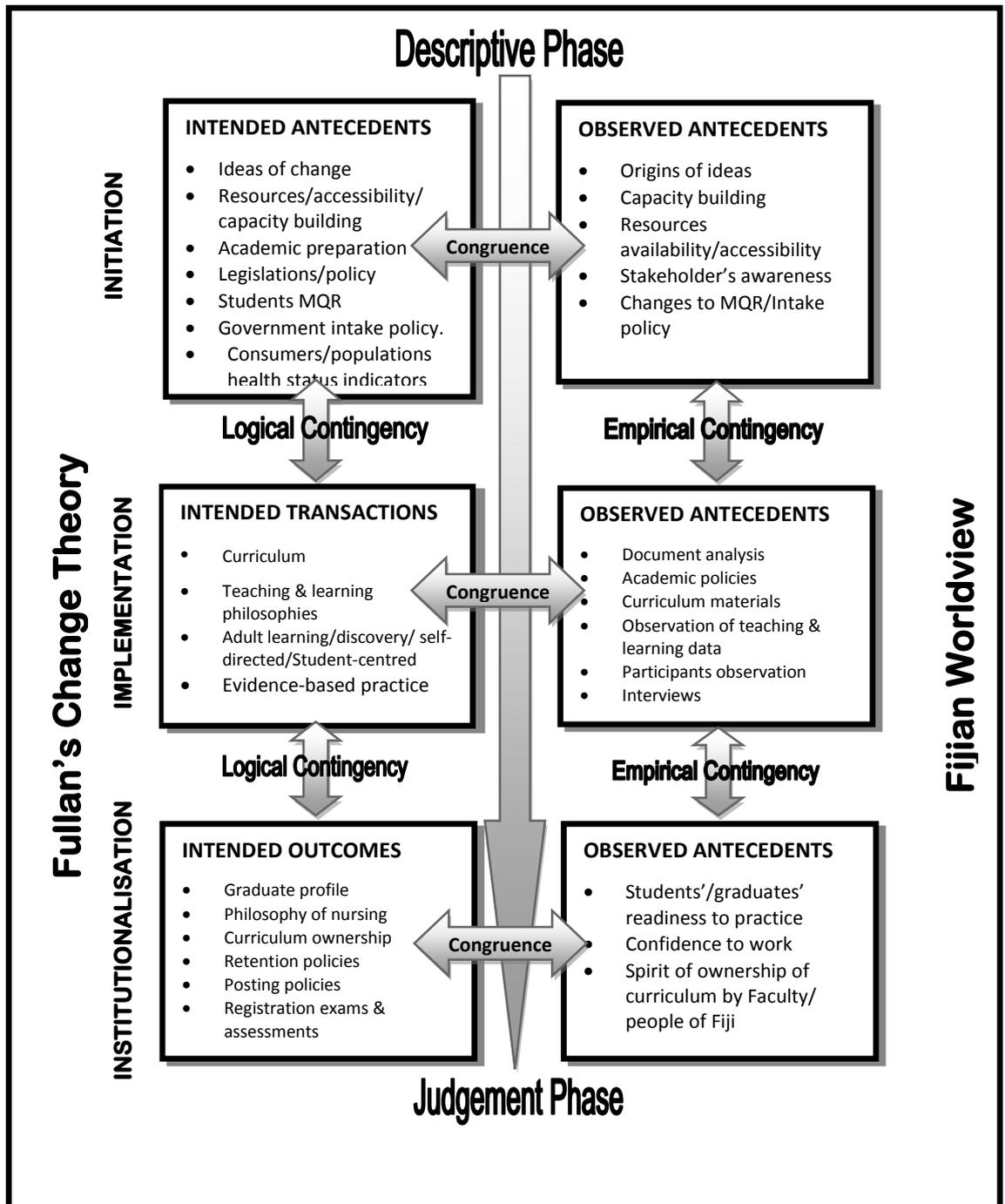


Figure 8. The data analysis model

Source. Adapted from Stake's evaluation model (1996)

The second matrix, transactions, refers to the processes that occur during the theory classes and the clinical experiences for students and their teachers, preceptors and nursing staff. The transaction matrix is described as the countless encounters of students with teachers, students with students, author with reader, parents with counsellor, and so many others that occur throughout the programme (Stake, 1996). This process is what Fullan (2007) refers to as implementation. Transactions occur throughout the programme and the main difference from antecedents and outcomes is that transactions are dynamic and the other two processes are static.

The third matrix, outcomes, consists of intentions, information and data that describe the student's ability, attitudes, behaviour, skills and aspirations at the end of an educational experience. Stake insists outcomes also include, apart from those elements that are evident at the end of a learning session, those applications, transfer and re-learning effects, which may be identified and measured long after the programme has ended. The 'outcomes' measurement of a programme may also indicate what Fullan (2007) referred to as the 'institutionalisation' of the programme whereby the faculty may decide whether the programme is a success or a failure or whether to claim ownership of it or reject it.

Contingencies and congruence (Figure 8) are two processes that describe the evaluation data especially applied to curriculum documents, teaching and learning processes and other curricular and policy documents included in evaluations. The principle of congruence is observed where the evaluation data either meets or does not meet the intentions of the curriculum and is observed during evaluation. Congruence does not indicate whether the outcomes are valid or reliable. Contingencies, on the other hand, are the relationships among the variables, which indicate the success of an outcome depends on a particular antecedent condition or an instructional transaction. Such contingencies may be planned or unplanned.

While the three matrices can adequately describe the model according to the analysis of the data collected, the quality of the curriculum under investigation was measured

against a set of professional nursing standards representing best international philosophies of nursing practice. In this study, the New Zealand standards for nursing practice were used to qualify the programme at three levels of practice: professional level, the traditional or indigenous level and the government or ministerial (employer) level (Nursing Council of New Zealand, 1996a). Fullan's theory and the Fijian indigenous worldview and epistemology guided the interpretation and analysis of the curriculum document and other policy and observational data for descriptive purposes. At the descriptive phase, both Fullan's theory and the indigenous Fijian worldview were used to analyse and describe the data.

Interview data was analysed through a thematic analysis using inductive and deductive processes according to Boyatzis (1998). Thematic analysis is a process of encoding and translating qualitative data which can then be grouped meaningfully into qualitative or quantitative data analysis and interpretation (Boyatzis, 1998). In such analysis, 'themes', which are patterns of meaningful observable phenomenon which maybe directly manifested in the research data or latently as underlying phenomenon. Themes according to Boyatzis (1998), can be generated either inductively from raw data or from encoding qualitative information, or deductively from prior research results and already existing theories.

According to Stake (1996) there are two major functions an evaluator needs to perform in a process of evaluation. The first is to describe the programme and the second function is for the evaluator to make a judgement on the quality of the programme that is being evaluated. Stake also reiterated the importance of passing 'judgement' on a curriculum being evaluated. Scriven (1967) in his earlier writings remarked that evaluation and judgement are two different processes altogether. He assigned the evaluators with the responsibility of passing judgements on a curriculum and indicated that there was no evaluation of the curriculum until judgement had been passed (Kyburz-Graber, 2004; Scriven, 1967).

#### **4.16 The issue of rigour in Case Study research**

Quantitative research studies set out to generate knowledge, to identify causal relationships and explanations; in this context, tests of validity, reliability are conventionally and appropriately applied to measure rigour. The increasing growth of qualitative research, however, has also increased the interest and arguments regarding the research rigour or the validity and reliability of qualitative approaches. Guba and Lincoln (1989) remarked that in research guided by an interpretive epistemological orientation, terms such as credibility, transferability, and dependability have replaced the usual positivist criteria of internal and external validity, reliability and objectivity. Many qualitative research approaches such as historical research, ethnography and narratives developed their own concepts or models to measure validity and rigour of qualitative research approaches.

In this study I have chosen to use the five quality criteria proposed by Kyburz-Graber (2004) as they are closely related to Yin's (1994) criteria of objectivity, reliability and validity. These five criteria are theoretical basis and case study control, triangulation of methods used, procedure documentation of a case study research project and case study report, designing a chain of evidence and the logic of generalisation. The theoretical basis of this study is supported by Fullan's educational change theory (2007) and the discourse on curriculum relevance in the Pacific, its teaching and learning philosophies and their appropriateness to the students as supported by Thaman (2003). As recommended by Stake (1995b), this study used the protocol of triangulation of data and data sources in order to gain insight of all perspectives into the case. In this study, participant observation data, documentary analysis and data generated from talanoa were triangulated to further illuminate data during thematic analysis. Rich data sources from triangulated methods enlighten data coding and guide inductive and deductive processes in the analysis.

The third criterion recommends the documentation of a case study report, which refers to the way in which the report is compiled and how the report and additional

material like the database can be made available for interested readers. Such criteria ensure that all sources of data and the types of data collected and all detailed descriptions of data analysis, evaluation and interpretation are reported and made available for further scrutiny when required by readers. This dissertation serves as a permanent record of the case study. In keeping with University protocols for research, raw data is stored for a prescribed period before it can be destroyed or removed.

According to Kyburz-Graber (2004) case studies are normally designed to reveal a distinct chain of evidence that is easily identifiable in reports. A chain of evidence may become visible in case studies during data collection where research questions reflecting the theoretical foundations of the study, may be evident in specific areas or concepts. Kyburz-Graber also indicated the chain of evidence may also be made visible through a structured data analysis and interpretation whereby a “coding system which links information to theories on one hand and research data on the other hand” (p. 61). Triangulated data in case studies serve to minimise subjectivity and enhance objectivity of the researcher and in thematic analysis, provides evidence through a charting of codes and themes generated from the data.

The logic of generalisation in case studies is an important quality criterion of qualitative case study research. However, the distinction between replication logic and statistical logic of generalisation needs to be made very clear because statistical generalisation can only be qualified through quantitative research methods where the basis of generalisations is made from a large quantity of survey data (Yin, 1994). Replication logic refers to the generalisation of the findings to the extent that they may be replicated in similar cases. Intrinsic types of case studies such as that used in this study have as its essential feature the uniqueness of a case that is being studied and that the findings from this study cannot be generalised to other similar cases (Stake, 1995a).

#### **4.17 Summary**

Stake's case study design was chosen for the exploratory nature of the research topic. Fullan's educational change theory and the Vanua indigenous research framework were used to inform the case study and to ground the research within the context of nursing education in Fiji. The use of both frameworks ensured the robustness of the methodology in terms of data collection and ensuring that the research was culturally sensitive and acceptable to participants. The Vanua framework privileged and facilitated the use of indigenous Fijian protocols and processes for research within a western oriented institution such as the Fiji School of Nursing and the Ministry of Health. The use of culturally appropriate methods of data collection such as Talanoa and the protocols of meetings, greetings and gifting were for the first time acknowledged and privileged within a western-based research process. The use of the Vanua research framework throughout the research process was a significant step towards the decolonisation of methodologies for Pacific research and the deconstruction of oppressive knowledge systems which according to Subramani (2001) would lead to the reconstitution and revitalization of traditional knowledge and ways of knowing of Pacific people.

## **Chapter 5: Antecedents of change**

### **5.1 Introduction**

The previous chapter described the methodology for this research and placed the study in its theoretical framework. This chapter discusses the intended and observed antecedents for the Diploma of Nursing (DipN) curriculum in Fiji including the initiation of the change, the processes involved, and the ideas that existed and were developed to support and guide the curriculum change. The two major themes which emerged from the analysis of the initiation phase of the change were: one, non-consultation of Fiji's Ministry of Health (MOH) and the relevant governing bodies of nursing education in Fiji on matters relating to nursing education; and two, the powerlessness that engulfed the teachers at the Fiji School of Nursing (FSN) during the initiation and implementation stages where the impacts of educational change antecedents are mostly useful. This chapter describes the observed antecedents as they related to the intended antecedents that were normally prescribed for the curriculum change. In this study it was found that all other antecedents in the initiation phase were linked to the primary element, which was the legislative authority to institute changes to nursing education.

### **5.2 The antecedents**

In any educational change, the prior existence of key antecedents such as students' attitudes and teachers' qualifications need to be established by the faculty (Stake, 1996). Antecedents are related to the pre-existing knowledge, qualifications, attitudes and behaviour that students and teachers bring into the curriculum which could contribute to the success of the programme itself. Antecedents could also include those factors that Fullan (2007) identified as initiation factors for an educational change, because they also have the potential of ensuring the success or the failure of

the programme. Antecedents that were found to be important in this study include those identified in Chapter 4 (Figure 4.2); these were analysed according to their existence and their role in the implementation and the continuation of the programme.

### **5.3 Legislative authority to support curriculum change**

Since its establishment, the FSN (formerly the Central Nursing School until 1978) has been administered by the MOH through the Nurses, Midwives and Nurse Practitioners Board of Fiji (NMNP Board). As previously discussed in Chapter 2, the NMNP Board administers and closely supervises the FSN through its academic arm – the Nurses Academic Committee (NAC). The NAC formulates and reviews all academic policies, provides guidelines and support for the administration of its policies and the implementation of all academic programmes.

The intended antecedents for the DipN programme included the existence of the legislation providing for the NMNP Board of Fiji to make or initiate changes to all nursing education programmes in Fiji.

The NMNP Board decides. Nursing education comes under the Board.  
(AD01, P.1)

While the Nurses, Midwives and Nurse Practitioners Act facilitates the decision making powers of the NMNP Board on matters relevant to nursing education, the power to make that decision also comes with the responsibility of placing the intended antecedents in the initiation phase of the change to ensure the success of the new programme. In the analysis of the initiation phase, it was found that the NMNP Board and the MOH failed in their legislative responsibility to put in place intended antecedents for the implementation of the curriculum.

#### ***The entry criteria***

The minimum qualification for entry into the new DipN curriculum is the same as for the previous curriculum, which includes that candidates must have attained passes in English, Biology and another Science subject with the total aggregate of at least 250 marks at Fiji School Leaving Certificate examination. Candidates must also be medically fit, must not have a police record and must pass an interview process conducted by the school's selection committee. The candidate must be aged between 18 and 25 years, single and a Fiji citizen (Fiji Ministry of Health, 2009). The different ethnic groups of people living in Fiji were all represented in the selection of students into the Fiji School of Nursing, which was guided by the affirmative action policy of successive Fijian dominated governments. The affirmative action policy allowed for the awarding of 50% of government scholarships to indigenous Fijians while the Indians and other ethnic groups shared the other 50%. The affirmative action policy also allowed indigenous Fijians greater access into tertiary institutions through the selection process and via the provision of a special fund to assist indigenous Fijians with scholarships into higher institutions locally and abroad. The rationale was to narrow the gap between the indigenous Fijians and the other ethnic groups especially the Indians. Over the years the affirmative action policy has seen both negative and positive effects on the nation's human resource capacities, but has not actually narrowed the gap between educational achievements as the attrition rate of indigenous Fijians from all institutions locally and abroad has continued to increase (Bacchus, et al., 2000). Sharma & Krishna (1996) noted that there were not many suitably qualified Fijians to take up the awards available to them so unqualified Fijians took up the awards, thus increasing the chances of attrition from the institutions of higher learning.

### ***The Diploma of Nursing curriculum document***

The curriculum document is an important antecedent, which can decide the implementation dates and the curriculum's success or failure. The DipN curriculum was mandated, as discussed in Chapter 2, to be a degree programme which was to be similar to the medical degree at the FSM (Biscoe, 2000). However the personal opinion of the then Permanent Secretary of Health (PSH) who was also chairman of the NMNP

Board kept the curriculum at a diploma level and not a degree as mandated by the Fiji government:

My personal view is that the basic nursing programme should be retained at diploma level, and the degree programme to be reserved for selected candidates (registered nurses) after a minimum service and experience requirement. (PSH/MOH: 30/4/02)

Absolute authority of the NMNP Board of Fiji can initiate a change or stop an innovation in nursing education such as that exercised by the PSH over the decision to develop a degree level course for nurses in Fiji.

On implementation in 2004, the curriculum as a document was incomplete with only the draft year one programme completed. Core subjects such as nursing practice were without their assessment forms and incomplete knowledge content. Other subjects such as Psychosocial nursing only had objectives and subject lecture headings.

### ***Educational policies***

The policies facilitating changes to the curriculum and its implementation were not developed by the NMNP Board or the Nurses' Academic Committee (NAC) as expected by legislation. As a result, the implementation of the new curriculum in September 2004 went ahead without the relevant policy changes until the teachers (FSN 05) and the curriculum consultant began to request it from the school management. The consultant tasked with the implementation of the curriculum also expressed, in her report at the end of the first year, the frustration of her assignment:

I requested a copy of the policies that were recently ratified by the NMNP Board from ...and..., to review these and discuss their implementation/suggest further policies; but I did not receive a copy of the policies (Tollefson, 2005, p. 5).

The absence of a guiding policy for the new curriculum created a lot of confusion amongst teachers and staff for the first year of the curriculum.

I was worried because there was no documented policy. You know a policy that you could see in black and white. My understanding was that if you have a new curriculum, you should have a new policy. (FSN 04: p.3)

The assessment policy (NMNP Board: 09/2005), ratified by the NMNP Board one year after the implementation of the new curriculum, was still in its draft form during this study. The policy describes the rationale for assessment and its importance in education but falls short of identifying the assessment methods for the competency-based curriculum being implemented. The policy also does not indicate the Board's requirement for registration since the curriculum uses the competencies that are assessed at every semester and at the end of the year. However in September 2007, the Board produced a separate policy for the final qualifying examinations for both schools of nursing in Fiji (the FSN and the TISI Sangam School of Nursing) (MOH, 2009). In the 2007 policy, the Board tabled the criteria required for completion of training and the final theoretical and clinical examination (OSCE). In its usual display of authority over the school, the Board stipulated that failures from the final theoretical and OSCE examinations may appeal to the Board for supplementary examinations and reconsideration of repeating the examinations at a later date. It is clear from this policy that there is a lack of authority vested in the Fiji School of Nursing as there is no consideration given to the roles of the existing examination committee of the school or the NAC, which is the academic arm of the Board. The NMNP Board is noted to be too directly involved with the affairs of the school overlapping with the role of the NAC. This has resulted in a case where the NMNP Board directly administers the school stepping over the NAC, the Principal and Deputy Principal and this dis-empowers the FSN. The school has thus become dependent on the Board for all decisions relating to its affairs. Such a relationship breeds helplessness and does not allow the school the freedom to do its work and conduct its own affairs as an academic institution. On the other hand the NAC was also observed to be idle, not having any influence or advocacy roles and input during the initiation period. During the first year of the implementation, there was no policy issued from the NAC given that its sole responsibility was the Fiji School of Nursing.

## 5.4 Resources to support curriculum change

Fullan (2007) identifies the availability of adequate resources, capacity of faculty and an external advocate as well as an internal desire of the faculty to change a curriculum as key determinants in a successful programme implementation. The NMNP Board of Fiji failed in its responsibility to nursing education, to put in place facilities, administrative and physical structures and resources to support a major curriculum change in nursing in Fiji. Academic support processes and physical amenities such as adequate classrooms and buildings to accommodate students' and teachers' needs are important antecedents that need assessment prior to any curriculum change (Keating, 2006).

The teaching and learning approach advocated by the new curriculum such as student-centred teaching and discovery learning strategies required a borrowing library and internet facilities, computer access and printers. These antecedents were not available to the students at the implementation of the new curriculum. For the first cohort of students, the study found that the large intake compounded many problems of overcrowding, stress and burnout of teachers and staff, shortage of equipment, shortage of textbooks and reading materials for students and a general lack of space for lectures and library.

The curriculum consultant in the FSN curriculum review listed her prioritised areas for the MOH to address prior to implementation of the curriculum as follows:

- The refurbishment, air-conditioning, equipping and stocking of the FSN library;
- The refurbishment and equipping of the FSN clinical skills laboratory;
- The employment of a clinical skills laboratory manager;
- ...The provision of adequate teaching resources;
- The refurbishment of the FSN kitchen/dining room, lecture theatre and auditorium; and
- The building of extra offices for teachers so that more classrooms could be available for tutorials. (Usher, 2004:5)

Most of the proposed improvements were met towards the end of the first year of implementation. However, the facilities were not capable of accommodating the needs of the 198 students who enrolled for the first intake into the new curriculum. The library capacity was further reduced from its former 60 seating capacity to 40 and its status changed to 'reference only' library indefinitely. The dining room took the whole year to be renovated and the only lecture theatre that could accommodate the new class was the 200 capacity school auditorium. Teaching resources did not improve or expand to accommodate the needs of the teachers. The library remained under resourced for books and computers and only one photocopier was available in the library for all the students.

### **5.5 Health status indicators**

Other variables that may influence the initiation of a change in the curriculum for nurses are the prevailing state of health of a country and the pressure from a single authority or a community. If education is a process of worthwhile learning then the curriculum should prepare the students with knowledge that will be useful in addressing community needs and its survival. In nursing curricula, the context of the education process includes the contemporary state of health of the people that may influence curricula content and the teaching methods and focus of the curriculum. At the time of the initiation of the change at the FSN, the health status indicators for the country indicated a triple burden of rising non communicable diseases (NCDs), the re-emergence of previously controlled infectious diseases such as tuberculosis and leprosy, and the continuing trend of communicable diseases, epidemics such as HIV/AIDS, avian flu and others (MOH, 2005). At the time of the review of the curriculum, Fiji was already using a multi-sectoral approach to addressing ill health and disease prevention. While this is not reflected in the curriculum document itself, health promotion as its main focus should be more readily integrated throughout the curriculum content.

## **5.6 External advocacy and consultation issues**

Fullan (2007) identifies external advocacy as initiation of an educational change from outside the institution, such as an outside organisation or the central administration. However, external advocacy can only work if the implementers of change within the institution accept the change and advocate the change internally. The subsequent success or failure of the change depends on the nature and the degree of internal advocacy displayed by the implementers within the institution.

For the FSN, the advocacy for change came from the NMNP Board and the MOH after the mandate came from the Fiji government (Biscoe, 2000). The decision to change the undergraduate curriculum at the Fiji School of Nursing was related to the Fiji government's plan to merge the FSN and the Fiji School of Medicine, a move which required the strengthening and improvement of the FSN's diploma level curriculum.

### ***Absence of consultation in the initiation phase***

The NMNP Board of Fiji decided and mobilised the process of reviewing the curriculum of the FSN without active consultation with the FSN. Documents analysed supported the statement that the NMNP Board 'decides' when a change is needed or not needed for nursing education. There is little evidence that the academic arm of the NMNP Board, the NAC, was fully aware of the imminent changes taking place in the FSN. Advocacy from the central organisation – notably by the NMNP Board – did not involve the FSN, as the school responsible for teaching the curriculum under review. In its decision to review the curriculum and develop a new programme, the NMNP Board had the responsibility of producing policies to guide the implementation of the new curriculum and to review the minimum entry requirement for candidates. In its capacity of administering the affairs of the school, the NMNP Board had already decided on the use of the competencies for the new curriculum. In the first place, the NMNP Board as the only Board responsible for nursing education has a duty to inform all stakeholders of the impending changes to the educational preparation of nurses in Fiji. The Board failed to fully prepare the faculty and the clinicians on the plans to review and develop a new curriculum. The official communication memorandums from

the Ministry of Health to the FSN informing them of the changes and the role of the school indicated a condescending attitude towards subordinates (MOH: MD 18/2/17:2002). The MOH and NMNP Board's non-consultative attitude towards the curriculum change manifested in a number of ways, as discussed below.

### ***Top-down approach to development and implementation***

Teachers and clinicians in this study stated that like many other things that happen in the Ministry of Health, they were 'just told' of the curriculum review. Many teachers were quite unaware of the decision to change the curriculum.

I am sorry to say that I am one of the lower ranks and half of the time I never knew what was happening from the top ranks. The idea to change the curriculum only came from above. You know what the nursing school is like; when any changes come, normally we are 'just told'. (FSA 02:1)

However, teachers were also aware of the need to review the curriculum and were therefore grateful for the opportunity to review and update the undergraduate curriculum. When asked about the idea of a change in curriculum a senior academic stated:

We come under the MOH; particularly under the direction of our nursing heads. When we were told about the change we were also convinced that the previous curriculum was old and there were parts that required reviewing. (FSN 01, p.1)

In a similar tone other teachers were excited at the idea of reviewing the curriculum and being involved in the change, even though they were not initially consulted by the Ministry of Health.

When they brought this idea across, I jumped because I thought this is a change; maybe it's good and 'let's take it on'. I saw it as a chance to improve the school. (FSN 04, p.1)

Teachers are excellent advocates of curriculum innovation when they can identify and understand the need for a change in curriculum. Teachers innovate daily within their classrooms, out in the field and at national level when the conditions are favourable and there is adequate support processes in place for them. For a major innovation project such as the new curriculum, the teachers' enthusiasm for a change needs support from management and the central administration to sustain the momentum

of change. When teachers become advocates for innovation, they become the best support system for their colleagues (Fullan, 2007).

There was no evidence that a contextual analysis was carried out by the NMNP board or the curriculum review team for the new curriculum, but the Board decided that the PHC approach of the previous curriculum was outdated. A contextual analysis of the curriculum would have revealed the relevance of the western oriented medical ideas in relation to the indigenous perspective of health and illness. The relevance of the curriculum knowledge to be advocated in the curriculum would have been analysed against other ethnic groups that also compose the Fijian population.

Contrary to what the JCU curriculum team stated in their report, the previous curriculum was developed by the WHO and the nurses of Fiji and not by New Zealand. The JCU in its rationale for review stated that the:

“...current FSN curriculum...was developed with the assistance of the New Zealand nurses in the early 1970s” and was thus justifiable and timely for a review (Usher, 2004a).

### ***Misunderstanding of curriculum review rationale***

The lack of consultation led to misunderstanding between teachers and foreign consultants and between clinical stakeholders and the teachers at the FSN. The teachers, the NMNP Board and the JCU team reviewing the curriculum, perceived the rationale for the review and the subsequent change in the curriculum differently from each other. While the JCU team explained that the review had a mission to upgrade the curriculum to a tertiary level programme in preparation for the merger of the FSN with the Fiji School of Medicine, the teachers understood that the older curriculum was only being reviewed for its knowledge content and to upgrade the same curriculum to a degree level. Senior academics at the school related their understanding of the change thus:

But we, the faculty, all we knew was that the older Diploma of Nursing programme was going to be reviewed and upgraded to a degree programme. The older things get renewed, new knowledge and out of date ones are removed and so forth. But we thought it was only a review where

we would just strengthen the parts that needed strengthening and then upgrade it. But it was not what those people from Australia had in mind. They had a different motive and we had a different one. (FSA 03: 2)

The clinical staffs from the two main teaching hospitals and the community health sector were not aware of the change in the curriculum at the FSN. Preceptors who were interviewed confirmed hearing about the change from attending a preceptors' workshop, which was conducted long after the programme implementation in 2004.

The FSN staff came and held workshops with us in Lautoka...and we were trained on the assessment and the new approach of the curriculum. (PR 01: 1)

### ***Non-consultation during the initiation stage***

One significant issue that became very clear during data collection was the lack of consultation of the NMNP Board in relation to the FSN and its stakeholders in the clinical practice areas as well as the consumers of health services during the initiation of change. Even though the NMNP Board is made up of representatives from the heads of all nursing division, the Principal of the FSN and the consumers' representative, the information on the activities of the NMNP Board and the JCU were never disseminated to the people they represented. There is no evidence of any effort on the part of the NMNP Board to consult with the school, the clinicians or other stakeholders such as the Fiji Nursing Association, the Fiji Medical Association the Fiji School of Medicine and the consumer representatives in Fiji.

I learned about the change from my friend (a tutor at the Fiji School of Nursing) who asked me informally if I knew about the change and the impending workshop for preceptors. (PR02:2)

Most of us at my level were not aware of the change in the curriculum at the school until it was implemented and then we were invited to that workshop for preceptors... I think the manager nursing from each base hospitals have a duty to inform us as we are the teaching hospitals. But we were never told; at least for me (a senior nurse manager) I did not know anything about the change until it was implemented. There was no consultation whatsoever during the review period. (PR 01, p.7)

The lack of consultation and the manifested spirit of *Veikalawaci* by the NMNP board were seen to have contributed to the problems that unfolded during the implementation of the 2004 curriculum. These problems manifested themselves within

each of Fullan's four main characteristics of curriculum change. They include the need for curriculum change, the clarity of the curriculum objectives, the complexity of the change and the quality of the curriculum to be used in the change.

## **5.7 Need for the change**

Many innovations are attempted without a careful examination of whether or not they address what are perceived to be priority needs ( Fullan, 2007, p. 88).

According to a former Principal of the FSN, the need to have the review done was tabled in 1998 and again in 2002 when the recommendation to merge the FSN with the Fiji School of Medicine was made by the World Health Organisation (FSN08). The study also identified other factors such as the need to align nurse education in Fiji to international trends (FSA01) and also to upgrade it to a degree level (FSA 03). The Ministry of Health used the opportunity for the curriculum review as a chance to address the need to put in place a performance management system for its registered nurses who are civil servants. Fiji, being a member of the Western Pacific and South East Asian Region (WPSEAR), chose to adopt draft competency standards developed at its 2002 meeting in Hong Kong. Ironically, the standards were developed to serve as a benchmark for all Pacific nurses intending to enter New Zealand and Australia and were adopted by Fiji in its draft format without any revision (WPSEAR, 2006).

The need for curriculum change can be discussed at three levels of the organisation. These are the school level or faculty level, the community level and the government level. Consistent with contemporary literature, the teachers at the FSN had long expressed the need to review and update the 1983 Diploma of Nursing programme (FSN 05; FSN 06; FSN 03; FSN 08) in order to address contemporary health issues in Fiji. The review became possible with funding from the AusAid's Fiji Health Sector Improvement project (FSHIP). At the community level, the media has highlighted the need for curriculum review. Media reports were often complaints and criticisms of nurses' negligence and unethical behaviour (M. Pande, Finau, & Roberts, 2004). While there were expressed needs for curriculum review by stakeholders of nursing

education, there were differences on what constituted the need for reform. The Fiji School of Nursing (FSN) identified different parts of the curriculum such as medical and surgical nursing as needing review, while the general public highlighted through the media the need to address the professional behaviour of nurses, which questioned the integrity of the curriculum. On the other hand the Ministry of Health (MOH) was more concerned with the need to produce nurses on a large scale to replace the continuous attrition of nurses overseas without interrupting the annual production of nurses to serve Fiji.

The health challenges for indigenous Fijians steadily worsened in the decade prior to the curriculum review (MOH, 2001). In addition, increased breakdown of indigenous social structures indicated by the worsening social diseases as STIs, HIV/AIDs, teenage pregnancies, drug related illnesses and crimes, psychiatric disorders mostly affecting teenage indigenous Fijians, demand a complete review of all school curricula. However, the NMNP board failed to recognise the need to re-focus the nursing curriculum on the worsening health and social indicators for the indigenous Fijians. The need for an improvement in the FSN curriculum was perceived to be closely related to contemporary trends in nursing education and more concerned with meeting off-shore standards and competencies than with Fiji's needs. The wholesale adoption of the Hong Kong draft competency criteria (Lum, 2002) without adequate local adaptation is evidence of Fiji's preoccupation with international standards without adequate consideration for local health needs of its people.

### ***Clarity of goals and objectives of the new curriculum***

Earlier studies by Gross, Giacquinta & Bernstein (1971) supported by Fullan (2007) warned that lack of clarity of goals has been a perennial problem of implementation; teachers and all stakeholders need to be fully aware of the goals, the philosophies and the curriculum approach long before any implementation takes place. In this study the teachers were found to be comfortable with a state of 'false clarity' whereby there was superficial understanding of curriculum processes, approaches and teaching methodologies. Fullan (2007) describes false clarity as "When change is interpreted in

an oversimplified way, that is, the proposed change has more to it than people perceive or realize” (p. 89). This was true for this study when at implementation, participants testified to being shocked at the nature of the new curriculum as they expected something similar to the previous curriculum (FSN 04, FSA 03, FSA 01 and FSN 03).

The study found that the teachers were teaching subject content that they were comfortable with, other than what was contained in the curriculum. Moreover, the teachers used teaching methods and assessments that they were familiar with and comfortable to use rather than those advocated by the curriculum. A common practice observed during the fieldwork was that teachers would change the content if they did not understand it and taught what they knew or what they felt was important for the students to know.

The lack of clarity of the curriculum was also demonstrated by the minutes of the Curriculum Development Committee (CDC) and the Teaching and Learning Committee (TLC), which were full of discussions of alignment problems amongst the four strands. After three years of implementation, the school continued to be confused over the curriculum and its different strands. The lack of clarity was also related to the fact that the teachers who themselves needed direction for teaching the new curriculum were also members of the curriculum committees with one of them being the Chairperson. The CDC, TLC and the Assessments and Examinations Committee, which were formulated to provide guidance and direction to the teachers and to develop policies for the new curriculum, were themselves in need of leadership and guidance. At the time of the research (2008) no mapping of the curriculum had been done considering the problems of overlapping content that the teachers experienced over the three years. The problem of clarity and non-clarity is discussed further in this chapter under implementation.

### ***Quality and practicality of the curriculum***

The quality of the new programme was assessed by the nature and characteristics of the curriculum documents produced by the project team. The participants felt that the new curriculum was incomplete when presented for implementation in 2004. The document was presented with the year 1 syllabus in draft form and the year 2 and 3 syllabi were not completed, with the expectation that the teachers would write them up as part of their curriculum development training and empowerment strategy. However, as I observed during data collection, the teachers did not understand this strategy and complained bitterly that curriculum was incomplete and they were too overloaded with work to carry out any curriculum development work (FSN 01). Moreover, the teachers lamented the lack of guidance to support them if they were to write up curriculum materials (FSA 02).

It was also found that the quality of the change was greatly affected by the manner in which the implementation took place. Firstly, the rushed commencement date of the programme (18<sup>th</sup> September 2004) was a very busy time for the Fiji School of Nursing when year 3 students were in their culmination period for their programme and the year 2 students were completing lectures and beginning the specialty areas in nursing. Secondly, the study found that the curriculum was implemented in spite of the gross deficit in resources to support a new curriculum. For example, the new curriculum advocated discovery methods of teaching, self-directed learning for students and expected students to type essays and assignments. However, there were no computers or internet facilities or printers available for students and teachers. The teachers who taught nursing subjects such as medical and surgical nursing, obstetrics and paediatrics suggested that the graduates ought to work under supervision for at least one year in the base hospitals before being posted to outer stations of the country. There was a general lack of confidence amongst the teachers over the skill levels and the safety of the nurses to practice without supervision in rural stations and communities soon after graduation, due to the many gaps in knowledge and clinical learning of the students.

Most of the teachers could not complete their teaching successfully for individual subjects and also did not have adequate time to do justice to each subject. Other subjects such as community health, which was totally missed out and replaced by primary health care, made the teachers more apprehensive about the integrity of the curriculum in adequately preparing the nurses for practice in the community and especially in the rural areas. In essence, from their perspectives, the curriculum did not produce the graduates required for practice in Fiji.

The issue of the practicality of the course was assessed against the transferability of the classroom learning to the clinical setting. This study found that problems in the implementation of learning in the clinical setting were caused by a number of factors related to the curriculum. There were no clinical guidelines or clinical assessment forms provided by the project team to be used with the curriculum document. This was compounded by the lack of awareness of the teachers about competencies and how students were to be assessed in the clinical settings. Secondly, 198 students enrolled in the first class of the new programme and this created an overcrowding in the low care wards available in the main teaching hospitals.

### ***Complexity of the change process and the demands made upon the teachers***

The complexity of any change is measured against the difficulty and the extent to which individuals and participants of a change contribute towards the implementation of the change. The Diploma of Nursing programme constituted a multiplicity of interacting variables which made the change very complex. At the curriculum level, the curriculum document demanded time and comprehension by the teachers to teach and administer it and the teaching and learning philosophies demanded a multitude of resources to support it. The annual budgetary allocation is never enough to support any innovation at the FSN. For a full scale curriculum project, foreign aid had to be sought to sustain its requirements for resources. The production of the required materials for individual subjects and the students was huge and demanded a lot of the teachers' personal resources. However, the school with a capable leadership can

regularly update curriculum content and skills through workshops and internal revision.

The complexity of the change ‘burdened’ the teachers; the implementers of the programme more than any other group of stakeholders in Fiji (see Figure 9). Teachers worked in a context without adequate support from the nursing leaders and the NMNP board of Fiji and the NAC. The complexity of the change forces was made complicated by the shifting of teachers from one strand to another within the first three years.

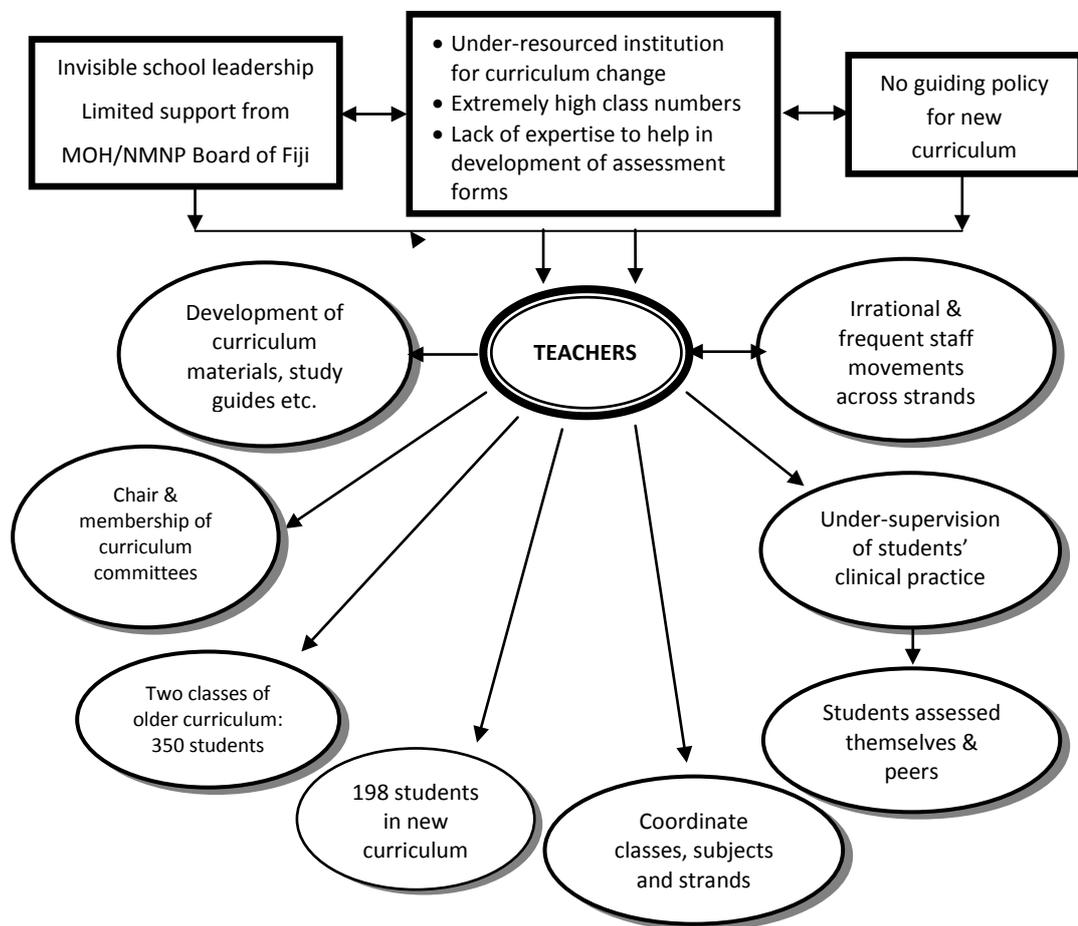


Figure 9. Complexity of factors and demands made on teachers at implementation of the curriculum

Teachers were expected to teach both cohorts of the older curriculum and the new curriculum and also to supervise their clinical practice in the community health nursing areas as well as the hospitals and special nursing areas such as obstetrics, paediatrics, psychiatry and others. The study found that the teachers found it difficult to teach two different classes with two different teaching approaches and learning demands. While the older classes required lectures only, the students in the new curriculum received lectures and tutorials immediately after lectures and thus demanded more time from the teachers. The nature and the structure of the new curriculum kept teachers with the new class longer than they spent with the older classes and this led to ill feelings between students of both classes (FSN 06).

### **5.8 Lack of buy-in commitment and hostility of clinicians**

Preceptors maintained that there were no consultations about, nor any awareness of, the review and the development of the new curriculum. The only invitation they received was for the nursing managers to attend the presentation of the curriculum review report. Senior clinicians referred to the lack of consultation by the NMNP Board and the senior nurses as well as the FSN's lapse of communication with its clinical partners.

I never knew anything about the change...until it was implemented and we were notified to attend the preceptors' workshop after the school implemented the curriculum in 2004. There was no consultation whatsoever during the review period... and we are the stakeholders and it would have been an opportune time for us to give our views... maybe the school was too busy to inform us but the NMNP Board has a duty to inform us because we are the training hospital! Even after the workshop, most of the clinicians just flatly refused to supervise or precept students. I think that was why there was so much hostility amongst us regarding the new curriculum (PR 01, p.8).

The FSN/JCU team did not consult the stakeholders like the clinicians in the two main teaching hospitals and divisions to create awareness and clarify teaching methods, curriculum approach and the role of clinicians in the new curriculum. The hostile relationships and the breakdown in the professional relationships of the teachers and the clinicians can be directly traced to the lack of initial awareness and consultations between the FSN/JCU/MOH and the stakeholders. The problems that ensued between the student/graduates and the preceptors are also directly related to the lack of

consultations by the Ministry of Health to create awareness of the curriculum change. In the words of a senior academic:

There was no consultation done with the consumers and stakeholders. To my knowledge, I have seen that people in the clinical do not quite understand this curriculum...there were no consultation and curriculum awareness was not done. My opinion is that it should have been done because they are the recipients of our graduates and our services...by contacting them we would have been doing the right thing. And if they had participated in this curriculum their cooperation would be better. (FSN 01, p.6)

The nature of the top-down administrative style of management prevalent in Fiji within the nursing division filtered down to the FSN and other nursing management areas were seen as autocratic and this created many problems for the students and the teachers in the new curriculum:

Whatever happens here reflects the leadership of the nursing fraternity in Fiji... As more of a traditional type, something that they inherited... I believe in participatory management...when we come up with ideas for innovations and we bring it across, they are just shunned! (FSN 04, p.9).

## **5.9 Capacity building**

In any educational change or innovation, the capacity to implement and sustain a programme depends on the capacity of the faculty or institution. Fullan (2007) refers to studies that explore the way in which the innovative capacity of an organisation and educational systems engage in continuous improvement as capacity building focused. The curriculum project team sought to initiate the changes and the capacity of the FSN and its personnel, to strengthen and improve its resources and all its support processes continuously from 2002.

(2006), in her description of the internal frame factors that are necessary to support planning and developing a new nursing programme, identified the resources and the capacity of the institution as having a major impact on programme's existence and sustainability. The capacity of an institution to sustain or to support a new programme includes the qualifications of the teaching staff, the leadership potentials of the head of the institution, the physical amenities such as the school buildings and the dining rooms; the academic facilities such as the library, the internet lab and the science and

demonstration labs are all key variables that need to be assessed before the implementation of any curriculum change, because they impact on the success or the failure of the programme. In the proposal to upgrade the FSN curriculum, the curriculum review consultants tabled the need to improve the capacity of the FSN before implementing any change in curriculum. A proposal by JCU to offer up-skilling programmes to improve the qualifications of the staff before improving the FSN's curriculum to tertiary level was accepted by the Fiji government in 2001(JCU: 20/11/2001). The WHO awarded 25 registered nurses including 11 teachers of the FSN for up-skilling programmes such as bridging courses to a BN degree, which were offered locally at the FSN campus. The Ministry of Health paid the total cost of the JCU's teaching locally at the Fiji School of Nursing campus the sum of \$AU153, 125.00 with the WHO paying for the 25 students' fees at \$F1197.50 per student as book allowance (MD18/2/54:14/5/02) ;(JCU: 26/03/02). Biscoe (2000) recommended the up-skilling of the teachers' qualifications to degree level and identified in her report that there were two universities already providing degree courses for nurses in Fiji each with its own campus. Fiji could have saved much of its In-service Training Funds by utilising the University of Southern Queensland and Central Queensland University to carry out its up-skilling programme as their campuses were already well established in Suva and they have been providing degree courses for nurses for more than a decade.

### **5.10 Local counterparts in curriculum review**

The Ministry of Health externally advocated the initiation of the FSN project with the NMNP Board of Fiji by recruiting the review team from Australia and effectively appointing the same institution to develop the new curriculum. No local counterpart or local advisor was appointed to work with the team from the James Cook University of Townsville in Australia as documented in the report of the review and the development of the curriculum (Usher, 2004a). The resulting alienation of the people included the teachers at the FSN, the clinicians who worked in the teaching hospitals as well as the community health areas and the consumers of the health services. The

project was typical of many previous Australian educational projects whereby Australian academics implement projects without local participation (Baba, 1985; Puamau, 2005; Sanga, et al., 2005). For the past 20 years, Pacific academics have been critical of Australian Institutions working in Pacific educational projects without the active participation of local academics and expertise. This activity by Australian institutions undermines the local expertise and resources that are available and the authority with which these resource personnel know their work. An academic summarised the general feelings of most FSN teachers who attended the curriculum review workshops thus:

We just felt 'used' by the consultants to put in what we felt should be in the curriculum by looking at the previous curriculum and how well we can improve them. They went away and when they came back with the draft document we saw that it was a totally 'different thing' from whatever we contributed and what we expected. Most of what came back was totally new to us (FSA 01: 2).

The teachers at the FSN questioned the nature of the curriculum review and the development of the new curriculum, as there was very little consultation at their level:

No one knew what was happening when they had meetings and they would come and go. They come to Fiji 3 or 4 times a year and we wanted to know what they were doing. I continuously asked for reports and I was not given any, I don't know why (FSN 04: p.7).

The JCU consultants on the other hand emphasised the need for the teachers to participate fully in the curriculum review and the development of the new curriculum (Usher, 2004a). While the requirement from JCU represented an attempt to address the issue of curriculum ownership for the local teachers, the teachers themselves were not aware of their expected level of contribution and this was not made clear to them during the review:

We went to the Southern Cross...and then another venue. They gave us themes and hours to cover and they were in the form of very broad objectives. Some faculty members were lost and they had no idea at all of what was going on. Well! We are nurses. And we were brought from the clinical [setting] straight to the school to teach. We were never told of the new approach of competency based learning or assessment. If this has been made known to us from the beginning, I am sure we would have been well prepared and interested to know about it. If the MOH or the FSN leaders could call us to inform us of all that was happening and JCU would come and help us through it, But No, they did what they are good at: just throw things

at us and expect us to perform and swallow everything we are given (FSA 03:6-7).

Teachers lamented the lack of preparation for the curriculum and were critical of the workshops conducted before and during the implementation period as not relevant to curriculum development or the development of the assessment forms. The consultant for the implementation of the programme reported that teaching skills workshops to familiarise the teachers with the new teaching methods were also conducted prior to and during the implementation period (Tollefson, 2005). However, the teachers reported that the workshops they attended conducted by the JCU team did not prepare them for the type of curriculum they were implementing.

There was no relevant preparation to help us implement the new curriculum approach. (FSN 04: 8)

### **5.11 The need for indigenous knowledge in health and illness**

The Fiji Education Review Commission (Subramani, 2000) clearly recommended that local knowledge of indigenous people ought to be vigorously explored and integrated into formal curricula of all levels of education in Fiji. The report also noted that curricula in Fiji continued to be heavily influenced by Western educational concepts and ideas and there was a need to integrate more indigenous knowledge and ways of learning in Fiji. Professor Tupeni Baba, a Pacific scholar, also voiced the need to explore the indigenous knowledge of health and practices of Pacific people and integrate them into the western dominated disciplines of medicine (Baba, 2004). Western medicine has been so dominant in health and nursing practice in the Pacific that indigenous knowledge and health practices are seen as superstitious or unimportant by indigenous health practitioners themselves. Tukuitonga (2000) reported that traditional healing is widely practiced in the Pacific and the many Pacific cultures continue to have health and illness beliefs that are shaped by these different cultures. However, Tukuitonga insists that these traditional cultural beliefs and practices compounded by Christian doctrines tend to delay the presentation of illness or injury to health care centres and thus delay the abilities of the western health practitioners to make health improvements and changes.

During the review of the curriculum, teachers recollected the lack of consideration for indigenous knowledge as important knowledge. However the Consultants' report mentioned that:

There remains room within this curriculum for traditional healing and cultural pragmatics to be explored alongside the more 'scientific' and technical explanation of the subjects and content including evidence-based nursing. (Usher, 2004a)

The exploration of cultural pragmatics and indigenous perspectives of health and illness needed to have been made clear to the teachers; it appeared that the teachers did not understand this intention of the curriculum and were not aware of this statement. The lack of cultural consideration of indigenous health practices of Fijian people within the medical and nursing curricula could be a major contributing factor in the increasing morbidity and mortality rates of Fijian people (M. Pande, et al., 2004). There was no evidence that the local ideas and knowledge of indigenous and cultural practices of health and illness were explored from teachers, students and the community to aid in the relevance and appropriateness of the curriculum content.

The experiences of implementing the new curriculum by teachers and students were not the same as for those advocating for the change. Whilst the JCU team and the nursing leaders including the school principal expressed their excitement about the new curriculum (Usher, et al., 2004), the teachers lamented the replacement of a better curriculum by one that was incomplete and compartmentalised:

I still feel that the last Diploma programme was a better one. The teaching was very clear, holistic and wholesome. You just teach the A & P, concepts, conditions and management. It is very clear. This one is like 'cut-cut' like you don't know what the other team is teaching. If you want to know you have to sit in their lectures (FSN 03: 20).

I feel that that this curriculum is so compartmentalised that we are risking leaving some important knowledge or gaps in it. I know that there are many disjointed bodies of knowledge being delivered and the teams continuously argue on alignment issues and overlapping in teaching. We have been talking of alignment for three years and we are still talking about it. That is not a good sign. In the previous curriculum everything was complete. I respect this curriculum but I personally prefer the older curriculum because of its completeness, its comprehensiveness and relevance to us in Fiji. I

don't know where this curriculum came from or if it was brought in because it worked somewhere! But I tell you it is not working in Fiji (FSN 05: 10).

Even though the MOH and the NMNP Board were the main advocates for the change of curriculum, their actions and record indicate otherwise. The steering committee mentioned in an MOH letter of assurance of support to the FSN never eventuated, as there were no records or recollections of the committees' work. The NAC being the academic arm of the NMNP Board never wrote a single policy before or after the implementation of the curriculum. In the words of a senior academic at the FSN regarding the NMNP Board and the NAC attitude:

I feel that the NMNP Board just left everything in the school; just like throwing them in the pool to swim and very little was given from them. When we take things to them they also never gave us any indication of their support. Like whenever a comment came, we were not sure whether they liked the curriculum or not! There was never a positive or supportive comment from them! At times I wondered whose decision was it to change the curriculum? Or what was their position in this change? For the NAC, I don't know what their role is anymore. In the last curriculum, they were quite ignorant, and we were the ones who had been telling them about the processes and what the policies were and then when we expected them to contribute more; they were also just depending on us (FSN 01: 7).

Another senior academic involved in the implementation of the new curriculum echoed similar sentiments.

What NAC? That NAC was very sickly! I doubt very much that the MOH /NAC was viable...I am not sure if the NAC was even aware of the curriculum (FSA 03: 10).

The NAC is composed of members of the NMNP Board of Fiji, the principal of the FSN, representatives of the Ministry of Education and a representative from the Fiji School of Medicine. According to a senior academic staff who was also a long time member of the NAC, the ad hoc nature of the way the NAC conducted its affairs and membership disillusioned the members, especially those from the other ministries and the FSM as they never had the time to prepare or make the time to come because of the nature of the meeting's notice and preparations:

I do not think the MOH knew about the many ad hoc members that the NAC had. When they cannot form the quorum, they will look out for any

available tutor to go in and sit and make up the numbers so that they can start the meeting (FSA 03:11).

## 5.12 Powerlessness of teachers and clinicians

The powerlessness of the teachers was exposed in the way they were dispersed to different subject strands during the curriculum review workshops.

Some of us were quite comfortable where we were working within the curriculum review and we did not want to move to another subject. But they (JCU) kept telling us that we SHOULD move. In PHC, all my team members were taken out and left me and one other tutor to remain in PHC. (FSA 03:2)

Another teacher recorded her experience of the review workshops:

While the curriculum review was going on...you know they changed us around; they took some people from some teams and put them to other teams. I was in FNP to start off with, and then went to PHC because of the IMCI connection and then I don't know what happened there, there was a total staff change and I ended up in PPD! The reason for the change was that (what they told us) was that everybody needed to understand the different strands. That was how it was put (FSA 02:3).

Teachers were treated as if they did not have a mind of their own and were ignorant. It was made clear from the feelings of teachers that they were undervalued and this feeling of not being important influenced their contribution to the review.

When they changed us around to areas we were not comfortable in, it did not go down well with many of us. There were a lot of ill feelings, uneasiness and feelings of rejection. I started off from PHC and then to Nursing Knowledge and then Nursing Practice...and I now I am in PPD as a 'reject' from the other three strands! (FSA 02:4).

Teachers were not allowed to decide their areas for maximum contribution to the review and to the curriculum development. JCU consultants also treated the staff with arrogance and were probably influenced by the way the MOH treated the teachers and the nurses in Fiji. The MOH did not grant the teachers any release time to attend the review workshops and a senior teacher reported that staff members were happy to move in and out of the workshops, which were becoming very boring

And just provided a platform for the consultants to play around with them and make them feel useless. Teachers would run away to the clinical area just to be away from the workshops (FSA 03, p.5).

Teachers found the workshops to be boring because they did not understand the process of curriculum development and they did not understand the main objectives of the workshops.

The FSN's administrative position within a service organisation such as the Ministry of Health, and not within the ambit of an educational entity, made it very difficult to address its educational needs posed by the impending change of curriculum. The positioning of the school within the MOH has more disadvantages than advantages. Apart from being isolated from the educational fraternity for a very long time, the school has become a political playground for the MOH and the Head Quarters staff and a sad replica of what it was 25 years ago. The legislative functions of the Ministry of Health in administering an academic institution contributed to abuse and manipulation of its functions by the political processes of the ministry. For example, the lack of control on the part of the school over both the size of the intake of students into the first cohort of the new curriculum and the start date of the programme, exposed the school's vulnerability as an institution easily manipulated by political forces beyond the control of the school. The on-going investigations into the allegations against a Minister for Health who charged students for government sponsored places at the FSN for a number of years is a further example of problems associated with a lack of academic autonomy (FT: 30/04/08). The teachers' lack of awareness of the new competency-based curriculum exposed the problem of isolation from mainstream educational ideas by the nursing fraternity in Fiji. The nature of the FSN's position within the MOH had the greatest impact on the initiation of the curriculum change and the actual implementation of the curriculum.

### **5.13 Summary**

The initiation phase of the educational change described the nature in which the decision to change the FSN curriculum was pursued by the NMNP of Fiji without due consultations with the Fiji School of Nursing leaders. Teaching staff at the FSN were instructed to attend workshops with the JCU consultants without adequate

consultation on the rationale for the workshops. The lack of enthusiasm displayed by the FSN staff and the difficulties they faced with writing the content of the curriculum are related to the lack of preparation and consultation on the part of the MOH and the NMNP Board. There were neither consultations nor consideration of the consumers and stakeholders' views on the curriculum review and the subsequent change. It could be argued that this lack of consultation represented negligence of curriculum protocol by the MOH and JCU to the people of Fiji. According to Fullan (2007, p. 83) "the process of initiation can generate meaning or confusion, commitment or alienation, or simply ignorance on the part of the participants and others affected by the change". The relationship between the initiation and the implementation phases is loosely interactive and the phases can easily affect one another depending on the nature of the events and the quality of participation in the implementation phase.

## **Chapter 6: The implementation of the curriculum**

### **6.1 Introduction**

The previous chapter discussed the initiation of the curriculum change at the Fiji School of Nursing and the experiences of the people involved in the planning process. Chapter 6 will describe the transactions that took place during the implementation process under the significant themes that emerged from the data. These are the state of un-readiness of the school, the pervasiveness of powerlessness and horizontal violence at all levels of nursing in the Ministry of Health, and the failure of the clinical component of the curriculum to prepare nurses for independent practice in Fiji.

### **6.2 A state of un-readiness**

There were many aspects of the Fiji School of Nursing (FSN) that were not ready to receive and implement the new curriculum. They included the teachers, the clinicians, the resources required to support a curriculum change, the curriculum document and its assessment tools, and the relevant policies required to guide the new programme.

#### ***The un-readiness of the teachers***

The curriculum was implemented on the 18<sup>th</sup> September 2004 despite the initial refusal and opposition of the teachers at the FSN. Earlier on, the teachers had requested the deferment of the implementation of the curriculum from September 2004 to February 2005 to allow them time to prepare themselves and also to phase-out one of the two classes following the older curriculum. The teachers expressed their frustration at being ordered to implement a curriculum which in their view was incomplete; in addition to work overload and the non-availability of resources. The nature and description of the incomplete curriculum is discussed later in this chapter. At the time of implementation in September 2004, the year two and year three students of the older curriculum were into the middle of their academic year. There

were no new staff recruited and the teachers who taught the older curriculum were also expected to teach in the new class and write up the course contents, assessments, course guidelines and develop their own tests and examinations for both classes. Teachers were also expected to continue with the clinical supervision of the students of the older curriculum in their various placement areas.

The Ministry of Health and the Nurses, Midwives and Nurse Practitioners' Board of Fiji (NMNP Board) nevertheless stood firm on its decision to implement the curriculum, citing staff shortage as the reason behind its decision (JCU01). The nature of the administration of the FSN by the MOH does not allow autonomy in terms of decisions affecting the conduct of business at the school.

I know that when we come up with ideas and innovations and we bring them across to the head of the institution (FSN), sometimes those ideas are just shunned. I think that the institution itself has no authority. That's my personal opinion; whether we have any power to control the running of the organisation or not. Because at most times when we need to decide on issues that concern the school, even the slightest decision has to be taken back to the Director of Nursing at the MOH headquarters. (FSN 04, p.9)

The order was that this change needs to take place and we had to move. But we were not ready. We asked a few times to give us time to prepare but NO; it had to be implemented. Management was adamant that it had to commence (I don't know whether it was the school management or from head quarters). They did not consider our plight! All of us (or most of us) were also teaching the other programme. But how could we work when we had nothing? (FSN 06, p.14)

Most of the planned refurbishment for the school library and the internet facilities were not available for the students for the whole of the first year of the curriculum (GR 03) and most of the teaching aids and printing had to be met by teachers paying from their own pockets.

### ***An incomplete curriculum document***

The teachers lamented at the state of the new curriculum when first implemented in 2004. Whilst all the teachers pointed to the lack of objectives and contents of the various subjects across the four strands, a JCU consultant explained that:

The curriculum was written in such a way that would encourage the development of the teachers in writing a curriculum. The JCU team developed all the materials for use in the first year of implementation. We

then gave them less material to work with in the second year and the third year we provided a 'bare' curriculum. (JCU 01, p.2)

A participant refuted this claim stating that the first year curriculum was not complete when implemented in 2004 and the teachers had to produce their own materials from nothing:

I had never worked so hard in my life to prepare my lessons, my tutorials, my study guides and so forth. At times I would not leave this building until 2am in the morning. In addition, there was no assessment tools developed for the teachers to use in the first year of implementation! (FSN 06, p.3)

The JCU curriculum consultant later clarified the project team required the teachers to complete writing of the subject content as the course progressed from year one to year three (JCU 01). The teachers were oblivious to the ideals espoused by the JCU team and were not aware of the intentions of the project team. This curriculum strategy appeared to have been understood by the Principal of the FSN but was never communicated to the teachers by the JCU consultants or the Principal and the leaders at the MOH (FSN 08). The incompleteness of the curriculum was also testified by a senior academic when she stated:

If the curriculum was complete when we implemented it, it would have been much easier. But we came across a lot of difficulties because the curriculum was incomplete and there wasn't enough material to refer to. (FSN 02, p.1)

My understanding of the new curriculum was that it's just a 'reviewed' curriculum but after I saw it, all strands were very different and had deviated completely from what the curriculum was before the review (older curriculum). (FSN 02, p.2)

We were not familiar with terms used. We were told what the expectations of a competency curriculum were...we contributed 'as we were told'; but where we were heading to, we did not know. (FSA 1, p.1)

They started to give us the themes and the hours to cover the themes; but when we looked at them (themes) they were in the form of very broad objectives. Some faculty members were really lost and did not know what was going on. FSA 03, p.6)

In this curriculum, you are discovering to teach as you go through it and it's so unfair to the students and the teachers. It was a half developed curriculum and we were forced to teach it. To be short of staff, trying to write up the curriculum and at the same time trying to teach it and looking back to see if it's the real thing, this is all of it or we were just teaching half of it. (FSN 02, p.11)

The description of an incomplete curriculum by the teachers fitted the type and form in which the FSN curriculum was presented. The new curriculum only presented the subject prescriptions, which in some cases were incomplete. While it presented a list of possible topics to be covered in each subject, many other subjects across the four strands presented a minimal list of topics to be considered. The lack of curriculum awareness in the FSN teachers contributed to their lack of understanding of the rationale proposed by the JCU consultants. While the JCU consultants expected the local teachers to produce the content and write up the tutorial scenarios with the assessment tools as an important curriculum development activity, the teachers saw it as an incomplete document. The absence of the clinical assessment forms and evaluation tools further compounded the incompleteness of the curriculum document.

The lack of objectives and the contents of the curriculum courses forced the teachers to write up the content and fill in whatever was required for a subject. The relevance and the quality of such material was secondary and for many subject areas such as Primary Health Care, therefore reverting to the content of the previous curriculum was inevitable and logical (FSN02).

The teachers were used to teaching from the previous Diploma of Nursing curriculum, which used a 'teacher-proof' approach to curriculum change (Macdonald, 2003). This curriculum detailed the whole course from course prescriptions, to course contents, assessment strategies to clinical learning tools and methods leaving the teacher very little to do with the subject except to teach it. The previous curriculum was compared to the new curriculum through its user-friendly presentation that anyone could pick up the document and teach from it. In the words of a senior academic at the school:

We are nurses; trained to be nurses and not teachers. We were brought straight from the clinical areas of practice to the school of nursing to teach! We know nothing about developing the curriculum and writing its content. (FSA 03, p.3)

### ***Knowledge gaps***

Teachers that were interviewed identified the gaps that existed across subjects in most strands. From the outset the NMNP Board of Fiji, in accepting the revised curriculum

and its accompanying review report, noted the gaps in the content and requested immediate redress from the curriculum consultants (ADN02). These gaps included blood transfusion and blood safety, nursing standards, family planning and holistic and spiritual care (NMNP Board, 2003). At the implementation of the curriculum and for the subsequent three years, the gaps first noted by the NMNP Board have not been addressed. The first graduates from the new curriculum identified many areas that were not covered during their three years of education, some of which were earlier identified by the NMNP Board before the curriculum implementation.

When we first graduated and entered the service, we worked as interns in the general and special units. We did not know many things...like drugs, protocols for drug administration, blood transfusions and blood safety, the emergency management of anaphylactic shock and a reaction to blood transfusions. (GR 01, p.8)

Other areas not covered in their curriculum included primary health care nursing and community health nursing knowledge (GR 03; GR 02). Apart from the many omissions, graduates also identified a number of procedures that were not taught. These included the underwater-seal drain, drug imprest system, and injection techniques for giving immunisation. The incomplete state of the curriculum created a lot of anxiety for the teaching staff as they struggled to understand the curriculum approach and to write up the curriculum content. A teacher described the level of stress and mental strain the incomplete curriculum and its expectation brought upon their health:

You know when I try to re-call what happened, again and again, I just thank God that I am still sane because when I think of those hours I used to be in my room trying to do the work; ugh! It was just terrible and I know it was affecting my health. I remember I lost a lot of weight! (FSN 04, p.4)

Similarly, another teacher described her experience with the incomplete curriculum:

We had to read and read. We sacrificed a lot of; our health, our families. We had so much to prepare in terms of teaching aids, guides and reading resources, materials apart from teaching the other classes of the old curriculum. I have never worked so hard before to prepare for tutorials, my lessons, guides and so forth. Sometimes I would never leave this building until 1 am or 2 am in the mornings. My husband would yell at me on the phone and sometimes I would just sleep here! You know other tutors too slept here. One night, a husband (policeman) came knocking here because his wife did not come home. She was found sleeping on the floor in her office. She was just too tired to go home! (FSN 06, p.13).

Teachers struggled to understand the new approach used in the curriculum to produce their course content and other requirements of the curriculum. Some teachers did not realise the new curriculum also needed to have a new set of assessment tools to guide the students' clinical learning. According to a senior academic staff member, the teachers took matters into their own hands when they decided to use their Christmas family excursion in a local resort to develop their clinical assessment forms (FSN 06). The outcome of this two-day workshop was a three-year assessment logbook for the new curriculum. This three-year logbook formed the basis of all subsequent assessment forms that were being written at the FSN.

The teachers' view of the curriculum document was that it should be written up and completed in all areas including the assessment forms and strategies. The rationale for curriculum ownership and empowerment used by the JCU whereby the teachers were expected to produce their own curriculum content and produce assessment tools was either unacceptable to, or misunderstood by the teachers.

### ***Subject mapping***

The process of curriculum mapping or subject alignment required each teacher to record or document her/his own teaching and then compare and examine with the other teachers for gaps and overlaps, redundancies and new learning (Udelhofen, 2005). Four years after the initial implementation of the 2004 curriculum, subjects taught across the strands continue to be mal-aligned leading to repetitions of themes and topics, as well as creating gaps and overlaps in knowledge and nursing procedures. Implementation of the curriculum was not easy, as the majority of the teachers did not fully understand the nature of the curriculum and its incomplete state created more confusion.

That is why when they (teachers) started to panic when the JCU consultants kept coming at us to implement it; most of them were not actually doing any work because they did not understand anything. They could not read the document; it made no sense to them. (FSA 03, p.3)

The former head of the FSN was fully aware of the difficulty faced by the teachers when she stated that the teachers were frustrated with the change, but fell short of

explaining the absence of curriculum leadership and guidance for the staff during this critical period of their development:

I found that they (teachers) were quite frustrated along the way. I don't blame them. Maybe because they lacked the relevant educational knowledge. They did not understand how I looked at things; I wanted them to learn and to be involved from the beginning. They really struggled. That's why we had a lot of frustrations, a lot of talks and finger pointing. (FSN 08, p3-4)

The rationale for providing an incomplete curriculum was known to the head of the institution but was never made known to the teachers; who were expected to carry out most of the curriculum work during the implementation period. However, the teachers interpreted this non-disclosure of the rationale for curriculum development as an absence of leadership and guidance on the part of their leaders when they needed it most (FSN 04).

We wanted to give these children (students) our best. I don't know what else to say to that when management cannot consider your request. It's like being thrown into the deep and they did not care. And you know, that's exactly what she told us "this curriculum is like being thrown into the water; you have to either swim or sink" I don't know if she knew what she was saying! (FSN 06, p.17)

The state of un-readiness of the school to implement an incomplete curriculum influenced the teachers' opposition to the Ministry of Health's implementation plans in 2004. When the teachers were made to implement the curriculum in 2004 there was no time to design and plan classes, to develop the content of the curriculum and to document and map the curriculum. Teachers interviewed for this research likened the process of implementation to 'building a ship and sailing it at the same time' (that is, writing the curriculum and teaching it at the same time), leaving them no time to make plans or review their subjects.

While it appeared that the MOH wanted the curriculum implemented in September 2004, knowing full well that it needed to be written up, the Acting Director of Nursing had this to say on interview:

You know they say that they were building their ship and sailing it at the same time. For each year, I believe the school had to write up the content and guides for the curriculum and then also write the assessments for each

year. It is not easy and I take my hat off for the staff of both schools for developing and teaching the curriculum at the same time. (ADN 02, p3)

The nursing division at the MOH was therefore fully aware of the difficulties that the teachers were going through, but allowed it to continue. The impact of such expectations and workload on the teachers was enormous, as described by one participant.

I was teaching Management to around 200 students from the older curriculum; where you know, you do everything. We teach, we mark assignments, set assessments and examinations and mark them. We counsel and supervise clinical practice. At the same time in (September) I received my package to do my Master's programme with JCU by distance. I didn't touch my books until December. And I led the Nursing Practice strand in the new curriculum and we had 198 students. I don't know if any other institution had done this to continue to write a curriculum and at the same time you are implementing it. I am amazed and I thank God we are still 'sane' after all that!! (FSN 04, p.3)

One of the participants at the time of implementation described the difficulties of the teachers implementing their subjects:

Teachers had difficulties identifying the linkages, continuity or the conceptual relationship of subjects taught within a semester. There were topics in PPD that needed to be linked to PHC strand and we tried to make sure that other strands do not repeat subjects already taught. Subjects such as Management, which is taught in PPD needed to be linked to PHC within the management of a nursing station, health centre or rural hospital. (FSN 01, p.4)

In fact a former Principal of the school knew the teachers struggled because they lacked the necessary and relevant educational preparation to undertake the curriculum development and implementation responsibility, but she fell short of providing reasons for the lack of guidance and why they were not provided. Principals, according to Fullan (2007), are the gatekeepers of change in their institutions and their actions may promote or inhibit change. The role of the Principal in a curriculum change will be discussed in-depth in Chapter 8 of this thesis.

Catching up, overlaps and missing links have been key features of the implemented curriculum (FSN 04; FSN 05; FSN 03; FSN 06). The problem of unrelated topics across the strands plagued the curriculum since its implementation and during the research period (2008), it was the key issue in all the curriculum development committee meetings at the FSN (FSN/CDC, 2005-2008).

Descriptions of overlaps appeared to be a common occurrence in the new curriculum as one participant described it:

Since I came into this new curriculum, all the teams have been struggling to align themselves to the same themes. Procedures such as ECG (electrocardiography), which were to be taught by the Nursing Practice strand, were taught by the Nursing Knowledge strand within abnormal obstetrics. (FSN 05, p2)

Overlaps in subject themes created frictions amongst teachers. Minutes of the curriculum development committee meetings had constant discussion of overlaps, gaps and mal-aligned topics, which were becoming a common practice in some strands since the committee's establishment. Those teachers who did not receive the required level of leadership and guidance in writing the content of their subjects resorted to teaching from the old curriculum using teaching methods that they were comfortable with (FSN 02;FSN 06). This was significant when teachers were taken out from the Nursing Practice strand to the PHC strand to teach subjects they had never taught before.

The overlapping of themes and topics also affected the assessment of the students whereby teachers in one strand had to review its essay topic and clinical case studies to make them relevant to knowledge covered during semester. A case in point was the Nursing Practice strand where a major reorganisation of themes and lectures had to be done before students could be expected to work on their clinical case studies (FSN 03).

We had to organise our themes to ensure that they were suitable for internal assessments and the clinical case studies required of students in year 2. We are going to sit often with the Nursing Knowledge to reorganise our themes to meet the needs of student's assignment and other internal assessment. (FSN 03, p.2)

Since there was no proper mapping of the curriculum by the teachers, the various strands would be teaching themes too far removed from each other:

At times what I gathered was that the FNK (Foundational Nursing Knowledge) would be far ahead and the other strands would be way behind or elsewhere in the curriculum. (FSN 05, p.2)

### ***Non-integration of the curriculum***

There were two major objectives of the Diploma of Nursing curriculum: one was the integration of knowledge that contributed to a well-rounded practice of nursing; and secondly, the curriculum was to be re-written and up-graded to a tertiary level in anticipation of any future movement to a university sector (Usher, 2003). As an intended antecedent, the objective of teaching the subjects and the themes on a horizontal strand did not materialize as initially anticipated.

I feel this curriculum is so compartmentalized that we are risking leaving some important knowledge or gaps in it...there is a lot disjointed bodies of knowledge being delivered here (in the FSN) and the teams continuously argue on alignment issues and overlapping in teaching. We have been talking about alignment for the past three years and we are still talking about it now. It is not a good sign. (FSN 05, p.10)

There was no attempt to integrate the different strands of the curriculum, and no evidence of integration throughout the curriculum document. There was also no logical continuation of themes across the strands, as a participant describes it:

A teacher in one strand teaches a concept and leaves it hanging in mid-air until another teacher from another strand brings it down to the ground (FSN 05, p.11).

However, this is not always the case at the FSN as some of the themes and subjects are incomplete and there are gaps already identified within the curriculum content.

### **6.3 The clinical learning component of the curriculum**

Clinical learning has always been an important component of the FSN curricula over the years. Graduates of the FSN were often judged on the basis of their clinical competency in a task oriented work environment. The 2004 curriculum, on the other hand, sought to emphasise a well-rounded competent and critical thinker in its philosophy (Usher, 2003), although the clinical learning hours covered major parts of year three. The use of the competency-based curriculum and its competency assessment tools was a strategy used by the curriculum consultants to realise the clinical objectives of the FSN. This study however uncovered many issues related to the clinical component of the curriculum and its implementation.

### ***Ignorance of clinical assessment strategies***

The use of clinical competency assessment format was a new development for the FSN teachers. Many teachers did not understand or have any idea of what a competency form looked like. The majority of the teachers had neither the experience of developing a competency assessment form nor using an assessment form for a competency-based curriculum. The curriculum consultant for the implementation of the curriculum described the lack of awareness of the competency assessment strategies as 'one of the biggest hurdles' in the whole exercise (JCU 01). She added that apart from the other factors such as the lack of experience in most of the teachers, key staff who were familiar with the curriculum approach were posted out of the school and replaced within six months of the implementation period. This explained the teachers' lack of preparation for clinical teaching and their general ignorance of the need for assessment tools after the implementation of the curriculum in 2004.

According to the teachers, the NMNP Board of Fiji was aware of the use of the Hong Kong competency model but failed to inform the school on its use in the curriculum (FSN 05). The NMNP Board of Fiji during the initiation stage of the curriculum change gave the Hong Kong model to the JCU team to use in the revised curriculum (JCU 01), but then failed in its responsibility to create awareness amongst the teachers and the clinicians. It was two months into the implementation of the curriculum when the Hong Kong model was made available to the teachers by the MOH, after the teachers began to question the JCU consultants about it.

In December 2004, three months after the implementation of the curriculum, the teachers turned their family Christmas break at the Fijian resort to develop and write competency forms in preparation for use by the students when they returned from their Christmas holidays. A teacher remarked that their frustration and their common need for guidance brought the teachers together to support and teach each other in developing assessment tools for the curriculum.

The excursion which took our two day break with our families was sacrificed ahead of the need to have assessment forms by January. However, it was a very sad as we were not supported by our nursing leaders; those that make decisions at the NMNP Board and the school Principal! (FSN 01, p.1)

The teacher added that their intention was to have some clinical assessment tools in hand when the students began their clinical rotation early in the New Year. The writing excursion produced the blue print and the foundational materials for clinical assessments from year one to year three. However, the non-attendance of the head of school and the lack of encouraging words or support from Fiji's nursing leaders indicated the teachers were on their own in the implementation of the curriculum.

At times, I wondered whose idea it was to change the curriculum; theirs or ours. Or whose curriculum was it? Since its implementation, there has never been a positive comment coming from them. (FSN01, p.1)

Leadership during the implementation stage was invisible according to the participants of this study (FSN 06; FSN 03; FSN 01). The lack of guidance, expert curricula advice and leadership were seen as contributing to the general confusion of the teachers at the FSN. Avoidance of leadership responsibilities or the lack of it during an educational change process constitutes a 'Bermuda Triangle' of innovations (M Fullan, 2007). The teachers, without the support of their leaders, found it very difficult to implement the new programme and the non-consultative approach of the MOH towards the teachers made it a very painful experience for many of them.

Management never listened to us; the people that do the work here. It was just listening to outsiders who just came and went. There must have been a big rush to get this curriculum implemented. Even we asked just for a few months to defer it; NO a big NO; we had to do it NOW! Do it for whom? For Australia or who? We are here for the Fijian people; for the people of this country. We want to give these children our best! (FSN 06, p.17)

Management worked in isolation from the teaching staff. Its non-consultative approach was seen as arrogant and showed a lack of respect for the teachers and the people of Fiji.

In the *vanua*, we would sit and talk and discuss about the equipment, the teaching, the classes and more so for important decisions such as the implementation of the curriculum. (FSN 06, p.15)

According to the teachers, the nursing leaders' approach to the curriculum change was foreign, especially when the leaders themselves were indigenous Fijians.

## **6.4 Failed Preceptorship programme**

Awareness of the overwhelming nature of the clinical supervision requirements came after the school considered their teaching workloads, and resulted in the decision to use 'preceptors' from clinical areas. Preceptors selected by the MOH were given a two-day workshop by the FSN to familiarise themselves with the requirements of the curriculum and the clinical teaching strategies (FSN 03). The teachers who were still in the process of understanding the assessment methods themselves facilitated the workshops for their counterparts from the clinical areas. According to a preceptor, the two-day workshops were not enough to adequately prepare and convince the preceptors of their roles and responsibilities for students in the clinical settings (PR 01). Other factors identified in this study indicated the failure of the preceptorship programme for the new curriculum; the lack of enthusiasm of the preceptors in their roles, the lack of awareness of the curriculum approach and the feeling of rejection by the preceptors and the clinical staff over the way in which the clinical staff were not informed of the change until the school needed their assistance in the supervision of students.

All preceptors interviewed in this research expressed a feeling of disappointment at the way they were appointed by the MOH and the failure of the FSN in informing them of the change in curriculum. A former Principal of the institution refuted the claim indicating that the NMNP Board was responsible for informing the clinicians and the rest of the MOH departments on the change in curriculum. A community health nursing preceptor indicated that her colleagues learned informally from a tutor that the curriculum has changed at the FSN (PR02). Similarly, other preceptors recorded being informed by the change at the preceptors' workshop; long after the curriculum was implemented at the school (PR 01; PR 03; PR 04; PR 05). The disappointment of the clinicians was related to the fact they worked in the main teaching hospitals for the Fiji School of Nursing and the Fiji School of Medicine, yet they were not considered

important enough to be informed of the change until the school needed their services as preceptors.

The clinical preceptors were selected by the MOH to assist the school in the supervision and assessment of the students of the new curriculum. Apart from holding fulltime work responsibilities in the clinical areas, most of the preceptors also held administrative positions in the hospitals and in the community health settings. Preceptoring student nurses were an added responsibility with inadequate remuneration or recognition for preceptors. As a preceptor described her experience:

For us the Sisters in Charge of the wards, people thought that we were the right people to look after students and to assess them. But I felt at the time that everyone should go for training so that we can all understand it and get the real picture of why we need to have preceptors when there are teachers who are there in the school and who should be coming down here to the clinical to assess the students. It's like a burden to us the Sisters in Charge to do assessments when we also have our own nurses who need to be trained and supervised in every shift and we have to assess them and monitor their performances as well. The preceptors' role includes monitoring students, supervise and assess them and record their attendance, call up the school for absence, sickness and so on. We also have our own training and supervision of new interns or other RNs on transfer from other parts of the service. We also want our wards to run smoothly. (PR 03, p.2-3)

Preceptors who held management responsibilities were often too busy to provide the required level of supervision to students in their wards, and would at times delegate their responsibilities to senior registered nurses or any registered nurse available to work with students. Such arrangements have often backfired against students, as the school would not accept assessments signed by registered nurses who were not preceptors. Such practices have caused dilemmas, as on one hand preceptors cannot sign assessments they did not supervise, and registered nurses who were not preceptors but supervised students and signed their assessment forms were not accepted by the school of nursing.

Most of the time, preceptors are not available. If we work morning shifts, the preceptor may be busy so we had to ask one of the registered nurses to supervise or assess us in a procedure. In this case the preceptor is busy and will not sign our forms because she did not assess us. On the other hand the registered nurse who assessed us cannot sign because she is not allowed to. This creates a lot of dilemma and frustrations for us (GS 03, p.9).

## **6.5 Discontinuity of learning: from classroom to clinical**

The discontinuity of learning for students which occurs within the classroom- clinical continuum, created problems. These problems include unsupervised learning of students through the absence of teachers from the clinical sites, the non-availability of clinical preceptors during the students' shifts, and the disorganisation of clinical learning programmes through wasteful decision making that disrupts clinical plans for students. A major challenge for nurse educators is the provision of a continuum of clinical learning from classroom contexts to that of clinical practice. Continuation of learning can manifest in areas where theories learned in classrooms and the clinical laboratories are transformed into clinical areas or are realised in clinical practice. These may also include environments, which are conducive to implementing learned theories, skills, procedures as well as the opportunity to nurture appropriate professional behaviour and attitude of students.

One of the problems we experienced at the FSN especially during clinical at CWMH hospital is the ability of students to hand over reports to the on-coming shifts because of running to and from the school bus. I feel the school should be able to devise a plan whereby the morning nurses are given time to hand over reports to the afternoon nurses and the afternoon nurses to the night nurses. (GR 03, p.14)

### ***Unsupervised clinical learning***

Graduates and students interviewed in this research discussed the absence of tutors and preceptors during their clinical attachments. Teachers were hardly around in most clinical rotation areas and students found it hard to contact them when in need. Students, graduates and clinical preceptors also described the school's habit of sending students off to the health centres unsupervised especially on the first days of clinical.

I would like to recommend here that the teachers accompany the students on the first day of their rotation. I am not complaining but I am only stating the importance of a proper handing over of students to us; the clinicians especially in this new curriculum, the new approach and the objectives of their clinical rotation. Most of us are new to the curriculum and we are used to previous year two and year three students' rotation and not the year one. (PR 02, p.1-2)

Students described occasions when there was no tutor and no preceptors on the floor or preceptors were on different shifts such as night supervision leaving students without much opportunity for supervision. Graduates and students identified a common problem in their training was the missed opportunities to practice and getting assessed on rare procedures as there were no preceptors or tutors in the clinical area to assist them. The graduates also expressed their frustrations at being left unsupervised by teachers during their clinical rotations and the failure of the preceptors to be available for them:

How they set up the clinical attachments is like they are just sending us to the clinical without plans to follow us up...but when clinicians are appointed as preceptors in the clinical they are the least bothered about us. I believe that the preceptor should be working with the students and not to ignore the students. (GR 02, p.2)

The students who were frustrated at being left unsupported by teachers, projected their feelings onto the preceptors as the responsibilities of clinical supervision shifted from the school to the clinicians:

We had problems with the preceptors. Most of the time they are not around and when we needed them for certain procedures that we needed assessments in, such as tracheostomy and other procedures; they are not there. ..we have to go around or ring around other wards for any available preceptors to sign our books. (GR 01, p.2)

Problems identified by the first graduates of the new curriculum continued to persist with the current students of the same curriculum three years on:

To me the 'preceptor' is just a decoration or a fancy word for this curriculum. I would rather call someone 'sister' who is in the ward and is there all the time to look after us rather than putting labels on people who are never there. The Sister is always there all the time and not all of them are preceptors. Sometimes there are no preceptors in the ward where we work. If we work in Labour and Delivery (Suite) our preceptor is in Post Natal ward and she has no time to come and see me and my group in Labour Ward, all our deliveries cannot be assessed. I think the school should review its system of preceptorship because it is not working as it 'thinks' it should. (GS03, p.10)

Appointed preceptors and senior clinicians were not very helpful to students even when students needed supervision and assessments on certain procedures. This frustrated the students more and led them to getting their clinical assessments done through other unorthodox methods:

The assessment form is there for us to do our supervised procedures and then our competencies. It is not there for a decoration but what has been happening is that we students will just do the procedures (assess each other) and we just go and tell the registered nurse that we have done the procedures. They would just take our logbooks and sign them. This is common and is widely practised by students because we have no choice and we want to get assessed and graduate in time; "this is a common practice" (GS 02, p.6).

Other students reported another common practice described by the same group:

To work with the 'right' registered nurse until the end of the week and the students will just give their logbooks with the relevant pages and procedures marked. Then the registered nurse will just tick 'C' and sign. The only thing is to please the preceptor and the staff and then it's done. It shows that the registered nurses maybe busy doing their work but they also don't care what level or standards of competencies we achieve in our training. However we don't blame them because the tutors who are supposed to be there with us are not there and we have no choice but to do what the registered nurses tell us to do. (GS 02, p.6)

Another problem leading to the difficulties with preceptorship was the refusal of some preceptors to assess students because there was no remuneration from the government. Even though the FSN and the teaching hospital are both government owned institutions, preceptors were recorded to have bluntly refused to teach or

assess students because 'they are not paid to do so'. A student described her experience with one such preceptor in Labour ward:

While I was doing my clinical in Labour Ward, the supervisor who was also a Sister in Charge told me that assessing us was not part of her job. And she told us that if we want our logbooks signed, then we should get our tutors from the school to come and sign the books because that is in her (tutor's) job description and not hers. (GS 02, p.7)

Teachers interviewed in this study expressed difficulties in coverage of duties and responsibilities to the various classes taught in classrooms and those on clinical practice. Those teachers who taught postgraduate classes and supportive subjects did not assist those overloaded teachers teaching clinical nursing subjects. During my observation, I noted that whilst there were no clinical plans in place for each teacher to supervise students on clinical rotation, there was always an expectation that all teachers would help out in the clinical supervision of students when the need arises. In such contexts, the supervision of students rested upon the professional integrity and responsibility of teachers at the FSN. The lack of support and enthusiasm evident in the absence of clinical supervision of students is also a symptom of 'burn out' and extreme stress levels in teachers and clinicians (Matheson & Bobay, 2007). It was observed that those teachers who were extremely overloaded with administrative and academic responsibilities were also the ones expected to supervise their students on clinical rotation.

### ***Disorganisation of clinical learning***

The total number of students in the class was 198 and this made clinical rotation plans for the first cohort of the new curriculum complicated. Overcrowding of wards in the main teaching hospitals led the school to rotate groups of first year students to the community health centres. The curriculum recommended the clinical rotation of first year students to low care centres in Fiji during year one semester one clinical plans (Usher, 2003). This was not followed, as Fiji does not have low care centres such as those in Australia and New Zealand. Students were rostered to general and acute wards of the hospitals, including obstetrics and community health centres so that all students could be accommodated in clinical settings.

Students, graduates and preceptors complained about the disorganisation of the clinical plans, the frequent changes or disruptions to the clinical plans and the late production of assessment forms and logbooks. The preceptors also identified the problem of late clinical rosters for students. At times students would just turn up in the clinical practice area without any note from the FSN or the programme coordinator. The logbooks containing assessment forms and other clinical requirements such as the attendance forms and the orientation checklists were often not ready when the students presented themselves for their clinical attachment.

At times students appear on Monday morning without any roster or any warning at all. As you know CCU (Coronary Care Unit) is so small and to accommodate about 8-9 students takes a great deal of skill and creativity. Sometimes I think the FSN should consider our workload here and give us the courtesy of at least a call to say that the students are coming or there has been a change in the roster and the students are coming to the ward! (Pr 03, p.11)

The 2004 class of the new curriculum came to the wards without their logbooks and the assessment forms were not ready. Somehow we were not sure of what they have covered at school and what they have not covered. I used to tell them to come down with a piece of paper listing all the procedures they have covered and we would try and get them to practice. (PR 03, p.6)

Students also described their frustration at the state of un-readiness of the forms for clinical assessment. According to a student in a focus group, going to work without the logbook is the same as being sent to work without appropriate tools and it is unacceptable:

I think the school should prepare the competency forms well ahead of our clinical rotation times. My experience (my first year) was that we were already in the clinical and we did not have the forms. We had completed our clinical in the wards than the logbooks were given out because of printing problems. (GS 03, p.5)

However, a participant pointed to the ignorance of the NAC and NMNP Board who literally 'pulled' the three-year logbook apart, which contained the assessment forms and the clinical guides for the three years, stating it was too bulky and needed to be separated for each year of training.

That three-year logbook was the hard work of the teachers at the Fijian Resort and it was printed and bound before the students began their

clinical. The truth of the matter is the NAC and the NMNP Board did not understand the assessment and the guides contained in the book. They were so confused themselves and to save their faces, they just pulled it apart and appointed a group of teachers to re-do them! Those teachers did not have the time or the resources to re-do the logbook. They returned the same logbook but in separate pieces to the NAC and NMNP Board and they (the NAC) could not tell the difference!! That's why it was late in printing. (FSN 06, p.6)

The absence of the logbooks also created a problem for students of missing out on being assessed on potential procedures; most of which were rarely carried out in the wards. One such procedure was the underwater-seal drain and other surgical procedures such as tracheostomy. Some students who were assessed without the forms found it difficult to convince the registered nurses and the preceptors to sign their forms long after those performances:

At times we would be sent to the clinical areas without the competency forms and when we returned we would be given the forms and told to find time to go and complete them in clinical. We needed to complete the forms at a certain level of our training so that we can progress to the next level. For Labour and Delivery assessments, the forms were very late and they came when we completed our clinical rotation in those areas and we were already in the Health Centres. When we requested to be rostered again to Labour and Delivery, the school refused to do so because there were other students already doing their rotation there. They did not consider that we did not get the forms on time and it was not our fault that the forms came in late. I think that was the one of the most 'pathetic' aspects of our programme. GR 02, p.4)

### ***Teaching a non-existent programme***

Teachers tend to teach about a health care system that does not exist or has ceased to exist; they continue to teach an idealised care that is non-existent and out of sync with the current health system (Diekelmann, 2003). The graduates of the curriculum posted to sub-divisional hospitals expressed the shock of walking into a hospital that was totally new to them and which was likened to the 'Back to the Future' movie. Graduates felt the theories and procedures taught in the school were textbook materials based on another planet and were just make-believe that did not exist in the majority of Fiji's hospitals:

The reality was very different. When we came in here (hospital), I felt like I came into a garage! The resources were very scarce. What we learnt in school were supposed to be implemented here and that was very challenging. We just forget about implementation and just do the best we

can for the patients given this kind of circumstances. There is nothing like we have been taught exists here. Practice is very different from the theory we have been taught (GR 03, pp.7-8).

The graduates described a system that lacked the equipment, resources and an environment that was not taught in the curriculum. Teachers can easily be teaching an idealistic health system that does not exist or one which is already outdated.

## **6.6 A make-believe policy**

Many policies implemented by the MOH and the FSN are not supported by resources available in the health services. Apart from the make-believe clinical environment teachers teach in, graduates were falsely protected by the MOH policy of mandatory six months clinical supervision in the hospitals in Fiji. A graduate described this experience of her first posting to the sub-divisional hospital after graduation:

We do not work under supervision; we work on our own. During morning shifts, we work alone in our wards and the Sister in Charge is there to supervise us. But in the other shifts, we are on our own and not one is there to supervise us (GR 03, p.8).

Graduates are working on their own in shifts where close supervision and observations are really needed. In such clinical contexts, graduates are forced into making the most and the worst of their clinical practice. Trial and error decision-making and make or break decisions were usually the order of events for new graduates. A graduate described this scenario as they either 'swim or sink':

Sometimes we just have to make our own decisions like in an emergency and you need a doctor. You just have to send a relative out to get another nurse or look for the doctor. Or, when a driver goes to pick the doctor on-call and the patient is dying, we just have to do CPR or give emergency drugs to keep a patient alive. At times the doctor is too late and we just make our own decisions because we want to keep the patient alive and we just have to do something...if we don't swim, we will sink! (GR 03, p.10).

New graduates work and make decisions over and above their experiences and preparation. The policy that the MOH requires new graduates to work under supervision within a major hospital does not have a supportive framework for its implementation. For the majority of graduates from the new curriculum, working in such hospitals, there were no set programmes for assessments of skills, identification

of gaps in knowledge and preparation for independent practice. Graduates identified many areas that they needed practice in and singled out one important area as grossly lacking in their preparation:

I feel that if one of us is sent to work in a health centre or a rural station, I am sure h/she will be lost because we have no idea of what happens there.  
(GR 02, p.5)

A graduate described the lack of resources for supervision of new graduate practice in a hospital and the lack of support for their graduate programme. According to the graduates, the hospital has a habit of rostering the new graduates on their own in shifts, such as the afternoons and the nights, where there is less or no supervision at all and expert assistance is not accessible to them. When the graduates find themselves in such situations, they elect their own leaders or someone at a similar level of experience to be a 'senior' registered nurse during the shift (GR 03).

In an interview with a preceptor who also held an in-service manager position of a major teaching hospital, she revealed the inadequacies of the hospital and the whole nursing division in the area of in-service and continuing education for nurses. In addition, there appeared to be no format or framework for assessing the competencies and the clinical needs of the registered nurses already in the service (PR 01).

## **6.7 Primary Health Care clinical learning component**

Graduates, like the teachers, were dissatisfied with the way Community Health Nursing (CHN) and Primary Health Care (PHC) were implemented. Peri-urban attachment is identified in this study as one of the worst and wasted clinical components of the curriculum in the way the hours were utilised. For the past four years, the PHC strand team has struggled to continue with the rural health nursing component of the curriculum. The CHN teachers argued for the continuation of the rural programme component of the subject citing its contextual merits and relevance in Fiji (FSN03). This was however denied by the FSN Principal and the teachers were directed to change it to peri-urban attachment. Peri-urban health areas include those areas within the

peripheries of the main urban centres, whereas the rural health centres included those that are at a fair distance from the urban centres and may consist of Fijian villages and Indian settlements. While there was no philosophical basis for this requirement from the school management, the fact remained the Principal had acted against the requirement of the curriculum and without adequate consultation with the teachers who were mandated to teach the curriculum.

My main concern was for the third year programme, which during the review stage, JCU stressed that the rural programme was to remain 'as is' but this was changed completely and taken away. The hours for students in community practice was reduced from 10 weeks to 8 and the whole objectives of learning were changed. (FSN 02, p.6)

On the removal of the rural health programme, a former Principal explained the rationale for the peri-urban attachment was to address the increasing rate of non-communicable diseases (NCDs). The claim that NCD rates are higher in the peri-urban areas than in the rural population groups cannot be substantiated through health report, as they only report ethnic and gender and chronological distribution of diseases and not residential differences. Even though the NCD survey of 2001 to 2002 reported an urban rate of 24.7% of Diabetes above the rural rate of 12.7% (MOH, 2005), the highly mobile nature of Fijian population cannot support the survey figures to be consistent for long periods of time. If the rationale for the clinical attachment of students was to address the high NCD rates in peri-urban areas in Fiji, then the objectives of clinical attachment should have been amended to accommodate the curriculum requirement. However, the fact remains the Diploma of Nursing curriculum requires graduates to be well-rounded practitioners of nursing in any clinical setting in Fiji including community health nursing. Spending eight to ten weeks in NCD prone areas does not adequately prepare nurses for community health nursing in Fiji.

The clinical attachment itself as experienced by the graduates was a failure and in their own words, stated:

I felt that we should not have had the peri-urban attachment. (yes, yes! Supported by the rest of the group) it was a very bad idea and wastage of ten weeks study time which we could have spent here learning something worthwhile. We came out of the attachment without learning anything but

it gave us a good time to roam around town and do our laundry! (GR01, p. 13).

The graduates exposed a major weakness in the curriculum, which was the planning and conceptualisation of the clinical teaching of CHN and the lack of clinical supervision and guidance by the teachers. According to the graduates, there were no guidelines, no objectives for clinical learning and there was no clinical supervision for their attachment. Students were given the National Centre for Health Promotion (NCHP) Family Assessment forms, which had no curricula relevance to students to collect data for the centre. A teacher within the PHC strand lamented the lack of consultation by the school management when it agreed to use the students to collect the data using the NCHP forms:

We were tasked to use the form by Principal and Management. In fact the Principal overruled us when we tried to explain to her that we knew what we taught and we preferred the students to use our own Family Nursing assessment model and community nursing models, which the students were familiar with. After a one day workshop to familiarise ourselves and the students on the NCHP forms, we found out later that we were used to pilot the draft forms and the proper forms are still being developed. How can you use your own students and compromise their learning? (FSN 02, p.7)

All graduate talanoa groups described their PHC/CHN experience as unsatisfactory and a failure because it failed to prepare them for practice in the community or in the rural health centres. Graduates working in the hospitals fear the prospect of having to be posted out to the rural nursing stations as they feel that they are not competent enough to practice on their own.

## **6.8 Horizontal violence**

A significant finding in this study was the pervasiveness and the proliferation of horizontal violence within the nursing division in Fiji. While the leaders at the FSN exhibited a fair degree of incivility and horizontal violence, the extent to which nurses practice it on nurses requires redress. Teachers at the school described many instances of horizontal violence during the implementation stage of the curriculum. Descriptions of bullying and living in a hostile environment were a normal part of the implementation process. Although horizontal violence has been evident in the nursing

profession for a long time, the nature in which it has been allowed to thrive and become normalised in Fiji was overwhelming. Horizontal violence is defined as an “act of subtle or overt aggressiveness perpetrated by one colleague toward another colleague” (Longo, 2007, p. 177). The phenomenon often described for nurses as ‘eating their young’ applies to situations where the display of violence occurs between individuals with unequal power such as the Principal and a subordinate faculty; or a registered nurse and a student nurse, or a newly registered nurse (Thomas & Burk, 2009). The act of violence could be verbal, physical or emotional with an active intent to harm or to distress the victim.

Teachers interviewed about their experience of implementing the new curriculum described the pervasiveness of horizontal violence within the institution with one participant comparing the school to a ‘hostile environment’ and a ‘ticking time bomb’ waiting to explode (FSN03). Reports of personality clashes, public shaming and betrayal games (Heinrich, 2007), descriptions of bullying, finger pointing, verbal attacks, favouritism, non-consultations over teaching loads and sideways transfers of teachers and withholding vital curriculum information were forms of violence that teachers endured throughout the implementation stage. As the MOH, with the support of the management at the FSN, decided to implement the curriculum despite the protest of the faculty, many teachers began to show contempt as one participant described:

The problem was with management. The end product was the creation of ill feelings, a very suspicious and stressful work place where people were like a ‘ticking time bomb; just waiting to explode at any minute. A lot of confrontations among the staff and all the bad things and relationships that ensued were all because of the arrogance of management in implementing a new curriculum when staff was not ready, the nature of grapevine decisions at the top created a lot of problems for everybody (FSN 06, p.19).

With a very hostile environment and the teachers threatening not to teach the new curriculum, the JCU curriculum team with the Fiji Health Sector Improvement Project (FHSIP) convened a team-building workshop for the whole school (FSN 06).

Morale was very low; the lowest I have ever seen here! There was no commitment from the staff and some openly challenged management to teach if they wanted the curriculum implemented. Some staff actively

looked for places to go to and they resigned and left the school. The rest of us had nowhere to go (FSN 06, p.19).

Teachers also described the failure of the team building exercise as the curriculum was implemented. Frustrations and stress created by a frenzy of irrational staff movement all over the curriculum strands followed the implementation of the programme. Two teachers related how they were taken from their respective strands and thrown into areas they have never worked in since their graduation over 30 years ago.

Management was not working in consultation with us the staff, it was deciding on its own and what it felt was right. There was a breach of confidence between staff and management and the students. At the *vanua* level, we would sit and discuss... and so forth. They did not want our views, our feelings; it was not important to their decision making. They did anything they wanted done. It was not in our culture to refuse to follow instructions and they abused that. They knew we were struggling and they did not care. (FSN 06, p.16)

Having not worked in medical and surgical nursing for a long time, a teacher who was taken from PHC lamented at the removal of two of her senior and very experienced teachers within the medical and surgical nursing areas to join other strands. This action by the head of school was in her view very irresponsible given the nature of the experiences and qualifications of the rest of the team members.

Then they had to take two senior members who taught Medical and Surgical nursing and Obstetrics! This created a lot of confusion and commotion in the team. Most of us who remained came from Community health or non-hospital areas. At times I felt that the Principal was trying to 'punish' me and my team. (FSN 06, p.7)

An observation of a coordinators' meeting in the school revealed the extent to which the teachers were subordinated and made powerless by the prevalence of an autocratic style of leadership:

All the four coordinators attended the meeting called by the Principal in the lecture theatre. There was no agenda but the meeting was deemed to be urgent and related to a decision by the MOH to continue with the Nurse Practitioners' (NP) course (which the MOH had earlier agreed to withhold for a year until after the implementation of the new curriculum) After a prayer, we went straight into the meeting and were updated with the recent developments at the MOH and the NP course and its impact on our staffing distribution and redistribution of workload. Then she (Principal) told us her plans that this senior teacher from the Nursing Practice strand to move across to PHC! I thought I heard incorrectly or there was a mistake because that particular teacher had only worked in ICU all her working life! But no, that was the right order. I protested, so did the other coordinator for another strand. I looked at the teacher with concern as she sat there

speechless and stunned! She was probably angry or shocked or both! The atmosphere became very cold and tense as the Principal tried to reassure the teacher that she needed the change and it would be good for her. I could not think of anything rational or logical that could warrant the change of subject for this teacher. I was also concerned for the remaining team members who were new in medical and surgical nursing and they came from Community Health Nursing. I looked at the other coordinators, who also sat shocked at what we just heard; and the reality that none of these teachers could stand up to these kind of decision making finally dawned on me. At that moment I felt my time has come for me to leave the school. (FSN02, p.10)

This is an example of the non-consultative approach used by the MOH on the FSN and repeated by the FSN leaders on their own staff. A victim of such a transfer in the school had this to say:

The school needs a good leader to lead us properly; and not to feed on hearsay and not to be biased. This is a good place to work; it's just the decision making, that at times it's so frustrating and a source of heartache (began to cry). How can you call yourself a Christian when you treat your colleagues this way as if they are pieces of paper! I get so frustrated at times that I just want to leave this place (FSN 03, p.17-18).

The teachers' negative responses to the new curriculum were all related to the initiation of the project and the non-consultative leadership style of the school and the MOH.

### ***Horizontal violence experienced by students***

Graduates and students of the curriculum also described their experiences as that of being subjected to verbal and emotional abuse, and hostile and sarcastic remarks from their clinical preceptors and registered nurses. Some examples of negative behaviour meted out to students included refusal of assessments and supervision of procedures, and remarks, which downgraded teachers' ability and clinical skills. Graduates on the other hand described the ways in which their rosters were made when they were newly registered nurses:

They expected us to know everything that they know. It was unacceptable to them that we did not know a routine or a procedure. With drug administration, we did not learn about the Imprest system and we always thought it was going to be taught to us later, but it was never taught. When I was assigned to be an Imprest nurse, I did not know what to do because I had never done it in my clinical rotation. And I was told that I should know because I just graduated (GR 0, p.1-2).

Another graduate described her experience of being ignored in the ward by the senior registered nurse.

In the wards, we have to tag along with an RN so we can learn some of the IV drugs we were giving. We did not know whether they can be given direct into the vein or into the chamber. And if we can ask the RN, she would probably tell us, but we were scared because they would just ignore us and our questions (GR 04, p.12).

New graduates were also rostered on shifts on their own without the supervision of a senior RN. Shifts such as afternoons and nights as well as weekends often had new graduates on duty without most of the experienced and senior staff. While this arrangement contradicted the MOH policy of graduates' working under supervision, graduates viewed this as a way of punishing them or the school because of their curriculum (GR 02; GR 03).

The first graduates of the new curriculum lamented the way the school decided to take away the rural community health nursing experience from their curriculum, believing it was in the interest of their safety and the reputation of the school. In actual fact the school deliberately 'misinformed' the students by withholding the truth about their clinical attachment at the peri-urban areas as a punishment for the behaviour of some members of the previous classes:

We were told the reason why they stopped the rural programme was because of what was happening in the previous classes where there were a lot of misbehaviour and problems like elopement with local boys from the community. I feel it is not fair to be punished for something that happened in other classes (GR 01, p.14).

Misinforming students and withholding vital information, such as the rationale for their clinical learning experiences is a form of horizontal violence where the dominant party oppresses and punishes the victim through false accusations (Heinrich, 2007). This case where the school management changed their clinical plans and lied to students about the rationale for the change is unethical on the part of the school and a form of abuse and violence on the students. Students were made to believe that the clinical plans were changed because of the misbehaviour of former students and they were made to feel guilty and bad about themselves.

## **6.9 Teaching and learning methods**

The teaching and learning philosophy set out in the curriculum document (Usher, 2003) urged teachers at the FSN to incorporate adult learning strategies by creating an environment conducive to collaborative and equal participation of students with teachers. Teachers were therefore expected to use flexible self-directed processes of teaching, which includes tutorials, student seminars, research and student exercises. However, such processes were not easily implemented for a number of reasons. One was the prevalence of the teacher-centred philosophies and practices within the western academic setting and the traditional Fijian educational environment in which the students and the staff live. Second, the teachers resorted to using teaching methods, which they were comfortable with rather than using new methods, which they lacked experience and confidence in. Third, the resources at the disposal of teachers at the FSN could not support a student-centred and adult learning framework.

## **6.10 The engagement of students**

Fullan (2007) advocated for the active involvement of students in all educational changes. In a democratic society, the engagement of students from the initiation phase through to the institutionalisation phase is vital if change is to be successful. The Fijian traditional society is not a democratic society and democracy in Fiji is normally associated with the central government after independence. The active involvement of students in a formal curriculum can therefore be expected to have difficulties if the strategies to be used are not planned carefully by the very people who are expected to use it; the indigenous Fijian teachers. The fact the students were aged between 18 and 25 years and still considered to be young adults and 'learning' under the direction of qualified teachers who were mostly mothers and elders in the Fijian society made the transition difficult for the teachers themselves.

The 2004 curriculum exposed a significant factor in which students took it upon themselves to rise above logistic and administrative problems at the FSN and took

advantage of the gaps in the curriculum organisation to successfully complete their programme through unorthodox means. Such creativity on the part of students included their taking advantage of the weaknesses of the school and the whole system of clinical assessment and devised their own strategies of ensuring their completion of their assessments at the end of their training. Such strategies included sacrificing their holidays to complete their clinical rotations, befriending RNs who were not preceptors to sign their assessments and competency forms off, and even assessing themselves!

While student engagement in the curriculum was minimal, there was evidence that teachers actively sought formative and summative evaluations of the teaching methods used in the various subjects, students and graduates confirmed most of their recommendations for change were implemented whilst some were probably thrown out or forgotten.

### **6.11 Summary**

This chapter described the results of the analysis of data for this study. This analysis focussed on the level of congruence of the intended transactions for the curriculum at the implementation stage and the nature of the experiences of those directly involved in the process. The findings signified that there was a state of un-readiness of the school and the faculty when the curriculum was implemented very late in the 2004 academic year. Also evident was the lack of consultation amongst stakeholders of the new curriculum was directly responsible for the many problems and confusion experienced by the teachers and the students at the FSN. The prevalence of an outdated autocratic and traditional leadership of the School of Nursing in Fiji perpetuated the powerlessness of the teachers and the absence of any degree of academic autonomy of the school to administer its own affairs. The obvious lack of educational and curriculum support from the Principal and the leaders of nursing based at the MOH presented the teachers with more problems and opposition during the most trying periods of implementation. The prevalence of horizontal violence at all levels of the nursing service in Fiji is testimony to the prevalence of an autocratic style

of leadership which has been allowed to flourish by the traditional Fijian ethos of silence, obedience and humility. The data showed that a failure in the clinical learning programme of the students and the failure of the Preceptorship programme were directly related to the lack of confidence of the graduates and the students of the new curriculum to practice in isolation or away from hospitals.

Four years after the implementation of the competency-based curriculum, knowledge gaps, overlapping of themes and subjects of different strands continue to plague the teachers at the FSN. The first graduates of the curriculum accepted their fate as 'guinea pigs' in a new curriculum, and they maintained a trial and error mindset throughout their training and after graduation. The graduates' lack of confidence in their skills and ability to practice independently maybe also related to the content of the curriculum and its relevance to the Fiji context. This is examined in detail in the next chapter.

## Chapter 7: Making the curriculum relevant to Fiji

### 7.1 Introduction

The previous chapter continued the discussion on the analysis of data from the research. This chapter shifts the analysis to the subjects taught within the curriculum and their relationship to the indigenous health knowledge and practices. According to Usher (2003, p. 11) the rationale for the curriculum under analysis was the need for a well-rounded registered nurse and this rationale underpins the indigenous analysis of the curriculum regarding the relevance and appropriateness for the preparation of nurses.

For this reason, this chapter documents the analysis of the content of the curriculum using the *vanua* indigenous framework. The chapter has two major sections. The first summarises the subjects covered by the Diploma of Nursing curriculum, using the *vanua* indigenous framework and highlights the biomedical or western focus of the curriculum. The second section describes the indigenous perspective of caring and the important indigenous knowledge of health practices, which need to be included in the curriculum.

The rationale for knowing the indigenous health practices of the Fijians is that the nurses and the other health professionals within the medical model are aware of the dynamics of the Fijian society and the way health and illness are defined and practised. With the abundance of research knowledge regarding somatic illness and the socio-cultural perspectives of health, nurses within multicultural societies like Fiji should be equipped with the relevant knowledge so that the cares given to indigenous and other ethnically diverse populations are safe, sensitive and relevant.

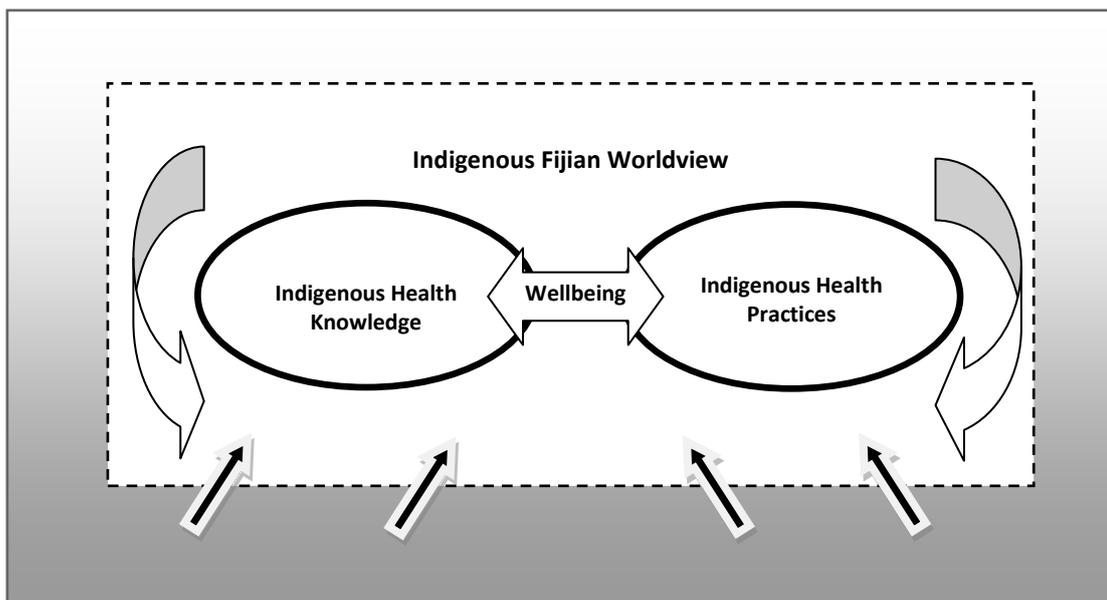


Figure 10. The indigenous framework for curriculum analysis

## 7.2 The Analysis Model

The analysis model (Figure 10) illustrates an indigenous person as having reached a state of wellbeing within a desirable balance of health knowledge and health practices. The wellbeing of an indigenous person is determined by their ability to selectively apply other perspectives of health foreign to Fijians and create a 'common ground' in which to live their lives. The reality of the Fijians' state of well-being is that they have lived in both the Western and the Indigenous worlds since the colonisation of Fiji in the 1870s. Fijians continued to use their own remedies and practised what they believed contributed to their health and well-being. An anthropological account of the existence of indigenous Fijians within two different worldviews documented almost 4 decades ago continues to thrive at the time of this research.

Under the neon glare of an operating theatre, a surgeon with a build of a prizefighter performs the last stage of a delicate eye operation. In a thatched hut lit by a hurricane lamp, an old woman brews a medicine of leaves to procure a child for a barren woman.

The pretty girl at the self-service store stabs briskly at her adding machine and hums the latest pop tune. Her married sister is beating tapa in a nearby village for a wedding.

A steel-helmeted miner is turning the drill on a seam of gold. A fisherman draws up his nets and throws back to the sea, the Turtle, which is the living spirit of his ancestors (Knox-Mawer & Carmichael, 1968, p. 11).

Later studies (Becker, 1995; Prosser, 2006; 1983, p. 34) into the indigenous societies in different parts of Fiji showed that despite the global changes affecting the very fabric of Fijian life, indigenous Fijians continue to live in what Champagne and Abu-Saad (2006) called a political and cultural common ground. Apart from the dominant western model of health, nurses in Fiji also need to possess a wealth of knowledge that could be adapted and integrated with the indigenous health knowledge of the Fijian people. These are discussed under the different themes for the various subject strands. While it is recognised Fiji is a multiethnic and multicultural society, the focus of this study on the indigenous people does not imply that the health perspectives of the ethnic minorities in Fiji are not important.

The health status of the indigenous people of Fiji, is similar to other indigenous people living in other countries such as the indigenous people of Aotearoa, New Zealand (Durie, 2003). The health status of indigenous Fijians in the past two decades has deteriorated in all aspects of their lives, compounded by new lifestyle conditions that are directly related to the breakdown in socio-cultural values of the indigenous people. The analysis of the curriculum should enlighten the role and the importance of the cultural perspectives of indigenous and culturally diverse people have over accessing health services and their influences on their health.

### **7.3 The Curriculum component**

The Diploma of Nursing curriculum is structured into four main subject strands: Foundational Nursing Knowledge, Nursing Practice, Primary Health Care and Personal Professional Development. The various subjects within the four main strands are described individually in relation to their relevance to the indigenous perspectives of health.

## **7.4 Foundational Nursing Knowledge**

The Foundational Nursing Knowledge (FNK) underpins the curriculum as it forms the foundation of all nursing subjects. Subjects covered in this strand include Anatomy and Physiology, Pathophysiology, Microbiology, Pharmacology, Genetics and concepts of mental health and illness. Alterations from normal physiology and development of diseases are covered and explored. Anatomy and Physiology covers in detail the relevant physical and physiological make up of a person.

Although FNK is supposed to provide the groundwork and the relevant contingencies for the remaining subjects in the curriculum, the subject lacks the psychosocial development aspect of a person. The psychosocial development component would provide a balance in the normal development of the person and could provide the vehicle for the delivery of mental health, cultural and indigenous health frameworks within the other subject strands such as Primary Health Care, Personal Professional Development and Nursing Practice.

### ***Anatomy and Physiology***

Anatomy and Physiology aims to provide an understanding of the normal structural and physiological processes of the human body. The subject is organised and taught through eight functional sections. These are the human body as a system, the internal environment, integration and control, body transport systems, obtaining and using raw materials for metabolism and excreting wastes, ensuring continuity, and movement and stability. The curriculum's one-dimensional view of man excludes the spiritual and social aspects of what makes a person human. A psycho-social perspective of the human body is important in understanding the indigenous view of health and illness within the Fijian people. For example, Fijians have high regard for the head. Touching or stepping over a person's head, or to place a food basket or to carry anything on the head is forbidden. The heads of chiefs are more sacred than others and cannot be touched by a common person. To touch a chief's head knowingly without asking for forgiveness invites the wrath of ancestors and sicknesses. Ceremonies of forgiveness

or for the appeasement of the spirits are usually performed to avoid the impact of violating taboos. Similar sentiments are accorded to the genitals by avoiding the direct naming or calling of the genitals by referring to totemic foods or identity of the person or tribe (Becker, 1995). Contact with a person's genitals is avoided as they are the most private parts of the body of a Fijian (Ravuvu, 1983). In nursing, utmost respect and deference is accorded to patients requiring examinations of genitals, or for procedures such as catheterization, and it is not unusual to find indigenous Fijian nurses requesting permission from the patient to handle or touch the genitals in the process of providing nursing cares.

### ***Heredity and Genetics***

The content of Heredity and Genetics offers only a biological perspective of the subject and has no mention of the indigenous perspective of genetics in the Fijian culture. While there are no studies on the susceptibility of indigenous Fijians to certain diseases, literature on genetic influences on certain diseases such as thalassaemia, sickle cell anaemia, keloids and lactase deficiency and lactose intolerance, describes the relationship of genetics to ethnicity or racial differences. Fijians also have a number of diseases such as narcolepsy; which are common to a number of tribes in Fiji, and such diseases are identified as totems for the particular tribe. Because they are regarded as totemic conditions, it is not seen as a medical condition and it does not require medical intervention. In fact to awaken or to disturb a victim in deep sleep would warrant a traditional punishment from the elders of the tribe. The inclusion of physiological and cultural impacts of genetics on indigenous cultures offers opportunities for critique and an evidence-based nursing knowledge for student nurses.

### ***Microbiology***

Microbiology is taught in parts through the strand within the first and second year of the programme. The subject is introduced in the first semester of year one and continues in the second part of semester two of year one with Pharmacology. The subject complements the western biomedical model in that it reinforces the germ

theory and all that is scientific in medicine and nursing. The introduction of microbiology together with the anatomy and physiology and its exclusion of the social aspects of development of the person lend more emphasis on the biomedical focus of the curriculum.

### ***Pharmacology***

Similar to Microbiology, Pharmacology is taught in 'pieces' through year one and two together with other subjects such as Microbiology, Clinical Pathology, Heredity and Genetics, Normal Pregnancy and Delivery. While the rationale for the piece-meal teaching is unclear, the implication of such curriculum designs can create problems in the continuity of learning in students.

Pharmacology lacks any acknowledgement of the existence of traditional medicine in Fiji and the prevalence of its use by the indigenous people. Such omission in the curriculum teaches students to reject all other perspectives of medicine apart from the more scientifically based western medicine. The general objectives of the course expect the students to know the major uses of herbal and traditional medicines in modern pharmacology, the specific objectives expect the students to identify the common herbal and traditional medicines and their potential interactions with conventional medicines (FN Team, 2007, p.30). However, the study guide is limited in its effort to meet the objectives by omitting any formal lectures on the subject.

A number of studies indicate pharmacology should be offered as a separate subject rather than with pathophysiology and microbiology, along with the commitment of the Fiji government to support traditional medicine (Fiu & Olutimayin, 2000; Strathy, 2000; Veitayaki, 2002). Its incorporation as a distinct subject would provide students with an opportunity to explore the reaction and the interactions between traditional medicines and the more scientifically based conventional medicine. How Pharmacology is currently taught does not reflect a commitment from the FSN to teach traditional medicine and health practices, and thus does not acknowledge the significant position of traditional medicine in indigenous societies.

### ***Pregnancy and Delivery***

Pregnancy and Delivery is taught in semester one of year two, with the three other subjects stated above (Clinical Pathology, Pharmacology and Heredity and Genetics). The subject aims to instil an understanding of the normal physiological changes throughout the lifespan beginning from conception to old age, including abnormalities of pregnancies and the newborn. However, the subject is heavily focused on the western medical model and lacks a cross-cultural perspective of pregnancy and delivery; given that the majority of women in Fiji are either indigenous Fijians or ethnic Indians. Moreover, the prevalence of traditional practices for pregnancy, labour and delivery and fertility amongst indigenous Fijians need to be addressed in the curriculum. Contemporary issues in obstetrics and midwifery such as community based midwifery practice and similar practices are not covered and nurses are only prepared for practice in a western medical context.

### ***Breastfeeding***

The curriculum teaches breastfeeding from a western medical perspective and disregards indigenous perspectives of breastfeeding. The practice of feeding the newborn infant with colostrum as opposed to the Fijian practice of discarding colostrum is a good example of contradicting worldviews of health and illness and needs to be addressed. While western medicine believes in the supply of antibodies and nutritional content of the colostrum as good for newborn babies, indigenous Fijians considers colostrum to be too rich in fat and can cause problems for a premature liver.

Fijians have many practices regarding breastfeeding, milk production and food types that increase or decrease milk production. Practices that increase milk production include eating grilled cassava and fish soup, green leafy vegetables, small mud crabs and drinking lots of warm beverage and water. Chillies, onions and spices, fried and dried foods are strictly avoided together with unwelcome stressors that can create difficulties in milk production. The integration of the indigenous Fijian perspectives of

breastfeeding can assist greatly in the prevention of post-delivery complications for Fijians, promotion of health for women and children and also provide a source of knowledge for the nurses who are younger and inexperienced in breastfeeding. A general list of foods that promote milk production and those that prohibit it should be included, explored by nurses and used in antenatal health education in Fiji.

### ***Mental Health***

Mental Health is taught within three strands; the Fundamentals of Nursing Knowledge (FNK), the Nursing Practice (NP) and the Primary Health Care (PHC). The teaching of Mental Health in three different strands at various times in the programme can create problems related to overlapping, repetition and 'gaps' in what is taught within the different strands. In the FNK strand, mental illness concepts such as anxiety, mental health conditions such as psychotic disorders, schizophrenia, mental retardation and mental assessments are included in the syllabus. The legal aspects of mental health, the role of nurses and the extent of the problem in Fiji are covered by the FNK instead of the PPD strand which teaches laws and legal aspects of Nursing. Mental retardation is taught by FNK as a component of mental illness instead of Paediatrics and the therapeutic processes and treatment protocols for the various mental disorders are taught within FNK instead of the Nursing Practice strand. In the Nursing Practice strand, mental health status assessment skills, treatment and management processes for mental illness and interventions are taught including the special care for clients with dementia and delirium.

### **7.5 Nursing Practice**

Nursing Practice (NP) includes all nursing and therapeutic management of all conditions covered in FNK. Such conditions include medical and surgical interventions, obstetrics, paediatrics and mental or psychiatric conditions. These include skills of assessments, planning, intervention, management and evaluation of individuals, families, and their responses to illness. The content is divided into basic nursing skills and care, nursing care skills for medical and surgical nursing, maternity nursing and mental health in year two and advanced and complex nursing in year three. The subject of nursing practice is taught in various depths and details throughout the three years of training. Nursing practice is applied to all nursing situations and management of patient care. Nursing practice includes a unit on low dependency nursing care for clients in low dependency facilities as well as those in medical and surgical wards of

the hospitals. The curriculum does not acknowledge the fact that Fiji does not have low care facilities, except old peoples' homes where the destitute are kept with those who are mentally retarded and are too old to live in the handicapped children's facilities. This fact is important in planning clinical learning experience for students that they are rotated to the appropriate clinical care settings. Nursing practice moves from the simplest bedside care to complex medical and surgical procedures, medication administration, psychological support for all types of patients and general and specialist care for a variety of clients. Nursing practice focuses on caring within a hospital or biomedical setting, and does not include any aspect of indigenous Fijian concepts of caring.

## **7.6 Primary Health Care**

Primary Health Care (PHC) as the third nursing strand in the curriculum focuses heavily on PHC concepts and public health issues. Epidemiology and health promotion are emphasised strongly in its use as a strategy to prevent illness in families and groups. Like FNK, PHC also uses the across-the-life-span approach. PHC, it is claimed in the curriculum document, forms the basis and framework of nursing in Fiji (Usher, 2003). This however, has not been visible in the subjects analysed and more so, within PHC itself. The western concepts of PHC are discussed and used to teach indigenous and non-western communities in Fiji about political concepts such as empowerment, and the Gibbs Trust model to assess indigenous families. Like other strands and papers, the PHC subject does not acknowledge the significance of indigenous health issues and the irrelevance of the Gibbs Trust model to indigenous Fijian families. The PHC strand also teaches subjects such as mental health concepts and paediatrics, and conducts workshops for students on Integrated Management of Childhood Illnesses (IMCI) as a policy of the MOH.

## **7.7 Community Health Nursing**

Community Health Nursing (CHN) is a component of the Primary Health Care strand and was initially omitted by the project team, but was included by the PHC teachers in

2005. Conceptualisations of important components of CHN such as the community, the environment and the family were absent and could not be used to evaluate themes taught in the subject. These concepts were seen by the teachers as very important within the context of an indigenous Fijian community as they dictate the dynamics in which the health programmes would be implemented or rejected. A typical indigenous Fijian community needs to be presented as an ideal type because even though there have been a lot of changes to its structure, the basic components have been constant over the years. The family, both nuclear and extended, remains the primary basis of communities and an assessment of the family and its dynamics reveal much about the status of the larger community it belongs to. The health assessment of a Fijian family needs to take into consideration its context and its identity in relation to the community it is a part of. Any model considered for family health assessment needs to consider the nature of the indigenous community or *vanua*, its physical and spiritual and psychological characteristics as these have a lot of bearing on the assessment of the family and the physical context of families themselves.

### ***Epidemiology and Reproductive Sexual Health***

Epidemiology is taught within the PHC strand. Reproductive Sexual Health and Family Planning are used as vehicles to teach epidemiology in the curriculum and its role of describing the nature of disease patterns in Fiji. The use of reproductive and sexual health in epidemiology can be interpreted to depict that the indigenous Fijian population is promiscuous and that other health problems do not exist. While the national policy of family planning is not clearly defined in the curriculum, the subject appears to project that the only significant factor in population growth and dynamics is contraception. Apart from HIV/AIDS and sexually transmitted infections, other conditions such as non-communicable diseases, drug abuse and lifestyles that are foreign to indigenous Fijians, can also impact the Fijian population.

## **7.8 Personal and Professional Development**

The Personal and Professional Development strand (PPD) teaches supportive subjects such as research, communication, professional ethics, laws in nursing, management, psychosocial nursing, critical thinking and reflective practice. Subjects included in the strand aim to enrich the nurses' personal and professional practice and behaviour in all nursing situations.

### ***Ethics and Laws in Nursing***

The law and ethics of formal nursing is grounded in western philosophies and principles of ethics such as autonomy, beneficence and non-maleficence, veracity and justice. Moreover, the theories of ethical reasoning such as teleology, deontology, feminism and virtue are all included in the development of an ethical guideline for nursing practice. Rules for law, ethics and moral reasoning within a western legal framework influences many health care services and the practice of care such as nursing and medicine. Western laws and the ethical principles of reasoning that govern nursing practice in Fiji must also align itself to the existing indigenous laws and mores underpinning Fijian worldviews and customs. Those that are relevant include those values that govern nurturing care, good health and survival (reproduction and continuation of generations and lineages).

Village by-laws govern the housing specifications in Fijian villages including measurements of sleeping houses, dining and cooking houses. The number of toilets and showers (source of bath and toilet water) is provided for in the regulations. The curriculum needs to address laws which are relevant so they can be appreciated and where applicable, upheld without unnecessary penalty for family members. The Fiji Public Health regulations do not allow more than one nuclear family to dwell within a single house. This provision, although based on the prevention of airborne diseases and disease outbreaks, contradicts the social functions of families in supporting and care-giving responsibilities to the most vulnerable members of the family, such as children and the elderly.

The important aspects of the village By-Laws which affect the existence and the healthy development of indigenous Fijians are not included in the PHC strand. The disadvantage of such laws in relation to the socialisation of children is only included when the teacher is an indigenous Fijian. Otherwise it's never mentioned. (FSN 06. p.6)

Children miss out on proper socialisation by older members of the families. A breakdown in social engineering and role modelling from all adults becomes compromised and a previously extended family network becomes a nuclear family with reduced support system available for children, mothers, fathers and other relatives.

### ***Professional decorum***

Fijians like many other traditional and indigenous people have values in grooming, dressing and behaving in their community. While nurses in Fiji wear knee length uniforms and dresses and male nurses wore long pants, it is disrespectful for a Fijian woman, especially for an adult nurse, a mother or a mature woman to show her legs in a Fijian village. Nurses hold respectable positions within a Fijian community and like teachers, they are expected to be exemplary in dress codes. While supervising nursing students on community health nursing attachment, a participant described her experience:

Before joining the FSN, I worked as a Health Sister in Tailevu and I supervised the clinical attachment of student nurses coming to my subdivision for 12 weeks. Students did not know how to dress up to go into a Fijian village...the appropriate protocols, how to stand up and to sit down. They have to know the language, the use of the eyes, the noise, their hairstyles and the chewing gum the make-up and the jewelry...I would make them sit down and stand up and make sure that their feet are placed correctly when they sit down and when they stand up. This is important in the Fijian context. At times before we board the bus, I have to return some students to the residence to change clothes because they are just not appropriate for the village. (FSN 06.p.9)

While the curriculum prepares the nurse for professional decorum, it does not consider the inappropriateness of the uniform, which was designed originally for use in western societies, in a Fijian context. Moreover, the curriculum fails to prepare nurses to work safely within an indigenous society.

### ***Psychosocial influences on nursing***

This subject aims to prepare the student in the understanding of the multitudes of contexts for human development and functions. The curriculum expects the students to understand the psychosocial contexts of the person without being first introduced to the psychosocial development knowledge in the FNK strand. The subject is an example of how the curriculum was not prepared to be relevant to the Fiji context and the teachers took the liberty to take it apart and teach Psychology and Sociology separately instead of the integrated psychosocial aspects development. The importance of the nurses understanding the psychosocial development of an indigenous person is discussed later in the chapter.

### ***Management***

The Management subject aims to prepare nurses for effective leadership and competence in managing organisations at all levels of nursing. However, the subject failed to conceptualise management and apply its concepts to nursing and its various contexts, including the indigenous and multicultural context of nursing in Fiji. The subject does not teach any theories of management which could be used to analyse the management of nursing within the MOH.

### ***Nursing Research***

Apart from the very brief preparation in nursing research, the curriculum focuses on developing skills for evaluating published research as well as the application of research information as evidence-based nursing practice. Research is a powerful tool for either liberation or the continuing oppression of the indigenous colonised people of the Pacific. To teach western academic research methods only without alternative methodologies and worldviews reinforces the power of colonisation over knowledge, and the subordination of alternative worldviews. Alternative worldviews and research methodologies that privilege indigenous or ethnic variations are well equipped to prepare indigenous students to critique their own indigeness, their culture, and their health values and compare them with the predominant western worldviews.

The intention of the curriculum to prepare Fijian nurses to provide evidence-based care, only reinforces and further strengthens the dominant emphasis on the western medical knowledge within an environment largely comprised of indigenous Fijians and other ethnic groups such as Fiji Indians, Chinese, Europeans and other people from the Pacific nations. The worsening health status indicators for indigenous Fijians are evidence the western medical model has not worked as well as it should. Many studies have been carried out on the indigenous people in Fiji out of concern for their health status have been done by non-indigenous people from more academically oriented western medical disciplines. These studies have not considered that the western medical model of health prevalent in Fiji for the past 200 years has not supported the traditional and indigenous perspective of health, and could be the main reason for the deterioration of indigenous health (M. Pande, et al., 2004; Tukuitonga, 2007).

Whilst other knowledge disciplines such as Education, Agriculture, Marine and Animal Sciences and Environment continue to testify to the perils of not considering indigenous Fijian perspectives and having taken steps to correct them (Strathy, 2000; Thaman, 2003a; Veitayaki, 2002), health professionals appear to ignore this fact and continue to depend on western medical experts who disregard indigenous health knowledge and practices. Research, as a tool for evidence-based practice, needs to be informed by indigenous worldviews and be a liberating experience for the indigenous people.

## **7.9 Creating an indigenous-centred nursing practice for Fiji**

In order to meet the health needs of the indigenous Fijians, Fijian nurses need to be aware of important indigenous knowledge of health and illness embedded in Fijian culture. Those that are important to nursing include the indigenous art of nursing, the psychosocial development and important milestones of Fijians, cross-cultural communication and the health perspectives of indigenous Fijians.

### **7.10 The art of nursing in the indigenous Fijian society**

Informal nursing is highly organised and articulated into the Fijian culture as concepts of caring based on powerful mores and customs. The social responsibilities of caring for one another and the society's older and weaker members acts as a social adhesive on which the foundations of the indigenous Fijian traditions are constructed and maintained over generations.

No one passes our house without my father's invitation to share our meals. And if they do come in, he will give his share of food and will never ask any of us to give in theirs. Such was our way of upbringing to teach us to value everybody and to share and care for everyone. (FSN 05.p.2)

Anthropologists investigating Fijian societies found the concept of caring to be synonymous with 'nurturing' and communal sharing of resources, food, wealth and knowledge and appeared to be an important social responsibility that identifies and sets an indigenous Fijian apart from any other ethnic group (Becker, 1995; Brison,

2007; Ravuvu, 1983). In describing important knowledge for the *Vugalei* people, Nabobo-Baba (2006) discussed the importance of ‘caring’ in an indigenous Fijian society where a spirit of sharing and caring for relationships is viewed as having more importance than material wealth. Similarly, Becker (1998) described the concept of *Vikauwaitaki* (caring) acted out on a daily basis in a Fijian village. Such actions as offering food to visitors, the never-ending invitation to all passers-by to join mealtimes, free dispensing of traditional medicine, the nursing of the sick in the village or in the hospital where relatives sleep with the patients in a show of concern and support for the sick person demonstrate the nature and depth of the integration of caring and nurturing values within the Fijian culture. Figure 7.2 describes the components of knowledge required for nurses in order to meet the health needs of the Fijian people and to make nurses’ practice culturally safe.

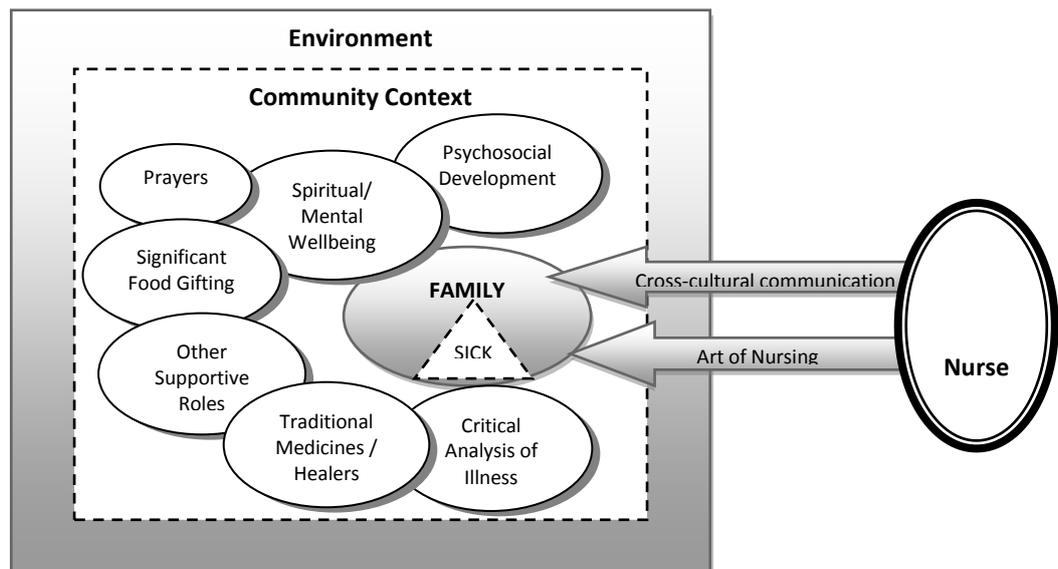


Figure 7.2. The art of indigenous nursing model

### 7.11 The sick role

Unlike the descriptions of the sick role by sociologists such as Parsons (1975), indigenous Fijians define the sickness or illness within the context of the community, so when a person is sick the entire family and the community is sick. The ‘sick’ event

denotes a cultural or social anomaly and therefore requires communal action for the restoration of health:

When a person is sick, the whole family is sick. The *vanua* is sick. When the sick person is admitted into the hospital, the whole community or the *vanua* is admitted into the hospital. (FSN09, p.10)

When the sick role is identified, the rest of the family quickly and almost naturally subdivide the roles each member needs to play in order to support and promote healing and rehabilitation of the sick person.

This is important in relation to health programmes, health promotions and patient education such as in Diabetes where we tend to wrongly educate the sick person. We indigenous Fijians know that we have to educate the whole family and the whole community because the responsibility of eating the right food and the change in lifestyle belongs to the community and not to the sick person (FSN 05: p.9).

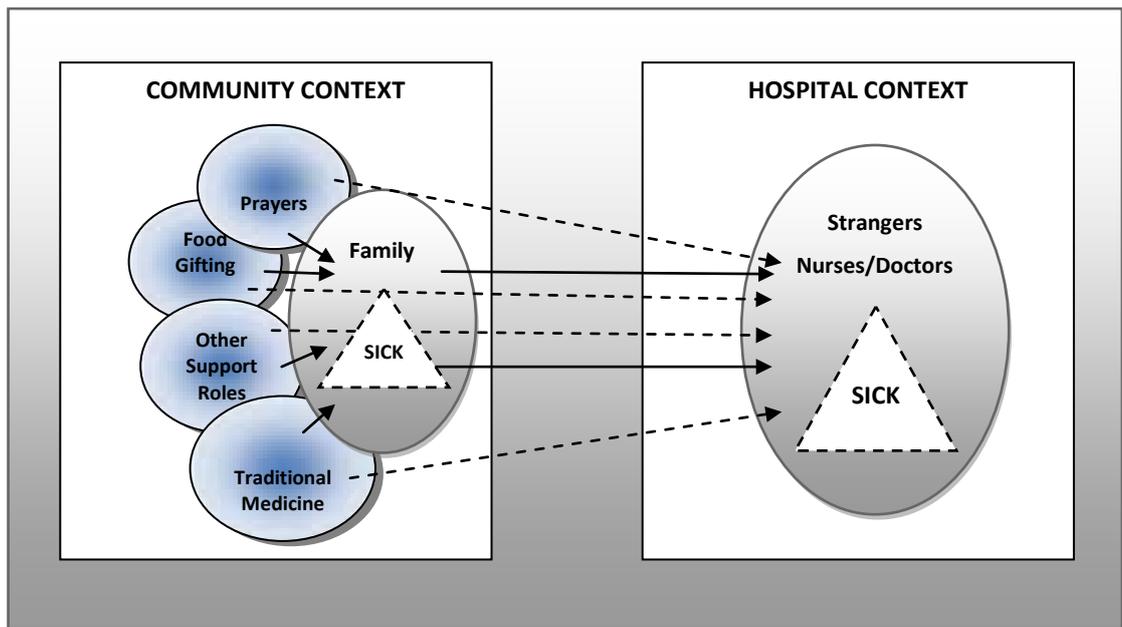


Figure 11. The indigenous nurturing-caring model

Figure 11 diagrammatically represents the nature of the distribution of the responsibilities of families, relatives of a sick person and how nursing care and nurturing as a component of the Fijian culture is demonstrated within the community context and extended into the hospital context when the sick person is admitted. A significant issue in the care of the sick or ill is the level of care and the caregivers'

position in the social hierarchy. As a hierarchical society, indigenous Fijians assign the care of socially high-ranking members to certain specific members of the group or tribe and to disobey means ill health or even death. Chiefs are seen as an extension and embodiment of the *vanua* itself, and are therefore treated and cared for through socially ascribed positions within the community. While the more common indigenous people tended to have given up to hospital protocols, difficulties arise when chiefs are admitted into the hospitals and their traditional caregivers are not allowed into the hospital to personally attend to them. According to a participant, nurses need to accommodate such traditional Fijian protocols as they influence the recovery of the sick person and the well-being of the carers:

As nurses we tend to believe that we know everything and what we know is the best for our people. But NO, what goes on within the spiritual realm requires that our people carry out their social obligations to each other. If we stop them, we are stopping them from maintaining their health and well being: both the chief and the traditional carers; the people and the *vanua*.  
(FSN 09.p.9)

Fijians believe an undisclosed pregnancy within the household of the sick person can cause the deterioration of the disease of an ill person or may cause death. Hidden pregnancy can also cause disaster at sea or create problems during a fishing expedition (Becker, 1995; Ravuvu, 1983). This knowledge is relevant in Fiji where nurses continue to be predominantly female and hidden pregnancies can be fatal for patients cared for within the hospitals.

### **7.12 Food gifting**

The practice of food gifting during the 'sick' period becomes problematic in conditions that require special diets such as diabetes mellitus, renal conditions and cardiac diseases, unless relatives are informed appropriately for the need of special dietary considerations. Staffs in hospitals do not recognise nor do they sympathise with the requirement of the 'sick' person to have a relative stay overnight or during mealtimes. It is therefore, not unusual to see relatives constantly entering the hospital premises and breaking visiting hour's protocols in order to provide a socially significant responsibility of caring and nurturing their sick or needy members. The caring–

nurturing role of the Fijian is a two-way process, whereby the sick person's need for recovery is provided for whilst at the same time the provision of care also meets the social responsibility of the carers. A participant's experience with a visitor at the main hospital while supervising students described the need for nurses in Fiji to be aware of the significance of food gifting and social support systems for indigenous Fijians:

A middle aged Fijian woman travelled from the western part of Fiji in a hired car to visit her distant cousin admitted in the surgical ward with below knee amputation from diabetic sepsis. The visitor held her large porcelain bowl with a freshly cooked whole fish and soup and some green vegetables. In another plate were two large cooked whole yams and lemons. The registered nurse on duty was telling her off for 'sneaking' in the food for the Diabetic patient. The visitor pleaded to let her cousin sip some soup from her bowl as she had caught and personally prepared the fish for her. (FSN09: p.11)

In the case of new mothers, the caregivers also include a confidante, an appropriately selected relative to provide emotional, spiritual and physical support to the new mother. Within the indigenous context, other family members or relatives within the community are expected to provide or contribute to the nourishment of the sick or the newly delivered mother. Becker (1995) observed during her fieldwork the process of *kabekabe*, or *ta'ita'i* (Tarabe & Naisilisili, 2008, p. 3) whereby cooked food was gifted daily from one house to another house for impromptu visitors, elderly kinsfolk, sick relatives or newly delivered mothers. Such socially prescribed customs of nurturing and nourishing the sick with healthy food everyday extends to the hospital environment when either a sick person gets admitted or a woman delivers her baby, relatives bring in cooked food to help with the healing process.

### **7.13 Social support networks, values and mores**

Fijian social relationships are based on the reciprocal exchange of care and the nurturing amongst Fijians and between Fijians and strangers or foreigners. Social functions and obligations are reciprocal and are based on the broad philosophy of contributing to the total survival of the immediate and distant tribal members and relatives. The fulfilment of caring roles and obligations of indigenous Fijians whether they are resident or not in their traditional villages, also contribute to their total health and well being as identified by a participant:

I am always present in my village from my school days until now as I am about to retire. Every *vanua* or church obligations... my name is there to contribute, and I value that. The call of my tradition, land and its spirit keeps me grounded in my work, my relationships, my well being and my whole identity.(FSN 06.p.2)

The social support system that exists in the traditional Fijian setting includes the provision of physical, social and spiritual support to the sick person and the immediate family. However, reciprocity and acknowledgement of support obligates the sick person and the family to express gratitude to relatives in return for the support rendered during their time of need. Nurses working within indigenous Fijian communities or in hospitals become ambivalent about accepting gratitude from clients and patients, relatives or families after discharges or even after deaths, deliveries, circumcision and other general services that are rendered by them or other health professionals. While the 'professional' ethical guidelines prohibit the acceptance of gifts from patients, Fijians interpret refusal of gifts as an offense or that they are not valued. In such circumstances, many clients do not fully recover and may always feel guilty or in debt to nurses (and others).

### **7.14 Traditional birth attendants and midwives**

The pharmacological component of the nursing curriculum does not consider the accessibility and use of traditional medicine by Fiji indigenous people. Yet, the practice of traditional medicine in Fiji is widespread, with 80% of people in the South Pacific dependent on traditional medicine and practices for health care (Fiu & Olutimayin, 2000). The socialisation of indigenous children on their roles and responsibilities within an indigenous Fijian context includes the transfer and inheritance of traditional indigenous knowledge of healing practices and medicines. Supportive structures relevant to the care of the sick and the infirm in traditional Fijian communities include traditional midwives, support for the disabled, traditional healers, traditional medicine and spirituality.

Traditional midwives have also played a significant role within the indigenous Fijian society. Despite a strained relationship with the western medical model, traditional

midwives have been the silent partners of public health nurses in the rural isolated areas of Fiji for a long time. Their activities and importance within indigenous Fijian society have been documented (Ravuvu, 1983). Lukere (2002) described how traditional birth attendants or traditional midwives were blamed for high mortality rates of indigenous Fijian infants in the late 1800s, and rather than unhygienic techniques originated from infections and diseases introduced by colonialists. Despite many opponents, traditional midwives continue to exist and practise in Fiji as their services have contributed to indigenous Fijians' survival. They have been valuable in areas where nurses cannot access women in time to deliver babies. They have been valuable supports for young inexperienced nurses who work alone in isolated islands and the rural interior of the main islands. The Primary Health Care strategy promoting accessible and available health service for all people by the year 2000 enabled traditional midwives to work freely with nurses and within Fiji's biomedical health services, either as village health workers or traditional birth attendants (Bannerman, Burton, & Wen-Chieh, 1983).

### **7.15 Traditional healers and traditional medicine**

Traditional practices and beliefs are followed by indigenous Fijians, as well as by other ethnic groups. Traditional healers include the traditional midwives and caregivers whose roles and obligations are to care for the sick members in their tribes. For indigenous people, traditional medicine is an important and visible component of health practice used to prevent the occurrence of sicknesses and treat many ailments and diseases. Fijian medicine can be used at three levels.

The first level is preventative, where medicine in a variety of preparations is administered to prevent the occurrence of flu, indigestion, thrush, obstetric complications, postnatal depression and prolonged labour. This level also includes medicines to improve appetite, detoxify the body and cleanse the uterus for married women. *Macake*, a common symptom of physical ill-health found mostly in children, usually presents with poor appetite, thick furry grayish nodes on the tongue and

signifies an abundance of unhealthy sugars and food toxins. Prevention or treatment of *macake* is documented by Becker (1995) as an obsession by Fijians across all ages. This consists of *Dranu* or concoctions of barks, leaves, roots, shoots, stems or fruits or combinations of two, three or more to prevent seasonal illnesses and the improvement of appetites. Second, curative measures like the use of *danidani* leaves to cure sinusitis and migraine. Puerperal psychosis is treated with a concoction of three or more leaves, a root and the shoot of the red coconut tree. The tertiary level of traditional medicine includes the regular dosing of specific medicines to control diseases, such as diabetes, high blood pressure, bladder infections, and gastritis or ulcers of the gastro-intestinal tract. Traditional medicine is also used to stop excessive bleeding in open injuries by directly clotting the blood on the wound and constricting blood vessels.

There are two groups of practitioners of traditional medicine. The first group consists of generalists who dispense widely known remedies by providing the medicine and empowering people with knowledge of traditional medicine. The generalists tend to receive their knowledge from their elders, friends, or may have amassed their knowledge from having special interest in the practice of traditional medicine. The second group of practitioners is specialists who usually treat and hold knowledge of a single type of illness or disease, and may have family ownership of the knowledge and the power to heal or cure. While both types of practitioners do not practise medicine to earn a living, the specialist practitioner is obligated to provide services to those in need. The power to heal is embedded within their families and tribes, with specific knowledge passed down from previous generations, except in circumstances where there is no family member willing, available or accessible to deliver such a service. In such situations knowledge is then passed to distant family members. An example of the embedded nature of healing powers within a family is the Fire walking tribe of *Beqa* Island, whereby family members who can walk on hot ambers without getting scorched can also heal burns. No apprenticeship is required as the ability to heal burns and scalds passes through generations and family linked to the fire walking tribe. Importantly, traditional medicine is not for profit or for sale and is practised with a

willing heart to serve humanity. The 'willingness' of family members to continue the practice of traditional healing is an important deciding factor for its continuation.

While some plants and their use are well known and freely available, there are some plants that are specifically owned and can only be administered by certain practitioners. The types of diseases and conditions treated range from hair loss to migraine, from sinusitis and colds to detoxification and fractures and other conditions such as psychoses. Health practices specific to the maintenance of health and the prevention of illness include all those traditional customs and practices used for the prevention of seasonal colds, detoxification of all age groups and for both men and women, the prevention of obstetric complications and emergencies, and the practice of healing through massage, gifted healing powers for burns, fractures and abscesses (Strathy, 2000; Veitayaki, 2002). Studies on the usefulness and the need for the integration of traditional medicine in the Pacific abound (Fiu & Olutimayin, 2000; Veitayaki, 2002) MOH Corporate Plan 1997-1999, June 1997).

The practice of traditional medicine in Fiji is widespread, with 80% of people in the South Pacific dependent on traditional medicine and practices for health care (Fiu & Olutimayin, 2000). However, the pharmacological component of the nursing curriculum does not consider the accessibility and use of traditional medicine by Fiji indigenous people. The absence of traditional medicine and health practices in the Diploma of Nursing curriculum cannot be justified, especially as studies have recorded diseases and conditions treated or managed by traditional medicine and practices over the years by indigenous Fijians and others who believe in their potency. Body systems and examples of conditions and their management regimes are also well documented (Becker, 1995, 1998; Strathy, 2000). Integration of traditional healing and western medicines is inevitable, and the Fijian people need to have informed choices on the best available treatment accessible to them – nurses have a role in this.

## 7.16 Traditional /Spiritual healers

Apart from medical diagnostic procedures, conditions and diseases, these are also diagnosed within the indigenous worldviews through processes such as '*Kila*' which relates to the ability of the traditional practitioner to 'know' and confirm the diagnosis or the illness through personal sensory experience, the use of touch such a light massage or palpation of the site of pain or illness, to 'see' or visualise the external site of the disease such as the abscess. Traditional practitioners tend to have an intuition simultaneously used with other processes for diagnosing a condition. Through intuition they may confirm or reject a condition as manageable by them or other practitioners. Nabobo-Baba (2006) described in detail the process of *Rai* or the *Seer* with supernatural powers in confirming the diseases and their treatments. Becker (1998) also supported another dimension of the diagnosis of illnesses and diseases in Fijian society by using postpartum psychosis as a vehicle to understand the psychosomatic nature of certain illnesses and how they are traditionally managed. The use of *vision* to confirm diagnosis is illustrated using a disease well known in Fiji as *Kalou ni Draki*. The condition is similar in clinical presentation to a Systemic Lupus Erythematosus (SLE), where the victim describes a vision of pigs eating away food, food gardens and anything that come their way. This vision if accompanied by a progressive loss of weight, hair loss and poor appetite by the victim are cardinal signs, and treatment although at times not always successful, is usually sought from the traditional healers of the disease. While many Fijians testify about the success of the traditional healing of the condition, the only other healing has been through prayers.

## 7.17 Critical analysis of illness

Critical reflection and critical analysis are important components of indigenous Fijian epistemology, and a significant component of the indigenous caring model. Analysis of illnesses, misfortunes, social anomalies such as suicide and teenage pregnancy or untimely death tend to generate a lot of analysis from all sections of the community.

With us Fijians, when something happens out of the ordinary such as sickness, death or accidents, we will sit down and talk about it and talk about it until we can identify links and solutions or treatments. Even in the

hospital, we will have relatives and friends who will come up to the nurses and ask about the cause of the sickness and then they take that information right back to the village where it's further analysed and their traditional remedy is given to the sick person. (FSN 09.p.12)

The day-to-day living experiences, events, and ceremonies are critically analysed and filtered, verified, and adjudicated before the right course of action is sought and carried out by the relevant members of the community.

After my father's untimely death, my uncle followed him just after one year. We as a family sat down with the church minister to analyse our family and ourselves. The minister had this to say "If what you came to do in this village is done; it's time to make the journey back to your *vanua* and *yavu*. This is not your village and not your father's. You have attained what you came for and it's time to move on." (FSN 09.p.6)

### **7.18 Cross Cultural Communication**

Communication has an objective in the curriculum, which states it would address the 'unique Fijian approaches to knowledge generation' (Usher, 2003, p. 23). Within the objectives, the student is expected to discuss specific ways of knowing including personal, cultural and spiritual and how they influence clinical practice. There is further mention of barriers to communication but cross-cultural communication within a culturally and ethnically diverse population as Fiji is not identified. However, the need to prepare the nurses to know how indigenous Fijians communicate within their own society and externally with all others is very important.

In the previous curriculum, all students were made to know and demonstrate their ability to perform a number of traditional Fijian ceremonies such as the *sevusevu* and the *tatau*. They were reminded to know their own tribes, their clans, their traditional lineages and relationships to other major tribes in Fiji. At least they were aware of the important ceremonies which guaranteed their admission into a village. (FSN 09.p. 10)

The nature of the indigenous Fijian communication can be described as internal and external, formal (ceremonial) or informal (common everyday communication). Internal communication occurs within the context of the home, families, tribal units and extended relatives who are familiar with one another. Informal contexts are varied and may consist of verbal or oral expressions, solemn or formal ceremonies, spatial, or

silence and gestures or aesthetics. As indigenous Fijians have a predominantly oral tradition, information is formulated, stored and conveyed through all other means except by written forms.

The nature of communication with older or senior members of the community, the families or those occupying higher social status whether young or old demand a set of protocols of respect and deference. It is insulting to speak with an older person without the appropriate words relevant to the context of conversation. Senior members by virtue of age or social status demand a lot of respect and consideration during any conversation or interactions in the hospital or any other setting (Seruvakula, 2000).

Indigenous Fijians use a channel of communication that is different from the western formal communication process. Within a traditional Fijian context of a village, information needs to flow through a culturally acceptable medium and agents if it is to create its intended impact (see Figure 12). Delays, problems and obstacles are encountered when traditional communication protocols are ignored. The third person is an important factor in traditional communication. The third person can be a herald, a wife, a close relative or someone whose traditional role it is to be a gatekeeper or censor of information directed at the other person.

### **7.19 Silence as a form of communication**

Silence is described in detail in Chapter 8 and its many meanings in the various contexts in Fiji. Indigenous Fijians equate silence with many things sacred and full of awe but it may also signify agreement or disagreement. Cross-cultural differences such as gestures are common sources of frustrations in communicating with indigenous Fijians. The use of eyebrows to show agreement, the shaking of one's head to show agreement, disagreement or frustration, concern and anger is very common in Fijians. Keeping one's head down with eyes fixed on the floor or away from the superior's eyes is a sign of respect and humility. A person of lower status or authority does not reply to questions or comments from a superior even if required to do so. To reply or answer

or engage in a question and answer interaction is frowned upon and deemed the height of arrogance or *viavalevu* (to step over one's authority or status in society).

The indigenous Fijians do not use fingers to communicate unless in a rage. However, the use of the whole hand or palms of hands with all the fingers is more diplomatic and permissible in communicating. Finger pointing at another person especially one of a higher social status or to finger-point at a grave is prohibited. Finger pointing is reserved for animals or inanimate objects like stones, woods or mountains. Indigenous Fijians shake their heads sideways to show dissent; the up and down motion and the lifting up and down of eyebrows indicates assent or agreement.

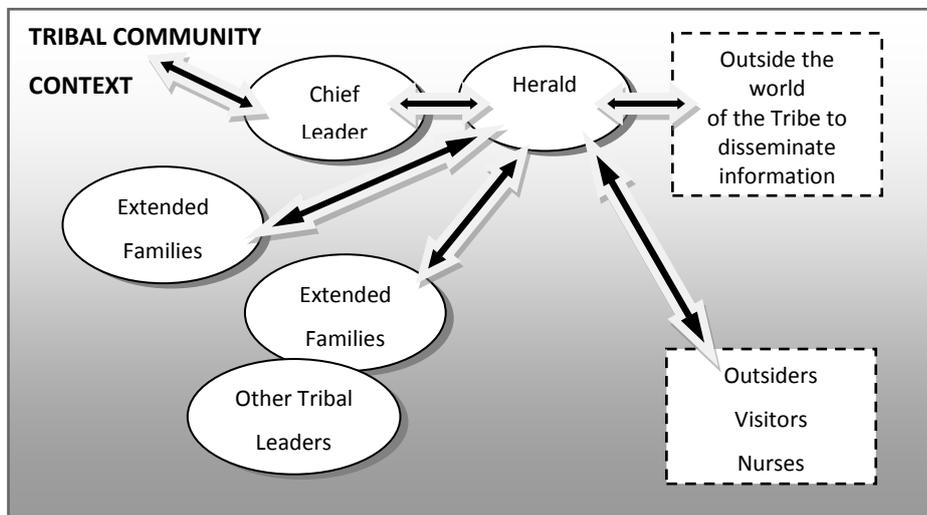


Figure 12. Indigenous system of communication

Shouting as opposed to silence is strictly prohibited in many contexts of Fijian communities and denotes disrespect and arrogance. Shouting such as calling out a name in the village, within a house or in the village green is seen as disrespectful and is likened to an uncivilized or uncultured person. Shouting in the forest or in the bush is also prohibited as it tends to disturb or show contempt for the spirit 'owners of the land' (Nabobo-Baba, 2006). In relating her teaching experiences in the 2004 curriculum, a participant recorded the following:

I find that some of these indigenous students who are brought up in the city really need to be taught the basic values of respect in our society. I was shocked..Almost had a heart attack when I was teaching this class (2004) and I turned my back to adjust the overhead transparency when one student shouted at another student who was just a one desk away from her!

I ran to her thinking that something happened or she was hurt! But no she just wanted to take her ruler back from the other student! Where is the 'respect; we teach our children? What's happening here? If that's how they treat us at the school, you don't have to wonder how they will treat their patients! (FSN 06, p.8)

## **7.20 Communicating through ceremonies: Formal communication**

The use of ceremonies is the most formalised medium to convey important information regarding genealogies, legends, tribal histories and to formally welcome and farewell important people. According to Brison (2001), Fijians use ceremonies to formally construct and reconstruct identities of tribes and link families, discuss protocols and formalise agreements. As an oral tradition, indigenous Fijians use the medium of ceremonies such as the presentation of *Yaqona* to formalise agreements, to formalise land transfer, to request financial support, to offer support to another party without having the need for documentation. Ceremonies are also used to socialise the young and the new members of the family such as new wives or husbands to learn about their new family. An important use of ceremony is the formal announcements of deaths or births in a family, which contradicts the use of telephones, letters and a one to one type of conveying messages.

### ***Internal communication***

Communication processes involving families, tribes and those from outside involve informal and formal processes. Internal communication processes and protocols differ from families and tribes from one part of the country to another. Some tribal customs and protocols prohibit any form of communication among parallel cousins of opposite genders, as well as between brothers and sisters in law. This includes the avoidance of eye contact, any verbal greetings, physical contact and the avoidance of being in the same room or environment on their own. The rationale was to prevent the incidence of incest amongst very close family relatives.

### ***External Communication***

While indigenous Fijians are free to communicate with friends, families and other members of their own local community in informal processes, there are strict

protocols related to the way different age and gender groups can communicate with adults and with each other. When these codes or protocols are violated, many social problems such as extra-marital affairs or pregnancies out of wedlock could arise. Formal processes or important information are taken through elaborate processes. In a typical indigenous Fijian village, communication systems are clearly understood and practised by members and when it is breached, disturbances within health and the physical environment are expected.

My people know me very well. As soon as I see something wrong, I go Bang! Nothing happens in front of me without getting corrected. I call them whether they are my very close families or not; if they live and belong to my *yavusa* (tribe), I have an obligation to correct them. They are not supposed to say such and such words, or to call out from one end of the village to another, I correct them on the spot. Dress codes such as dresses that are too short or trousers, I tell them straight. Go and change, or go and live in towns where no one cares. Our relationships are very sensitive in here and we have to protect our younger generation. (FSN 05.p.4)

As a hierarchical society, indigenous Fijians exist in some kind of rank and order, dictating the way information is transferred and circulated. Meeting notices, ceremonial functions and news related to celebrations such as a birth, a wedding, graduation or news about sickness, death or loss are not publicly declared until after the news has been formally conveyed to the tribal leader or chief.

The intricacies of communication from an indigenous perspective are important in the implementation of health programmes, and should be considered and integrated in the curriculum. Nurses and health workers need to know and acknowledge the existence of the communication protocol within indigenous Fijian societies, as appropriate communication is vital when implementing health promotion programmes and disseminating health information. The protocol outlines the channel of communication to be followed by outsiders or workers whenever they access an indigenous community in Fiji. Failure to do so has created problems for nurses and outsiders who work with the indigenous Fijians.

When students do not follow protocols for entry into a village or when they abuse protocols, their learning and the success of their health projects becomes very difficult. And some students leave villages without completing their projects. (FSN 05.p.9)

A case in point was observed during the fieldwork for this study. A group of student nurses was taken by their PHC tutor to a Fijian peri-urban settlement not too far from the school:

The headman was alerted that the students were at the gate with their tutor from the FSN. He approached the tutor and students with respect but firmly advised the tutor that they, the FSN, needed to follow protocols and ask for permission from the Naitasiri Provincial Office and from the Tribal Chief that owns the land on which the settlers live. Even though they came from different parts of Fiji to live and work in Suva, they were still indigenous Fijians and they would only welcome the students if their Chief is accorded the appropriate respect and protocols were followed. The students were returned to the campus and kept in class while the school had to present a traditional apology to the Provincial office and to the *vanua chief* for breaching protocol and then to formally request entry into the settlement. (Obsn. Notes: FSN02/02/07)

### **7.21 Mental wellbeing**

The component of mental health in the Diploma of Nursing curriculum lacks any reference to the Fijian indigenous perspective of health. The mental well being of Fijian people is closely integrated with the socio-cultural and spiritual components of health in an indigenous context. To attain mental wellness, a Fijian will first identify herself/himself and her/his position in society. The formation of his/her identity would then inform the rest of the other components of health, such as the social and cultural obligations, the spiritual component and the physical component such as the land or Vanua, the totemic food or object, the language spoken. The identity of a person includes membership of a family, a clan, a tribe and a *vanua*. Identity is confirmed and made complete by the ability to speak one's dialect or language and a person's ability to describe his/her father's links and *yavutu* (Ravuvu, 1983).

Mental wellness for a Fijian is attained when their sense of identity is confirmed and supported by the carrying out of traditional obligations and responsibilities as dictated by roles and status in a given society. A person is not mentally healthy if he/she is not able to fulfill his/her social responsibilities to society. Violations of hereditary rights and responsibilities, the act of usurping traditional positions of authority, leadership, titles and names, the occupation of land to which one has no entitlement are related

to mental illness. Fijians tend to relate the misappropriation of land including a wrongful transaction of land, the wrongful occupation of a 'yavu' (house mound) to the incidence of mental illness in a family or in an individual (Brison, 2007). Other manifestations of mental ill-health include the acts of rape, incest and other socially demeaning crimes that demand traditional ostracism and banishment from tribal lands. Such perspectives of ill-health also find support in the belief a family that alienates another person or family by wrongful possession of land, titles and other properties suffers similar experiences through humiliation, alienation and public shaming. For the indigenous Fijians, to lose a *yavu* or land (the elevated mound which belongs to a family and on which a dwelling house has been built for generations which is a part of the family's identity) is the worst kind of alienation and it is tantamount to losing one's identity. The loss of identity leads to loss of social status, roles and responsibilities and this has an impact on the ability to meet one's social obligations. Indigenous Fijians are referred to as 'aimless' when they do not meet their traditional obligations (Ravuvu, 1983).

## **7.22 Spirituality and Wellness**

Fijians have always worshipped a 'God' and are deeply spiritual in nature. All indigenous cultures, customs, values and practices and every aspect of Fijian indigenous lives are guided, ruled and defined by the depth of their spirituality and their relationship to God. The rationale for all indigenous customs and practices are driven by the need to be spiritually and physically healthy and to prevent the occurrence of diseases for themselves, their children and their descendants. Whether Fijians are referring to their Christian God or ancestral God, there is always an acknowledgement that a supernatural being watches over Fijians and is usually aggrieved by a lack of adherence to customs, values and responsibilities. Spirituality is perhaps the most significant determinant of health and well being for Fijians and the worship of God is central to their lives and their very existence (Mizayaki, 2004; Ravuvu, 1983). Ravuvu (1983) documented at length the various forms of worship of the Fijian people and the many forms in which the belief in God influenced almost

every aspect of Fijian society. Respect, fear, and reverence to God are also accorded to God's representations on earth and to whatever object or person known to be ordained by God within the physical realm. In describing important indigenous knowledge to the *Vugalei* people, Nabobo-Baba (2006) claimed that *Lotu* (worship/spirituality) is important knowledge, central to life in *Vugalei*. Vanua and all its components is thus subject to God or Spirit and the prosperity of the Vanua or its demise depends on how indigenous Fijians worship and perform their duties to God. A researcher also recorded this aspect when he quoted:

If you want Fiji to live...let Fiji restore the manner in which our ancestors attended God. Our ancestors accepted Christian clothing in 1835. The way God is worshipped today in Fiji is not proper. That is why we have more rape and more murder today and the prisons are full. This is not the customs of the Fijians (Mizayaki, 2004, p. 94).

Fijians closely relate the neglect of worshiping God to their wellbeing spiritually, mentally, economically and physically. In another study, Newland (2006) described the role played by Pentecostalism in rural villages in Fiji whereby villagers sought God's intervention in reconciliation, healing of diseases and cleansing of the *vanua* (land) after there were 50 deaths in one village within one year and many families were embroiled in disputes, sicknesses and anti-social behaviour. Tomlinson (2004) examined the use of chain prayers in Fijian villagers to enlist God's power in diffusing the power of evil spirits or demonic ancestral spirits.

### **Prayers**

The offering of healing prayers for the sick person in a Fijian traditional context is an important part of the community support process. Almost all Fijians are Christians and Christianity is the dominant religion in any Fijian village. In an indigenous context of the sick person, the offering of prayers from relatives and family members is normally expected even when the sick person is admitted into the hospital. A participant related an experience where the patient's need for prayers was not facilitated by the nurses on duty:

The man had a diving accident in his village and has been paralyzed from the neck down and was on nursing care in the Rehabilitation Hospital at Tamavua. There was a healing crusade from an overseas evangelist and the

man's cousin came and requested the nurses that his cousin could be taken down to the crusade. However, the nurses refused to let him go but the patient signed himself out to go for the evening service. The man was healed that night and its 7 years now since he was healed and he is back in the village diving and running his tourism business. (FSN 09.pp.5-6)

### 7.23 Postpartum psychosis

Postpartum psychosis (*tadoka ni vasucu*) or puerperal psychosis (*cavuka* or madness) is a well-known complication of delivery in the indigenous Fijian worldview. Indigenous Fijians describe the condition as relating to the premature exposure of newly delivered mothers to physical, emotional, spiritual and psychological stressors without an adequate support network (Becker, 1998). The illness according to Becker, reflects not only on how the distress is experienced and communicated through a somatic idiom in Fiji but also on how the Fijian body is firmly situated in a social matrix. A Fijian does not understand any other explanation of pathophysiology of a puerperal psychosis except the social cultural perspective they hold. For this reason the western medical model as Becker (1998) and Ravuvu, (1983) both explained, needs to integrate or make provision for the use of indigenous socio-cultural management of such diseases. To treat an illness or disease medically, without considering the socio-cultural perspectives, is futile and arrogant and a waste of resources.

Becker's (1983) study on the nature of postpartum illnesses in Fiji determined a breakdown or non-compliance with the indigenous prescription for newly delivered mothers resulted in a 'distress' that followed mood disturbances in women. This study indicated a close co-relation between the socially prescribed care for the postpartum period described by Ravuvu (1983) and Becker (1998) and the onset of the flu of childbirth (*tadoka ni vasucu*) and its complication called the *cavuka* (puerperal psychosis). Indigenous Fijians, like other indigenous societies, prescribe a certain norms and values to be followed by women and their families. Postnatal mothers given a proper supportive environment can expect to be exempted from heavy work for a whole year until after the child is properly weaned. Moreover, Ravuvu (1983) recorded for at least the first 3 months the mother was not allowed to go out of the house,

restricted to feeding and attending to the infant only while other surrounding or extended families are expected to feed her and assist her with her duties. Becker documented:

In the several weeks immediately after childbirth a Fijian mother's role is initially restricted to nursing her infant and eating. When possible a caretaker is designated for each other to assist with infant care and to attend to her personal needs. An exhaustive list of foods are either prohibited or prescribed, generally for their effects on the breast milk and the infant. In addition a postpartum woman is protected against certain activities understood to be potentially harmful either to her or her infant, including sitting up, physical exertion, combing her hair, ...To this end she is encouraged to remain lying down while she nurses her infant and eats. Finally the father of the child is prohibited from approaching her for sexual relations (Becker, 1998, p. 432).

The onset of the postpartum illness or psychosis is often related to the violation of one or more of the socially prescribed behaviours identified, or a correction of the anomalies or mistakes committed by the woman and her family. In addition to the use of traditional medicine as herbs and prayers, usually given by caregivers or other relatives, therapies for postpartum psychoses include indigenous practices such as traditional medicine, steam and sitz baths, Indian and Asian herbs as well as western conventional medicine (Becker, 1998).

## **7.24 Psychosocial Development of the person**

The normal psychosocial development of the person has been omitted from the strand and the whole curriculum. It may provide the groundwork and a reference point for other subjects and themes taught, such as mental health, psychosocial nursing and disability care. Descriptions of the psychosocial development of an indigenous person provide a multidirectional opportunity for nurses to analyse their own behaviours and their developmental patterns.

## **7.25 Key milestones for the indigenous Fijians**

The life cycle of the indigenous Fijian differ from western psychoanalytic theorists in that Fijians identified stages from birth to childhood, adulthood to old age and death.

These life stages accompanied by major milestones usually marked by elaborate ceremonies, which ensure the health and wellbeing of the people involved, as well as the relatives. Ceremonies and rituals marking these major life events such as marriages, birth, circumcision as a male passage to adulthood, and the safe passage of the spirit of the death to the next world also ensure surviving relatives live economically viable, healthy and successful lives. The indigenous Fijian worldview classifies life stages and their attainment after successful initiation ceremonies such as the *tiko-i-bure* (male circumcision rites), marriages and death rites.

### **7.26 Birth and delivery**

The life cycle of the Fijian begins from birth to death, and the health and virtual success of the person throughout life is determined by the care the child receives at birth. The delivery of a child and the afterbirth is of significant importance in the wellbeing of a Fijian. The social rank of the parents of a child dictates the manner in which the child delivered is nursed for the first ten days after birth. While many Fijians will bury the afterbirth (placenta) in a significant place with a fruit tree to symbolize the link of the child to his/her Vanua (land and the people), Fijians believe the treatment of the umbilical cord would determine the child's destiny in life. The fallen cord ensures a 'seafarer' if its thrown to the sea; or a person grounded and infinitely linked to the land if the cord is buried; and a useful and fruitful life is ensured if the cord is buried with a fruit tree like a coconut tree or a similarly useful tree.

Other rituals and ceremonies, such as keeping the child in-house for the first month and the complete and tight covering of the child's body is a rationale for keeping the body's fragile skin in good health and away from invading bacteria, the 'evil eye' and other bad spirits from the spirit world. Mothers are also expected to sleep with their babies for the first few months and are not allowed to leave the child alone for the first four weeks. This also allowed them to incubate the child to help with the growth and development of important vital organs such as the skin, the eyes, the brain and lungs, which the Fijians believe would grow and mature faster if they are properly incubated

after birth. This practice, however, has been eroded by the hospital schedules such as the two weeks postnatal clinic for both mother and baby, the family planning clinic for mothers at 4 weeks and the employment conditions for working mothers. Infants are not allowed to sleep alone in the night and lights are never put out for fear of the evil spirits that may endanger the life of the child. When a child is strong enough to be taken out of the house, it is usually taken out fully wrapped during the early hours of sunrise when it is cool and the air is crisp enough for the child to breathe. Most of the practices of indigenous Fijians for the newborn are performed to ensure the wellbeing and the good health of the child immediately and subsequently in the later years.

### **7.27 Tiko-i- bure: The Ritual of Male Circumcision**

An important milestone in the transition of young boys to adulthood is the ritual of *tiko-i-bure* described by Ravuvu as the period when young boys exclusively spend time together in the bure (house). Even though *tiko-i- bure* denotes the circumcision of the young boys to become adults or reach manhood, the period is one of great preparation for parents and close relatives from the day in which a male child is born. Literally, the bure is where the men live apart from the women and the children. For young boys to enter the 'bure' is a significant milestone of joining the ranks of male adults in the *community*. The following ritual and the ceremony was reinforced by Christianity where the circumcision of all male children as a holy covenant with God. The ceremony involves the restriction of the circumcised boys in a specially designated house for a number of days where they are fed, sleep, and cared for until the fourth day when parents present food and wealth to the maternal relatives and the priest or the doctor who performed the circumcision. The *tiko-i-bure* is the last ritual that a child goes through before marriage. The Fijian life cycle lacks the adolescent stage of life, therefore the western adolescent crisis is not recognised or acknowledged as an important milestone in the indigenous Fijian life cycle.

## **7.28 Marriage**

Marriage is one of indigenous Fijians' long surviving institutions, which has withstood the trials and challenges of global change. Previously arranged for political and family alliances, marriages in Fiji continue to forge and strengthen family connections and tribal lineages. The significant health and wellness issues in marriages are that it is blessed by both parties and the church. Traditional ceremonies involving both the bride and the groom's families ensure the couples are blessed and they have a fruitful and a lifelong commitment to their respective extended families. Ravuvu (1983) documented the nature and the costs of an 'elopement' of a couple when both sets of parents disagree with the intended union:

Normally a number of good-sized whale's teeth are offered to the woman's group by the man's relatives as atonement for the 'wrong'. And during the presentation ritual the man's group would admit their guilt and jointly accept the ensuing humiliation. Requests for forgiveness and tolerance of the untraditional and irresponsible action of one of their members with expressions of a desire to maintain good relationships (p. 46).

The desire and the action to publicly apologise for wrongs caused, and shaming another family is to ensure the wellbeing of both parties as well as any future offspring of the union.

## **7.29 Pregnancy**

Pregnancies are both celebrated in the case of a married couple, and shameful in out-of-wedlock events for the woman's parents and relatives. While pregnancies of properly wedded mothers are much anticipated, the pregnancy of a single or unwedded woman point to a breakdown in social values instilled by parents and relatives, and may also indicate a traditional wrong committed by the woman's parents. There are many beliefs held by Fijians about pregnancies and the signs of pregnancies, such as the dislike of certain foods and the craving for green or sour fruits. Fijians believe in the owl flying over a woman's house in an early evening as a sign that someone in the house is pregnant (Ravuvu, 1983). A hidden pregnancy is known to have caused many deaths, worsen sicknesses and created disasters in the sea or forests (Becker, 1995; 1983). Once a pregnancy within a marriage is confirmed,

a ceremonial presentation of food is made by the man's family to the woman's relatives to publicly inform them of the pregnancy.

During the stages of pregnancy, a woman is usually fed the best of food available to her and physical activities are restricted to light work around her home. Prohibition of certain foods such as pork, eels and others are to ensure an unblemished healthy child. Pregnant women are not allowed to wear necklaces or to tie clothes or cords around the neck to prevent the umbilical cord from getting entwined around the infant's neck during delivery. Traditional masseurs or midwives normally carry out light massage over the uterus to position the growing foetus in the appropriate part of the uterus and also to prevent antepartum haemorrhage or early detachment of the placenta. Fijians use concoctions of leaves and traditional Fijian medicine to prepare the woman for labour and delivery, to prevent postpartum haemorrhage and to ensure an uncomplicated delivery.

Fijians also have fertility remedies for barren women and they also have remedies to prevent unwanted pregnancies. However, barrenness in the Fijian worldview is also a sign of displeasure of their ancestral spirit. Couples having difficulty in conceiving a child are usually advised to perform a cleansing ceremony of forgiveness to their relatives especially their parents. Increasingly, most couples first seek forgiveness from their families and seek God's blessing for children before presenting for medical intervention.

The Nursing curriculum is silent on the well-documented traditional perspectives of pregnancy, delivery and the care of mothers and babies in Fiji. Pregnancy and delivery in the curriculum is referred to as Reproductive Health, although it medicalises pregnancy and delivery with a tendency to alienate the mother and her family from the pregnancy and delivery. In such contexts, the relationship with mothers may not be that of partnership but of dominance. Clients are subjected to waves of medical protocols and processes, which ensure when the delivery of the child is completed the woman is completely transformed out of her indigenous world and space. The

'takeover' of pregnancy and delivery by medicine also physically and spiritually removes the mother from her normal indigenous and cultural environment where her support network and safety systems are positioned and established (Ravuvu, 1983). In Fiji, no birth is allowed outside the hospital under any circumstances, and any such births are treated with disinfection and management protocols.

The curriculum ensures the complete assimilation of the indigenous Fijian through the medicalisation of a normal life process by teaching only the western medical perspective of health and illness, pregnancy and delivery and completely disregarding any other alternative viewpoint of pregnancy and delivery. Disruptions to a culture-based mandatory period of rest and recuperation of newly delivered mothers is a factor considered in the post partum depression and anxiety called the "*tadoka ni vakasucu*" or *cavuka* (madness) (Becker, 1998). Mothers who suffer from postpartum psychosis tend to have a history of early mobilisation or traveling between hospitals and home during a traditional period of mandatory rest after their delivery. Women have often had to fend for themselves in unsupportive environments, such as the hospitals or distant relative's homes in urban centres. Women who have been relocated to deliver their babies have often testified experiencing depression and swinging moods during their postpartum period (Becker, 1998). Tarabe and Naisilisili (2008) described the advantage of birthing in familiar environment in their village of Cu'u:

The personal relationship between the mother, the baby and Kuku Tupou (*the traditional midwife*) and a familiar environment, makes the birthing process a less traumatic experience. Kuku Tupou is very careful, very patient and connects in a personal way when the birthing is taking place. This is because the mother and baby are parts of her . . . (p. 5) (*italics added*).

Nurses need to be sensitive to the socio-cultural impacts of antenatal and postnatal care protocols in Fiji and put in place the mechanisms to prevent the complication of delivery.

### 7.30 Abnormal Obstetrics

In the Fijian worldview, the purpose of the woman is to bear children, and thus ensuring the continuation of their generations. All socialisation from birth to death has a part to play in the survival of the indigenous Fijian from generation to generation. Abnormalities of pregnancies, difficulties with childbirth and barrenness of the woman to bear children are usually held in suspicion and are usually explained in relation to acts of social wrongs, violation of norms, values and mores by either or both husband and wife or immediate families. Other explanations could be attributed to a socially mismatched union that may cause barrenness, stillbirths, and miscarriages. A well known example of such a union was the case of *Ratu Sukuna*, Fiji's colonial statesman, a high chief who married a commoner against the wishes of his chiefly family. After three years of marriage,

There were three tiny graves in the garden at *Naiqaqi*..one child a stillborn, two children who died soon after birth, all of them boys. The message was clear...*Maraia* went to *Bau* with *Tabua* and *Yaqona* and humbled herself before her husband's angry mother, *Adi Maopa*. It was in vain, for though *Adi Maopa's* forgiveness was forthcoming, that of the ancestors was never forthcoming. Her womb was not fitted to carry a *turaga bale* (noble blood) (Scarr, 1980a, p. 84).

While traditional and arranged marriages are rare in urban centres, it's still very much a part of the Fijian culture and is widely practised in the rural parts of Fiji. Nurses, both indigenous and non-indigenous, can only provide relevant and appropriate services if they are prepared accordingly within the curriculum by being made aware of traditional beliefs and values of pregnancies.

### 7.31 Other important indigenous knowledge relevant for nursing in Fiji

#### ***Food and Nutrition***

Food and its preparation is an important activity in the indigenous life process. Traditionally, food has its own set of norms and values and demands a code of respect when handling it regardless of the context. Younger members are socialised about food values to prevent many sicknesses and conditions. The representation of food is usually whole and uncut depending on the importance of the guests or the mealtime.

Sunday meals are usually significant and full of reverence. Food prepared, such as fish, taro and any other accompaniments, will be cooked and presented whole on the meal table or the mat. It is disrespectful to present pieces of fish or cut up taro, or yams to guests or even to their own families on a Sunday. Many food taboos are observed within most of the indigenous people of Fiji, and their violation is relevant to understanding the health problems of the victims.

Food in any form, raw or cooked, demands a lot of respect. Food throwing at another person or dog is prohibited, and passing food over the head of a person is highly disrespectful, often demanding immediate punishment. Food for adults is never mashed. Mashing food or over cooking food is a show of carelessness and disrespect, if it's cooked for an adult with a good set of teeth. Children as young as 18 months to 2 years maybe found with large pieces of yams or taro during meal times, food only being mashed for a toothless person or infants.

Fijians respect for food also includes the allocation of meal areas as out of bounds for any unclean activity. To sit and eat at the lowest part of the house close to the door entrance is the worst place for anyone to eat. Meal times are the most important times, second only to a church service, for most families. While there have been changes to the seating arrangement and the precedence of eating due to the availability of dining tables and chairs, the value accorded to the head of the household remains the same. Children and mothers are expected to wait for the head of the household to take his place and pray. In my own childhood and in my family, I was taught to wait for my father and my older siblings before eating. We were not allowed to leave the table with a mouth full of food. During mealtimes, everything else stopped and the head of the household directed all the conversations. Violation of these protocols, I was often reminded by my parents and my 'many relatives' who shared our meals regularly, led to stomach cramps, aspiration of food into wrong channels, potbelly and many other intestinal problems. No one was allowed to leave the table in a hurry ahead of the others. While the values accorded to food and meal times may appear irrelevant to nursing, the impact of these values have on health is

very important. Many contemporary nurses and health practitioners are brought up with similar western lifestyle settings where families do not have meals together anymore. The importance of eating slowly, without unnecessary talks between mouthfuls, prevent accidents of aspiration of food by children or adults, children eat a full meal and not just pick a little and then eat snacks afterwards. Sitting still under supervision and under strict protocols ensures that everyone devotes a full concentration on eating and finishing a meal instead of jumping around with mouthfuls and with unfinished plates. Ravuvu (1983) documented this protocol in his study:

One does not leave the eating mat immediately after finishing the meal. One has to wait until the head of the house or the head diner finishes and moves away from the mat or when one of those serving the food, gives one permission to do so (p. 34).

Other food values important to indigenous Fijians are the place of eating and the context of serving food. Food is never served nor eaten in bed, in sleeping areas, over a pillow or lying down. The only exception is when a woman has just delivered a baby and she is not allowed to eat outside her bedroom and not allowed to sit up to eat. Food taboos and food totems are common in Fiji and may create difficulties in health care settings if not considered by the nurses' or caregivers. Ravuvu (1983) documents the food taboo known as *veibatiki* observed by certain tribes in his province. In a *veibatiki* relationship, the totemic food cannot be eaten by one tribe in the presence of the other tribe.

The members of my group, the *Waimaro* people at *Nakorosule* in the upper *Wainimala* river, must not eat fish when the *Nasautoka* people are present because fish is traditionally forbidden as food for the *Nasautoka* people. Likewise *the Nasautoka* people must not take pork or coconut in our presence, because pork and coconut are traditionally prescribed as our food (pp. 35-37).

When food taboos are broken knowingly, ailments such as *vula* (skin discoloration) may affect the victim, but this can be averted once ceremonies of appeasement and apologies are conducted. However, in a hospital situation nurses need to be aware of the existence of such protocols amongst Fijians, and should always consult with clients when meals are not touched or when patients refuse to eat for other reasons. In Fiji,

no menus are provided and patients are expected to eat whatever is provided during mealtimes. When there are no choices for patients, tribal members who are *veibatiki* to each other and are admitted in the same wards will find it hard to eat even if they are hungry. In such cases, nurses need to provide choices to patients so that their health and recovery are not compromised.

It is a custom in Fiji to keep the doors open during mealtimes so passers-by could be invited to share the meal. To close the doors is seen as being selfish and greedy (Becker, 1995); FSN 06). The custom is based on the value of sharing food and produce together so that no one is hungry. This value is also extended in the hospital where Fijian patients who receive food from home get to share their food with every other patient in the 'open' cubicle, including the nurses. Problems arise in the hospitals when patients who are on strict diets, such as cholesterol reduction diet or diabetic diet, also receive shares of food without the nurses' knowledge. Such knowledge of food values and customs would help nurses to advice patients on nutritional and dietary plans.

### ***Time values***

Value relating to time schedules or work organizations within the Fijian worldview is directly opposite that of western worldview. Nabobo-Baba described the common time values of Fijians, stating:

For Fijians it is far less important that a ceremony starts on time than that all-important participants are present (2006, p. 56).

The curriculum should include reference to the fact that the Fijians have their own values, and are therefore more akin to pay lip service to western time schedules rather than jeopardize their own. Ambiguity in time schedules is most common despite the availability of watches, clocks and mobile phones. The time value affects the way the health service is run away from the main urban centres; nurses need to schedule clinic times and other health activities in consideration of their clients' schedules.

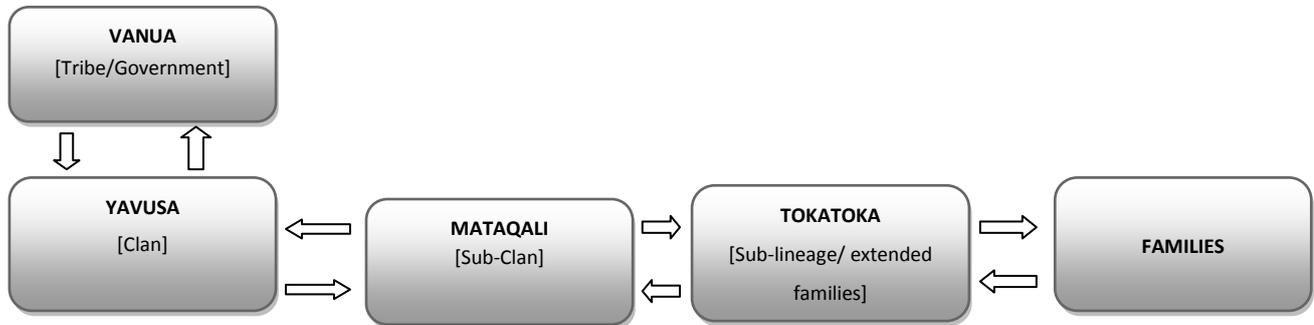
### ***The environment***

Fundamental to a Fijian worldview is the existence and the relationship of an indigenous person to his/her environment, comprising social, spiritual, and physical

entities. The social environment includes the relationships between and amongst families, the cultures and traditions within the community and with the outside world of the Fijian. The spiritual environment includes the worship of spirits or of God and centres on the relationship of man and God. The physical environment constitutes the land, the people, the sea, mountains, rivers, the trees and all those physical entities that Fijians have a relationship with. For an indigenous Fijian, the environment encompasses and represents their identity, their lives, their existence and their health and well-being. An understanding of the relationship and the dynamics between the environment and the indigenous people would encourage the planning and implementation of culturally safe and sensitive health strategies appropriate for the Fijian people. It is therefore appropriate to have an indigenous health model specifically developed for indigenous Fijians, and which encompasses the dynamics of a person's relationship to the environment. This will be discussed further in Chapter 8.

A typical Fijian community needs to be presented as an ideal type because even though there have been a lot of changes to its structure, the basic components remain the same. The family (both nuclear and extended) remains the primary basis of communities, and an assessment of the family and its dynamics reveal much about the status of the larger community it belongs to. The health assessment of a Fijian family needs to take into consideration its context and its identity in relation to the community it occupies. The significance of knowing the Fijian social structure and all the relevant communication lines and social dynamics, authority and leadership structures informs nurses and community health workers' health educational programmes. The lines of communication within a traditional setting are very different from the western system of communicating directly with the identified person in a community. This has been discussed under communication as a subject in this chapter. The lines of authority and leadership are important knowledge as it defines the point of contact and empowerment of the whole community (Figure 13). The concept of empowerment in health promotion works for Fijians if one empowers the person that has leadership or dominance over the whole group. Laverack (1998), in his research on power and empowerment in a Fijian traditional context, suggested there was no comparative Fijian concept of empowerment except for '*veivakakaukauwataki*', which

literally means to encourage and make someone powerful or to support physically, mentally and spiritually. Fijians equate 'power from within' (*kaukauwa*) or as embedded within an influential person, such as a hereditary chief or a traditional leader, or a person having the appropriate qualifications and charisma, as having the potential to make decisions and advice that unite all the people.



*Figure 13.* The basic structure of an indigenous Fijian community

Identification of the indigenous pedagogical strategies that are culturally sensitive and safe for different communities is vital in health promotion. Seasonal or times of greatest economic and social activities need to be identified so that meetings, screenings and health educational activities are scheduled to maximise attendance and participation. It is important that the indigenous leadership structures are followed as Fijians are very sensitive to traditional leadership, and need to support health promotion. Ravuvu (1983) discussed the difficulties of governing the indigenous Fijians using European principles of governance when Great Britain first colonised Fiji. The British colonial government since 1874 adopted a system of indirect rule, where the Fijians were ruled by their own traditional chiefs, as a government within a government.

The system emphasized the need to administer Fijians according to their customary forms of government and on the principles of how Fijians hold rights to land (Ravuvu, 1983, p. 112).

Ravuvu (1983) further emphasised Fijians were administered according to their customs through ordinances formulated for their good government and their well being saying that such regulations:

Supported the continuance of certain moral and customary sanctions practiced in the traditional Fijian social system and provided a simple code of law suited to the Fijian way of life (p. 113).

Leadership and coordination of health activities and committees within the community level need to be left with the traditional leaders that command the respect of the rest of the community. Community Health Nursing needs to integrate with the traditional care givers to give it relevance and accessibility to the community. Acknowledgement of the indigenous perspectives of health and illness are important in gaining acceptance in the community.

### ***Health Promotion***

The Health Promotion component of PHC has not made any attempt at co-opting or integrating the indigenous perspectives of health and practices. The theme of HP is poorly developed and lacks any depth in critical analysis of the health status indicators of the population. Much of what is taught in the curriculum is drawn from the Ottawa Charter for Health Promotion as well as the strategies for instituting inter-sectoral collaboration from government sections without the most important stakeholders, the consumers. Health Promotion for Fijians may take many forms but they have to be culturally safe and relevant. A number of perspectives need to be addressed in any health promotion programme for the Fijians. These are the cultural identities of the Fijians, spiritual health, physical health, dominant lifestyles and the degree of participation in society, which in turn is directed by the clarity of a cultural identity of the Fijian.

The cultural identity of the Fijian has been discussed earlier in this chapter. The emphasis is placed on the ability of a Fijian to identify himself/herself according to his *vanua*, God and his/her social position within the social context. Cultural identity allows one to clearly identify his/her role, status, responsibility and obligations within a given social context. Ravuvu (1983) described Fijians' health status as one's ability to carry out his/her social obligations to his/her people. Nabobo-Baba (2006) also stated a Fijian's state of health and wellbeing is indicative of one's relationship with the

*vanua*, and the degree and the nature in which one's social responsibilities are being carried out.

### ***Disability Care***

The concept of disability, both physical and mental/intellectual, differs from the indigenous Fijians' perspectives. The belief that disability is related to parents or family disobedience to traditional authority, violation of traditional protocols and the possibility of generational curses cannot be ruled out. Anthropologist Brison (2007) also records this view in her study of a Fijian community in western Fiji where she found parents who felt guilty of violating such protocols, and therefore they were keeping their disabled children from school to prevent further embarrassment to them and their families. The relevance of this indigenous view of disability may assist nurses and health care workers in providing culturally safe and sensitive advice for parents and relatives. However, many practising Christian indigenous Fijians now believe that the risen Lord Jesus Christ has redeemed all those who believe in Him of their sins, curses and strongholds and therefore disabled children have equal rights to healing and salvation (Tagituimua, 2009). It is therefore appropriate for nurses in Fiji to be aware of spiritual convictions of indigenous Fijians as well as their traditional perspectives of health and illness so that optimum assistance can be provided for the disabled persons.

### **7.32 Summary**

This chapter discussed an analysis of the content of the new curriculum and its relevance to the indigenous Fijian perspective of health and health practice. The analysis found that while the content met the requirements of a western medical model of health common in western countries, very little or no attempt at all was made to address the prevailing health status indicators of the country and the health perspectives of indigenous Fijians. Therefore, what is important health knowledge for the indigenous Fijians within the four major curriculum strands of the new curriculum were reviewed, and it is evident that the health knowledge and health practices of

indigenous Fijians are inherently included within the Fijian culture. The various bodies of knowledge and practices, although discussed separately within the four subject strands, are interrelated and interconnected.

Much of what is written and taught at the FSN is based on the western medical model of health. However, the integration of indigenous perspectives of health and illness of Fijians could make the curriculum more relevant and appropriate for nurses working in Fiji. Moreover, the inclusion and the practice of a culturally safe practice and relevant knowledge ensure all other ethnic groups in Fiji would have more chances of being acknowledged for their cultural differences and uniqueness in their health practices. There is also a proposal that culturally relevant and safe evidence-based nursing practice could be informed by indigenous research frameworks that address important indigenous health knowledge and practices. To this end, the next chapter will present the main discussions pertinent to the main concerns and the main questions raised in this study.



## Chapter 8: Discussion

### 8.1 Introduction

Previous chapters have presented significant findings from this study. This chapter discusses the final phase of Fullan's change theory; the stage of institutionalisation and the spirit of ownership of the change by the local staff at the Fiji School of Nursing. In this chapter, important findings that have implications for the curriculum changes at the Fiji School of Nursing are further examined, and located within contemporary literature and the *vanua* epistemology.

### 8.2 Institutionalisation and ownership of the curriculum change

Fullan describes the continuation of a programme as representative of a decision to continue a programme regardless of its failures. However, institutionalisation refers to the spirit of ownership of a programme by those who developed and taught it. As discussed in Chapters 3 and 4, successful management of the first two phases, initiation and implementation, logically lead to the institutionalisation phase. In this study, neither the initiation phase nor the implementation phases were successfully managed. Factors contributing to the teachers' dissatisfaction with the change, and the general absence of the spirit of ownership or adoption of the programme were identified. Such factors were:

- The rationale for the change was never understood by the FSN staff, and no efforts were made by the MOH or the NMNP Board to discuss it at the initiation phase.
- The teachers and clinicians at the major teaching hospitals felt left out by the MOH and the JCU curriculum team during the initiation phase, and then were expected to implement an incomplete curriculum.
- The high level of external agents making decisions for the FSN disempowered and disillusioned the teachers, and made it difficult for them to accept the curriculum as theirs. These agents left at the time when the teachers needed their help and the Nurses Academic Committee were of little assistance.

- Teachers could not foresee the success of the curriculum due to the general lack of resources and support structure to continue teaching the programme.
- The Principal lacked the leadership skills and wisdom to oversee an educational change for a clinically-based profession. Furthermore, decisions made during the curriculum's implementation created more damage to staff relationships, morale and professional development than expected.
- The staff rated the curriculum as culturally unsafe and inappropriate for Fijians and other ethnic groups. During fieldwork observations, staff used subject themes appropriate for indigenous Fijians' health perspective and practices, which were not in the curriculum.
- As an educational aid project, the curriculum change did little to initiate a spirit of ownership of the curriculum due to the failure to provide appropriate training in curriculum development and empower teachers to develop the incomplete Diploma of Nursing curriculum. However, the failure to empower local teachers could be viewed as a deliberate strategy commonly used by international funding agencies to keep locals dependent on foreign expertise and funds. Therefore the recipients become more alienated in their own countries. During the course of the implementation of the curriculum change and during this research, the JCU team continued to offer bridging courses at the FSN, developed a mental health nursing curriculum, reviewed and developed a new midwifery curriculum for Fiji, in addition to consultancies on nursing in Fiji and the Pacific.

The factors identified in this study are related to the teachers' reluctance and rejection of the curriculum as foreign, and after graduating its first cohort of students, the relevance and appropriateness of the curriculum continues to be an issue. This study identified a number of important issues that were directly related to the nature of the curriculum project and its failure to create the required impact in nursing education in Fiji. These are the importance of leadership in the management of educational change, the role of external aid in the continued reproduction of foreign curricula and the continued colonisation of previously colonised countries, and the need to decolonise nursing education and nursing practice through embedding indigenous knowledge of

health and illness within the current western dominant nursing curriculum and practice models.

### **8.3 Leadership in educational change**

CHANGE IS A DOUBLE-EDGED SWORD. ITS RELENTLESS (sic) pace these days runs off our feet...For better or for worse, change arouses emotions, and when emotions intensify, leadership is key (Fullan, 2001, p. 1).

Leadership during an educational change is vital to the success of the change. According to Fullan (2001), dynamic leaders are required in an environment of constant complex changes, such as whole system reforms, which demand five components of effective leadership. Moral purpose refers to making a positive difference in the employees' lives, which according to Fullan, will become more prominent and important for leaders to acquire in order to be effective in complex times. Second, in addition to moral purpose, leaders ought to understand the change process in order to understand the complexity of the demands the change would have on the teachers and resources. Third, improvement in relationships is a recipe for successful change initiatives, thus leaders according to Fullan (2001) "must be consummate relationship builders" (p. 5) with diverse people, groups and those different from themselves. Fourth, leaders in a change environment need to be capable of knowledge creation and sharing within the organisation and with those external to the organisation. Dynamic leaders constantly facilitate the generation of knowledge and sharing of information among staff and external stakeholders. Knowledge means growth, and information creates relationships, and leaders need to master both to create a positive environment for complex changes. Last, coherence making according to Fullan is a perennial pursuit, especially for leaders working within a culture of change marked by constant disequilibrium. The ability to foster coherence in a change environment is a valuable commodity in leadership.

Leadership in a society or environment undergoing change has been a challenge for Fijian institutions since the last century. Fijian leaders have had to negotiate the demands and challenges of two vastly different systems; that of the indigenous Fijian

and the European. The dilemma of leadership for indigenous Fijians lies within the conflicting demands of embracing and operating within a western environment of continuous changes, while at the same time maintaining indigenous Fijian traditions and values (Nayacakalou, 1975). Nayacakalou warned the failure to negotiate and accommodate the demands of both the western bureaucratic ideologies and the more conservative Fijian leadership values would be a critical factor in the future management of socio-economic changes in Fiji.

The implementation of the new curriculum occurred at a number of levels: the national level, school level, the clinical practice level, and the students' level. At the national level, the advocacy roles of the NMNP Board and the MOH were short lived as the role ended when the change was implemented by the FSN. The complexity of the change was underestimated by the Ministry of Health and the JCU project team, evident by the lack of leadership and guidance given to the teachers during the implementation period. By the end of the first year of implementation, the impact and complexity of the change created burn out, stress and low morale for teachers. Further, the FSN lost four senior teachers to the new TISI Sangam School of Nursing, leaving the remainder to cope in a critically short-staffed institution.

The NMNP Board's position within the Ministry of Health, and in Fiji, was one of a leadership and advocacy for nursing and public safety. One of Fiji's great statesman and high chief emphasised, in one of his speeches to the Great Council of Chiefs in Fiji, the need for chiefs as leaders of Fijians to make moral decisions in relation to institutional changes, and how they can affect Fijians:

We are the high chiefs of these islands. We are the leaders of the people. On us is the duty of pointing out to them the right courses. We have to lead on two points – hold back those who advocate radical changes for which we are not *sufficiently educated* . . . (Scarr, 1980, p. 125). (*Italics inserted*)

In the *vanua* context, the NMNP Board members, as a collective, are the leaders and have a moral duty to ensure nurses are on the right course for the safety of the general public. In this study, the NMNP Board had the responsibility to reject a curriculum not adequately developed for implementation. The NMNP Board also failed to put in place

the required policies for the new curriculum as well as ensure adequate resources were in place to support it. Stake (1996) identified important antecedents for a new curriculum, which include the curriculum document. The operational policy produced a year after the curriculum implementation lacked reference to the new curriculum, and contained descriptions of the old curriculum and its assessment formats. It is also argued that the NMNP Board, as a public statutory body charged with safeguarding the practice of nurses and the safety of the public, became an agent of neo-colonialism, reinforcing western medical ideologies which regarded indigenous Fijian epistemology as irrelevant, superstitious and unimportant.

The NMNP Board, as indicated in this study, needs to be reviewed in terms of operational functions, membership, management and its statutory responsibilities. While the current format and operational functions worked for the colonial government and early years of political independence, it has outgrown contemporary professional and educational demands on the nursing profession. The current composition and the operation of the Board do not allow for transparency and cannot guarantee fairness in its adjudication, calling into question whether it can be expected to impartially carry out its duties and also be accountable to the nursing profession and the people of Fiji.

The failure of the NMNP Board to prepare nursing stakeholders and the people of Fiji for the impending change was related to its non-consultative approach. The NMNP Board also failed in its legislative responsibility to adequately prepare the school and other stakeholders before implementing the new curriculum. Whilst this study has portrayed a seemingly arrogant image of the NMNP Board regarding the way it initiated and implemented the change, the passivity of the FSN teachers' responses to this arrogance decided the fate of the curriculum.

The absence of a culturally relevant framework to guide nursing leadership and education contributed to the failure of the NMNP Board in leading and guiding the curriculum change at the FSN. The descriptions of the curriculum in this study

indicated a lack of communication between the NMNP Board and the stakeholders during the initiation phase of the change. The general confusion and frustration experienced by the teachers can be attributed to the lack of communication between the NMNP Board, the FSN, and the clinicians. Similarly, the clinicians felt isolated and ignored, reinforced by being overlooked for consultation by both the NMNP Board and the FSN.

The formal bureaucratic nature of the MOH influenced the way in which the MOH nursing leaders and NMNP Board made decisions related to the new curriculum. Downes (2001b) observed the way the NMNP Board selected candidates who did not apply to undergo training in the Nurse Practitioners' course, and rejected those that showed interest in the course by applying. Such bureaucratic behaviour by the MOH and NMNP Board was directly related to the attrition rate of Nurse Practitioners during the course and after graduation.

#### **8.4 Institutional autonomy**

Fullan (2007) identified several factors which influenced the need to change, and in this study major influences were the government and other external bodies funding the curriculum review and development. While the FSN welcomed the innovation as it offered an opportunity for funds and development, it did not appear to have anything directly to do with the initiation of the project. The school, as an academic institution, lacked the necessary autonomy it should have had, especially as almost every curriculum issue had to be referred to the MOH. The lack of autonomy by the school was also a source of frustration for the JCU consultants during the implementation of the programme. In addition, the bureaucracy within the school created oppressive structures, and together with the MOH restrictions do not provide any room for autonomy in decision making and policy development. This claim is confirmed by participants' statements that they were not informed or told of the MOH plans of an impending review until it was underway (FSN 04; FSN 03, FSN 02, FSN 06). Many problems which emerged were related to the nature of administration of the FSN,

which also resulted in a lack of consultation between the government and those affected by the change. Other issues that emerged in the study were also related to the administration of nursing, including the presence of the top-down administrative approach of the MOH Nursing Division.

The teachers who participated in this research recorded their frustrations at the expectation to implement the new curriculum without a clear guiding policy. Similar sentiments came from the JCU consultant for the implementation phase that the NMNP Board was too slow in addressing the need for a policy before the implementation of the programme (FSN 09). Evidence gathered from the study indicated that there was a general lack of awareness of the nature of the educational innovation amongst the NMNP Board members and the MOH nursing leaders as well as the FSN. Apart from Principal at FSN, all other members lacked educational qualifications necessary for understanding curriculum development and its change. Moreover, as a former principal of the FSN stated, the Board members represent clinical practice areas in Fiji and the only member from the FSN – the Principal. The Board members did not understand their legislative responsibilities concerning the change, and most were unaware of the support structures that needed to be in place before the implementation of the curriculum. The study found members did not understand the new competency-based approach of the curriculum, and therefore it appeared the FSN was left to work this out on its own (FSA 01).

## **8.5 Disrupted relationships**

The role of the leader is to ensure that the organisation develops relationships that help produce desirable results (Fullan, 2004, p. 77).

In every successful change initiative, according to Fullan (2004), the common factor is that relationships between workers and leaders improve. Lewin and Regine (2000) described the importance of nurturing people, and to value their relationships, and the contribution they make to the life of an organisation. In the *vanua*, indigenous Fijians value their relationship more than material wealth. Brison's (2007) aptly titled book,

*“Our wealth is loving each other”*, described how indigenous Fijians’ life world revolves around relationships, obligations, support and caring in order to maintain social cohesion and survival.

Fullan’s (2008) six secrets of change identified the first secret as ‘love your employees’ and is a reference to the notion of valuing teachers and staff as much as customers, such as the children and their parents. Furthermore, Fullan maintains the success of an educational change depends on the way employees are treated. Loving your employees involves creating a work environment for staff to develop meanings, to succeed, to experience skills satisfaction, and make useful contributions to the organisation, as well as to themselves and their families. In contrast to Fullan’s first secret of change, leadership at the FSN created an environment whereby teachers experienced role confusion, lack of skills satisfaction, frustrations over meaningless changes in curriculum content, and low morale of teachers and students. Similarly, Gaius Petronius is recorded to have remarked 2,000 years ago on the same problem:

We trained hard . . . but it seemed every time we were beginning to form up into teams we were reorganised. I was to learn later in life that we tend to meet any situation by reorganising, and what a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency, and demoralization (cited in Fullan, 2004, p.43).

## **8.6 Veikalawaci: The spirit of arrogance**

In the Fijian context, non-consultation or the failure to sit and talk about an issue that affects the welfare of the people, tends to be viewed with trepidation and disdain. *Na ‘Veikalawaci’* relates to non-consultation and non-collaboration, and in the *vanua* context means to ‘walk over’ someone; which itself denotes arrogance and disrespect. While non-consultation has been discussed at length in Chapter 5, the lack of collaboration in the whole curriculum change exercise was also seen as a result of the non-consultation stance of the MOH and the JCU consultants.

*Na Veikalawaci* is a serious breach of Fijian protocol where the person committing the offense has not bothered to inform the people, the relevant leaders, or subordinates of any changes or any events that may affect the community. *Na veikalawaci*, became

a hallmark of the initiation phase of the curriculum change in Fiji. *Na veikalawaci* is based on a Fijian proverb '*e kalawaci ga na vatu*', which is usually translated as 'you only step/walk over the stone' (the stone being an inanimate object has no feelings). The proverb refers to the feelings of hurt, shame or embarrassment of being snubbed and overlooked when an offense is committed by someone who is aware of the lines of communication and protocols that exist but ignores them. In a context where respect is highly valued, consultation is a way of showing respect and of acknowledging people and their worldviews over issues that bear a lot of importance to them. To consult is to seek knowledge, advice, support and blessings, and shows respect and humility for the people.

### **8.7 A culture of silence: Nurses as indigenous people**

The lack of consultation by the nursing leaders and the curriculum consultants engaged for the curriculum project was supported by the bureaucratic structure and organisational culture prevalent at the MOH. This created two major problems: one, it effectively 'silenced' the faculty and the stakeholders of nursing education in Fiji, and two, it completely disregarded the indigenous peoples' health perspective. The teachers at the school had two characteristics that made them vulnerable to domination by western academic systems of education and administration. First, they were nurses and the prevalence of the Nightingale ethos of respect, meekness and silence continues to disadvantage them. Fijian nurses have been made 'voiceless' by their colonised history (Battiste, 2000), and 'silenced' by the more powerful medical paradigm in which nursing exists (Doering, 1992). Freire's (1967) concept of predatory colonisation can be applied to Fijian nurses whereby the dominant elite (authority) uses slave labour and excessive power on the oppressed subordinate. Such oppressive treatment for lengthy periods of time engenders muteness of the oppressed group contributing to their inability to speak for themselves. Second, the teachers as indigenous Fijians exhibited silent or passive responses to a dominant and threatening environment when exposed to situations they were not comfortable with.

This behaviour of indigenous Fijians is well documented in the literature (Nabobo-Baba, 2006; Otsuka, 2005, 2006; Ravuvu, 1983). The silence of the indigenous Fijians can create grave misconceptions when foreigners are unaware of such behaviour. Silence indicates politeness in a context where indigenous Fijians would avoid open confrontations in order to maintain harmony. Indigenous Fijians would stay silent in order to allow others, especially visitors or important people, to express themselves even if they know their viewpoints about local situations are wrong.

This is similar to Smith's assertion (1999) that Western intellectuals cannot assume to know what is important for indigenous people on the basis of their brief encounters with them. Non-consultation is a reminder of an imperialistic attitude prevalent within the MOH nursing division, where a top-down approach to administration continues to thrive. Participants in this study claimed this administration style is out of date and a major cause of frustration at the FSN (FSN 06). A top-down management approach assumes subordinates do not know what is right or what is best for them, and has been identified by participants in this study as highly prevalent within the MOH nursing division in Fiji. However, it is also a responsibility of academics and intellectuals, as agents of change, to correct anomalies and institute contemporary as well as best practice incentives that are safe and relevant to the context of practice. Hereniko (2000), while writing on academic imperialism asks the question, "Do outsiders have the right to speak for and about Pacific Islanders? (Hereniko, 2000). Regardless of the continued emphasis on inclusiveness, consultations and provisions of space for Pacific islanders in matters relevant to their indigeneity and cultures, Hereniko has this to say:

The least outsiders could do, if they wish to speak as though they were some authority on Pacific society is to invite indigenous PI to share the space with them, either as co-presenters, discussants or respondents (2000, p. 86).

In curriculum development lacking input from relevant stakeholders, the content is always questionable in terms of its relevance to the teaching context. The non-contribution with FSN, apart from the lack of consultation, was perpetuated by the condescending attitudes of nursing leaders and consultants towards the FSN staff. According to a participant, consultants already knew what should go into the

curriculum and the staff's inclusion in the curriculum workshops were just formalities (FSA 01; FSA 03). Moreover, the staff's participation in the curriculum workshops was passive and more obligatory than anything else (FSA 03). For those who attended the workshops, they generally did not contribute anything and when they did their contributions did not appear in the curriculum document (FSN 06; FSN 01). A participant described the passivity of their contributions this way:

They told us to stand, we stood; they told us to sit, we sat. They told us to speak; we opened our mouths and said what they wanted to hear! (FSA 02).

Participants from the school continued to label the project as an Australian project and the curriculum as foreign because they felt that they did not contribute anything to its development. While it can be argued that the teachers did not make use of the workshop as an opportunity to contribute to the curriculum, Thaman provides an alternative viewpoint where Pacific Islanders "tend not to question consultants or experts on proposals because they don't want to be impolite and it is also the easiest way of getting rid of them" (2004, p. 6).

## **8.8 The teachers' role**

The research found the teachers only realised the MOHs and NMNP Board's lack of support long after the implementation of the curriculum, when they did not have any choice but to continue with it. The complexity of the change has been discussed earlier in the chapter and how it permeated through the whole innovation. The teachers were the main change agents at the school level, and their role in the implementation of the curriculum had both professional and personal consequences, including the success or failure of the educational change. The burden of implementing the curriculum fell on the teachers, who were vulnerable not only lacking the relevant experience and educational preparation to facilitate such a change, but also lacking the physical and professional support to guide them. For the first year the teachers played 'catch-up', producing curriculum materials as they taught, assessed and supervised students in two different curricula, both in the classrooms and the clinical practice. The quality of curriculum materials, documents and study guides reflected the levels of stress the

teachers worked under during the first three years of implementation. Apart from the difficulties with curriculum implementation and development, the workload and obvious lack of concern for the teachers' welfare appeared to be a constant complaint in staff meetings. Minutes of staff meetings consistently tabled the chronic staff shortages, overloading of teachers, and the lack of supervision of teachers who appeared to be just floating around with little work when the rest were barely surviving. The study found the teachers had difficulties in adequately covering teaching of their classes and conducting tutorials in addition to finding the time to supervise students on clinical placements.

### **8.9 Moral obligation of the teachers**

The view taken in this study is the change was implemented through the moral imperative of the teachers, and not only because of the directives from the MOH and NMNP Board. The implementation of the new curriculum burdened the teachers more than any other group involved with the curriculum innovation. Despite the absence of support and guidance from the NMNP Board, the Nurses Academic Committee and the JCU consultant, the teachers opted to get on with the development of the curriculum content and the study guides. The teachers held a deep moral conviction that it was their moral obligation to the students and to the people of Fiji to implement the curriculum, despite all the difficulties and the state of un-readiness of the school. Participants quoted their Christian convictions and indigenous Fijian values of respect, selflessness and service to the people of Fiji as major motivating factors keeping them working in a very hostile, stressful and unsupportive environment. The teachers believed, as indigenous Fijians, regardless of how they were treated and how they felt about the initiation period, it was their duty to implement the curriculum and teach the students who were already enrolled. This research found the teachers did what 'they' had to do; what any indigenous Fijian would do in a similar situation.

The teachers recalled being confused by the whole change with new words and concepts they did not understand. They did not have anyone to turn to for help and

reassurance except to God and each other (FSN 06). The expectation of the JCU that teachers write their own contents and develop their curriculum materials was unrealistic as none of the teachers had experience or qualifications in curriculum development. Even though the MOH and the Principal knew about the teachers' deficits, no one made any attempt to address them, as recorded by a participant:

They knew we were struggling, but they did not care. They could not even listen, and they threw anything at us to be done. It was not in our culture to refuse instructions and they abused that. (FSN 06:16)

A former Principal confirmed teachers struggled with the implementation of the curriculum, but no assistance was provided to the teachers during the three years. The Principal also failed to justify the absence of any leadership and guidance at a crucial time in educational change (FSN 08). The teachers' struggles were not confined to the content; in giving their 'all' trying to carry out their superiors' orders, their health and their families were burdened. Students recalled the teachers were always late to classes and too tired to teach (GS 01).

### **8.10 Teaching indigenous students: A re-colonisation process**

“Every relationship of ‘hegemony’ is necessarily an educational relationship”  
(Bullivant, 1983b, p. 227)

Holloway and Penson (1987) pointed out nurse education is a process of social control, which was “externally imposed and eventually internalized” (p. 235). Social control is a mechanism by which individuals are made to conform to rules, regulations, protocols, behaviour and norms of a specific group, such as the nursing profession. In nursing, control begins from outside the school where prospective students are screened for prerequisite demeanor, aptitudes, intellect and even gender and marital status. The inculcation of specialised knowledge, practices and language distinguishes a member from a non-member, a novice from experienced experts and professional boundaries between the profession and the lay public. Strict conformity to all aspects of social control tends to be the norm and non-conformity tends not to be tolerated. In Fiji, the professional education of nurses became a mechanism of social control and an agent of re-colonisation by western medical ideologies.

Student nurses enrolled at the FSN are usually aged between 18 and 25 years, single, and tend to enter the school straight from homes or boarding schools. The study identified a theme of alienation of students from their indigenous cultures and a system of re-socialisation into a new culture of western medicine and formal nursing. Groups of students in various years of their new programme and the first graduates from the new curriculum had common experiences of alienation of the change by being systematically pushed to learn everything that is thrown at them.

Students were taught a new culture of western health knowledge and formal nursing practice to replace their traditional indigenous health perspectives. The alienation of students occurred in three ways: one was through the knowledge content of the curriculum. Second, the teaching and learning methods used and third the complete removal of the community health nursing from the community to the FSN campus and peri-urban health centres.

### **8.11 Cultural safety component of the curriculum**

The contextual relevance of the 2004 curriculum is identified in this study as a major weakness of the change. Cultural safety is defined by the Nursing Council of New Zealand (NCNZ) as the effective nursing of patients from other cultures by nurses who have undertaken a process of reflection on their own identity and recognise the effect of their culture on their nursing practice (Richardson & Carryer, 2005). Cultural safety allows the consumer of health and nursing services to contribute to the services she/he receives by influencing the service providers' educational preparation. Ramsden (2002) describes cultural safety as a power sharing framework for the consumer of care and the provider where both benefit from the relationship. The lack of consideration for cultural safety in the curriculum could be attributed to the absence of a cultural safety competency in Fiji's nursing standards. Surprisingly the team of consultants involved in the development of curriculum omitted or did not consider the inclusion of cultural safety competency as contemporary safe nursing

practice, especially when New Zealand and Australia are advocates of its adoption in its professional practice competencies.

During my fieldwork observations, it became obvious the curriculum was being taught with the support of a hidden curriculum consisting mainly of what the teachers felt should be taught, such as the indigenous knowledge. This however does not guarantee indigenous knowledge of health and illness will always be taught as they were only taught by indigenous teachers. The teachers who taught Fijian indigenous knowledge believed nurses needed to be aware of the cultural differences of their clients, in order to be effective in their practice (FSN 05). Greaves (1987) described the hidden curriculum as that covert part of the curriculum which prepares the student on how to cope and how to survive the rites of passage through which they must progress their training. Anderson (1992) further explored the hidden curriculum in paramedical education and insisted that the hidden curriculum was one of three facets of an educational experience; the first two being the physical structure and the fundamental knowledge. According to Anderson, a successful radiology education results from an effortless integration of the three components with the hidden curriculum determining the successful application of the other components. The hidden curriculum therefore consists of the unwritten component of the formal curriculum and includes caring, valuing, respect and a development of patient advocacy in radiologists which are covertly imparted by teachers. Similarly in nursing education much of what the students learn is covertly imparted by their teachers or by clinical rotations, such as shift work routines, the management of stress and anxiety associated with the first days in a new area, and coping with rejection and ostracism. Much of what student nurses learn in clinical rotations is not contained in the nursing curriculum, but is generally expected by the teachers to be learned during clinical shifts.

Lawton's definition of education as the reproduction of worthwhile learning fits well with the teachers' concern for a relevant education programme for the nurses who would largely practise in Fiji. The knowledge content analysed in Chapter 7, lacked indigenous health perspectives and practices. The complete disregard of local

indigenous health practices in the curriculum created a hegemonic relationship between the indigenous Fijian knowledge and Western health, whereby western scientific and medicine dominates indigenous health practices to the point of alienating indigenous knowledge systems. The prevalence and extent to which indigenous Fijians continue to practise indigenous health practices apart from the widely accessible western health system (Becker, 1995; M Pande, Finau, & Roberst, 2004; Qetaki, 2003; Veitayaki, 2002) is evidence nurses are not adequately prepared within the current western education model to care for the indigenous Fijians.

### **8.12 Indigenous pedagogy**

The teaching and learning methods used in the new curriculum were foreign to students, and methods used contradicted indigenous values of respect, and precedence of senior members of society. The curriculum encouraged the use of contraception for young unmarried youths and adults, and expected students to teach youths and adults the use of contraception. In the *vanua* context, students were too young and being unmarried, were unqualified to teach family planning or give advice regarding pregnancy, delivery and mother craft.

One of the important components of indigenous knowledge is spirituality and this was singled out during a focus group with students as requiring redress by faculty. Indigenous Fijians are deeply spiritual and the curriculum failed to address this aspect of nursing, thus failing to prepare the nurses appropriately (ST2A: GS 02). The 2004 curriculum change was another ongoing attempt of what Thaman (2004) calls “an epistemological silencing of any meaningful discussion and exchange of ideas about indigenous knowledge systems” (p. 12), which continues to privilege western academic knowledge and institutions. The argument presented here is that the JCU lost an opportunity to address indigenous knowledge systems relevant to health, making the new nursing curriculum more relevant to Fiji. Instead, the curriculum change continues to reproduce western ideologies and nursing knowledge, which privileges western perspectives of health and illness and not Fiji.

For an innovation to succeed, Fullan (2007) contends students need to be considered as important participants in the whole process of education. A significant feature of the curriculum was the lack of engagement of students in the teaching and learning process. Students identified a lack of interest by teachers to address anomalies and inconsistencies in teaching. While a focus group reported having filled in an evaluation form after completion of a subject, suggestions for change in teaching methods and other relative problems remained unresolved up to the third year of the curriculum change (GS 02,GS03).

In describing the concepts of belongingness and ownership within a *vanua* context Nabobo-Baba (2006) pointed out that indigenous pedagogy ought to acknowledge the importance of making students feel they belong to the school. In addition, there needs to be an assurance for students that the school or the subject is their property before they can be expected to participate in their learning. Belongingness is an important way of knowing for indigenous Fijians and it is a prerequisite for learning and analysis of learning. Fijian children are not normally taught to judge or evaluate things, processes they do not own. To do so, is seen as rude, arrogant and generally not an acceptable or respectable value to have. Even in group or community ownership, the privilege to question processes does not belong to all members. Certain members have the right to question, analyse or critique communal knowledge (Nabobo-Baba, 2006). While questioning elders or seniors is commonly prohibited across indigenous Fijian communities, public speaking and or questioning is a right and privilege of only certain members. Children of these privileged groups would then be expected to be vocal in schools, not for themselves but for the rest of the indigenous Fijian children.

Discovery learning and student-centred methods of teaching have never worked in the Pacific, even in primary and secondary schools. Earlier studies in educational methods in the Pacific as early as 1980s highlighted the failure of these concepts for Pacific children in all levels of schooling (Teaero, 2002; Thaman, 1990, 1991, 2004). Discovery

learning philosophy contradicts the indigenous Fijian culture of learning from senior members of society.

The curriculum lacked a community health nursing component, and omitted the rural nursing programme from its year three programme. According to JCU consultants, the rural nursing component was understood to be an important aspect of nursing in Fiji and was to be continued in the new curriculum. However, a participant explained the absence from the curriculum was not what JCU recommended, but an action by the FSN leaders themselves. The rural attachment programme allowed students to live within a rural community and apply the concepts of community health nursing and primary health care learned in the three years within a community setting. The students used family nursing models and the nursing process to assess families, groups and communities, and concepts of management to manage a nursing station, a health centre and carry out health promotion programmes. Students are expected to be able to assess, implement and evaluate health intervention programmes that work collaboratively with other government ministries and indigenous communal structures. A former Principal of the FSN defended the change as being responsive to contemporary health needs of the country, and that the students learned to collect data for the MOH (FSN08).

The students in the three focus groups, however, all voiced concern about the lack of structure for their 8-week community attachment in the peri-urban areas, especially as their time was mostly spent on laundry and shopping in town (GS 01; GS 02; GS 03). The graduates' focus groups identified the need to include the rural attachment programme in their curriculum, as they needed to be adequately prepared for work in rural areas of Fiji (GR 01;GR 02).

The rural component of the curriculum needs to refocus the western approaches to health practice onto indigenous people and their ways of life. Even though the indigenous health perspective was not officially acknowledged in the curriculum, it is in fact prevalent and used concurrently with western medicine and needs recognition in

the undergraduate curriculum. Failure to refocus the curriculum to the community and its needs alienates not only the student but the community as well.

### **8.13 Clinical practice level of implementation**

The study identified a major flaw in the curriculum change as the non-involvement and non-consultation of the stakeholders, such as the clinicians of the major teaching hospitals. While JCU reported the clinicians' attendance at workshops held, the participants refuted this claim stating that they were never informed or aware of any curriculum change at the FSN (PR 01; PR 02; PR 03). The curriculum change also brought in changes to clinical assessments and clinical learning strategies, which clinicians had never used before. Even though the preceptors were selected by the MOH to supervise students, the FSN teachers remained primarily responsible for the clinical learning of students. Beattie (1998) pointed out that teachers should never expect clinical preceptors to be always willing and able to teach, supervise and assess students whenever the need arises. According to Beattie

Some faculty members appear reluctant to hand over responsibility for clinical assessment, yet assume that the clinical teaching of student nurses by preceptors implies acceptance of the responsibility for clinical assessment of the students. However, this responsibility has not been accepted by all preceptors (1998, p. 16).

Even though the FSN teachers conducted workshops for the preceptors and clinicians to learn about the new curriculum and assessment format, during this study it was found the preceptors found the assessment strategies complicated and most refused to supervise and assess students when they reported for clinical attachment. The rejection of students by some preceptors was found to be unhelpful and frustrating for students. According to Kleehammer, Hart, and Keck (1990) faculty ought to maintain a consistently positive and supportive approach in order to minimise students' stress, especially when preceptors and clinicians refuse to supervise students in their units. On the other hand, Kelly (2007) reported that learners who feel that they were accepted by staff enjoy clinical learning and such positive relationships contributed to gainful learning of students in clinical.

The overall implementation of the curriculum at all levels failed to create the intended impact as stated in the curriculum document. It is argued here the implementation of the clinical component of the curriculum failed because of the nature of the project's initiation and the lack of consultation by the MOH, the NMNP Board and FSNs nursing leaders with the clinicians prior to the curriculum's implementation. Second, 12 students in each ward increased the workload of the clinicians and were too many for the short-staffed hospitals. The NAC, NMNP Board and the MOH were over-involved in the administration of the school. This external over-involvement was beyond the control of the school, and led to hostility, frustration, and powerlessness of the teachers.

Further it is argued that the invisibility of the school leadership created more work for staff who were overloaded with responsibilities beyond their abilities and positions. Moreover, teachers were appointed to at least four different committees, chaired by fellow teachers. The Principal and the deputy Principal did not belong to any of the committees, leaving teachers without any curriculum advisor or guidance. A participant in the study recorded her disappointment at the way the leaders instructed them to form committees, and then delegated their responsibility of chairing such committees to the senior tutors. Teachers were assured that taking on chairing responsibilities for the committees were for their own good and professional development (FSN 04).

#### **8.14 Decolonising nursing in Fiji**

The application and integration of indigenous Fijian epistemology is expressed in two ways: *vanua* consciousness (Nabobo-Baba, 2006), which is the state of being culturally aware of the ways and knowledge of the indigenous Fijians; and indigenous knowledge also called *vanua* knowledge (Tarabe & Naisilisili, 2008), and is the lived expression of *vanua* consciousness such as customs, spiritual practice and relationships. The process of decolonisation of nursing knowledge follows that described by Thaman (2003b), and Hereniko (2000) whereby the indigenous foundations of caring, nurturing and

wellbeing are recognised and acknowledged for their potential to affect the survival of the indigenous Fijians. Decolonising nursing in Fiji includes embedding in the curriculum indigenous perspectives of health and illness at three interrelated levels: the consciousness level, knowledge level and at practice level (Figure 14). At the consciousness level, decolonisation is directed at changing the attitudes and behaviours of the leaders of nursing by exposure to literature and alternative perspectives of health and illness. According to Thaman (2003b), little literature exists on the impact of colonialism on the minds of the colonised people of the Pacific. Decolonising the mind refers to critically using and acknowledging the oral traditions and cultural values of the indigenous Fijians as they relate to wellbeing. Decolonising the mind also refers to the acceptance of other ways of knowing and living apart from the dominant coloniser's culture and knowledge systems. Thaman (2003b) argued that decolonising the mind involves decolonising culture and changing a mindset, ultimately leading to changes in attitudes and behaviour. This brings forth new perspectives on issues and social concepts that affect the way people live on a daily basis.

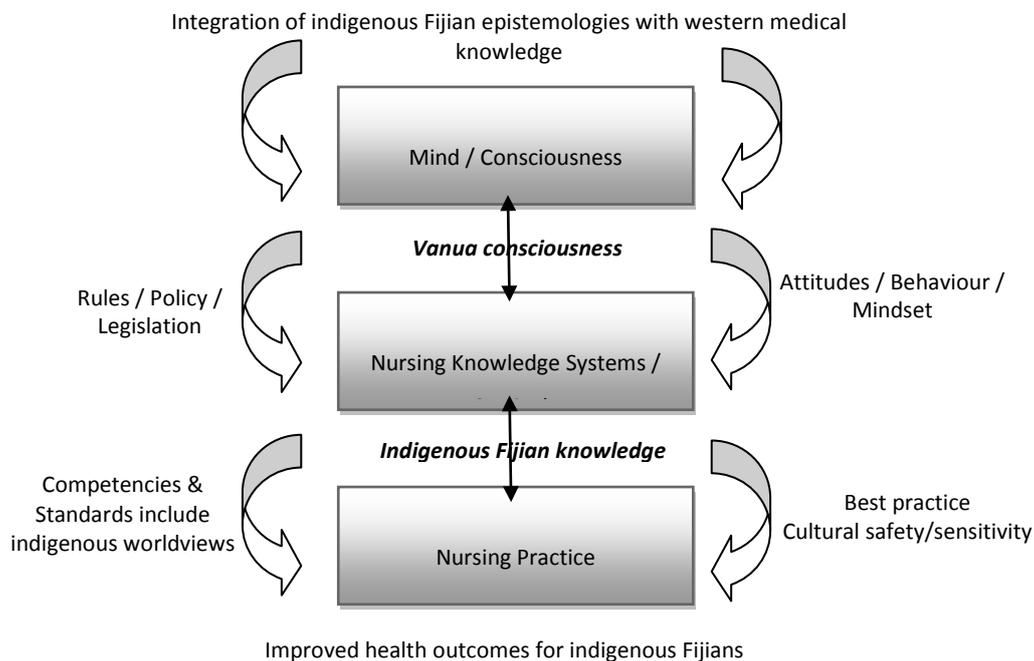


Figure 14. The decolonisation model for nursing in Fiji

### 8.15 Embedding indigenous Fijian ideology of health and illness

Decolonising nursing knowledge challenges the foundations of western medicine and nursing imperialism in Fiji. It involves a deep sense of commitment and recognition of the need to embed indigenous Fijian knowledge of health and illness in the curricula, pedagogy and research methodologies and protocols. Embedding indigenous Fijian perspectives of health and illness within the undergraduate curriculum addresses differing worldviews and the need to incorporate indigenous epistemologies in the preparation of nurses. Such preparation produces nurses who are culturally safe to practise within an integrated knowledge paradigm, such as western medicine and indigenous Fijian epistemologies. For Fiji, the process must begin at the leadership level transcending all other levels to the practising nurse in the hospital and the public health nurse in the clinic. A health model developed from this study is called the *vale ni bula* model (see Figure 15) which theorizes indigenous health and wellbeing and is appropriate for the integration of the indigenous perspective of health and illness with the western medical model of nursing.

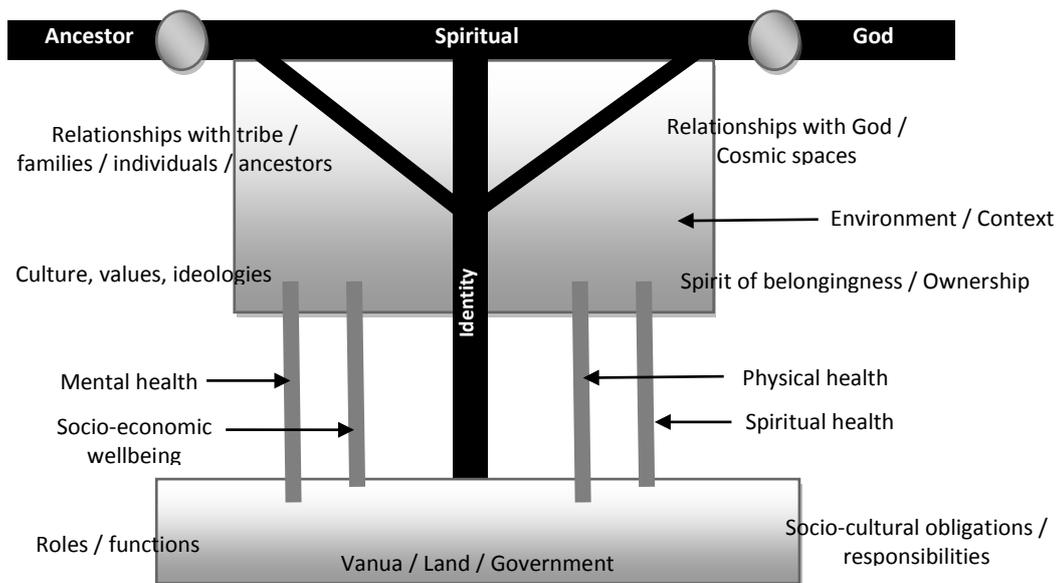


Figure 15. Na vale ni bula health and wellness model

The *vale ni bula* model is useful in curriculum development and evaluation, in analysis and evaluation of the health of individuals, of families, of communities both within and outside the hospital environment. The model is also useful to assess healthy and sick people in both general and mental health clients. A similar model, developed by Durie (1998) for Maori health, is called Te Whare Tapa Wha, which depicts the four walls of a house as referring to the four tenets of Maori health and well-being. The model describes the house being dependent on the combined and integrated well being of all the walls. When one wall is weak (sick), the others will fall or the whole house falls.

The structural parts of the *vale ni bula* have interrelated and interdependent functions to play in order to keep the house in order. When one structure is weak, other parts of the house become weak and may lead to the eventual weakening and breakdown of the whole building. The principal structures of the model include the *Bou*, which is the central beam, the *yavu* or the raised earth mound which is the foundation, the *Duru* which are the four principal posts supporting the four corners of the house, the roof and the *Bewa*, with two rounded ends.

### ***The Bou: The central beam : Identity***

Identity is allocated to the *Bou* or the central post which holds the house together and keeps it firmly in its foundation. The *vale ni bula* model has 'identity' as the central concept in the wellbeing of the indigenous person. Participants in this study identified Identity as the central tenet of health and wellbeing for indigenous Fijians (FSN 09). An identity is defined either spiritually in reference to God or to ancestors who may include ancestral gods, or in relation to original tribal land, village, *vanua* or government (traditional or formal), or both. A weakness in the *Bou* will create a weakness in the rest of the structures, which may render the house weak and defective.

At the top of the *vale* (house) model, a person's identity is further defined by religious or spiritual affiliation and belief, which could be either ancestral God or the Christian God or in some cases, both. Identity is complete when the person can identify the physical land, *vanua* or government of his affiliation. The two rafters that attach the *Bou* to the top rafter or *Na i Sa* signify the reality of relationships that Fijians have towards God and the *vanua* as defining their identity in the Fijian worldview. Identity defines the person's relationships to ancestors, the environment, to the people or communities or other tribes. It also defines the relevant cultural values, ideologies, relationships to cosmic spaces, principles of ownership of land, language and artifacts and the roles and responsibilities one has for the *vanua* and the people.

### ***Duru – four posts***

There are four posts or *duru* in a typical Fijian house and they take up the four corners of the house supporting the *Bou* and the rest of the rafters that rise up to meet the top of the house. The four posts signify the four perspectives of health for the indigenous person; the physical, spiritual, mental and socio-economic aspects of living. The four aspects of wellbeing arise out of a well articulated 'identity', firmly grounded in the *vanua* and with God, and which negates a spirit of belongingness and ownership of spiritual and physical tribal or clan realms such as the sea, the land, trees and

mountains. The four aspects of indigenous health define the roles, the responsibilities and the obligations of an indigenous person to his/her *vanua* and to God. Failure to carry out such functions and responsibilities is identified as being 'sick' (Nabobo-Baba, 2006; Ravuvu, 1983).

***Lalaga: the four walls***

The four walls of the house signify the interrelatedness of the four perspectives of health and illness and their interdependence for the total health of a person. The four walls refer to the warmth, belongingness, obligations and relationships that are created and are to be maintained and strengthened throughout life. From the exterior, the four walls when strong and tightly woven without gaps represent the strength of relationships and responsibilities to families and community which provide protection from outside forces, evil spirits and a barrier to unwelcomed intruders.

**8.16 Embedding indigenous Fijian epistemology at leadership level:  
Nurses Midwives and Nurse Practitioners' Board**

***Consultation and Collaboration in External Aid***

In the *vanua* system of consultation, we sit down and talk about important things as equal players. We respect each other and what each of us can contribute to the change. (FSN 06. p.10)

The review and the development of the new curriculum at the FSN were made possible by the availability of funds from the AusAid's Fiji Health Sector Improvement Project (FHSIP), which was centred at the Ministry of Health headquarters in Fiji. While the provision of funds by AusAid appeared to have solved the curriculum problems at the FSN, this study found the project, as executed, followed a classical educational aid process in which Australia has often been criticised by Pacific academics since the early 1980s. Teachers in this study were passive participants in the whole innovation, and felt left out by the way the MOH and the NMNP Board initiated the change. Participants in this study complained about the lack of consultation and collaboration in the curriculum project, which they felt was particularly disappointing in that

although when they were invited to attend reviews and curriculum workshops, their contributions were not evident in the final document (Baba, 1985).

Aid funds, such as that provided by FHSIP, tend to be paternalistic in the way Aid is administered. The FHSIP recruited the JCU team from Australia for the curriculum project without engaging any local counterpart from the FSN. During the project year, the teachers and the registered nurses in Fiji enrolled in up-skilling and bridging courses from the James Cook University in Australia, despite the same courses being offered in Fiji by other providers at a cheaper cost. The system of employing Australian academics and Australian domestic institutions ensures Australian money is spent within Australian Institutions. That is, the money spent educating nurses within Fiji was siphoned back into Australia through school fees, text books and Australian teachers who travel from Australia to conduct block courses at the FSN.

External change agents play important roles in any innovation, but the success of the project or change depends on the strength of the internal leadership of the school. In this study, the external change agents included the JCU project team, the NMNP Board, the FSHIP team and the MOH. One significant dilemma that became evident during the study was the simultaneous role of the NMNP Board had – that is, its legislative function while coordinating the project externally from the MOH. On the same note, the JCU project team did not have a local counterpart to work with them during the project period.

This study found that the FSN was heavily administered or controlled from outside the institution by the NMNP Board and the MOH, and the decision to change was advocated externally from people and organisations not involved in the implementation of the curriculum. Internal leadership within the institution was also 'invisible' to the teachers, most participants lamenting the absence of leadership, guidance and support from within the institution and the NMNP Board. Fullan (2007) stated:

Strong leadership internal to the school or to the district is a crucial variable.  
Without quality internal leadership, you end up not with limited innovation

but rather its opposite- too many fragmented uncoordinated, flavour of the month changes (p. 76).

Usher (2003) reported a consultant from the James Cook University had been tasked to oversee the implementation of the new curriculum for the first three years. However, evidence from the study indicated a failure of this arrangement as the consultant would visit Fiji at least three times a year while conducting classes for the BN students and at the same time would assist in the progress of the curriculum. A participant had this to say about this arrangement:

The consultant would only come to teach the BN classes and then would schedule 2 hour separate meetings for the four strands to check on our progress and problems. But most of the times, the teachers are working either here (in school) or in the clinical or elsewhere. Everything seemed to be rushed and rushed! They just fly in and fly out. We wanted someone 'here' to help us through the 3 years. (FSN 04)

The arrangement by the AusAid and JCU failed to meet the objective of guiding the school through the first three years and the NMNP board of Fiji did not have any contributions to make towards assisting the teachers during the innovation. Evidence from the study indicated that the teachers became so disillusioned by the extent of outside interference and control that they became passive participants in their own work.

### **8.17 Summary**

This chapter discussed the dilemma of continuing with a curriculum that the teachers have already rejected as foreign and externally imposed by foreign consultants and external aid. To a large extent, the teachers were by default, the main change agents in the whole curriculum innovation, as those who first advocated the change left in the beginning of the implementation phase. The moral responsibility of teaching nurses in Fiji and their Christian conviction became the only incentive to keep teaching the new curriculum. Teachers also felt morally obliged to use the hidden curriculum to ensure the relevance of the curriculum to the Fiji context. Significant issues of re-colonisation of student nurses through its education curriculum and the need to decolonise nursing practice and health services through an indigenous health model have been proposed in the chapter. For a more relevant and culturally sensitive nursing service for

indigenous Fijians to be realised, a comprehensive integration of both the western and the indigenous Fijian perspectives of health needs to be embedded at all levels of nursing in Fiji.

The next chapter is the final chapter of this thesis and it summarises the whole research findings. Recommendations and the implications of the study are discussed with regard to nursing education and nursing practice, as well as the health of indigenous Fijians.

## Chapter 9: Conclusion

### 9.1 Introduction

This chapter summarises the thesis and draws together the central themes identified in the study. In this chapter the major implications of the study on nursing education, nursing services and nursing leadership in the context of educational reforms are also discussed. The implications of the research for nursing and health research and the consideration of indigenous health perspectives are identified. The four broad aims which guided the study were to:

- Explore the 2004 competency-based Diploma of Nursing curriculum document its origins and nature, its implementation process, identifying its strengths and shortcomings, its relevance to Fiji, and to make appropriate recommendations for its improvement;
- Examine the ways in which the people involved (teachers, students, clinicians and the consumers of health services) responded to the curriculum change and their experiences in the implementation of a new curriculum;
- Discover the relevance of nursing and health knowledge taught within the nursing curriculum to meeting the health needs of the Fijian people; and,
- Provide policy makers with relevant information and insights that may contribute towards more effective formulation; and to contribute to the research literature on curriculum change in nurse education in developing countries.

The 2004 competency-based Diploma of Nursing curriculum became a victim of the circumstances in which it was implemented as its strength and shortcomings were influenced by the way the curriculum was developed and implemented in Fiji. Stake (1996) reminds us in curriculum analysis and evaluation the main task is not only to evaluate and assess but also pass judgment on the programme. As a competency-

based programme, the Fijian Diploma of Nursing curriculum was comparable to degree programmes in New Zealand and Australian institutions. Even though the curriculum addressed current approaches to nursing education, it did not comprehensively cover all aspects of nursing relevant to nursing practice in Fiji, such as indigenous health, community health nursing and the spiritual aspects of nursing. Evidence from this study suggests the lack of collaboration with the teachers at the initiation phase of the curriculum change was related to the limitations in the curriculum content, leading to an incomplete curriculum document. The 2004 curriculum thus became the victim of the circumstances surrounding its implementation, where its success depended on the antecedents that directly influenced and impacted its implementation. The failure of the curriculum to realise its full potential, impacting on the quality of nursing is related to the passive nature of the teachers' coping with the curriculum change without adequate preparation and supervision. Evidence from the study also indicated the FSNs infrastructure was inadequate to support a new curriculum. The review of the old curriculum resulted in a change that promised improved resources, as testified by a participant during the interview:

Personally, when they brought this idea across, I jumped! Because I thought this is a change and this is a new thing and I felt, maybe it's good and lets 'take it on'. I saw it as a chance to improve the school (FSN 04,p.1).

However, this study showed the excitement was short lived and did not last in the first year of the curriculum's implementation. Minthrop (2004) and Kanter (2004) reported (as cited in Fullan, 2007) that when things go wrong in schools and there is no help from outside the school, even the most qualified and talented teachers leave to avoid the stress and depression of working in a failing school or project. Trial and error in teaching, learning, and practising nursing by students and graduates marked the implementation of the 2004 curriculum. Teachers were not sure of what they were teaching and trialled teaching methods and assessments (FSN 04, FSN 05); and students referred to themselves as 'guinea pigs' (GR01, GR 02, and GR03) in an incomplete curriculum.

The extent of the hidden curriculum in the 2004 curriculum is suggestive of content that is either incomplete or irrelevant to its context. Evidence from the study revealed the majority of teachers were teaching from a hidden curriculum, and did so to ensure the students could survive in the community and what they learned was relevant for nursing in Fiji.

## **9.2 Powerlessness**

Powerlessness was expressed in a number of ways in this study. One, the teachers lacked decision making powers in a curriculum development process whereby participants described the lack of acknowledgement or appreciation of their contribution by the curriculum consultants, compounded by their lack of choice over their teaching areas. School management decided where the teachers should teach, regardless of their area of expertise or interest. Also, the decision to review, change and implement a new curriculum rested with Fiji's MOH not with the FSN staff. Two, the study revealed the teachers' frustrations at the lack of decision making powers within the institution and the need to refer every little decision to the MOH. Three, academic structures such as committees for candidate selection, disciplinary matters, and overseeing examination processes were selected and convened by the MOH. Last, the administrative position of the FSN within a service-oriented organisation, such as the MOH, exposed the institution to systemic abuse and abuse of authority, identified in this study as significant factor in the powerlessness of the teachers to contribute effectively to the implementation of the curriculum.

## **9.3 Impact of colonialism**

Despite Fiji gaining political independence thirty years ago, its western-based institutions, such as medicine and health services remain colonised by western ideologies and epistemologies. Gegeo (2001) writing about the Solomon Islands remarked that political independence is meaningless if former colonies remain epistemologically colonised. Bullivant (1983a) argued that education and curriculum are agents of cultural hegemony whereby the culture of a minority population is

oppressed, or where former colonialists remain dominant, reproducing dominant western ideologies and knowledge through its western education institutions. Neo-colonialism influences nursing leadership, education and practice and ultimately affects the health of individual Fijians. Educational aids, such as the 2004 curriculum tend to be supported by former colonists who continue to extend the legacies of colonisation. Foreigners have re-constructed identities of indigenous nurses and the Fijian people as in need of the expert assistance of the more developed western nations. In such contexts, former colonies, such as Fiji, become passive recipients of health programmes and curricula, which have little or no concern for indigenous health. Hancock (1991) argued such a relentless method of providing external aid stifles the intelligence, the progress and the creativity of the locals in prioritising their needs and working hard to meet them.

#### **9.4 Dependency on external aid**

The Fiji School of Nursing's curriculum development project was similar in many aspects to other educational activities initiated by international agencies in the Pacific region. The curriculum project is an example of how external aid agencies can use curricula as agents of further colonisation of the people of Fiji. In this study, the curriculum privileged the western academy and knowledge by using foreign experts and excluding local and indigenous counterparts. The problems associated in implementing 2004 Diploma in Nursing curriculum supports the argument that the degree of clarity in the curriculum goals and approaches determines the success or failure of a curriculum change.

The teachers' high stress levels, depression, and dissatisfaction by what they termed an incomplete curriculum were related to inadequate preparation by the MOH and the JCU team, as well as the absence of leadership to guide them in the implementation phase. This was compounded by the limited consultation that occurred over the curriculum change process, and the lack of awareness and preparation in curriculum development, and the curriculum approach and its requirements. Moreover, the

teachers and students suffered horizontal violence and bullying, forced into implementing the curriculum change in an unprepared state by the members of the nursing fraternity in more powerful positions.

The central thesis of this study is that the development and the implementation of the 2004 Diploma of Nursing curriculum in Fiji demonstrates further colonisation of nursing and the Fijian people, and therefore does not prepare registered nurses to adequately and appropriately nurse indigenous Fijian peoples.

### **9.5 The implications of the study**

Issues relating to the preparation and retention of nurses within countries globally have gained momentum in the past decade. Fiji also faces problems retaining its registered nurses, especially when other countries offer better service conditions and salaries (Armstrong, 2005). Nurses continue to be the main movers of health care in any country, and in Fiji they are at the front-line in all health care services and programmes. The high intake of nurses at the FSN since 1990 (120 to 150 per year, and 198 in 2004) (Fiji School of Nursing, 2010) is indicative of the number of nurses leaving the country in any given year. While the Fiji government is committed to providing a safe and efficient health service for the people of Fiji, the high turnover of nurses from the FSN and health services affects the quality of the nursing services provided for the people of Fiji. Moreover, registered nurses who leave the country are usually the most experienced and have postgraduate qualifications making them more marketable overseas. The shortage of nurses in Fiji is aggravated by a gap in experience, which affects the quality of all health services available to the people of Fiji, and also places enormous demands on the remaining nurses. This study explored the competency-based curriculum and its ability to prepare nurses to meet the health needs of the Fijian people.

### ***Implication for leadership in nursing education***

Evident in this study was the lack of leadership, a major weakness in the implementation of the curriculum change at the FSN. Fullan (2001) emphasised the importance of leadership in a culture of change as he believed the expectation and demands on the leader in an educational change is multidimensional and requires the leader to develop a new mindset about his or her responsibility to himself or herself and to the people that are being led in a change situation. A convergence of all the dimensions such as knowledge creation and sharing, relationship building, the curriculum and the change process, coherence making and moral purpose encompass the characteristics necessary for leadership in a successful curriculum change. This study identified a major weakness of the implementation of the curriculum, and the many problems encountered by the teachers, were related to the lack of or absence of leadership and a breakdown in relationship amongst staff. Leaders, according to Fullan (2004), need to have a good understanding of the change process and in this study, the Principal, the NMNP Board of Fiji and the Nurses Academic Committee all needed to have a good understanding of the curriculum and the change process to be able to lead and make informed decisions for the FSN and provide the required level of assistance for the teachers. Leaders within the FSN need to be able to make curriculum decisions and they would be able to do so if given the right preparation and the freedom to do so by those in authority. Tollefson, the JCU consultant appointed to oversee the implementation of the curriculum had this to say in her report:

There does not seem to be any one person who has both the responsibility and the authority to implement the curriculum. Strand leaders are working well, but there is little coordination and no one has sufficient authority to make decisions stick (i.e. everything has to be deferred to a higher authority- diminishing the effect of the decisions) (2005, p. 6).

### ***Implications for nursing education, curriculum development and policy development***

The lack of knowledge and experience of faculty and leaders in the FSN and MOH of curriculum development was also a main problem in understanding the needs for the management of a major educational change. Appropriate supervision, policies for implementation, and support networks were needed to be in place before the

implementation process. Another major problem in the curriculum's implementation related to the nature of the FSNs administrative relationship with the MOH. The direct supervision and administration of the FSN by the MOH is a hangover from the colonial administration of the school (Stewart, 2007), which phased out in late 1970s. Problems and disadvantages of service administrations directly influencing an education institution include first, their different priorities to the school, which has academic priorities compared to those of service ideals and priorities. Second, an employer cannot directly control the education of its potential employees, due to the potential of influencing the school's specific functions, including its curriculum processes, intake policies, assessments, and others. In Fiji's case, such arrangements are related to the political interference and the involvement of non-academics in selection committees, interviews, and other internal academic processes.

The MOH relationship with the FSN tends toward political interference, domination, and oppression of the faculty by those in leadership positions. Furthermore, faculty exhibited behaviour and experiences similar to what Paulo Freire (1993) calls oppressed group behaviour. Oppressed group behaviour manifests as low self esteem, submissive-aggressive syndrome, assimilations and horizontal violence. Political interference also became evident during the research period; daily newspapers published progress on the prosecution of a former Assistant Minister for Health charged with bribing student nurses and parents to get placements at the FSN (Naivaluwaqa, 2008).

The MOH not only ideologically dominated the school, but also regularly withdrew and diverted budgeted funds for the FSN to other prioritised services within the government (FSN 08). This study also found faculty were powerless, with the NMNP Board and MOH functioning by using traditional top-down administration and decision making, which disadvantaged the school in many ways. An example of this was the reversal of the WHO's recommendation for the development of an undergraduate degree programme for the FSN. This decision solely made by the then MOH CEO, in

favour of the continuation of a Diploma level programme after the curriculum was approved by the Cabinet (MOH Memo, 2003).

***Nursing service development: in-service education and capacity building***

A significant finding in this study was the need for capacity building, and appropriate post-registration education and training for the nursing workforce in Fiji. Ninety percent of the staff at the FSN possessed an undergraduate degree, including all nursing leaders at the school and similar to those at the MOH. Almost all of the staff lacked qualifications or experience in curriculum development. Most of the problems encountered during the implementation of the curriculum were related to the lack of understanding of curriculum building processes by the faculty and the NMNP Board. A participant made this comment in relation to their handicap in curriculum development:

What the MOH forgets is that we are nurses and not teachers. Most of us were just sent straight from the hospitals to teach here! (FSA 03, p.4).

Capacity building in terms of bridging the qualifications of teachers did little to ensure the successful implementation and sustainability of the curriculum, as the teachers still did not understand the curriculum, and became quite confused and frustrated at the whole project. The capacity building strategy of the MOH, in conjunction with JCU, involved the preparation of Master's degree candidates for leadership in Fiji (2004). Ironically, during the research and writing of this thesis, the three Master's degree graduates from the JCU continued working as tutors in the FSN, while the leadership positions were rotated between staff without Master's degrees. Capacity building is related to empowerment and self determination, moving toward independence from the external aid donors. The MOH as an administrative organisation for the school had an obligation to ensure teachers had the necessary qualifications or experience in curriculum development, and should develop plans toward achieving such an objective.

Moreover, the MOH and NMNP Board's actions enabled the JCU team to handover a curriculum with knowledge gaps, such as the absence of the indigenous and spiritual

aspects for nursing, blood transfusion and community health nursing. The spiritual aspects of nursing were specifically requested by the NMNP Board to be included in the curriculum. This study provides a reference point for the MOH to promote nursing education that is dynamic and responsive to its context of practice and contemporary to international trends. The FSN continues to teach a Diploma of Nursing (now located within a university framework), whereas all other health programmes have undergraduate degrees.

The manner in which the curriculum was implemented resulted in a worse state of resources to support a curriculum, and demanded more from the teachers than what was available. Previous projects within the MOH and FSN followed similar patterns and suffered the same fates. Such projects include the 1983 Diploma of nursing curriculum, funded by the World Health Organization and the Japanese government. At the end of the project years, the Fiji government could not sustain the curriculum at the implementation level, allowing it to slowly disintegrate in substance and integrity. The physical buildings, teaching aids and PHC programme vehicles, which facilitated the PHC focus of the curriculum were either lost or in dire need of repair after the first five years.

### ***Implications for Indigenous health and Cultural safety in nursing***

Neo-colonialism was identified as a major precursor to the lack of the curriculum's relevance for the indigenous people of Fiji. The study exposed the dominant nature of western health knowledge and the colonisation of Fijian indigenous knowledge of health and illness. All participants in the study valued indigenous knowledge, the Fijian perspective of health and ill-health and its role in the maintenance of health and illness prevention for indigenous Fijians. However, most did not integrate it with the formal subjects, keeping it as the hidden curriculum. It is argued here that given the pervasiveness of western medical knowledge and the declining status of health of indigenous Fijians, the 2004 curriculum project missed an opportunity to address what Australia and New Zealand have addressed in their own nursing curricula – indigenous health. What is suggested in this thesis, is what Thaman (2003b) calls the 'decolonizing

of the mind' of indigenous teachers and the courage to explore, document, develop and apply an indigenous health services model appropriate for indigenous Fijians.

An analysis of the curriculum, as discussed in Chapter 7, exposed the complete disregard for indigenous perspectives of health and illness in the curriculum by the JCU team and the teachers. However, as previously mentioned, some teachers taught indigenous practices for the maintenance of health and prevention for illness as a hidden curriculum. Even though indigenous Fijians form the majority of the Fijian population and their health status has not improved for the last 20 years, the study found the curriculum did not consider exploring the western dominated health models used in Fiji for their relevance within the Fijian context.

Participants, students, teachers, and preceptors overwhelmingly reported a desire to reconsider indigenous issues in health and social services. Teachers also lamented the socialisation of students into a western medical model without any consideration of the Fijian indigenous perspective of health and illness. Students in a focus group complained about the inappropriateness of teaching methods adopted by the school, and the lack of sensitivity to indigenous cultures. They also requested realignment of the programme with their culture, to eliminate the clash of values that was apparent. Teaching methods need to include indigenous methods of teaching and learning.

### ***Implications for future research***

While the use of a case study method was the most appropriate for an exploratory type of research into unknown phenomena, the research data and the experience itself unearthed themes requiring the application of discourse analysis theories and more critical qualitative strategies. Also identified was the need for further exploration into the social and medical anthropological issues relevant to the development of an indigenous health model for Fiji. The research method used did not allow for in-depth discourse analysis on indigenous health concepts, as they were not directly appropriate to the topic under investigation. This study has broken new grounds normally reserved for western academic research, and used Fullan's Change theory

together with the Vanua Research Framework. Guided by the Vanua Research Framework, the research ensured that both institutional and indigenous Fijian protocols were observed and protected so the largely indigenous Fijian participants felt comfortable and forthcoming with their contributions. Similar studies within western academic institutions in Fiji should further privilege indigenous Fijian nurses and indigenous Fijian culture.

The study used *talanoa* in its interview and focus group discussion, which achieved a general atmosphere of informal, relaxed and facilitative type of discussion between the participants and the researcher. While *talanoa* has been used extensively in Pacific Islands research in areas of education and social sciences (Nabobo-Baba, 2006; Otsuka, 2005, 2006; A. Sharma, 2000), its value in health and nursing research has not been tried prior to this study. The use of *talanoa* and the Vanua Research Framework in this study also identified another area, which needs to be addressed; that is, the development of indigenous research protocols and guidelines for those wishing to undertake indigenous health studies in Fiji. Similar to the protocols developed by Nabobo-Baba (2006) for Fiji and Linda Smith (1999) for Maoris, an indigenous health research protocol should serve as a guide for those wanting to study indigenous health in Fiji.

Other research areas identified in this study include: one, the closer examination of the relationship between nurse attrition and migration and the prevalence of bullying and horizontal violence in Fiji. Second, the degree of dependency on externally funded health service programmes in Fiji and its relationship to the health status of the indigenous population. Research into the health of indigenous women, mentally sick and the impacts of health promotional programmes in Fiji on the health of the indigenous populations also need to be explored.

## 9.6 Recommendations

This study has a number of recommendations to improve the curriculum change for nursing education in Fiji, and the delivery of nursing that is culturally safe and relevant to context and contemporary practice. These are:

- **RECOMMENDATION 1**

*Curriculum development knowledge/qualification be included as a core requisite for teaching and leadership at the school of nursing.*

The study identified a major weakness in the whole change process in that the teachers and those advocating the change lacked curriculum development awareness and were helpless without expert assistance. The teachers' problems were made worse by the lack of change management experience by the nursing leaders. Management of an educational change requires wide consultations with stakeholders, consumers, teachers, students and a change in leadership style from an autocratic and traditional to one that is consultative and facilitative for the staff.

The study revealed that the decision to implement a competency-based curriculum was also influenced by the MOHs need to use a performance assessment system for its registered nurses (RNs). A more appropriate approach to developing an assessment system for RNs would be the simultaneous implementation of the competency assessment protocol for all nurses registered with the NMNP Board of Fiji and working in Fiji, together with the 2004 Diploma of Nursing curriculum. The rationale for the simultaneous implementation is that both the teachers and the clinicians would be motivated to 'learn' and to 'know' the nature of competencies and how they are applied to students' assessments and to the clinicians continuing assessments of clinical competencies using the same criteria adopted by the NMNP Board.

- **RECOMMENDATION 2**

*All future external educational or health projects should appoint local counterparts so there is an equal level of consultation and collaboration between foreign and local experts occurring throughout the project. This should also ensure indigenous*

*and local conditions and health knowledge are acknowledged and included in any programme having an intended impact on Fijian peoples' health.*

In most international projects and external aid agencies, foreign experts are normally expected to secure local counterparts to help provide the local scenarios. Such arrangements act to provide a balance and an accurate representation of the school to the project. The appointment of local counterparts indicates the commitment of the external agency to the continuation of the project when the foreign consultants leave. Local counterparts to the project or to subjects in the curriculum tend to become empowered by new knowledge and curriculum development skills by working closely with foreign experts.

- **RECOMMENDATION 3**

*The undergraduate curriculum integrates strategies of social justice, mentoring and precepting junior students by their seniors, as a means of instilling 'caring' and 'nurturing' as a professional attitude for nurses.*

It is argued that unresolved bullying and violence could be a factor in the high attrition of nurses from Fiji to other countries or from nursing to other jobs within Fiji. Integration of social justice into the undergraduate curriculum serves to prepare the young ones to cope with workplace conditions such as bullying, and differences in culture and ethnicity. Nurses in Fiji need to be aware of the prevalence of bullying and violence in nursing worldwide and in Fiji and recognise its unhealthy effect on the younger inexperienced nurses. The study exposed the depth of stress and trauma caused by horizontal violence at all levels of nursing in Fiji, and the plights of those nurses who could not escape out of nursing or out of Fiji and the coping mechanisms they had to develop to stay in the profession.

- **RECOMMENDATION 4**

*The FSN develop and implement research protocols in nursing and Indigenous health; and create a body corporate to safeguard and administer the protocols in its use, application to research, and to advocate for indigenous health practices and issues in Fiji. In addition, the FSN establish a centre for indigenous health research with a mission to creating awareness and networking and a positive impact on indigenous Fijian health.*

A recommendation for the formulation of an indigenous health research protocol is recommended for the purpose of ensuring there is accountability in the methods and information that are collected, used, publicised or reproduced. Indigenous health research includes all nursing contexts and institutions affecting indigenous health. Similar to protocols developed for New Zealand's *Kaupapa Maori* and the Pacific health research protocols for Pacific Islanders in NZ, the indigenous health research protocol ensures the participation of an indigenous Fijian researcher as the Principal investigator. In studies involving nursing experiences of indigenous nurses or indigenous clients, investigating teams will include an indigenous nurse as the Principal investigator. The implementation of this recommendation would empower indigenous nurse researchers in Fiji, privilege the indigenous worldviews of Fijians, and provide a platform in which health strategies for Fiji could be debated and negotiated.

- **RECOMMENDATION 5**

*A revision of NMNP Board competency criteria is carried out to include cultural safety and sensitivity to the indigenous Fijians as well as the various ethnic groups in Fiji's population, and suitable for the Fijian context. The revisions should then inform and underpin the integration of Indigenous perspectives of health and illness in the content of the curriculum.*

The study exposed the weaknesses and shortcomings of the curriculum related to the concepts of health and illness for indigenous people. Recent studies in education and social sciences (Becker, 1995, 1998; Nabobo-Baba, 2006; Newland, 2006) highlight the indigenous peoples' continued emphasis and application of indigenous knowledge of health and prevention of illness their everyday life. The progressive nature of the worsening health index for indigenous Fijian is testimony to a more hegemonic relationship between the dominant western medicine and the more informal indigenous perspective of health and illness. Pande (2004) and Tukuitonga (2007) both suggested the need to reconsider the indigenous, cultural and traditional health practices of the Pacific Islanders as a strategy to re-address the worsening rate of lifestyle diseases affecting the Pacific population.

- **RECOMMENDATION 6**

*An indigenous health model is used to guide the delivery of indigenous health content, as well as identify relevant indigenous methods of teaching and learning, and theorising in an indigenous worldview.*

This study recommends the integration and the use of an Indigenous health framework to guide undergraduate nursing curricula in its content and delivery so that nurses are able to provide a service that is sensitive and appropriate for Fijians. A framework developed from the analysis of the content of the Diploma of nursing curriculum called the 'vale ni bula' model is recommended for the purpose of providing a guideline for development of curriculum content, the teaching and learning strategies for students and teachers. The model is also useful for a holistic assessment of an indigenous client such as the individual, the family, a community or in planning and assessing health programmes directed at indigenous people.

- **RECOMMENDATION 7**

*The Nurses, Midwives and Nurse Practitioners' Board of Fiji function independently from the Fiji government, with more accountability for public safety.*

The study recommends that the NMNP Board should be made independent from the government with an office, administration structure, and its own budget. The complexity of the nurses' scope of practice and the issues that affect nurses have become too complex to be handled by a Board that cannot guarantee impartiality and only meets three or four times in a year. This study revealed the curriculum change at the school was beyond the Board's capability to provide expert advice and guidance, and address many of the problems that transpired at the FSN due largely to the NMNP Board's decision making. The Board has outgrown its initial function as the legislative arm of the MOH for nurses and it needs to be made responsible and accountable to the public for decisions affecting nurses and nursing education in Fiji.

## **9.7 Limitations of the study**

The limitations of the research may be inherent in the research method used, the researcher or the research topic under investigation. The case study method, as

outlined by Stake (1995a) and Yin (1994), does not provide an analysis framework. However, this limitation became an opportunity for the use of other analytic frameworks, and allowed for other interpretive frameworks to be used concurrently.

Limitations of the study also include the loss of primary and official documents such as minutes of committee meetings, records of the initiation of the project and its subsequent implementation and others. The gap in the data created an unprecedented setback to the time allocated to data collection and the researcher had to rely on secondary data sources.

In this thesis the limitation of using an indigenous framework includes the disadvantages and shortcomings of the methodology that is grounded in a culture with elaborate rituals, ceremonies and time values, which is in contrast to the western concept of time (Liamputtong, 2010). As an indigenous Fijian researcher, the use of an indigenous research framework can be time consuming for a set time and expensive for a low research budget. While there are many advantages of being an insider-researcher in a Fijian context, the gifting and greeting of both dead relatives and those who are alive is an elaborate process for indigenous Fijians. While the use of indigenous research framework is a privilege for both an indigenous researcher and the researched person, the methodology is cheaper in terms of costs and time if it is used by a non-indigenous researcher.

## 9.8 Concluding remarks

“My love for nursing and for my country kept me going; at times I just want to throw in the towel, and then the faces of these children staring at me just keep me in here(FSN 06).

In doing this research and writing the thesis, I also re-lived the difficulties of implementing a programme with all the trials and tribulations faced in any new programme. In exploring a programme which had created so much stress and frustrations in the teachers at the FSN, I began to realise it has been a healing exercise for all participants. Spiritualising the experiences of the participants by looking further than the curriculum project itself allows one to focus on the contributions of the change to nursing education and to the people of Fiji. Teaching, at the school of nursing for many teachers has become more an obligation than a passion. Like most indigenous Fijians, it is culturally appropriate to serve communal interests first and self last. I have chosen this study not because of a personal interest in curriculum development but as an obligation to my people and the nurses who care for them. What I have learned from this exercise is what the late Fijian statesman and High chief stated almost half a century ago:

*Na veiliutaki sa sega ni I tekiteki*

(Literally leadership is not a decoration, it is a responsibility)

Ratu Sir Lala Sukuna circa 1950s

Hopefully, this thesis will in some way lighten the weight of that responsibility on my part and create a space in the minds of indigenous teachers and leaders of nursing to reflect on their practice and its impact on the Fijian people.

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## **APPENDICES**

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**APPENDIX 2.B: DIPLOMA OF NURSING PHILOSOPHY STATEMENT**

## APPENDIX 1. A: MOH FIJI ETHICAL APPROVAL

**DINEM HOUSE**  
88 AMY ST., TOORAK  
BOX 2223, GOVT. BUILDING  
SUVA, FIJI

MINISTRY  
*Of* Health  
Shaping Fiji's Health

PHONE : (679) 3306177  
FAX : (679) 3306163  
EMAIL: [info@health.gov.fj](mailto:info@health.gov.fj)

Reference: EDP: 31459

Date: 15/06/2007

Ms Alisi Vudiniabola  
School of Health Sciences  
Social Science Tower  
Massey University  
Turitea Campus  
Palmerston North  
NEW ZEALAND

Dear Madam

RE: Permission to access Ministry of Health reports and records for research.

This is to inform that the Ministry has approved your request to access any Ministry of Health records in Head Office and other health facilities that are related to your research topic. This will include a number of evaluation reports relating to Diploma of Nursing curriculum in Fiji and Nurses, Midwives and Nurse Practitioners' Board decisions papers.

We hope that the little support we have will enable you to collect and collate relevant data and information required by the programme that you currently undertaking.

We wish you all the best.



.....  
Nanise Raika [Mrs]  
**for The Permanent Secretary for Health**

cc: The Director Curative Health Service  
The General Manager Corporate  
The Director Nursing and Health Standard  
The Director Public Health  
The Director Cent East Health Services  
The Principal Nursing School

## APPENDIX 1.B: MOH FIJI ETHICAL APPROVAL LETTER



### Fiji National Research Ethics Review Committee

Phone • (679) 3221424/3221427    Mr. Ravi Reddy, Secretariat    FAX • (679) 3318227  
Ministry of Health  
P.O. Box 2223, Govt. Bldgs.  
Suva, Fiji Islands  
Email • ravi.reddy@health.gov.fj

15<sup>TH</sup> November 2007

Alisi Vudinibola  
c/- Dr. Denise Wilson  
College of Humanities & Social Sciences  
Massey University  
Albany  
New Zealand

Dear Ms Alisi,

Thank you for your application for ethical review to the Fiji National Research Ethics Review Committee (FNRERC).

I am pleased to advise that the FNRERC has approved the following proposal submitted to the Secretariat.

**Project Title**

“The appropriateness of a competency-based Diploma of Nursing programme in preparing nurses to meet the health needs of the Fijian people”.

**Primary Investigator:**    Ms. Alisi Vudinibola

**FNRERC reference Number: 020 – 2007**

I am pleased to advise you that the FNRERC has granted Ethical and Technical approval for your above-mentioned study with conditions.

The Project has been approved for the period expiring 31/12/08. It is your responsibility to ensure that all people associated with this particular project are made aware of what has actually been approved.

Please apply for renewal of your current approved study before December 2008.

## APPENDIX 1.C: MASSEY UNIVERSITY ETHICS APPROVAL



**Massey University**  
AUCKLAND

OFFICE OF THE DEPUTY VICE-CHANCELLOR  
(AUCKLAND & INTERNATIONAL)  
Private Bag 102 904  
North Shore 0745  
Auckland  
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[www.massey.ac.nz](http://www.massey.ac.nz)

30 October 2007

Alisi Vudiniabola  
c/- Dr Denise Wilson  
College of Humanities and Social Sciences  
Massey University  
Albany

Dear Alisi

**HUMAN ETHICS APPROVAL APPLICATION – MUHECN 07/057**  
**“An exploration into the appropriateness of a competency-based Diploma of Nursing programme in preparing nurses to meet the health needs of Fijian people”**

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Dianne Gardner  
Acting Chair  
Human Ethics Committee: Northern

cc: Dr Denise Wilson  
College of Humanities and Social Sciences

## APPENDIX 2.A: FIJI NURSING COMPETENCIES

### Fiji Nursing Competencies

**Functional Competency:** Provides quality client care with an effective care delivery environment.

- 1. Therapeutic and caring relationship:** Establishes partnerships with clients to promote their wellness in health, in illness, and in the healing process.
  - 1.1 Demonstrates caring, empathetic and supportive attitudes to clients.
  - 1.2 Establishes rapport and trusting relationships to facilitate treatment and rehabilitation processes of clients to achieve the expected outcome.
  - 1.3 Supports sensitively, clients to enable them to express needs and concerns.
  - 1.4 Facilitates client's effective coping with their illness/disability/distress/loss.
  - 1.5 Provides health education to facilitate client's understanding and participation in own management.
- 2. Care management:** Uses structured approaches to deliver effective health and illness management.
  - 2.1 Plans are based on client's needs, assessment data and multidisciplinary input using adopted nursing standards. Prioritizes and coordinates overall care of clients with both acute and chronic health problems.
  - 2.2 Monitors the health progress of client against expected outcomes, and reviews care plans according to assessment and evaluation data.
  - 2.3 Facilitates the continuity of care and appraises the overall wellness of clients as they adjust to their health problem in their actual living context.
  - 2.4 Maintains accurate and comprehensive documentation.
  - 2.5 Responds promptly and effectively in emergency situations.

**3. Knowledge and skill application:** Demonstrates specific knowledge, skills technology use and evidence based practice in client care processes.

3.1 Demonstrates knowledge of the rationale and benefits of clinical and therapeutic procedures and the ability to promptly identify undesirable effects and complications on client.

3.2 Applies established nursing care standards vigilantly and proficiently.

3.3 Works efficiently and effectively with health care technology.

3.4 Uses critical thinking skills to accurately interpret the client data and the clinical picture.

**4. Quality and Risk management:** Promotes a quality service environment and system to improve the standard of care.

4.1 Maintains a quality service environment to support treatment and health related activities.

4.2 Continuously review current practices and processes to identify areas for quality improvement.

4.3 Assists in planning and controlling the use of resources.

4.4 Demonstrates the ability to identify and control risks.

**Personal Competency:** Personal quality and professional attributes expected of a nurse.

**5. Personal Qualities:** The quality and characteristics of a reliable and responsible person required to fulfill nursing duties.

5.1 Respects life, death, dignity and rights of human beings, regardless of nationality, race creed, age, sex and social status.

5.2 Manages self in a professional manner and demonstrates resilience in stressful situations.

5.3 Accepts challenges and growing responsibilities with a positive attitude.

5.4 Demonstrates personal integrity, honesty and self discipline.

**6. Professional Attributes:** The commitment to strive for excellence in providing holistic care services, and safeguarding good practice.

- 6.1 Maintains and promotes the professional image of nursing.
- 6.2 Continuously updates knowledge and skills. Keeps abreast of current trends and advancement in health care.
- 6.3 Is accountable for own judgment and actions in work.

**People and Team Competency:** Works harmoniously and supportively within a team.

- 7. Teamwork:** contributes to the effective functioning of teams.
  - 7.1 Demonstrates effective interpersonal skills and shows respect for others.
  - 7.2 Share workload and assists other staff when needed.
  - 7.3 Asserts nursing input to maximize client outcome in multi-disciplinary care process.
- 8. People development:** Enhances staff development by cultivating a supportive and participatory environment.
  - 8.1 Delegates and supervises subordinates to achieve targets.
  - 8.2 Provides coaching and mentorship for junior staff and student nurses.

**Organization Effectiveness:** Ability to contribute to the establishment and development of a successful organization.

- 9. Service development:** Facilitates changes within the dynamic environment and supports initiatives leading to organizational effectiveness.
  - 9.1 Integrates organizational core values and objectives into daily work.
  - 9.2 Revises work processes innovatively to improve efficiency and effectiveness.

- 10. Legal and ethical practice:** Ensures the protection of individual client and the community as well as accountability for the public.
  - 10.1 Acts in accordance with Nurses, Midwives and Nurse Practitioners Act, Code of Ethics, and Public Service Commission regulations.
  - 10.2 Promotes client safety.
  - 10.3 Fulfils legal and ethical responsibilities as required in law,

## **APPENDIX 2.B: PHILOSOPHY OF THE FIJI SCHOOL OF NURSING**

### **Educators:**

The FSN will employ highly qualified nursing lecturers to teach in the school. The FSN shall ensure that its nursing lecturers are well educated, well informed, competent, appropriate and motivated. Further, the nursing lecturers shall maintain professionalism in their roles at all times. There shall be an emphasis on teaching, educating and equipping Fiji nurses to be highly skilled and competent leaders of health care as well as leaders of the nation of Fiji.

### **Graduates:**

The mission of the FSN includes the production of dynamic, innovative nurses for Fiji as reflected in the FSN graduate profile. The FSN shall strive to produce highly qualified, competent and safe practitioners with a sound theoretical background and diversified nursing skills.

### **Curriculum:**

The FSN shall provide a curriculum that meets the evolving health needs of Fiji, ensuring that the curriculum underpins and supports all efforts to improve quality of nursing education in Fiji. The curriculum shall be continually revised to reflect modern trends in nursing education and the health needs of our societies.

### **Teaching**

The FSN shall provide a challenging and conducive learning environment, utilizing effective teaching methods and technologies. The FSN shall undertake these duties whilst meeting the corporate goals and objectives of the Ministry of Health, Fiji.