

School of Nursing, Midwifery and Paramedicine

**The Influence of Participation in an International Clinical
Placement on the Cultural Competence and Career Planning of
Newly Graduated Nursing Students**

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**This thesis is presented for the degree of
Doctor of Philosophy
of
Curtin University**

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number SON&M33-2012.

Signature

March 2020

Abstract

The influence of international student experiences on the cultural competence and career choices of newly graduated nursing students

BACKGROUND: In a time of globalisation, culturally competent health practitioners are of recognised importance. International clinical placements are increasingly included in university undergraduate nursing programs to prepare nurses to work with diverse cultures within their own country, and globally. Studies have highlighted gains in cultural competence in the short term, but little is known about the enduring impact of these experiences. Furthermore, there is a paucity of evidence regarding the impact on students' career planning, including their desire to engage in providing nursing care with culturally diverse communities, either in their own country or overseas.

METHODS: Using an exploratory longitudinal multiphase mixed methods approach this study examined the influence of an international clinical placement on *career planning* and *cultural competence* in undergraduate nursing students from four Western Australian universities. Placements were undertaken in Tanzania, Cambodia, the Philippines, Thailand and India, and were up to four weeks duration. Qualitative data on cultural competence and career planning were collected via individual semi-structured interviews conducted prior to the placement, and 12 months after students returned. Quantitative data on cultural competence were collected prior to the placement, within 2 weeks of return from placement and 12 months later. The instrument used was the Inventory for Assessing the Process of Cultural Competence – Revised which is designed to measure the cultural competency of health professionals such as registered nurses (Campinha-Bacote, 2007).

FINDINGS: Through various *cultural encounters* nursing students learned to value and understand patient-centred care and cultural safety. From having first-hand experience of being a minority, participants came to understand the feelings associated with looking 'different', and intended to use this new *cultural awareness*

to improve the experiences of patients from diverse cultural backgrounds seeking health care in Australia. Furthermore, through the development of *self awareness*, they also identified unacknowledged prejudice and their own strong beliefs in universal health care.

Participants learned to develop relationships despite language, cultural and practice differences. This new *cultural knowledge* and *cultural skill* improved participants' understandings of the expectations of patients from diverse backgrounds, which they felt would enable them to ask appropriate questions and address patient concerns. They had an enhanced *cultural desire* to practise *culturally appropriate care*.

While the placements mostly confirmed their capacity to engage in positive cultural interaction in diverse settings, some nursing students found some contextual, systemic and clinical challenges difficult to reconcile. This was reflected in a significant decrease in the quantitative constructs of cultural skills, cultural awareness and cultural desire immediately postplacement, aligning with the qualitative findings. The role of the supervisors in this context was highlighted. Interestingly, these construct scores increased significantly 12 months later, returning to preplacement levels.

Interview data pertaining to future *career planning* revealed participants were motivated by intrinsic factors such as self-fulfilment and empowerment of others. Roles involving variety, pace and clinical complexity were of interest, as were roles in international settings, with the aim of effecting change. The empowerment of women and vulnerable minority groups was highlighted, with some participants wanting meaning and a desire to promote social justice in their future nursing roles.

CONCLUSION: International clinical placements can be effective in building and maintaining cultural competence over the longer term, but targeted planning of placements is necessary to ensure diverse cultural encounters to do not lead to increases in cultural barriers. Undergraduate nursing students who participate in an international clinical placement express interest in pursuing international nursing roles, including in health policy, to reduce global health disparities and improve health equity for vulnerable groups.

Campinha-Bacote, J. (2007). *The process of cultural competence in the delivery of healthcare services: The journey continues*. (Fifth ed.). Cincinnati: LH: Transcultural C.A.R.E Associates.

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Publications, Presentations and Awards

Publications

- 2019** Gower, S., Duggan, R., Dantas, J.A.R., & Boldy, D. (2019) One year on: Cultural competence of nursing students following international service learning, *Journal of Nursing Education*, **58(1)**, 17-26. DOI:[10.3928/01484834-20190103-04](https://doi.org/10.3928/01484834-20190103-04)
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- 2016** Gower, S., Duggan, R., Dantas, J., & Boldy, D. (2016). Motivations and expectations of undergraduate nursing students undertaking international clinical placements, *Journal of Nursing Education*, 55(9), 487-494. DOI: 10.3928/01484834-20160816-02.
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Awards

- 2014** Curtin Mark Liveris Research student seminar (2014) Best Poster Presentation: *Motivations and expectations of undergraduate nursing students who choose to participate in international clinical placements*.
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Co-author Contributions

Co-author contribution statements are required for submission of theses that contain published articles arising from doctoral research at Curtin University. An adaptation of The International Committee of Medical Journal Editors (ICMJE) guidelines for authorship are presented below for each published manuscript contained within this thesis. A rating of 0–3+ symbols is given to differentiate levels of contribution from each co-author, with 3+ being the highest contribution. The articles are listed below in the order they appear in the thesis.

Note:

Permission has been sought from the publishers to include the articles in the thesis. Professor Duncan Boldy sadly passed away in 2019, but was involved in review and quantitative analysis of all articles.

Article Two (Chapter 4):

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NB. Tables from the manuscript in chapter four are not included in this list as they are labelled as per the published version of the manuscript.

List of Abbreviations

ANMAC	Australian Nursing and Midwifery Accreditation Council
CALD	Culturally and Linguistically Diverse
CNS	Clinical Nurse Specialist
COVID-19	Coronavirus Disease 2019
ED	Emergency Department
GHAWA	Global Health Alliance of Western Australia
GP	General Practice/Practitioner
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
ICU	Intensive Care Unit
IAPCC-R	Inventory for Assessing the Process of Cultural Competence - Revised
IES	International Education Survey
NHMRC	National Health and Medical Research Council
NCD	Non-Communicable Diseases
NCAS	Nursing Competency Assessment Schedule
NMBA	Nursing and Midwifery Board of Australia
NP	Nurse Practitioner
RN	Registered Nurse
RFDS	Royal Flying Doctor Service
SPSS	Statistical Package for Social Sciences
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
UNDA	University of Notre Dame Australia
UNHCR	United Nations High Commissioner for Refugees
US	United States
WA	Western Australia
WHO	World Health Organisation

1. Introduction and Background to the Study

1.1 Introduction and Rationale

Globalisation is shaping our world in ways never previously seen. Prior to the Coronavirus Disease 2019 (COVID-19) pandemic (World Health Organisation, 2020a), people were able to move easily between nations and did so in unprecedented numbers. Some were fleeing conflict or persecution and sought refuge in safe countries such as Australia (United Nations High Commission for Refugees, 2016). Others moved for employment and trade purposes due to the interconnected nature of the global economy (United Nations Department of Economic and Social Affairs, 2017). Many migrants remain in the countries to which they travelled. In a time where globalisation and the interconnectedness between nations are highlighted as never before, culturally competent health practitioners are of acknowledged importance.

Cultural competence is now recognised in Australian and in international competency and regulatory standards, and nurses are expected to adhere to the principles of cultural safety in their clinical practice (Migrant and Refugee Women's Health Partnership, 2018; Nursing and Midwifery Board of Australia, 2016; Nursing Council of New Zealand, 2011). In addition to cultural competence, strengths in communication skills, critical thinking and problem solving skills, and an ability to show leadership are needed in what has become a global knowledge-based workforce (Liu & Aunguroch, 2018).

The Ebola outbreak in West Africa in 2014 (World Health Organisation, 2018) and other outbreaks like the Swine Flu virus (H1N1), Severe Acute Respiratory Syndrome (SARS) and the Coronavirus (COVID-19) pandemic that spread across the world in 2020 (World Health Organisation, 2020a) demonstrate the need for nurses to have an understanding of the importance of a global approach to health. Voluntary and forced global migration has occurred in unprecedented numbers, especially for health professionals. Nursing education and health policies need to prepare nurses to understand the nature of global health, including health disparities and priorities (Bradbury-Jones, 2009; Mill, Astle, Ogilvie, & Gastaldo, 2010), the

health needs of other nations, and the social determinants of health (Chowell et al., 2015; Johnston, Rogers, Cross, & Sochan, 2005; Mill et al., 2010; Parker & McMillan, 2007). Nursing students need to be encouraged to consider global health disparities and to think beyond the health needs of their own nations (Chowell et al., 2015; Mill et al., 2010). International clinical placements are seen as an effective way to develop this awareness, and to develop cultural competence in pre-registration nursing students. Gains in this area have been found in the short term (Watson, 2015). However, there is limited research on the enduring influence of international clinical placement experiences on cultural competence and career intentions.

There is a recognised nursing shortage globally both in the developed and developing world, including Australia, with a particular need in areas such as rural and remote health (Drennan & Ross, 2019; World Health Organisation, 2016, 2020b). Proposals have been posited to increase the number of nurses in rural and remote areas in Australia including the development of nurse practitioner programs specifically for rural health (Francis et al., 2014) and case-managed recruitment programs (Morell, Kiem, Millsted, & Pollice, 2014). For new nursing graduates, the transition to practice can be daunting and particular support may be required for those choosing to work in rural and remote areas (Lea & Cruickshank, 2015). The decisions nursing students make upon graduation regarding their career are influenced by a number of factors including previous health-related encounters and experiences during clinical placement (McCann, Clark, & Lu, 2010).

It is against this background that this study explored the enduring influence of participation in an international clinical placement on students' cultural competence and career planning. This includes their desire to engage in providing nursing care with culturally diverse communities, either in their own country or overseas.

A longitudinal convergent parallel mixed methods design was utilised to collect both subjective and objective data in order to fully explore the objectives of this study. The quantitative data was collected and analysed alongside the qualitative data, and the findings combined to produce a holistic account. In this way the strengths of both qualitative methodology, grounded in the constructivist paradigm, and quantitative

research, grounded in the positivist paradigm, are combined to achieve greater understanding of the phenomenon (Polit & Beck, 2018; Richardson-Tench, Nicholson, Taylor, Kermode, & Roberts, 2018). The meaning constructed by participants as they reflected on their experiences was captured by qualitative exploration using semi-structured interviews. To add depth, self-report quantitative data on cultural competence was collected via questionnaire.

Qualitative and quantitative data were collected concurrently in two phases, at three time points, over a 12 month period. Data were analysed separately and the findings were merged to create a holistic interpretation of the influence of the placement experiences on participants' cultural competence and career planning, both immediately and over the subsequent 12 months (Richardson-Tench et al., 2018).

International clinical placements were undertaken in five countries: Tanzania, Cambodia, Thailand, India and the Philippines. In Tanzania, students worked in public and private metropolitan hospitals, with some brief experience in rural communities. In Cambodia, Thailand and the Philippines students were placed in rural primary health care community clinics and communities, and engaged with their hosts, nursing student peers, at local universities. In India, the student was involved in a service learning project, conducting a needs assessment within one community and implementing a health intervention. All placements were between two and four weeks duration.

Placements in Cambodia, Thailand and the Philippines were organised by individual universities. Edith Cowan University deployed students to Cambodia, Thailand and the Philippines. Murdoch University deployed students to Thailand. Supervising faculty were provided by those universities. The Tanzanian placement was the result of a partnership between the Western Australian (WA) Department of Health and the five WA universities. Students were placed in inter-university groups, and each group was supervised by faculty from one of the participating universities. The Indian placement was a single university, multidisciplinary placement with supervision provided by occupational therapy faculty from Curtin University.

This first chapter provides context for the study, outlining the impacts of

globalisation, and the importance of cultural competence as a component of nursing registration and practice. Global differences in health systems are introduced, including health disparities and priority setting, and how these influence the international clinical placement experience. The chapter further discusses career planning in nursing students, including the decisions students must make in a profession that is increasingly diverse, both in the nature of nursing care and the variety of domestic and international career paths available. The chapter concludes with an outline of the purpose, significance and objectives that guided the study.

1.2 Globalisation

In recent years, globalisation has resulted in greater mobility, social interdependence and electronic interconnectedness between countries (Kruk, 2012). The current levels of global migration are unprecedented, reaching 258 million in 2017, a significant increase on previous years (United Nations Department of Economic and Social Affairs, 2017). Australia has a long history of accepting migrants and the Migration Program has an annual intake of approximately 190,000 people. This number is comprised of skilled migrants, their families and other migrants with special eligibility from countries such as India (21.2%), China (15.4%) and the United Kingdom (9.3%) (Australian Government Department of Immigration and Border Protection, 2017).

Additionally, under the Humanitarian Program, Australia accepts and resettles approximately 14,000 to 18,000 humanitarian entrants each year who have been granted refugee status. This number was boosted in 2015–2016 by the federal government's commitment to provide a further 12,000 places for people displaced by the Syrian conflict. In addition to the diversity created by people migrating to Australia, Aboriginal and Torres Strait Islander Australians make up 3.3% of the total Australian population (Australian Bureau of Statistics, 2016) representing numerous different nations with unique laws, languages and cultures (Dziedzic & McMillan, 2016).

It is becomingly increasingly necessary for Australian nurses to have the competence to provide appropriate and acceptable care across the diversity of cultures, religions,

languages and health-related beliefs within and between these groups. Australian nurses need to work seamlessly with this diverse population, complying with what is mandated in the Australian Registered Nurse standards for practice (Nursing and Midwifery Board of Australia, 2016).

Increasing levels of migration, including that of health professionals, means that not only do nurses need skills to provide care for culturally diverse patients, they also find themselves working within an increasingly diverse nursing workforce. In 2011, census data indicated that 48.3% of nursing and midwifery professionals in Western Australia were born overseas, the highest proportion in the country, with a significant increase in nurses born in India and the People's Republic of China (Negin, Rozea, Cloyd, & Martiniuk, 2013; Ohr, Parker, Jeong, & Joyce, 2010). According to the 2016 census, 26% of the general population and 35% of the population aged over 15 years were born overseas (Australian Bureau of Statistics, 2017a; Australian Government).

The increase in electronic information has led to a greater awareness of international health issues, resulting in the development of programs such as those related to the United Nations Sustainable Development Goals, to reduce health disparities (United Nations, n.d.). At the same time, non-communicable diseases (NCDs) such as obesity, cancers, diabetes (type 2) and hypertension are more prevalent globally, including in developing countries (Mishra, Neupane, Preen, Kallestrup, & Perry, 2015). Outbreaks of diseases since 2000, such as Ebola (in 2014 and 2018) (World Health Organisation, 2014, 2018), swine flu (H1N1), SARS, and COVID 19 have highlighted the need for Australian nursing students to be aware of the health needs of other nations, the interconnectedness of nations and the social determinants of health (Chowell et al., 2015; Johnston et al., 2005; Mill et al., 2010; Parker & McMillan, 2007)

The World Health Organisation (WHO) recognises the critical role that nurses play in the provision of frontline services around the world. By providing primary and acute care in developing countries, nurses are recognised as important contributors to the UN member countries' efforts to achieving the Sustainable Development Goals by 2030 (Benton & Ferguson, 2017). The WHO Strategic Directions for Nursing and

Midwifery 2016–2020 stresses the importance of a competent, motivated nursing and midwifery workforce to the achievement of population and community wellbeing, which WHO describes as a basic human right (WHO, 2015). In order to make the WHO vision a reality, nursing education and policy needs to respond to the changing nature of global health and prepare nurses to work with diverse cultures within their own country and overseas (Benton & Ferguson, 2017; Bradbury-Jones, 2009).

1.3 Ethnocentrism

Ethnocentrism was originally defined as “the view of things in which one’s own group is the centre of everything and all others are scaled and rated from it” (Sumner, 1906, p. 13). Since then the definition has been broadened to include “the universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways” (Purnell, 2013, p.7). It is a self-focused view that is insensitive to the variety and diversity of beliefs and values within and between groups.

Ethnocentrism may restrict a nurse’s ability to understand cultural subtleties of patients, leading to misdiagnosis, alienation, poor patient experiences and adverse outcomes (Amerson, 2010; Dayer-Berenson, 2011; Dunagan, Kimble, Gunby, & Andrews, 2014; Kokko, 2011). It is also a barrier to developing cross-cultural understanding, and a moderately strong inverse relationship has been found between ethnocentrism and cultural competence (Capell, 2008).

Ethnocentrism is a universal tendency, with many human beings perceiving that their way of thinking, acting, and believing is the right, proper and natural way. Problems occur in situations where nurses have limited or no cultural knowledge about the ‘other’ group (Canales, 2000). This in turn can result in false assumptions being made or assumptions that are based on limited experience. When the values and principles of others are not considered valid, those who are ethnocentric can antagonise and alienate people from other cultures (Amerson, 2010; Campinha-Bacote, 2002; Witt, 2016).

Simultaneous dual ethnocentrism is a component of every nurse-patient relationship

(DeSantis, 1994; Lequerica & Krch, 2014). Nurses use their own cultural values and biomedical points of view to assess, evaluate, and react to patients. Simultaneously, patients evaluate their nurses and the Western health care system using their own cultural values and beliefs (Sperstad, 2010). Examining one's own ethnocentrism can lead to growth in cultural competence and a shift towards ethnorelativism. This is a related concept whereby one considers the values and beliefs of an external culture to hold equal validity to one's own. The extreme version of this occurs when one's own values are discarded in favour of those of an adopted culture (Sutherland, 2002). According to Bennett (1993) there are six stages in the transition from ethnocentrism to ethnorelativism: denial of difference (extreme ethnocentrism), defence against difference, minimisation of difference, acceptance of difference, adaptation to difference, and integration of cultural difference. When a shift is made from ethnocentrism towards ethnorelativism, this is termed an ethnocentric shift (Michael, Della, Stoddart, Jones, & Gower, 2011). Students who have limited awareness of their own culture, and the values that inform it, are limited in their ability to understand the cultures of others. Addressing ethnocentrism is the key to the development of cultural competence (Witt, 2016).

1.4 Cultural Competence

Cultural competence is a set of attitudes, skills and beliefs that health professionals may draw upon to continuously strive to provide appropriate care to culturally diverse patients. This may include working with the patient, their families and the broader community (Campinha-Bacote, 2002). Within the nursing profession, cultural competency is increasingly important as nurses find themselves working with clients and colleagues from diverse backgrounds with a broad range of health-related values and beliefs (Cushman et al., 2015; Kokko, 2011; Torsvik & Hedlund, 2008).

There is evidence that patients from diverse cultural backgrounds may receive a lower quality of healthcare that fails to attend to their diverse cultural needs (Australian Medical Association, 2014; Komaric, Bedford, & van Driel, 2012; Robertson-Preidler, Biller-Andorno, & Johnson, 2017; Rodriguez, 2013). They may have poor levels of access to health care services, and experience discrimination and

stigma from care providers (Mengesha, Dune, & Perz, 2016; J. Ussher et al., 2012). Poor communication between care providers and patients leads to reduced satisfaction, a lack of compliance with care plans, and a lack of trust in the health care system (Purnell, 2013). There are limited studies on patient outcomes, but improvements in engagement have been noted with health promotion programs that are adapted to meet cultural needs ((Bender, Clark, & Gahagan, 2014).

Despite this obvious need, nurses feel they lack the required cultural competency skills in providing care for diverse patients (Markey, Tilki, & Taylor, 2018). Such skills include knowledge of non-biomedical views regarding illness and treatment, and adaptation of health care provision to meet cultural needs. A lack of in-service education in cultural competence is highlighted in the literature, despite acknowledgement that domestic nursing experience alone is insufficient to develop these skills (Alpers & Hanssen, 2014).

1.5 Regulatory Requirements for Cultural Competence

Internationally, nurse educators and regulators recognise the need to prepare student nurses to be capable of providing culturally congruent nursing care practices. In New Zealand (NZ), the Nursing Council, as the regulatory authority, is required by law to set standards of cultural competence that must be demonstrated by nurses before gaining registration. In alignment with this, the NZ Nursing Council has developed a model for the teaching of cultural safety and Maori health, including details of the Treaty of Waitangi, in nursing programs (Nursing Council of New Zealand, 2011). The Nursing and Midwifery Board of Australia has developed specific competency standards in this area. Nurses must consider the spiritual, cultural, familial and language needs of their clients when developing care plans so as to attain as positive an outcome as possible for the patient (Nursing and Midwifery Board of Australia, 2016).

Aligned with this, the Australian Nursing and Midwifery Accreditation Council (ANMAC) standards require universities to provide opportunities for development of cultural respect and safety (ANMAC, 2019). To assist with incorporating cultural competence into curriculums in America, the American Association of Colleges of

Nursing has created an educational framework, which includes a toolkit of appropriate learning strategies. One of their recommendations is a cultural immersion experience, including immersion in diverse communities, however this recommendation has not been updated in some time (American Association of the College of Nursing, 2008).

1.6 Cultural Competence in Nursing Education

Australian universities are expected to incorporate cultural competence into their nursing undergraduate curriculums (Nursing and Midwifery Board of Australia, 2016). A number of methods are currently in use including written assignments, simulated nurse-patient scenarios in controlled settings, community engagement or service learning experiences (Witt, 2016). In addition, nurse educators plan and implement international clinical placements as one method to develop cultural competence in nursing students using direct cultural encounters (Browne, Fetherston, & Medigovich, 2015; Kohlbry, 2016; Kokko, 2011; Long, 2014; Reid-Searl, Dwyer, Moxham, Happell, & Sander, 2011).

In order for nursing students to develop a clear awareness and understanding of global health disparities and diverse cultural views on health, educators are moving beyond traditional teaching methods and developing direct international clinical experiences. Traditional lectures and textbooks are no longer adequate teaching methods for the degree of cultural competence and global understanding required in multicultural migrant-driven nations (Caldwell & Purtzer, 2014; Long, 2016). Face-to-face experiences with other cultures may be an effective way to improve cultural competence, decrease health disparities and improve patient experiences and outcomes (Amerson, 2010; Zoucha, Mayle, & Colizza, 2011).

1.6.1 International clinical placements

International clinical placements provide an opportunity for students to step outside their own ethnocentric beliefs and develop a more global perspective of their role (Ballestas & Roller, 2013; Browne et al., 2015; Edmonds, 2012). Being immersed in a culturally diverse environment enhances the development of true cultural awareness in ways that formal education cannot provide (Charles et al., 2014). Care

must be taken however, to balance the learning needs of the students with the rights of the host patients to receive culturally appropriate care. While participating in international clinical placements, students must reflect upon their own biases and how these may impact on the care they are providing in other countries (Levi, 2009).

The planning and conducting of international clinical placements is time consuming and resource intensive. University schools of nursing may not receive additional funding to support the financial and staffing requirements around these placements and nursing schools thus may bear the financial burden themselves. Faculty staff are generally released to accompany students, at considerable financial cost to a school. However, schools of nursing value the opportunities that international clinical placements provide to students to develop specific graduate attributes such as recognising and applying international perspectives; thinking critically, creatively and reflectively; and communicating effectively (Curtin Learning and Teaching, 2017). These experiences are perceived to enhance personal and professional growth, provide opportunities for interprofessional experiences and serve to promote the school and its activities. Further, international clinical placements are seen to promote social responsibility and demonstrate a social commitment from the university to provide benefits to the global community. Universities are also mindful of the need to establish sustainable programs that are value-adding and capacity-building, leaving a positive legacy in the host countries (P. Roberts, personal interview, May 8, 2012).

The international clinical placements in this study were offered by participating universities as an alternative to community placements provided in Australia. They are designed to build cultural awareness, understanding of health systems and health priorities in the host countries, and teamwork and communication skills (Browne & Fetherston, 2018). This may be considered a greater priority than the development of clinical skills.

Although there is some recognised short-term benefit to students by participating in an international clinical placement (Browne et al., 2015), some studies have found that negative experiences can increase ethnocentrism and lead to judgemental attitudes (Harrowing, Gregory, O'Sullivan, Lee, & Doolittle, 2012; Hovland &

Johannessen, 2015). Furthermore, the sustainability of any perceived benefits in cultural competence over the longer term remains unknown (Adamshick & August-Brady, 2012). A detailed review of the literature in this area is presented in chapter 2.

1.7 Global Health Systems

Nursing education and policy needs to prepare nurses to understand the nature of global health, including health disparities and priorities. Participants in this study undertook placements in health care settings very different to Australia, where lack of accessibility and affordability of healthcare created barriers for some sections of the local population. Only a minority of low and middle income countries are able to provide universal health coverage (UHC), despite it being described by the World Health Organisation as “the single most powerful concept that public health has to offer” (Chan, 2012, para.51). Studies in resource-poor nations have shown that out-of-pocket payments for health care create a significant economic burden for the poor and disadvantaged in many parts of the world (Barennes, Frichittavong, Gripenberg, & Koffi, 2015; Masiye, Kaonga, & Kirigia, 2016). The health system context also influences nursing practices, and priorities used to decide the specific mix of programs, resources and strategies required to manage the burden of disease. These may differ substantially from the health system that Australian nursing students are trained in.

1.8 Health Disparities

International clinical placements **in nursing** are often undertaken in low and middle income countries such as Tanzania, Malawi, Cambodia and Thailand (Browne et al., 2015; Halcomb, Antoniou, Middleton, & Mackay, 2018). In these countries, students will witness the continued prevalence of communicable diseases, high infant and maternal mortality, and growing health disparities (Lee et al., 2015). Unlike the countries the nursing students come from, causes of mortality in the settings in this study still include HIV/AIDS, lower respiratory infections, tuberculosis, diarrhoea and malaria (Centers for Disease Control and Prevention, 2010; Lee et al., 2015; WHO, 2012). In addition to this, low and middle income countries are suffering the double burden of epidemiological transition. This occurs when improved food security and innovations in public health lead to an increase in NCDs such as

ischaemic heart disease, stroke and diabetes mellitus, more usually associated with higher income countries. When this occurs concurrently with the persistence of communicable diseases, there is an extra burden to resourcing these poor health systems (Abegunde, Mathers, Adam, Ortegón, & Strong, 2007; Lee et al., 2015; WHO., 2012). There is a need for students to know what drives health in settings different to their own.

The double burden of disease impacts on how resources are allocated, how the workforce is deployed, the clinical decisions made within those systems and the patient experience (Hipgrave, Alderman, Anderson, & Soto, 2014). Cultural views on health are informed by, and contribute to, health provision in those settings. International clinical placements may offer an opportunity for students to gain knowledge of different health systems and to witness the patient experience in the host countries. However, it is unclear whether students are more capable of providing culturally appropriate care through gaining knowledge of the health environments that migrants into Australia come from. Furthermore, the international clinical placement experience on students' career planning is not well understood.

1.9 Influences on Career Choices of Nursing Students

A body of knowledge has been developed on the career preferences and decision making of nursing students (Birks, Al-Motlaq, & Mills, 2010; Birks, Missen, Al-Motlaq, & Marino, 2014; Bloomfield, Gordon, Williams, & Aggar, 2015; Boyd-Turner, Bell, & Russell, 2016). However, very little literature exists on how international clinical placements in particular, influence these choices.

1.9.1 Specific career preferences of nursing students.

Whilst some students have specific ideas about future careers, many students prioritise keeping an open mind and gaining experience in a range of broad fields (McKenna & Brooks, 2018). However, in terms of preferred areas of practice there is a clear preference in the literature in first-year students for areas such as acute care of the adult and child, highly technical areas such as ICU, along with midwifery and general paediatrics. The least popular areas are aged care, community nursing and mental health (Birks et al., 2010; Birks et al., 2014; Happell, 2002; Kloster, Hoie, &

Skar, 2007; McCann et al., 2010; McKenna, McCall, & Wray, 2010). Similarly, primary health care is not popular with Australian nursing students (Bloomfield et al., 2015). Aged care and mental health have been shown to be unpopular both in Australia and overseas in first-year students, and this has not changed in some time (Happell & Gaskin, 2013; Haron, Levy, Albagli, Rotstein, & Riba, 2013; Hoekstra, van Meijel, & van der Hooft-Leemans, 2010).

In studies that explore changes in career preferences over time, although acute care remains popular, by third year the appeal of midwifery appears to reduce slightly (Happell, 2002; Kloster et al., 2007; McCann et al., 2010). Interestingly, McCann (2010) and Kloster et al (2007) found mental health or psychiatric nursing increased in popularity by third year, in contrast to Happell (2002). This was possibly due to students having direct contact with mental health patients earlier in their course in the McCann study (McCann et al., 2010). Aged care remained unpopular in all studies. Despite a thorough search of the literature, no specific research was found on the influence of international clinical placement experiences on career planning of nursing students. There is a distinct lack of studies exploring the influence of an international clinical placement experience on the career decisions made by students, post-graduation.

1.10 Theoretical Frameworks

1.10.1 The Process of Cultural Competence in the Delivery of Health Care Services

The theoretical framework for cultural competence used for this research study was Campinha-Bacote's *The Process of Cultural Competence in the Delivery of Health Care Services* model (Campinha-Bacote, 2007a). An alternative framework considered was the Cultural Competence and Confidence model (CCC) by Jeffreys (2012). The CCC model also comes with an attendant questionnaire called the Transcultural Self-Efficacy Test. Both frameworks were developed specifically for health professionals. However, because the Campinha-Bacote model specifically measured cultural competence following *Cultural Encounters* it was decided that this would be the best fit to evaluate the international clinical placements which were based on direct cultural encounters.

The Process of Cultural Competence in the Delivery of Health Care Services model consists of five constructs: cultural desire, cultural encounters, cultural skill, cultural knowledge and cultural awareness. Campinha-Bacote argues it is important to include all five constructs in one's nursing practice for the most effective transcultural nursing care, and to maximise patient outcomes and experiences.

Campinha-Bacote's framework has been used in many nursing studies; for example, to evaluate the effectiveness of cultural competence education in nursing pre-registration programmes (Field & Bell, 2012; Messler, 2014; Noble, Nuszen, Rom, & Noble, 2014); evaluating the cultural competence of nursing faculty (Caboral-Stevens, Rosario-Sim, & Lovence, 2018; Wilson, Sanner, & McCallister, 2010); and evaluating cultural competence in clinical practice (Bjelica & Nauser, 2018; de Beer & Chipps, 2014).

The questionnaire developed from this model was used for quantitative data collection. The questionnaire used is the *Inventory for Assessing the Process of Cultural Competence – Revised* (Campinha-Bacote, 2007a). The constructs also guided the development of the qualitative interview guide, along with recommendations from literature.

Constructs of the Model

Campinha-Bacote's (Campinha-Bacote, 2002, 2007a) five constructs are defined as follows:

1. **Cultural awareness:** Awareness begins with looking inwardly at one's own cultural belief and values and how these may impact on practice. This includes an examination of unconsciously-held stereotypes. From this process one may develop awareness and sensitivity to the cultural beliefs and practices of others.
2. **Cultural knowledge:** Knowledge involves the deliberate seeking and acquisition of information on the worldviews and health practices of other cultures. This includes acknowledging the variations and diversity within cultures.
3. **Cultural skill:** Skill involves the confidence and ability to ask relevant questions of clients to determine cultural needs during assessment and

treatment processes.

4. **Cultural encounters:** Encounters involve direct engagement with clients and family members of diverse cultural groups. In the international clinical placement context this is the primary goal. Through direct encounters the other constructs of the model can be developed and applied.
5. **Cultural desire:** The model describes this construct as the foundation upon which all the other constructs are built. Without a desire to become culturally competent there is little chance of progress. Desire involves the motivation to care for clients of diverse background in a way that is respectful, and promotes dignity and justice.

Assumptions of the Model

The following assumptions inform the framework of Campinha-Bacote:

1. Cultural competence is an organic process with no definable end point. One's cultural competence is under continuous development and is something that increases rather than is 'achieved'.
2. Cultural competence consists of five interrelated constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.
3. Culture is not homogenous. There is more variation within ethnic groups than across ethnic groups.
4. Effective and culturally sensitive care to diverse clients is only possible when cultural competence is present (Campinha-Bacote, 2002, 2007a, 2011).

1.10.2. Nursing Career Development Framework

In exploring the influence of the international placement on career planning and development, the constructs of the *Nursing Career Development Framework* (Hickey et al., 2012) was used (Figure 1.1). This framework is developed from Bronfenbrenner's Sociological Theory of Development, which describes a set of interrelated systems of influence on development. They are: *the person, the context, the process* and *time* (Bronfenbrenner, 1992). The *Nursing Career Development Framework* begins with the influence of personal characteristics such as motivation, age and gender. It then depicts the influence of the context within which nursing students make their career decisions, broken into multiple environmental systems.

These include family expectations and commitments (micro/meso level), industry requirements and clinical experiences (exo level) and the broader, systemic and global influences (macro level). The continuous interaction process between each of these systems informs development, in this case the development of career planning. Time also influences career planning as nurses' priorities and objectives alter with age and as health systems change.

Chrono: Plans change over time

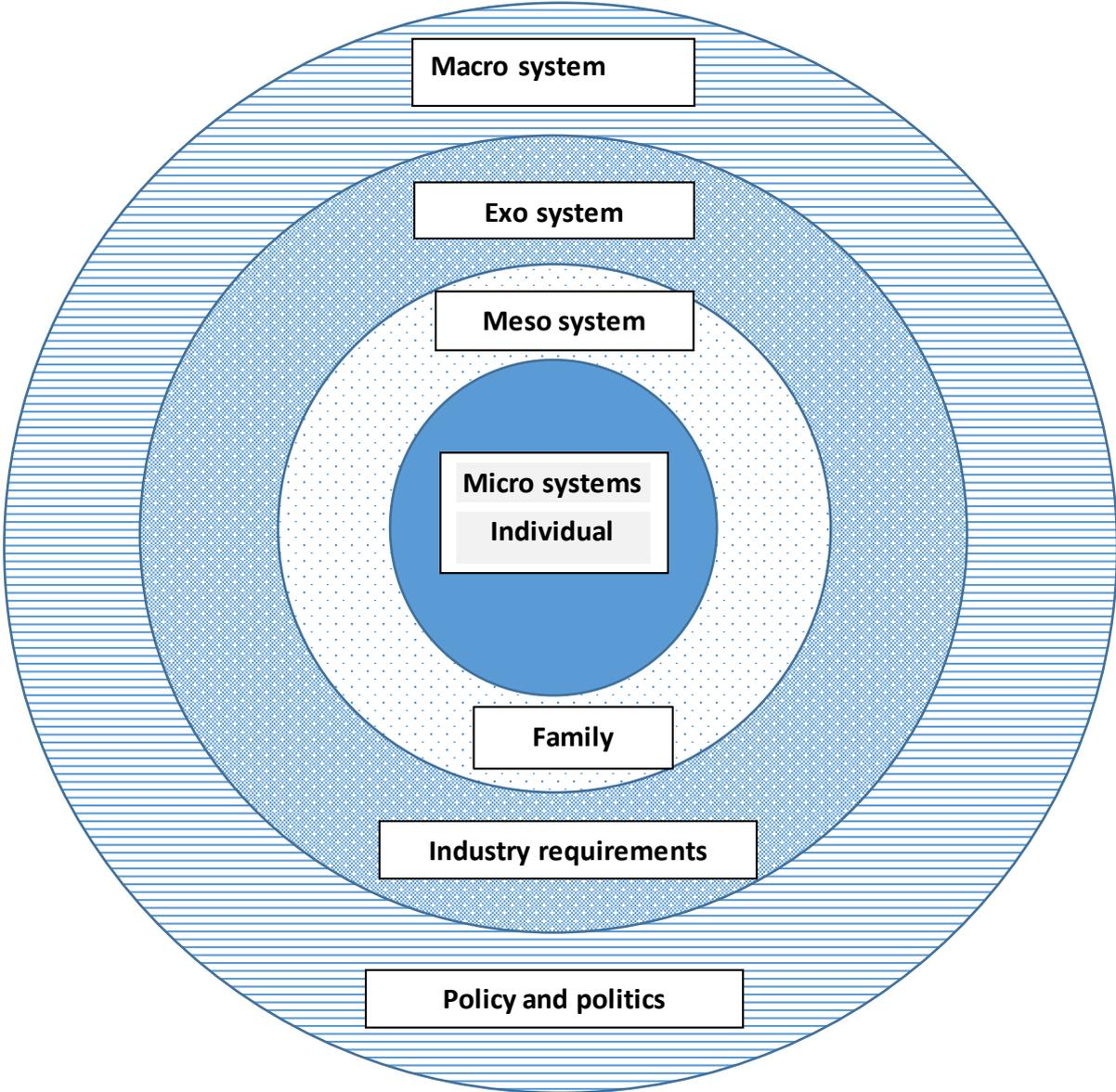


Figure 1.1 Nursing Career Development Framework (Hickey et al., 2012)

The frameworks that underpin this study will address the research question of the longer-term influence of participation in an international clinical placement on students' cultural competence and career planning. The frameworks will guide the structure of the study, frame the analysis, add rigour to and organise the findings, and address the gap in knowledge.

1.11 The Research Questions and Objectives of the Study

This study aims to explore the impact on cultural competence development of nursing students who participated in an undergraduate international clinical placement experience and to determine if there is an influence on career planning.

1.11.1 Research Question

This study was designed to answer the following research questions:

1. What is the influence of participation in an international clinical placement as part of an undergraduate nursing program on the cultural competence of nursing students?
2. What is the influence of participation in an international clinical placement as part of an undergraduate nursing program on the career planning of nursing students?

1.11.2 Research Objectives

The following objectives guided the study:

1. To explore the initial impact of participation in an international clinical placement on students' cultural competence.
2. To explore the maintenance of cultural competence 12 months after an international clinical placement.
3. To determine the impact of the international clinical placement experience on individual career planning 12 months after the experience.
4. To explore the influence of an international clinical placement on students' desire to work with culturally diverse populations, including returning to developing countries as registered nurses.
5. To explore the relationship between the country and setting of the international clinical placement, and students' cultural competence and career planning.

1.12 Significance of the Study

This study will address the gap in the literature on the continuing influence of participating in an international clinical placement on the career planning of nursing students. It will explore whether international placement experiences impact on

students' willingness to return to developing countries to work in humanitarian or other contexts. The particular influence of a country and placement setting on students' career planning may be useful to universities in determining settings with the strongest influence. It will enhance understanding of the value to universities in making international clinical placements an option for Australian pre-registration nursing students, and of the effect on students' preparedness to work with culturally diverse people in developing countries, or within Australia.

It is important to have an understanding of the sustainability of the benefits ascribed to international clinical placements in order to determine their educational value to students, given the costs and risks involved for universities. The findings will assist nurse educators to plan specific placement activities that enhance the development of cultural competence in a structured and supported way. The study will also assist educators to encourage students to consider their future career planning in the context of the international clinical placement and assess the application of the skills they develop, both personal and professional.

1.13 Positionality Statement

It is important that qualitative researchers recognise the impact they may have on each stage of a study, including outcomes (Malterud, 2001). A researcher should situate themselves within the research, and acknowledge their experience and approach to knowledge construction. The following account aims to position the present Researcher and assist readers in interpreting the study's outcomes.

The Researcher is an Anglo-Saxon Australian female who first became interested in cultural competence during her undergraduate years when she majored in Japanese and history as part of a Bachelor of Arts undergraduate degree. The Researcher's extended immersion experience (in an educational setting) as a young adult in Japan was very formative as the Researcher consolidated her understanding of the language and culture and underwent considerable adjustments in both personal resilience and global perspective. This taught the Researcher humility and respect for difference in addition to shaping the Researcher's view of cultural competence, which is in line with the theoretical framework used in this study.

In Japan the Researcher was involved in developing and facilitating student exchange experiences and understands the complexities of that undertaking. Postgraduate studies in education led to the Researcher having 10 years teaching experience at both the secondary and tertiary level in health sciences, and becoming familiar with the role of international exchanges and clinical placements in education.

The Researcher's interest in research was fuelled by personal experiences with the health system, leading to her pursuing further tertiary qualifications in health management. The Researcher has worked in health research since 2008, with a focus on women's experiences of maternity care, cultural competence of nursing students (Michael et al., 2011), and evaluation of Australian government-funded health educational interventions in Tanzania (Gower, van den Akker, Jones, Earnest, & Duggan, 2016). These experiences led to an interest in the longer-term impact of the international clinical placement experience on nursing students' cultural competence and careers. Furthermore, the Researcher's experience in health management and policy gives her an understanding of the context that Australian nursing students are working in upon graduation. The Researcher is not a registered health professional, which allows her to remain separate from the nursing 'identity' and able to listen objectively to participants' experiences.

The Researcher broadly believes that immersion in a culturally diverse community enhances cultural awareness and competence. However, having read the reflective journals of nursing students on previous international clinical placements to Tanzania, the Researcher became aware that certain experiences had been confronting for participants, and may have impacted on their reactions to the host culture. Other areas of research work have included Australian-based studies of refugee students' experiences of education (Fagan et al., 2018), and settlement issues facing refugee women (Dantas, Lumbus, & Gower, 2018). These projects have given the Researcher an interest in the provision of culturally appropriate health care to these populations.

The above-mentioned projects were mostly qualitative in nature, sometimes participatory, with a focus on individual semi-structured interviews to capture the

nuances and deep perspectives of participants. The Researcher is inclined to the constructivist paradigm, discussed further in chapter 3. The Researcher did not have any connection to the participants in an educational role. The Researcher was not involved in lecturing or tutoring the participants in this study. Since commencing this study, the Researcher has delivered lectures in *Health in Cultural Contexts* and *Refugee and Migrant Health* at both undergraduate and postgraduate levels. However, the participants in this study were not part of the Researcher's student cohort.

1.14 Organisation of the Thesis.

In this chapter, the global context within which this study sits was introduced, including the rise of globalisation, the interconnectedness between nations, and global health disparities. The importance of providing culturally competent care was highlighted, and a model that can be used to guide the development of this competence in health professionals was outlined. Career planning in nursing students was introduced, including some of the salient influences on students' decision making in this area. Finally, the purpose and objectives of this study were presented.

Chapter 2. Literature Review. A more in-depth review of the literature on the influences of participation in an international clinical placement on students' cultural competence and career planning is provided. The earlier sections present an examination of the outcomes of participation in international clinical placements on nursing students' short- and long-term cultural competence, personal growth and professional development. The latter section discusses the dearth of literature on the influence of international clinical placements on career planning.

Chapter 3. Methodology. In this chapter the epistemology guiding the study is outlined and the longitudinal multiphase convergent parallel mixed methods design is introduced. The aims and objectives of the study are presented. The recruitment and sample strategies are described, along with a description of the international clinical placement settings and organisation. The data collection phases are explained and the quantitative and qualitative data collection tools are outlined. The quantitative and qualitative data analysis methods are explained. Ethical

considerations are then outlined. To conclude, the rigour for the study is demonstrated for both quantitative and qualitative components.

Chapter 4. Findings: Cultural Competence. This chapter is divided into three parts. Part 1 details the findings of the preplacement interviews. It presents the expectations and perceptions of nursing students participating in an international clinical placements regarding cultural competence. Article one (Appendix A), builds on the findings in this section.

Part 2 presents the quantitative data pertaining to the transitions in participants' cultural competence from phase one to phase two. The changes in cultural competence immediately postplacement are highlighted, and the maintenance of those scores over time are discussed, with a particular focus on the separate constructs of the Campinha-Bacote model. This section provides a connection in the data between phases one and two. The section is presented as a published manuscript in a peer-reviewed journal.

Part 3 presents the findings from analysis of the data collected in phase two, 12 months after return from placement. The findings presented in this section are qualitative in nature and detail the shift in global perspective, self-awareness and cultural competence that occurred in the participants. Article three (Appendix B) builds on the findings in this section.

Chapter 5. Findings: Career Planning. This chapter is divided into two parts. Part 1 presents a comprehensive outline of participants' preplacement motivations regarding career planning and their expectations of the impact of the placement experience on their global perspective.

Part 2 presents a comprehensive exploration of participants' perceptions of the enduring influence of the placement on their career planning over 12 months. Article three (Appendix B) demonstrates the interconnections between the international placement experience and participants' global perspective, and the subsequent influence on career planning.

Chapter 6. Discussion (including recommendations and limitations). This chapter brings together the qualitative and quantitative data as it pertains to the development of cultural competence and career planning of the students. The section outlines the alignment of the qualitative and quantitative data, and presents a holistic and integrated interpretation embedded within extant literature of how the potentially transformative experience of international clinical placement manifests in professional and personal cultural competence and growth. The influence of the placement on the career intentions and planning of the students is explained using the Nursing Career Development Framework (Hickey et al., 2012), and integrated with the cultural competence model to highlight how immersion in a culturally distant and diverse environment influences students' thoughts on career pathways and preferences. Recommendations are made.

1.15 Conclusion

Previous studies on student participation in international clinical placements have provided some evidence as to the enduring influence on personal and professional growth. However, information on how international clinical placements have influenced the career planning of students, and specifically their desire to pursue careers in caring for culturally diverse populations following international clinical placements, has not been studied. Further, there is a paucity of Australian studies on the topic, with most research to date coming out of North America or Scandinavia. Recommendations from previous studies have included using placements over multiple countries (Amerson, 2009) and an exploration of the enduring impact on cultural competence over time (Ballestas & Roller, 2013). These recommendations have influenced the objectives of this study. This study explores the enduring influence of participation in an international clinical placement on students' cultural competence and career planning, including their desire to engage in providing nursing care with culturally diverse communities, either in their own country or overseas.

2. Literature Review

2.1 Introduction

This literature review evaluated empirical and theoretical published articles on the development of cultural competence of nursing students following international clinical placements, and explored the impact of those placements on career planning. The review attempts to understand the evidence pertaining to the personal and professional outcomes experienced by nursing students following international clinical placement, with a focus on personal transformation, cultural competence, and professional skills. Additionally, it explores the influences on nursing students' career intentions and planning. This chapter links with and expands on the literature review presented in chapter 1 which was used to frame the research problem.

An abundance of literature was found on the personal, cultural and professional growth experienced by students following international clinical placement. However, there were very few studies exploring the direct influence of international clinical placements on students' career planning. Further, no studies combined the influence of international clinical placements on both cultural competence and career planning, which is the focus of this study. As such, this review is separated into two sections: the first section reviews the literature on the development of cultural competence and, personal and professional growth following participation in an international placement. The second section reviews the scant literature available on how international clinical placements impact on career development.

2.2 Search Strategy

This review examined literature reporting a range of methodologies and research traditions including experimental, non-experimental, empirical and theoretical (Whittemore & Knafelz, 2005). There is considerable variation between studies in international placement designs, content, assessment of student outcomes, destination country and length. Furthermore, there is variation in the terms used to describe outcomes for students, be they clinical, personal, cultural or professional. For example, 'cultural competence' is slightly different conceptually to 'cultural self-efficacy', as is described later in this chapter. This makes it difficult to compare

outcomes of studies in a consistent manner.

Relevant articles were identified via a computer-assisted Boolean search using “AND” and the keywords ‘international clinical placement’, ‘nursing’, ‘nursing students’, ‘cultural competence’, ‘career planning’ and ‘career intentions’. The search term *cultural competence* generated a large number of irrelevant articles. For example, articles focusing on the experiences of international students from non-English speaking backgrounds at American or Australian universities. As such, it was subsequently decided to modify the search strategy to include only articles that contained the term *cultural competence* in the abstract. In addition, differences in educational terminology for *international clinical placement* between countries were identified, with the result that new searches were conducted using the terms *study abroad* and *international service learning*.

When large numbers of articles were identified as discussing cultural competence in universities’ nursing curriculums, a new Boolean search was undertaken using “NOT” curriculum (in the title). Five electronic databases were searched for peer-reviewed articles with no date limitations, namely ProQuest, CINAHL, PubMed, Ovid and Scopus. Searching was terminated after five databases as there were many duplicates, and no new relevant literature was found.

2.2.1 Inclusion and Exclusion Criteria

Articles considered for this review included peer-reviewed empirical and theoretical research articles, theses and dissertations. Only articles written in English were reviewed. Articles were included if participants were nursing students, of both English and non-English speaking background, who undertook short-term international clinical placements in developed or developing countries. Studies with interdisciplinary groups of students were also included, but only the findings pertaining to nursing students were reviewed.

Articles were excluded if participants were not nursing students or if they studied overseas in semester-long programs. Articles were also excluded if the studies discussed the planning and development of international placements, transcultural nursing placements in domestic contexts, methods used in teaching cultural

competence, or the cultural competence of university staff. Newspaper articles were excluded. After excluding irrelevant studies, the final number of studies for inclusion was 57.

A conceptual map was created to identify common themes and variables, and relationships between themes were highlighted using a constant comparison and iterative technique (Holloway & Wheeler, 2010). The themes identified in the conceptual map became the sub-headings of the literature review.

2.3. International Clinical Placements

2.3.1 Models of international placement

International nursing clinical placements are used by universities to teach the social determinants of health, build cultural competence and expand students' global knowledge (Browne et al., 2015; de Ruiter, 2016). A number of approaches to developing clinical placement experiences are based on a variety of broad principles that are applied in various combinations and that result in different placement models (de Ruiter, 2016). One common international placement model is that of a 'missions focus', where students are placed in a resource-scarce community and undertake projects to build capacity and help the community achieve specified local goals such as the building of classrooms or refurbishment of medical clinics (Kohlbray, 2016).

This is also termed service learning (Kohlbray & Daugherty, 2013; Long, 2014) and differs from placement models that are more clinical in focus. The emphasis in clinical placement models is on students' exposure to clinical experiences, with direct involvement in patient care (Kohlbray & Daugherty, 2013). Where such placements occur in a host country that is less economically developed than the source country, they are sometimes referred to as *educational health tourism* (de Ruiter, 2016; Pinto & Upshur, 2009). Some authors have expressed concern about such placements lacking attention to local needs, with the focus being on sourcing unique clinical experiences for students (Levi, 2009; Pinto & Upshur, 2009). Despite these concerns, there are some recognised benefits to the local community in the form of additional staff, and to students who gain practical and clinical experience (de Ruiter, 2016).

Clinical placement experiences also often include service learning projects (Levine, 2009; Main, Garrett-Wright, & Kerby, 2013). The most preferred model is that of a partnership, where “participants from both countries consider each other as equals while respecting the fact that there are differences” (de Ruiter, 2016, p.254). This model aims to use collaboration between students from both the source and host countries to reach mutually created goals, and minimise any potential sense of superiority from the source country (Bosworth et al., 2006; de Ruiter, 2016).

In all of these models there may or may not be an element of cultural immersion, where students are welcomed into the homes of local community members, and develop cultural knowledge through direct encounters in the domestic, spiritual and social life of the community (Harrowing et al., 2012). However, with the rise of the internet and social media it has been noted that it is virtually impossible now for students to immerse themselves in a foreign culture to the extent where they are completely removed from their home environment. Contact with family and their own culture is nearly always at hand, which limits the full immersion experience (de Ruiter, 2016).

2.3.2 Duration and content

Earlier studies advocated for long placements of several months (Kauffman, Martin, Weaver, & Weaver, 1992; Koskinen, 2003), and stronger gains in cultural competence and personal growth have been found in longer placements (Zorn, 1996). However, given the financial and practical limitations of remaining in a host country for long periods, shorter programs have been developed, often covering just a few weeks (Kelleher, 2013; Murray, 2015; Ulvund & Mordal, 2017).

A variety of learning activities may occur during an international clinical placement. These have included: clinical nursing experiences in metropolitan hospital settings (Evanson & Zust, 2006; Hovland & Johannessen, 2015; Murray, 2015; Ulvund & Mordal, 2017), collaboration with local nursing students on health projects (Caldwell & Purtzer, 2014; Carpenter & Garcia, 2012; Sloand, Bower, & Groves, 2008); service learning community development projects (Main et al., 2013; Murray, 2015), visiting rural community clinics and working with local health staff (Adamshick &

August-Brady, 2012; Levine, 2009), study tours that include lectures and excursions for students to visit cultural centres and hospitals to speak with staff (Edmonds, 2010), and cultural immersion including home stays (Levine, 2009; Sloan et al., 2008). Caldwell and Purtzer (2014) suggest transformational learning is most likely to be achieved when there is a combination of clinical opportunities, thorough preparation of students prior to departure and long-term partnerships with the host community that teach students the importance of both sustainability and ethical responsibility.

Supervision of students is usually undertaken by university staff who accompany students to the destination country, although their experience with health systems in the host countries is sometimes unclear in the literature and may be limited (Caldwell & Purtzer, 2014; Harrowing et al., 2012; Murray, 2015). In addition, local registered nurse supervisors may also be used to assist students (Mkandawire-Vallmu & Doering, 2012; Ulvund & Mordal, 2017). The staff may be closely involved in the design and delivery of the clinical placement program (Harrowing et al., 2012; Levine, 2009; Main et al., 2013) or may use external organisations to assist with planning and coordination (Reid-Searl et al., 2011; Tuckett & Crompton, 2014). Students' ability to incorporate their placement experiences into an integrated learning outcome and into their practice has been linked to the quality of supervision (Kokko, 2011; Ulvund & Mordal, 2017). Where supervisors were able to explain differences and mitigate negative views, students were more likely to make the necessary shifts in cultural competence (Ulvund & Mordal, 2017).

Clearly identifying the cultural outcomes of international clinical placements can be problematic due to the variety of terms that are sometimes used interchangeably with 'cultural competence' in the literature. These include cultural self-efficacy: confidence in one's own ability to care for CALD patients (Long, 2014; St Clair & McHenry, 1999); and cultural sensitivity: interpersonal skills, empathy, patience (Papadopoulos, 2006); and humility (Caldwell & Purtzer, 2014). Cultural sensitivity is described as an awareness that people in other countries are 'just like me' with the same needs and aspirations and a realisation that prejudice and discrimination are borne of ignorance (Caldwell & Purtzer, 2014).

The literature review below reveals that some positive gains have been found from the shorter placements, but that further studies are needed to provide more evidence to make decisions about the value of international placements on cultural competence and longer term career planning.

2.4 Short-term Impacts of International Clinical Placements

The majority of studies looking at the short-term impacts of participation in an international clinical placement utilised a qualitative approach. Apart from two studies, sample sizes were generally small reflecting the limited numbers of students undertaking international clinical placements at any given time. All samples were of adult nursing students, mostly Caucasian and predominantly female. This demographic dominance is noted by Edmonds (2012) who calls for further research exploring the experience of students from more diverse backgrounds.

The destination countries for the placements reviewed in the literature were in Africa (Ethiopia, Swaziland, Botswana, South Africa, Tanzania, Malawi, Ghana), Asia (Cambodia, Vietnam) and in Central America (Mexico, Guatemala, Honduras, Haiti, various Caribbean islands). Studies usually reported findings from placements in only one country, making it difficult to assess any differences in how context and setting influence outcomes. Placement duration ranged from 1 day to 12 weeks. The difficulties in synthesising and comparing findings between studies is highlighted in a systematic thematic synthesis of the literature on international clinical placements for Australian nursing students (Browne et al., 2015). Browne et al. reviewed placements undertaken in both developing (Thailand, Nepal, Tanzania, Cambodia, India) and developed countries (England and Northern Ireland), and the studies used a variety of data collection techniques across different time points, and with small sample sizes.

There were geographical, economic, political and social differences between host countries that also influenced the students' experiences and hindered comparison. In the Browne et al., (2015) review the authors focused only on studies that explored international clinical placements for Australian students. As there are relatively few studies identified that focus on Australian students, this present chapter includes

studies from other countries that send nursing students on international placements, such as the US and Norway. In reviewing the findings of the studies, a number of themes were revealed. These are discussed in more detail below.

2.4.1 Cultural competence

Cultural competence is a recognised outcome of short-term international clinical placements and has been described using both qualitative and quantitative methodologies. It involves adapting behaviours, attitudes and care in a way that recognises cultural differences and health-related beliefs in a non-judgemental manner (Capell, 2008; Dudas, 2012). Whilst many scholars in the nursing profession accept that cultural competence is a meaningful construct in health care, it is suggested by Beach et al. (2005) that the degree to which this construct is distinct from established constructs, such as racism or interpersonal skills, has yet to be established.

According to Campinha-Bacote's model (discussed in chapter 1), cultural competence is a combination of developments in five constructs – cultural encounters, cultural knowledge, cultural awareness, cultural skill and cultural desire. Cultural encounters with diverse groups enable health practitioners to step outside their own cultural values and challenge their stereotypes and previously held beliefs (Campinha-Bacote, 2007a). This constitutes development of cultural awareness, both of students' own cultures, as well as those in the host culture.

Improvements in cultural competence have been identified in a number of qualitative studies. It was common for students to experience what it is like to be a minority and have a different appearance, often for the first time in their lives (Sloand et al., 2008; Ulvund & Mordal, 2017). They became aware they were unique, different, outside their normal life parameters and had to experience life under difficult circumstances (Levine, 2009). The placements gave them appreciation for and awareness of the experiences of minority groups in their home countries (Halcomb et al., 2018; Sloand et al., 2008).

Some qualitative studies have reported that meaningful cultural encounters enabled students to move beyond their initial stereotypical view and come to understand that

variations exist both within the host culture and within their own (Caldwell & Purtzer, 2014; Main et al., 2013; Ulvund & Mordal, 2017). Students were able to recognise previously held biases and to recognise the impact of stereotyping on their own practice and that of their colleagues (Edmonds, 2010; Ulvund & Mordal, 2017).

There were also developments in students' self-awareness, an important part of cultural competence (Caldwell & Purtzer, 2014; Main et al., 2013), which resulted in an ability to understand how their own cultural influences impacted on their world view (Ulvund & Mordal, 2017). For example, students sometimes had different views to the host culture on the degree of involvement of families in health care decision making (Kokko, 2011; Murray, 2015). Students were sometimes exposed to cultures where families were informed of the patients' illnesses before the patient, a new dynamic for students that highlighted clear differences in health-related values between cultures (Ruddock & Turner, 2007; Torsvik & Hedlund, 2008).

Improved acceptance of different cultural views and practices was a common development following international placement (Kokko, 2011) This included the role of religion in health care practices and decision making (Davis et al., 2015), differences in communication styles (Edmonds, 2010) a slower pace of life (Koskinen, 2003) and differences in family roles, particularly in the provision of health care (Reid-Searl et al., 2011). Students expressed the importance of remaining open minded when working with diverse cultures (Halcomb et al., 2018) and noted that their experience had improved their tolerance and acceptance of others (Tuckett & Crompton, 2014).

Although there were common themes identified in the qualitative studies, there was variation in the timing of the postplacement interviews between the studies. In some studies, students were interviewed some months after return from placement (Adamshick & August-Brady, 2012; Ulvund & Mordal, 2017). As such, the authors suggest some of the initial culture shock may have dissipated. However, had students been interviewed immediately upon return the results may have been different. It may be important to understand immediate impressions to mitigate negative aspects of the experience. Understanding students' immediate views can assist educators with guiding students' cultural competence journey.

In contrast, one study collected data from students during their placement (Reid-Searl et al., 2011). Students had not had time to reflect on their experience in a supported way. In this study, participants were more focused on the group dynamics of their cohort than the cultural learning opportunities at hand (Reid-Searl et al., 2011). Another study reported similar findings to previous studies (Adamshick & August-Brady, 2012; Ulvund & Mordal, 2017) but did not identify the amount of time that had passed between the placement and the data collection (Murray, 2015), making it difficult to assess the influence of time on the outcomes. As such, further research is required to consolidate these themes.

The development of cultural knowledge, borne of direct cultural encounters, has also been measured in a small number of quantitative studies. There are a variety of tools that have been developed to measure changes in health professionals' competence following exposure to culturally diverse groups. One of these is the Transcultural Self-Efficacy Tool (TSET), which has 83 items that measure confidence on a 10 point rating scale, with 10 being 'totally confident'. The tool has three subscales: the *Cognitive* scale (25 items) measuring cultural knowledge; the *Practical* scale (28 items) measuring communication skills with diverse patients; and the *Affective* scale (30 items) assessing values, attitudes, beliefs and cultural awareness. Amerson (2010) used this tool to explore the experiences of nursing students from the US who were involved in service learning projects during one semester of their nursing undergraduate program.

Students were administered the TSET at the beginning and end of semester to measure changes in cultural self-efficacy. Results showed a significant increase in posttest scores in overall cultural self-efficacy and a particular increase in the cognitive subscale, which is closely linked with cultural knowledge. However, of the 69 students in the study only six had travelled internationally, namely to Guatemala for a one-week placement. The remaining students had stayed in the US and completed service learning projects in local communities. As such, they had not been exposed to the broadly different health system, language or sociopolitical values that were experienced by the students who travelled abroad for clinical placement.

Kohlbray (2016) is one of the few researchers to have quantitatively studied the cultural competence of students travelling to multiple countries. She used the Inventory for Assessing the Process of Cultural Competence (student version) (IAPCC-SV) to measure the cultural competence of 121 undergraduate nursing students from three Californian universities who travelled to a variety of countries including Mexico, Belize, Vietnam and Ghana, to undertake service learning activities with a health focus. The placements varied in length from 1 day to 3 weeks. Whilst significant gains were found in the constructs of cultural knowledge and cultural skill, there was no demonstrated increase in overall cultural competence, as scores remained the same. The majority of students were at the culturally competent level prior to the placement and remained at this level postplacement. This could possibly be explained by the short duration of some of the placements.

Ballestas and Roller (2013) also used the IAPCC-SV in a quantitative pre-post design to measure changes in cultural competence in 18 nursing students who travelled to Costa Rica on a community service academic activity for 6 days. Students performed health assessments for both adults and children at community health clinics, and visited the local hospital. Overall mean scores increased significantly postplacement with 13 students moving from being culturally aware to culturally competent. The same authors contacted the students 1 year following the placement and measured cultural competence in 15 of the original 18 students. Overall scores had not changed significantly in that time, however two students had moved from the culturally competent level to being culturally proficient (Roller & Ballestas, 2017). Although the study demonstrated that cultural competence had been sustained, participants had all travelled to the one destination country, Costa Rica, and were all from the same university, limiting generalisability. The authors noted the difficulties in comparing the development of cultural competence between placements due to the diversity in placement lengths, destinations and content.

However, not all studies have identified positive outcomes. Some studies raise concern at the negative reactions in some students following exposure to diverse cultures (Adamshick & August-Brady, 2012; Harrowing et al., 2012; Hovland & Johannessen, 2015). These reactions have included negative judgements regarding professional competence of host nursing staff, infection control and professional

communication (Johannessen, Hovland, & Steen, 2014; Murray, 2015; Sandin, Kronvall, & Kronvall, 2004). The authors consider this a demonstration of ethnocentrism, where students' own cultural values were seen as superior. For example, a large qualitative study by Hovland and Johannessen (2015) found only a minimal gain in cultural competence, including cultural awareness and knowledge. In this study, the reflective journals of 197 nursing students from Norway who had undertaken placement in Tanzania, Botswana and South Africa between 2003 and 2011 were analysed using content analysis. Placements had been between 8 and 12 weeks in duration, providing substantial opportunities for reflection. Analysis of the journals revealed that students had experienced strong emotional reactions to what they perceived as poor professional practice, discourteous communication, and low levels of compassion. They were openly critical and judgemental of the nursing care they witnessed and compared it unfavourably to the nursing care in Norway. Students did not attempt to associate the influence of poverty with the decisions and practices of the nursing staff.

Nor did they reflect on the possibility that values held dear by Norwegian culture – individual autonomy, confidentiality and efficiency – may not be considered as important in other cultures. In order to gain cultural competence, an individual must begin with an awareness of their own culture. This does not appear to have happened in this cohort of students. However, the authors note that restricting the study to textual analysis may have been a limitation and that using in-depth interviews or focus groups, or quantitative tools to measure cultural competence may have yielded different perspectives. Unfortunately, the reflective journals were not identified by country or year, making it hard to see how the different contexts influenced students' experience and if this changed over time.

The same sceptical conclusion was reached in a Canadian study of 14 nursing students who participated in a four-week nursing placement in Malawi as part of a semester-long health promotion unit (Harrowing et al., 2012). Narrative essays were collected from students at three time points in the semester and analysed for cultural understanding. The authors concluded that short-term international placements do expose students to different socioeconomic environments influenced by poverty and other structural factors, which leads to reflection and re-evaluation. However, the

authors suggested placement experiences do not make students experts in their cultural understanding of the lived experience of diverse groups. Even though benefits do exist from participation in international clinical placements, they may be to a lesser degree than reported in the literature. The variety in outcomes and interpretations in studies exploring cultural awareness, cultural knowledge and cultural competence indicates there is further work to do in this area.

2.4.2 Communication skills

A number of studies have shown that participation in international placements can lead to improved communication skills, also known as cultural skill. This has taken the form of increased verbal skill, as well as the development of nonverbal skills (Murray, 2015; Ulvund & Mordal, 2017). The important role played by facial expressions, hand gestures and smiling has been highlighted (Halcomb et al., 2018). Without the benefit of a common language, students need to think more deeply about what they are asking patients, and the treatments they are proposing, in order to communicate that in a clear way (Murray, 2015).

Students came to understand the importance of interpreters and how necessary they are to a positive patient experience (Ulvund & Mordal, 2017). They were also exposed to the challenges involved in working with them. This was highlighted in the study by Halcomb et al., (2018) where students worked with interpreters in community settings in Cambodia and nursing colleagues helped interpret in the hospital settings. Even though they had interpreters the students realised there was a limit to their deeper understanding of their conversations with patients.

However, there was inconsistency among studies regarding the provision of interpreters. In the study by Hovland and Johannessen (2015) interpreters did not appear to be available, or were insufficient in number, and students reported barriers to effective care and in being able to provide health education to patients. This impacted on their ability to improve communication and cultural skill. Similarly, Murray (2015) found there was a lack of interpreters and students reported feeling alienated from their Swaziland nursing colleagues who only spoke the native language. The opportunities to learn and to teach were hindered, as were opportunities to develop cultural and communication skills (Murray, 2015; Ulvund &

Mordal, 2017). Where language skills were limited, so was the interaction with local community members, which compromised the opportunity for the acquisition of cultural knowledge (Caldwell & Purtzer, 2014).

Where interpreters were not available, concerns were also raised about the potential ethical implications of having limited language. It was difficult for students to know whether their interventions were appropriate as they were not able to properly engage with patients (Caldwell & Purtzer, 2014). Furthermore, some patients were not comfortable receiving education or treatment advice in English, which was difficult for students who had no other way of communicating (Murray, 2015).

The importance of pre-trip language preparation was highlighted with calls for greater emphasis on this skill (Caldwell & Purtzer, 2014). The preparation should include specific nursing and medical terms relevant to nursing practice (Murray, 2015). There was considerable variation between studies regarding the amount of language and cultural preparation undertaken by students prior to the placement. Preparation programs varied between 2 days (Hovland & Johannessen, 2015; Main et al., 2013), and two or three sessions (Halcomb et al., 2018, p.2; Murray, 2015). Some studies did not quantify the amount of preparation provided (Ulvund & Mordal, 2017). While some studies were clear in describing the content of preparation programs (Halcomb et al., 2018; Sloand et al., 2008) others did not mention it at all (Harrowing et al., 2012).

Some programs focused heavily on cultural or practical preparation (Caldwell & Purtzer, 2014; Murray, 2015; Sloand et al., 2008; Ulvund & Mordal, 2017) but had limited language preparation. A number of programs prioritised raising funds and gathering donations of medical supplies and equipment to take with them (Sloand et al., 2008; Ulvund & Mordal, 2017) which in itself might suggest a pre-conceived attitude that the nursing students were there to 'help' rather than 'learn.' Such inconsistency makes it difficult to separate the differences in preparation of the students from the differences in impact of the placements on cultural skill. It is therefore necessary for further exploration in this area to determine whether participation in international clinical placement enhances communication skills, and to assess the impact of communication skills on students' ability to engage in their

placement experience.

Despite differences in the language experiences of students between studies, upon return home most students reported a heightened appreciation of the experiences of CALD patients who do not speak English and how unsettling this would be for them. They described an enhanced understanding of the importance of communication and language when developing rapport with patients, and an ability to really listen to patients and ascertain their unique needs (Levine, 2009). Their confidence in their ability to ask relevant cultural questions of patients improved (Murray, 2015). Students demonstrated their development of cultural skill in recognising the importance of ‘letting them (patients) talk because they reveal so much’ (Main et al., 2013, p11).

2.4.3 Desire to improve patient experiences

Linked with students’ experience with communication challenges was a personal commitment postplacement in some students to improve healthcare for marginalised populations. Most studies reported students felt more compassion for the experiences of CALD patients with limited language skills and were committed to using more empathy in their nursing practice (Levine, 2009; Murray, 2015; Sloand et al., 2008; Ulvund & Mordal, 2017). A small number of studies revealed students’ commitment upon return from placement to improving the lives of others by planning to return to the host country for international aid work (Callister & Cox, 2006; Hovland & Johannessen, 2015). Other studies found that students wanted to improve health care for minority groups within their own communities (Davis et al., 2015). Students expressed interest in, and sometimes undertook, volunteering roles both at home and abroad following placement and identified ‘a calling’ (Main 2013, p.11).

In the very limited number of studies that explored students’ motivations and expectations prior to the international placement there was minimal discussion of the concept of improving care for CALD patients within communities and hospitals in the domestic setting (Burgess, Reimer Kirkham, & Astle, 2014; Reid-Searl et al., 2011). Only one Australian study discussed students’ pre-trip desire to help internationally, and for some students in that study their desire to complete a nursing degree was to enable them to work in international settings (Tuckett & Crompton,

2014). Further research is required to explore how students feel prior to international clinical placement experiences about improving care in their own communities, advocating for CALD patients, or engaging in international humanitarian work.

2.4.4 Enhanced global understandings and international perspective

Following an international placement students reported feeling part of a bigger whole (Caldwell & Purtzer, 2014; Main et al., 2013). They expressed a greater sense of place in society and in the world, and revealed a sense of being better able to be global citizens (Main et al., 2013; Zorn, 1996). They had a greater awareness of being part of a global community with a shared responsibility for social justice (Main et al., 2013). A number of studies revealed that students had developed awareness of how political systems and resource allocation impact on the quality of health systems and the social determinants of health (Caldwell & Purtzer, 2014; Murray, 2015). The impact of structural barriers such as poverty, poor roads, and lack of staff on the provision of health care was highlighted for students. They questioned the unequal allocation of resources between countries and the factors that determine relative wealth (Evanson & Zust, 2006). However, this differs from Hovland and Johannessen's (2015) findings in their large qualitative study that structural factors and cultural differences had not been considered by students in their critical judgements of the host countries' nursing practices.

2.4.5 Facing challenges leads to personal growth and self-awareness

Students experienced a degree of shock when they encountered the differences in resourcing, practices and conditions of the communities and health systems of developing host countries (Caldwell & Purtzer, 2014; Halcomb et al., 2018; Hovland & Johannessen, 2015; Ulvund & Mordal, 2017). They described resources as being 'rationed' (Murray, 2015, p.69) noting the minimal use of pain relief and basic dressings, and were challenged by the lack of diagnostic equipment (Evanson & Zust, 2006; Halcomb et al., 2018). Students were confronted by poor processes such as infection control and instrument sterilisation (Murray, 2015). At a broader systems level they were surprised by the lack of government-provided support systems such as child welfare departments for fostering orphaned or mistreated children (Hovland & Johannessen, 2015).

The levels of poverty experienced by the host communities was confronting to the students, who often felt helpless, and a sense of guilt (Murray, 2015; Ulvund & Mordal, 2017). Students tried to overcome the difficult nature of this experience by noting that the people seemed content and expressed their admiration for the strength of family connections, simplistic lifestyle, and low levels of materialism (Adamshick & August-Brady, 2012; Caldwell & Purtzer, 2014).

Students revealed strong emotional responses to some of their professional experiences. This was particularly the case for students on placements in Africa. Students were challenged by the differences in nursing practices and roles they encountered. Although they did not question the theoretical knowledge of the host nurses, they perceived their willingness or capacity to put it into practise to be lacking (Hovland & Johannessen, 2015). This may have included a lack of patient education, paternalistic care, and the subsequently necessary blind trust placed in the nursing staff by the patients (Murray, 2015; Small & Pretorius, 2010). One of the greatest challenges was the perceived lack of empathy and compassion shown by the nursing staff (Hovland & Johannessen, 2015; Murray, 2015; Small & Pretorius, 2010) whose practice was described by students in terms such as 'restricted' (Murray, 2015, p.570) or 'unprofessional' (Hovland & Johannessen, 2015, p.49). Nurse-patient communication styles were seen to be 'disrespectful' and not at all patient-centred.

Authors reported different explanations for how students managed these challenges. Whilst most believed students reflected on the confronting experiences and experienced personal growth (Sloand et al., 2008; Ulvund & Mordal, 2017), others cited examples where ethnocentrism was strengthened in these scenarios (Harrowing et al., 2012; Hovland & Johannessen, 2015). In facing these challenges, students may have experienced significant levels of personal growth. Levine (2009) described this as an enhanced ability to understand self, including one's own abilities, strengths, faults, and weaknesses. A full range of emotions were experienced by students such as sadness, anger, frustration, and helplessness related to the situations they encountered (Murray, 2015), but also happiness and satisfaction when they were able to attend to patient needs, no matter how small (Caldwell & Purtzer, 2014; Hovland

& Johannessen, 2015).

In some of the qualitative studies in this area, students used storytelling, and comparison and contrast with their own practice and nursing values, to evaluate the practices in the host country (Murray, 2015). In the study by Ulvund and Mordal (2017) students used processes of comparing and contrasting to manage the differences in values and beliefs they encountered and integrate them into a greater overall understanding. This technique was also used by students in a study by Murray (2015) but with less effect. In this study, six nursing students from the US travelled to Swaziland to undertake service learning projects, work in clinical settings in hospitals and run community health clinics, giving them a wide exposure to the health system of the country. Students were interviewed one month after their return, with the aim of exploring the personal and professional growth the students experienced. It was found that students had experienced personal hardships, emotional reactions and language difficulties. More significantly, they had experienced 'cultural dissonance' where their nursing values had been confronted by the nursing practices they witnessed in the hospital (Murray, 2015).

This extended to concern at the values they perceived to be demonstrated by the broader health system, which involved a lack of compassion. Students used storytelling, comparison and contrast of social issues, health care and nursing between the US and Swaziland to reframe their thinking, leading to personal growth. However, the findings indicated there were more negative outcomes for students than positive. The study did not report the duration of the placement, so it is difficult to gauge whether students had sufficient time to make the necessary personal adjustments in values and beliefs to truly incorporate their observations. The negative reports of the Swaziland health system given by the students could be attributed to the lack of opportunities for debrief noted in the article, but also, as the authors state, because interviews are 'inherently subjective' and the students' observations of the Swaziland nursing culture may not necessarily be interpreted as reality (Murray, 2015, p.571). The need to reflect in a structured way is very important to capture initial perspectives and ensure learning does occur in a guided manner (Alpers & Hanssen, 2014; Kohlbry, 2016; Kokko, 2011; Riner, 2011).

The comparing and contrasting approach appeared to help students to reflect on the emotions they were feeling and explain their sometimes unexpected negative reactions. Others displayed a sense of ethnocentrism, believing their own culture to be superior. They used this as a 'buffer' between their emotions and the scenes of poverty they were witnessing (Adamshick & August-Brady, 2012). Of interest in all these studies is the students' inability to use knowledge of cultural differences to explain differences in behaviour (Hovland & Johannessen, 2015).

The cultural and clinical encounters they experienced led to an assessment of students' personal and professional values. Values and beliefs were confronted as students moved from a position of ethnocentrism to one of embracing the cultures of other countries. This occurred in the interpretive phenomenological study by Adamshick and August-Brady (2012) which aimed to uncover the meaning of international clinical placement experiences in students on their return to university and subsequent clinical placements at home. Eight students participated in a placement in Honduras for 1 week, visiting remote villages to evaluate health needs and visiting one hospital and one clinic in an urban area. Students completed reflective journals during the placement and were interviewed in focus groups at 3 weeks and 4 months postplacement.

Whilst students demonstrated initial ethnocentric attitudes to the new environment, it emerged that reflection on their immersion experiences had resulted in inner conflict as they struggled to accept the impacts of poverty and perceived injustice. This led to a reconnection with the values that led them to nursing in the first place, to care for people in need (Adamshick & August-Brady, 2012) They looked beyond their own personal nursing values and to the value of the nursing role itself, wanting greater autonomy and control to care in alignment with their personal values and not according to the values of the US health system. They became more aware of the 'dichotomy' of living and working in an environment that is materially plentiful but missing what they considered to be true nursing values (Adamshick & August-Brady, 2012, p.195). As with most of the studies in this area, although the outcomes demonstrated significant personal growth and awareness, it is not possible to know whether this was maintained over time. As such, further exploration into the longer-term impacts of international clinical placements is warranted.

A common response to international clinical placements described in the qualitative literature is a heightened awareness of the privileges and conditions within which nursing care is provided in students' home countries (Adamshick & August-Brady, 2012). Students expressed a sense of gratitude for the health systems they work in and the opportunities for good health outcomes they provide (Caldwell & Purtzer, 2014; Hovland & Johannessen, 2015). They described a new perspective, seeing how people live in countries where living conditions are difficult (Caldwell & Purtzer, 2014; Evanson & Zust, 2006; Hovland & Johannessen, 2015) which leads to greater levels of compassion in students (Murray, 2015). Accompanying these feelings of gratitude and compassion is a corresponding sense of guilt in some students, who highlighted the wastage they see in their own countries (Evanson & Zust, 2006; Murray, 2015; Ulvund & Mordal, 2017). They challenged the relatively extravagant provision of care in their home country (Adamshick & August-Brady, 2012; Murray, 2015).

The positive outcomes reported in some studies were in contrast to those that reported more negative outcomes. In some studies students expressed concern that they had not been able to offer as much assistance as they would have liked, due to lack of resources, language skills, the overwhelming nature of the problems or their own status as student nurses (Murray, 2015; Ulvund & Mordal, 2017). Others expressed concern that their presence might in fact contribute to changes in the host culture, especially in areas where placements are undertaken several times a year. Students felt uncomfortable with this and questioned the value of the placement to the host communities (Caldwell & Purtzer, 2014) and whether they may have in fact caused harm, or at least done minimal good (Caldwell & Purtzer, 2014; Murray, 2015). Future studies on the long term impact on host communities were recommended (Caldwell & Purtzer, 2014).

Of interest is the important role played by the clinical supervisor. In the study by Adamshick (2012) where the experiences were managed well, or students were well-enough prepared, the disruption caused by the unsettling experiences was utilised and turned into a transformative experience. When students were not supported well, or not prepared well, that sense of superiority may have remained and the

opportunity to undergo transformative learning may have been lost. The study by Murray (2015) would indicate that students did not reach the point of transformation and were not able to reframe or integrate their experiences into their world view. As such, the potential of international clinical placements to be transformative experiences that result in changes in cultural awareness, cultural skills and personal attitudes requires further research, particularly in the longer term.

2.4.6 Impact on nursing practice

In addition to the afore-mentioned impact on communication skills and ability to engage with patients, students also reported increased confidence in their nursing skills (Main et al., 2013; Murray, 2015; Sloand et al., 2008). This included improved confidence in their basic assessment skills and ability to assess without diagnostic equipment (Halcomb et al., 2018). In an Australian study by Halcomb (2018) eight students travelled for 2 weeks to Cambodia where they practised in rural health settings providing primary care. Students were interviewed in person, and by telephone, within 6 weeks of returning from placement. Whilst initially confronted by the lack of resources and equipment, students reported developing an appreciation for holistic clinical assessment skills and, felt these skills would be useful on their return to practice in Australia.

Availability of time was also highlighted. Some students reported wanting more time to spend with patients to provide the holistic care they feel is the essential basis of nursing (Main et al., 2013). This included more autonomy and control over their care in order to appropriately respond to patients' cultural needs (Adamshick & August-Brady, 2012).

International clinical placements have also resulted in students having an enhanced understanding of interdisciplinary roles, particularly when the placement has included students from mixed disciplines. Students reported a greater ability to work in collaborative interdisciplinary teams where respect and understanding of each other's roles is needed (Sloand et al., 2008). Overall, the enhanced teamwork improved students' ability to problem solve in clinical and community settings both at home and abroad (Main et al., 2013). The challenges to their beliefs and values led to transformative learning in some cases, which in turn altered their perspectives on

their return home (Adamshick & August-Brady, 2012). However, whether these perspectives remain for the longer term are unclear (Murray, 2015) and further exploration is required in this area.

2.5 Long-term Impacts of International Clinical Placements

Whilst there is a plethora of studies undertaken immediately upon or soon after return from international placement, only a limited number of good quality quantitative and qualitative studies have explored the longer-term impacts of international placements. There are anecdotal accounts, and non-measurable predictions made about the long-term impacts of international experiences from short-term studies (Kelleher, 2013). One of the earliest quantitative studies exploring long-term impacts was conducted by Zorn, Ponick and Peck (1995) who used the Measure of Epistemological Reflection (MER) and found significant cognitive growth in US nursing students who had participated in an international placement. However, the placements had been longer than most — a whole semester — and in England, a country with arguably fewer cultural challenges for students than other host nations.

Zorn then developed and utilised the International Education Survey (IES). This 29-item tool consists of four constructs: students' international view; perspective of their professional nursing role; personal development; and intellectual development. Surveys were administered to students between 1 and 14 years following placements in England, Denmark, Scotland and Russia. Placements had ranged from 2 to 16 weeks, with stronger gains found following the longer placements. Gains were found in all areas, but particularly in personal development and global understandings. The impacts reduced over time, leading Zorn to recommend repeated opportunities for international placement throughout the working life of nurses (Zorn, 1996). Very similar findings were achieved by Dedee and Stewart (2003) who used the IES with 38 nursing students who had participated in two-week placements in France, Belgium and England.

Smith and Curry (2011) found higher gains in the professional nursing role construct compared to the previous studies, and stronger gains in the other constructs.

Placements were in Ecuador, which is a developing country of greater cultural distance and disparities in health outcomes than the European countries reported in the previous studies, which the authors suggest may account for the higher scores. Roller and Ballestas (2017) measured cultural competence immediately following and 1 year after return from placement in Costa Rica using the IAPCC-R and found the levels had been maintained over 12 months. However, this was just one destination from one university and the authors recommended further studies on varying destinations.

In a qualitative descriptive study by Caldwell and Purtzer (2014), 41 nursing students from the US travelled at separate times over 3 years to remote Honduras for a 10-day placement. This entailed service learning, working with community members to collaboratively identify specific local health needs and developing educational workshops to address those. Students completed written questionnaires one or more years postplacement, which were analysed using thematic analysis. The authors found that students recognised their preplacement tendency to stereotype people living in poverty and marginalised situations. They also recognised the importance of self-awareness and self-reflection and were able to replace some of their previously held beliefs with a new set of values that aligned with their international experience: that structural and political factors contributed greatly to a population's health. Their developing humility and sensitivity improved their ability to engage with people of a diverse background. However, one of the authors of the study was also a coordinator of the international placement, and it is possible that students gave socially desirable responses due to the author's involvement. Furthermore, this was not strictly a clinical placement, as the group was interdisciplinary and had a public health focus.

In a qualitative study with 10 nursing students, Levine (2009) found positive effects 3 to 13 years postplacement. The students had participated in placements of between 6 and 9 weeks in various developing countries across Central America, Southeast Asia and Eastern Europe. Students had worked in a variety of formal and informal settings including hospitals, community health centres, family homes and in public health. There had been opportunities to engage directly with the host culture by living with local families, engaging in domestic chores with them, eating the local food and joining in religious celebrations. Student interviews revealed development

of an ability to be caring, accepting, open and understanding in diverse contexts, and of valuing others. They also revealed a focus on social justice, and an ability to recognise racism and bias and act against it, had been sustained over time. These findings align with those of Caldwell and Purtzer (2014) who found that 12 months or longer after placement in Honduras students were still committed to making a difference in society, had volunteered or moved overseas to work on service projects, or had commenced postgraduate studies in order to be better prepared to facilitate change. Enhanced flexibility and creativity in nursing care was also found, which included an ability to be innovative with clients of different backgrounds with unique needs (Levine, 2009).

This differs from others who show that while characteristics such as a sense of social justice, a desire to advocate for others and to create change are developed following international placement, they are hard to maintain over time and students have difficulty finding ways to enact them. Ongoing feelings of guilt are experienced by students who feel they have inadequately created or sustained change (Evanson & Zust, 2006). Furthermore, in the Levine (2009) study the author was also the coordinator and supervisor of all the international placements, suggesting the possibility of bias in the overwhelmingly positive outcomes reported. Further studies are needed on the sustained impact of the influences of participation in international clinical placement on cultural competence, personal growth and nursing practice.

2.6 Cultural Safety

In recent years there has been an additional focus on the concept of cultural safety.

This concept lies between cultural awareness and the mastery level of cultural competence. In 2018 the Nursing and Midwifery Board of Australia integrated cultural safety into the Code of Conduct for Registered Nurses (Nursing and Midwifery Board of Australia, 2018) and it is also highlighted in the 2019 ANMAC standards (ANMAC, 2019).

Cultural safety differs from cultural competence in subtle yet important ways.

Typically, cultural competence is pursued at the individual practitioner level and

entails the development of knowledge and skills of both one's own culture but also the cultures of others. Cultural safety similarly requires that individuals examine their own realities, beliefs and values, and how these impact on care (DeSouza, 2008). However, it also requires an examination of historical, cultural and structural factors leading to power differences and inequalities in health care (Kirmayer, 2012). Cultural safety occurs when practitioners engage in self-reflection of their own privilege, beliefs and values, along with their relative power as the health practitioner. Cultural safety goes beyond developing a set of knowledge on cultural practices and beliefs of other cultures, and aims to redress power differentials through reflexive thinking (McGough, Wynaden, & Wright, 2018). Health inequities cannot be addressed without acknowledging the broader health system and social structures within which health care is provided (Curtis et al., 2019).

There is a burgeoning focus on enhancing cultural safety at institutional level where policies and procedures can be implemented that recognise power disparities and promote shared decision-making. Cultural safety is ultimately determined by those receiving the care, rather than those providing the care. It entails a process of decolonising, considering power relationships, and reflection on self-identity. There is a change of focus from the culture of the patient, to the culture of the practitioner and clinical environment (Curtis et al., 2019).

Narrow understandings of cultural competence infer that developing cultural knowledge alone is akin to providing cultural safety. This is insufficient and has a potentially limiting impact on health inequities. The model of cultural competence used in this study emphasises the importance of self-awareness through the construct of Cultural Awareness. As such, it offers a broader understanding than simply acquiring knowledge of other cultures. By also reflecting on power and privilege

and how these are distributed through the health system, cultural safety can also be realised (Berg et al., 2019; McGough et al., 2018).

2.7 Influence on Career Planning of Nursing Students

Some of the factors that influence career planning in nursing students include the influence of *domestic* clinical placements, the undergraduate course curriculum and geographical location of possible employment positions. However, there are few studies on the specific influence of participation in an *international* clinical placement on career planning of nursing students. Little is known about the long-term influence of exposure to a diverse cultural and nursing practice environment on career planning post-graduation.

One study explored semester-long study abroad experiences, and found these impacted positively on career self-efficacy (Farris, 2012). However, this is a different experience to a short-term clinical placement in a non-university setting. Another study found that prior to departure students expected the international clinical placement experience to enhance their employment prospects, as the unique personal and professional development opportunity would make them more attractive to employers (B. F. Green, Johansson, Rosser, Tengnah, & Segrott, 2008). However, this study was not followed up postplacement and a link with employability was not established.

The study by Halcomb et al. (2018) of eight Australian nursing students who visited Cambodia demonstrated that exposure to primary health care provision on placement had generated interest in pursuing a primary health career after graduation, or at least highlighted the importance of this role. However, 25% of the students in this study were still in the first year of their course, and a further 50% were still in the second year. As such, they had not been exposed to all areas of nursing and had limited practicum experience upon which to base their choices. Whilst this finding is encouraging, further work is needed to confirm the role international clinical placements can play in influencing nursing students to pursue primary health care roles.

In another qualitative study by Sloan et al., (2008), 24 undergraduate nursing students travelled from the US to three sites; St Vincent and the Grenadines, US Virgin Islands and Haiti. The placement was one week in duration and the focus was on public health. Students conducted health education sessions, home visits and community assessment. Although the aim of the study was to explore gains in cultural competence, the students also reported the experience had 'enhanced and/or cemented their interest in public health and international nursing and provided new considerations for a future professional role' (Sloan et al., 2008, p.37). Where they had intended to consolidate their skills in hospital settings prior to the placement, the option of public health had become a more appealing career choice. However, the placement duration of only one week was one of the shortest described in the literature. Furthermore, students completed the data collection questionnaire between one and seven days after returning from placement, giving them little time to reflect and consolidate their experience. It is not known whether these views were maintained over time.

Finally, an Australian study by Tuckett and Crompton (2014) of 39 undergraduate nursing students who travelled to Cambodia in three separate groups over a three-year period found students felt their experience had provided a platform for possible future international aid work, and given them insight into the requirements of work in community settings. The authors concluded that an international placement experience might provide options for future careers for students involved, but that further work is necessary. The authors called for future research to be conducted in this area (Tuckett & Crompton, 2014). However, the study aimed to broadly describe student experiences and did not have a specific focus on career planning. Studies looking specifically at the postplacement impact on students' career intentions or planning do not exist, and further work has been requested in this area (Halcomb et al., 2018; Kelleher, 2013).

2.8 Conclusion

This literature review has described the short-term and long-term impacts of participation in an international clinical placement on cultural competence, personal and professional growth and career planning of nursing students. Short-term impacts

of international clinical placements include the development of cultural awareness and cultural knowledge. Students are more able to challenge stereotypes and develop awareness of others' cultural health-related beliefs. The findings of studies using both qualitative and quantitative methods demonstrated improvements in cultural self-efficacy and in cultural competence. However, not all studies concluded that there are clear benefits from international clinical placements; indeed, some studies cited increases in ethnocentrism.

Despite the short-term personal benefits of participation in an international clinical placement for the nurses involved, doubts remain about the longer-term impacts. Even though some positive outcomes have been identified, it remains unclear as to whether those impacts can be sustained over time (Adamshick & August-Brady, 2012; Curtin, Martins, Schwartz-Barcott, DiMaria, & Soler Ogando, 2015). Methodological inconsistencies between studies made it difficult to form firm conclusions. Further research is needed that extends beyond the immediate postplacement period to explore how the development of cultural competence progresses over time (Ulvund & Mordal, 2017). In particular, the literature is extremely limited on the impact of placement experiences on nurses' career planning. While there is some evidence to show it may improve students' interest in primary health care, further exploration is required. Whether the development of cultural competence and global perspective contributes in any way to nursing students' career intentions and pathways remains unknown. Chapter 3 will outline the methodology used in this study to meet the research objectives in this study.

3. Methodology and Methods

3.1 Introduction

This chapter outlines the reasons behind the choice of methodology for a study of the influence of an international clinical placement on the cultural competence and career planning of undergraduate nursing students. The chapter begins with an outline of the philosophical worldview, the research design and specific approach. A justification is made for why a multiphase mixed method design was chosen as the most appropriate research methodology to address the specific objectives of this study. Following discussion of the ontological basis of the study, the specific methods used to address the research objectives are outlined. These include the sampling and recruitment strategies, data collection and data analysis methods, and ethical considerations. An outline of measures taken to ensure trustworthiness in the qualitative component and reliability and validity in the quantitative component concludes the chapter.

3.2 Ontology and World View

Researchers seek to understand the nature of reality and existence, known as ontology (Guba & Lincoln, 1994). An ontological pursuit of knowledge is framed by what the researcher deems to be valid knowledge, which depends upon the researcher's ontological stance, or view of reality and what can be known. This is referred to as the researcher's epistemology (Liamputtong, 2017), paradigm (Mertens, 2010) or world view (Creswell, 2014). Epistemology is the theory of knowledge or knowing, with a focus on the researcher's beliefs about the links between the researcher (the knower) and the phenomena of study (Denzin & Lincoln, 2011). A researcher's epistemology, or world view, is a 'general philosophical orientation about the world and the nature of research that a researcher brings to a study' (Creswell, 2014, p.6). Although the research question and objectives will influence the choice of methodology and methods used, a researcher's world view will inform the principles and ideas (methodology) and choice of methods to meet the objectives of a study (Holloway & Wheeler, 2010; Koch, 1999).

There are many worldviews used in research, but traditional debate has centred

around positivism and constructivism, with an alternative suggested in the form of pragmatism.

Positivism is sometimes called the scientific method, or the *traditional* approach to research that relies on objectivity and empiricism. This approach assumes there is an objective reality in naturally occurring phenomena that can be measured if the correct methods are used (Gray, Grove, & Sutherland, 2017), and defined and tested through theory (Creswell, 2014). In this world view the researcher stands separate from the world to study it (Bredo, 2006). Positivists believe there are antecedent causes of all realities that are ordered and regular (Polit & Beck, 2018). However, whilst aiming for maximum objectivity, there is now acceptance that researchers will probably never know absolute truth, leading to the development of the post-positivism approach. A researcher may maintain independence and a focus on objective measurement, but without the attendant rigid adherence to other positivist elements such as belief in a single reality (Biesta, 2015). Positivism and post-positivism are most closely associated with quantitative research.

Constructivists oppose positivists in that they assume reality is composed by individuals, and that its interpretation is subjective. Where positivists aim to control variables and research conditions, constructivist researchers interact with the world and participants and believe knowledge cannot be separate from interpretation (Merriam, 2009). Constructivism suggests that there are multiple realities that are individually constructed via our psychological (cognitive) processes and structures at individual level (Liamputtong, 2017). A similar concept is that of constructionism, where the world around us is considered to be socially constructed through interaction. “Participants and researcher construct meaning together” (Holloway & Wheeler, 2010, p.338). The philosopher Rorty was a proponent of pure constructionism who believed there is no mind-independent reality, that all reality is constructed, and that every phenomenon has a social component (Simon, 2019; Stieb, 2005).

Research designs in the constructivist paradigm are often flexible and emergent, use an inductive approach to produce theory (Richardson-Tench et al., 2018) and aim to gather a broad range of views to understand the different interpretations individuals

bring to a phenomenon (Polit & Beck, 2018). Constructivist researchers will use open-ended questions to explore the interactions between participants and their environment in order to better understand the historical and cultural influences of participants' perspectives (Creswell, 2014). Constructivism is most closely associated with qualitative research.

Philosophers have long recognised that although both approaches are valid, the dichotomy of the positivist-constructivist divide may serve to limit the depth of inquiry. Biesta (2015) is among the key philosophers to propose a third approach, namely the pragmatic approach. This approach has the research problem as its central focus; the research question drives the design of the study (Tashakkori & Teddlie, 2003). Pragmatism was founded in the late 19th century to help solve the problems faced by researchers struggling with the dualism of constructivist versus positivist thought (R. Johnson, de Waal, Stefurak, & Hildebrand, 2017). The pragmatic approach can incorporate both the worldview that reality can be objectively measured, as well as the world view that reality is in the mind, and can combine them in a way that most effectively addresses the research question. The intention of pragmatic research is to find solutions to problems, including problems of social justice. In that way, the pragmatic approach has the flexibility to draw upon both quantitative and qualitative research methods (R. Johnson et al., 2017).

Pragmatism is not without weaknesses. It is time consuming and possibly resource intensive as large amounts of data must be collected and analysed (Creswell, 2014). The research methods are more complicated as the researcher must have skills in both qualitative and quantitative methods (Richardson-Tench et al., 2018). However, pragmatism provides a world view that enables researchers to explore the middle way between the duality of constructivism and positivism to generate findings that work practically for a given population (R. Johnson et al., 2017).

The world view chosen to underpin this study is pragmatism. Pragmatism shaped this research as elements of both the constructivist and positivist philosophies were required to answer the research objectives. The objective measurement of cultural competence was chosen as the clinical placement experience was structured and time-bound, in many ways representing an intervention. This allowed for the

effectiveness of the experience in relation to the development of cultural competence to be specifically measured. Furthermore, being able to quantify the attribute of cultural competence would give objective and empirical evidence to universities planning and deploying students and staff to international clinical placements. However, the constructivist approach was also embedded to provide a deeper explanation of the quantitative changes in cultural competence using interpretations of participants' perceptions of their complex cultural encounters.

To answer the objectives pertaining to the influence of the experience on career planning, a positivist approach was chosen to identify participants' interest in specific speciality areas, while the constructivist approach allowed for the exploration of the factors and influences behind those preferences. By combining the two approaches it was considered possible to provide evidence related to the influence of the international clinical placement experience in encouraging students to work in humanitarian settings, or other areas of need. In summary, the pragmatist worldview taken in this study determined the choice of research design (Cameron, 2010). As both positivist and constructivist approaches were applicable in answering the research objectives most effectively, a mixed methods design was chosen.

3.3 Mixed Methods Approach

For some researchers, the differences in the epistemologies, or ways of knowing, of qualitative and quantitative approaches are too distinctly opposed and cannot be combined (Aliyu, Bello, Kasim, & Martin, 2014; Biesta, 2015; Polit & Beck, 2018). However, in the 1980s and 1990s the mixed methods approach was developed, and, having gone through a number of developmental phases, is now an accepted and recognised methodology, particularly in the field of nursing education (Beck & Harrison, 2016; Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2010). The mixed methods approach discards the argument that quantitative and qualitative methodologies cannot be combined, and proposes the utilisation of multiple methods to collect, evaluate, organise and interpret data that draws upon the strengths of both methodologies (Creswell, 2014; Tashakkori & Teddlie, 2010, 2012). Appropriate rigour in the collection and analysis of both quantitative and qualitative data is applied, and the findings are merged or connected.

The mixed method approach, also known as integrating, synthesis, and multimethod, has the potential to offer broader interpretations of complex phenomena than stand-alone methodologies (Creswell, 2014; Richardson-Tench et al., 2018). Mixed methods studies are applicable to researchers and areas of research where both subjective and objective knowledge, and the philosophical assumptions behind them, are valued. Mixed methods studies combine not only multiple methods of qualitative and quantitative data collection and analysis, but the philosophical assumptions that underpin each research approach (Richardson-Tench et al., 2018). The mixed methods approach can acknowledge the subjective reality of the constructivist worldview as well as the objective reality of the more positivist worldview, in a way termed ontological pluralism (R. B. Johnson & Gray, 2010). Ontological pluralism recognises the multiple realities of the human world and connects them through the mixed methods approach.

A mixed methods design was considered the best method for this study as the two forms of data, collected concurrently, could be integrated during data analysis to form a holistic explanation of how cultural competence changes following an international clinical placement, and how this in turn impacts participants' global perspectives. The participants' views obtained from the qualitative data were triangulated with the quantitative results (see section 6.12). The individual perspectives obtained from the qualitative findings served to explain the quantitative data, strengthening understanding of the phenomenon and enhancing coherence of the findings (Creswell, 2014; Polit & Beck, 2018). It was anticipated this would highlight areas of specific need and strength in the international clinical placement design. It was also envisaged the quantitative data would inform interpretations of how exposure to diverse cultural experiences influences participants' career planning.

3.4 Quantitative Component Design

A quasi-experimental multisite pretest-posttest longitudinal design was chosen for the quantitative component of this study to explore the influence of the international clinical placement on participants' cultural competence. A true experimental design

with random sampling was considered impractical due to the limited pool of possible participants and a desire to include as many as possible (Polit & Beck, 2017; Richardson-Tench et al., 2018). For this reason a quasi-experimental approach was used. Participants were recruited from four different universities, and undertook placements in five different countries, enabling a multisite study. The design aspect was chosen to explore differences between the country of placement and cultural competence outcomes, adding strength to the findings

The pretest-posttest time series design was chosen as the international clinical placement functioned as a form of intervention, and the intention of the study was to measure changes over time. The collection of baseline data prior to the international clinical placement allowed for comparison with posttest scores, giving an ability to draw conclusions about changes in cultural competence as a direct result of the placement (Richardson-Tench et al., 2018). These scores were subsequently compared with scores obtained 12 months after return from placement. There was no control group in this study as there were no suitable domestic clinical placements that provided exposure to diverse cultural environments that would offer a good comparison. The longitudinal element of the design (discussed in section 3.6) served to assess changes over time. Whilst causality cannot be inferred from this design, changes in cultural competence scores can be attributed to the intervention (Polit & Beck, 2018).

3.5 Qualitative Component Design

A qualitative descriptive exploratory approach was used for the qualitative component of this study because, not only does it provide rich and detailed findings from the participants' perspective, but also it is particularly suited to mixed methods studies (Colorafi & Evans, 2016). The approach is flexible enough to accommodate quantitative techniques, enabling the researcher to more fully describe the phenomenon of interest. The qualitative descriptive approach can draw upon a variety of theoretical approaches, sampling techniques and data collection strategies (Colorafi & Evans, 2016; Polit & Beck, 2018). In this way, it allows for the application of practicality more befitting the nursing discipline that desires outcomes readily applicable to practice. As such, it is particularly suited to the pragmatic world

view, or ‘way of knowing’ (Thorne, 2013). Relevant aspects of the qualitative design and methods such as the longitudinal approach, semi-structured interview process and thematic analysis will be discussed across the chapter.

3.6 Longitudinal Multiphase Design

In this study, a longitudinal multiphase convergent parallel mixed methods approach was considered ideal to meet the specific objectives of the study (Creswell & Plano Clark, 2011), which were:

1. To explore the initial impact of participation in an international student placement on students’ cultural competence.
2. To explore the maintenance of cultural competence 12 months after the experience.
3. To determine the impact of the international experience on individual career planning 12 months after the experience.
4. To explore the influence on students’ desire to work with culturally diverse populations, including returning to developing countries as registered nurses.
5. To explore the relationship between the country and setting of the international student placement, and students’ cultural competence and career planning.

To address the objectives, the same group of participants was followed for a 12 month period, with quantitative and qualitative data being collected over two phases, at three time points (Figure 3.1). Longitudinal studies allow the same group of participants to be followed for a long period with data collected at multiple points to identify changes over time (Liamputtong, 2017; Polit & Beck, 2017). The longitudinal approach was necessary as the aim of the study was to explore not only the initial changes in cultural competence following the international clinical placement, but the maintenance of cultural competence over time. Furthermore, to assess the influence of the placement on participants’ career planning it was anticipated that its effects would not be apparent immediately following the placement and would take time to emerge.

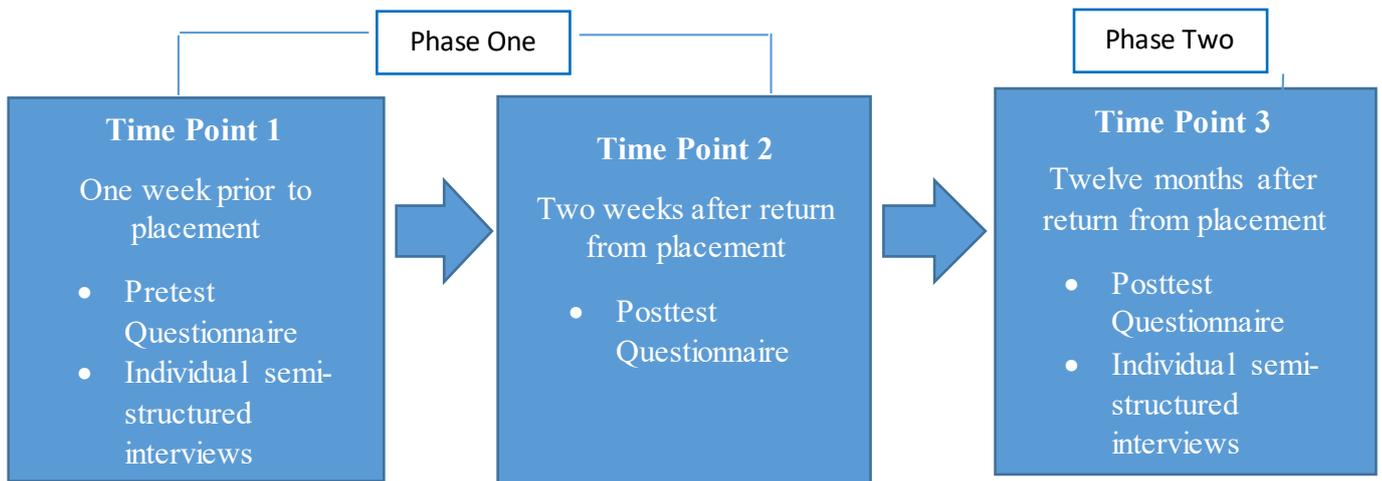


Figure 3.1. Longitudinal multiphase convergent parallel mixed methods design of the study

Time point 1. One week prior to the international clinical placement: Individual semi-structured interviews were conducted to explore participants’ motivations and expectations of placement, their current career plans and their views on cultural competence. A quantitative tool was also administered to measure baseline cultural competence of participants and to collect demographic information. The tool was the Inventory for Assessing the Process of Cultural Competence – Revised and is outlined in detail in section 3.9.2 (Transcultural C.A.R.E. Associates, 2015).

Time point 2. Two weeks following return from clinical placement. The quantitative tool was administered again to measure the initial posttest cultural competence of participants.

Time point 3. Twelve months following return from placement. Individual semi-structured interviews were conducted to explore participants’ views on the influence of the placement on career planning and cultural competence. The quantitative tool was administered for a third time to measure any changes in cultural competence since return from placement.

At time points one and three a convergent parallel mixed methods design was used (Creswell, 2014). To explore participants’ cultural competence quantitative and qualitative data were collected using the same constructs. The constructs were cultural desire, cultural awareness, cultural encounters, cultural skill and cultural

knowledge, and are discussed in more detail in chapter 1, section 1.10.1. These constructs were taken from the quantitative instrument and informed the qualitative interview questions. Embedded within the qualitative data collection were additional qualitative questions pertaining to the influence of the international clinical placement on participants' career planning. In this way, the convergent parallel mixed methods design used the respective strengths of each of the quantitative and qualitative methodologies and utilised a combination of measurement and interpretation across three time points to form a coherent understanding of the phenomenon (Biesta, 2015). Figure 3.2 demonstrates the convergent parallel mixed methods design used at time points one and three.

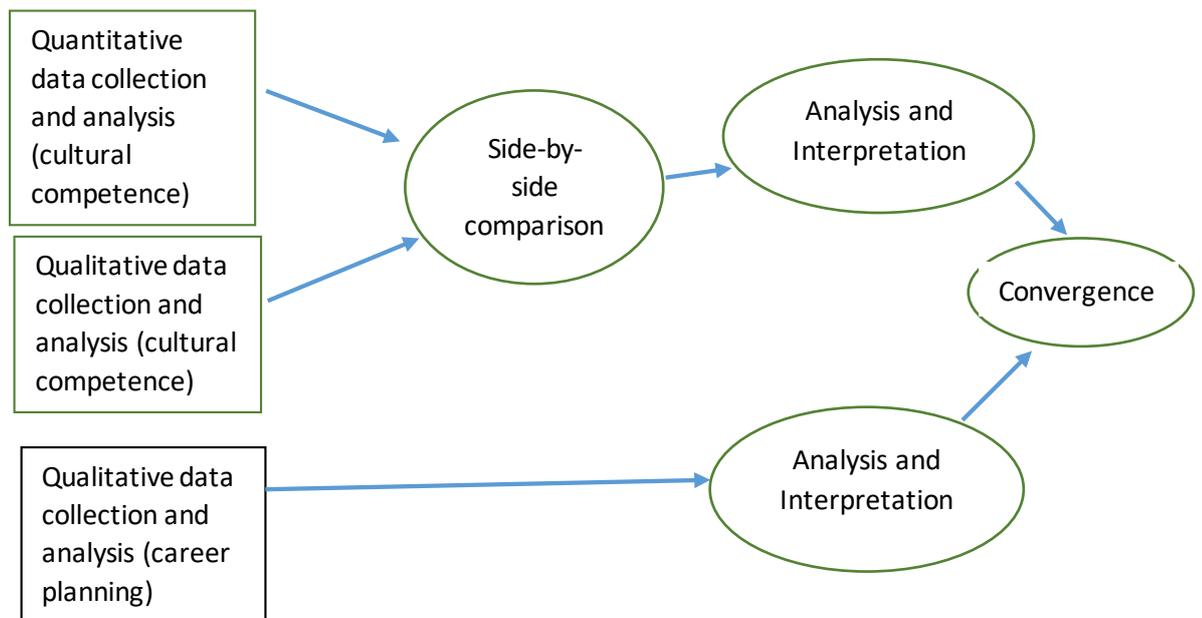


Figure 3.2. Convergent parallel mixed methods design modified from Creswell (2014, p.220)

In the convergent parallel mixed method design, quantitative and qualitative data on participant cultural competence were collected concurrently, but analysed separately. The findings were then compared to ascertain points of divergence or confirmation (Beck & Harrison, 2016; Creswell, 2014). The rich participant perspectives emerging from the qualitative data were compared with the results of the quantitative data collection and used to address the study objectives.

The synthesised findings on cultural competence addressed objectives 1 and 2 of the

study. The data on participants' career planning were analysed separately and addressed objectives 3 and 4 of the study. The findings of both the cultural competence data and the career planning data analyses were then integrated to explain the relationship between the country and setting of the international student placement, and students' cultural competence and career planning. This synthesis addressed objective 5 of the study.

3.7 Participant Recruitment

3.7.1 Sampling and recruitment

Non-probability sampling was used for this study; participants were chosen using non-random methods. This is opposed to probability sampling where some form of random selection is utilised (Schneider, Whitehead, LoBiondo-Wood, & Haber, 2016). Whilst probability sampling is considered more rigorous for quantitative studies, and enhances the generalisability of the findings, non-probability sampling is more appropriate in qualitative studies and in studies where there are limited numbers of people with the knowledge or experience to participate (Polit & Beck, 2018; Schneider et al., 2016). The particular non-probability technique used in this study was purposive sampling. This type of sampling was considered appropriate because the participants would provide rich descriptions of their experience, thereby providing relevant in-depth data from which to develop understandings of the phenomenon of interest from multiple perspectives (Graneheim & Lundman, 2004; Liamputtong, 2017).

Inclusion criteria for the study allowed for the participation of undergraduate nursing students who had applied for and successfully selected to participate in an international clinical placement as part of their undergraduate nursing program. To be accepted for the placement the universities required applicants to: meet minimum grade requirements; perform satisfactorily in a selection interview; and submit a written application outlining their understanding of the host country, previous experience with culturally diverse communities and the strengths they would bring to the group (Gower, Duggan, Dantas, & Boldy, 2016).

Participants for this study were recruited from four Western Australian universities:

Curtin University, Edith Cowan University, Murdoch University and the University of Notre Dame Australia. Participants were travelling to five host countries: Tanzania, the Philippines, India, Thailand and Cambodia. These settings are described in detail in section 3.8. Maximum variation sampling was used to garner a rich variety of perspectives (Creswell, 2015). Variation was sought in participant gender, age, country destination and university attended. Maximum variation sampling was considered appropriate as it would enhance the study's ability to capture diverse responses to the range of conditions to which participants would be exposed, as well as identify common themes across the variety of participants (Palinkas et al., 2015).

A total of 66 students were identified as potential participants for the study. Recruitment began in November 2012 and continued until November 2013. To approach students travelling to Asia, the Researcher attended four placement planning sessions held by the universities in the weeks leading up to each of the Asian placements. To approach students travelling to Tanzania, the Researcher attended placement planning sessions at the Health Department of WA. At each of the planning sessions the Researcher provided an explanation of the study to students and invited them to participate. Details of the other topics covered by the organisers in the planning sessions are provided in article three (Appendix B). Following a verbal explanation of the study to the group, information sheets (Appendix C) were distributed and participants were given an opportunity to ask questions. They were also informed they had the right to refuse and to withdraw from the study without impact on their academic standing or participation in the placement (Holloway & Wheeler, 2010).

Willing participants submitted signed consent forms (Appendix D) at the conclusion of the information sessions and arrangements were made for the Researcher and participants to meet individually for the initial data collection at time point 1. A total of 52 participants completed the questionnaire and agreed to meet for an interview prior to departure (time point 1). At time point 2, all participants were sent the quantitative data collection tool via Survey Monkey, and 47 responded.

At time point 3, all participants were emailed and/or contacted by mobile phone. To

encourage participation at time point 3 of the study, shopping vouchers to the value of \$15 were offered to participants. The vouchers compensated participants for their time and any travel costs associated with meeting the Researcher. An interview time was arranged with all participants who responded.

A number of participants were not contactable at time point 3. The year following graduation is known to be a particularly busy and stressful time for new graduates and as such could have influenced their decision to not respond to requests for interviews. Further, some students had travelled interstate or to rural areas for their graduate program. This made communication difficult.

Qualitative data collection and data analysis were conducted concurrently during this phase, and data saturation was reached with a sample of 25 participants. Quantitative data was collected from 23 of those participants as two participants declined to complete the questionnaire. Figure 3.3 shows the sample size at each of the data collection points.

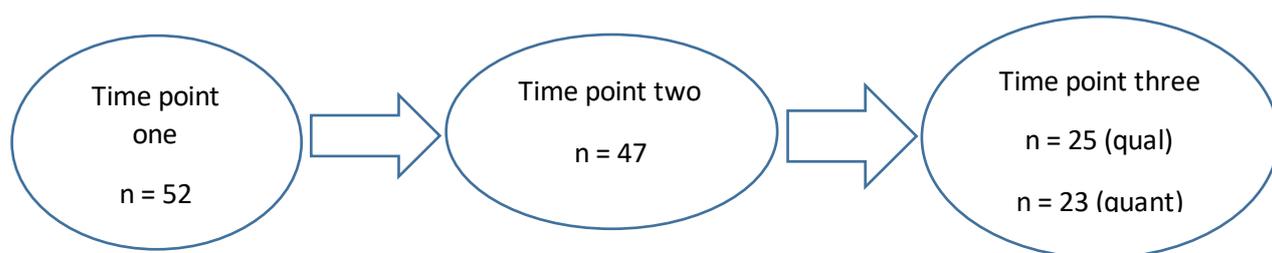


Figure 3.3 Sample size at each data collection point

3.8 Setting of Placements

Participants travelled to five developing countries for their international clinical placements: Tanzania, Cambodia, Thailand, India and the Philippines. For the purposes of this study, the latter four countries are grouped as ‘Asia’. Participants who travelled to Tanzania were part of the Global Health Alliance of Western Australia (GHAWA), a collaboration between the universities in Perth that offer nursing programs, and the Health Department of WA. GHAWA’s purpose is to build capacity in the nursing and midwifery workforces in Tanzania and other countries to improve transcultural health. GHAWA supports pre-registration nursing students from Western Australian universities to travel to Tanzania annually.

Participants travelling to Tanzania with GHAWA are allocated to mixed university groups of five people; each group is supervised by a staff member from one of the member universities. Participants who undertook their placement in Asia travelled in single university groups and were supervised by a staff member from their own university. More details about the activities undertaken at each setting are provided in article three (Appendix B).

There were some notable differences between the settings. In Tanzania, participants worked in metropolitan tertiary and secondary hospitals and as a result were exposed to patients with high acuity and trauma. This included patients with HIV/AIDS and victims of motor vehicle accidents. Many of the participants witnessed pain and death, including the death of children. Due to their limited scope of practice, different patient identification practices in the hospitals and limited ability to communicate in the local language, many of the placement experiences for the students in Tanzania were observational. However, they also visited rural community clinics and participated in community health care. In Asia, participants did not work in hospitals as the placements had a community focus. Participants travelled to rural areas where community clinics were established, often only for 1 day in any given location. Participants worked with local health care professionals, nurses and doctors, to provide primary health care to village residents.

3.9 Quantitative Data Collection

As outlined in section 3.6, quantitative data were collected at all three time points to evaluate the impact of the international clinical placement on cultural competence. This included both demographic data and empirical data.

3.9.1 Demographic data

Demographic data was collected to describe the sample and to aid in transferability of findings. This included information on participants' country of birth, gender, age, previous travel and employment experiences, relationship status, and stage in their nursing course. The location and duration of the placement was also collected in order to explore correlations between placement settings and cultural competence

scores.

3.9.2 Inventory for Assessing the Process of Cultural Competency-Revised (IAPCC-R)

The IAPCC-R is an instrument that measures the overall cultural competence of respondents, and is designed specifically to measure the cultural competence of health professionals (Transcultural C.A.R.E. Associates, 2015). Although the author of the tool, Dr Campinha-Bacote, gave permission to use the tool for data collection in this study, due to copyright restrictions of the IAPCC-R, Dr. Campinha-Bacote does not allow for the tool to be copied. Please refer to Dr. Campinha-Bacote's website at www.transculturalcare.net/iapcc-r, or contact her at meddir@aol.com to obtain a copy of this tool.

The 25 items contain five subscales, each containing five items that align with the constructs of the theoretical framework for this study. The constructs are cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire; these are explained in detail in chapter 1, section 1.10.1.

The instrument is self-report with participants providing responses on a Likert scale. The Likert scale anchor points are scored from 1 to 4. Typically, the anchor points are *Strongly Agree, Agree, Disagree and Strongly disagree*. However, some questions have different anchor points. For example, questions 6, 8 and 10 have the anchor points *Very knowledgeable, Knowledgeable, Somewhat knowledgeable and Not knowledgeable*. Questions 9, 12, 15, 16 and 20 have the anchor points *Very aware, Aware, Somewhat aware and Not aware*. These items do not necessarily measure cultural knowledge or cultural awareness.

Most items are scored with 4 points allocated to the extreme positive end of the scale (*Strongly agree/Very knowledgeable/Very aware*) down to 1 point allocated at the negative end of the scale (*Strongly disagree/Not knowledgeable/Not aware*). However, five items are scored in the reverse.

The instrument is scored summatively, the total ranging between 25 and 100. Overall cultural competence is indicated by four categories determined by total score:

culturally incompetent (25–50), culturally aware (51–74), culturally competent (75–90), and culturally proficient (91–100) (Campinha-Bacote, 2007b; Gower, Duggan, Dantas, & Boldy, 2019). Scores for each of the subscales (representing the constructs) are also scored summatively.

3.9.3 Psychometric properties of the tool

The reliability of an instrument reflects its ability to consistently measure the same attribute over time (Schneider et al., 2016). A tool should be able to give the same result when administered repeatedly (test-retest reliability). There should also be consistency between items within the tool to ensure all items are measuring the same attribute (internal consistency). One way of measuring internal consistency, or homogeneity, of a tool is to calculate a correlation coefficient, providing a score between zero and 1. The closer the score is to 1, the more reliable the tool. On tools that have Likert scale responses, a widely used test of internal consistency is the Cronbach's alpha test (Bonett & Wright, 2015; Vaske, Beaman, & Sponarski, 2017).

The Cronbach's alpha measures each item simultaneously against the other items of the tool to assess consistency in measuring the attribute. Cronbach's alpha scores greater than 0.80 indicate a reliable tool (Schneider et al., 2016). Internal consistency for the IAPCC-R has been demonstrated across numerous studies with a Cronbach alpha score ranging from .72 to .90 (Kardong Edgren et al., 2010; Riley, Smyer, & York, 2012). The samples in these studies were graduating Bachelor of Science Nursing students, and diploma-trained nurses entering a Bachelor of Science Nursing course. As such they are similar in make-up to the participants in the current study. Construct validity assesses the similarities or differences between the tool and other tools measuring similar or related attributes (Schneider et al., 2016). Construct validity has been assessed positively by other authors (Capell, 2008; Mesler, 2013). For example, an inverse relationship between cultural competence as measured by the IAPCC-R, and ethnocentrism as measured by the Ethnocentrism Scale was found by Capell (2008).

3.10 Quantitative Data Analysis

Quantitative data were analysed using the Statistical Package for Social Sciences

(SPSS) version 22 (IBM Corp., 2013) Windows computer software. Data were entered manually and then checked for accuracy by the researcher and a second colleague with expertise in SPSS.

3.10.1 Missing data

Due to study attrition, the overall participant number was reduced to $n = 47$ at time point 2 and $n = 23$ at time point 3, from $n = 52$ at time point 1. Of the remaining participants, data at time points one and two did not contain any missing data. However, at time point 3, missing data were noted for one participant for questions Q24 and Q25 and addressed using the Expectation Maximisation method. As both the normal and non-parametric distribution method of the Expectation Maximisation method arrived at similar results it was decided to use the normal method.

3.10.2 Demographic data

Frequencies and means were tabulated to describe the demographic characteristics for the participants.

3.10.3 Questionnaire data

Descriptive and inferential statistics were used to analyse the data derived from the IAPCC-R questionnaire which was administered at three time points. Significance was set at $p < .05$. The Shapiro-Wilks test and the Kolmogorov-Smirnov test were used to test for normality and it was found the data collected were normally distributed.

To test for significant differences between responses to the IAPCC-R instrument at time point 1, time point 2 and time point 3, parametric paired samples t-tests were used as the data were normally distributed. Analyses were conducted to compare the means on the total scores across all three time points (time point 1, time point 2 and time point 3), and to compare the mean scores of each of the constructs. For time point 2 to time point 3, analysis was done only on the number of participants who had completed the instrument at both time point 2 and time point 3 ($n = 23$). The copyright restrictions of use of the questionnaire are such that researchers are not allowed to report on individual items, therefore an analysis of the individual items

was not undertaken.

3.10.4 Random Effects Regression Model

To confirm the changes over time, a random effects regression model was used to analyse differences in total scores and each of the constructs across all three time points. Only the 23 participants who completed all three time points were included in the analysis. Random effects models are able to take into account the repeated measures nature of the data. The model included Time as a fixed effect and treated as a factor with three levels representing each of the time points, and Participant as a random effect, thereby allowing for individual differences at baseline.

Analysis was also done to find correlations between age, setting of placement and total score. Correlations between scores and placement length were not analysed as there was only one student who completed a 4-week placement. The vast majority of students completed placements of 2–3 weeks and it was felt a separate analysis was not necessary as the experience would not be considerably different between 2 and 3 weeks.

3.11 Qualitative Data Collection

In qualitative descriptive exploratory studies, data collection aims to explore ‘the who, what and where of events’ and experiences (Sandelowski, 2000, p.339). The purpose of the qualitative component of the study was to explore the participants’ perspectives on how the international clinical placement had influenced their cultural competence and career planning. Individual semi-structured interviews are a suitable data collection strategy for descriptive qualitative exploratory studies and were chosen as the data collection strategy in this study because participants’ own perceptions regarding cultural competence and career planning were sought (Colorafi & Evans, 2016). In particular, their individual perspectives on self-awareness and cultural desire, as the foundations for cultural competence, were important. It was felt that focus groups could have the effect of causing some participants to feel uncomfortable about their personal views and remain quiet, or be dominated by more verbal participants, a known weakness of focus groups (Creswell, 2015). Furthermore, as students lead busy lives it was impractical to get participants

together in one place at a mutually convenient time.

3.11.1 Strengths Of Semi-Structured Interviews

Qualitative interviews can overcome the positivist-constructivist divide, whilst simultaneously recognising the validity of both those approaches (Miller & Glassner, 2016). Interview data allows researchers to understand participant perspectives of their experience and the social and cultural world within which it occurs (Creswell, 2014; Holloway & Wheeler, 2010). Qualitative interviews allow researchers to understand in depth and in detail the social world of participants, without necessarily being able to 'mirror' that in a positivist way. By aiming to understand participant perspectives subjectively, researchers can come to understand the reality of those experiences (Holloway & Wheeler, 2010; Liamputtong, 2017; Miller & Glassner, 2016).

The positioning of the researcher is an important element of the qualitative data collection process. It is important for qualitative researchers to identify and make visible their own background, perceptions, interests and desires (Munhall, 2013). Meaning is constructed by both the participant and researcher through their interaction and the historical and social influences they both bring to the interview context (Holstein & Gubrium, 2016). For example, the topics raised by researchers may be considered irrelevant or misinterpreted by participants, prompting further questions, possibly from the participant, which in turn leads to the further production of data that reveals culturally-embedded realities (Miller & Glassner, 2016).

Meaning is created through the interaction between the researcher and the participant (Holstein & Gubrium, 2016). In this way, both the researcher and the participant are engaging in interpretive behaviour. The positionality statement of the Researcher is outlined in detail in chapter 1, section 1.15.

3.11.2 Weaknesses Of Semi-Structured Interviews

In the same way that the interaction between researcher and participant can lead to rich discussion, it can also be a limitation. Participant responses may be influenced by who they perceive the researcher to be, based on age, gender, class or race. There may be issues of trust, or of language. Lack of membership of a particular group may

limit a researcher's understanding of phenomena or topics. Conversely, being seen to already hold knowledge of a topic or be close to the participant group may limit participants' responses, or cause them to withhold personal information due to concerns about confidentiality (Creswell, 2015). To counteract these potential weaknesses the Researcher travelled to Tanzania with two groups of participants, using the shared experience to develop trust, which gave the participants confidence to disclose their experiences, even those that were not positive. Furthermore, as the Researcher was not involved in teaching any of the participants during their undergraduate programs, or in the planning of the placements, participants felt able to reveal their perceptions without fear of repercussion in relation to their university studies.

3.11.3 Interview Guide

A semi-structured interview guide was developed to provide structure and consistency across the interviews (Appendix E and F). The questions in the interview guide were developed using *The Process of Cultural Competence in the Delivery of Health Care Services* model, along with recommendations from the literature. Questions on career planning were informed by the *International Education Survey* (Zorn, 1996). Semi-structured interviews were used to capture aspects of the framework, but also to allow discussion of topics outside the framework. As such, the qualitative data collection was done in such a way to capture data from pre-determined categories as well as data from outside the restrictions of the framework.

A semi-structured interview guide is useful because although questions are pre-determined, and the control therefore remains with the researcher, there is flexibility for unexpected perceptions and views of the participant to be followed and developed (Gerrish & Lathlean, 2015). As a result of additional questions being asked, each interview was slightly different, and was able to capture the unique experiences of each participant (Liamputtong, 2017), including their specific future career intentions.

Before the start of the interview, participants were informed of the Researcher's background, experience with international health projects and with international student experiences. It is necessary for participants to be aware of the researcher's

background and interests, including the rationale for the study and how the results will be disseminated (Creswell, 2014).

The interview guide used prior to the placement opened with a question about participants' career interests. This was supplemented with a number of prompts the Researcher could use to facilitate further discussion with the participant (Morris, 2015). This question was included to obtain baseline information on participants' career interests. This included particular speciality areas and more broad long-term plans. Two more questions pursued exploration of career planning with participants, including the possibility of an international dimension.

The next two questions explored motivations and expectations for the placement. These questions were included to capture participants' baseline expectations around the resource-poor environments to which they were travelling, and their personal motivations for applying for an international clinical placement opportunity. This encompassed the construct of cultural awareness which includes self-awareness. Questions 6 to 9 revolved around participants' understanding of cultural competence and their preparedness both personally and professionally for working in a culturally diverse setting.

At the commencement of qualitative data collection at time point 3, a pilot interview was conducted with one participant to test the relevance and clarity of the interview guide. Following this interview, adjustments were made to include more prompts and an additional question on participants' interest in health policy in response to what was emerging from the data.

The postplacement interview guide opened with a 'grand tour' question asking about overall perceptions of their placement experience. This open-ended question was designed to give participants the flexibility to describe their experience unencumbered by the restrictions of the theoretical framework or their previous interview experience. It was considered important to avoid trying to simply confirm the theoretical framework, and to be open minded to all participant experiences (Ulvund & Mordal, 2017).

Questions 2 to 5 centred on the influence of the placement on career planning. A number of prompts were available to the Researcher to facilitate participants' thoughts. This was important because participants revealed they had given little thought to career planning as it related to the clinical placement before the interview. The prompts helped participants formulate their thoughts. Questions 6 and 7 explored participants' perceptions of how the placement experience had influenced their cultural competence. The questions were deliberately left broad and open, however prompts were developed to facilitate discussion on each of the specific constructs of the theoretical framework (cultural desire, cultural awareness, cultural encounters, cultural knowledge and cultural skill). The prompts were also informed by the International Education Survey (Zorn, 1996).

This survey is explained more thoroughly in chapter 2, and was appropriate to inform the interview questions as it measures the constructs of students' international view, perspective of their professional nursing role, personal development, and intellectual development.

With the permission of the participants all interviews were digitally recorded to facilitate transcription (Liamputtong, 2017). During the interview process notes were taken by the Researcher to provide context or clarification, but in a manner not distracting to participants. Following the interviews, field notes were made by the Researcher reflecting on initial thoughts and decisions. Further details were recorded on the physical environment, including distractions, and participants' body language, mood, and emotions displayed during the interviews. These field notes provided context and added depth to the early data analysis (Polit & Beck, 2018).

Data analysis occurred concurrently with the data collection. This process, combined with reading the interview transcriptions, the field notes and referring to related literature, allowed the Researcher to develop thoughts and concepts as the data collection continued (Liamputtong, 2017). The notes included reference to the Researcher's own thoughts and experience with international clinical placements and cultural immersion and were discussed with the supervision team as part of the process of ensuring rigour. Reflexivity was important in order to maintain an understanding of how the Researcher's views were impacting on interpretation of

data (Creswell, 2014). As a result of early analysis, some questions were added or altered as the interviews continued.

Interviews were conducted in participants' homes, the Researcher's home, and at university libraries. These settings, chosen for their convenience, privacy and level of comfort for participants, were important as a naturalistic setting allowed participants to relax and enhanced the potential for the Researcher to obtain authentic data (Creswell, 2015; Liamputtong, 2017).

Interviews lasted between 15 and 90 minutes, in keeping with the recommended length for individual interviews (Whiting, 2008). This length of time maximises the opportunity for the collection of authentic data as the participant and interviewer move through the phases of rapport building, reducing apprehension, exploring participant views through deeper prompting, and reaching cooperation and full participation (Whiting, 2008). Participants were informed the interview would take 60 minutes and as much as possible this was maintained.

3.12 Qualitative Data Analysis

The literature is inconsistent in regards to the meaning of description versus interpretation in the analysis of data in qualitative descriptive studies. Some authors say that, as the overarching aim of a qualitative descriptive study is to describe participants' experiences, content analysis is best suited to the qualitative descriptive approach (Colorafi & Evans, 2016; Polit & Beck, 2018). It is true that in qualitative descriptive research, the researcher stays close to the data, aiming to provide a rich description using the participants' language as much as possible (Neergaard, Olesen, Andersen, & Sondergaard, 2009). However, Sandelowski (2000) posits that even though description is the goal, there is always an element of interpretation involved, albeit at a low level, as the researcher is immersed in the data. That is, the proximity of the researcher to the original data means that descriptions depend on the 'perceptions, inclinations, sensitivities and sensibilities of the describer' (Neergaard et al., 2009, p.2). In this way, qualitative descriptive studies are sometimes referred to as interpretive description (Thorne, 2013).

Two common types of qualitative analysis techniques are content analysis, and thematic analysis. Content analysis may be considered a relatively systematic process, and may involve quantitative counts of the frequency of responses (Liamputtong, 2017; Wilkinson, 2016). Conversely, thematic analysis is purely qualitative, more detailed, and looks for patterns and themes in a more subtle analysis of the data (Braun & Clarke, 2006). Both require breaking down the data into small units for analysis, with a view to moving from particulars to universal themes (Polit & Beck, 2018; Rapley, 2016).

In this study the thematic analysis technique developed by Braun and Clarke (2006) was used to analyse the interview data. In addition to thematic analysis, and in keeping with the pragmatic nature of qualitative descriptive studies, participant responses pertaining to preferred nursing specialty areas were quantified using descriptive statistics. Although only a supplement to the more nuanced qualitative analysis, this ‘quasi-statistical’ approach allowed the Researcher to report the frequency of responses and add depth to the data summary (Neergaard et al., 2009, p.3).

3.12.1 Data saturation

Data collection and data analysis occurred concurrently and enabled data saturation, which in turn determined sample size. Data saturation occurs when data collection reaches a point where no new information is obtained from data collection methods, and participant accounts become repetitive (Schneider et al., 2016). By achieving data saturation, the researcher is assured that the phenomenon has been thoroughly explored.

At time point 1, data saturation was considered achieved at 43 participants, but an additional cohort of nine participants travelling to Tanzania were recruited in 2013 to bring the number of participants visiting Africa to be approximately equal with the number visiting Asia. At time point 3, data saturation was considered achieved at 21 participants, but a further five interviews were conducted across participants that travelled to both Africa and to Asia to confirm and establish that saturation had been reached. The final sample size for time point 3 was 25, made up of 12 participants who had visited Africa, and 13 who had visited Asia.

3.12.2 Thematic analysis

Thematic analysis identifies recurrent experiences across a data set and seeks to find the meaningful patterns relevant to the research question (Braun & Clarke, 2012; Saldana, 2016; Vaismoradi, Turunen, & Bondas, 2013). Thematic analysis allows researchers to explore both the manifest content, that which is identifiable and obvious in the language; and latent content, or the assumptions behind the words (Braun & Clarke, 2012).

An inductive thematic analysis technique was considered appropriate to analyse the qualitative data as there were no previous studies in this area, particularly on the topic of career planning following international clinical placement (Hsieh & Shannon, 2005). Using an inductive approach, the themes were derived initially from the data and closely linked to the semantics (Braun & Clarke, 2012). In addition, for the data pertaining to the influence of the international clinical placement experience on cultural competence, the concepts of the theoretical framework, *The Process of Cultural Competence in the Delivery of Health Care Services*, were used to help define and organise the final themes, linking the findings with the five constructs of the framework (Campinha-Bacote, 2002). This deductive approach is useful when the study has a theoretical framework, or is trying to compare data across different time periods (Hsieh & Shannon, 2005; Vaismoradi et al., 2013). Coding is rarely purely inductive or deductive, and often a combination is useful, realistic and, gives coherency to the final product (Braun & Clarke, 2012). Using the framework to guide the qualitative data collection allowed themes outside the framework to emerge. When the qualitative data were analysed and themes emerged the Researcher began to consider the framework and how the themes linked with the quantitative data. Not restricting the data collection and analysis solely to the framework allowed the data to speak for itself and allowed themes that were not reflected in the framework to become evident.

The inductive thematic analysis was conducted following the six-phase process proposed by Braun and Clarke (2006), the entire process being conducted at both data collection phases one and two. In this way, themes were developed from the qualitative data on participants' perceptions of cultural competence and career

planning before the international clinical placement, and 12 months after their return. The data analysis phases were as follows.

Phase one: Familiarisation with the data. All audio recordings of individual interviews were transcribed verbatim. Identifying information was removed from transcriptions and participant numbers were allocated. The majority of the interviews were transcribed by the Researcher, and the remainder were transcribed by a professional transcriber. In transcribing the interviews personally, the Researcher was able to develop a strong understanding of the content of the interviews. In addition, field notes were taken immediately following each interview and formed part of the data set. These included body language, overall tone of the interview and any interruptions that may have affected the quality of the interview. The Researcher read and re-read each transcript several times, thereby becoming immersed in the data (Liamputtong, 2017). Annotations were made in the margins of each transcript by hand, forming the preliminary analysis of potential meaning in terms of participants' assumptions and experience (Braun & Clarke, 2012). Transcripts were then entered into the NVivo version 10 software package (QSR International, 2014) for management and further coding.

Phase two: Generating initial codes. The NVivo software program was used to generate initial codes. Codes are small units of data that are later used to build more substantial themes. Codes may reflect the semantics of the data and be closely aligned with it, or may reflect the latent meaning behind the language (Braun & Clarke, 2012). During this phase both manifest and latent codes that were considered potentially useful to answering the research question were generated by the Researcher. These reflected participants' experiences, but also formed the beginnings of interpretation (Braun & Clarke, 2006, 2012). At all times the participants' voices were central to the process. The NVivo software allowed for flexibility with re-wording of initial codes as more transcripts were read. This was also the beginning of the development of broader categories and themes.

Phase three: Generating themes. After all the transcripts were coded, the Researcher began the process of combining codes into categories and in turn into common themes (Creswell, 2015). Initially this was done by copying codes into a table in a

Microsoft (MS) Word document. The MS Word document was easily manipulated and codes were easily transferred between abstract categories and themes as the analysis process developed. Participant quotes attached to each code were also included in the MS Word document. In developing the preliminary themes, it became clear that some codes were not relevant to the research question or could be combined with others. As such, some codes were discarded, and others were clustered to form subthemes as the relationship between codes and themes became clearer (Braun & Clarke, 2006).

Phase four: Reviewing themes. During this phase it becomes necessary to read all the participants quotes, or extracts, associated with each theme to determine the coherence of the theme. In doing so, themes were discarded, collapsed into separate themes, or combined (Braun & Clarke, 2006). This process entailed exploring and comparing the codes captured in the previously mentioned MS Word document against the initial codes stored in the NVivo software program. Through refinement the final themes were grouped and organised until the Researcher felt the final themes accurately represented the data set; and a thematic map was developed to visually represent the themes (Braun & Clarke, 2012). The Researcher then re-read all the transcripts to confirm this was the case. Some additional codes were added at this point, which formed subthemes.

Phase five: Defining and naming themes. Having finalised the themes, further analysis was required to determine the ‘essence’ of each theme in order to define them. This process ensures there is adequate separation between themes and clarifies how each theme fits into the final picture (Braun & Clarke, 2006, p.92). In analysing the essence of each theme a number of decisions were made regarding the naming of the themes. Initially themes were labelled Personal, Professional and Cultural to represent the main areas of influence of the international clinical placement experience. However, through further analysis the theme names were changed to those that appear in this thesis (see chapters 4 and 5), because a number of the subthemes across the Personal and Professional themes were transferable and overlapped. That is, they applied at both a personal and professional level. For example, the subtheme, ‘*I will be challenged by the low-resource setting*’ applied to both personal (lack of running water and flushing toilets) and professional (lack of

medications, bandages, etc.) contexts. There was a distinct blurring of the lines in the perceptions of students between the personal and the professional influences of the international clinical placements. Furthermore, it became clear that the concepts of the theoretical framework of the study could be used to name and define some of the themes as part of a coherent whole, particularly for the preplacement findings.

Phase six: Write-up of findings. After the themes and subthemes were finalised the findings were written up in both chapter format for this thesis and in journal article format for publication. Participants' quotes, stored in the NVivo software program, were carefully chosen to represent the meaning of the themes and subthemes and tell the story of the data set as a whole. By providing a detailed description of each theme, supported by participant quotes, an argument was developed that answered the original research question (Braun & Clarke, 2006).

3.13 Rigour and Trustworthiness

The concepts of reliability and validity have long been associated with quantitative research and the positivist paradigm (Polit & Beck, 2018). They are often associated with a set of procedures that help to control the circumstances of a study and reduce bias (Polit & Beck, 2018). The reliability and validity of the quantitative data was ensured by the use of previously validated instruments, described earlier. It is acknowledged that the IAPCC-R was administered in two different formats in phase one: face-to-face for the pre-test, and online for the posttest. This method was chosen because it was considered the most effective way of obtaining the relevant data in the context of this study, where gathering participants in person after the placement was considered unlikely. Intra-rater reliability was preserved by the adherence to a written protocol for the administration of questionnaires.

However, reliability and validity are not concepts considered by some scholars to be applicable to the epistemological principles of qualitative, interpretive research and may limit researchers' flexibility to interpret data (Holloway & Wheeler, 2010; Liamputtong, 2017). As an alternative to reliability and validity, Lincoln and Guba (1985) formulated a new approach, termed *trustworthiness*, to demonstrate rigour in qualitative research. Under the original framework there were four primary concepts;

dependability, credibility, transferability and confirmability. In 1994, a fifth criterion was added; authenticity (Guba & Lincoln, 1994).

Dependability is the degree to which a study is consistent and reliable over time. It is often linked with the positivist criteria of reliability or accountability (Polit & Beck, 2018). In this study dependability was demonstrated through detailed description of the research context and processes, allowing other researchers to repeat the study as desired (Holloway & Wheeler, 2010). Furthermore, in many of the findings there was consistency between participants, despite having travelled to different parts of the world. Where there were differences, they could be attributed to the specific influences of the different environments.

Credibility relates to the level of confidence in the accuracy and truth of the findings, and is most closely related to the concept of internal validity. Participants perspectives must be accurately portrayed (Holloway & Wheeler, 2010). Credibility may be demonstrated by using procedures to enhance believability of the researchers' interpretations (Liamputtong, 2017). In this study credibility was demonstrated by prolonged engagement with the data. The period of data collection and analysis extended over 2 years, resulting in complete immersion in the data. Furthermore, as each participant was interviewed twice, 12 months apart, the Researcher was able to engage with the perceptions of each participant as they changed over a 12 month period. Previous interpretations of the data were re-examined when participants were interviewed a second time, resulting in a form of member checking. Self-reflection (Hardcastle, Usher, & Holms, 2006) allowed further monitoring of how the Researcher made choices during data collection and analysis, and whether participant perceptions were being accurately represented. The triangulation of the quantitative and qualitative data served to enhance the accuracy of the findings, creating a coherent whole (Polit & Beck, 2018).

Transferability refers to how applicable qualitative findings are in a different context. It is most closely related to the concept of generalisability in the positive paradigm (Polit & Beck, 2018). Researchers must provide thick, rich descriptions of the setting and participants to allow researchers and consumers to consider the applicability of findings to their own research or practice contexts (Holloway & Wheeler, 2010).

Transferability is best achieved by reaching data saturation and taking comprehensive field notes (Polit & Beck, 2018). In this study, transferability was achieved by providing rich description of the participants' demographic variables, and the settings of each of the international clinical placements in addition to the achievement of data saturation. The detailed account provided here of how the study was conducted, and decisions made, forms an audit trail that other researchers could follow to replicate the study (Liamputtong, 2017). The findings are thoroughly documented which allows others to transfer the findings to their own contexts.

Confirmability relates to the degree to which the findings represent the data provided by participants, and not the influence of the researcher's own biases and preconceptions (Creswell, 2015). In this study, confirmability was achieved through peer review (Liamputtong, 2017; Polit & Beck, 2018). Findings and interpretations were discussed with and, checked by, a member of the research supervision team. Furthermore, the open-ended narrative style nature of the interview questions provided participants with the freedom to express their perceptions and views fully (Schneider et al., 2016).

Authenticity refers to the ability of the findings to transport the reader into the participants' world. The voices, perceptions and thoughts of the participants as they describe their lived experience must be clear to the reader (Creswell, 2015). Authenticity can be achieved by prolonged engagement with the data, audio recording of the data and the use of participant quotes (Polit & Beck, 2018). Authenticity in this study was demonstrated by all of those elements. Verbatim quotes are included throughout the findings chapter, highlighting participants' voices and allowing readers to make connections between the raw data and emergent themes. Participant quotes allow readers to determine for themselves the synergy between the participants' recounts of their experience and the Researcher's interpretations.

3.14 Ethics

Modern ethical research guidelines were established following World War II in the Declaration of Helsinki (1964) (Loff & Black, 2000) and have been continuously

developed since (World Medical Association, 2018).

In Australia, research ethics are governed by the National Health and Medical Research Council (NHMRC) who publish the National Statement on the Ethical Conduct of Research (2007). Ethical procedures used in this study adhere to the requirements of those guidelines.

Ethical approval was initially obtained from the Curtin University Human Research Ethics Committee (SON&M33-2012) (Appendix G). Following this, reciprocal ethics approval was obtained from the Edith Cowan University (ECU) Human Research Ethics Committee (approval number 8948). Murdoch University and the University of Notre Dame Australia (UNDA) did not require an application to be sent through their ethics approval processes as the Curtin University ethics approval was considered sufficient. Permission was obtained from the heads of Schools of Nursing (or their representatives) of all participating universities to access nursing students with the aim of recruitment (Associate Professor Catherine Fetherston [Murdoch University], Dr Natalie Giles [UNDA], Professor Phill Della [Curtin University], Tania Beament [ECU], personal communication, October 2012).

The major ethical principles relevant to research studies are respect for human dignity, autonomy, justice, and non-maleficence (Polit & Beck, 2018). Respect for human dignity was ensured through the provision of a comprehensive information sheet to participants at the time of recruitment (Appendix C). Participants were fully informed of the purpose of the study, their required commitment and their right to refuse or withdraw without penalty. Participants were provided with opportunities to ask questions both at the information sessions attended by the Researcher, via email with the Researcher, and before the commencement of interviews. Full disclosure meets the requirements of self-determination in that participants were then able to make a fully-informed decision regarding participation (Polit & Beck, 2018; Schneider et al., 2016).

In the interests of ensuring participant autonomy (Staunton & Chiarella, 2017) written consent was obtained from all participants at the commencement of the study, and this consent applied across the 12 months of data collection (Appendix D). In

addition to the original consent, willingness to participate was confirmed again at each time point, aligning with the principles of informed consent as a process and ensuring participants' preferences had not changed (Helgesson & Erikson, 2011). At time point 2, consent was implied with return of the completed online questionnaire. At time point 3, the continuing willingness of the participants to be involved in the study was ascertained verbally or by email by the Researcher when arrangements were made to meet with the participants to conduct the interviews.

Participants were assured that confidentiality would be maintained. Participants' identifying information was removed from all transcripts and published articles. Digitally recorded interviews were deleted from the recording device following transcription. Ensuring confidentiality in this way adheres to the ethical principles of justice (Holloway & Wheeler, 2010; Polit & Beck, 2018).

Confidentiality was also ensured through secure data management and storage. Recordings of interview audio files were transferred as soon as practically possible from the recording device to a password-protected computer at the School of Nursing, Midwifery and Paramedicine at Curtin University. The audio files were then deleted from the recording device. Audio files were saved onto the secure research drive (R:Drive) at Curtin University, which is only accessible by the Researcher and supervisory team. Completed online questionnaires were saved on the Survey Monkey platform, which is password protected. Questionnaires were also printed from the platform. All written material that contained identifying information such as printed questionnaires, consent forms and field notes were stored in a locked cupboard at the School of Nursing, Midwifery and Paramedicine at Curtin University. This study was considered low risk and as such an adverse events protocol was not considered necessary. However, participants were informed that should they choose to withdraw from the study there would be no impact on their university course or results, thereby ensuring non-maleficence (Creswell, 2015; Schneider et al., 2016).

3.15 Conclusion

In this chapter the philosophical underpinnings of the choice of the mixed methods

design for this study were presented. Detailed descriptions of the sampling approach, the participant recruitment process, and the various settings of the study were provided, followed by an outline of the collection and analysis of quantitative and qualitative data. The concurrent collection of quantitative and qualitative data across two phases were explained via a justification of the choice of quantitative tool and description of the individual interview process. In the following chapter, the results of the analysis of interview and questionnaire data pertaining to cultural competence are presented. These findings reveal rich information about the cultural competence of participants immediately before and after placement (phase one) and, changes in quantitative scores and participant perceptions of their own cultural competence 12 months after return from placement.

4. Findings – Cultural Competence

4.1 Chapter Structure

This chapter begins with a description of participant characteristics in tabular and text format (table 4.1). It then moves on to the presentation of the findings regarding the development of cultural competence in participants.

The findings are presented in three parts which correspond to the journey the participants followed over the course of this study. The findings are divided into three parts to aid reading and understanding, but there is some overlap between each of the parts to represent the continuous and evolving influence of the international clinical placement over time. They provide insight into changes in participants' perceptions regarding cultural competence; from their preplacement expectations and understandings of cultural competence through to the continuing influence of the placement 12 months after their return on their cultural competence in the Australian nursing practice context. Qualitative and quantitative data are presented side-by-side to reflect the multiphase parallel convergent mixed methods approach adopted in this study (Cresswell, 2014).

Part 1: presents a comprehensive outline of participants' preplacement expectations and motivations regarding cultural competence. These findings are presented in text format and supported by a published manuscript (Appendix A). Part 1 provides some baseline qualitative data and sets the scene for understanding the findings related to objectives 1 and 2 of the study. Further understanding of participants' preplacement cultural competence is provided through quantitative analysis presented in part 2.

Part 2: presents the initial quantitative changes in cultural competence demonstrated by participants soon after their return from placement. These findings also include the changes in participants' cultural competence over time, through to 12 months following return from placement. They are presented in the form of a published manuscript. This part connects parts 1 and 3.

Part 3: highlights further findings to support those presented in part 2. They provide a

comprehensive qualitative exploration of participants' perceptions of the enduring influence of the placement on their cultural competence over 12 months. By presenting both qualitative and quantitative findings a holistic account of the influence of the placement on cultural competence is achieved.

The findings in this chapter relate to objectives 1, 2 and 5 of the study:

- Objective 1: To explore the initial impact of participation in an international student placement on students' cultural competence.
- Objective 2: To explore the maintenance of cultural competence 12 months after the experience.
- Objective 5: To explore the relationship between the country and setting of the international student placement, and students' cultural competence and career planning.

Objectives 3 and 4 are addressed in chapter 5.

4.2 Participant Characteristics

Table 4.1 presents the characteristics of the participants in this study.

Participants came from four different universities, each offering an undergraduate nursing program, but with slightly different program structures. Thirty-eight participants were at the end of their undergraduate program at the time of the placement, with 12 participants being earlier in their program. The mean age of participants was 27 years, however the age range was skewed towards younger participants, reflecting the typical age of undergraduate students. The median age was 23 years. The vast majority of participants were female, and all were English speaking. These characteristics are common in nursing students who undertake international clinical placements, both in Australia and internationally.

Approximately half of the participants undertook their placements in Tanzania (n = 22) with the remaining participants completing placements in Cambodia, Thailand, the Philippines and India. The majority of placements were of 2 weeks duration, with a small number being longer. All participants worked in rural areas during their placement, but the participants who went to Tanzania also spent time in metropolitan

hospital settings. The majority of participants had travelled overseas previously, as tourists.

Table 4.1 Participant Characteristics ¹

Variable	Number
Total Participants	52
Age:	Range: 19-55 years Mean: 27.1 years Median: 23 years
Gender:	
Female	48
Male	3
Country of Birth:	
Australia	37
UK	9
Other	5
Country of Placement:	
Tanzania	22
Thailand	14
Cambodia	8
The Philippines	5
India	1
Placement Setting:	
Rural	28
Rural and Urban	22
Length of placement (weeks):	
2	39
3	10
4	1
Point in Nursing Course:	
Second year:	12
Third year:	33
Fourth year:	5
Semester:	
Three:	1
Four:	11
Five:	9
Six:	22
Seven:	7
Previous travel experiences:	
None	3
1-2	11
3-5	19
More than 5	17
Travel Capacity:	
Tourist	40
Work/Volunteer	7

¹ Gower, S., Duggan, R., Dantas, J., & Boldy, D. (2016). Motivations and expectations of undergraduate nursing students undertaking international clinical placements. *J Nurs Educ* 55(9) 487–494. Reprinted with permission from SLACK Incorporated. See above for citation information.
 Gower, S., Duggan, R., Dantas, J.A.R., & Boldy, D. (2017). *Something has shifted: Nursing students' global perspective following international clinical placements*. *Journal of Advanced Nursing*, 73, 2395-2406.

4.3 Part 1: Participants' Preplacement Perceptions of Cultural Competence

Part 1 presents participants' perceptions of the meaning of cultural competence preplacement. The findings in this section are shaped by the theoretical framework of *The Process of Cultural Competence in the Delivery of Health Care Services* (Campinha-Bacote, 2007). An understanding of participants' perceptions regarding cultural competence before the international clinical placement is necessary to explain the changes in their understanding, perceptions and approach to clinical practice after the experience.

Analysis of the interview data revealed six major themes pertaining to cultural competence: *understandings of cultural competence, cultural desire, cultural skill, cultural encounters, cultural awareness, and cultural preparedness*. Each of these themes is discussed with reference to the theoretical framework. To ensure confidentiality, participant quotes are labelled with a code beginning with either AS or AF. AS indicates the participant travelled to an Asian country (India, Cambodia, Thailand or the Philippines) and AF indicates they travelled to Tanzania. The digit represents their participant number. For example, AS06 is the sixth participant in the cohort that travelled to an Asian country. AF08 is the eighth participant in the cohort that travelled to Tanzania.

4.3.1 Understandings of cultural competence

Participants' understandings of the concept of 'cultural competence' varied. Broadly speaking, participants felt it was important to be aware of cultural differences, to respect those differences, and to be able to work with the patient to get the best outcome for the patient.

So being aware of different cultures, what different cultures may require and being open and willing to learn and absorbing what is required. (AS15)

Being aware that there are people that are different and then being able to work with that to achieve the best for people. Being able to acknowledge the difference and work with that rather than against it. (AF12)

There was variation among participants regarding how prevalent the concept of cultural competence had been during their undergraduate program. It was not seen by participants as a concept that had been threaded through their degree.

I just can't think if we've done a particular unit on cultural competence. It was so long ago. I just remember year one, just learning all about it and all the terms that are part of cultural care and stuff. (AS06)

It's an unfamiliar word really. I would kind of picture it is someone's ability to niche (sic) and interact with people of different cultures. When I saw the word I thought 'cultural competence'? I haven't really come across that before. (AS03)

Other participants felt it had been a continuous part of their program, but when asked to describe it, appeared to respond as if cultural competence was an academic concept they had not necessarily internalised.

Being culturally competent. Gosh I should know that we did heaps on it. (AS25)

I feel like I'm sitting an exam. (AS23)

4.3.2 Cultural desire

Despite their challenges in defining cultural competence, the development of cultural competence was seen by the participants as being an essential part of nursing preparation, particularly when working in Australia's culturally diverse society. Many participants already felt comfortable providing health care to patients of diverse backgrounds. When describing their perception of caring for CALD patients, participant responses ranged from 'it is exciting and interesting' (female, 21yrs, Tanzania) through to providing more circumspect responses such as stating they 'did not have a problem with it' (AS15).

I like seeing different cultures and what they have to offer and how everyone looks at the world differently. (AF20)

Doesn't bother me where they are from really. (AS24)

However, others were apprehensive and lacking in confidence in this area, stating it was difficult to develop a trusting therapeutic relationship with non-English speakers.

There are just lots of barriers between trying to work with different cultures like language barriers and things like that. (AS22)

I just feel as though I haven't got enough knowledge to ask the question, or to know how to form the question. (AS14)

Most participants hoped their international clinical placement would give them the overall confidence and capability to provide culturally congruent care to diverse patients.

I'm hoping I can become a little bit more culturally competent and that this experience will assist with those fears and anxieties in relation to asking questions about culture. (AS14)

I will be a lot more confident with interacting with those people after I get back, if I get someone from Thailand I'll be able to talk to them and interact with them in that way. (AS03)

4.3.3 Cultural skill

It was revealed that students expected to develop communication skills as a primary outcome of the placement. Participants hoped the communication skills they expected to develop on their international placement experience would allow them to practise in a culturally appropriate way upon return to Australia.

I think it will give me a lot more confidence, it will give me communication skills with a different sort of diverse culture. (AS16)

Communication, that is a big key one I'd like to work on. I've had a bit of experience, but not really extensive experience working with people who don't speak English so that will be a good and interesting experience. (AF20)

I think it will be more about building relationships with the people and not so

much actual nursing skills. More relationships and communication with them.
(AS17)

Most participants had been introduced to the host country language through the preparation sessions run by the universities. However, few participants had focused on language as an essential part of preparation. This was compounded by the timing of the placement, being soon after final exams.

I keep trying to read through this and nothing is sinking in maybe it's because I had exams and had a lot going on. (AS23)

I should've started to learn a bit of Swahili by now but I haven't. I figure I'll just work it out as I go along. (AF04)

Despite a recognition of the potential communication difficulties on placement, the participants expected to have more time to care and hoped to be able to develop the cultural skills to alleviate suffering at an individual level.

I just hope to make a difference in someone's life each day. (AS20)

4.3.4 Cultural encounters

The students' desire for stimulation and variety was reflected in their expectations about the upcoming placement, during which they hoped to experience interesting cultural encounters with local colleagues and patients. Students revealed their decisions to apply for the international placements had been motivated by a love of travelling, an interest in 'foreign' cultures and a strong desire to develop cultural knowledge and awareness.

I think it will open my eyes and give me more awareness. I think with Cambodia it's a different environment for humanity, how they treat each other, how they remedy each other, how important family is and things like that. (AS08)

They were highly anticipating 'an amazing experience' (T1202) where cultural knowledge would be developed through exposure to diverse cultural practices, belief systems, and diversity of food and living conditions. Participants hoped that through these encounters with local people they would develop the confidence to ask about

specific health beliefs and requirements, thereby improving their cultural skill as health professionals.

Going to this Thailand trip is going to be a good experience to learn that culture, understand how they work and maybe then in our health care setting if I come across someone from the same culture I can use those skills. (AS02)

Participant quotes and further elaboration on participant expectations regarding cultural encounters can be found in article one (Appendix A).

4.3.5 Cultural awareness

Students were anxious not to appear to be imposing their world view on the host culture. They were keenly aware that they would be guests in the host country and were determined to conduct themselves in a way that would enhance relationships and collegiality. Participants were very keen to learn from their host colleagues, both culturally and in relation to nursing care provision.

I'm purely going there to learn how their health care system is and how they adapt to things and to learn from them. (AS09)

I probably don't know a great deal about other cultures but I'm willing to learn, I'm interested in different cultures. (AS23)

Their cultural desire to practise in a culturally congruent way was also strong and they were anxious to work within the expectations, values and mores of the local culture. An example of this was their preparation to wear more modest clothing.

Obviously in the rural and remote areas we are aware that we cover up. You know, wear longer clothes past the knees, if you're going for a swim cover up. (AS30)

4.3.6 Cultural preparedness

When asked if they felt culturally prepared for the placement there was a strong sense of uncertainty and of being unsure as to how to prepare. However, most were comfortable with having limited cultural knowledge about the host country, feeling their previous travel experiences had prepared them for visiting culturally diverse

places.

I feel quite confident. I know it's totally different but I've been to Bali a lot of times and I try to niche (sic) myself into their culture. I try to learn their language and dress appropriately. I go visit their temples and try to take in their history, try and understand their culture and be a part of it. So, I do feel confident because I think I will do the same as I do in Bali. (AS03)

Many participants felt it was unwise to prepare too much as they did not want to create unrealistic expectations. They felt it best to wait until they were immersed in the culture before trying to understand it.

I didn't want to learn heaps in case I get over there and it's not quite like what I've read and I'm like 'this isn't right it's not supposed to be like this.' I'm trying to go over there really open minded. (AS07)

I honestly don't know how I'm going to react to it cos (sic) you can't really process before it happens. (AF18)

Further elaboration on how participants prepared for the placement, including participant quotes, can be found in published manuscript one (Appendix A).

4.4 Part 2: Transitions in Cultural Competence

Quantitative data were collected to measure participants' cultural competence prior to departure, immediately upon return, and 12 months after return from placement.

This section is a manuscript of the published paper on the changes in cultural competence across all three time points. The findings demonstrated that overall scores increased immediately following return from placement, and students moved from being 'culturally aware' to 'culturally competent' (Campinha-Bacote, 2007). However, there were significant reductions in mean scores in the constructs of cultural awareness, cultural skill and cultural desire. The higher total scores were maintained over the 12 months postplacement, and there were increases in the mean scores of all constructs, except that of cultural encounters.

The internal consistency of the questionnaire was measured at all three time points and a Cronbach's Alpha score was obtained. Results were as follows:

Time 1: $\alpha = 0.747$.

Time 2: $\alpha = 0.851$.

Time 3: $\alpha = 0.828$.

According to George and Mallery(2006)these scores are considered acceptable (0.7 - 0.8) or good (0.8-0.9) and demonstrate that reliable quantitative data were collected.

The manuscript presented here has addressed reviewers' comments prior to publication.

Reference:

Gower, S., Duggan, R., Dantas, J.A.R., & Boldy, D. (2019) One year on: Cultural competence of nursing students following international service-learning, *Journal of Nursing Education*, 58(1), 17-26. DOI:10.3928/01484834-20190103

4.4.1 Article Two

One Year On: Cultural Competence of Australian Nursing Students Following International Service-Learning

ABSTRACT

BACKGROUND: The effective delivery of health care to the growing multicultural population within Australia is a challenge for the nursing profession. A breakdown in cross-cultural communication and understanding, which stems from the tendency of nurses to project their own culturally specific values and behaviours onto patients and colleagues from other countries, can contribute significantly to non-compliance in migrant populations and conflict in collegial relationships

METHOD: The *Inventory for Assessing the Process of Cultural Competence-Revised* was administered immediately before, immediately after and twelve months following return from international clinical placement to Australian undergraduate nursing students, and data were analysed using descriptive and inferential functions of SPSS.

RESULTS: Overall cultural competence increased immediately following the placement and was sustained over time. However there were significant differences among the five constructs measured.

CONCLUSION: International clinical placements enhance cultural competence but targeted activities need to be undertaken pre-placement to develop specific aspects, in particular Cultural Desire.

Background

Australia has an increasingly rich culturally and linguistically diverse population. According to the 2016 census, 26% of the general population and 35% of the population aged over 15 years were born overseas, with the largest numbers of recent migrants arriving from India and the People's Republic of China (Australian Bureau of Statistics, 2017a; Australian Government). The effective delivery of health care to the growing multicultural population within Australia is a challenge for the nursing profession. A breakdown in cross-cultural communication and understanding, which stems from the tendency of nurses to project their own culturally specific values and

behaviours onto patients and colleagues from other countries, can contribute significantly to non-compliance in this patient population and conflict in collegial relationships (Cushman et al., 2015; Esterhuizen & Kirkpatrick, 2015). Not only is cultural competence essential for effective care provision to patients, it is critical for a cohesive nursing workforce. This is particularly the case in recent times when international migration of nurses has increased markedly. In 2011, census data indicates 48.3% of nursing and midwifery professionals in Western Australia were born overseas, the highest proportion in the country (Negin et al., 2013).

Internationally, nurse educators and regulators recognize the need to prepare student nurses to be capable of providing culturally congruent nursing care practices (Nursing Council of New Zealand, 2011). In Australia, standard 1.3 of the Registered Nurse Standards for Practice (2016) states that the registered nurse “*respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures*”. In addition, an ability to reflect on one’s own beliefs and values and how they shape practice is also required. The effectiveness of other educational programs designed to enhance cultural competence besides study abroad programs have been measured quantitatively. One study in the U.S. evaluated the effectiveness of classroom-based learning packages designed to improve nursing students’ cultural competence (Govere, 2016) and found a significant increase in overall score and in each construct apart from cultural desire.

Cultural encounters in the local community have also been shown to have a positive influence on cultural competence of nursing students (Witt, 2016). The cultural competence scores of students in their final year of the nursing course, who had experienced cultural encounters via community-based clinical placements were higher than first-year students who had not yet commenced their community placement program. Interestingly, scores were also higher in the specific constructs of cultural knowledge, awareness and encounters. An increasingly common way to prepare undergraduate nurses for providing culturally competent care is participation in an international clinical placement.

International Clinical Placements

International clinical placements are supported by universities as they can offer unique, practical ways to develop desirable graduate attributes such as ‘*effective communication*’ and ‘*intercultural awareness and understanding*’ (Curtin University, 2016) that are not always readily attainable in the university classroom environment (Ballestas & Roller, 2013). International student placements provide an opportunity for students to step outside their own ethnocentric beliefs, where one’s own culture and approach to health care is deemed superior, and develop a more global perspective of their role (Browne et al., 2015; Edmonds, 2012). To develop true cultural awareness and competence, one must spend some time living in a culturally diverse environment and not rely solely on formal education sources (Charles et al., 2014).

Qualitative studies reveal immersion experiences have improved students’ confidence in nursing skills as they adapt to different nursing environments, resulting in greater appreciation of their nursing knowledge (Caffrey, Neander, Markle, & Stewart, 2005; Murray, 2015). However, the ethical challenges of decision-making in resource-poor environments has been shown to be confronting, particularly where allocation of scarce resources inevitably results in patient deaths (Kaddoura, Puri, & Dominick, 2014). Enhanced communication skills have been developed, particularly in situations where the host language differs from students’ native language (Bohman & Borglin, 2014; Gower, Duggan, Dantas, & Boldy, 2017; Kaddoura et al., 2014).

Students described a greater awareness of health systems and global issues, including the concept of social justice (Mkandawire-Valhmu & Doering, 2012); and demonstrated an increased desire to affect change via routes such as international health policy and participating in future international aid work (Gower et al., 2017). The value of international clinical placements in improving cultural competence has been reported and includes enhanced cultural sensitivity (Charles et al., 2014), and cultural awareness (Bohman & Borglin, 2014; Murray, 2015; Smit & Tremethick, 2013). Students have broadly described an ability to reflect on the complexity of intercultural relationships, particularly as they pertain to health care, and have developed confidence in asking the necessary questions of patients in order to provide culturally congruent care (Reid-Searl et al., 2011; Tuckett & Crompton,

2014).

Two quantitative studies have looked at the effectiveness of international clinical placement experiences, focussing on American nursing students' cultural competence (Ballestas & Roller, 2013; Kohlbry, 2016). Both studies found an increase in total cultural competence scores immediately post-placement, although changes were only significant in the Ballestas and Roller (2013) study (n=18). The same authors surveyed their participants one year following the placement, and found that cultural competence scores had been maintained (Roller & Ballestas, 2017). However, Roller and Ballestas (2017) surveyed only one intake of students at one university, and all students visited the same destination country. Hence the result might not be generalizable outside the context of their study and further evidence is needed for students outside the US.

Kohlbry (2016) (n=161) found non-significant increases in scores for the constructs of cultural desire, awareness, and encounters, and significant increases in cultural knowledge and cultural skill. Further studies are needed in measuring these separate constructs. Placement lengths varied between one day and three weeks duration, and caution was advised in interpreting the results of the shorter placements of one week or less. Difficulties in comparing studies due to varying placement lengths and destination, placement content and student preparation were noted and make it difficult to determine evidence-based guidelines for international clinical placements (Ballestas & Roller, 2013).

Whilst qualitative exploration of the influence of study abroad programs on students' cultural competence is common, rigorous and appropriate, there are only a limited number of studies that have undertaken a quantitative approach (Ballestas & Roller, 2013). Furthermore, previous quantitative pre-post studies have measured the immediate influence on students' cultural competence soon after return from placement, leaving a gap in knowledge of the longer-term influence of study abroad programs on cultural competence (Ballestas & Roller, 2013). This study addresses that gap and describes the quantitative exploration of the influence of an international clinical placement experience on the cultural competence of participants in both the short-term and 12 months later.

Method

Theoretical Framework

The theoretical framework used for this research study was Campinha-Bacote's *The Process of Cultural Competence in the Delivery of Health Care Services* model (Campinha-Bacote, 2002). This model of cultural competence for health professionals incorporates the five constructs of cultural awareness, cultural knowledge, cultural skills, cultural desire and cultural encounters. Within this model, it is possible to develop cultural competence through exposure to diverse cultures and a personal commitment to consciously integrate the five component constructs (Campinha-Bacote, 2007a). The questionnaire used in this study was developed from *The Process of Cultural Competence in the Delivery of Health Care Services* model and was chosen for this study because it is designed specifically to measure the cultural competency of health professionals (Campinha-Bacote, 2007a).

Research Design, Setting and Sample

Design

This study used a longitudinal approach to survey students using a Likert scale questionnaire, the results of which were analysed using descriptive & inferential statistics. Participants completed the questionnaire at three time points. *Time 1*: within a week prior to the placement; *Time 2*: within two weeks of returning from placement; and *Time 3*: 12 months after returning from the placement.

Setting

The international student placements were undertaken in five countries; namely Tanzania, Cambodia, Thailand, India and the Philippines. For the purposes of analysis, the latter four countries are grouped as 'Asia'. Whilst recognising the differences between these countries, it was considered pertinent to group these countries due to the similarities in the placement structure, and the activities undertaken by the students. In Asia students provided primary health care in rural community clinics and communities. This included administration of medication and referral to hospital care if required. In Tanzania students worked in public and private metropolitan hospitals, with some brief experience in rural communities.

In Tanzania students were exposed to health care situations of greater acuity and

trauma levels than the Asian placements, including care of patients with HIV/AIDS, and most students witnessed death. Many of the placement experiences in Tanzania were observational as differences in documentation and medication administration processes rendered the provision of care outside the scope of practice of the students. Placements in Asia were single university groups with supervising faculty provided by that university. The Tanzanian placement was the result of a partnership between the Western Australian Department of Health and five universities in Perth, Western Australia (WA). Students were placed in inter-university groups, supervised by faculty from one of the participating universities. All placements were between two and four weeks duration. Students were housed in local hotels or guesthouse accommodation close to placement sites.

Whilst on placement students were required to complete a Student Clinical Portfolio and Reflective Journal. This document was a modified version of the Nursing Competency Assessment Schedule (NCAS). NCAS is a standardised assessment tool used by many Australian universities to ensure students meet the requirements of the Nursing and Midwifery Board of Australia *Registered Nurse Standards for Practice* (2016). Students were required to write placement objectives and exemplars to describe the care they had been involved in and other learning opportunities. Faculty attending the placement assessed the students' competence in 4 domains over the duration of the placement; being *professional practice, critical thinking and analysis, provision and coordination of care* and *collaborative and therapeutic practice*. Students from one university were also required to complete a written essay focussing on the social determinants of health in Tanzania including political and socio-economic structural factors contributing to health outcomes. Whilst challenging from a time-management point of view, students reflected that it had helped them incorporate placement experiences into their world view (Gower et al., 2017).

Sample

All four universities in Western Australia who offer international clinical placements as part of a pre-registration undergraduate Bachelor of Nursing program, were invited to participate, and all agreed. Students in their second or third year of pre-registration nursing programs participating in international student placements

were identified. Placements were nursing-only and other disciplines were not included. Using a non-random purposive sampling technique, students were invited to participate in the study during pre-placement information sessions organised by participating universities. Of the 66 students identified, 52 agreed to participate at time 1. This number reduced to 47 at time 2 as five participants did not respond to emails. At time 3, attrition resulted in a final sample of 23.

Ethical considerations

Ethical approval to conduct the study was obtained from Curtin University Human Research Ethics Committee (approval number SONM33-2012). Reciprocal approval was then obtained from the other three universities whose students met the criteria for participation. Approval was also obtained from the Heads of School of Nursing at all participating universities to access undergraduate nursing students. Potential participants were verbally informed of the study and given an information sheet at pre-placement information sessions organised by the universities about one week prior to departure. Written informed consent was obtained from students who were made aware that participation was voluntary and refusal would not impact on their placement experience, or their course progress in any way. Hard copies of the questionnaire completed at the three time points were stored in a locked cupboard, and electronic versions were stored on a secure online drive at Curtin University.

Instruments

Demographics: Information was collected on participants' age, gender, previous travel and employment experiences, relationship status, and point in course.

Inventory for Assessing the Process of Cultural Competency-Revised (IAPCC-R):

The IAPCC-R is a 25-item instrument that measures the model's constructs of Cultural Knowledge, Cultural Skill, Cultural Desire, Cultural Encounters and Cultural Awareness. The Likert-scale anchor points are scored from 1 to 4, with 5 items scored in the reverse. The instrument is scored summatively, giving a total of between 25 and 100. The level of cultural competence is indicated by four categories determined by total score – *culturally incompetent* (25-50), *culturally aware* (51-74), *culturally competent* (75-90) and *culturally proficient* (91-100) (Campinha-Bacote, 2007a). Reliability has been demonstrated across numerous studies with Cronbach's

alpha scores ranging from .72 to .90 (Riley et al., 2012). Construct, content and face validity are all reported by the author of the instrument (Transcultural C.A.R.E. Associates, 2015) who also provided permission for its use in this study.

Data Collection

At Time 1 participants completed the 25 item IAPCC-R questionnaire during pre-trip information sessions, which were returned to the researcher immediately and de-identified participant numbers were allocated to each completed questionnaire.

At Time 2 participants were sent the questionnaire by email using a secure survey delivery system. Participants who did not respond were contacted by email after four weeks.

At Time 3 the researcher (S.G.) met with participants in person to administer the questionnaire. For a small number of participants the questionnaire was delivered by email as per Time 2.

Data Analysis

The analytic procedures undertaken for this study included descriptive and inferential statistics in keeping with the exploratory nature of the study. Quantitative data were analysed using the Statistical Package for Social Sciences version 22 (IBM Corp., 2013) Windows computer software. Data were entered manually and then checked for accuracy by the researcher (S.G.) and a second colleague with expertise in SPSS software. Significance was set at $p < .05$.

Using the descriptive function of SPSS-22, descriptive statistics were computed on the data from the Demographic questionnaire. To test for significant differences between responses to the IAPCC-R instrument at Time 1, Time 2 and Time 3 parametric paired samples t-tests and non-parametric Wilcoxon Signed Ranks tests were used.

Missing Data

Missing data for individual questionnaire items were addressed using the Expectation Maximisation method. As both the normal and parametric distribution method of the Expectation Maximisation method came up with similar results it was

decided to use the normal method. Time 2 results did not contain any missing data, however the overall participant number reduced to n=47. In time 3 (n=23) the Expectation Maximisation method was used to calculate a score for missing data in Q24 and Q25.

Results

Demographic results – sample characteristics

The majority of the sample (n=50) were female, and had a mean age of 27 years. Half of the cohort were aged 19-22 years, and the older half were aged 23-55 years. Most were born in Australia, with 26% born in the UK or other countries. Participants represented four universities in Western Australia. As per requirements for entry to the international placement, most students were in their final year of their course of study, and were completing their first tertiary qualification. Some had completed previous educational courses such as Technical and Further Education (TAFE) Certificates.

For a very small number of participants this was their first overseas visit; most had been overseas as tourists previously, and some had worked overseas. Approximately half had previous employment experience in the health care sector as Enrolled Nurses, Aged Care Assistants and Patient Care Assistants. Just over half of participants were in a relationship and one third had dependents. Table 4.1 outlines the demographic characteristics of the participants. [Table 4.1 is located at the beginning of chapter 4]

Questionnaire Data

Total Score Time 1 – Time 2

Paired sample t-tests were performed to compare the means from Time 1 to Time 2 on the total scores as the data were normally distributed. The results showed a significant increase in the mean total scores between Time 1 (M=71.19, SD=6.55) and Time 2 (M=75.77, SD=7.68), $t(46) = -5.44$, $p < .001$, $r = .68$

The effect size of $r = .68$ indicates a meaningful result. These results show the initial impact of participating in international placements on students' cultural competence. The change in mean scores indicate that participants moved from being

Culturally Aware to Culturally Competent.

Constructs Time 1 - Time 2

Paired sample t-tests were performed to compare the means of each of the constructs as the data were normally distributed. Results show a significant difference in all constructs, albeit in differing directions (table 2). Mean scores in the Cultural Awareness, Cultural Skill and Cultural Desire constructs decreased significantly immediately following the placement. Mean scores in the Cultural Knowledge and Cultural Encounters constructs increased significantly immediately following the placement.

Table 2: Mean scores for constructs time 1 to time 2

Construct	Time 1		Time 2		Time 1 vs Time 2			
	M	SD	M	SD	t	df	Sig.	r
Cultural Awareness	14.85	1.73	8.17	1.92	26.62	46	.000*	.48
Cultural Knowledge	11.65	2.28	13.38	2.45	-5.213	46	.000*	.54
Cultural Skill	13.26	1.81	9.77	1.20	13.217	46	.000*	.28
Cultural Encounter	14.08	1.86	15.98	2.15	-6.744	46	.000*	.54
Cultural Desire	17.42	1.75	13.70	1.28	15.723	46	.000*	.44

Total Score Time 2-Time 3

Paired sample t-tests were performed to compare the means from Time 2 to Time 3 on the total scores as the data were normally distributed. Analysis was done only on the number of participants who had completed the instrument at both Time 2 and Time 3 (n=23). The results showed no significant change in the mean total scores between Time 2 (M=74.87, SD=6.88) and Time 3 (M=74.71, SD=7.16), $t(22) = .140$, $p = .890$, $r = .70$. The total scores at time 2 had been maintained to time 3. Participants who completed the instrument in both time 2 and time 3 remained in the *culturally aware* category.

Constructs Time 2-Time 3

Paired sample t-tests were performed to compare the means of each of the constructs as the data were normally distributed. Results show a significant difference in four out of five construct means (table 3). Mean scores in the Cultural

Awareness, Cultural Skill and Cultural Desire constructs increased significantly 12 months after the placement. Mean scores in the Cultural Knowledge construct showed no significant difference, and mean scores in the Cultural Encounters construct decreased significantly 12 months after the placement.

Table 3: Mean scores for constructs time 2 to time 3

Construct	Time 2		Time 3		Time 2 vs Time 3			
	M	SD	M	SD	t	df	Sig.	r
Cultural Awareness	7.96	1.22	15.39	1.75	-22.03	22	.000*	.454
Cultural Knowledge	13.04	2.40	13.09	2.19	-.11	22	.912	.672
Cultural Skill	9.65	1.03	15.09	1.81	-16.39	22	.000*	.482
Cultural Encounter	15.56	1.83	13.93	1.60	4.35	22	.000*	.454
Cultural Desire	13.70	1.18	17.21	1.80	-9.12	22	.000*	.287

Random Effects Regression Model

To confirm the changes over time, the Random Effects Regression Model was used to analyse differences in total scores and each of the constructs across all three time points (table 4). Only the 23 who completed all three time points were included in the analysis. Mean scores were adjusted for the number of participants that completed questionnaires at all three time points. The random effect takes account of repeated measures on individuals. The intercept function was used to allow for individual differences at baseline. Analysis was also done to find correlations between age and setting of placement and total score. There were no marked difference between age-groups ($p=0.653$) or setting of placement ($p=.392$). Correlations between scores and placement length were not analysed as there was only one student who completed a 4-week placement. The vast majority of students completed placements of 2-3 weeks and it was felt a separate analysis was not necessary as the experience would not be considerably different between 2 and 3 weeks.

Time was a significant influence on total scores. There was a significant increase in total scores at time 2 ($p=.021$), and from time 1 to time 3 ($p=.029$). There was no significant difference between time 2 and time 3 ($p=.892$). Significant increases in total scores occurred following the placement, and these were maintained for 12 months.

Cultural Awareness scores reduced very significantly from time 1 – time 2, following the placement, and then increased significantly to time 3. *Cultural desire* scores reduced significantly from time 1 – time 2, immediately following the placement, and increased again significantly from time 2 – time 3. *Cultural Skill* scores reduced significantly from time 1 – time 2, and then increased very significantly to time 3. *Cultural Encounters* scores increased significantly at time 2, following the placement, and then reduced again significantly to time 3. *Cultural Knowledge* scores increased significantly at time 2, following placement, but did not change significantly to time 3.

Table 4: Differences in total scores and constructs over time

Outcome	Time	Adjusted Mean score	p-values for differences	
			Time 2	Time 3
Total Score	Time 1	72.064	.021*	.029*
	Time 2	74.870		.892
	Time 3	74.709		
Cultural Awareness	Time 1	14.913	<.001*	.181
	Time 2	7.957		<.001*
	Time 3	15.391		
Cultural Desire	Time 1	17.732	<.001*	.124
	Time 2	16.696		<.001*
	Time 3	17.214		
Cultural Skill	Time 1	13.309	<.001*	<.001*
	Time 2	9.778		<.001*
	Time 3	15.096		
Cultural Encounters	Time 1	14.100	<.001*	.881
	Time 2	15.986		<.001*
	Time 3	14.045		
Cultural Knowledge	Time 1	11.701	<.001*	<.001*
	Time 2	13.413		.536
	Time 3	13.169		

Discussion

This study explored the initial impact of participation in an international clinical placement on the cultural competence of undergraduate Australian nursing students and the maintenance of any changes over time. Results demonstrated the effectiveness of international clinical placements in improving overall cultural competence scores in the short-term. This is supported by previous research

(Amerson, 2010; Ballestas & Roller, 2013; Bentley & Ellison, 2007; Kohlbry, 2016). Uniquely the results also demonstrated that this improved level of competence was maintained over time. However, there were interesting results when the individual constructs were considered (figure 4.2). This supports previous research demonstrating improvements in cultural competence do not occur evenly across all the components of cultural competence (Isaacs et al., 2016).

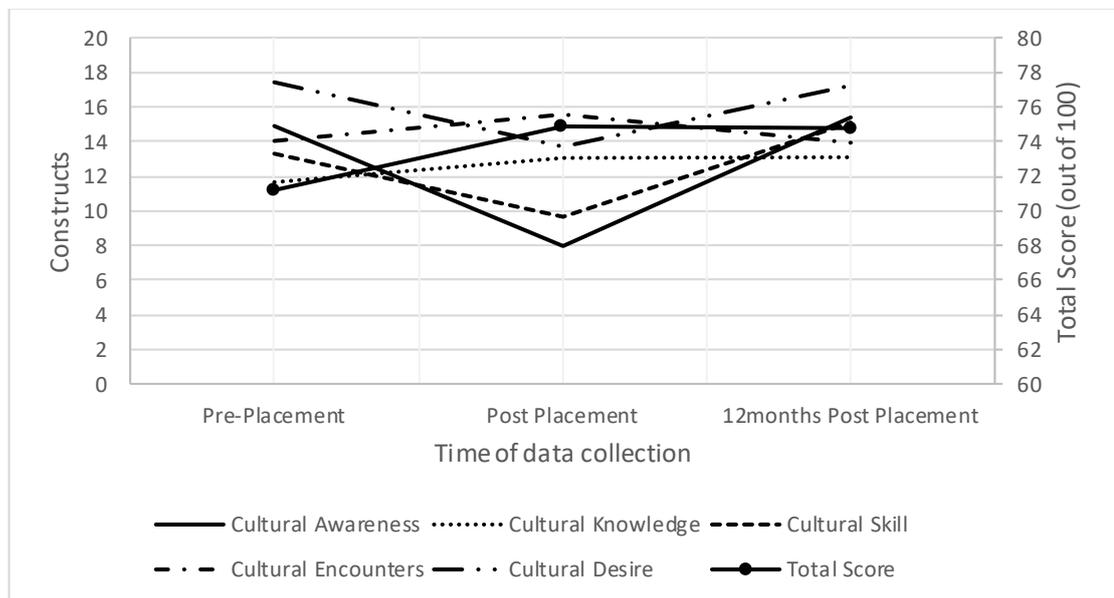


Figure 1. Changes in cultural competence scores over time

Time 1 – Time 2

Immediately following the placement there were significant decreases in the scores for Cultural Awareness, Cultural Skill and Cultural Desire. In the case of *Cultural Awareness* this indicates a shaking of the beliefs of participants who perhaps realised for the first time how much they did not actually know (Ulvund & Mordal, 2017), were confronted by a realisation of their own previously-held stereotypical views (Kohlbry, 2016) or were confronted by cultural practices that challenge their own deeply-held beliefs such as the belief that the state should support abandoned children (Murray, 2015). The experience appears to have broadened their world view.

Cultural Skill encompasses communication skills, something that previous studies have shown students clearly struggle with during their placements (Murray, 2015;

Tuckett & Crompton, 2014). Qualitative data collected concurrently revealed that for students in Tanzania, communicating without an interpreter was extremely challenging. This limited their ability to ask relevant questions pertaining to cultural needs of patients and build rapport. For those in Asia, interpreters assisted with the communication process, but the process was not always smooth (Gower et al., 2017). As Cultural Skill is so reliant on an ability to communicate, it is possible this component of cultural competence cannot be developed from international experiences where interpreters are not provided.

There was a surprising and significant drop in *Cultural Desire* immediately post-placement. This could be explained by some of the unexpected challenges faced by participants during their placement which included a perceived lack of compassion of staff, a perceived devaluing of human life, poor administration, and a lack of evidence-based practice. The students who visited Tanzania appeared to be confronted by the low-resource setting, and had more difficulties adjusting to different nursing practices (Gower et al., 2017). Previous work has demonstrated similar challenges experienced by nursing students, particularly in Africa (Johannessen et al., 2014). Qualitative data reported in a previous article demonstrated students had a limited awareness of the political, economic and social determinants of health in their placement countries and limited awareness of the cultural norms around the concept of 'care' in health settings (Gower et al., 2017). The sometimes confronting reality of health care in developing countries experienced by participants may have reduced their feelings of self-efficacy when dealing with patients from diverse cultural backgrounds in the short-term as they struggled to incorporate the more culturally distant practices and values they were witnessing, such as differences in the value of human life.

The higher scores in these constructs prior to the placement could also be a result of providing socially desirable responses, a known limitation of self-report questionnaires (Gozu et al., 2007; Loftin, Hartin, Branson, & Reyes, 2013). These questionnaires in this study were not anonymous, in keeping with the longitudinal nature of the study, and students may not have been objective (Gozu et al., 2007). High pre-placement scores may be the result of poor awareness in students of their own ability (Isaacson, 2014), given their self-reported limited exposure to caring for

patients from diverse backgrounds to that point (Gower et al., 2017) . Lokkesmoe, Kuchinke, and Ardichvili (2016) highlight the dangers of this as “where individuals overestimate their own competence, cognitive and cross-cultural blind spots are likely to lead to cultural misunderstandings and culturally inappropriate behaviours and interpretations that may have grave consequences in terms of ...personal effectiveness.”(p.167)

Time 2 – Time 3

Twelve months following the placement mean scores in the *Cultural Awareness* construct increased significantly. This indicates students were engaging with their diverse patient population with a broader mind and had possibly been reflecting on their own beliefs and values over time (Isaacson, 2014). Over twelve months, participants had time to reflect on their experiences and assess their periods of discomfort and challenge when they were no longer confronted on a daily basis. Structured reflection has been posited as key to transforming perspectives, particularly following challenging immersion experiences such as international placements (W. W. Chang, Chen, Huang, & Yuan, 2012; Riner, 2011). Further work is needed to explore this proposal, with a particular focus on the length of time necessary before clear reflection is possible.

The significant improvement in *Cultural Skill* possibly reflects participants’ ability to once again communicate with patients, either in English, or via hospital-provided interpreters. Their confidence in their ability to ask relevant and culturally-appropriate questions appears to have increased. It is possible that participants had a number of opportunities to practice their acquired nonverbal communication skills over the twelve months, fine tuning and developing the skill further.

The increase in *Cultural Desire* possibly reflects their greater feeling of self-efficacy, control and confidence in being in the Australian health system where they have the necessary social and cultural capital, and practical resources to provide care to their own standards. Further research is required on whether twelve months of post-registration experience builds the confidence of newly graduated nurses in engaging with culturally diverse patients and applying the knowledge and skills learnt on international placements.

The *Cultural Encounters* score decreased significantly twelve months after return from placement. Despite the multi-cultural nature of Australian society, the Anglo Saxon culture is still dominant (Australian Bureau of Statistics, 2017b). Participants would not be experiencing the depth of cultural exposure they experienced in their overseas immersion experience, nor would they be required to adapt to the degree they needed to while on international placement.

Interestingly, *Cultural Knowledge* scores increased immediately post-placement, but there was no significant change over the subsequent twelve months. This suggests participants gained knowledge of culturally-related treatments and practice whilst on placement, but had not had the opportunity to develop that knowledge further on return to Australia. This indicates there may be a need for targeted professional development opportunities for new graduates to expand upon their Cultural Knowledge.

The findings highlight that despite an overall improvement in cultural competence scores, and an observed maintenance over time, there are significant differences in the five constructs. The differences in the results between the 5 constructs suggests pre-trip preparation activities, as well as in-country learning activities, need to be specially designed to target each of the constructs individually in order to maximise development across the entirety of the cultural competence spectrum (Salisbury, 2011). This is particularly important for the construct of Cultural Desire, which is considered the foundation upon which all further cultural competence development is based (Campinha-Bacote, 2002).

To enhance self-awareness (part of cultural awareness), students could be required to complete a structured reflection pre-placement on how they think the experience will impact on their professional practice, their cultural competence and their career planning. This may help to mediate against motivations based purely on cultural curiosity.

To enhance cultural knowledge and encounters, students should undertake learning on the historical, cultural and structural factors impacting on the current health

system in the destination country. This will include political influences, how the system is funded and the roles of various health professionals. Students need sufficient time before departure for the study abroad program to develop this knowledge. Some ethics-based training needs to be included pre-placement to help students manage the confronting decisions they may need to make or observe in resource-poor environments (Kaddoura, 2014). On return from placement students could provide a presentation to other students or to work colleagues on their experience. This will help them to define and reflect on their experience, and its contribution to personal and professional development. A structured, supported discussion with faculty who had attended the placement would be part of the preparation for this presentation.

Limitations

It may not be possible to generalise the findings of this study to other international placement programs given the wide variations between international placements including length, destination, and point of course of students. The relatively low number of participants that completed questionnaires at all three time points (n=23) means results should be interpreted with caution.

Conclusion

The present study adds to the body of knowledge on the effectiveness of study abroad programs on cultural competence. Unlike other studies, this study measured the cultural competence of participants over the longer term, twelve months following return from placement. Results indicate international clinical placements can be effective in building and maintaining cultural competence over the longer term. However, not all aspects of cultural competence develop equally. Targeted activities need to be developed to ensure improvements in all aspects of cultural competence occur equally with particular emphasis on strengthening Cultural Desire. Consideration also needs to be given to the optimum passage of time needed after returning from placement for students to effectively integrate their learning into practice in a truly transformative way.

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4.5 Part 3: Enduring Influence on Cultural Competence

Part 3 continues on from parts 1 and 2. This approach has been used to demonstrate the continuous journey experienced by participants as the influence of the international clinical placement unfolded. Part 3 presents the qualitative data on participants' perceptions on the longer-term influence of the placement experience on their ongoing cultural competence and relates to objective two of the study.

Objective 2: To explore the maintenance of cultural competence 12 months after the experience.

Participants were contacted 12 months after their return from international placement. Of the initial 52 participants, 25 responded to a request for an interview. These findings describe the perceived influence of the international clinical placement on participants' professional nursing practice, and the development of cultural competence as health practitioners. The personal, professional and cultural growth that resulted from the placement experience have been framed by the constructs of Campinha-Bacote's (2007) *Process of Cultural Competence in the Delivery of Health Care* theoretical framework.

Analysis of the interview data collected 12 months after return from placement revealed three themes (table 4.2): *Learned to approach care differently*, *Reduced cultural competence* and *Personal growth*. The experience impacted on their nursing practice, and there was some evidence of improved or maintained cultural competence across all five constructs of the framework. However, students did come to realise their limitations in this area, especially where there were language barriers. In some cases, there appeared to be an acknowledgement of reduced cultural competence.

Personal growth and resilience had occurred in most students, through confronting personal challenge and difficulties. Students became more aware of global health disparities, but poor supervision in some instances meant the opportunities for true reflection were lost. Students at times felt frustrated they had not been able to achieve more.

Table 4.2. Personal and professional growth and cultural competence 12 months following placement

Theme	Subthemes
Learned to Approach Care Differently	Learned from cultural encounters Developed communication skills Developed awareness of self, global health disparities and different health systems Developed cultural knowledge
Reduced Cultural Competence	Understanding the complexity of cultural competence The supervisory role
Personal Growth	Faced challenges Personal resilience Culture shock on coming home

4.5.1 Learned to approach care differently

It has given me a broader understanding of their culture and gives me a different view on how I do things in my practice today. (AS19)

Aligned with pre-trip expectations, participants perceived they had developed cultural understandings and had formed ideas as to how these could be applied as health professionals. Even as the level of development was dependent on the degree of engagement in the clinical setting, exposure to different cultural encounters — with their associated values and mores — promoted a broadening of cultural awareness, knowledge and skills of most participants and allowed them to see health care from a different perspective. In particular, participants highlighted the development of their nonverbal communication skills and the cultural skill to have the confidence to ask questions about patients’ health-related beliefs in order to practise culturally congruent health care. In summary, participants learnt how to approach care differently.

It’s given me I guess the knowledge to actually ask about someone’s cultural beliefs and what other things might be going on because maybe they don’t want to be treated by a doctor. Maybe they are getting other care from home as well. (AF11)

4.5.1.1 Learned from cultural encounters

During the placement experience, participants were exposed to a variety of cultural encounters with local colleagues, patients and families. These included health-related encounters in the clinical setting with patients, collegial encounters with staff and local nursing students around clinical practice, as well as informal encounters in the local neighbourhoods with families, shopkeepers, children and community members. With the exception of language preparation, most participants felt they had been culturally well prepared for their experience and were broadly aware of cultural expectations and possibilities.

We were prepared, we had a lot of cultural lessons and language lessons prior to leaving. We did group counselling sessions working on how we would work as a team and what we would be confronted with and we had a lot of cultural lessons so we wouldn't risk being rude once we got there in terms of how they eat and a lot of their traditions. So we were very prepared in that regard, culturally. (AS19)

The [pre-trip] meetings worked really well with letting you know what to expect to a certain extent. (AF19)

Despite an initial awkwardness, participants in the Asian placements were proud to have developed positive professional and personal relationships with local colleagues and people. They described a sharing of knowledge and new mutual understanding.

Took a while to bond with the Thai nursing staff, it was just building up that relationship with the other team. Once that was established it worked pretty well. They were absolutely amazing people. (AS25)

Participants expressed particular respect for the medical staff in the host country, noting that the doctors often performed the role of both doctor and nurse. Particular mention was made of the interpersonal skills of the medical staff in Asia, being able to speak several dialects and engage with people at all socioeconomic levels. Their dedication and commitment to the local people was noted.

They were awesome, absolutely amazing. They just work until there are no more patients. Nothing is too much trouble over there, nothing is too small,

nothing is too big. (AS15)

However, due to language barriers and sometimes limited understanding of each other's roles, engagement was not always possible. Tanzania participants were somewhat disappointed with the lack of opportunities to liaise with local nursing staff and patients. This was partly due to the differences in staff roles and scope of practice. Participants perceived that the nursing staff were not performing tasks that are typically the responsibility of nurses in Australia. Those tasks were instead being performed by the medical staff. Participants therefore engaged more with the doctors, with whom they discussed cases and treatments.

They were all really willing to share all of their information and I think it helped that we were all eager to learn as well. You know, it goes both ways. (AS23)

In some cases, participants had a perception the nursing staff had not been happy to have them in the hospital.

But we felt like they [the nurses] didn't really want us there to be honest, like we were in the way some of the time. (AF06)

Engagement with patients had also been limited in the Tanzanian hospital setting. Differences in documentation, the high potential for medication errors and participants' limited scope of practice in that setting had rendered patient interaction difficult.

We didn't engage with patients. Facilitators wouldn't let us do anything. (AF14)

However, participants in the Asian settings had been able to interact directly with patients. The primary care focus allowed participants to use skills within their scope of practice. This had provided first hand experiences for participants in responding to local consumer beliefs and health priorities.

There was a man whose blood pressure was over 200, 200 and something over I can't remember what it was. And telling him that he needed to go the hospital and he just flat out refused and walked back across the field. (AS25)

In summary, the degree of engagement the students experienced within the activities in the clinical setting influenced their perceptions, reflections and cultural growth.

4.5.1.2 Developed communication skills

In Tanzania, despite having learnt a small amount of Swahili before the placement, participants found their ability to interact with patients and staff had been limited by the language barrier and absence of interpreters. This in turn had impacted on their capacity for learning from the placement, and on the relationship with local staff.

What would have usually been like a quick 5 minute thing turned into like a 45 minute thing just because of the communication. (AF11)

And that is actually the barrier, the language more so than the culture or anything else. And it also meant they couldn't understand why we were there. (AF09)

To be honest we didn't do a lot of communicating with other people there anyway because we didn't care for the patients much. (AF14)

In Asia, participants had been able to liaise with local staff and people through interpreters. However, working through an interpreter presented some challenges.

To be able to express what you need you really had to be one hundred percent reliant on the interpreter all the time and then it goes back to that frustration when they are not communicating exactly what you want to say. (AS08)

We had just one translator between the three of us students. If one of us was going into a different room we couldn't communicate at all. (AS06)

Despite these communication challenges, very few participants mentioned the difficulties faced by non-English speaking patients in the Australian system. They did not seem to reflect on the similarities between their own language experience and that of CALD patients in Australia.

However, in the majority of cases these communication difficulties had led to participants developing a range of nonverbal communication skills such as miming, using facial expressions, building patient rapport through smiling and being creative in getting the message across. Alternatively, English-speaking staff from the international placement setting had been sought for help.

Yes, probably helped improve those just trying to get the basics across to people with a language barrier. You've just got to find different ways, whether it was showing them something or getting someone to translate or just showing them something. Also just facial expressions. (AS15)

The communication was a barrier because we didn't speak the language but we learnt to use interpreters, learnt to use facial expressions and hand gestures. We took bubbles and skipping ropes and toys to engage with the kids in another way. Instead of being able to speak we engaged with them through play. (AS17)

Participants revealed that the development of nonverbal communication skills had been transferable to their practice in Australia, where the patient community and nursing workforce are culturally diverse. Participants had become more proficient in finding varied methods of communicating essential information.

I don't shout now because there is no point, because I realise they don't understand. I did know that before, but I do think I used to shout and speak in a funny accent. (AS25)

Just things like implied consent. There is such a big language barrier if someone puts their arm out for a blood pressure then that is OK, they don't have to physically say it. And just learning to communicate with body language and how important it is to go in with a smile. They might not speak your language so body language is a big thing. (AS27)

Even now I draw pictures for people if I have to, find other ways of communicating. (AS17)

Those that had committed to language preparation and used their cultural skills were

able to develop positive associations. Where participants had been able to form positive connections with medical and nursing staff, experiences were enhanced.

You just had to give a little bit and then you got a lot! (AF05)

Well in Africa I tried to learn Swahili before I went as much as I could and even that made such a difference when people knew you were trying to speak Swahili you could see the big smile on their face and they would try to speak English back to you. (AF11)

The importance of language was highlighted by the students, and there was a general recognition that focusing on language as a pre-trip priority would have enhanced the placement.

And I think it would have been a different experience if we had more language preparation. Like an intensive Swahili week or something like that. (AF02)

A lot of people think oh its ok I'll just pick up the language when I get there but I knew we wouldn't be able to, you can't learn enough in a couple of weeks, you need to start preparing at least a year ahead. (AF15)

4.5.1.3 Developed awareness of self, global health disparities and different health systems

Self-awareness

Aligned with developments in cultural awareness of the host countries, a corresponding growth in self-awareness eventuated. When immersed in the different context, some were shocked to identify they had an innate racial or cultural prejudice, something they had not believed they had prior to departure. It was not until they were forced to deal with a different culture and context as a minority group member that they were able to see this trait for the first time. They were also able to recognise it in their colleagues.

And it's really difficult because you have got all this inbuilt prejudice and you don't like to think that you are, but to be honest with yourself you are. (AF07)

I remember the other students saying all the African people were very rude.
(AF05)

Others revelled in new-found independence and resilience. For some, it was their first time travelling outside Australia and they embraced the broader horizons. A call was made for such placements to be compulsory for all young people, not just nursing students. It was felt this would enhance global understanding, tolerance and personal resilience in young people.

I think everyone should have to do it. I think it should be a rite of passage. I think if governments from developed nations sent every high school student, or everyone aged 30 has to go and do 6 months. (AF07)

Exposure to a different culture, with its associated values and beliefs promoted a broadening in the minds of some participants and allowed them to see life from a different perspective. For some, this shift in values meant slowing down and being thankful, for others it meant a greater commitment to family.

I think for me it was taking the time to slow down and appreciate things. Taking a step back when you get so busy and so full of life, for me I have definitely been able to take a step back and take it all in and realise how lucky you really are. (AS19)

I think seeing that they are very family orientated in Thailand shows that we don't do that here in Australia for a lot of things. So I've been trying to do a bit more stuff with the family here. (AS04)

Some participants were able to clearly articulate new priorities, with an element of humility and regret at past behaviours. To a degree they were struggling to align their transformed priorities with those of Australian society.

I'm even angry at my friends, they will complain that it took an hour to get through to Centrelink and 'they are only going to give me \$400 a fortnight'. I'm like, are you kidding me? (AF16)

When I was working full time, every Friday night my friend and I would go out to dinner and go shopping after and I wouldn't do that now. (AF15)

Being the minority

For many participants, this was the first time they had experienced being part of a minority group. They experienced what it felt like to be stared at, and to witness local people talking about them openly. Some had experienced challenging reactions from children in particular. This was their first experience of being the ‘other’.

And it was very different being the minority group. We learnt the Swahili word for white people and you could then hear and recognise the locals around you that would point and say white person. So, it was quite interesting being the person that everyone was like ‘look over there’. So, it was different. (AF19)

It is awful when children cry because I think they hadn’t seen white people before and they just looked at us and started crying which wasn’t a very good feeling. (AS21)

Just an awareness of how traumatic it can be if you don’t have an understanding of health and stuff like that.....how traumatic it can be for these people, and how frustrating if they are not getting information in a manner in which they understand. Doctor speak is doctor speak. So, I think it has made me more aware of that. I don’t know whether that is a direct result of seeing it, or a direct result of actually feeling what it is like to be powerless and not really understanding what is going on, not being able to communicate. It’s really isolating. It’s really isolating. (AF07)

Awareness of global health disparities

Participants discussed their enhanced awareness of global health, economic and social disparities. Their awareness of the wealth divide between regions and nations was heightened. A range of responses revealed this new shift in perspective. Some participants were angry at the injustices they witnessed. Their new knowledge of disparities had caused some participants to struggle with their place in the world, and their possible contribution to the status quo. Many expressed sadness, particularly at the plight of children.

Others felt frustration at what they saw as the overwhelming nature of the problems and their limited capacity to address change in such a short time frame.

I guess it's a mixture of like disappointment that this is how far we've come. There's so many advances that we can appreciate here but then it hasn't really advanced at all there, if anything, maybe the gap's gotten bigger between the developing and developed world. There's definitely sadness and empathy towards the people living in those conditions as well. (AF11)

It is frustrating in a way because as much as you would like to dedicate your life to doing that you can't, because you need to make your own living here. (AS19)

I think internationally the world is becoming smaller, I guess. So, it's important to have an understanding of what's going on internationally as well, the Ebola outbreak and that type of thing. Although it's not close to home it has potential to become so. (AS23)

And that is one of the things that I really struggled with when I got back, because it was so overwhelmingly consumer driven and I was part of it! I was part of it! (AF07)

Participants also came to understand how the disparities had impacted on their placement experience. The large amount of donated medical equipment the students had taken with them was received by some clinical areas in a transactional way, being used as a form of payment that allowed certain access and privileges. Participants were surprised at the realities of a system where donated goods became a commodity. There was some frustration that their strong cultural belief in well-intentioned generosity had possibly not been received the way it was intended. This clash of cultural beliefs and values had been difficult for participants.

We only got to go into the neonatal room and play with the babies because we had bought about 200 nasal prongs, oxygen cannulas for neonates. That's how we got in. It shouldn't be like that. It's definitely not a positive thing that we are viewed as bearers of stuff. (AF14)

However, there was also some pragmatism in their approach to the global disparities they encountered. Some felt their experience had shown how small actions could make a big difference, something that gave them hope for the future. They perceived targeted action could leave a lasting outcome.

A lot of the time we are thinking too big. We are wanting to fix things too quickly and fixing very difficult problems. Whereas if we take a step back we can fix the smallest things quite easily. They might be small to us but they are massive to the people that you are helping. (AS19)

Awareness of different health systems

For the majority of participants, this was their first experience of a health care system that required patients to pay for care. Participants were confronted by the resulting fragility of access to health care.

They were trying to put in a cannula in the head of the baby, and they kept going and going and attempting it and the needle was dirty and they were putting it on the desk and then picking it up, using the same one again and we asked why do you use the same needle when it's not clean anymore and they said because the mum has to pay for each new needle. (AF11)

Differences in sterility, documentation, dispensing of medication and general hygiene were also at times confronting for the participants. Participants working in the Tanzanian metropolitan hospital system struggled to understand how the hospital system could be effective.

On the first day it was just like where am I and what am I doing here and how am I meant to help these people when there are no resources available that I am used to using to actually help them? (AF15)

I think the thing that stood out the most for me was the lack of resources as well as the lack of skilled care available to the labouring women in the hospital. It was really confronting to see women laying on the floor in labour and crying out for help with no one to help them. As well as this we saw dead babies and that was really confronting. (AF04)

Going into the hospitals was like a massive culture shock. On the first day we walked in and there was someone not breathing on one of the beds and when we notified the nurse she kind of just put a sheet over his head and it was like whoa, straight into the deep end. (AF02)

The lack of cultural knowledge of the realities of practising nursing in a resource-poor environment had a notable influence on students' perceptions. The apparent practice of treating symptoms without investigating causes, and diagnosing without tests caused concern in some participants, challenging their belief in evidence-based practice. In Asia, participants were initially surprised by what they perceived to be the practice of repeated diagnoses of only two or three specific conditions in all clinic patients, and administration of only selected medications, without examining for alternative causes of symptoms.

The only medication they give is multivitamins and antibiotics and Panadol. (AS06)

It [the diagnosis] was always 'muscle pain' from working in the fields, or 'respiratory' because of the smoke in the houses, or scabies. (AS25)

However, despite their concerns about the limited regulation around dispensing medication, the participants who travelled to Asia found the health system to be effective. After adjusting to local practices, they found they were able to work with their host colleagues and deferred to their decisions. The focus on primary health care in the Asian placements was in alignment with participants' professional nursing values. They saw it as cost effective and, could see how it could be applied to health care in Australia.

Their whole focus was more on primary health care and preventing illness rather than treating illness because they really don't have the money to be able to treat it. Which was quite interesting. And they have got a lot of really good programs we got involved in to do that and it was a really eye-opening experience. (AS17)

I think it is really great, even though their health system is a lot poorer than ours, it is still running and, it is still working and, it's actually pretty good the

way the system is. (AS18)

As they navigated their way through the placement, participants developed new cultural awareness of their own strong belief in the value of universal health care. Participants saw first hand the poor health outcomes faced by patients with limited access to the social determinants of health. Participants blamed the political system for what they perceived as ineffective priority setting that left patients vulnerable.

I feel like it's not the people in Africa's fault that they get sick. It's their health care setting rather than them not brushing their teeth or washing their hands. It's the country as a whole, they don't have access to that information or the resources to help them to build those things that we do here every day and don't think twice about. I've realised it's not the individual's fault but sometimes it's the system. [before the placement] I thought that sometimes it might be their own fault. (AF19)

These people have to walk for miles and get buses to come and see the doctors and to get their medication. Yeah we are just so lucky really. (AF16)

Of particular note, participants were grateful for the access to universal health care in Australia that is available irrespective of a patient's ability to pay. Participants also noted the availability of resources in the Australian health system and how this impacts clinical practice. The ease with which they were able to access equipment, knowledge and other health professionals, including specialists, was highlighted. This heightened level of gratitude was in line with participants expectations, as they had anticipated this result prior to departure.

If there is not a vital sign trolley for three patients you shouldn't really get upset because really, they don't have anything. It does help you put it into perspective, what we have got. (AS15)

I think it makes you more grateful for having the resources and the ability to help in a more prominent way over here [in Australia]. (AS08)

4.5.1.4 Developed cultural knowledge

Participants were able to gain a stronger understanding of the expectations of CALD

patients in Australia, based on the type of health care such patients may have experienced in their own country. By understanding the expectations and previous experiences of care of CALD patients, participants were motivated to ‘*make it better*’ (AS06) for them in Australia. Participants’ immersion in a different cultural context resulted in an increased confidence in asking questions about cultural needs to gain cultural knowledge in caring for patients from CALD backgrounds.

I was always a bit shy really, especially as a student. I wasn’t too confident with people that much. I had been travelling but I hadn’t spent much time with locals. So, I think it has influenced there. I do feel more confident now.” (AS18)

Before I was worried about offending them or doing something wrong but now I go in with open eyes and you ask questions and you listen to them and pick up on their vibe of how they do things. (AS27)

Just a broader understanding of where they are from and what they are used to and how different things are done here and keeping that in mind. I think it makes you a lot more aware and knowledgeable. There is a lot more involved than what meets the eye. (AS19)

For some participants there was increased cultural knowledge of the social determinants of health, that there are biological, social, religious and land-related concepts involved.

It kind of helps me understand that not everyone has a western view of health, not everyone has a biological view of health, it is biopsychosocial. That it’s to do with religion, and land and stuff like that which Tanzania opened my eyes up to. (AF05)

Cultural knowledge gained from observing communities in action was highlighted. As reported in article three (Appendix B), the resilience shown by communities was highlighted for participants. Whilst acknowledging the hardships of life in those communities, participants appeared to interpret the behaviour of most patients in

these settings as being happy, contented and grateful for the available health care.

There is that real sense of community. And sense of you know looking after each other so yeah that was what I saw largely out there. (AS23)

Yeah you just see how the family comes together and they all work together for everything. With their traditions they hand them down to each generation, I think that is a really good thing and, I think we lack that in Australia sometimes. (AS04)

A minority of students seemed to accept the situations in these countries, and hold little concern at the difference in conditions. There was a perceived simplicity to the lifestyles the participants encountered, which some regarded as preferable to Australian society. The cultural desire for social justice or to effect change was limited in these participants.

Initially I felt a bit sorry for them but then I realised that they don't know any different. That is what they are used to. That is all they pretty much know. (AS04)

4.5.2 Reduced cultural competence

Qualitative data revealed that despite expectations to the contrary, participants had struggled with the concept of cultural competence, mostly because they came to understand its complexity.

4.5.2.1 Understanding the complexity of cultural competence

When asked about requisite characteristics to care for CALD patients, some participants, despite their well-meaning attitudes, were not able to articulate the specific requirements of cultural competence. The cultural barriers remained in place, or felt stronger, as students realised that cultural competence was more complex than expected. When asked to describe cultural competence they did not refer to awareness of their own culture or asking specific questions about cultural needs. There was a general perception that empathy and kindness would be sufficient, in the same way that nurses would use those skills with local patients.

Have an open mind, empathy, even sympathy, all the normal things that you need to deal with any person who is going through whatever they are going

through at that particular time. (AS15)

Many participants mentioned 'patience' as being an essential skill with CALD patients, whilst waiting for them to express themselves in English. Participants appeared to believe patience was the best option, rather than learning some basics in a foreign language themselves, or engaging hospital interpreters. However as demonstrated previously, their capacity to reflect had been heightened. It may be that the term cultural competence is simply not well understood.

Interestingly, as students became aware of the complexity of cultural competence they realised their limitations in this area. Exposure to the variety of cultural encounters, their lack of communication skill and an inability to ask culturally appropriate questions left some students feeling reduced in their capacity.

I think if anything, I felt less culturally competent coming out of it. Just because you are more, more aware. Even in Africa it's not just one cultural belief it's like hundreds of different beliefs. Before we left, we sort of researched and it was just a more general thing but when you get there everyone is different and they have so many different belief systems in place there, so yeah, I think I felt worse about my cultural competence coming out of it. (AF11)

Some participants revealed a desire to transform the health settings they were in to be 'more like Australia', with evidence-based practice and free universal health care for all.

That desire was in opposition to their preplacement determination not to impose their world view on the host setting. Some reported the perceived deficiencies they had witnessed in some of the health systems had made them want to 'fix it'. There appeared to be a lack of awareness in some participants of differences in health systems, health funding models and the impact of the double burden of communicable and non-communicable diseases faced by some of the countries they were visiting.

And I have this thought and it sounds so wrong but they just need a western organisation to come in, take over the hospital, clean it up, get it running

again and retrain people. And it would be great. Even in the public hospital you have to pay for your medication and everything. Nothing is free so I think we definitely have a role, definitely. (AF18)

The quote immediately above highlights the participant's lack of understanding about the funding of the health system in Tanzania and, how it impacts on care provision and health workforce issues. The participant seems to feel that by getting the system 'organised' then health care can be provided for free.

4.5.2.2 The supervisory role

Where supervision had been strong and effective, participants were able to clearly cite the benefits to their experience, both culturally and clinically. Difficult cultural situations were explained and put into context. Where clinical practice differed, or was outside the scope of students, effective supervisors were able to still facilitate clinical learning.

We were lucky the facilitator had been before so she knew exactly what would happen and what we would be doing and what to expect. (AS17)

I learnt a lot from the tutors. (AS25)

The importance of continuity in the supervisory role was highlighted. In Tanzania, supervisors were usually visiting Tanzania for the first time, which impacted on the participants' experience of placement. Unrealistic expectations were placed on them even as they were managing culture shock and adjustment. Despite general recognition of the difficulties of the role, and praise for how that role was usually fulfilled, participants did note that in one group the pressure on the supervisory staff led to disagreements and conflict, which had impacted on the student experience.

I know that my supervisor did not cope at all. A couple of times I asked her if she was alright. Not that she really said much but by the end of the first week I thought 'she's not doing so well'. And I know one of the other supervisors, although she loved the experience, she had quite a few days where it was clearly hard for her. And I think for some of the younger students that weren't coping so well themselves it made it hard to see she was falling hard as well. (AF14)

We did have issues with our supervisors when we were there. One of the students made a point that the only arguments were between the staff looking after us. Some of them were really, really bad. On a couple of occasions, it was really unhelpful and quite public. (AF09)

4.5.3 Personal growth

Participants faced considerable personal, cultural and professional challenges during placement. The shift in global perspective experienced by students partly as a result of these challenges is summarised in article three (Appendix B). The challenges faced by participants are also discussed here, but from the viewpoint of cultural competence.

4.5.3.1 Faced challenges

Despite the pre-trip preparation, participants were confronted by unexpected professional and clinical differences they encountered on placement. In some ways these experiences served to create barriers to the development of cultural competence. Prior to the placement participants had intended to be accepting and open minded, however there were specific encounters that they found difficult to overcome.

The biggest challenges were professional, such as a perceived lack of compassion from nursing staff in Tanzania (Horiuchi et al., 2016). Some participants found it difficult to accept that their deeply-held value of the role of compassion in Australian nursing was absent in the Tanzanian context (as they perceived it).

A lady gave birth to a still born baby and was like screaming and screaming and the nurse like hit her and said in Swahili like 'enough enough' and I was like 'Oh My God'. (AF05)

I knew what to expect in one way but in another way I was completely shocked like at the way the nurses treated some of the patients. (AF18)

Where they had expected a resourceful nursing workforce they were confronted by what they perceived to be nursing apathy, and a lack of nursing contribution to patient care. Unfortunately, some participants attributed this behaviour to culture rather than focusing on potential contextual and systemic causes.

I really was quite disappointed actually. I thought there was huge capacity for nurse intervention and they just didn't seem to do anything. And I also felt like I didn't understand why. (AF18)

The nurses don't do anything. They basically hand out medication. They don't wash or feed or clean or make beds or any of the stuff that we do. (AF07)

I feel like I have learned what NOT to do as a nurse. (AF14)

Some of the challenges were the result of being in a low-resource setting such as lack of pain relief options for patients and poor facilities. In these cases, participants were more able to reconcile what they had witnessed with the context within which they occurred.

I guess it was a clean technique because they didn't have a sterile field or a sterile trolley. So they were doing the best with what they had but there is no way I would do it that way. (AF15)

In some students there was recognition that the socioeconomic-political situation contributes to the way the health system runs, the attitude of nursing staff and the priorities within it. Participants became aware of how the low status of nursing and the power structures within health in their host countries had sometimes resulted in poor professional identity.

But looking there and being in the schools and seeing the nursing students and how little they get paid for what they do, you can see why sometimes they have to resort to things they do. It's not because they don't know better, sometimes that is all they can do, the corruption. Put the pulse oximeters on the ward and go back the next day and they are gone. Once you see how they live and how much they get paid you can see why those things might happen. (AF19)

One particularly unexpected challenge among some participants was difficulties within the Australian cohort of students. Some participants felt their colleagues had not been open minded enough in approaching nursing practice differences. They perceived a sense of cultural superiority being displayed by their colleagues.

They [my colleagues] were like 'Why are they pouring bleach into ulcerated wounds, that is so dumb' whereas I thought 'they are just doing what they have got the resources for'. I just saw it differently. (AF05)

There was also a perception of ethnocentric behaviour by fellow students. Of concern, this included disregard for patient dignity.

It's a general courtesy that before you go into somewhere, you ask them if it's OK, you treat them with dignity and respect and, you give them a choice and I don't think we did that there. (AF05)

On the day that we went into labour ward, there was a woman whose baby had just died. And they are all standing there in a group saying 'when is someone going to come in labour, when can we see, is that lady going to give birth?'. I was so sickened, creating all of this hype and excitement around these mothers who aren't even allowed to grieve the fact that they have lost their babies. And there is a bunch of students in there whooping and yee hahing because they ended up seeing someone give birth. There were so many things that were so inappropriate. It was a blatant disregard to moral and ethical behaviour. And that is what it was, like a free-for-all. It was seriously like a free-for-all. I was embarrassed. (AF07)

4.5.3.2 Personal resilience

Despite these challenges, coping with the daily stressors of climate, language barriers, resource limitations, cultural differences and group living had enabled some participants to find new inner strength and self-awareness. Participants revealed they now drew on their experience as a coping mechanism, and had a sense of satisfaction from what had, for most, been an uplifting and inspiring experience. This capacity to look within themselves during difficult situations had continued following their return from placement.

I was a lot stronger than I thought I was. (AS28)

Resilience! Resilience to heat and having bad hair and people you don't get along with and things you don't like seeing and food you don't like eating and having to find a good thing out of each of those bad things. I would say resilience and a positive attitude towards things that suck. (AF05)

Probably a thicker skin. You are a bit overwhelmed and you kind of just keep going. (AF18)

4.5.3.3 Culture shock on coming home

Some participants struggled culturally with re-entering Australian society and the nursing work environment. They were frustrated by what they perceived as greed and a lack of gratitude in Australian patients. They also felt the Australian health system was wasteful of resources.

I actually got quite a lot of culture shock when I got back. Just in regards to, again our health care system and the patients we have and the things they expect, it made me quite angry, knowing what people in Tanzania go through, how patient they are, how tolerant they are and we have people complaining that they've only got a sandwich and fruit for lunch or the meal is late or the bed is uncomfortable. You didn't change my sheets today, well you are lucky you have got sheets. So I did become a little bit intolerant of people here. (AF16)

I found it really hard to fit back into my life when I came home and that had more effect on me than going away over there did. (AF14)

This dissatisfaction extended to concern they had been of very little benefit to the host communities. A large amount of money had been raised by the students with the intention of giving it to a needy cause in the host country. Some of this money had returned home with participants and remained unallocated. This was partly due to the Thailand health system being well funded by the royal family, but also a perceived lack of transparency.

We've got about \$5000 still and we keep meaning to send it over to the royal

fund. That will happen. I did try to arrange it before the other group went over. But it never sort of happened. But it is still sitting there so it will get over. I know the last team before us that went to Laos they had problems in using up the money as such. (AS25)

And we all worked hard, I personally raised nearly \$5000. I had people over for curry nights, I made 50 million cupcakes, I made my husband sell cupcakes at work. We put in a lot of effort. But there has been nothing to say 'Group of 2012 this is how we spent your money'. We bought this or we have set up this. Nothing. (AF07)

Ethical concerns were raised by participants who expressed regret they had been unable to do more to change local situations. They also felt opportunities for ethical or personal expansion had been lost, and some could not identify an overall purpose for the placement.

There was no opportunity to make a difference. (AF14)

I don't know what their goal is. I don't know what they are trying to achieve out of that [the placement]. What is the point? (T1207)

Very few participants had been given an opportunity to discuss their experience after returning, and some described a feeling of abandonment and a need for debriefing and reflection. Participants had witnessed some distressing clinical scenarios and seen the impact of poverty first hand. No post-trip support or counselling had been offered for those that had felt confronted or shocked by their experience.

Because I did find it very odd that we were kind of dumped when we got home. And that is what it felt like. (AF14)

There was never any offer of post-trip counselling. Nobody called to say 'Hey listen you have just been through a really big cultural shock and experience, are you ok, are you coping?'. (AF07)

Participants had difficulties at times articulating the influence of their experience and some stated that the interview with the researcher had been the first time since

returning from the placement 12 months earlier they had reflected in any detail on their experience.

The only follow up or discussion we ever had about this was with you, now.
(AS08)

4.6 Combining Qualitative and Quantitative Data on Cultural Competence

This chapter has outlined the qualitative and quantitative data pertaining to cultural competence and personal growth experienced by participants following their international clinical placement. In many ways the quantitative data aligned with the qualitative data to create a holistic account of the influence of the experience.

Table 4.3 shows the themes emerging from the qualitative data and how they correspond with the constructs used in the quantitative data collection on cultural competence. Qualitative data collected 12 months after the placement showed that participants had learned to approach care differently. They were able to articulate where they had developed enhanced cultural awareness, skill and desire and how they were applying that to their nursing practice. However, they were having fewer cultural encounters and had not gained new cultural knowledge since their return from placement. This is reflected in the quantitative data in each of those constructs.

For theme two, reduced cultural competence, both the quantitative scores and the qualitative data reflect areas where participants experienced challenges during placement that impacted on their cultural desire, cultural skill and cultural awareness. This was particularly evident in the quantitative data collected immediately following the placement, when significant reductions in those three constructs occurred.

Table 4.3: Cultural competence and personal growth 12 months postplacement

Theme	Sub-theme	Construct Mean Scores	Immediately Postplacement	12 months postplacement	$P < .05$
Learned to approach care differently	-Minds were broadened	C. Awareness	7.96	15.39	.000*
	-Cultural learning and cultural safety	C. Knowledge	13.04	13.09	.912
	-Communication skills	C. Skill	9.65	15.09	.000*
	-Caring for CALD	C. Encounters	15.56	13.93	.000*

		Construct	Preplacement	Immediately	
		Mean Scores		Postplacement	
	patients -Self-awareness -Experienced being a minority	C. Desire	13.70	17.21	.000*
Reduced cultural competence	-Difficult cultural experiences	C. Awareness	14.85	8.17	.000*
	-Inability to accept the practices of others	C. Knowledge	11.65	13.38	.000*
	-Communication difficulties	C. Skill	13.26	9.77	.000*
		C. Encounters	14.08	15.98	.000*
		C. Desire	17.42	13.70	.000*

4.7 Conclusion

Through the various cultural encounters participants experienced on placement, students learned to value and understand cultural safety. From having first hand experience of being a minority, participants came to understand the feelings associated with looking ‘different’. Participants intended to use this new cultural awareness to improve the experiences of patients from diverse cultural backgrounds seeking health care in Australia.

Participants learned to develop relationships despite language, cultural and practice differences. Participants intended to use this enhanced cultural skill to improve their provision of culturally congruent care to all patients, and to pursue careers that would enable them to provide holistic care to patients and their families. The cultural knowledge gained improved participants’ understandings of the expectations of patients from diverse backgrounds, which they felt would enable them to ask appropriate questions and address patient concerns. They had an enhanced cultural desire to practise culturally appropriate care.

Participants’ minds were broadened. They learned about global health disparities and the impact of resource scarcity on health outcomes and practice. However, expectations of a resourceful and grateful nursing workforce in the host countries

were not necessarily met. Participants developed self-awareness (cultural awareness). They identified unacknowledged prejudice and their own strong beliefs in universal health care. However, in some students the experience had served to increase barriers and possibly reduce their cultural competence. Students made judgemental comments, perceived themselves as being superior in a nursing sense and were not able to separate their own values and beliefs from those of the placement setting. Through the personal and professional challenges encountered, participants developed resilience and experienced personal growth. They became aware of global health disparities, which enabled them to see the interconnectedness between countries.

Chapter 5 will present the findings pertaining to the influence of the international clinical placement experience on participants' career planning.

5. Findings: Influence on Career Planning

5.1 Chapter Structure

This chapter presents the findings regarding the influence of the international clinical placement experience on the career planning of participants. It also makes some observations concerning the influence of such placements on the global perspectives of participants. The findings are presented in two parts that correspond to the journey the participants followed over the course of this study. The findings provide insight into changes in participants' career planning; from their motivations to apply for the international clinical placement through to the continuing influence of the placement 12 months after their return.

Part 1: presents a complete outline of participants' preplacement expectations and motivations regarding career planning and changes to their global perspective. Understanding participants' career preferences and global perspectives prior to the placement gives context to their preplacement perceptions and provides a baseline from which to see changes in their career planning and global perspectives following the placement.

Part 2: presents a comprehensive exploration of participants' perceptions of the enduring influence of the placement on their career planning over 12 months. Article three (Appendix B) gives meaning to the data presented in part 2, demonstrating the interconnections between the international placement experience and participants' global perspective, and the subsequent influence on career planning.

5.2 Part 1: Preplacement Career Planning

The findings in relation to participants' preplacement career plans were drawn from the qualitative interview data (Y. Chang, Voils, Sandelowski, Hasselblad, & Crandell, 2009). Quantitative data on participants' preferred career speciality area are presented in table 5.1. These data were not collected in quantitative format and the numbers have been ascertained from interview transcripts. As participants typically nominated more than one area of interest the numbers presented are more than the total number of participants. In most cases, participants found it difficult to define one specific speciality area on which to focus their career. The specialty areas identified in table 5.1 have been arranged in order of frequency from highest to lowest.

Table 5.1: Speciality areas preferred by participants preplacement

Specialty Area	Number of responses (n=52)	Cross-section of participant quotes
Emergency Department (ED); Paramedicine	19	<ul style="list-style-type: none"> • <i>I'm working in ED right now on prac. I love it. The diverse patients you get to see, the fast-paced nature of it all and the more acute situations I love. (AS09)</i> • <i>So, I actually really like the ED environment, basically because you see bits of everything and, you never quite know what's coming through the door. (AF05)</i> • <i>I like the fast-paced environment, the fact that you don't have the Ward work, like there's constantly changing patients and you've got a lot of time management skills you've got to learn and you get a lot of interesting things like cardiac patients. (AS02)</i> • <i>I already know I want to go back and study paramedicine (AS06)</i>
International work – developing country (voluntary or paid); Work with refugees in Australia	18	<ul style="list-style-type: none"> • <i>There is something called Project Smile where nurses will take 2 weeks annual leave, go over and do free operations and things like that. And that is something, I'd love to do. (AS07)</i> • <i>I would like to go maybe for two to three months and just work in their country to improve their areas. (AF02)</i> • <i>I just think I would prefer to work in a developing country because I would like to see the difference I can make. (AS29)</i> • <i>I'd like to get involved in Medicins Sans Frontiers and Red Cross and things like that. (AF08)</i> • <i>Probably developing country. Because I think they need more help. (AF11)</i>
International work – developed country	15	<ul style="list-style-type: none"> • <i>If I was to go international it wouldn't be like in Asia or a third world country it would be more...my family is from America and Canada so it would probably be Canada or America. (AS09)</i> • <i>I'm actually interested in doing nursing in different health care settings like in England and America, in particular, because I think there would be different aspects which I could learn from that and bring it to here. (AS02)</i>
Preceptor role; Tertiary teaching role	16	<ul style="list-style-type: none"> • <i>I like to teach people, even in my hospital with other nurses or students. Without thinking about it I will go into an education role and I'll quiz the other students or I'll say 'have you seen this?' (AS03)</i> • <i>But I have been approached by a couple of people that do the clinical preceptoring and they said that I should consider doing that when I finish...so I wouldn't mind doing that. (AS26)</i>
Midwifery	14	<ul style="list-style-type: none"> • <i>After I finish my degree I want to do one grad year and then I want to do midwifery. That's because I have been watching the shows on TV. (AS29)</i> • <i>At this stage I'd like to go into midwifery. I will need midwifery to do RFDS. (AS23)</i> • <i>I actually want to work in Afghanistan doing midwifery. They have really, really bad maternal outcomes there, and neonatal outcomes, as well. I have a few friends who are in the army and go over there and that's why I originally got interested. (AS21)</i> • <i>When I was in my first year I had a prac at this little hospital in Margaret River... and on the last day I was there this lady came in and she was giving birth and she allowed me to sit in there and watch and help and assist, and it was a massive thing, I was like 'I think I will [do midwifery] one day', it was one of the best memories I've had so far. (AS18)</i>
Indigenous health (interested but wary)	13	<ul style="list-style-type: none"> • <i>Definitely interested in Indigenous health because after doing my assignment on Primary Health Care that highlighted the importance and the big discrepancies between the Indigenous population and non-Indigenous population and things like that, things that can be improved. (AS02)</i>

		<ul style="list-style-type: none"> • <i>I think a lot of the issues in Indigenous care are being tackled the wrong way. (AF09)</i> • <i>I guess I just see the Indigenous people of Australia as a need group that is close to home that I can relate to and share a land with ... so I think that could be an area that I could maybe do. The only thing is it is remote and rural. (AF12)</i> • <i>It is something I definitely do want to try, just to see how I go, but I don't think that it's something I would do for a long time. (AF03)</i>
Community health; Primary health; Health promotion	12	<ul style="list-style-type: none"> • <i>I did a community placement for midwifery at a child health clinic and I loved that. I don't know if it was because of the continuity of care side that I was seeing. (AS06)</i> • <i>In community, I think it would be an interesting way to, like, do Primary Health Care and stuff. If you're going into the community and you're going into their homes, you can sense more of the psycho-social aspect of things. (AS02)</i> • <i>I wouldn't want to go into the community straight away because I feel I would lose my skills that I'd developed. (AS03)</i>
Critical care; High dependency; Intensive Care Unit (ICU)	9	<ul style="list-style-type: none"> • <i>Critical care and high dependency. That stuff really interests me. (AF06)</i> • <i>I really feel drawn to ICU. I like the whole critical thinking aspect. (AF07)</i> • <i>At the moment, I think I want to go into ICU, so high acuity areas. (AF11)</i>
Paediatrics	8	<ul style="list-style-type: none"> • <i>I didn't think I wanted to work in paediatrics until I had my prac there and I really enjoyed it. and I really liked the atmosphere so, I thought this is where I want to get into. (AS03)</i> • <i>Paediatrics Emergency is the main career goal if I have to say anything, because of the fast pace, the uncertainty. (AS19)</i> • <i>I've always had an interest in paediatrics, I like children and the way they develop and everything like that. (AS18)</i>
Postgraduate education	7	<ul style="list-style-type: none"> • <i>My plan now is to do some post grad studies and then maybe in the future be a uni tutor. (AF11)</i> • <i>I'd love to keep studying, I love studying, I don't want to work next year I just want to keep studying. And also, that's why I think oh maybe I'll go into health promotion stuff because then I can do a post grad in something. Definitely open to it. (AS17)</i>
Nurse Practitioner; Medicine	6	<ul style="list-style-type: none"> • <i>I want to do my Masters as quickly as I can so that way I can get onto training to be a Nurse Practitioner which is like my ultimate goal. (AF02)</i> • <i>I've always had in the back of my head I might go and do medicine. I just want to keep on learning. (AS27)</i> • <i>I'm really interested in studying medicine after I finish. (AF08)</i>
Royal Flying Doctor Service (RFDS)	5	<ul style="list-style-type: none"> • <i>Down the track once the kids are a bit older I'd probably like to go royal flying doctors. (AS23)</i> • <i>I was thinking of doing flight nursing because I had an experience in July working for the RFDS in Sydney and worked for flight nursing over there. So, something that will get me outside the hospital. (AF05)</i>
General Ward Nursing	5	<ul style="list-style-type: none"> • <i>I just like being on the ward as opposed to being in ED or theatre or ICU. I just like being in the ward. It's the personal contact you get on the wards, and the teamwork with the girls and just the environment. (AS05)</i> • <i>I just really want to be a ward nurse that looks after people. (AS25)</i>
Theatre	3	<ul style="list-style-type: none"> • <i>At the moment my current career plans are to hopefully get a grad program as a theatre nurse and work from there and eventually do theatre. (AF01)</i>
Palliative Care	2	<ul style="list-style-type: none"> • <i>I'm interested in palliative care. (AS28)</i>

The nursing students' expectations of the influence of the placement on career planning was broader than simply the development of an interest in a specific speciality area. The influence extended to overarching values and principles, with a focus on stimulation, social justice and inclusiveness. As such, it is the reasons behind their career preferences, more than the numbers allocated to specific speciality areas that are the primary focus in this section.

Preplacement interview data analysis revealed five major themes pertaining to career planning, with associated subthemes: variety and stimulation, social justice, holistic nursing care, leadership and autonomy and multifactorial career influences. Two themes emerged regarding their expectations of the influence of the international placement experience on their career planning which were testing future capacity and personal benefit (table 5.2).

Table 5.2: Preplacement themes regarding career planning and expectations of placement

	<i>Theme</i>	<i>SubThemes</i>
<i>Career Planning</i>	Variety and Stimulation	Desiring careers in ED/ICU/RFDS
	Social Justice	Desire to help those less fortunate Indigenous health Helping future students
	Holistic Nursing care	Care at meaningful life points Desire to be culturally competent
	Leadership and Autonomy	Medicine and Nurse practitioner Postgraduate studies
	Multifactorial Career Influences	Family commitments Age
<i>Expectations of Influence of International Placement on Career planning</i>	Testing Future Capacity	Testing capacity for future international aid work. Expect challenge, fulfilment and gratitude. Want to test basic nursing skills.
	Personal benefit	Will enhance my curriculum vitae Will give me a professional advantage

5.2.1 Desire for variety and stimulation

Participants expressed a strong desire for roles with variety, stimulation and excitement. There were a number of areas they felt they could achieve these.

5.2.1.1 Desiring careers in ED, ICU and RFDS

Prior to undertaking the placement there was a strong desire among participants to work in fast-paced speciality areas with high levels of variety. When asked about future career intentions, interest in working in emergency departments (ED) of metropolitan hospitals was high. Participants described the pace, variety and unpredictable nature of ED work as appealing. Aligned with this was an interest in Intensive Care Units (ICU), trauma and critical care work. Critical thinking, high acuity and high patient turnover were highlighted as being an attractive feature of work in these areas, with the rapid transition through diagnosis, treatment and conclusion of care being attractive to participants.

I did a prac in an overflow ED, an AAU (acute adult unit) and I really found it interesting, different people, fast-paced, you see lot of different things, there is lots of change all the time, and I really enjoyed it. It's not just one thing that you are doing all the time. (AS24)

Critical care... I love like thinking about...I like the acute illness of patients, dumb as it sounds. I don't know... seeing things work on them so quickly like in the ED just treating them, especially in resus, and just looking at them there and then and treating them acutely. (AS16)

For some, the plan to seek work in the ED and ICU was in preparation for work in the Royal Flying Doctor Service (RFDS), a flight-based health service operating in the rural and remote regions of Australia. Employment with the RFDS requires experience in ED or critical care nursing, along with midwifery. For those seeking employment with RFDS the stimulation and variety of care experiences were prominent, but so was the potential to be removed from hospital ward nursing, which was perceived as boring and repetitive.

I was thinking of doing flight nursing because I had an experience in July working for the RFDS in Sydney and worked for flight nursing over there. So,

something that will get me outside...something in health care for sure but I don't think there's many options for nurses outside the hospital apart from flight nursing or community nursing. I don't think nursing is the career for me forever in a hospital setting. (AF05)

A desire to work outside hospitals was also cited by those intending to retrain as paramedics. Some had already worked in this field and reported enjoying the community-based nature of this work, as well as the stimulation and variety. Others had not experienced paramedical work, but had already made the decision during their undergraduate nursing degree to return to further education in paramedicine after consolidating their nursing skills for several years.

My current career plans is to get into the emergency department and eventually probably get into paramedicine. I currently volunteer for the ambulance services, and have been doing that for about 3 years and I have a bit of a passion there for helping people in the community. (AS13)

5.2.2 Social justice

A desire to contribute to social justice was strong in participants. They expressed a wish to 'give back' to the community.

5.2.2.1 Desire to 'help' those less fortunate

Participants expressed a desire to be able to 'help' and effect change, both in the upcoming international placement and throughout their career. This was a particular motivation for participants in choosing to apply for the international placement and reflected their overall approach to career planning. Participants felt providing care in the destination countries of their placements would be more rewarding than working in Australia, as they perceived patients in those contexts to be in greater need.

I wanted to see or help people that really need it. (AF04)

I'd like to work somewhere where they are still needing more help to even bring it up to an average level of health care. They are still using old techniques to treat illnesses and a lot of them don't have education that work in the hospitals. I don't know how many of them are actually trained nurses. (AF11)

*It just interests me to help people that are less fortunate really, I like that.
Working with the underprivileged interests me. (AS22)*

Participants clearly felt the Australian system would be more technologically advanced, better resourced and of a higher standard than the host countries' health systems.

I think it'll be a very eye-opening experience to how far we've come I guess...how high tech some of our things actually are...how much understanding and learning we have been done to get to this point... medical interventions and nursing as well... to compare their view of nursing and the role of nursing to over here...I think it'll really give me a perspective of basic nursing care. (AF12)

Participants hoped their contributions as student nurses would be welcomed and effective. They hoped their skills would be sufficient to quickly and easily alleviate suffering on an individual level where possible, revealing a strong desire to 'give back'.

I don't feel obliged to put back into developed countries, but I feel as a human being it's a responsibility for us wealthy people to do something. (AS29)

I would like to be able to contribute. Just to be able to provide health care to everyone, equal health care. (AS23)

I hope to be able to give back to other communities. (AS15)

Participants felt that to truly effect change it would be necessary for them to travel overseas, as it would be unlikely to happen in Australia. Some perceived their impending international placement would reaffirm their belief in the nursing role and help them become reacquainted with why they originally chose nursing as a career.

I think it will be an eye-opening experience and I think it will help justify why I am doing nursing... not justify... remind me of why I am doing nursing. To reach out to people who sort of need it. (AF20)

There was also a perception that the patients in developing countries would be more appreciative of the nursing care the participants would provide, unlike Australian patients who “*take things for granted*” (AS25).

Because the nurses who have come and spoken to us are saying they [Tanzanian patients] are quite stoic and don't show their pain as much but I've had some patients here that complain about everything. (AF01)

They are just a happy race as well, they seem to be grateful for what little they have where we seem to be so ungrateful. (AS05)

And people that don't have anything compared to what we have over here, and they are still happy and they still manage and they are still grateful. (AS27)

Hopefully it doesn't make me say to patients 'suck it up you should see what I saw in Cambodia'. (AS07)

5.2.2.2 Indigenous health

Aligned with the concept of social justice was a desire in some participants to do future nursing work in remote Indigenous communities in Australia. Similar to the views expressed by those planning international work, remote Australia was seen to be an ‘area of need’ and participants felt a moral responsibility to help those people with whom we ‘share a land’.

I guess I just see the Indigenous people of Australia as a need group that is close to home, that I can relate to and share a land with ... so I think that could be an area that I could maybe do. The only thing is it is remote and rural. (AF12)

I would like to do the health education, that primary health care, with the Indigenous in the remote areas and just teaching about diabetes, or hand hygiene, that aspect of day to day living that actually prevents a lot of illnesses from occurring. (AS30)

However, plans were for short-term stints in remote and rural communities in

Australia, as the distance to family, friends and metropolitan amenities was perceived as a barrier to long-term commitment. Most participants, whilst expressing concern for the health disparities in Indigenous communities, were not specifically planning to work in that area.

I would only imagine it to be a 6 month thing, I wouldn't do it for a long time.
(AS10)

5.2.2.3 Helping future students

Linked to their desire to do 'good' and effect change was an interest in providing education to future generations of nursing students. Participants expressed an interest in providing preceptorship to students on clinical placement, or returning to the university environment as lecturers or tutors. In all cases, these were long-term plans to be implemented after some years of clinical work experience. Participants liked the idea of helping students and sharing their knowledge with others. The role of providing continuing professional development to staff was also seen as an attractive future career option, to be reserved for a time when they felt age precluded them from other roles such as ED and night shift.

I learn best from teaching others. I have been told that I am good at explaining things or translating things. I have been told I am a good teacher so that is something I would like to do. (AF17)

I would like to pass on my skills and educate others, which would be good. I'm not really at a level at the moment but in a good couple of years' time I would like to help other nurses improve their skills. (AF20)

5.2.3 Holistic nursing care

Care for patients across all aspects of psychosocial health was important to participants. In particular, they wanted to help patient navigate significant life moments in a patient-centred and culturally appropriate way.

5.2.3.1 Care at meaningful life points

Relationships were highlighted by those participants that mentioned midwifery as a potential future career path. Midwifery was identified as both a primary choice as well as a conduit to the RFDS. For some, midwifery was described as "*the happy*

side of nursing” (AS18) and they felt drawn to the prospect of being involved in a significant moment in a family’s life. The positive media representations of midwifery as a profession, including television dramatisation and documentaries, had contributed to some participants’ interest in this field. The possibility of providing continuity of care throughout the antenatal, intrapartum and postpartum periods was attractive to some participants seeking opportunities to provide holistic care. Others saw midwifery as a stepping stone to their ultimate goal of working with the RFDS, for which a midwifery qualification is essential.

I find them [midwifery and paediatrics] very holistic so you are looking at the whole family and all of that influence on health, it’s not just that one patient. (AF17)

I think it [midwifery] is a bit more personal, a bit more one-on-one. It’s not just that patient in that bed, it’s more personal. I really like that one-on-one contact with the mother and the baby. (AS22)

Yes, Royal Flying Doctors is my goal and to do that I need to work in ICU and be a midwife. (AF16)

Although low in numbers, palliative care was also identified by 2 participants as an area of interest, again due to the possibility of helping families at a meaningful and significant moment.

I like the idea of palliative care at some stage. It’s just a very personal approach to nursing to people because when you are there for their last days of life ... you feel the humanity. (AS08)

5.2.3.2 Desire to be culturally competent practitioners

Participants articulated the importance of cultural competence in working with patients from culturally diverse backgrounds. Participants hoped their international placement experience would allow them to practise in a culturally appropriate way upon return to Australia.

I think it will give me a lot more confidence, it will give me communication skills with a different sort of diverse culture. (AS16)

Communication, that is a big key one I'd like to work on. I've had a bit of experience, but not really extensive experience working with people who don't speak English so that will be a good and interesting experience. (AF20)

They felt they did not have a good understanding about other cultures, and had a perception that CALD patients would have more social issues that would need to be factored into care planning. A few participants were somewhat frightened about travelling to a developing country with significantly different cultural and clinical contexts for their placement.

I am actually terrified as to the limitation of what I will feel comfortable to do. Because I think we've been told so many horror stories... fifty percent AIDS, needle stick injuries and don't catch the baby because you'll be responsible. (AF11)

One of the supervisors was saying that when they [patients] are getting their wounds done apparently you don't talk to them or comfort them, which I think I will really struggle with. (AF01)

It scares me a bit because there are things I don't know, that I might come across as being rude. (AS02)

Participants saw the opportunity to gain cultural knowledge through authentic cultural encounters as a critical and important asset to their future nursing role. Participants were able to describe what they perceived to be clear differences between their own and the host countries' cultures, expressing a strong desire to experience cultural encounters that would 'open their eyes'. They felt strongly that professionally 'everything would be different', both in positive and potentially challenging ways, a prospect that was very appealing and motivating.

I'm expecting to be shocked. I'm expecting it not to be easy and expecting to really enjoy it. (AF05)

I see this as possibly one of the most challenging things that professionally and personally I can probably do at this particular point in my life. (AF07)

5.2.4 Leadership and autonomy

Despite being still in the undergraduate programme, some participants were thinking to the future with the intention of developing skills for autonomy and leadership.

5.2.4.1 Medicine and nurse practitioner

Although most participants intended to stay in nursing, a small number of students were already looking to leave registered nursing/midwifery roles and move onto other roles within healthcare. Three students expressed an interest in returning to university following graduation to enter the medical course. Others were planning to become nurse practitioners, a plan requiring significant further study and possibly a move to other parts of Australia.

I hope to go on to do my Masters so I can get onto training to be a Nurse Practitioner because they have the clinical skills as a GP and they can prescribe medications and things like that. (AF02)

5.2.4.2 Post graduate studies

They cited a desire to build on what they had already learnt, undertake what they perceived to be a more challenging profession and enhancing autonomy as their motivations. A number of students were interested in completing postgraduate education, reporting enjoyment of study generally, or a desire for promotion as the primary reasons. Postgraduate education was highlighted by other participants as a pathway to leadership roles such as Clinical Nurse Specialist. In all cases, there was a desire to be more autonomous, and influential over practice or policy.

I just want to keep on learning... I want to work my way up. That's why I really like nursing cos you can work your way up. (AF20)

Nurse practitioner... cos they have the clinical skills as a GP yeah and they can prescribe medications and things like that. That's what I was kinda hoping to do. (AF02)

I'm doing nursing now and I love it but for me I find it time consuming, I don't find it challenging and I want to be challenged. (AF08)

5.2.5 Multifactorial career influences

It must be noted that when considering their career intentions prior to the international placement, very few participants were focused on career development alone. They appeared to be factoring the needs of children, partners and future family circumstances into their planning.

5.2.5.1 Family commitments

Participants with children cited them as a reason for not being able to consider careers that involved international travel, being away for extended periods of time or moving to rural or remote locations. Children's education and stability was a high priority for participants and career options they perceived to potentially jeopardise these were not considered.

I'd love to be able to go to work in an Aboriginal community or something like that or somewhere remote for a while, but with children I don't think that will happen. Not in the near future anyway. Not until they move on until high school or near the end of it. (AS05)

In cases where the family had a financial dependence on the partner's income, the partner's job took priority and decisions about location, workload and type of career were secondary. Financial security and partner acceptance were the priority, and career decisions were being made with consideration to how employment conditions would impact their partners.

I would consider doing rural, it's just the whole logistics of it, how it would fit because my partner has a job in the city and it is very orientated to that. (AF20)

Interestingly, participants who did not yet have partners or children were still including potential future family situations in their planning. Location and type of career were to be dependent on the partner's employment and needs of the children. This was particularly prevalent in discussions around moving to rural, remote or international locations. Participants were identifying and planning for the career interruption of future child-bearing.

So it's a matter of the right thing coming up and the timing coming up and it depends on whether we have kids. (AS07)

5.2.5.2 Age

Age also emerged as a salient feature of career planning. Participants who were young discussed the need to have their travel and international experiences ‘*while they were still young*’. They also perceived that work in ED would be best done whilst young and energy levels were high. They perceived community work to be a useful alternative as a future career option when balancing family commitments, or when increasing age meant they would be less inclined to night shift.

But then I want to get married and have kids before I'm 30 so I then I don't know if I want to do it [international work] before then or wait until I'm in my late 40s or 50s when the kids have grown up... I don't know. (AF01)

Mature-aged participants cited age as a barrier to pursuing their ideal careers, such as in ED or in international aid work. They felt family commitments, or physical stamina limitations would preclude them from entering those fields.

If I was 20 years younger I'd probably do ED but I think that ship has sailed for me which is a bit sad. (AS14)(54yrs)

Participants appeared to have a multifactorial whole-of-life approach to career planning which included the needs of significant others, both current and future. The influence of international clinical placements could not be clearly isolated within this perspective.

5.2.6 Testing future capacity

Participants felt strongly that the international clinical placement was a way to test their capacity for future challenging situations involving disadvantaged populations.

5.2.6.1 Testing their capacity for future international aid work

Many participants had firm intentions to use nursing in the future in areas where they perceived there was social injustice and patient need. The primary way they described doing this was via humanitarian aid work in developing countries. For a minority of participants, the long-term goal of undertaking international humanitarian or aid work had been the primary reason for commencing a nursing degree.

The reason I became a nurse is because I wanted to go to Ethiopia and work at the hospital by the river, the one that Katherine Hamlin started. That's why I started nursing after I read her book. (AF16)

For most, humanitarian work was to be a temporary but meaningful way to use their nursing qualification. For the majority in this category they expected their future international work would be with short-term voluntary projects of a few months, focused on providing paediatric health care, or maternity care.

After I've got some experience over here eventually I do want to work overseas in developing countries with an aid organisation, especially with women's health. (AF22)

Once I've got some experience I am hoping to go to developing countries and help train and educate nurses and midwives in other countries, but not so much in our ways. I want to help them practise their own ways more safely. (AF14)

I'd love to be involved in something called Project Smile where nurses will take 2 weeks annual leave, go over and do free operations and things like that. I know it sounds cheesy but I think every kid deserves a smile. (AS07)

Those that planned future international aid work saw the international clinical placement as an opportunity to experience working in a resource-poor setting in a safe and structured context backed by the support of the universities and health department. They felt that prior to committing to a 6-month period of international work without trial, this placement would offer them the opportunity for a short term, supported and supervised experience that would test their resilience and capacity for further international work in the future. Most expected their plans for international work would not change significantly after the placement.

This is a good way for me to be introduced to it as well because it's a program that has been going for a while. They know what they are doing, I have people there for support and peers as well. (AF10)

I think it will encourage me and give me the drive to continue on the path that

I'm already on. (AS13)

*Well I sort of see it as a stepping stone to where I want my pathway to go.
(AF14)*

*I think it will decide whether I really do want to go overseas and live over there
for a few years and whether I want to nurse there. (AF01)*

Participants saw the international placement as an opportunity to develop skills of resourcefulness, adaptability and flexibility in a low-resource setting. They considered these skills to be useful not only for future international work, but for all future roles as registered nurses. Despite being concerned at the potentially confronting nature of working with limited resources, they were comforted by their expectation that their nursing colleagues in the host countries would be able to demonstrate and advise on techniques for using resources efficiently and creatively.

*Maybe that I'll learn one thousand uses for tape or something. Just how they
could use one object for a million things. (AF05)*

*I'm purely going there to learn how their health care system is and how they
adapt to things and to learn from them. (AS09)*

Participants also expected to be able to teach the nurses in the host countries, their colleagues, in what they hoped would be a knowledge transfer between groups. They were keen to pass on their acquired knowledge, whilst at the same time being open to the potential new knowledge they could gain from international nursing colleagues around diseases and treatments that are not prevalent in Australia.

*I think it will be two fold. One – hopefully I'll be able to teach people over
there, which will give me confidence in my own knowledge and skills, and
then I think I will learn things I've never been taught here. Like I've never
treated anyone with malaria, barely anyone with HIV, and TB I've never even
heard of here so I think I'll be learning as well... and that can only advantage
me in the future. (AF11)*

It will give me a different insight and be able to educate. It is something

different, I mean you can only learn so much in a hospital but to see it in another country, to see how they do it and also learn about their health as well. (AS04)

5.2.6.2 Expecting challenge, fulfilment and gratitude

Participants expected to be challenged professionally, physically, emotionally, culturally and with resource availability. They were expecting to be shocked at the clinical acuity, and challenged by the potential of witnessing death. For most participants, the potential challenges were welcomed.

It's quite daunting I think because I'm going to see things that I've never seen before, lots of infections, lots of wounds, I'm expecting to see people die, I've never actually watched someone die. (AF13)

I think it will be an eye-opener and a shock. I've got an idea that I will see something that might shock me. (AS30)

I wanted to go somewhere where I thought it would be more hard core. I wanted a challenge. (AF04)

They expected everything to be different, including the nursing facilities and practices and, that this would broaden their understanding of global health systems.

I think their health care system is not going to be like ours in any way shape or form. (AS13)

It will give us a real different side of actually how things work when you don't have all the wealth of the country that you are living in. (AS15)

Despite the potential challenges, participants were looking forward to what they perceived would be an authentic and fulfilling experience. They were seeking a meaningful experience, where they could experience a sense of reward for their nursing work. The need for fulfilment was prevalent.

Conditions will be really tough and completely different to what we

experience here but I think it will be rewarding and worthwhile. (AS17)

I think nursing people that I don't even speak the same language as and being able to help them will be really rewarding. (AS27)

So I'm hoping that overall it will be educational and uplifting. (AF09)

They expected the experience to increase their nursing confidence and build resilience and coping skills. They anticipated enhanced coping skills would be of use both personally and professionally.

I think I will learn coping skills as well. Probably help me develop not just career wise but as a person as well. Just coping. (AS11)

I don't find nursing challenging and, I want to be challenged. (AF05)

As a result of these challenges, participants expected to feel a sense of gratitude for the resources, health care and living conditions in Australia. Indeed, participants were hoping the experience would allow them to focus on 'what is really important' which they described as being amenities for living such as running water and access to health care.

I think I will appreciate the resources that we do have and what we have available, and I will appreciate the struggle that other cultures face and the challenges that they face. (AS13)

I'll probably appreciate not only our health care here but just everything we have that we take for granted all the time. And how we complain about small problems really like maybe our power goes out for a few minutes during a storm and they don't even have power or clean running water in the villages. I think just a greater appreciation for life maybe. (AF11)

5.2.6.3 Desire to test basic nursing skills

Despite their concerns about the potential challenges of the placement, students were looking forward to what they perceived as getting "back to the basics of nursing" (AS15). They were excited by possible opportunities to use their holistic

observational nursing skills and, to develop and strengthen their clinical skills without technology. They saw the placement as an opportunity to use their autonomy and, be of personal value.

I think it will really give me a perspective of basic nursing care; the foundations of nursing and how they are so important. (AF12)

You can use your patient and you can pick up signs from your patient themselves by feeling the pulse and doing things like that - doing everything manually. Um, I think it will teach me not to rely on technology so much. That's a big thing. (AS02)

It is autonomy. I like the idea that I would know enough to be entrusted to make some of those decisions. And I want to know that much. (AF07)

5.2.7 Personal benefit

A small number of students revealed some motivation for personal gain from participating the international clinical placement.

5.2.7.1 Enhancing the curriculum vitae

A small number of participants revealed they have been motivated to apply for the international clinical placement partly to enhance their curriculum vitae.

It will look good on my resumé. (AS29)

5.2.7.2 Professional advantage

They felt their international experience might provide them with some advantage over other job applicants in a competitive job market.

I'm just hoping that maybe it will just be a little bit more experience than some of my peers may have, so it may be an advantage for the grad programs. (AS20)

5.3 Conclusion

Participants appeared to have a multifactorial whole-of-life approach to career

planning, taking into consideration existing and potential future family commitments and the limitations these would place on career options. This approach flavoured all discussions around potential career choices. However, against that background there was a strong interest in careers that offered variety and stimulation, including potentially working overseas. The international clinical placement was seen as a 'test' for themselves to determine their suitability and capacity for future international work, particularly in resource-scarce settings. Participants revealed an interest in social justice and had a desire to help others, which manifested in several different ways, including planning a move to medicine. Careers that offered the opportunity to develop relationships with people were important to participants, who wanted to care holistically and in a culturally appropriate way. In the shorter term, most participants expressed a perceived need to consolidate clinical skills before embarking on broader career expansion.

5.4 Part 2: Postplacement Career Planning

Part 2 demonstrates the continuous journey experienced by participants as the influence of the international clinical placement unfolded over the 12 months following return from placement. It outlines participants' perceptions on the longer-term influence of the placement experience on their career planning and global perspective.

Participants were contacted 12 months after their return from international placement. Of the initial 52 participants, 25 responded to a request for an interview. These findings describe the perceived influence of the international clinical placement on participants' planned areas of speciality (table 5.3), and their professional nursing practice, 12 months after return from placement. As participants identified more than one area of interest, the numbers presented in table 5.3 sum to more than the number of participants. Speciality areas of interest are listed in order of frequency from most to least popular. Table 5.3 also shows the links between the emerging themes from the postplacement interview data and the identified areas of speciality.

Postplacement findings are supported by article three (Appendix B), which expands

upon the enhanced global perspective developed by participants and reveals how this in turn influenced career planning. There is some overlap of information between the themes presented in the written section, and those presented in the article. The themes are referred to more than once in this way to highlight different aspects of the international clinical experience.

Table 5.3: Speciality areas preferred by participants postplacement

Preferred speciality area	Number of responses (n=25)	Emerging themes	Participant quotes
International aid work – developing country	20	Pre-trip plans confirmed, short- to medium-term projects, work with an organisation, need to consolidate, need experience first, realistic goals	<ul style="list-style-type: none"> • <i>“I knew I wanted to travel but when you are there yourself and helping I realised I am so passionate about that and I want to do that definitely. Philippines definitely influenced that.”</i> (AS18) • <i>“Going there in that capacity with the support of people that had been there before and everything was organised for us I think it was a good way to get an introduction to that kind of work and it has solidified for me that I definitely need to go back and want to go back.”</i> (AF16)
ED, paramedicine, trauma, critical care	10	Variety and stimulation, clinical complexity	<ul style="list-style-type: none"> • <i>“I am sometimes so set on doing paramedical science especially when there are MET calls at work it is just so exciting.”</i> (AF02) • <i>“Probably emergency department, try and do that for a bit and then becoming a paramedic. Converting to paramedicine after having two years in critical care. You can see a great deal of difference in the patient in a short time. They get better, or they get worse and you have to take them to a higher care facility. Rapidly changing situations, the excitement.”</i> (AF19)
Midwifery	9	Continuity/relationship, for RFDS, professional autonomy	<ul style="list-style-type: none"> • <i>“I actually went on to complete a Graduate Certificate in Midwifery and I am currently completing a Graduate Program at King Edward Memorial Hospital [tertiary maternity hospital in Perth].”</i> (AF06) • <i>“Next year I will do midwifery, I’ve been accepted into the midwifery course at King Edward. And I think the Philippines experience influenced me to do that.”</i> (AS17)
Community work	8	To help people help themselves, relationships,	<ul style="list-style-type: none"> • <i>“I was always interested in community health and primary health care but now I am even more interested. I would like to get into community health one day.”</i> (AS17) • <i>“I like the idea of getting people to help themselves. And if there are family members that have the same problem and then they can help them. I don’t like seeing people completely relying on others it’s important for people to help themselves.”</i> (AS27)

Indigenous health	8	Interested in culturally appropriate care	<ul style="list-style-type: none"> • <i>“It just opened my eyes and my mind to thinking, because I get so many Indigenous kids from the country at PMH [Princess Margaret Hospital]. And learning how to interact with their parents is really important particularly because you want to build rapport and you want them to comply with medication at home. It [the placement] shapes your ability to be able to do that.”</i> (AF05) • <i>“I think it has made me more interested in the Aboriginal community. They are a minority group in Australia, even though we have really good health care and good primary health care, a lot of the time they don’t receive it, or a bit against getting help from us and receiving PHC at times. So it would be good to find ways to overcome that.”</i> (AF19)
Further education	7	To be Clinical Nurse Specialist; to get into policy/bigger picture	<ul style="list-style-type: none"> • <i>“Curtin does a course in international health and one of the areas that I looked at is women and child international health.”</i> (AS23) • <i>“Maybe doing a Masters in something. It just depends on what area I end up in. I’d like to be a clinical nurse and I’m pretty sure that in a lot of areas where you do have to do your masters in order to become a clinical nurse in that area.”</i> (AF15)
International work – developed country		Need to speak English, family connections	<ul style="list-style-type: none"> • <i>“Definitely want to try it, but not in a country where I don’t speak the language. Just because it’s hard, it’s difficult.”</i> (AS28)
GP practice nurse	2	Family-friendly	<ul style="list-style-type: none"> • <i>My little boy was very upset I didn’t get to see them very often so it was just juggling that. So, I’m working part-time in one of the local GP’s practice which is good.”</i> (AS23)

As with pre-trip findings, it is the reasons behind participants' speciality preferences that have been expanded upon in the written section, with particular focus on how their international placement experiences influenced those decisions (table 5.4). Analysis of the data from the postplacement individual interviews conducted 12 months after participants' return from international placement revealed four themes pertaining to career planning, with associated subthemes: stood the test, empowerment of others, variety and stimulation, and competing realities (table 5.4). Students felt their international experiences had largely been positive, and confirmed their desire to work internationally in the future. Students also had more understanding and appreciation of the importance of primary health care, an improvement on pre-trip interview data when some participants did not understand the term 'primary care'. Roles with variety, pace and clinical complexity were still of interest, as were leadership and policy roles. Students' interest in the empowerment of women and vulnerable groups was highlighted, as participants searched for meaning in their nursing roles.

Table 5.4: Postplacement themes regarding career planning

Theme	SubThemes
Stood the test	Confirmed desire to work/help internationally Primary care Gained professional knowledge and skills relevant to international work
Equity and Empowerment	Awareness of inequities in Indigenous health care Empowerment of women Leadership and policy
Variety and Stimulation	Seeking this via career or travel Open and exploring
Competing realities	Financial and family commitments No identifiable impact

5.4.1 Stood the test

For most participants the international experience had been positive and fulfilling and they felt they had met the challenges faced.

5.4.1.1 Confirmed desire to work/help internationally

For most participants the international clinical placement had confirmed their desire to return to international settings to undertake humanitarian aid work, or participate in short-term volunteer projects. There was a strong feeling among participants that

they had coped with the experience and become stronger, confirming for them their capacity to work internationally and engage in positive cultural encounters in diverse settings.

So it has solidified I guess that it is still something I want to do and that it wasn't just a fantasy. And I know I could do it, and I know it is something I still want to do. Certainly solidified my thoughts. (AS15)

Even before Africa I kind of thought that I did want to work internationally but I didn't know where that would come into my career, and I think I have brought it forward because of that experience. (AF11)

I think I still feel quite empowered and a desire to go over and do it but I want to do it the right way more than on a whimsical sort of idealistic day dream. (AS08)

Their increased awareness of health systems and health disparities had led them to develop a more targeted approach to their international plans. For many, the need to consolidate skills prior to returning to international settings in the future was paramount, with a recognition that they would be 'more useful' with experience and firm skills under their belt. The cultural knowledge and skill gathered from their cultural encounters meant participants had developed more realistic ideas about how they could be of use overseas. They had come to realise the enormity of some situations, and were clear that their efforts would need to be targeted at a specific area, such as vaccination or infection control, rather than an overall broad desire to help.

I think you need to go over with a goal like we are going to get them to wash the floor every day. And that will be the goal for that ward. And it might take 6 months to get them doing that, but that is the goal. And then the next goal will be aseptic technique dressings. Or wearing new gloves with every patient. (AF14)

They also felt there would be a benefit in working with an established organisation rather than volunteering as an individual, as had been their previous intention. Participants had witnessed individual volunteers on placement who they felt had

been working within existing systems rather than being an agent for change. Participants felt the individual volunteers had not had any capacity to improve conditions for patients.

We met two German nurses who were volunteering over there but they were volunteers who were sort of adapting to the African health system rather than the other way around so nothing was actually, like they weren't there to change anything. I don't see the benefit, once you leave there nothing would have changed. (AF11)

I have realised that I really need to go with an organisation like GHAWA or MSF [Médecins Sans Frontières] that has a long-term plan. (AF06)

5.4.1.2 Primary care

Following the international clinical placement participants also came to understand the benefits of primary care and their potential role in that field. It was seen as more holistic and person-centred and, participants admired the focus on preventative health care. As outlined in chapter 4, it aligned with their nursing values.

I think just being able to help more people who don't go to hospitals. More primary health care. Because that was what Thailand was, more holistic. (AS25)

I was always interested in community health and primary health care but now I am even more interested. I would like to get into community health one day. I really like primary health care and trying to prevent things rather than treat it and I like health promotion. I think ultimately I will go down that path. (AS17)

5.4.1.3 Gained professional knowledge and skills relevant to international work

Despite some clinical challenges, participants revealed the experience had given them skills in teamwork and maintaining professionalism in difficult contexts. This included leadership opportunities in Thailand where participants worked with Thai nursing staff to set up and allocate staff to primary health clinics.

Learnt lots of teamwork, teamwork! (AS25)

They felt their clinical experiences had improved their preparedness to work with traumatic injury and high acuity in patients, something they felt would be transferable to the Australian setting.

And the second week having to prepare a 5 year old boy's body for the morgue after he passed away from a chest infection and the mother was crying on the ground. It's kind of like an experience where I come back to Australia and I can't see anything worse than that. It has kind of prepared me so much for my career. I feel as though I almost can't be shocked because of what I have seen there now. It's like it prepared me for the worst and now I am prepared for anything. (AF02)

They had also been exposed to clinical situations not commonly seen in Australia. This included diseases with low prevalence in Australia, or the progression of conditions that are typically treated at an earlier stage.

Now I know what scabies looks like. (AS21)

I definitely learnt more about diseases like malaria, HIV and AIDS. The treatment of AIDS actually was greatly managed, amazing. (AF18)

So it was interesting from that perspective, seeing diabetic ulcers at the extreme. (AF19)

The improvement in confidence extended to a greater awareness of the importance of the role of nurses in the global health system; in particular, the role of basic nursing care such as feeding, showering, asking about pain and providing general comfort to patients. Participants observed health systems where that basic care had been provided by families, not nurses. The difference in outcomes in patients without family members highlighted the importance of basic nursing care to participants.

You could see the difference between people that had family coming in to do the basic nursing care and those that didn't. Nurses don't do it over there. To see the health status of the difference between those two groups was pretty striking. So I think it makes you a little bit more aware of doing the little things as well that you think are nothing but they could be the things that change the day for that person that day. (AF14)

The importance of broad underlying principles around quality and safety, such as documentation, decision making and evidence-based practice, were highlighted for participants. Previously, participants had considered these principles as a lower priority than clinical skills prior to the placement, but they were now able to recognise the foundational nature and impact of these principles.

Having been an enrolled nurse before I went, all the paper work we had to do used to annoy me but since going there I have seen... it is so clear why we do it. It is quite evident. It was really good learning for me. You just have to do these things and go through the motions and it's really annoying and it takes up all your time but now I understand why. (AF16)

And I think I have a greater appreciation of all the different jobs, and pain relief, so everybody's role in the health care system. The multidisciplinary team, the doctors, the nurses, the cleaning staff. Over in Africa I saw that the registered nurses didn't do a lot. Everything was done by the enrolled nurses and the orderlies. Everyone else just sat around. So the fact that we have all these different jobs that come together for a good experience for the patient. (AF16)

And the fact that we use evidence-based practice and I've just become more confident that we are definitely on the right track with that. (AF11)

Whilst many participants were planning to work in developing countries, a small number of participants had decided to focus their international employment plans on developed, English-speaking countries. Those participants had found the language barrier on clinical placement to be too difficult, and were hoping for less culturally distant and possibly less clinically confronting work environments.

A non-English speaking country: I don't think that would do. (AF12)

[I am interested in working overseas] but not in a country that foreign. I wouldn't mind doing it for a small period of time but for a long period of time I think it would be quite stressful. To be so far out of your normal culture. I wouldn't mind going to England or America, seeing what it is like over there.

(AS27)

5.4.2 Equity and empowerment

One salient feature of this finding was the desire participants had in empowering patients to care for themselves and to therefore have dignity. It was important to them to be able to empower people through their role as a nurse.

5.4.2.1 Awareness of inequities in Indigenous health care

For some, the pre-trip interest in humanitarian work with a social justice motivation had been transferred to the Australian Indigenous population. Through their cultural knowledge, they saw that the need in Australia was similar to situations that they had witnessed overseas and they felt a moral obligation to attend to those issues.

I am taking myself to Meekatharra to work with Indigenous adults, like what am I doing! But I just think I want to consolidate those adult skills, I want to consolidate those like skills to be culturally sensitive and be able to care in different cultures and work with people who aren't, you know, white. (AF05)

Others expressed guilt at not being interested in this area, which they saw as being of similar magnitude to that they had been exposed to on placement. There was a heightened cultural awareness of the need for culturally appropriate care for patients from Australian Indigenous communities. Even though not all participants were interested in working in this area, they were all able to verbalise the importance of culturally appropriate care.

Has it given me a greater interest in our own Indigenous health? Yes. From a cultural perspective. (AF07)

I feel guilty that I'm not more interested in it. But I'm more interested in refugees. (AS21)

5.4.2.2 Empowerment of women

Their international cultural encounters led to an interest in empowerment of women in particular. Midwifery was identified as a discrete area of career interest. Whereas in the pre-trip interviews it has been mentioned as just one of a list of possibilities, or as a pathway to the RFDS, in the post-trip interviews it attained its own identity. For

many, the cultural desire to empower women in international settings through provision of maternal health care was an international goal. Others focused on the need to use cultural knowledge and skill for more culturally appropriate care for Australian Indigenous women who currently face having to leave country to birth in large regional or metropolitan hospitals. Some described an interest in midwifery from an early age.

Midwifery has always been a goal of mine but I think the international placement gave me a real appreciation for cultural safety. I think it is so important for each woman to feel safe throughout pregnancy and birth and I hope to be able to assist in women having positive birth experiences. (AS23)

Since I was about 10 I wanted to be a midwife. I don't know what initially interested me. I just like the idea of being part of something that is so special in someone's life, such a big event. (AF18)

When I went to Tanzania I vividly remember the labour wards and this has remained in my mind and also formed part of the reason I have undertaken further studies in this area. (AF04)

It made me want to go back (overseas) and educate or work in an active role as a midwife to provide a better standard of care. It has opened my eyes about how midwifery and nursing care has evolved in first world countries allowing higher standards of care to be provided and significantly reducing maternal and neonatal mortality rates. (AF16)

Some participants had described an interest in midwifery prior to departure, and the international experience served to redirect the interest to address equity and justice in that field. For others experience in maternity settings during the clinical placement made midwifery a more real career option. In both cases, the cultural knowledge gained during their experience created an appreciation for inequity or lack of culturally sensitive care in their own country, indicating an expanded perspective or worldview, which had in turn broadened their career planning.

Yes so they [Australian Indigenous women] can still birth on land with the medical equipment nearby if something goes wrong but still be able to keep

within their cultural means and the way they want things to happen for their family. I don't see why they can't have the best of both worlds it's just a matter of planning and money. (AF14)

5.4.2.3 Leadership and policy

An interest in leadership roles also emerged as participants discussed intentions to engage in further education such as postgraduate Masters programs. Their motivation to do so was to enable them to become Clinical Nurse Specialists (CNS) or Nurse Managers or work at policy level in public health. Participants felt this would enhance their capacity to effect change at both a local and global level. Participants' desire to effect change was strong and they were seeking ways to maximise their potential to do so. One student had been motivated to work overseas on a broader policy level, hoping to create change via policy development, rather than through volunteering in the clinical area.

That is what I want to do ... if I get into the Masters degree ... like designing policies and things to sort of put in place things so they are more using evidence-based practice rather than just following what someone before them has done which is the way it used to be here. So it [my career focus] has changed completely. (AF11)

I would love the opportunity to really get my skills up and be one of those nurses that work as a coordinator or a CNS and be really good in my knowledge and have team leading skills. (AS27)

5.4.3 Variety and stimulation

Participants retained their desire for challenge, variety and stimulation in their nursing role.

5.4.3.1 Seeking this via career or travel

There continued to be an interest in nursing roles that would provide variety, pace

and stimulation. Clinical complexity was also of interest to participants, with a desire to engage in critical thinking and clinical decision making. High acuity environments were appealing to participants.

It [paediatric emergency] has always been something that interests me. I just like the uncertainty of the day and the fast-paced environment. (AS19)

I would like to get a job in ED and just really work on my assessment skills and being able to quickly assess and care for someone in the most critical state and from that I would like to join a shock relief team so I can travel to these countries where it is more common that there are natural disasters like earthquakes and stuff. I think I would find it quite thrilling. (AF15)

Aligned with this theme were the continued preferences of some participants to be in roles outside hospital-based or ward-based nursing such as the Royal Flying Doctor Service. There was a perception in some participants that ward nursing would be boring and unfulfilling. In part, this was attributed to the repetitive nature of ward nursing and the limited opportunities to gain new knowledge once attached to a particular ward.

Ward nursing kills me, it's just the same thing over and over again. (AS06)

However, participants also mentioned being frustrated when treating patients with perceived self-inflicted illnesses caused by lifestyle factors, such as type 2 diabetes. There was a perception that compared to the health issues they had witnessed whilst on placement, many health issues in Australia were preventable. There was an element of victim-blaming inherent in their statements and a reiteration of the preplacement perception that patients in developing countries are 'more in need', something that their cultural encounters had confirmed.

The ward I am on at the moment is cardiothoracic and vascular and half of the people definitely need our help but half of them are self-inflicted, the damage they cause themselves. Sometimes we just get them fixed and they come back. I don't think either of us put in as much effort, both the patients and the workers. (AS18)

People are so uneducated, how can you have that many co-morbidities and

not be educated about your health? It just fascinates me. Like you can have renal failure and be on dialysis and have no idea about what your medications are for. (AF06)

Participants expressed a strong desire to continue travelling, in both developed and developing countries. For some, the decision to commence a nursing degree was made to facilitate travel opportunities for cultural encounters and to build cultural knowledge and skills. The desire for adventure and stimulation was pertinent, particularly in the younger participants. There was a belief that the international placement experience had given them wings to explore and broaden further horizons.

In some, the complex diversity of their cultural encounters was ‘mind blowing’, prompting a search for meaning. This opening up of the mind had led to a strong desire to continue travelling to other developing countries, and some had already committed to international aid projects in developing countries.

It was such a successful trip and so uplifting and really good for the soul. It definitely encourages you and excites you to be able to continue. (AS19)

I am working with a team of people to create these community projects. One team are using recyclable material from cargo ships to build environmentally sustainable housing in Sierra Leone. They have already purchased land outside the capital Freetown and we are working in that division to create sustainable housing. (AF02)

Some participants planned to use their *cultural skills and knowledge* in nursing to facilitate that travel, others simply wanted to explore the world. Others were actively seeking further opportunities for international aid work. Typically, participants who were seeking international projects had chosen to look beyond the country of their placement to other developing countries in the region.

I now think the world is big and diverse and fun and ridiculous and horrendous and awesome all at the same time. (AF05)

I don't want to settle and live in a concrete building apartment in the middle

of a city and just go to work every day. There has to be more out there, there is more to life than that, there has to be, I'm going to go searching for it.

(AF06)

Yeah I don't really want to go just to one place. I don't feel drawn to just one place. I'd want to do it in like different places. Getting my travel out of it kind of thing. (AS06)

5.4.3.2 Open and exploring

There was a definite sense that participants were open to and exploring the variety of options available to them. Most were still in their graduate program year, or still at undergraduate level and as such still had limited experience. Those that had completed their graduate year were more focused on the immediate decision of where to focus their employment-seeking energies. Very few participants were able to nominate one career pathway, most still had several areas of interest.

I'm pretty early on in my career and I have time, I'd like to try a few different things before I decide on what I want to do eventually. (AS28)

You are just open to anything that walks in and out of your life and you embrace everything that happens and I think you learn something from each thing that walks through and walks out. (AS19)

5.4.4 Competing Realities

When considering their employment futures, participants were faced with a number of competing realities.

5.4.4.1 Financial and family commitments

Participants' discussion of their future career options was set against the backdrop of systemic and personal considerations facing them. The difficult labour market meant some had faced difficulties finding graduate programs or employment and were therefore prioritising employment in any field over specific choices.

It really just depends what I can get into. It's difficult at the moment with no jobs around. Just depends what I can get into. (AF04)

Others identified personal considerations such as age, children and mortgages that they felt precluded them from certain options such as those involving international travel. This resulted in some career plans being pushed to the future rather than being enacted immediately.

Family constraints see me sticking with my initial plan of graduating and getting a job within the closest hospital to my house. (AS05)

If I didn't have kids and if I was already qualified I would have already gone back there again to keep working there, volunteering. (AF14)

5.4.4.2 No identifiable impact

Where some participants were able to clearly identify the impact of their international clinical placement experience on their plans for future career development, others were less clear and found it difficult to articulate links. For some, other priorities such as family, budgets and the realities of making a living in Australia, meant their focus quickly shifted upon return to Australia. Others revealed they were more influenced by the graduate program experiences, or their other placement experiences within Australia. Whilst the international clinical placement experience for these participants had clearly been a personal growth experience and definitely had impact on nursing practice at home, it had limited impact on career planning.

I don't think I was over there for long enough for it to have a massive effect. I was only there for 2 weeks and it was a really rushed trip. So I think I would need longer for it to have a more drastic effect on me. (AF15)

You think 'oh my gosh that was so great, definitely going to take things back from that', but yeah the truth being you kind of don't as much as you think you would. (AS06)

5.5 Conclusion

The international clinical experience confirmed participants' desire to work internationally, with most wanting to return to a developing country context in the future. Some developed an interest in policy and leadership, with the aim of effecting

change. Participants were confronted by some of the situations they encountered and as a result were inspired to help in the future in a meaningful, if at times paternalistic way. In managing the clinical, cultural and professional challenges, participants developed nursing confidence and personal resilience. This confidence helped participants to feel more prepared for their nursing role in Australia after graduation.

Through their experiences on international placement, participants developed an appreciation of Australia's health system and resources, as well as their own education and nursing preparedness. This strengthening in their beliefs of the value of a Western approach to nursing at times threatened to limit participants' ability to look openly at the practice of others. However, it did reaffirm to participants the value of the nursing role, helping them to appreciate the benefits of good quality nursing care to patients and the role they could individually play in providing such care.

Participants continued to seek variety and stimulation, either through career choices or further international travel. Work in the emergency department or other areas with high clinical acuity or rapid change remained popular. Careers where relationships with patients could lead to empowerment and dignity were also valued. In particular, the provision of holistic care was important to participants. They were open to and exploring available options. Competing realities such as the current job market and family commitments flavoured participants' discussions around career planning. These extrinsic factors were more influential for some participants than others. For some participants, the international experience had no identifiable impact on career planning per se, but still resulted in a transformative experience at the personal level.

In the next chapter the study findings are discussed and explained within the context of existing relevant literature. Recommendations for placement design, and pre- and post-placement activities are provided, along with recommendations for future research.

6. Discussion Recommendations and Conclusions

“It wasn’t a light bulb moment but....” (AF18)

6.1 Introduction

This study explored the influence of participation in an international clinical placement on the cultural competence and career planning of nursing students. Participants travelled from four Western Australian universities to five developing country contexts for clinical placement. Data were collected prior to the placement, immediately postplacement, and 12 months following return from placement using both qualitative and quantitative methods. This is the first Australian study to measure the longer-term influence of participation in an international clinical placement, and so expands the body of knowledge. The following objectives guided this study:

1. To explore the initial impact of participation in an international student placement on students’ cultural competence.
2. To explore the maintenance of cultural competence 12 months after the experience.
3. To determine the impact of the international experience on individual career planning 12 months after the experience.
4. To explore the influence on students’ desire to work with culturally diverse populations, including returning to developing countries as registered nurses.
5. To explore the relationship between the country and setting of the international student placement, and students’ cultural competence and career planning

The chapter begins with a discussion of the findings related to cultural competence against existing literature, and how they relate to objectives 1, 2, 4 and 5 of the study. Mezirow’s Transformative Learning Theory is used to explain the findings pertaining to changes in the students’ understanding of the constructs of cultural competence including cultural awareness (including self-awareness), cultural knowledge and, changes to professional and personal values. This is followed by

explanations for the reduced cultural competence in some participants, which include a possible lack of understanding of the concept of cultural competence. The second part of this chapter focuses on the findings pertaining to career planning, which will be explained using the Nursing Career Development Framework (Hickey et al., 2012)(see p15 for an outline of the Nursing Career Development Framework). Combined with evidence from existing literature, the influence of the experience on participants' career planning and career motivations will be discussed in relation to working in international settings and within Australia, thus addressing objectives 3 and 4.

The findings suggest that international clinical placements increase aspects of participants' cultural competence, and help to develop competencies in specific areas such as communication skills, which are maintained over time. Furthermore, the findings revealed an intersection between cultural competence and career planning. That is, exposure to a diverse environment allowed participants to develop cultural, personal and professional growth, which in turn influenced participants' global perspectives and career planning postplacement. However, in their current form, international clinical placements do not always have a uniformly positive influence across all constructs of cultural competence, and may indeed serve to reduce cultural competence where supervision is not effective. Whilst the placements mostly confirmed participants' capacity to engage in positive cultural interaction in diverse settings, some students found specific challenges difficult to reconcile. These findings are relevant for educational policy makers, and universities offering international clinical placements for nursing students.

6.2 Cultural Competence

6.2.1 Improvements in cultural competence

Interview data collected preplacement revealed participants felt a strong cultural desire to practise in a culturally congruent way during placement and were committed to a humble approach of not imposing their own worldview on the host countries' practices. They were motivated by a sense of cultural curiosity and looked forward to interesting cultural encounters. They anticipated a broadening in their

cultural knowledge through direct experience of different languages, religious beliefs and cultural practices, and expected this cultural knowledge would be useful to them in their practice on return to Australia. They were concerned about a potential barrier to communication with patients in the host country but felt this would be their greatest area of learning when on placement. They expected their experience would improve their cultural skill and make them more confident to address patients' specific cultural needs. However, they demonstrated very little cultural awareness of their own cultural beliefs, or of how their own values and beliefs would impact on their interpretation of their placement experience. Few participants recognised that they had their own world view which shaped their thoughts and actions. The participants were focused on what they were going to do but did not consider what they would take with them. For example, students were not aware they held strong beliefs as regards individual autonomy, confidentiality and efficiency. Participants need to be guided to foster self-awareness through structured activities prior to departure that encourage self-reflection (Meyer, 2014).

The nature of the participants' understanding of culture seemed to be that it was something fixed and unchangeable, and easily identified; this is known as an essentialist understanding of culture (Burgess et al., 2014; Gower, Duggan, et al., 2016). They were not able to see that culture is fluid, varies within groups and is dynamic, changing with time.

Interestingly, even though they were still students, they expected to be able to teach qualified nurses in the host countries. This demonstrates a possible element of ethnocentrism, or a misunderstanding of the nature of health care in developing countries. They also expected patients in the host countries to be in greater need than Australian patients and appeared to hold deficit assumptions about the host communities, believing prior to the placement the host communities would have lower levels of health, fewer resources and less control over their own health (Ponzoni, Ghorashi, & van der Raad, 2017). They also assumed the communities would be happy with small changes, something they felt Australian patients did not appreciate due to higher patient expectations. Participants need to be supported to overturn these deficit assumptions if they are to develop the capacity to use collaborative, strengths-based interventions in international aid work, or in

community health (Dantas et al., 2018). Such capacity may potentially be achieved through continued cultural encounters following return from placement, and is discussed later in this chapter (section 6.2.3).

Quantitative data revealed that in the preplacement period participants' mean total score for cultural competence was in the culturally aware category according to the scoring of the IAPCC-R instrument (Gower et al., 2019). This is the second lowest scoring category, with only culturally incompetent scoring lower. This shows there is room for improvement in undergraduate students' understanding of the concepts of culture and cultural competence.

Immediately postplacement the mean total score for cultural competence increased and participants' moved from the culturally aware to the culturally competent category. This indicates there was an improvement in overall cultural competence as a direct result of the international clinical placement. These findings align with those of Ballestas and Roller (2013) who used the Student Version of the IAPCC tool and found cultural competence scores increased immediately after placement from culturally aware to culturally competent in 13 out of 18 US nursing students who travelled to Costa Rica.

However, the findings of the current study differ from the study by Kohlbry (2016) who explored the cultural competence of US nursing students travelling to Mexico, Belize, Vietnam and Ghana. Despite having similarities with the current study in terms of having multiple destination countries, the data collected by Kohlbry immediately postplacement showed no significant improvement in cultural competence scores. This could be explained by the relatively short duration of some of the placements, which were as limited as 1 day in length (Kohlbry, 2016).

6.2.2 Inconsistencies in improvements in cultural competence

Although total scores improved in the current study, there was variation in the constructs. In particular:

- Significant decreases in cultural desire, cultural awareness, and cultural skill.

- Significant increases in cultural encounters and cultural knowledge.

Kohlbray (2016) identified similar variations between constructs in that there were significant gains in the cultural knowledge and cultural skill of US nursing students. However, there were no decreases in scores in any of the constructs. The findings of the current study are unique and not seen in the Australian context, or internationally. It would appear that students felt less culturally competent immediately following the placement in relation to specific constructs. Immediately following the placement they had less desire to become culturally competent and work with CALD populations, had less clarity in their awareness of their own and others' cultural views and felt less able to communicate in ways that were culturally appropriate.

Previous quantitative studies have not explained changes in construct scores following placement. However, qualitative data collected in phase two of the current study offer some explanations for the reduced scores. For example, 12 months following the placement there was a realisation among participants of inadequacies in their cultural knowledge and awareness prior to placement.

In the big scheme of life I've got a little bit of knowledge and information but once you look at the big picture of the world you realise that what you don't know is huge and what you do know is tiny. (AS14)

These concepts align with explanations from other qualitative studies in this area. Ulvund and Mordal (2017) reported a similar realisation among nursing students of inadequacies in their prior cultural knowledge and awareness having undertaken an international clinical placement in Ethiopia. Further examples of how participants' beliefs were challenged and altered, providing some explanation for the quantitative findings, are given later in the chapter when the results of phase two are discussed.

6.2.3 Longer-term impacts

In phase two, qualitative and quantitative data were collected 12 months after return from placement. These data show the enduring influence of participation in the international clinical placement on cultural competence and, subsequently, nursing practice. Quantitative data collected in phase two, 12 months postplacement, indicates the mean total score was maintained in the culturally competent category.

This has been found in only one previous study that explored long-term quantitative outcomes (Roller & Ballestas, 2017). However, that study covered only one destination country and involved US nursing students from only one university. The current study had participants from four different universities visiting five different host countries across two continents, providing a wider exploration of the generality of findings across countries. Furthermore, this is the first study exploring the longer-term impact on cultural competence on nursing students from Australia.

However, although total scores did not change significantly over the 12 months, there were significant increases in cultural awareness, cultural skill, and cultural desire, which returned to their higher preplacement levels (Gower et al., 2019). The increases indicate students were engaging with their diverse patient populations with a broader mind and had possibly been reflecting on their own beliefs and values over time (Isaacson, 2014). They had opportunities to practise their communication skills and build confidence in that area. They were also practising in an environment where they had social and cultural privilege (Cushman et al., 2015), meaning they had benefits not necessarily available to all, and had the agency to take action to create change. That is, when practising in their home setting, they were not simultaneously confronted with unfamiliar environments, a foreign language and with being a minority while trying to practise in a culturally congruent manner.

Qualitative data revealed that, overall, most participants were able to verbalise the importance of culturally appropriate care and intended to practise it. This is a significant outcome of having the international clinical placement experience and the finding aligns with the few previous qualitative studies exploring the longer-term influence of international clinical placements. However, those studies were conducted with American nursing students (Caldwell & Purtzer, 2014; Levine, 2009). The current study is the first Australian study to explore the longer-term impacts, demonstrating transferability and showing breadth of applicability.

Participants mostly reported better self-awareness, being able to identify their own biases and previously held beliefs (Caldwell & Purtzer, 2014). One example of this is an enhanced appreciation of Australia's health system, including the emphasis on evidence-based and universal health care, which they came to identify as one of their

core health-related values. This has also been found in previous Australian studies (Halcomb et al., 2018; Tuckett & Crompton, 2014) and internationally in the short term (Murray, 2015) but the current study indicates that this influence extends over time. There is a potential benefit to health managers and policy makers who wish to improve morale, loyalty and retention of staff in the Australian health care system. It would appear that exposure to different health systems enhances gratitude and appreciation related to the Australian system, and that it continues over the longer term.

Participants in the current study also recognised within themselves some previously unacknowledged prejudice, which was challenged by their cultural encounters. Similarly, the participants in Kohlby's study (2016) also revealed latent prejudice in the qualitative written survey data collected alongside the quantitative data. That participants recognised and reflected on this bias is a positive outcome of the placement.

6.2.4 Being the minority

From their experience as a minority group, most participants became aware of the implications of being the 'other' to the dominant culture; being considered separate from the accepted cultural norm with visible physical differences such as skin tone and recognisably different language (Basselet, 2015). They were able to reflect on that experience and many extrapolated it to the experiences of CALD patients in Australia who must navigate the health system in a different language and cultural context (Degrie, Gastmans, Mahieu, Dierckx, & Denier, 2017). This broadened participants' views and deepened their ability to empathise, something that has previously been found in short-term studies both in Australia and overseas (Adamshick & August-Brady, 2012; Halcomb et al., 2018; Murray, 2015).

Participants in this current study voiced an intention to use their new cultural awareness to improve the experiences of CALD patients. This is a unique finding, as previous studies have not explored whether this desire to improve care for CALD patients has endured past the period immediately following return from placement, especially in the Australian context. The current study shows that whilst this desire was initially reduced immediately following placement as participants renegotiated

and reframed their beliefs and perspectives, it returned over time. Twelve months after return from placement participants in this study were able to articulate the impact of their international experience and identified a desire to provide culturally congruent care to patients in their practice. In this way, the international clinical placement gave participants the opportunity to meet the requirements of the Australian Nursing and Midwifery Registered Nurse Standards for Practice 1.2: *develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice* (Nursing and Midwifery Board of Australia, 2016).

6.2.5 Better understanding of CALD patients' experiences

Through the various cultural encounters participants experienced on placement, students gained a degree of cultural knowledge. Twelve months after returning from placement, when practising as Registered Nurses in Australia, some participants felt that they now had a greater understanding of the expectations and needs of patients from the countries they had visited on placement. This aligns with the findings of Levine (2009) who found that up to 13 years postplacement the participants felt they were able to develop rapport and have a better therapeutic relationship with CALD patients than their colleagues who had not been overseas. It was also found in the study by Charles et al. (2014) that Australian nursing students who had undertaken a placement in India felt they had a greater understanding of cultural needs of not only Indian patients, but other diverse patients.

This finding shows that international clinical placements help nursing students develop competency in Registered Nurse Standard 1.3: *respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures* (Nursing and Midwifery Board of Australia, 2016). Participants gained cultural knowledge and felt they were better prepared for — and had a greater understanding of — the expectations of CALD patients. Although there is no acknowledged endpoint to the development of cultural competence (Campinha-Bacote, 2007a), participants in this study appeared to make progress on the continuum.

6.2.6 Lack of continuing professional development in cultural competence

However, participants in the current study felt their cultural knowledge had not been enhanced since their return from placement due to a lack of professional development opportunities in the intervening 12 months. This was reflected in the quantitative data where there were no significant changes in cultural knowledge scores between time point 2 and time point 3, and a significant decrease in cultural encounters. Not only did participants have fewer cultural encounters in the hospital setting, but interview data revealed many did not actively seek out opportunities for interaction with diverse groups in their personal time. In summary, there was a lack of opportunities to further enhance cultural knowledge postplacement, either personally or professionally. Furthermore, there is no specific requirement in the Nursing and Midwifery Board guidelines on continuing professional development for compulsory cultural competence training post-registration (Nursing and Midwifery Board of Australia, 2019). It may be that this is reflective of the relatively recent inclusion of the concept of cultural safety in the nursing and midwifery discourse.

Cultural safety as a broad principle was only added to the Australian Nursing and Midwifery Board Code of Conduct for Nurses in 2018 with the addition of Principle 3: *Culturally Safe and Respectful Practice* (Bryce, Foley, Reeves, & Clark, 2018; Nursing and Midwifery Board of Australia, 2018). The code now requires nurses and midwives to have self-awareness of their own values and beliefs and reflect upon how they influence care. It also expects nurses and midwives to respect diverse cultures, beliefs and experiences, and to understand the social, historical and economic factors impacting on the health of diverse patients (Nursing and Midwifery Board of Australia, 2018).

The previously low priority of cultural competence in health care organisations means studies exploring the cultural competence of Australian health professionals are lacking. Even though there is some justifiable focus in the literature on staff competence with Indigenous Australians, it does not extend to the broader CALD population (Downing, Kowal, & Paradies, 2011; Ewen, Paul, & Bloom, 2012; Kurtz et al., 2018).

The viewpoints of Australian registered health professionals on cultural competence

are also not well understood, with a paucity of literature on this topic (Hughson et al., 2018; Truong, Gibbs, Paradies, & Priest, 2017). A US study of the perspectives of 56 health care professionals towards cultural competence showed participants mainly viewed cultural competence as holding practical knowledge and skills such as knowledge of specific customs and how to access interpreters. Although concern for CALD patients was highlighted, participants did not incorporate more overarching principles of cultural competence into their practice such as a recognition of power imbalance, racism, majority culture biases and self-awareness (Shepherd, Willis-Esqueda, Newton, Sivasubramaniam, & Paradies, 2019), which possibly reflects the poor quality or lack of cultural competency training programs for health professionals. International literature indicates cultural competency education programs for registered health professionals are not well-developed, and there is evidence to show that some programs may in fact produce opposite outcomes to those intended, in particular those that use a 'blame and shame' approach towards the dominant culture (Dobbin & Kalev, 2016; Shepherd et al., 2019).

Cultural competence of practising health professionals has also been linked with the cultural competence of the leaders of health services; role-modelling and priorities set by management and leadership teams influence the capacity of staff to develop or aspire to cultural competence (Dauvrin & Loran, 2015). In a qualitative study of 19 health professionals in a maternity hospital in Australia, participants reported that organisational restrictions such as limited time to spend with patients and lack of availability or appropriateness of interpreters impacted on communication and the care provided to CALD patients (Hughson et al., 2018). A second Australian study in the community setting found that CALD patients were mostly satisfied with their care, but there were concerns about the general trend in health care towards a business-focus rather than client-focused care (Truong, Gibbs, Paradies, Priest, & Tadic, 2017). Australian nursing graduates are unlikely to build upon gains made during international clinical placements if they perceive cultural competence to be a low organisational priority, are not able to see competent practitioners at senior levels in nursing, and are not able to access ongoing cultural competence training. Further research in this area is warranted.

6.2.7 Improved professionalism

Participants came to understand the importance of communication in patient care, particularly when communication was impeded by a lack of interpreters. Participants learned to use nonverbal forms of communication where necessary and felt they had developed cultural skill in their enhanced capacity to develop relationships, despite language and cultural differences. They had become interested in providing holistic, culturally congruent care that encompassed newly developed communication skills and a confidence to ask appropriate questions. This competency is specifically referred to in Registered Nurse Standard 2.2: *communicates effectively, and is respectful of a person's dignity, culture, values, beliefs and rights* (Nursing and Midwifery Board of Australia, 2016). An ability to '*communicate for work*' was also highlighted by the Australian Government in the *Core Skills for Work Framework* which provides guidance to institutions on the graduate attributes most desired by the employment sector (Australia Department of Industry & Australia Department of Education, 2013, p.24).

Participants in this study developed an awareness of the importance of effective communication in a health care setting, and developed skills in communicating nonverbally. These findings have previously been reflected in Australian studies exploring the short-term influences of international placements which found increased confidence in nursing skills and ability to communicate (Halcomb et al., 2018) and, a desire to practise holistic care (Geraghty, Davison, DeLeoc, & Bloxsome, 2019; Reid-Searl et al., 2011), but this current study is the first to explore that this was maintained over time.

The qualitative data also showed benefits in the areas of teamwork skills, similar to the findings of Halcomb et al., (2018) in their study of Australian nursing students in Cambodia. Personal maturity and growth, personal and professional resilience, and an appreciation of the nursing role were also highlighted. These findings align with other Australian and international studies in this field (Adamshick & August-Brady, 2012; Browne et al., 2015; Reid-Searl et al., 2011; Tuckett & Crompton, 2014). An ability to '*Connect and work with others*' and '*Recognise and utilise diverse perspectives*' are also considered essential requirements in the Australian Government Core Skills for Work Framework (Australia Department of Industry &

Australia Department of Education, 2013, p.29,34). Participants who travelled to the Asian placements learnt to work in teams across both language and cultural barriers as a result of being given the opportunities to work with a team of local nurses. Exposure to diverse cultural and clinical practices enhanced global perspectives, and enabled participants to develop cultural awareness and skills.

6.3 Benefits to Universities

Overall, the findings, and results of this study provide universities with recommendations to have better planned, more evidence-based clinical placements that enable universities to meet the Australian Nursing and Midwifery Accreditation Council Accreditation Standards (ANMAC, 2019). Of particular relevance is standard 3.7: *The program's content and subject learning outcomes embed principles of diversity, culture, inclusion and cultural safety for all people*. Findings of this study indicate that international clinical placements provide participants with an opportunity to develop necessary cultural awareness, knowledge and skill to appreciate cultural diversity. When considering the personal and professional growth of participants, and their resultant increased capacity to contribute to society, it would seem offering international clinical placements presents a positive return on investment for universities. The private and social benefits of higher education such as access to employment and leadership positions (Ruber, Rees, & Schmidt-Hertha, 2018) improved wellbeing and life satisfaction (Heckman, Humphries, & Veramendi, 2017) and greater participation in civic and political life (United Nations, 2015) can be realised.

Interestingly, the outcomes described by participants were the result of sometimes confronting experiences, both clinically and culturally. Exposure to different health systems and clinical practices had challenged some of the participants' views of nursing and patient care. For example, their belief that society should always care for children had been challenged by their experience. Where participants had previously believed this would be a universal cultural value, the limitations in state-provided care for orphaned or disabled children in some of the placement sites had tested their confidence in their cultural awareness of other cultures. This is supported by the findings of Murray (2015) and Hovland and Johannessen (2015) who explored

nursing students' experiences on placement in various African countries. Participants in those studies had found some experiences contrasted with what they held to be universal values of compassion and the nursing role, which had in turn shaken participants' understanding of cultural awareness. Through both positive and negative experiences, many of the students had experienced a personal transformation in their worldview, their nursing role, and the importance of cultural safety in health care.

The role of this disruption in the transformation of participants' beliefs and values is explored below using Mezirow's Transformative Learning Theory (Mezirow, 1991, 1997). Mezirow's Transformative Learning Theory explains the findings that in addition to changes in cultural competence, and development of career plans, participants also experienced significant personal and professional growth following the international clinical placement. These findings are not explained by the two frameworks used to underpin the study, and Mezirow's theory offers further explanation of the deep personal change that participants experienced.

6.4 Mezirow's Transformative Learning Theory

Participants' transformation as a result of the international clinical placement can be explained using Mezirow's Transformative Learning Theory (Mezirow, 1991). This theory posits that after experiencing a disruption or shock to core values and beliefs, new perspectives and meaning can be developed in adult learners. Transformative learning occurs when fixed frames of reference are altered in ways that make the learner more discerning, reflective and open to change. Examples of fixed frames of reference include cultural bias, socioethical assumptions (Blanchet Garneau, 2016) and moral-ethical norms (Mezirow, 2003). Transformative learning experiences allow participants to gain new knowledge, but also to engage in self-reflection to reassess their perspectives (Santos Zanchetta et al., 2017). In the current study, participants' beliefs and values around the clinical and compassionate role of nurses, the provision of universal health care and the value of evidence-based practice were challenged, and left participants feeling morally confronted. According to Mezirow (1997), transformative learning is "the process of using a prior interpretation to construct a new or revised interpretation of the meaning of one's experience in order

to guide future action’’ (Mezirow, 1997, p.9).

In order to assess and understand one’s previous frame of reference, critical self-reflection and self-awareness is necessary (Blanchet Garneau, 2016). This reflection allows the learner to then make a judgement about new experiences that challenge their original interpretation of ‘truth’. This reflection may occur from a perspective of social justice, analysing privilege and power, and will often require the support of an effective facilitator (Blake-Campbell, 2014; Blanchet Garneau, 2016; Santos Zanchetta et al., 2017). In this way, previously held sociocultural beliefs may be better understood and assessed for legitimacy. That legitimacy may be challenged when considered in a new environment (Blanchet Garneau, 2016). With support and guidance, disruptive experiences can lead to a transformation of perspective, a new world view and subsequent actions towards a more inclusive approach to life (Mezirow, 2003). Difficult cultural and clinical experiences such as those faced by the participants in their international clinical placements may act as catalysts for a deep and structural level of learning not possible in a classroom environment (Blanchet Garneau, 2016). Meaning can be created from the experience, explored through the changes in beliefs and values (Blake-Campbell, 2014; Santos Zanchetta et al., 2017). When transformation is complete, the new perspective leads to changes in actions, priorities and in the case of a health professional, in practice (Blanchet Garneau, 2016; Caldwell & Purtzer, 2014).

In the current study, participants experienced disruption to their values and beliefs, but did not necessarily have the opportunity or support for structured critical reflection with a facilitator, or with others who had also been through the same experience (Blake-Campbell, 2014; Blanchet Garneau, 2016). In this regard, it is very possible that the full potential for transformation that international clinical placements offer was not realised in some participants. A study by Curtin, Martins, Schwarz-Barcott, DiMaria and Soler Ogando (2015) exploring the use of critical reflective inquiry following international placement, found that postplacement students needed help moving from giving merely a description of their experiences to critically analysing their experience with a view to deeper learning.

The authors recommend structured reflective discussion with two or more colleagues

to facilitate the process (Adamshick & August-Brady, 2012; Curtin et al., 2015). Guided reflection would help students integrate the disruption that comes from experiencing personal and professional challenges into postplacement practice (W. W. Chang et al., 2012; Maginnis & Anderson, 2017; Riner, 2011). It was apparent in some participants that without this reflection, the experience had become simply a memory (Riner, 2011). In others, it had been a source of negative emotion they were struggling to reconcile. The potential emotional impact of participation in an international clinical placement is high, and this needs to be managed both during the placement experience and on return (Maginnis & Anderson, 2017). Without this reflection, there is a risk that participants may experience reduced cultural competence (Gower et al., 2017).

6.5 Explanations for Reduced Cultural Competence

Even though students highly valued their experience, not all were able to achieve personal transformation across all areas. Qualitative data revealed students had been challenged by low-resource settings, some nursing practices, high acuity, different roles of nurses, lack of universal health care, language barriers, and some gaps in supervision. There were indications in both the quantitative and qualitative data that some participants felt less culturally competent after their placement. The combination of shock (Maginnis & Anderson, 2017) and moral disruption, being overwhelmed by global health disparities, and the lack of opportunities for guided reflection, resulted in some participants experiencing difficulties coping with the challenges of placement. They became aware of their lack of knowledge and their possibly unrealistic expectations prior to placement. These findings are reflected in previous studies where participants struggled with the nurse-patient relationships and a perceived lack of compassion from nurses (Geraghty et al., 2019; Hovland & Johannessen, 2015; Murray, 2015) and frustration at poor organisation and lack of privacy for patients (Adamshick & August-Brady, 2012; Charles et al., 2014).

In this way, for some participants the experience served to maintain or possibly increase cultural barriers. Students sometimes made judgemental comments; some perceived themselves as being superior in a nursing sense and were not able to separate their own values and beliefs from those of the placement setting.

Participants appeared to be applying their own cultural values of efficiency and compassion, without considering there may be other viewpoints, demonstrating continuing ethnocentrism (Hovland & Johannessen, 2015; Ng, Goddard, Gribble, & Pickard, 2012). The findings of this study are similar to the findings of Hovland and Johannessen (2015) in their study on Norwegian nursing students on placement in Africa.

Although many students tried to consider the host country perspective, some students could not separate the impact of resource scarcity on health outcomes and practice and attributed poor practice to cultural preference. Despite acknowledging the effectiveness of the nursing role in the host rural communities, participants expressed some disappointment when their expectations of a resourceful and grateful nursing workforce in the cities were not necessarily met. In these cases the participants maintained a sense of superiority (Ng et al., 2012), indicating the retention of some ethnocentrism and limited movement towards ethnorelativism. This could in part be due to a lack of time to make the necessary adjustments in understanding. The placements in this study were between two and four weeks in length. It is possible this was insufficient time to overcome the initial shocks of placement and develop the necessary socioeconomic-political knowledge required to improve cultural competence (Sloand et al., 2008; Ulvund & Mordal, 2017).

Language barriers meant they could not always develop the degree of cultural skill during placement to ask the right questions of the host nurses in order to try to understand differences in practice. This aligns with previous studies, although those only assessed short-term influences, and were not Australian (B. F. Green et al., 2008; Murray, 2015; Ulvund & Mordal, 2017). Interpreters were not provided in all placements. Sometimes, in cases where interpreters were provided, there was a lack of clarity in their role. In other instances qualified interpreters were not always available and community members were sometimes used. The importance of effective communication was highlighted for participants, and frustration with not being able to communicate was one of the strongest negative outcomes of the placement (Halcomb et al., 2018; Murray, 2015). There was also inadequate language preparation of the participants themselves; they did not realise beforehand the importance of the ability to communicate. Language preparation is critical for

participants to be capable of interacting with host staff and patients, but may be unrealistic given the relatively short lead-up times to placement. Planners must therefore ensure effective interpreters are available to reduce communication barriers and enhance understanding.

Some participants experienced ethical challenges and questioned the contribution they had made to the host community. Prior to departure, participants had wanted to learn from the host countries' nursing practices, and to have an impact on the health of the community. However, limitations in their scope of practice, and the resource-poor environment meant there was poor sustainability of interventions, which left participants feeling they had made no difference to health outcomes. In some cases, participants had limited opportunities for hands-on clinical practice and could only observe the practice of host nurses. This resulted in a gap between participant expectations and the reality of the placement experience. They felt powerless and useless, especially in Africa, and were not able to help in the way they had anticipated. This led to feelings of stress and disappointment (Reid-Searl et al., 2011).

They also queried whether there had in fact been some unintended harm. For example, participants were concerned about discussing unobtainable treatment techniques. This is supported by previous literature (Caldwell & Purtzer, 2014; Harrowing et al., 2012) who found participants suffered ethical doubts following placement. These findings suggest nursing students are interested in experiences that are not only of clinical value, but have ethical integrity as well (Melby et al., 2016).

In some cases, participants in the current study had been upset by the behaviour of some of their colleagues; they perceived it to be unethical and inappropriate, leaving them feeling embarrassed. Other participants felt their colleagues had treated the experience as a holiday and not taken opportunities for cultural learning. This discomfort distracted from participants' ability to engage fully with local nursing staff (Long, 2014). Participants need to be encouraged to consider their motivations for applying for placement, and given clear instructions on behavioural expectations. They also need to understand the potential impact on individual responses of living and working in stressful conditions which may include confusion, anger and grief

(Maginnis & Anderson, 2017).

The importance of the supervisory role has been highlighted by these findings and in another Australian study on nursing students on placement in Thailand (Reid-Searl et al., 2011). Effective supervision is an essential requirement of the Australian Nursing and Midwifery Accreditation Council's Accreditation Standards for universities providing nursing courses. Standard 1.4 requires universities to provide *registered nurses who are prepared for the supervisory role and able to supervise and assess students during all professional practice experiences* (ANMAC, 2019). The findings show that where there had been continuity of supervisors to international settings, such as in Asia, learning had been more comprehensive and transformative. Where supervisors were experienced in the host culture, learning was most effective (Halcomb et al., 2018). In Tanzania, most supervisors did not have previous experience with the Tanzanian health system and students found it difficult to get comprehensive explanations of stressful encounters they were experiencing. Competing responsibilities were placed on supervisors as they were required to facilitate the placement experience for students as well as manage culture shock and their own adjustment. This meant some participants did not have the opportunity for a guided reflection on their experience and were unable to effectively integrate the experience into their practice. Some students experienced ongoing emotional challenges from events they had witnessed. There is a need for participants to engage in an ongoing and expanding exchange of ideas and experiences, ideally with supervisors who were directly involved in the clinical placement. Previous authors have highlighted the need for this reflection to complete the transformative experience (Adamshick & August-Brady, 2012; W. W. Chang et al., 2012; Maginnis & Anderson, 2017; Riner, 2011).

Due to the unique settings and clinical complexities in some of the placements it is necessary for universities to ensure clinical supervisors have sound understanding of not only clinical practice in the local context, but also the social determinants of health and the principles of cultural competence (Nilson, 2011). Supervisors need to be trained and supported to facilitate the students' learning and manage the emotional journey. Without adequate supervision, participants' cultural development and overall learning experiences may be superficial (Alpers & Hanssen, 2014;

Kohlbry, 2016; Kokko, 2011)

The final barriers to participants' ability to engage with host staff and community members was the element of competing demands. Some participants were required to attend to other commitments such as completing coursework assignments and applying for graduate programs while on placement. This detracted from the time available to engage in learning opportunities through cultural encounters with locals (Sloand et al., 2008). Furthermore, full immersion in the host community was impeded by participants' access to social media. Participants were always able to contact home via telephone, skype or social media platforms. It is more difficult to make strong connections with locals when you are strongly tethered to your own home culture (de Ruiter, 2016).

6.6 Lack of Understanding of the Principles of Cultural Competence and Cultural Safety

Most participants displayed a lack of understanding of the broad principles of cultural competence. Responses were often brief and lacking in depth, simply referring to empathy and patience. This could be confused with 'kindness' or 'humility' which are different concepts (Isaacson, 2014). Although well meaning, 'kindness' is not deep enough and demonstrates a lack of understanding of true cultural competence that incorporates notions of power imbalance and privilege (Johannessen et al., 2014; Shepherd et al., 2019). In addition to learning cultural norms and health-related practices, cultural competence requires awareness of the impact that cultural beliefs have on practice from the individual level through to the institutional level (Beach et al., 2005; Shepherd et al., 2019). Many participants also mentioned 'patience' during communication as being an essential skill for cultural competence. That is, waiting for the interpreter, or for CALD patients to speak English, indicating some remaining ethnocentrism. Whilst patience is preferable to impatience, few participants considered it necessary to learn another language themselves.

At the extreme end, a small number of participants could not articulate if the experience influenced them culturally or professionally at all. This aligns with Forsey, Broomhall and Davis (2012) who found some participants displayed minimal

personal insight, and were relatively shallow in their responses when asked to describe their learning following international study experiences. It may be that the term 'cultural competence' is not well understood. This raises a question: if students are not clear on what the experience is meant to bring and are not able to articulate what cultural competence is, or how behaving in a culturally competent way should look, how can these placements be effective?

It is also possible that students were limited in their ability to give reflective answers because they perceived the placement to stand separate from the rest of the course. Some could not make the link between the activities they were exposed to during the international experience and the clinical focus of the curriculum of the nursing course. Due to the limited opportunities to provide clinical hands-on care, participants had some difficulty relating the focus on cultural awareness to what they had learned clinically at university and in previous hospital placements. This indicates possible deficiencies in preparing participants for the nature of the placement, the conditions of the host country, or for a globalised context in general (W. Green & Mertova, 2016). It also highlights the low priority of cultural competence in undergraduate nursing programs. An international clinical placement alone is not enough to develop cultural competence as students will always be seeking a clinical component in addition to the cultural experiences (Lokkesmoe et al., 2016).

Participants also did not appear to reflect on their relative power as health professionals, a key component of cultural safety. They did not challenge the structures of the current health system that reflect the historical and social dynamics of Australian society. There was little to no mention of how organisations and institutions could incorporate cultural safety into their policies and processes. This could be because data were collected at a time when cultural competence was foremost in attempts to reduce health inequities, rather than cultural safety. The challenging of power structures within the health care system was only beginning at that time, and they were possibly unaware of the need for engaging in critical consciousness of health care institutions.

6.7 Impact of Country and Setting of Placement on Cultural Competence

Objective 5 of the study was to explore the relationship between the country of setting and cultural competence. Interestingly, in the quantitative analysis there was no relationship between the country of setting and cultural competence scores.

Participants who travelled to Africa did not score significantly differently at phase two from those who travelled to Asia. This is despite the small sample size at phase two which could be considered to create more variability. However, qualitatively, participants who travelled to Africa appeared to witness more confronting clinical situations such as patients in intense pain without pain relief, and unattended bodies of patients who had died. They also witnessed delays in attention to patients presenting with acute conditions such as serious fractures, practised in lower-resource settings and had more communication problems due to a lack of interpreters. These factors led to greater negativity being expressed by participants in this cohort, particularly in terms of their perspectives on the practices of host nurses. This mirrors findings from other studies on nursing international clinical placements in Africa (Geraghty et al., 2019; Hovland & Johannessen, 2015; Murray, 2015). Some participants had difficulty reconciling local practices with socioeconomic and political conditions in the country. It may be that settings with high acuity and extremely poor resourcing may not be the most appropriate settings for undergraduate participants, particularly if the intention is to improve cultural competence. This may have impacted on their cultural desire postplacement, and possibly contributed to increases in ethnocentrism.

Participants who travelled to Asia appeared to have a more positive experience, possibly due to the nature of the clinical aspects of the placement. They were working more in primary care roles, were able to provide nursing care rather than simply observe, and were not confronted with high acuity. They were exposed to lower risks, and were part of the host nursing care team. Also, as they were provided with interpreters, they were able to work more closely with local health professionals and had more personal interaction with patients. They were better placed to understand and work with the culture they had encountered.

6.8 Career Planning

This is the first Australian study to specifically explore the motivations and career expectations of students as they relate to participation in a future international clinical placement. There is very limited international literature on how international placement experiences influence career planning, particularly in an Australian context.

Prior to the placement participants showed interest in roles with variety and stimulation. This desire in a nursing role is supported by other studies on Australian student nurses' career preferences (Birks et al., 2014; McCann et al., 2010). However, these studies were not linked to international clinical placements and were conducted in university undergraduate settings.

Participants also felt they were testing their capacity for future international aid work, particularly those who had a burgeoning interest in social justice. A Canadian study also found the concept of social responsibility was ranked higher by nursing participants as a motivating factor in applying for international clinical placement than meeting academic requirements, indicating this concept is of interest to nursing students around the world (Kent-Wilkinson, Dietrich Leurer, Luimes, Ferguson, & Murray, 2015).

A desire to help others was another motivating factor identified by participants. They felt that 'doing good' was not part of mainstream nursing in Australia, and believed it was necessary to go elsewhere to effect a change. This aligns with Burgess, Reimer Kirkham and Astle (2014) who found Canadian nursing students participating in international clinical placements were more often motivated by altruism, and felt they had a responsibility to 'help' host patients they perceived may not be capable of helping themselves. This indicates a potentially paternalistic approach to nursing internationally, and is further evidence of the 'deficit notion' participants held about patients in host communities.

Interestingly, the participants believed they were not able to make effective social, structural or clinical change in their own communities. Further research is warranted into how undergraduate nursing students perceive the role of the nurse in the

Australian setting.

Participants expected that working in a developing country would be more holistic, and they looked forward to doing head-to-toe assessments and building therapeutic relationships with patients, something they felt they could not always do in an Australian setting. Caring is considered a core component of nursing practice (Roach, 2008; Sawatzky, Enns, Ashcroft, Davis, & Harder, 2009) and appeared to be a principle highly valued by the participants.

They also anticipated having fewer resources, and less technology, which they saw as a positive challenge. Participants expressed some frustration with nursing in Australia, and the use of technology to support care was construed negatively by some participants. However, their desire to get 'back to basics' before the placement seems in contrast to their choices of future employment pathways such as ED and critical care. Further exploration of how nursing students view the role of technology in nursing is warranted.

6.8.1 Autonomy

Autonomy was important to students, evidenced by the excited anticipation of participants preplacement that they would have more autonomy in their practice when on international placement. The perspective of nursing students regarding professional autonomy has been studied by Arreciado Marañón and Isla Pera (2019) who revealed there were false expectations around the concept of autonomy. The nursing students felt autonomy in clinical decision making was necessary for professional recognition as nurses, but did not expect to be able to practise autonomous decision making in collaborative interprofessional situations with medical staff present. Interestingly, they did not mention the role of caring during discussions of autonomy. Caring is a role that is exclusive to nursing, separating nurses from medical staff, and an area where nurses should achieve relative autonomy (Sargent, 2012). Other studies posit that the concept of autonomy in nursing is ill-defined and poorly measured (S.-L. Varjus, Leino-Kilpi, & Suominen, 2011) and that autonomy in the nursing profession is fragile, because the increasing trend towards the biomedical model in nursing has meant a corresponding lower value placed on the traditional role of caring (Galbany-Estrague's & Comas-

d'Argemir, 2017).

The technical and physical skills of nurses are recognised and measured, but caring activities do not receive as much professional recognition (German & Hueso, 2010; Huercanos Esparza, 2010). Given the emphasis placed on the technical skills and clinical knowledge of nurses, it is possible the view held by participants in the current study that they would have more autonomy whilst on international clinical placement was driven by an ethnocentric belief they would have more skills and knowledge than local nurses, even as students. Alternatively, it may reflect a belief that health care in less developed countries is simpler and their skills would be adequate for professional autonomy and recognition. Further research around how this view is formed about resource limited contexts would be valuable.

Autonomy was also important to them in their careers, a finding supported in another Australian study (Hickey, Sumsion, & Harrison, 2013). Some participants expressed an intention to become Nurse Practitioners (NP) or study medicine in order to achieve professional autonomy. The NP role was seen to be similar to that of a GP in terms of having autonomy. In fact, the NP role is very different from a GP but their roles complement one another (Royal Australian College of General Practitioners, 2016). There are clear links in the literature between autonomy and job satisfaction (Baykara & Şahinoğlu, 2014; Iliopoulou & While, 2010) and this may explain the participants' desire for roles they perceive to have autonomy.

More support and guidance is needed in terms of career planning for newly qualified registered nurses. It would seem that decisions are based on a lack of professional maturity and experience rather than on knowledge or fact. There is scant literature exploring the concept of professional autonomy with Australian nursing students, with most studies coming out of Europe (Baykara & Şahinoğlu, 2014; S. L. Varjus, Kilpi, & Suominen, 2010). Further studies to understand what autonomy means to newly graduating nursing students would be warranted. At present they appear to feel it is only related to more advanced roles.

Interestingly, a number of participants in the current study reported they had not given any thought to how the placement would influence their career planning prior

to being interviewed. Participation in this study was a catalyst for career-related discussions in the student cohorts for the first time.

When they were over there the students were mentioning the questions from this study. It's an interesting spin off that it is making people reflect and think about why they are doing it and what they want to get out of it. (personal communication, Caroline Browne, supervisor, Tanzania)

It would be beneficial for participants in international clinical placements to reflect on what they want to achieve professionally from the experience and how they feel it might influence their future career planning. This could include undertaking activities preplacement to consider their current career planning. The interview guide used for the current study could provide a suitable framework to structure such a reflection or discussion.

6.8.2 Working in international settings

When interviewed 12 months postplacement most participants felt they had 'stood the test' and had confirmed their desire to pursue future roles in international aid work. This aligns with the work of Tuckett and Crompton (2014) who found Australian students felt their international clinical placement experience had prepared them for this possibility. The experience allowed them the opportunity to work in a developing country context in a way that could not be replicated at home. The elements of safety and support provided by participating in a program organised by a university or health department was important to students who saw the placement as 'an amazing opportunity'. Nursing students appear to have a desire to travel within nursing, particularly in a role that provides help (Main et al., 2013; McKenna et al., 2010). The concept of giving back or helping others seems relatively prevalent in nursing (De Cooman et al., 2008), and may be particularly prevalent in nurses who choose to undertake international clinical placements (Tuckett & Crompton, 2014). Particular personality types may be attracted to the international placement experience and further research is needed to explore the link between personality type and career choices in nursing.

Some participants had a desire to influence health policy at home and globally. This is a unique finding not present in previous literature. These participants reported their

experience had shown them that individuals working in developing country clinical settings as volunteers were not able to change structural and policy factors that were leading to poor outcomes. By working as an individual nurse in a developing country hospital setting they felt they would need to work within existing structures, which would restrict their ability to effect change. They wanted to be able to create change on a broader scale and felt policy development would help them achieve that. This realisation showed they had evolved in their understanding of the social determinants of health as a result of the international clinical placement, which was a positive outcome of the experience. Pathways could be created postplacement for students interested in pursuing roles in health policy. Collaboration between the clinical nursing undergraduate courses and public health policy courses could be strengthened using international clinical placement experiences to highlight the role of policy in health care. This could serve to increase the number of students interested in pursuing international health and health policy pathways.

They also came to appreciate the importance of primary care. This was a change from their preplacement attitudes where some participants appeared to have no understanding of primary care at all. Preplacement, there was confusion in participants' understandings between working in the community and 'primary care'. This is backed up by McKenna and Brooks (2018) who suggest it is a lack of exposure to the term 'primary health care'.

An increased interest in primary care postplacement was also found in a previous study with Australian nursing students undertaking clinical placement overseas (Halcomb et al., 2018). The current study expands on this finding to show that many students came to understand the importance of primary care, particularly such care provided by nurses in low-resource settings that focused on prevention. They were particularly affected by situations where primary care was not provided, and saw the escalation in acuity in patients where adequate primary care had not been received. Further research into the benefits of international clinical placements as an effective primary care placement is warranted. Furthermore, research related to what nursing students understand about primary health care and why they have a view they cannot practise this type of care in Australia is recommended.

6.8.3 Equity and empowerment

Some participants also demonstrated an interest in equity and empowerment of marginalised populations. A nursing advocacy role was important to them. Participants had a desire to empower patients to care for themselves and to therefore have dignity. One participant had already found a position in Indigenous health care in remote Western Australia following her international placement experience. Another participant had become involved in an international organisation building capacity in a community in Sierra Leone. For some, their international cultural encounters led to a particular interest in empowerment of women. Midwifery was identified as a discrete area of career interest, specifically for future work among Australian Indigenous women or women in developing countries. A study of Australian midwifery students who participated in international clinical placements in Tanzania and the Philippines also found that the desire to practise midwifery in a holistic and meaningful way had been strengthened (Geraghty et al., 2019).

Interestingly, despite the interest in equity, participants expressed frustration with Australian patients whom they felt had not ‘taken responsibility’ for their health and were perceived as ungrateful. They were not able to tease out the social and cultural factors affecting the thinking and behaviour of locally-born patients in the Australian setting and appeared to view them as a homogenous group, continuing their essentialist approach to culture. Cultural competence theory clearly states that there are more variations within cultural groups than between them (Campinha-Bacote, 2011) but participants continued to make generalisations. Their statements indicated a lack of understanding about the social determinants of health, something that would be necessary in an advocacy role and better prepare students for international aid work opportunities or working with the broad spectrum of people from different socioeconomic backgrounds experiencing social vulnerability within Australia itself.

There is a paucity of evidence on nursing students’ understanding of the social determinants of health, either in Australia or overseas. A search of the literature found studies on interventions designed to enhance students’ understanding of the social determinants of health in Australia (Townsend, Gray, & Forber, 2016) and in Canada (Bryant-Moore et al., 2018) but these were not pre-post studies and did not reveal students’ understanding prior to the interventions. Further research is required

to ascertain Australian nursing students' current understanding of the role of the social determinants of health in health outcomes, and how this impacts on career choices.

The participants lack of awareness in this area may also be a reflection of the privileging of medical knowledge over the social determinants of health in Australian health policy (Fisher, Baum, Macdougall, Newman, & McDermott, 2016). The biomedical view of health and illness continues to dominate Australian health politics and policy, with its attendant tendency for victim-blaming, and less focus on addressing the broader social, financial and cultural factors impacting on health inequity (Cashin, 2015; Fisher et al., 2016; Wade & Halligan, 2017). It is possible this policy dominance creates a culture of biomedical nursing that filters down to nurses even at undergraduate level, making it difficult for them to consider sociocultural factors in health care, and influencing their career choices.

However, participants were able to see the links between poverty and the significant health disparities in the host countries. Where participants had expected a simple clinical context in which they would be able to provide holistic care, the experience provided many of them with a greater appreciation of how complex the issues and impacting factors are in resource limited countries, such as the epidemiological shift and the double burden of communicable and non-communicable diseases (Lee et al., 2015; WHO, 2012). Even though this was a positive outcome it should be noted that not all nursing students participate in international clinical placement experiences and that such opportunities are often on a volunteer basis. Hence, there is a need to increase the focus on social determinants of health in nursing curriculums to ensure that graduates are better prepared to provide care within the Australian context and globally.

6.9 Global Nursing Workforce

The WHO and the International Council of Nursing (ICN) promote the significant role of nurses in providing health services around the world (International Council of Nurses, 2019; World Health Organisation, 2016). This applies at the policy level, clinical level and community level. In the arenas of policy development, frontline

clinical care and community development, the role of nurses in improving social justice and access to good quality health care is well-recognised. Furthermore, as the world aims to achieve the United Nations Sustainable Development Goals (United Nations, n.d.) the contribution of nurses will be critical. For this to be achieved ‘cross-cultural understanding and global cooperation’ in nursing will be essential (World Health Organisation, 2015, para. 1). It bodes well that many participants in this study were motivated to pursue work in global health, and that this motivation was reinforced through the international clinical placement experience. With some focus on reducing participants’ paternalistic approach, improving their knowledge of the social determinants of health and enhancing their capacity to work collaboratively with host communities (Lee et al., 2015), it would appear that international clinical placements provide a rich preparation for nurses willing to contribute to the arena of global health.

6.10 Nursing in Australia

When discussing their future nursing role in the Australian context, participants maintained their interest in roles that had variety and stimulation. They admitted the portrayal of nurses and doctors on television medical shows drives this desire for stimulation. Other studies have come to the same conclusion (Birks et al., 2014) showing how television shows portray midwifery and paediatrics as the ‘happy’ areas of nursing (McCann et al., 2010; Ward, Bosco, & Styles, 2003). Participants were also motivated to use their nursing qualification to gain exciting experiences through travel. This seems to be a powerful drive, not easily altered. It is likely to be related to the relatively young age of participants.

When asked about their desire to work in community settings upon their return to Australia, most were hesitant. They wanted to consolidate their skills in a hospital environment, ideally metropolitan, before branching into specific areas, or going rural, aligning with the findings of other Australian studies (Geraghty et al., 2019; McKenna et al., 2010). They felt unprepared for the clinical responsibility they associated with community settings, and preferred comprehensive settings with clinical oversight. This might also reflect the general understanding that hospital is where nurses work (McKenna & Brooks, 2018). Interestingly, despite feeling

unprepared for the autonomy of community work, some participants viewed the community setting as being 'slower' and an area of work more suitable for older nurses.

Similar concerns were held about the possibility of working in rural settings. Even though some participants would consider short-term rural work, they were apprehensive about the isolation, both socially and clinically. This supports the work of McKenna et al (2010) who found geographical and professional isolation a barrier for undergraduate nursing students to choose rural work. Concerns about going rural add depth to the findings in that it highlights that such career decisions are impacted by how prepared participants feel for their future RN role. There seemed to be a natural link between how prepared the student felt for the RN role and their willingness to take on what they perceived to be a more independent role.

Overall, nursing identity was strengthened in participants in this current study. Registered Nurse Standard 3.7 states that a nurse *identifies and promotes the integral role of nursing practice and the profession in influencing better health outcomes for people* (Nursing and Midwifery Board of Australia, 2016). The participants returned from placement with a realisation they had greater nursing knowledge than they had previously assumed. Their nursing confidence improved and the experience affirmed for them their capacity as nurses. Their personal identity was interwoven with their professional nursing identity, and the cultural and professional shocks they experienced disrupted their personal selves, which fed through to their nursing selves. This compounded the strength of the influence of the experience and has been found in international studies (Adamshick & August-Brady, 2012; Curtin et al., 2015). This is the first Australian study to highlight this phenomenon.

Despite having some clear career preferences, participants recognised that the competing realities of the Australian nursing employment market and family commitments limited their ability to completely pursue their career goals. When interviewed 12 months after returning from placement, participants revealed the influence of the placement had become evident on an ongoing and evolving basis, continually fostered and moulded by workplace and other life experiences participants had encountered after their return from placement, which will now be

discussed.

6.11 Nursing Career Development Framework

The Nursing Career Development Framework (Hickey et al., 2012) was chosen to explain participants' postplacement career planning. This framework was outlined in chapter 1. The original framework has been adapted to incorporate the specific influences of the international clinical placement on participants' career planning. The framework is based on Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979, 1992), which purports that over time an individual is influenced by separate but interrelated environments, each with its own set of norms and expectations. At different points in time the strength of interaction and influence between the person and each of the environments varies.

Student career decision making is influenced by a wide variety of factors ranging from personal desires and immediate family commitments and plans through to wider policy, job market realities and global conditions (Hickey et al., 2012). The Nursing Career Development Framework is able to embrace all those factors. Furthermore, by having the person at the centre it is able to recognise the many individual differences between participants, and the personal circumstances affecting their career choices (Hickey et al., 2012). Figure one demonstrates the various factors that influenced career planning identified in this study, and the point in the socioecological framework they occur. Explanations for each level of the framework are provided following the figure.

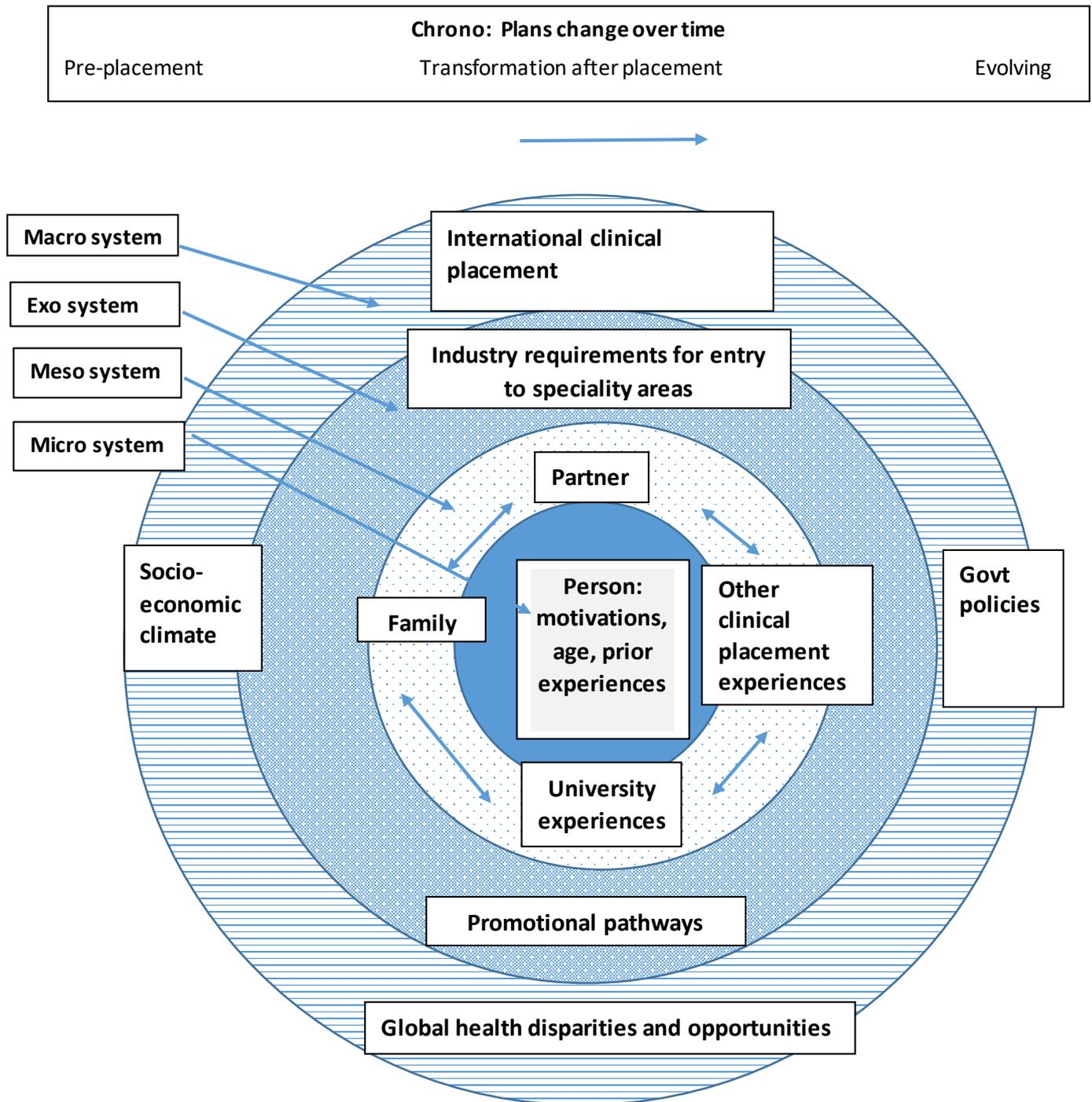


Figure 1: Influences on career planning. Adapted from Nursing Career Development Framework (Hickey et al, 2012)

Students were influenced by factors at all levels in the socioecological framework. The international clinical placement, along with global health disparities, is a *macro* factor that influenced participants' career planning in this study. However, it was

difficult for students to isolate exactly the influence of the international clinical placement because factors at all levels were simultaneously at play (micro, exo, etc).

Micro system influences. Participants were influenced by personal motivations informed by their age, their personal values, and previous health experiences. Younger students were more likely to see international travel experiences as possible. Altruism may have played a role at the micro level, however exploring this was not within the scope of the current study. Further research could explore the role of altruism in students' career planning (Tuckett & Crompton, 2014).

Meso system influences. Many participants cited family commitments and the needs of partners as being a priority in their career planning decisions. Interestingly, this included participants who did not currently have partners or children, but were including them into their lifelong planning. Proximity of living arrangements to the workplace, as well as transportation to and from work, have also been found to be important to nursing students in choosing workplaces internationally (Toren, Zelker, & Port, 2012).

The role of gender in career planning was outside the scope of this study, but previous studies have shown that gender identity and traditional caring roles are connected, which in turn impact on career progression (Hamilton Volpe & Marcinkus Murphy, 2011; Matsui, Sato, Kato, & Nishigori, 2019; S. Ussher, Roche, & Cable, 2015). In the health sector, a study of female medical students also found that participants were factoring family commitments into their future career planning, even before marriage (Kwon, 2017). These authors argue that workplaces assume staff do not have commitments outside the organisation, which in turn constrains women's decision making around career.

Clinical placements within Australia both prior to and following the international placement experience were also a meso-system influence on how participants perceived different career options. Clinical placements that were perceived as lacking in clinical learning opportunities were poorly regarded by participants. In contrast, students were more likely to consider applying for future employment with an organisation, irrespective of the speciality field, if they perceived their learning

experience during placement to have been supportive and beneficial. This aligns with the work of Boyd-Turner, Bell and Russell (2016). For example, previous placements or work experience in rural and/or community settings had led some students to express interest in working in these areas. At phase two of the current study, most participants had completed their nursing degree and had a range of domestic and postgraduate clinical experiences. Some of these had been influential enough to be a direct catalyst for future career planning, a finding that replicates the work of Robinson, Hills and Kelly (2011). Placements (local and international) can be influential on student decision making and counselling should be available to students to help both mitigate negative experiences and build on positive experiences to help them integrate their experiences with their career planning (McKenna et al., 2010).

Exo system influences. Even though the participants were new graduates, many were looking ahead to future careers in management, clinical specialities, education or flight nursing. Some students felt their international clinical placement experience may be beneficial for their curriculum vitae, being a point of differentiation between themselves and other job applicants (B. F. Green et al., 2008). As such, their decision to go on international clinical placement was part of the longer-term career decision making for some participants. They were interested in pursuing pathways to senior positions and felt they needed to be distinguishable from other aspirants. They were also aware of the additional study requirements or practical experience they would need to achieve those positions. For some participants, those requirements were a barrier, mainly for financial or time management reasons. They were aware of the limited availability of some of those positions and how this in turn reduced choices.

Macro system influences. Global health disparities and opportunities to work for international aid organisations are the broadest factors influencing career choices. Participants were motivated to address global health disparities through direct clinical work or via policy development. They were aware of the additional experience they would require to be accepted into aid organisations. They had also developed more realistic expectations of their ability, and that of aid organisations, to effect real change. Factors at all levels of this framework combined to influence career planning for participants in this study.

These findings pertaining to career planning show that nursing students who participate in international clinical placements are powerfully intrinsically motivated. They have a desire to care holistically (Geraghty et al., 2019) and are interested in roles that promote equity and social justice at the global level. However, when considering their nursing role in the Australian setting, they retain their interest in roles that offer variety, and are primarily based in the metropolitan area. There is an element of pragmatism to their career planning as extrinsic factors such as job market realities and family commitments hold equal importance in their planning. Although other Australian studies have looked at career planning of Australian nursing students and new graduates (Hickey et al., 2012; McCann et al., 2010), none have looked specifically at the impact of an international clinical placement on career planning and motivations. The findings of this study would indicate that after an initial period of consolidation of skills in areas of typical interest to new graduates, participants in this study may be encouraged to consider roles at a policy or clinical level.

6.12 Integration of Findings

This section presents the overall influence of the international clinical placement on cultural competence and career planning. It outlines the intersection between the exposure to a diverse cultural environment and the resultant cultural, personal and professional growth, which in turn informed participants' career planning post-registration. It is presented in textual and table form (table 6.1) and combines the two frameworks used in this study: the Nursing Career Development Framework, and the Process of Cultural Competence in the Delivery of Health Care Services. In this way, the two arms of the study have been brought together.

At a micro level participants revealed their improved cultural skill and cultural knowledge had prepared them for working with CALD populations, either in Australia or internationally. They felt confident to use their improved cultural skill to develop therapeutic relationships with patients in a culturally appropriate way. They also felt they had confirmed their personal capacity to work internationally, and a number of them intended to follow that path.

At a meso level their understandings and desire for social justice had increased, and they hoped to use their nursing role to improve experiences in marginalised populations. However, their career planning was still heavily dependent on family and financial commitments.

At the exo level, participants developed an interest in policy. This took a number of forms, including: interest in the cultural safety of organisations such as hospitals and health services; and interest in the impact of culturally inappropriate care, especially on Indigenous Australians. As a result, there was desire in some participants to pursue leadership and policy roles where they could have more of an influence on the overall provision of care.

Finally, at the macro level, their cultural encounters had led to improved understanding of global health disparities. This had made them motivated to return to overseas settings. Some participants saw midwifery as a particular area of need and were planning to undertake postgraduate midwifery studies as a conduit to international work. They had developed a strong appreciation for the Australian health system and their own education, but recognised that working overseas, particularly in a humanitarian aid context, would be most effective if supported by an established organisation rather than as an individual.

Underpinning all findings was the participants' openness to opportunity and their acknowledgement that all their career planning could change with time and circumstances.

Table 6.1. Influence of an international clinical placement on cultural competence and career planning.

INFLUENCE OF INTERNATIONAL CLINICAL PLACEMENT ON CULTURAL COMPETENCE AND CAREER PLANNING			
Macro	Exo	Meso	Micro
Stood the test of international aid work but need to go with an organisation	Indigenous health – interest in cultural appropriateness, policy	Career planning still heavily dependent on financial and family commitments Competing realities	Seeking relationships with patients/empowerment of patients Improved ability to work in a team
Midwifery – conduit to international work	Leadership – want to be CNS, be involved with policy as a result of seeing situations overseas.	Value social justice. Understandings of social justice were improved by placement	Motivated by variety
Impact of placement helped students appreciate the Australian system and want to use their Australian training to improve situations overseas	Lack of job availability limits choices		Stood the test of international aid work – have confirmed can personally do it
Socioeconomic climate impacting on job opportunities	Interest in whether hospitals provide culturally appropriate care		Improved cultural skill (communication, building rapport with CALD, caring for CALD)
Cultural encounters led to improved understandings of global realities, motivated them to return	Impact of placement on importance of organisational cultural safety		Improved cultural awareness, including self-awareness
COMPETING REALITIES ACROSS ALL SYSTEMS			
Chrono			
Acknowledgement that these plans can and will change over time			

6.13 Strengths and Limitations

6.13.1 Strengths

There were a number of strengths in the design of this study:

- The longitudinal design of the study meant that 12 months elapsed between the time of the international clinical placement and the final interviews. This allowed the Researcher to explore the longer-term influence of the international clinical placement on cultural competence and career planning, something unique to this study.
- The longitudinal design was particularly useful for the exploration of career planning. Participants had a full year to consider their career planning during their graduate program. The exploration of career planning is also unique to this study.
- Participants from four different universities were recruited for the study. Preparation programs for participants and the level of experience of the facilitators differed between universities. This allowed for maximum variation between participant experiences.
- Participants undertook placements in five different settings. This allowed the Researcher to evaluate differences between settings. This added depth to the findings, revealing some commonalities in experience, as well as distinct differences between settings.
- The mixed methods approach allowed for the collection of qualitative and quantitative data, allowing for triangulation and confirmation.

6.13.2 Summary of unique findings

The following points constitute the unique findings of this study that add to the body of knowledge on the influence of international clinical placement on nursing students' cultural competence and career planning.

Participants felt *less culturally competent* immediately following the placement in specific constructs. Immediately following the placement some had less *desire* to become culturally competent and work with CALD populations, had less clarity in their awareness of their own and others' cultural views and felt less able to communicate in ways that were culturally appropriate. This was probably a result of

significant disruption to their own health-related values and beliefs, and a realisation of the complexity of cultural competence.

Despite initial disruption, the desire to improve care for CALD patients endures for the longer term. Twelve months after returning from placement, participants intended to use their enhanced *cultural awareness* to improve the experiences of CALD patients. This is the first time this has been found in the Australian context.

Participants expressed some frustration with nursing in Australia, feeling they did not make a difference to health outcomes. This is a concerning finding that warrants further exploration.

Some participants had a desire to influence health policy at home and globally. They wanted to be able to create change on a broader scale and felt policy development would help them achieve that more than working as an individual nurse.

Australian nursing students who participate in international clinical placements are powerfully intrinsically motivated. They have a desire to care holistically and are interested in roles that promote equity and social justice.

Participants' personal identity was interwoven with their professional nursing identity, and the cultural and professional shocks they experienced disrupted their personal selves, which fed through to their nursing selves.

6.13.3 Limitations

All studies have limitations. The following list constitutes the limitations of the current study.

- This study was undertaken in Western Australia, and documented the experiences of undergraduate nursing students undertaking international clinical placements from this state only. Participant numbers were limited to the pool of students that participated in an international clinical placement in 2012 and 2013, the two years of data collection. However, the participants

were from four different universities and travelled to five different countries, enhancing variation in the sample and allowing for a broader understanding of the international clinical placement experience to emerge.

- Immediately post-placement questionnaires were administered which yielded interesting results. Conducting interviews at this time point may have been helpful to interpret or explain this result. Participants were followed for only 1 year after returning from placement, due to time constraints. Expanding data collection beyond 1 year could provide rich data and give students additional time to integrate their transformative experience into their nursing practice and career planning. While this was not logistically possible in this present study it is recommended that future research into this area consider data collection over a longer period to explore the enduring impact of international clinical placements on future nursing practice and career choices.
- Participants in international nursing clinical placements must apply for and undergo an interview process to participate in the placement. Self-selection may lead to some bias in the type of people who choose to participate in international clinical placements (Smith & Curry, 2011). It is likely that the personal characteristics of students choosing to apply for these programs include altruism, and an interest in culturally diverse populations. Although these characteristics were not measured as part of this study, it is likely that students may have been particularly motivated to improve their cultural competence. This should be considered when reviewing the findings.
- Participants in this study may have had high levels of empathy, an ability to identify with the feelings of others (Penprase, 2012). Nurses have been found to have higher levels of empathy than the general population, and nursing students in the final stages of pre-registration programs have more empathy than students beginning their course (Penprase, 2012). Participants in this study were in the final semester of the pre-registration nursing course and may have had particularly high empathy levels, although they remain unmeasured. Future research could measure the empathy of nursing students undertaking international clinical placements and compare them to a cohort that is not.

- Although all students undertaking international clinical placements in 2012 and 2013 were invited to participate in this study, not all students consented. There is a possible bias in the sample of students who chose to participate. For example, they may have been more altruistic.
- Participants in this study were predominantly female and Caucasian, typical of students undertaking international clinical placements. Further studies could include the experiences of a more diverse range of students, where possible.
- Questionnaire responses were self-report evaluations. This may have led to students providing socially desirable responses, a known limitation of self-report questionnaires (Spence Laschinger et al., 2016).
- There were logistical complications in finding and accessing participants at phase two. This resulted in some attrition, however it still allowed for a sample that resulted in accurate testing.
- Following the placement, students were very focused on performing well in their graduate program and had not properly considered the influence of the international clinical placement on their future nursing roles. They were in a transitional period from being an undergraduate student to a Registered Nurse and were very preoccupied with this transition process. Future studies need to consider the timing of postplacement data collection so it does not coincide with other major career development events. The timing of data collection in this study was chosen because there was a candidacy requirement; the study had to be completed within a specified time frame.
- The findings of this study describe the changes in cultural competence of individual health practitioners following international clinical placement. Since the data were collected for this study there has been an expansion in focus from cultural competence of individual practitioners, to the consideration of power disparities between practitioners and patients in health care institutions; being cultural safety. The findings of this study should be applied in that broader context.

6.14 Recommendations

The recommendations below are divided into five sections and are aimed at

strengthening international clinical placement for nursing students. The first outlines recommendations for international placement design with a focus on structure, timing, content and supervision. The second section provides recommendations for preplacement preparation of students in order to maximise the potential for international clinical placements to build cultural competence and to inform career planning. The third section provides recommendations for supervisors during placement. The fourth section provides specific recommendations around support provided to students on return from the international clinical placement, with a focus on reflection. Some recommendations in this section require reflection to start during the placement itself. The final section provides recommendations for further research.

6.14.1 Recommendations for design and delivery of international clinical placements

- To maximise the effectiveness of the international clinical placement universities should have some specific objectives tied to the cultural competence constructs of the specific framework or theory they choose to use. In this study the *Process of Cultural Competence in the Delivery of Health Care Services* model was used. Achievements against these objectives can then be measured for students undertaking international clinical placements.
- Supervisors need to be supported to have an understanding of the components of cultural competence prior to placement, including how it is developed and how to integrate it into practice.
- Learning activities need to be planned in relation to outcomes so as to achieve the cultural competence aims and the development of professional skills.
- Learning activities also need to be planned to allow participants to reflect on the historical, structural and cultural factors that may have led to power disparities in both the host country and their home country. This will improve participants' ability to provide culturally safe care on return.
- As much as possible universities need to aim for continuity of supervisors from year to year. This may result in better relationships with hospitals, and therefore better learning opportunities for students. It will also allow for the

supervisors to reflect on and develop their cultural competence skills over time.

- Timing of placements need to be carefully considered to maximise their effectiveness. For example, when placements are too soon after final examinations, students dedicate much of the time in the lead up to the placement preparing for exams and not for the placement itself (learning language, etc.)
- A review is required of the current practice of students fundraising and taking large amounts of medical supplies on placement. This practice may be restricting collaborative interactions with local nursing staff who may view these students solely as sources of physical materials.
- Host organisations should clearly identify cultural outcomes for their staff from engaging with supervisors and students from a country different to their own. This would show true collaboration.
- Once nursing-only placement programs are well established, multidisciplinary international placements could be considered to expose nursing students to the perceptions, understandings and roles of other health professionals. This could also include students from non-health faculties such as humanities students studying anthropology.
- Educators could consider providing experiences that offer the same disruption or cultural dissonance within one's own country, without the cost and time implications of organising an international placement. This could include experiences at locations specifically providing clinical care to diverse populations. An example of such a placement in Western Australia could be the Ishar Multicultural Women's Health Service which provides a range of health and social services to CALD women in a culturally appropriate manner. This would provide similar opportunities for learning for those students who cannot afford to undertake an international placement (Murray 2015).

6.14.2 Recommendations for preplacement education/preparation of students

- Prior to departure students need to be assisted to identify their motivations and expectations of the placement. This could help to mitigate unrealistic

expectations and help facilitators develop targeted activities to harness positive motivation.

- University preparation programs need to put a greater focus on language preparation. This may include the mandatory use of apps and other translation technologies available, and more preplacement sessions on language basics with native speakers. The use of essential basics of the local language shows the host community that students are interested in learning which is often seen as a respect for their culture. Language ability would enhance the learning opportunities for students.
- Students should be taught about the five constructs of cultural competence: Cultural Desire, Cultural Awareness, Cultural Encounters, Cultural Skill and Cultural Knowledge. These are *principles* which guide interaction with people in a culture different to one's own. The specifics then about particular communities can be learnt using these principles or skills as the situation or context dictates. If students are not clear on what the experience is supposed to achieve, and are not able to articulate what cultural competence is, or how behaving in a culturally competent way should look, there is a risk of the placements doing more harm than good. This will help to ensure sustainability of relationships with the host communities. Without good preparation of students there is a risk of the host communities feeling resentful (Cuellar, 2016).
- Student preparation could be guided by the following document: *Culturally Responsive Clinical Practice: Working with People from Migrant and Refugee Backgrounds - Competency Standards Framework For Clinicians* (Migrant and Refugee Women's Health Partnership, 2019) (see Appendix H).
- Students need to be taught skills around managing conflict with peers who may respond differently to cultural encounters and display different levels of cultural competence.
- Students need to learn more about the basics of health economics and the social determinants of health. Not only on how these impact on health outcomes of patients, but also their influence on how health systems are organised. They should be exposed to the socioeconomic, political,

historical and structural factors that influence health policy decision making in the settings they visit. This will help them reflect on the different health systems they will come across. This should be embedded across all years in the undergraduate curriculum.

- Students should be encouraged to discuss their career intentions prior to placement, and to consider the potential impact of the placement on their career planning. Universities could discuss career options like health policy with the students. Universities should consider international clinical placements as offering exposure to different career options, as much as cultural exposure.
- Cultural competence should be built into all simulation learning activities. Scenarios could be created based on the stories of students who undertook the placement in previous years.
- Preparation programs need to dedicate time to students exploring their own self-awareness and cultural values. Students should be asked to consider and describe their values and beliefs in relation to the causes of ill health, the treatments of ill health, and the role of nurses before departure. This may help them to understand their expectations of the placement.
- Educators need to include ethics-based training for the confronting decisions participants may observe clinicians making in resource-poor environments such as the allocation of limited life-saving resources to many patients (Kaddoura et al., 2014).

6.14.3 Recommendations for during placement

- Quality supervision by university staff is very important. In environments where there is little ability to help patients, supervisors need to be able to support students in managing confronting situations that may challenge students' values.
- Debriefing sessions are required while on placement so that students can reflect on difficult clinical or cultural encounters they may have experienced and their 'performance' within these settings to help them grow during the experience.

6.14.4 Recommendations for postplacement reflection/integration

- Students could keep a journal across the placement and then have help mapping journal contents against the constructs of cultural competence. A similar process could be undertaken to map how the placement experience impacted on career planning.
- Students need further cultural competence training after graduation. There needs to be ongoing professional development for registered nurses in this area. For example, new graduates should be encouraged to seek opportunities to practise their acquired nonverbal communication skills over the 12 months following return from placement, fine tuning and developing this cultural skill.
- Students need require professional development to raise their awareness of cultural safety so they can build upon post-colonial understandings and develop culturally safe relationships with patients of CALD backgrounds
- A structured reflection session, or series of sessions, is necessary. Ideally, this would be with the supervisor who accompanied the students on the international clinical placement. Further work is needed to determine the length of time necessary before clear reflection is possible. Students need some time to reflect, but consideration needs to be given to minimising the time students could be living with negative ethical issues, or trauma, that may impact on emotional wellbeing. Participants could provide a presentation to other students or to work colleagues on their international clinical placement experience. This would provide an added opportunity for the participants to reflect and integrate what they have learnt into their practice.
- It is essential that students and new graduates have positive role models in senior health professionals' attitudes and skills, such as linguistic ability, or a willingness to consider alternative treatments to protect cultural safety for diverse patients. To improve the cultural competence of new graduate nurses they need to have good role models in Australian hospitals. Senior health professionals need to have specific training in diversity and inclusion, the influence of privilege, and possibly to supervise international clinical placements themselves.

- More support and guidance is needed in terms of career planning for newly qualified registered nurses. It would seem that decisions are based on perceptions rather than on knowledge or fact. The process could follow the career planning conversations that are offered to more established staff. That is, knowing one's strengths and goals; researching options for career advancement; taking action to advance along identified pathways; and finally, to make choices (Northland District Health Board, 2016; Willett, 2008).

6.14.5 Recommendations for further research

This section provides recommendations for further research.

- Further research is required into how best to incorporate the process of improving cultural competence into students' practice after they return home. This includes incorporating professional development in relation to cultural competence into graduate programs.
- More longitudinal studies are required. Follow up could be conducted four to five years following placement to allow students to have more reflection and integration time. It takes more than 1 year for students to integrate such an overwhelming experience into their personal and professional lives. By delaying the postplacement data collection to 4 years post-placement, it is less likely to coincide with other major career development events for participants such as the graduate program.
- A comparative study of the career motivations and planning of final semester students who *have not* been on an international clinical placement is recommended to identify factors that guide their career choices in the absence of an international clinical placement experience.
- Further research could explore the impact of access to social media, and therefore the home culture, on the development of cultural competence following an immersion experience. This could follow a quasi-experimental design with two groups. The intervention group could have access to social media, and the control group would not.
- Midwifery researchers could explore the impact of an international clinical placement experience on students' intentions to pursue midwifery, or in

helping students understand the concept of being ‘with woman’, a core midwifery value, in different cultural contexts.

- Further qualitative research could include an interpretive study on participants’ worldview in relation to health beliefs and the role of Australian nurses *before* leaving for the clinical placement. This would provide a frame of reference for both participants and educators, and may help participants and educators to understand participants’ expectations of the placement.
- Future studies could explore the perspectives of the host nursing staff towards international clinical placements and the roles of the visiting nursing students. This would include host nurses’ perceptions on receiving donated medical supplies and how this impacts their views of visiting nursing students.
- Data should also be collected on the benefits of the placement for the host institution or hospital; as well as the community impact of the placement when rural areas are visited. This would seem vital to ensure harm is not being imposed on host communities (Caldwell & Purtzer, 2014).
- Further exploration is required into how nursing students view the role of technology in nursing. There were disparities in the findings of this study between participants desire to ‘get back to basics’ during placement, but then return to a role in ED or ICU where technology is prevalent.
- Particular personality attributes may be prevalent in students attracted to the international placement experience and this warrants further research.
- Participants’ understanding of primary care increased as a result of the placement. Further research could be conducted into the benefits of international clinical placements as an effective primary care placement.
- Further research could develop a tool to measure the influence of an international clinical placement on career planning. This could then be used in a mixed methods study incorporating both quantitative and qualitative techniques. The tool could also serve as a guide for students making career decisions.
- The cultural competence of supervisors could be explored pre- and postplacement.
- The experiences of supervisors could be explored, focusing on the enablers and barriers to effective facilitation of student experiences in a culturally

complex health care setting with scarce resources.

- Future research could explore the long-term impact on cultural competence and career planning of students following involvement in projects supporting marginalised populations within their own country (Main et al., 2013).
- Further research is required to ascertain Australian nursing students' current understanding of the role of the social determinants of health in health outcomes.
- Further studies on exploring the concept of professional autonomy with nursing students to understand what it means to them would be warranted. At present they appear to feel it is only related to more advanced roles.
- Further research is required on the cultural competence of Australian health professionals with CALD populations.
- The influence of an international clinical placement experience on the career planning of students from other professions could be a topic for future research.

6.15 Conclusion

This study revealed undergraduate nursing students who participated in an international clinical placement intended to pursue international nursing roles, including in health policy, to reduce global health disparities and improve health equity for vulnerable groups. International clinical placements can be effective in building and maintaining cultural competence over the longer term, but targeted planning of placements is necessary to ensure diverse cultural encounters to do not lead to increases in cultural barriers.

Participants experienced overall positive personal and professional growth that raised awareness and understanding of cultural differences. Despite some definite improvements, it was not always positive for all students. Both the qualitative and the quantitative data revealed that participants experienced barriers and even regression in the development of their cultural competence at some points. The qualitative data, although largely positive in nature, revealed the difficulties participants faced at times. These findings support previous studies that show international clinical placements alone do not necessarily lead to immediate

improvement in cultural competence.

Participants' relatively brief time in the host cultures did lead to some improvements in cultural competence, and certainly resulted in personal growth, but the experience does not make them cultural experts (Salisbury, 2011). It is critical that participants are given the opportunity to discuss, evaluate and incorporate their experience into their world view. This will help participants manage any disruption to their strongly held health beliefs and values and consolidate their expanded perspective. Cultural competence training should be continued post-registration. This training should also include the principles of cultural safety, requiring participants to engage in reflexive thinking on power, privilege and social structures that lead to health inequities.

Participants' international clinical placement experiences lead to stronger interest in global nursing policy and international nursing roles. There was particular interest in roles that enhanced equity and empowerment in marginalised populations. Some participants had taken action towards achieving roles in that sphere. Despite a number of other equally compelling competing influences on participants' career planning, there was a general willingness to explore and engage with opportunities, both at home and internationally. This openness could be harnessed via targeted career counselling following the international clinical placement that explores their emerging career interests.

7. References

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APPENDICES

Appendix A: Article one

Gower, S., Duggan, R., Dantas, J., & Boldy, D. (2016). Motivations and expectations of undergraduate nursing students undertaking international clinical placements, *Journal of Nursing Education*, 55(9), 487-494. DOI: 10.3928/01484834-20160816-02

Motivations and Expectations of Undergraduate Nursing Students Undertaking International Clinical Placements

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ABSTRACT

Background: International clinical placements are common in preregistration nursing programs in Australian universities to enhance awareness of cultural needs and global health issues. Yet, little is known about the motivations and expectations of nursing students who choose to participate. **Method:** Using a qualitative exploratory design, individual semistructured interviews were undertaken with 52 preregistration final-year nursing students from four Western Australian universities 2 weeks prior to departure to the developing countries of Tanzania, Thailand, the Philippines, Cambodia, and India. Data were analyzed using thematic analysis. **Results:** The interviews revealed that students were motivated by cultural inquisitiveness and a desire to help. They expected to gain cultural learning, to be challenged, to be fulfilled, to experience professional growth, and to feel gratitude. Developing an understanding of culture was a crucial outcome. **Conclusion:** By understanding the impetus and personal motivations of students, educators can guide students toward a more transformative experience whereby a more multicultural perspective on health care can be developed. [*J Nurs Educ.* 2016;55(9):487-494.]

In recent years, globalization has resulted in greater mobility, social interdependence, and electronic interconnectedness between countries, especially among professionals in the health care sector (World Health Organization, 2007). More than ever before, Australian nurses need to be aware of the impact that migration, culture and diversity have on the nursing workforce and on the patients for whom they care, who are likely to hold a wide range of diverse health-related beliefs and cultural values (Australian Bureau of Statistics, 2011; Caffrey, Neander, Markle, & Stewart, 2005; Kokko, 2011; Mill, Astle, Ogilvie, & Gastaldo, 2010).

Nursing education and policy needs to respond to the changing nature of global health and prepare nurses to work with diverse cultures within their own country and globally (Bradbury-Jones, 2009; Mill et al., 2010). The Ebola outbreak in West Africa in 2014 (World Health Organization, 2014) and other outbreaks, such as the swine flu (H1N1), Middle East Respiratory Syndrome (MERS), and severe acute respiratory syndrome (SARS), have raised awareness of the need for Australian nursing students to be aware of global health disparities, the health needs of other nations, and the social determinants of health (Chowell et al., 2015; Johnston, Rogers, Cross, & Sochan, 2005; Mill et al., 2010; Parker & McMillan, 2007).

Australian nurse educators and regulators recognize that nursing graduates should be capable of providing culturally congruent and safe nursing care. The Nursing and Midwifery Board of Australia (2006) has developed specific competency standards outlining that nurses must tailor their care to cater to the spiritual, cultural, familial, and language needs of their clients in a manner that achieves as positive an outcome as possible for the patient. Aligned with this, the Australian Nursing and Midwifery Accreditation Council standards require universities to provide opportunities for development of cultural competence, with international clinical placements being increasingly included in undergraduate nursing programs in universities. In Western Australia, all four universities providing preregistration nursing programs offer international clinical placements between 2 and 3 weeks in duration in developing countries. Although this study was conducted in Australia, it is applicable to any nursing program worldwide that is seeking to achieve

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cultural competency goals, particularly those that are engaging in international learning experiences.

INTERNATIONAL CLINICAL PLACEMENTS

Much of the existing literature regarding international clinical nursing placements is written following the placement, with a focus on the professional and personal influences on students and their nursing practice. Studies have found improvements in cultural self-efficacy, self-confidence, assertiveness, and global perspectives (Amerson, 2010; Caffrey et al., 2005; Lee, 2004; St. Clair & McHenry, 1999; Walsh & DeJoseph, 2003). Exposure to cultural differences has enabled students to develop a greater appreciation of and respect for the cultural values and beliefs of others regarding health care (Ruddock & Turner, 2007). Communication skills have also been developed. Where students have experienced immersion in a host country whose official language differs from their own, new methods have been developed, such as a focus on nonverbal communication skills and a commitment to learning a new language (Hagen, Munkhondya, & Myrhe, 2009; Lee, 2004; Watson, 2015).

However, some concerns have been raised about international placements, especially in resource-poor settings. During placements of short duration, the experience may reinforce rather than challenge stereotypes and perpetuate perceptions of cultural differences (Smith-Paríolá & Gòkè-Paríolá, 2006). A lack of cultural competency training for students traveling on placements on the ethical dilemmas they may face in global health may leave them unprepared and at risk of causing harm to host patients and communities and experiencing emotional distress themselves (Pinto & Upshur, 2009).

A lack of structured, faculty-led discussions with students to help them to integrate the experience into their learning and future lives has been identified (Smith-Paríolá & Gòkè-Paríolá, 2006), raising concerns about the sustainability of any perceived benefits (Reimer Kirkham, Van Hofwegen, & Pankratz, 2009). Ethical issues must also be considered regarding the transfer of nursing theories and models from high-income countries to developing countries (Mill et al., 2010). This can be accomplished by reflecting on how the care provided may affect others and on the possibility of these placements becoming clinical tourism, where the focus is on exposure to different cultures and unique clinical situations for students without consideration of local needs and structures (Levi, 2009; Pinto & Upshur, 2009).

In light of these concerns, it is important to review the motivations and expectations of nursing students undertaking international clinical placements. Only one study has been identified, in which nine students intending to travel on international placements from two Canadian universities were interviewed to explore their motivations for applying for the placement, their expectations of, and their understandings of global citizenship and social justice (Burgess, Reimer Kirkham, & Astle, 2014). Students' global awareness had been stimulated by interested family members, university teachers, media, and faith and led them to develop a desire to move beyond awareness to having actual global engagement through participating in an international clinical placement. This motivation to travel on international placement was fuelled by prior travel experiences, a

desire to experience a different culture, and perceived personal and professional benefits. Students' expectations of the global engagement included a well-meaning wish to teach and help host nationals and to learn about a new culture. An expectation that they would be outside their comfort zone, both culturally and as related to resource levels, was revealed, and students viewed the experience as a potential testing ground for future international nursing work. Overall, understanding of social justice issues, the social determinants of health, and how they related to the pending placement was lacking. This included a sense of fatalism that conditions in these countries would remain unchanged (Burgess et al., 2014).

Themes that emerged from studies exploring the motivations of students from other disciplines, such as medicine, and physician-assistant seeking international experiences included family encouragement, previous travel abroad, interest in learning about diverse cultures, a sense of altruism, and personal challenge (Luce, Stewart, & Davison, 2007; Pan, 2012; Sarfaty & Arnold, 2005). Wehbi (2009) cited similar motivations for social work students. However, a dearth of evidence remains on nursing students' motivation to volunteer for such an experience and their expectations. The Canadian study (Burgess et al., 2014) that examined students before departure had a small sample size, and other studies collated their evidence after students returned (Luce et al., 2007; Pan, 2012).

This study examined the motivations and expectations of undergraduate nursing students from four Western Australian universities undertaking international clinical placements in the final year of their nursing degree.

SIGNIFICANCE

To maximize the benefits in the host setting and minimize any possible harm arising from international nursing placements, for both students and the country where the placement takes place, it is important to have an understanding of nursing students' expectations and motivations in applying. In gaining this understanding, nurse educators will be more able to implement effective placements that demonstrate value to both students and the host country and ensure that expectations are realistically tempered.

METHOD

A qualitative exploratory design (Polit & Beck, 2010) was deemed as appropriate for this study because it allowed the researcher to interpret the social reality of students and describe their lived experiences (Holloway & Wheeler, 2010). A purposive sampling technique was used to identify 66 students in their final year of preregistration nursing programs who had applied for and been successful in gaining a position in the international placement program offered by each university. Students were required to participate in an individual interview and meet minimum grade requirements to be accepted into the placement. Students were asked to describe their reasons for applying, examples of their previous experience with culturally diverse populations, their understanding of the demands of the various settings, how they felt they could contribute, and characteris-

tics of positive team membership. The placements were offered to students as an alternative to a local community placement, where students are required to undertake service-learning in nonhospital settings. Purposive sampling of students with direct experience of applying and preparing for international student placements in multiple settings added to the richness of the data and increased the possibility of developing understandings from multiple perspectives (Graneheim & Lundman, 2004). In-depth, semistructured individual interviews were conducted with students from four Western Australia universities 2 weeks prior to departure to Thailand, India, Cambodia, the Philippines, and Tanzania. Interviews were conducted by the first author over a period of 12 months because the placements occurred at different times of the year. This allowed for prolonged engagement with the data. Interviews ranged in duration from 20 to 75 minutes, were conducted either in person at the students' homes and universities or by telephone, and were digitally recorded. Interview questions explored the themes of students intentions to travel on international placements, student expectations of the health system, their views on cultural competence, and how they expected the experience to affect them professionally. Prompts included asking about their expectations on coping with resource-poor environments and the potential influence on nursing skills and personal growth. Further questions examined aspects of career planning, which are outside the scope of this article. Transcription was completed by the first author ($n = 40$) and a professional transcriber ($n = 12$). The first author checked all transcriptions against the original recordings for accuracy, which allowed for further immersion in the data. Transcriptions were read and reread by the first author, which helped in identifying emerging codes.

Data Analysis

Qualitative analysis allows for subjective interpretation of text content through the classification of manifest and latent themes into themes of common meaning (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). In this study, inductive thematic analysis was used to identify the themes from transcribed data from the interviews. Analysis involved three stages of coding that moved from description of the data to the development of themes and ordering of subthemes.

Coding

Initially, the codes were descriptive in nature, capturing key thoughts and concepts of both latent and manifest content. This led to the identification of interpretative codes as insights were gained into the processes occurring and meaning could begin to be attached to the statements (Burns & Grove, 1997). Further analysis of the codes revealed links in the meaning and context and allowed for the collapsing of the codes into subthemes. As the study progressed, commonalities of meaning across subthemes and differences between subthemes began to emerge. At this point, themes were developed and clustered, leading to a conceptual overview of the findings (Graneheim & Lundman, 2004). Analysis was done in tandem with the data collection, allowing questions to be refined with subsequent interviews. Any new data that differed from previous findings were explored with deeper questioning of the participant. Themes and

subthemes were discussed against the raw data with the rest of the research team prior to interpretations being made final (Holloway & Wheeler, 2010).

Ethical Considerations

An information sheet introducing the researcher and explaining details of the study was provided at information evenings arranged by each university prior to travel to the placement. Interested students voluntarily contacted the researcher and expressed their interest in participating. Written consent was obtained from students who agreed to participate. All students were informed that they could withdraw at any time without compromising their position in the international placement, or in their graduate year. The researcher was not directly involved in providing education to the students. Approval was obtained from the Human Research Ethics Committee at Curtin University. Following this, reciprocal ethics approval was obtained from the other three Western Australian universities students were attending, and permission was obtained from the heads of schools of nursing to access students. Audio files and transcriptions were stored on a secure shared drive at the School of Nursing, Midwifery and Paramedicine at Curtin University.

FINDINGS

Of the 66 students identified, 52 agreed to participate. Just under half of the predominantly female students were traveling to Tanzania, with the remainder visiting southeast Asian countries. The majority of the students ($n = 29$) were in their final semester, although 12 were in only their second year of the course (**Table 1**). The second-year students had been allowed to apply for the placement program after all interested final-year students had been assessed. The content of the nursing courses being undertaken by the students across four universities was similar, leading to registration as a nurse; however, one university offered a unit in Global Community Health Nursing, which had some content on health in developing countries. To meet the assessment criteria of that unit, students were required to undertake additional assignments while on placement.

All participants were required to participate in a number of preparation sessions conducted by their universities or by the Global Health Alliance of Western Australia, an amalgamation of the schools of nursing of all five universities in Western Australia and the Western Australia Health Department. The sessions covered language, cultural considerations (such as cultural understanding, sensitivity, and safety), clinical safety, accommodation, and itinerary.

Four themes were identified from the data that centered on expectations and motivations: Cultural Learning, Challenge and Flexibility, Personal and Professional Growth, and Gratitude. Each theme had a number of subthemes (**Table 2**).

Theme One: Cultural Learning

Students revealed their decision to apply for the international placements had been motivated by a love of traveling and an interest in foreign cultures. Students expressed a strong desire to develop cultural knowledge and awareness and expected the greatest cultural learning to come in the form of enhanced

TABLE 1
Participant (N = 52) Characteristics

Variable	Number
Age (years)	
Range	19-55
Mean	27.6
Median	23
Gender	
Female	49
Male	3
Country of birth	
Australia	38
United Kingdom	9
Other	5
Country of placement	
Tanzania	22
Thailand	16
Cambodia	8
The Philippines	5
India	1
Placement setting	
Rural	30
Rural and urban	22
Length of placement (weeks)	
2	40
3	11
4	1
Point of placement in nursing course	
Second year	12
Third year	35
Fourth year	5
Third semester	1
Fourth semester	11
Fifth semester	10
Sixth semester	23
Seventh semester	7
Previous overseas travel experiences	
None	3
1-2	11
3-5	20
> 5	18
Travel capacity (n = 49)	
Tourist	42
Work or volunteer	7

communication skills with culturally diverse patients. They anticipated this would be of use in their future work as an RN in Australia, which has a rich sociocultural diversity. Students commented:

- I just want to learn and educate and get an idea for remote and rural health care. But I just expect to gain...knowledge. I'm expecting to learn a lot. (Female, 26 years, Thailand)
- It will also help me in understanding people that are over here, that are away from their homes and their family who have moved here. Being in such an isolating experience will help me be a bit more knowledgeable and more sensitive to cultural differences. (Female, 39 years, Cambodia)

Cultural Preparedness. There was a strong sense of uncertainty and of being unsure how to prepare for the placement. Students described emotions ranging from excitement to concern. Preparation strategies included Internet searching on the destination culture, speaking to students who had undertaken the same placement in previous years, language learning, and a specific university unit on global community health. Students who completed this unit revealed greater understanding around structural factors such as health systems, political and economic factors, and the value of primary health care.

In some cases, students had decided on a deliberate strategy of not preparing at all, to prevent the development of unrealistic expectations. The need to keep an open mind was particularly important to the students. Most of the students anticipated that they would not begin to understand the culture and context until they were immersed. Students were also anxious not to appear to be imposing their world view on the host culture. Their comments included:

- I don't really know how to prepare and I don't know what to do. (Female, 22 years, Tanzania)
- I am mentally preparing myself for it not to be easy. I don't want to get there thinking it's going to be easy and then not have a good time because I'm stressed. [I am] just preparing myself to go with the flow a little bit. (Female, 19 years, Thailand)

Theme Two: Challenge and Flexibility

Students expressed a strong expectation that the experience would be physically and emotionally challenging. There was general consensus that "everything would be different" and that it would be "an amazing experience." Students expressed:

- I'm expecting to be shocked. I'm expecting it not to be easy and expecting to really enjoy it. (Female, 19 years, Thailand)
- I see this as possibly one of the most challenging things that professionally and personally I can probably do at this particular point in my life. (Female, 38 years, Tanzania)

Resource-Scarce Setting. On a professional level, students expected to be confronted by the low-resource settings they would be working in and that they would need to develop resourcefulness, adaptability, and flexibility to provide care with the resources available. There was a strong sense they would learn these skills from their nursing colleagues in the host countries, who, they anticipated, would be adept at using resources efficiently and creatively. Students' comments included:

- I feel that I'm going to come back and be the MacGyver of nurses, like I could take a blood pressure with a paper clip

and a rubber band. (Female, 19 years, Tanzania)

- I think they will be quite good with their resources and those sorts of things and they would make the most of what they have but I think it's going to be... very third world, I suppose. (Female, 21 years, Cambodia)

Theme Three: Personal and Professional Growth

Students clearly articulated the perceived differences between the host country's culture and their own, indicating a desire for cultural experiences that would "open their eyes." They expected the experience to increase their nursing confidence and knowledge, reaffirm their belief in the nursing role, and build resilience. They also saw the placement as a safe

and structured opportunity to confirm their own capacity to work internationally in the future. Students said:

- I think it is going to open my eyes to a lot more health care needs of people of third-world countries. I guess it is easy for us to say what we think they need, but it will be good to actually go there and see what their main needs and requests and wants are to improve their health and well-being. (Female, 22 years, Cambodia)

- I think it will decide whether I really do want to go overseas and live over there for a few years and whether I want to nurse there. (Female, 20 years, Tanzania)

Desire to Help. A desire to help others and to teach local colleagues was salient, with a view that patients in the destination countries were in greater need than those in Australia. Participants thought providing care in those contexts would therefore be rewarding. Although the perception existed that long-term systemic change was not possible over such a short duration, there was a belief that the host patients would be grateful for, and pleased with, small contributions. They hoped their skills would be sufficient to quickly and easily alleviate suffering on an individual level where possible. This desire to "give back" was expanded on, as some students revealed an expectation that nursing in a developing country context would be more fulfilling than working in hospitals in Australia. Their comments included:

- I've always wanted to go [to the Philippines], just to be able to say that you've been able to give back to someone else and this I guess is my personal journey as well. (Female, 44 years, Philippines)

- And also it'll be cool to help and to make a difference. That's also a huge reason why [I applied]. I wanted to help. (Female, 20 years, Tanzania)

TABLE 2
Themes and Subthemes Identified in the Pretrip Interviews

Theme	Motivation, Expectation, or Subtheme
Cultural Learning	I love to travel.
	I will have better cultural awareness.
	I will have improved cross-cultural communication skills.
	I don't know how to prepare. I am keeping an open mind.
	I am willing to learn. I am hoping to teach.
Challenge and Flexibility	It will be a physical and emotional challenge.
	Everything will be different.
	I will need to be flexible in my use of limited resources.
Personal and Professional Growth	I will reinforce basic nursing skills, learn new nursing skills, and develop nursing confidence.
	I want to help. It will be fulfilling and rewarding.
	It will open my eyes.
	I will become more resilient.
Gratitude	It will be a testing ground for future international nursing work.
	I will come back with heightened gratitude.

- Here [in Australia], I don't feel as nurses we are much of a help. (Female, 20 years, Tanzania)

- We are going back to the basics, which will be interesting. That is one of the reasons I chose it because most nurses these days rely on machines. (Female, 53 years, Thailand)

- I don't find nursing [in hospitals in Australia to be] challenging, and I want to be challenged. (Female, 19 years, Tanzania)

- Conditions will be really tough and completely different to what we experience here but I think it will be rewarding and worthwhile. (Female, 26 years, Philippines)

Resilience. Students expected to confront the challenges they would be facing, becoming more resilient and resulting in improved coping skills. They anticipated these skills would be of use at both a personal and a professional level, stating:

- I expect to be challenged and I expect it to be scary and I expect to be more confident when I come home because of it and to have gained insight. I expect as a whole to have improved transcultural skills and develop resilience because we have to see things that we wouldn't be exposed to normally. (Female, 20 years, Tanzania)

- I think I will learn coping skills... [Skills learned] probably help me develop not just career wise but as a person as well. Just coping. (Female, 20 years, Cambodia)

Getting Back to Basics. Students expected they would be required to "get back to the basics of nursing," which was something they were anticipating with pleasure. The opportunity to undertake head-to-toe assessments without technology and to use their observational nursing skills to lead to a diagnosis was appealing to them. Students were hoping to have autonomy in their practice, while working under the super-

vision of a clinical supervisor within their scope of practice. They commented:

- I think it will really give me a perspective of basic nursing care...[and] the foundations of nursing and how they are so important. (Female, 22 years, Tanzania)
- Things like doing [obtaining a manual blood pressure reading], which you don't really do in hospitals now, and looking at patients holistically is going to be good. (Female, 20 years, Thailand)
- And I think the head to toe assessment, that'll be good to do. Just to be able to actually try and get information from them to try and work out what their complaints are. [For] all the other [practicums] I've done, people have already been admitted and diagnosed and everything is already done. Where with this we need to do a broader assessment. (Female, 31 years, Thailand)

New Nursing Knowledge. Students expected to learn new ways of doing things and to be exposed to diseases and acuity they would not experience in Australia. Their comments included:

- Hopefully, they can show us some things. I'm sure they have really crafty ways of doing wound dressings. (Female, 19 years, Tanzania)
- Hopefully, I will pick up a bit of an understanding of some of our diseases that we probably shouldn't see anymore. But we do, and I have a personal hate for malaria. (Male, 42 years, Tanzania)

Theme Four: Gratitude

Nearly every participant expressed an expectation of returning with a heightened sense of gratitude for perceived personal and professional advantages of living in Australia. This included amenities of living, such as running water and electricity, and access to a wide range of comparatively unlimited health resources, consultants, technology, and equipment. One student stated:

I think it will give me an appreciation for what we have and how lucky we are to be able to get everything we really need. Maybe I won't be one of those complaining nurses that complain about money. (Female, 26 years, Thailand)

On a more intangible level, students expected that the experience of living in a resource-scarce environment would “help them to appreciate the little things in life” and “realize there are bigger issues out there.” There was a strong sense of living in “a lucky country” and a hope that they would no longer take that for granted, as reflected in this comment:

Hopefully, I'll be reminded of what is really actually important. It does really sound clichéd but it's true. (Female, 19 years, Tanzania)

Aligned with the theme of gratitude, there also emerged a belief in some students that people in the host countries would be “happy with what they have got,” which is a concept that was viewed as an admirable attribute and one they hoped to emulate. One student said:

And the people are so friendly, as well, in some countries. I just love...how happy they are with what little they have, so I think that's good. (Female, 20 years, Philippines)

DISCUSSION

This study examined the motivations and expectations of undergraduate nursing students from four universities in Western Australia participating in international clinical placements. Students in this study were seeking global learning and teaching experiences, challenges, opportunities to develop resilience, and personal and professional growth in a diverse environment. They expected the placement to confirm or provide direction for future nursing pathways. These findings align with previous research in this area where students were motivated by a “cultural curiosity” and a desire to make small but helpful contributions (Burgess et al., 2014; Wehbi, 2009). A desire to help and to teach nursing colleagues in the host country could be interpreted as somewhat paternalistic (Burgess et al., 2014); however, these motivations were moderated by a strong desire to learn from their experience and from the nursing practices of their hosts, fueled by a strong sense of altruism and cultural interest.

Students' descriptions of expectations of the cultural environment they were about to enter into were primarily *essentialist*—an understanding that culture is fixed and unchanging, rather than seeing it as a dynamic process (Gregory, Harrowing, Lee, Doolittle, & O'Sullivan, 2010). Some were quick to ascribe moral superiority to their hosts and were reluctant to criticize any aspect of the host culture. This indicates they were starting from a point of ethnocentrism, where the cultures of others are considered superior to one's own (Sutherland, 2002). The emphasis appeared to be on recognizing the *other*, without necessarily beginning with an awareness of their own culture (Campinha-Bacote, 2007; Cushman et al., 2015).

This essentialist view of culture has been found previously among nursing students (Gregory et al., 2010). In that study, Gregory et al. found that students from other disciplines were more constructivist. That is, they viewed culture as constantly changing and complex and thought that individuals within a culture may not necessarily adhere strongly to the cultural norms. This raises questions about the way culture is taught in nursing education and, by extension, how cultural competence is also taught.

Students expressed an overall desire to learn from their host colleagues but did not reveal an awareness of how socioeconomic, political, and other factors might determine health status or disparities. An overriding interest in cultural differences and a desire to help at the local level seemed to be driving the students more than a need to understand or be critical of the global context (Burgess et al., 2014).

Of interest was the evidence that some students expected nursing in a developing country context would be more fulfilling than working in hospitals in Australia. This indicates a level of misunderstanding of the Australian nursing context, with an undertone of dissatisfaction. Their desire to practice holistically, with time to focus on the whole patient, possibly reflects a sense of frustration at the conflict between nursing ideals and values developed during their training, and the efficiency and time demands of nursing in Australia, with students reporting that “it burns people out a lot just because it's so busy.” Difficulties with new graduate transitions to professional nursing are well established (Maben, Latter, & Macleod Clark, 2006;

Pineau Stam, Spence Laschinger, Regan, & Wong, 2015), but the current study has found that students are anticipating those difficulties before graduation.

A desire to care for others and to work in a fulfilling profession have been cited as reasons for choosing nursing as a profession by beginning nursing students (Cook, Gilmer, & Bess, 2003). The students in the current study were mostly in their final year; however, they clearly still held a desire to care and to be fulfilled. That some students expected this would not be forthcoming after they entered the nursing profession needs to be explored further.

Students' uncertainty about how to effectively prepare for their placement was clear. Cultural competence training, beginning with gaining an awareness of self, could lead to a more transformative experience that allows students to develop a greater understanding that culture is changing, evolving, and complex. This could help them challenge the essentialist conception; consider the difference between generalization and stereotype and recall that there is often more diversity within groups than between them (Campinha-Bacote, 2007). Prior to departure, nursing students should undergo preparatory programs to assist with gaining an awareness of the myriad cultural influences on one's own biases and values, as well as relevant training to guide students toward becoming culturally competent health practitioners in diverse settings (Campinha-Bacote, 2007). Helping students to reflect on their own expectations of the placement could highlight the ethical demand to do no harm so that the international experiences are sustainable, mutually beneficial, and culturally safe for visitors and hosts.

CONCLUSION

Nursing students participating in international placements in this study were seeking learning and teaching experiences, fulfilment, challenge, growth, resilience, and an opportunity to make a difference. They were determined not to impose their own cultural values on the host culture, yet were not able to clearly articulate their own cultural framework. They revealed a respect for cultural differences but did not know how to prepare for encountering them. Further research could explore how nursing students understand the concept of culture, the influence of cultural competence training on students' experience of international placements, and how students perceive their role as graduate nurses in Australia.

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Appendix B: Article three

Gower, S., Duggan, R., Dantas, A.R., & Boldy, D. (2017). Something has shifted: Nursing students' global perspective following international clinical placements, *Journal of Advanced Nursing*, 73(10), 2395-2406. DOI: 10.1111/jan.13320

Something has shifted: Nursing students' global perspective following international clinical placements

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Abstract

Aims: To examine understandings of global health issues among nursing students following participation in an international clinical placement during their pre-registration university education.

Background: Universities use international clinical placements, especially in developing countries, to develop cultural awareness in students; however, little is known about the longer term influences on students' understandings of global nursing.

Design: A retrospective cross-sectional design was used, using an exploratory, descriptive qualitative approach.

Methods: Individual semi-structured interviews were conducted in 2014 with a purposive sample of 25 pre-registration nursing students from four Western Australian universities who undertook clinical placements across five countries. Data were analysed using inductive thematic analysis.

Results: Findings highlight that students developed new understandings around health systems including fragility of resource access, differences in clinical practice and variances in nursing roles between settings. Students also experienced challenges but were able to appreciate alternative world viewpoints.

Conclusion: International clinical placements can develop greater awareness and help students form realistic strategies for using their nursing skills globally. Pre-placement training in cultural awareness and health system realities, along with strong supervisory support, is critical to success.

KEY WORDS

global health, health systems, international placement, nursing students, transcultural nursing

1 | INTRODUCTION

As countries become more inter-connected and global migration continues, nursing education and policy needs to prepare nurses to understand the nature of global health, including health disparities and priorities (Turale, 2015). With the current

unprecedented movement of people and ideas around the world, it is imperative that nurses develop an understanding of the health knowledge, health practices and health expectations of all groups, to facilitate their response to the newly globalized health environment (Ferguson, 2015). Universities use international clinical placements, especially in developing countries, to develop global and cultural awareness in students; however, little is known about the long-term influences on students' understandings of global nursing.

1.1 | Background

Differences in health systems result in varying levels of accessibility and affordability of health care for local people. Despite universal health coverage (UHC) described as the “the single most powerful concept that public health has to offer” (Chan, 2012), only 20 low- and middle-income countries have UHC (Reeves et al., 2015). In many parts of the world, the poor and disadvantaged still experience significant economic burden from high payments for health care to a lack of trained professionals and limited access to services. Studies in resource-poor nations have shown that out-of-pocket payments for health care and accessing health services significantly impact spending on life’s necessities and can thrust families into poverty (Barenes, Fritchavong, Gripenberg, & Koffi, 2015; Masiye, Kaonga, & Kirigia, 2016).

Participants in this study travelled to five different clinical placement sites, each with a health system and list of health burdens disparate to Australia. To provide context for the experiences of the nursing students, details of the various health systems, including how they are financed, are presented.

1.1.1 | Health disparities

In low- and middle-income countries (LMIC), there is a continued prevalence of communicable diseases, high infant and maternal mortality and growing health disparities (Lee et al., 2015). Indeed, the top five causes of mortality in the settings of the study reported in this article are HIV/AIDS, lower respiratory tract infection, tuberculosis, diarrhoea and malaria (Centers for Disease Control and Prevention 2010, Lee et al., 2015, WHO 2012b). However, the recent increase in non-communicable diseases (NCDs) such as ischaemic heart disease, stroke and diabetes mellitus, more usually associated with higher income countries, has added extra burden to resource poor health systems (Table 1) (Abegunde, Mathers, Adam, Ortegón, & Strong, 2007; Lee et al., 2015, WHO 2012a).

1.1.2 | Health systems

The health expenditure ratios of the LMICs used for student placements in this study vary considerably to Australia (Table 2). Private providers finance a significant proportion of the health systems of the LMICs in this study. Thailand is a notable exception with only 19.9% of total health expenditure coming from the private sector (WHO 2015a). Thailand successfully achieved UHC in 2002. Several social health insurance schemes have been introduced in the other countries by their governments (Table 3), but out-of-pocket payments remain high. Interestingly, Tanzania spends considerably more on education as a proportion of GDP than Australia, and most of the other countries, perhaps, made possible by the receipt of external resources for health. In Thailand, only 4% of GDP is spent on health, despite the introduction of universal health care. However, they have the highest proportion of GDP spent on the education sector

Why is this research or review needed?

- Nursing education and policy needs to prepare student nurses to understand the nature of global health, including health disparities and priorities.
- Universities are increasingly using international clinical placements to develop cultural and global awareness in students.
- There is limited research on the longer term influence of international clinical placements on nurses’ understandings of global health systems.

What are the key findings?

- Students developed new understandings around health systems where access to health is fragile, with differences in clinical practice and roles between settings.
- Students experienced challenges and difficulties, including feeling helpless, but developed skills in teamwork and maintaining professionalism in difficult contexts.
- Students gained a broader perspective on life and changed their perception of the world, including home, from an altered viewpoint.

How should the findings be used to influence policy/practice/research/education?

- Pre-placement training in cultural competence and health system realities is critical.
- Supervisors need support to be able to offer a comprehensive placement experience for students that will have enduring impacts on student careers and practice.

(The World Bank 2016). This reflects the importance of the macroeconomics of health care.

Pre-registration nursing programmes in Australia increasingly have international clinical placements in developing countries included to expose students to global health realities, different health systems and cultural diversity. The short-term impacts of these experiences include improvements in cultural self-efficacy, self-confidence, communication skills and understanding global perspectives (Browne, Fetherston, & Medigovich, 2015; Larson, Orr, & Miles, 2010; Murray, 2015). However, little is known about the longer term influence; these experiences have on nurses’ understandings of global health systems and the social determinants of health, nor on any influence on students’ practice in the Australian health system after graduation.

A large study was undertaken in Western Australia (WA) aimed at exploring the influence of participation in an international clinical placement on cultural competence and career planning in undergraduate nursing students. This large study was guided by Campinha-Bacote’s (2002, 2007) Process of Cultural Competence in the Delivery of Healthcare Services model. Campinha-Bacote contends that the key to cultural competence is the *Cultural Desire* to see different

TABLE 1 Health statistics by country

	Cambodia	India	Philippines	Thailand	United Republic of Tanzania	Australia
Population (2013) (million)	15.13	1,252.14	98.39	67.01	49.25	23.34
Nursing/Midwifery personnel per 1,000 population	0.79 (2012)	1.71 (2011)	6 (2004)	2.08 (2010)	0.44 (2012)	10.65 (2011)
Leading causes of death (2012)	1. Ischaemic heart disease (IHD) 2. Tuberculosis 3. Stroke 4. Lower respiratory infection (LRI) 5. HIV/AIDS 6. Road injury 7. Preterm birth 8. Liver cancer 9. Birth trauma	1. IHD 2. Chronic obstructive pulmonary disease (COPD) 3. Stroke 4. Diarrhoeal disease 5. LRI 6. Preterm birth 7. Tuberculosis 8. Self harm	1. IHD 2. Stroke 3. LRI 4. Diabetes mellitus 5. Tuberculosis 6. Hypertensive heart disease 7. COPD 8. Kidney diseases 9. Interpersonal violence	1. IHD 2. Stroke 3. LRI 4. Road injury 5. COPD 6. HIV/AIDS 7. Diabetes 8. Liver cancer 9. Trachea, lung cancer	1. HIV/AIDS 2. LRI 3. Diarrhoeal disease 4. Malaria 5. Stroke 6. Birth trauma 7. Preterm birth 8. IHD 9. Road injury	1. IHD 2. Stroke 3. Alzheimer's and other dementia 4. Trachea, bronchus, lung cancer 5. COPD 6. Colon cancer
Life expectancy at birth (2013)	Female: 75 Male: 70	Female: 68 Male: 65	Female: 72 Male: 65	Female: 79 Male: 71	Female: 65 Male: 61	Female: 85 Male: 80
Maternal mortality rate/100,000 live births)	161 (2015)	174 (2015)	114 (2015)	20 (2015)	398 (2015)	6 (2015)
Population using improved sanitation facilities (%) (2015)	Rural: 30.5 Urban: 88.1	Rural: 28.5 Urban: 62.6	Rural: 70.8 Urban: 77.9	Rural: 96.1 Urban: 89.9	Rural: 8.3 Urban: 31.3	Rural: 100 Urban: 100

Figures obtained from WHO Global Health Observatory data repository <http://apps.who.int/gho/data/node.home>

approaches to health care, which is the foundation for the other model constructs: *Cultural Knowledge*, having a strong educational framework about other cultural beliefs and health practices; *Cultural Awareness*, a willingness to learn about other worldviews; *Cultural Skill*, the ability to conduct holistic health assessments; and *Cultural Encounters* necessary to build real-world experiences. In the larger study, this framework was used to guide the development of interview questions and analysis of interview data.

2 | THE STUDY

2.1 | Aim

This article presents the findings from a phase of the larger study mentioned above and examines the understandings of global health issues among nursing students following participation in an international clinical placement during their pre-registration university education.

2.2 | Design

An exploratory, descriptive qualitative approach was used for this arm of the study (Polit & Beck, 2017). Qualitative research is most appropriate when rich and detailed information on a topic is sought that cannot be obtained from a quantitative approach (Creswell, 2013). A qualitative approach was considered suitable because it allowed

participants to highlight their lived experience and provided a mechanism for the researchers to interpret the social reality of their international clinical placement experience (Holloway & Wheeler, 2010).

2.3 | Participants

A sample of undergraduate nursing students using maximum variation sampling for clinical placement site was used for this study. Purposive sampling was chosen as students with direct clinical placement experience in multiple settings would provide relevant, in-depth and rich data on their experiences (Graneheim & Lundman, 2004). Inclusion criteria included being in the final year of undergraduate nursing study and partaking in a supervised international clinical placement. The researcher presented study information to potential participants at information sessions organized by the universities in preparation for the placement. The sessions included information on host country culture, clinical practice, safety and daily itinerary. Potential participants were given an information sheet about this study, provided an opportunity to ask questions and informed they had the right to refuse and to withdraw from the study without impact on their participation in the placement, or on their university grades. Those who were willing to participate signed a consent form at the completion of the session or returned the consent form at a subsequent information session. The final sample size of 25 pre-registration nursing students was determined by data saturation.

TABLE 2 Health expenditure ratios, by country, 2013

	Cambodia	India	Philippines	Thailand	Tanzania	Australia
Total expenditure on health as a percentage of GDP	5.93	4.53	4.56	4.00	5.57	9.36
Expenditure on education as a percentage of total government expenditure (2012) ^a	7.5	14.1	13.2 (2009)	21.4	19.6 (2010)	13.2
Government expenditure on health as a percentage of total expenditure on health	20.5	32.2	31.6	80.1	36.3	67.01
Private expenditure on health as a percentage of total expenditure on health	79.5	67.8	68.4	19.9	63.7	32.99
External resources for health as a percentage of total expenditure on health	13.3	1.1	1.4	3.8	33.2	0.00
Out of pocket expenditure as a percentage of private expenditure on health	75.1	85.9	82.9	56.7	52.1	57.08
Out-of-pocket expenditure as a percentage of total expenditure on health	59.7	58.2	56.7	11.3	n/a	18.83
Private prepaid plans as a percentage of private expenditure on health	0.3	4.8	12.4	31.3	1.5	25.36

Table modified from WHO data <http://apps.who.int/gho/data/node.main.75>

^aSource: World Bank—Expenditure on education as % of total government expenditure. <http://data.worldbank.org/indicator/SE.XPD.TOTL.GB.ZS>

TABLE 3 Social health insurance schemes

Country	Consumer health financing options	Population served	Coverage
Cambodia	Government Midwifery Incentive Scheme (Ir, Korachais, Cheng, Horemans, Van Damme, & Meessen, 2015)	Poorest	75% of health care is still paid for through out-of-pocket payments (Annear <i>et al.</i> 2012)
	Health equity funds	Poorest	
Thailand	Universal health coverage		100% covered.
	Three social insurance schemes (Tangcharoensathien, Limwattananon, Patcharanarumol, Thammatacharee, Jongudomsuk, & Sirilak, 2014).	Civil servants medical benefit scheme Social security scheme	
Philippines	Social Health Insurance Scheme	Employed	50% of health expenses covered. Poorest unable to pay (Ramesh 2014)
	National Health Insurance Programme	Poor	
Tanzania	Several health insurance schemes are in place (Mtei, Makawia, & Masanja, 2014)	Formally employed Informal sector	15% of population covered.
India	Government-sponsored insurance.	Poor	70% of health care is paid for by out-of-pocket payments (Joe 2015)

2.4 | Data collection

Individual semi-structured interviews were used to collect data by the first author.

The interview guide was informed by the International Education Survey (Zorn, 1996), which measures the impact of international placement experiences on the constructs of intellectual development, expanded international perspectives, personal development and the professional nurse role. Topics in the interview guide included the influence of the international placement on professional practice, with prompts on nursing confidence and culturally competent care; the influence of the placement on participants personally, with specific prompts on beliefs, values and international perspectives; and whether they felt they had made a difference.

The interview guide was piloted with one of the participants for face validity. This led to a greater focus being placed on participant awareness of social determinants of health in subsequent interviews. Interviews were approximately 40 min long and were conducted over a 6-month period from June - December 2014, 12 months after participants' return from Tanzania, Thailand, the Philippines, Cambodia and India. Interviews were conducted in participants' homes, by telephone or in community-based locations and were digitally recorded. The first author transcribed all interviews verbatim to strengthen the process of data immersion.

2.5 | Ethical considerations

The study was approved by the University Human Research Ethics Committee (approval number: SON33-2012). Following this,

reciprocal ethics approval was obtained from the other three WA universities the students were attending and permission was obtained from the Heads of Schools of Nursing to access students. Audio files and transcriptions were stored on a secure shared drive at the University who originally approved the study. It is important to note that the researcher was not directly involved in providing education to any of the students. This alleviated any potential power imbalance in recruitment of participants. Interviews were conducted at a time and place that was convenient and familiar to participants, ensuring their comfort and safety. The interview transcriptions were de-identified with the names of participants, universities and supervisors being removed. Participant codes were allocated to transcripts to ensure confidentiality.

2.6 | Data analysis

The data were analysed using a process of inductive thematic analysis supported by NVivo version 10 (QSR International 2014). Transcribed data were repeatedly read, allowing for an overall understanding of the data set and the noting of initial meaning units. Coding involved organizing semantic meaning of interview data units into groups. Codes were then collated into broader relevant themes. Further analysis of latent meaning units enabled interpretations to be made regarding the broader implications of the student experiences. The analysis was reviewed by the other authors and discussions ensued until consensus was reached regarding interpretations (Braun & Clarke, 2006; Clarke & Braun, 2013).

2.7 | Rigour

Lincoln and Guba's (1985) framework for trustworthiness was used to ensure application of rigour. Credibility was obtained by prolonged engagement with the data over a 6-month period, with data collection and analysis occurring simultaneously allowing for the researcher to become immersed in the phenomenon of interest. Space triangulation and sampling for variation ensured dependability. Investigator triangulation in the data analysis process enhanced confirmability.

2.8 | International clinical placement settings

2.8.1 | Tanzania

The students who travelled to Tanzania were supported by the Global Health Alliance WA (GHAWA), which is an amalgamation of the schools of nursing of all five universities in Perth, and the WA Department of Health. GHAWA's role is to facilitate improvement in transcultural health through the provision of nursing and midwifery education in developing countries to build capacity in the local health workforce. GHAWA works in partnership with the Ministry of Social Health and Welfare (Tanzania) and the Faculty of Nursing at the Hubert Kairuki Memorial University, Dar es Salaam, and deploys expert WA nursing and midwifery educators to Tanzania for periods of up to 3 months. Pre-registration nursing students are sent on

placements on an annual basis. For the duration of the placement, they are allocated to mixed university groups.

Participants in this study worked in two urban hospitals, one public and one privately operated and rotated through several areas including male and female surgical wards, paediatric and emergency departments, and observed in the labour ward. They also visited two rural clinics where they observed local health professionals, assisted where possible and engaged with children at the local school. The mixed groups were supervised by one faculty member from each participating university. The faculty did not have experience nursing in Tanzania, but were registered to practice in Tanzania for the duration of the placement. They attended the placement preparation sessions, along with the students and were given additional preparation from placement organizers. In Tanzania, faculty were supported by an additional faculty member from one of the participating universities who had previous experience with clinical placements in Tanzania. This faculty member's role was to assist newer faculty with facilitating placement clinical experiences and provide general support and advice.

2.8.2 | Cambodia, Philippines, Thailand and India

Placements to Cambodia, the Philippines and Thailand were developed through established relationships between one WA University and local universities and Government ministries in the host countries. In all three countries, the placements were in part facilitated by an Australian education exchange organization (Edith Cowan University 2016). The nursing placement in India was part of a multidisciplinary placement programme run by a different WA university who works with an Australian NGO and commits to a 5-year presence in a particular district of India, undertaking needs analyses and implementing relevant health programmes (Curtin University 2015).

Students who travelled to south-east Asia worked in rural clinics alongside local health professionals. Their roles included assessment, assistance with diagnosis and dispensing of medications. They also conducted primary health assessments and education at local schools and orphanages. Students travelled in single university groups, with approximately 12 students per cohort. They were supervised by a faculty member from their university. A single student travelled to India and took part in a primary health needs assessment and initiated a hand hygiene project at a local school. Students were supervised by faculty from their university. The accompanying faculty had previous experience in the host countries and had facilitated numerous clinical placements in those regions. Through these experiences, the faculty had built up a body of knowledge of the nursing practices and beliefs around disease causation in those regions. They were registered to practise in the host countries.

2.8.3 | Differences in nursing education and graduate roles

Nursing education programmes in Australia are offered at baccalaureate level (3–3.5 years), and graduates are registered with the

Australian Health Practitioner Regulation Agency (2017). Nursing in the host countries is offered at both diploma and baccalaureate level. The Cambodian health system is still rebuilding following the civil war in Cambodia, and baccalaureate programmes are emerging (Henker, Prak, & Koy, 2015). In Tanzania, a baccalaureate nursing programme has been in place since the late 1980s, but the status of nursing remains low and role of the graduate nurse remains unclear (Mkony, 2012). In Thailand, the introduction of universal health care led to increased use of health care and an increase in the number of places in pre-registration nursing programmes. All nurses complete a 4-year baccalaureate programme offered by both public and private nursing schools (Reynolds et al., 2013). In India, nursing programmes are offered at both non-baccalaureate and baccalaureate (4 years) level, with graduate roles commensurate with level of training. However a “brain drain” to other countries has resulted in a continuing nurse shortage (Tiwari, Sharma, & Zodpey, 2013). In the Philippines, nursing is a 4-year baccalaureate programme. The deliberate production of nurses for the international workforce means the majority of professional nurses leave the country (Marcus, Quimson, & Stephanie, 2014).

3 | FINDINGS

The study participants ranged in age from 19 to 55 years, with the majority being female (Table 4). The 25 participants were from four WA universities who participated in clinical placements of 2–4 weeks duration across five countries (Table 4).

Following analysis of the interview data, three themes were identified (Table 5). The themes were New understandings; Challenges and opportunities; and Something has shifted in each of these themes were several sub-themes. Participants’ quotes are coded according to destination country, year of travel and position number in the travelling cohort. For example, T1208 implies the participant went to Tanzania in 2012 and was participant number 8 in that cohort.

3.1 | Theme 1: New understandings

3.1.1 | Health systems

For the majority of participants, this was their first experience of a healthcare system that required patients to pay for care. The resulting fragility of access to health care was highlighted for the participants, who admitted that in Australia we “take health care for granted.” The impact of government priority setting on resources available for health and the resultant vulnerability of patients was noted:

It only costs about AUD \$12 to put a plaster cast on someone but over there [Tanzania] \$12 is 6 months wage. So they had to go around to all their friends and family and borrow all this money just so they could get a cast on their broken arm. And stuff like that. And I

TABLE 4 Participant characteristics

Variable	Description	Number
Total participants		52
Age		Range: 19–55 years Mean: 27.6 years Median: 23 years
Gender	Female Male	49 3
Country of birth	Australia UK Other	38 9 5
Placement of setting	Rural Rural and urban	30 22
Length of placement (weeks)	2 3 4	40 11 1
Point in nursing course	Second year Third year Fourth year	12 35 5
Previous overseas travel experiences	None 1–2 3–5 More than 5	3 11 20 18
Travel capacity	Tourist Work/volunteer Not travelled	42 7 3

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TABLE 5 Themes and subthemes identified

Theme identified	Sub-themes
New understandings	Health systems Differences in clinical practice
Challenges and opportunities	Helplessness Professional skill development through challenge
Something has shifted	Global perspective Given me wings

thought that is not fair, how can their government let their people suffer like that? (T1202)

The government sells off a lot of their mineral resources to China instead of investing into social networks and social reforms and lifting people out of poverty. The level of poverty in Cambodia is horrific. (C1304)

Participants strongly expressed a feeling of gratitude for access to the universal healthcare system available in Australia and the subsequent impact on the health of Australian people. They also noted the availability of resources in the Australian health system and how this has an impact on practice:

I think it has made me grateful for what we do have and how easily we can seek medical care here. (Th1304)

Their gratitude extended to an appreciation of the role of basic nursing care such as feeding, asking about pain and providing general comfort to patients; something they had questioned the need for prior to departure. This change of attitude occurred after witnessing systems where that basic care had not been provided by nurses, but by families and they saw the rapid deterioration of patients without families:

It was interesting, it made you realize how much care we provide to our patients and how important some of that care can be. (T1307)

3.1.2 | Differences in clinical practice and roles

When revealing new understandings, differences in nursing and medical practices were discussed, including the participants' perceptions of practice in some LMICs of treating symptoms without investigating causes and diagnosing without tests. Furthermore, in some cases, participants were initially surprised by what they perceived to be the practice of repeated diagnoses of three specific conditions in all clinic patients and administration of only three selected medications, without examining for alternative causes of symptoms:

We would talk over suggestions that we thought the patients might be experiencing but at the end of the day it was their decision really and we went along with that. (Th1306)

The limited regulation around dispensing medication had also caused concern. However, after overcoming initial doubts and concerns, participants in south-east Asia nursed in accordance with local practices, deferring to decisions made by local colleagues. They admired the focus on primary health care as cost effective:

Their whole focus was more on primary health care and preventing illness rather than treating illness because they really don't have the money to be able to treat it. Which was quite interesting. And they have got a lot of really good programmes we got involved in to do that and it was a really eye opening experience. (P1305)

While the role of the Registered Nurse was at times unclear to participants and some practices were questioned, attempts were made by some of them to try to understand the rationale behind those practices and the context where they occurred:

I saw some really poor nursing but that is largely because of making do with what you have. Not because they didn't know they were doing the wrong thing or there are better ways of doing it. (T1209)

Despite these efforts, rather than looking at contextual issues, some participants focussed on what they perceived to be nursing apathy and a lack of compassion, which they struggled to reconcile. Participants described disappointment that their expectations of a resourceful nursing workforce had not been met and they perceived a lack of nursing contribution to patient care:

I really was quite disappointed actually. I thought there was huge capacity for nurse intervention and they just didn't seem to do anything. And I also felt like I didn't understand why. (T1306)

3.2 | Theme 2: Challenges and opportunities

3.2.1 | Helplessness

Despite expecting low-resource settings, participants were still confronted and overwhelmed and some found the facilities and resulting impacts on patients difficult to accept. Differences in sterility, documentation, dispensing of medication and general hygiene were confronting for the participants. Where participants in south-east Asia had felt able to help, participants working in the Tanzanian health system struggled to understand how the hospital system could be effective and at times felt powerless and hopeless:

It was a shock at first, just the differences in the standards and their facilities I suppose. I knew they would be not as good as ours but it was still a shock. It was really shocking. (T1204)

And I think a lot of this is feeling completely powerless. Just completely powerless. I found that really frustrating. (T1207)

3.2.2 | Professional skills

Despite these challenges, participants revealed the experience had given them skills in teamwork and maintaining professionalism in difficult contexts, with a range of personalities and cultural backgrounds. They felt more prepared to work with traumatic injury and high acuity in patients. They had developed nursing confidence and had been given leadership opportunities. In Thailand, participants had taken turns to coordinate the daily clinic which involved working in partnership with local colleagues regarding staff allocation and clinic set up:

You are just more confident in yourself and more confident in your abilities as a nurse. (Th1309)

3.3 | Theme 3: Something has shifted

3.3.1 | Global perspective

Participants revealed a greater awareness of social, economic and political events in other countries and their potential to have an impact on Australia. They expressed a broader view of the world

and, in some, a greater passion for discussing international issues. The international clinical placement created a shift in their perception and worldview:

It made me more aware of so many different things going on in the world. (P1305)

I tend to have pretty strong views. And a lot of the people I speak to are a bit naïve. In their own little bubble and they don't think about it. They don't see why we should be sending people to help in West Africa. I can understand why Australia wants to save their nurses and keep them here until it [Ebola virus] possibly gets further but if you can stop it where it is now you don't have to wait for it to get closer. (T1307)

A range of responses highlighted this new shift and perspective, including anger and sadness, as well as some pragmatic approaches to managing these. This knowledge of disparities had caused some participants to struggle with their place in the world and their possible contribution to the status quo. Others felt frustration at what they saw as the overwhelming nature of the problems and their limited capacity to address change in such a short time frame:

It is frustrating in a way because as much as you would like to dedicate your life to doing that you can't, because you need to make your own living here. (I1301)

I wish there is something we could do to make it long term. We wished that we could have done something else. (P1305)

There was admiration for local resilience in the face of difficulties, and most patients in these settings appeared to participants to be happy, contented and grateful for the available health care. The importance of family relationships was noted, particularly inter-generational family members and the willingness of the community to help in times of need. These attributes were seen as admirable and something to be emulated, especially the appreciation for health care, with some participants lamenting the corresponding lack of appreciation shown by Australian patients.

3.3.2 | Given me wings

In some, the complex diversity of what the world has to offer was "mind blowing," prompting a search for meaning. This opening up of the mind had led to a strong desire to continue travelling to other developing countries and some had already committed to more international projects:

I now think the world is big and diverse and fun and ridiculous and horrendous and awesome all at the same time. (T1205)

I don't want to settle and live in a concrete building apartment in the middle of a city and just go to work every day. There has to be more out there, there is more to life than that, there has to be, I'm going to go searching for it. (T1206)

3.3.3 | Difficulties coming home

Having experienced a shift in values, some participants found it difficult adapting to personal and professional life back in Perth. This included difficulties in coping with ungrateful Australian patients, frustration at the waste of resources and perceptions of greed in Australian citizens:

I actually think I have less tolerance for people and their minor complaints; when they complain about the health-care system I get a bit frustrated (P1305)

Another adjustment made was to question some of the Australian approaches to health care, described as "doing too much." Very few participants had been given an opportunity to discuss their experience after returning and some described a feeling of abandonment and a need for debriefing and reflection:

Because I did find it very odd that we were kind of dumped when we got home. And that is what it felt like. (T1301)

4 | DISCUSSION

This study explored the personal and professional development and global understandings gained from participation in an international clinical placement in a developing country context. In most participants, these outcomes have been sustained for 12 months, and there are indications that participants' decision will continue to be influenced into the future. In general, participants had become more appreciative of their own health system, had altered their perspectives on life and had come to see the realities of global health disparities. Students also had more understanding and appreciation of the importance of primary health care and were particularly interested in the cost effectiveness of a focus on prevention rather than treatment of chronic illness. Given the international trend towards strengthening delivery of health care in primary care settings (Bjork, Berntsen, Brynildsen, & Hestetun, 2014), further research into the benefits of international placements as effective primary care placements is warranted.

There were underlying differences in experiences between those who had attended a placement in south-east Asia and those that attended a placement in Africa. Broadly speaking, participants in south-east Asia had an inspiring time, they felt that they had

made small but meaningful differences in the patients' lives (Reid-Searl, Dwyer, Moxham, Happell, & Sandere, 2011; Tuckett & Crompton, 2014) and could see the benefits of primary health care. Participants who travelled to Africa were confronted by the resource poor and difficult conditions they experienced and they felt unable to help and were less able to engage (Johannessen, Hovland, & Steen, 2014; Murray, 2015). However, they came away with strong personal growth and a strong desire to return in a meaningful way.

However, participants also displayed a lack of understanding of different health systems, how they are funded and how this impacts on patient care. They were clearly used to and expected universal coverage whereby "the health system would be financed in accordance with the ability to pay and benefits received in accordance with the need for health care" (Mills et al., 2012, p1). While some attempts were made to try to understand the rationale behind nursing practices and the context where they occurred, there was a general lack of recognition that the socio-economic-political situation contributes to the way the health system runs, the attitude of nursing staff and the priorities in it. Health system limitations included a lack of independence of local districts from national priority settings, weak supply systems, the dominance of medical groups and the restrictions of an unreliable financial system (Hipgrave, Alderman, Anderson, & Soto, 2014). In addition, the simultaneous burden of both communicable and NCDs had created complexities in deciding the specific mix of programmes, resources and strategies required (Hipgrave et al., 2014; Morand, 2004). Western healthcare models and theory often cannot be directly applied and need to be made culturally and contextually relevant (Jayasekara & Schultz, 2006; Lee et al., 2015).

Interestingly, the student nurses in this study seemed unaware of these contextual factors and sometimes appeared judgemental. In view of this, pre-placement training in the health systems of the country they are travelling to is warranted, including aspects of resources, access, UHC and training of health professionals (Mills et al., 2012; WHO 2015b). Other historical, structural and cultural influences on current healthcare practices and infrastructure should also be discussed. For example, the changes in Tanzania when fee-for-service health care was introduced in the 1990s after more than two decades of free health care (Mtei, Makawia, & Masanja, 2014). Mills' Sociological Imagination Template which facilitates the examination of a society by focussing on historical, structural and cultural origins of current issues may be particularly useful in this context (Germov, 2014).

Nursing students participating in international placements need more robust preparation in how to ask questions about the healthcare system and the practices they observe. They need assistance moving away from pre-conceived assumptions that all health care priority setting is achievable in a way that meets the needs of all stakeholders and is effective and acceptable to all (Hipgrave et al., 2014). Understanding of these issues could prevent nursing students participating in international placements developing misconceptions or developing misguided views about in-country "cultural practices."

Providing students with the capacity to ask relevant questions in a culturally sensitive way about health systems and practices will help them arrive at the answer to "why." The risk of not preparing them to do this is a potential widening of cultural misunderstandings and strengthening of cultural barriers, increased intolerance and possibly reviving elements of neo-colonial attitudes (Bleakley, Brice, & Bligh, 2008; Smith-Parfolá & Goke-Parfolá, 2006).

The potential for strong personal impact on students, both positive and negative, is high. This needs to be carefully monitored by supervisors and followed up afterwards. Where health disparities were strongly evident, participants became distressed as their philosophy of caring was challenged by what they perceived as uncaring governments (Lee et al., 2015). Postplacement discussions are warranted, delivered in a structured way to allow students the opportunity to reflect on the meaning and usefulness of their experience and its applicability to future nursing practice in Australia (Green & Mertova, 2014). These findings highlight the importance of the supervisory role in helping participants make sense of their experience and the differences they encounter. The learning experience seemed better with supervisors who had experience in the host country (south-east Asia), and this should be a priority. Supervisors need support to be able to offer a comprehensive placement experience for students that will have enduring impacts on student careers and practice.

4.1 | Limitations

Participants in this study were from universities in one state of Australia only, which may have an impact on transferability to other university cohorts. Furthermore, participants voluntarily applied for the international placement positions, are therefore self-selected and possibly already have some personal attributes of global citizenship. The length of stay in the host countries was also relatively short, to a maximum of 4 weeks. Results may be different with longer placements.

5 | CONCLUSION

Nursing students undertaking clinical placements in developing country contexts can experience strong personal growth, develop greater global awareness and form realistic strategies for using their nursing skills in the global context. Immersion in a different health system can help students develop a greater appreciation for the nursing role in Australia (Maas 2011). However, for these results to be achieved, pre-placement training in cultural awareness and health system realities is critical. Strong supervisory support is required both in country and on return. The IES used in this study was appropriate to the development of the interview guide and provided relevant structure to exploring the phenomenon of interest.

Recommendations include further research into why the placement experiences of students varies between different country contexts and how placements can be tailored to maximize student and host country

experiences in various settings; and the strengthening of the teaching in Australian nursing curricula of how the political and health financing systems of countries have an impact on health practice.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (<http://www.icmje.org/recommendations/>)]:

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

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Appendix C: Participant Information Sheet



INFORMATION SHEET

PROJECT TITLE

The influence of international student placements on the cultural competence and subsequent career choices of Australian nursing students

You are invited to participate in this project.

Aim of Project

This study aims to explore the influence on cultural competence development in nursing students who participated in an undergraduate international student experience and to determine if there is an influence on career planning.

Significance

It is anticipated that the findings of this study will enhance understanding of the enduring influence of an international student experience on the career planning of nursing students, including their preparedness to work with culturally diverse people in developing countries or within Australia.

Approval

This study has been approved under Curtin University's process for lower-risk Studies (Approval Number SON&M 33-2012). This process complies with the National Statement on Ethical Conduct in Human Research (Chapter 5.1.7 and Chapters 5.1.18-5.1.21). For further information on this study contact the researchers named above or the Curtin University Human Research Ethics Committee c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.edu.au.

Procedures

If you agree to participate you will be required to provide information at two time points, twelve months apart. These include:

1. *Before the international placement:* Following one of information evenings held to

prepare for the placement, the project will be explained and you will be invited to participate in this study. If you agree, at the subsequent meeting you will be given a consent form and asked to provide your name and contact details. If you consent, you will then be given a questionnaire to complete in time allocated after the meeting. The questionnaire will take approximately 20 minutes to answer. Please do not place your name on the questionnaire. The researcher will collect the completed questionnaires and consent forms immediately upon completion and place them in individual sealable envelopes. Your contact details will be kept confidential by the researcher, and then used to contact you to arrange an interview at a time convenient to you in the two weeks before you leave. The interview will take about 30 minutes, will be audio recorded, and notes will be taken.

2. *After the international placement:* In the two weeks after you return from your placement a questionnaire will be sent to you via Survey Monkey. It will be the same questionnaire you completed before the placement. You will be asked to complete the questionnaire within one week. Your email address will be uniquely linked to your returned questionnaire, so your responses will not be anonymous. However, confidentiality is assured. A reminder email will be sent to you two weeks after the initial email if you have not responded.
3. *Twelve months after you return from your placement* you will be sent another online questionnaire via Survey Monkey. This questionnaire will be different to that at point one, and will take approximately 30 minutes. It will contain a section asking you about any travel you have undertaken since your international placement, a survey on cultural competence, and the International Education Survey which will ask you about the enduring influence of your international experience on personal and professional development. There will also be an open-ended question on your career plans. You will be asked to complete the online survey within one week. Your email address will be uniquely linked to your returned questionnaire, so your responses will not be anonymous. However, confidentiality is assured. A reminder email will be sent to you at one week, two weeks and four weeks after the initial email if you have not responded. You will also be contacted by the researcher to arrange an interview at a time and place convenient to you. The interview will take approximately 30 minutes, will be audio recorded, and notes will be taken.

Between point one and point two the researcher will maintain contact with you via email, Facebook private messaging and telephone for the sole purpose of maintaining an up-to-date

contact list of participants. Email and Facebook contact will be restricted to one line requesting confirmation that you still have the same email address and telephone contact details. If no response is received electronically, telephone contact will be made.

Confidentiality

All the information collected will be treated in strict confidence. The audio recordings will be transcribed verbatim and entered into a software program for analysis. Names will be deleted from the transcriptions. It will not be possible to identify you from the transcript or in any future analysis of the data. Access to the stored transcripts and associated analysis will be restricted by a password known only by the researcher. All audio recordings will be deleted following transcription. Questionnaires will be stored safely in a locked cupboard in an area allocated to the researcher at Curtin University. A participant identification number will be allocated to your consent form, questionnaires and interview transcriptions. A coding sheet containing participant numbers and contact details will be developed, and will be kept with the consent forms, in a secure location at the School of Nursing and Midwifery at Curtin University, separately from your questionnaires and interview transcriptions to maintain confidentiality.

Online questionnaires will be returned via Survey Monkey. Your email address will be uniquely linked with your submitted questionnaire, and as such will not be anonymous. However, when the data is converted to SPSS software the questionnaire will be allocated the same participant identification number from phase one; *no names will be used*. At that point questionnaires will be deleted from Survey Monkey. Access to the electronic data will be restricted by a password known only by the researcher.

All data will be stored with the researcher at the School of Nursing and Midwifery at Curtin University for five years following any publications, according to NHMRC guidelines. After this time, all electronic data will be deleted, and any printed material will be disposed of via the confidential waste service available in the School of Nursing and Midwifery at Curtin University. The results of the project will be reported, but it will not be possible to identify individual participants or institutions.

Request for Further Information

You are encouraged to raise any issues or questions regarding this project with the researcher at any time. You should feel confident and secure about your involvement in the study.

Should you have any questions regarding the study, please contact Shelley Gower, on +61 8 9266 2362 or shelley.gower@curtin.edu.au

Refusal or Withdrawal

Participation in this project is entirely voluntary. You may refuse to participate and can withdraw from the project at any time without any impact on your position or student status.

Risks and Benefits

There are no direct benefits to you if you participate in this project. However, you will be contributing to the body of knowledge around the influence of international student experiences. There are no foreseeable risks for participants. If you feel uncomfortable at any stage you are free to withdraw without penalty.

Thank you for considering participation in this study. Please do not hesitate to contact me if you have any questions or concerns about this research project.

Kind regards

Shelley Gower

PhD Researcher

Appendix D: Participant Consent Form



CONSENT FORM

Thank you for agreeing to participate in this study. Your signature verifies that you have decided to participate in the project, having read and understood all the information provided. Your signature also officially confirms that you have had adequate opportunity to discuss this project with the researcher and all your questions have been answered to your satisfaction. You will be given a copy of this consent form to keep.

I, _____

Please PRINT

of

_____ (Address)

s)

Postcode _____

Phone _____

Mobile _____

Email

address _____

I am on Facebook and give permission for the researcher to contact me via private message to confirm contact details.

I freely give my consent to participate in this project: I am over 18 years of age.

I understand and accept the nature of the study which has been explained to my satisfaction by the researcher and give my permission for any results from this project to be used in research publications and conferences, on the understanding that confidentiality will be maintained. If I have further questions I may contact Shelley Gower on (08) 9266 2362 or shelley.gower@curtin.edu.au.

I have been given and read a copy of the Information Sheet and Consent Form.

I understand that I may withdraw from the study at any time without impact on my student status.

I understand that all the information given will be treated in strict confidence with numerical coding, be password protected, and kept in a secure cabinet by the researcher.

I understand that on completion of the project, all data will be stored in a secure and confidential location with the researcher for five years. After this time, all data will be destroyed.

Participant's Signature _____ *Date* _____

Researcher's Name _____

Researcher's Signature _____ *Date* _____

Appendix E: Interview Guide – Time Point 1

Individual semi-structured interview guide – Time point 1

1. What are your current career plans?

Prompts:

- a) Which specialisation of nursing interests you most?*
- b) Do you have any preference for metropolitan versus rural nursing?*
- c) Do you have an interest in working in remote Australia?*
- d) Working with diverse cultures*
- e) Work in community health*
- f) Work in the public or private sector*
- g) Work in primary health care*
- h) Educating other health professionals about culturally competent care*

2. Is there an international dimension to your career plans?

Prompts:

- a) Do you have an interest in working in a developing country? Another developed country?*

3. How do you think the experience will impact on you professionally, in terms of career planning?

4. Why did you decide to take part in this study tour?

5. What expectations do you have of the study tour?

Prompts:

- a) learn nursing skills specific to resource-poor environments?*
- b) learn about other health care systems?*
- c) Gather skills or knowledge to help with your future career plans working overseas?*

6. How would you explain the term cultural competence?

7. Have you done any preparation for this tour? If so what?

Prompt: a) reading, internet searching

b) speaking to people who have been before

c) formal preparation through the university? Completion of a specific unit? Attendance at information evenings?

8. How culturally prepared do you feel to take part in this learning experience?

9. How do you think the experience will influence you personally?

Appendix F: Interview Guide – Time Point 3

Individual semi-structured interview guide – Time point 3

1. How do you feel about what you saw on your international placement?
2. How has your international placement experience influenced plans for your career and/or further education?
3. How has this experience affected your interest in working as a nurse overseas?

*Prompts: Would you be willing/keen/interested to undertake such work in future?
In the country where you did your placement; or in a different country?*

4. How has the international experience influenced your interest in indigenous health?

Prompt: Would you be keen/willing/interested to undertake work in this area in the future?

5. How has your international experience impacted on your professional practice?

Prompts:

- a) interest in providing care for culturally diverse patients (Cultural Desire)*
- b) interactions with patients from culturally diverse backgrounds (Cultural Encounters, Cultural Skill)*
- c) confidence in your ability to ask appropriate questions to ascertain patients' health-related beliefs and preferences (Cultural Skill, Cultural Knowledge)*
- d) awareness of impact of your nursing care on patients (Cultural Awareness)*
- e) if you could choose your own professional development activities, what would you choose? (behavioural)*

6. How has your participation in the international clinical program impacted on your understanding of cultural competence? Please provide an example if possible.

Prompts:

- a) how has it influenced your interest in engaging or volunteering with people from*

diverse cultures? (Cultural Desire, Cultural Encounters)

b) what do you plan to do to engage with culturally diverse groups? (Cultural Skill)

c) Have you provided presentations or educated others about your experience?

(Cultural knowledge)

7. How has your international experience influenced you personally? (Cultural Awareness)

Prompts:

a) self confidence,

b) self awareness,

c) communication skills,

d) beliefs and values,

e) international perspective (How do you view the world now? How does it make you feel?)

Appendix G: Ethics Approval Including Extension



Memorandum

To	Professor Rene Michael, Ms Shelley Gower, Professor Duncan Boldy, Dr Pam Roberts
From	Professor Dianne Wynaden
Subject	Protocol Approval SON&M33-2012
Date	28 September 2012
Copy	

Office of Research and Development
Human Research Ethics Committee
Telephone 9266 2784
Facsimile 9266 3793
Email hrec@curtin.edu.au

Thank you for your "Form C Application for Approval of Research with Low Risk (Ethical Requirements)" for the project titled "*The influence of international student experiences on the cultural competence and career choices of newly graduated nursing students*". On behalf of the Human Research Ethics Committee, I am authorised to inform you that the project is approved.

Approval of this project is for a period of twelve months 28th September 2012 to 28th September 2013.

The approval number for your project is **SON&M 33-2012**. Please quote this number in any future correspondence. If at any time during the twelve months changes/amendments occur, or if a serious or unexpected adverse event occurs, please advise me immediately.



Professor Dianne Wynaden
Minimal Risk Coordinator/ Ethics Advisor
School of Nursing and Midwifery

Please Note: The following standard statement must be included in the information sheet to participants:
This study has been approved under Curtin University's process for lower-risk Studies (Approval Number SON&M 33-2012). This process complies with the National Statement on Ethical Conduct in Human Research (Chapter 5.1.7 and Chapters 5.1.18-5.1.21).
For further information on this study contact the researchers named above or the Curtin University Human Research Ethics Committee c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.edu.au.

Memorandum

To	Professor Rene Michael, Ms Shelley Gower, Professor Duncan Boldy, Dr Pam Roberts
From	Professor Dianne Wynaden
Subject	Protocol Approval SONM33-2012
Date	2 October 2013
Copy	

Office of Research and Development
Human Research Ethics Committee
Telephone 9266 2784
Facsimile 9266 3798
Email hrec@curtin.edu.au

Thank you for your "Form C Application for Approval of Research with Low Risk (Ethical Requirements)" for the project titled: "*The influence of international student experiences on the cultural competence and career choices of newly graduated nursing students*". On behalf of the Human Research Ethics Committee, I am authorised to inform you that the project is approved.

Approval of this project is for a period of 3 years from the 28th September 2013 to 28th September 2016.

Your approval has the following conditions:

- (i) Annual progress reports on the project must be submitted to the Ethics Office.
- (ii) **It is your responsibility, as the researcher, to meet the conditions outlined above and to retain the necessary records demonstrating that these have been completed.**

The approval number for your project is **SONM33-2012**. Please quote this number in any future correspondence. If at any time during the approval term changes/amendments occur, or if a serious or unexpected adverse event occurs, please advise me immediately.



Professor Dianne Wynaden
Minimal Risk Coordinator/ Ethics Advisor
School of Nursing and Midwifery

Please Note: The following standard statement must be included in the information sheet to participants:
This study has been approved under Curtin University's process for lower-risk Studies (Approval Number SONM34-2012). This process complies with the National Statement on Ethical Conduct in Human Research (Chapter 5.1.7 and Chapters 5.1.18-5.1.21).
For further information on this study contact the researchers named above or the Curtin University Human Research Ethics Committee c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth 6845 or by telephoning 9266 9223 or by emailing hrec@curtin.edu.au.

Appendix H: Culturally Responsive Clinical Practice: Working with People from Migrant and Refugee Backgrounds - Competency Standards Framework for Clinicians

The link below will provide access to the Culturally Responsive Clinical Practice: Working with People from Migrant and Refugee Backgrounds - Competency Standards Framework For Clinicians (2019) compiled by Migrant and Refugee Women's Health Partnership.

<https://www.culturaldiversityhealth.org.au/wp-content/uploads/2019/02/Culturally-responsive-clinical-practice-Working-with-people-from-migrant-and-refugee-backgrounds-Jan2019.pdf>

Appendix I: Permission Statements from Publishing Journals.

Journal of Nursing Education



March 16, 2020

Shelley Gower
Curtin University

Reference #: J23526037

Material Requested: Full-text.

Usage Requested: Print and electronic permission to include the following *Journal of Nursing Education* article in the appendices section of a PhD thesis. After examination, the PhD thesis will be in the electronic repository at Curtin University Library and will be accessible to students and staff at the university.

Citation: Gower S., Duggan R., Dantas J., Boldy D.(2016). Motivations and Expectations of Undergraduate Nursing Students Undertaking International Clinical Placements. *J Nurs Educ.* 55(9) 487-494. doi: 10.3928/01484834-20160816-02

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Date: 1/4/2020.

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Journal of Advanced Nursing

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Mar 05, 2020

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